## Components and Characteristics of the Oral Health Environment–FSM/Pohnpei State (2019)

| Components of Oral Health Environment | Strengths | Weaknesses/Challenges/Gaps | Opportunities |
|---|---|---|---|
| **Oral health needs/demands& how measured**<br>Example: DMFT, Basic Screening Survey; waiting lists for non-urgent care, including citing some available data, e.g., XX# of DMFT for 8-9 year olds. | **DMFT:** In 2018, among 3rd grade children, average dmft was 4.2 and DMFT was 2.1.<br><br>**DMFT/dmft/BSS:** Currently collecting these data on ECE, 1st, 2nd, 3rd, and 4th grades; will continue in 2019-20 school year. | **Serious oral health problems**: high caries prevalence among children (including early childhood caries), high prevalence of oral cancer (related to betel nut use), diabetes, cardiovascular disease, tobacco and alcohol use, and poor diets.<br><br>**Referral slips for urgent care**: Sent to parents but most do not bring them in for needed treatment.<br><br>**Adults:** There isn't the capacity to conduct population-based oral health surveys among adults to determine oral health status. Also, there isn't the capacity to provide comprehensive antenatal dental care to women. | **Moving forward:**<br>Need to adopt a standard population based oral health survey system for all age groups to determine oral health status of population.<br><br>Exploring use of the data collected on children to make a more compelling case for more dental providers, and for other non-dental providers, e.g., nurses, to deliver preventive care to children, such as fluoride varnish and silver diamine fluoride. |
| **Delivery sites& programs**<br>**>Portable**(e.g. in schools, community centers, libraries, etc.)<br>**>CHC**<br>**>Hospital** | **CHC**: Collaboration with Dental Program, e.g., sharing EDDA to ease the workforce shortfall; ongoing services provided at CHCs and dispensaries.<br><br>**School Dental Program:** Ongoing and use portable dental units. | | **Moving forward:**<br>Need to collect and report the services delivered, e.g., type of service, age, gender, etc.). Together with the current waiting lists for care, could document the overall effective demand for care. |

| | | | |
|---|---|---|---|
| **Funding for Oral Health Program and Services, including impact of Compact status (if appropriate):**<br>➢ General/local funding<br>➢ Medicaid and other health insurance<br>➢ Patient fees & copays, by age-group, e.g., free for young children, co-pay for prostheses<br>➢ Other sources of programfunding or income, e.g., grants | **Compact Funding:** Covers all dental operations and staffing<br><br>**Patient Fees:** All patients pay for services rendered to them at the dental clinic. CHC has a sliding fee schedule. Dental fees collected within the hospital go into the general fund.<br><br>**MiCare:** This is FSM's health insurance that all National and State government employees are encouraged to enroll in. In turn, MiCare sends quarterly payments (capitation) for all services provided to enrolled individuals, including dental services.<br><br>**MCH Program**: Provides some funding for dental supplies<br><br>**NGO:** Missions Across His Islands (MAHI) International is a non-governmental organization which has assisted Pohnpei State Government for several years and targets health, education and public safety. MAHI has provided support to the Dental Program, e.g., mobile dental clinic, dental equipment, supplies and volunteer dentists. | **Local funding:** Current funding from Compact resources and Federal programs is insufficient to support needed oral health services. | **Moving forward:** Need to adopt a standard oral health survey method and reporting system across the FSM. This is especially important since most FSM state dental program funding is based on reported data and resultant justification. |
| **Workforce, including types of staffing (ages/soon to** | **Current staffing**<br>**Pohnpei State Hospital:**<br>• 2 local dentists and 2 expatriate | **STILL LACKING ADEQUATE WORKFORCE** | **Moving Forward:**<br>Explore ways to conduct Preventive Dental trainings |

| | | | |
|---|---|---|---|
| **retire, vacancies, etc.), onsite training and those in pipeline (e.g., at FNU)** | • 1 Local & retired dental nurse<br>• 6 Expanded Duty Dental Assistants (EDDA)<br>• 4 dental assistants<br>• 1 administrative assistant<br>• 2 dental lab technicians<br>• 2 dental lab assistants<br><br>**HRSA CHC:** 1 EDDA<br><br>**Department of Education**: 1 Dental Nurse | **Pipeline:** No students currently in training programs<br><br>**Current dental budget:** No funding to support more trainees abroad<br><br>**Vacancies:** 1 vacant Dentist position and 4 vacant Dental Nurse positions | and/or follow-up trainings for non-dental health staff (e.g., Health Assistants, Public Health Nurses, Pediatricians, Pediatric Nurses and CHW's)<br><br>Explore how HRSA Oral Health Workforce grant project, Pacific Oral-health Education and Training (POET) Program at the College of Micronesia, can assist in enhancing the Pohnpei State Dental Program. |
| **Policy-mandate**<br>➢ HRSA:CHC dental component, MCH-NPM13; local school oral health mandate for children<br>➢ Oral health care guidelines and protocols, e.g., for pregnant women, for diabetic patients, etc. | **MCH Title V NPM13:** This is especially important because NPM 13 was chosen and the upcoming five-year needs assessment will include oral health. The findings from this will form a component of the five-year MCH Title V plan (FY2021-2025). Activities include: providing fluoride varnish, dental sealants, oral prophylaxes, oral hygiene kits and health education to MCH clients.<br><br>**Betel Nut and Tobacco Policies**: These laws have been in place since 2017 for all FSM states. However, although health education and promotion efforts are ongoing, enforcement and penalties by Public | **Betel Nut and Tobacco Policies:** Enforcement of the current betel nut and tobacco laws is weak.<br><br>**Lack of a National Dental Director:** Currently, although there are a national FSM Medical Director and national FSM NCD Director, there is no national FSM Dental Director. | **Moving Forward:**<br>Need to strategically and effectively advocate for the appointment of an FSM National Dental Director. |

| | | | |
|---|---|---|---|
| | Safety are not widely administered. | | |
| **Partnerships-collaborations with other disciplines e.g., WIC, NCD, Early Education/Head Start, including:** kind of collaboration, e.g., informal, MOU, co-funding (oral health receives some fundingfrom other programs or co-located services, like dental hygienist placed in prenatal clinic) | **MOU:** There is an MOU between the Ministries of Health and Education<br><br>**NCD:** Co-location of EDDA to provide services within diabetes clinic<br><br>**Collaborations/Working Partnerships**<br>• Early Childhood Education and Elementary Schools<br>• Maternal and Child Health (NPM13) and within Immunization Program<br><br>**Dispensary Strengthening Program:** This has been supported with WHO funding and will start its 2nd Phase. The intent is to have the Primary Health Care Programs, including dental, extend screening services into community settings vs. waiting for residents to come to dispensaries seeking care. This was part of NCD State of Emergency and intended to enhance access to and availability of health care. | **Coordination and collaborations**: These need to be strengthened amongst health programs, e.g., establish formal and enhanced partnerships and coordination and integration like joint program planning. | **Collaborations with other health programs:** Need to explore ways to enhance collaborations with other "sister" health programs |