

**Strategic Prevention Framework - State Incentive Grant
(SPF-SIG) 2009 - 2014**

Federated States of Micronesia

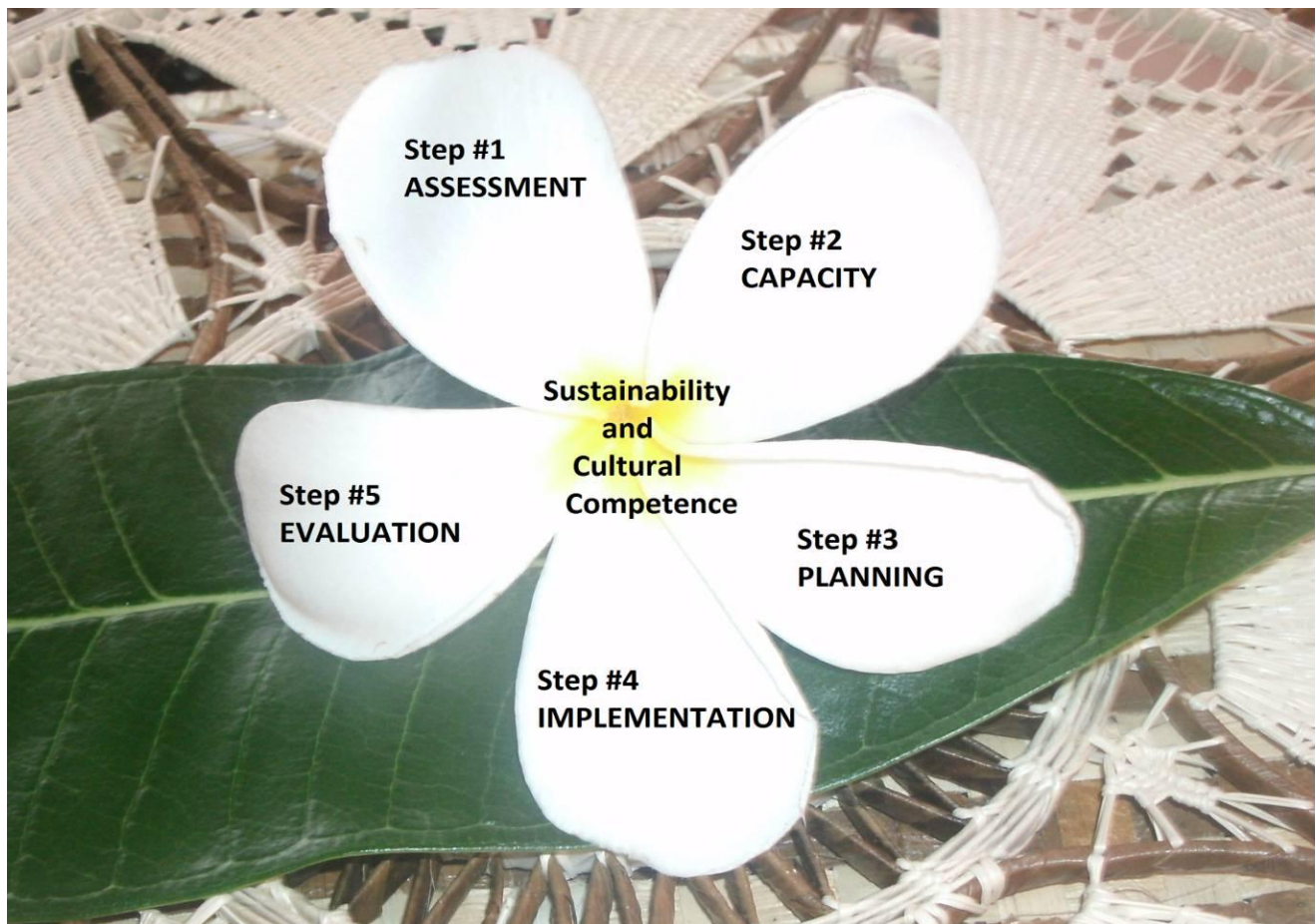
Kosrae

Pohnpei

Chuuk

Yap

SUBSTANCE ABUSE PREVENTION PLAN



**THE SPF 5 STEP PROCESS,
IN THE EYES OF THE PEOPLE OF THE FEDERATED STATES OF
MICRONESIA,
WITH THE ANTICIPATION OF SUSTAINABILITY, AS DEVELOPED WITH
CULTURAL COMPETENCE FOR IMPROVEMENT**

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SPF SIG Micronesia Executive Summary

In November of 2008, the freely associated states of the Federated States of Micronesia (FSM), under the leadership of President Mori and the Department of Health and Social Affairs, submitted a proposal to the US Department of Health and Human Services and was awarded a five year Strategic Prevention Framework State Incentive Grant (SPF-SIG) beginning from 2009 to 2014. This grant envisions the use of SAMSHA's Center for Substance Abuse Prevention, Strategic Prevention Framework approach to:

- Reduce the onset and/or progression of substance abuse including childhood and underage drinking.
- Reduce substance abuse-related problems and
- Build capacity and infrastructure for data-driven substance abuse prevention at the national and state levels.

The intent of this SPF-SIG Micronesia is to create a sustainable infrastructure with institutionalized policies and practices to prevent and/or reverse the current trend toward unhealthy risk-taking behaviors, especially with the two selected priority areas of: 1) Underage Drinking and Driving (past year) and 2) Underage Current Drinking (past 30 days). The identified sub-recipients of the SPF funding will use the Strategic Prevention Framework to identify and implement evidence-based prevention strategies and program models that target the strategic priority areas, individuals, groups, and environmental change that are based on each states risk factors and that are specifically adapted to each local distinct culture and linguistic groups in all four FSM states of Yap, Chuuk, Pohnpei and Kosrae.

SPF SIG Micronesia is led by the FSM National Government Department of Health and Social Affairs; the four State Government Departments of Health Services; the SPF Advisory Council and EBI sub-committee workgroup; the SEOW; the State SAMH Advisory Councils and SPF Project staff and is pleased to submit this SPF SIG Micronesia Prevention Plan. As shown and described on the cover page, the FSM SPF 5 Step Process is presented with the plumeria flower showing the anticipated sustainability and commitment to the implementation and evaluation of the evidence based strategies of the project in all four states. This plan also sets the stage for sustainable data collection and tracking in the FSM and will coordinate and emphasize collaborative efforts between and among the states to improve substance prevention services by building a prevention system with a formal mechanism for national/state level coordination and documented data-informed decision making on substance abuse policy and practice.



****participants of the October 25th to 29th 2010 Strategic Prevention Plan meeting/workshop in Pohnpei, FSM****

ACKNOWLEDGEMENT

In the FSM, a flower or lei, when presented to another, is a symbol of love and anticipated sustainability in a given relationship or circumstance.....

As the Secretary of the Department of Health and Social Affairs and SPF SIG Project Director, I would like to extend a special thank you,

- *Kulo Malalap (thank you in Kosraen)*
- *Kalahngan (thank you in Pohnpeian)*
- *Kilisou Chapur (thank you in Chuukese) and*
- *Komagar (thank you in Yapese)*

to the following FSM SPF-SIG Advisory Council members; SEOW members; and the SPF-SIG staff at the National and State Offices for all the hard work placed into the development of this 5 Year Strategic Prevention Plan. I would also like to extend our sincere appreciation to the following SPF-SIG Partners for their eager sustainable support and collaborative assistance. We strongly believe that with the continued collaboration of the following individuals, and agencies, the success of the implementation of this FSM Strategic Prevention Plan / SPF-SIG 5 Step Process will be achieved.

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2. CAPT West RT
3. College of Micronesia, FSM

4. State Departments of Public Safety
5. State Departments of Health Services
6. State Departments of Education
7. FSM Office of Customs
8. FSM SBOC Office (Statistics Office)
9. FSM and State SAMH

BACKGROUND INFORMATION

- **Federated States of Micronesia**

The Federated States of Micronesia (FSM) is a young independent nation comprised of a loose federation of four states---Chuuk, Kosrae, Pohnpei and Yap. FSM was a United Nations Trust Territory of the Pacific Islands (TTPI) administered by the United States of America, until the two nations signed a Compact of Free Association in 1986, leading to the termination of the trusteeship by the United Nations in 1991.

Although it has a declared Exclusive Economic Zone of over 1 million square miles (1.6 million sq. km.), the total land mass is only 438 square miles (702 sq. km.) divided among 607 islands. This is an extremely important fact, because the distance and population dispersion across so many islands present a formidable challenge to data collection and to the provision of prevention and treatment services. Travel, to many of the outer islands is infrequent and erratic, and the telecommunications network is not yet extensively developed to ensure total coverage of the population.

The four states are geographically, politically, culturally and linguistically distinct. The *State of Chuuk* consists of approximately 290 islands in three distinct groupings---the administrative center of the State located on the island of Weno, a group of islands within the Chuuk lagoon, and a third set of islands in a series of 14 outlying atolls. Because of the vast expanse of water between islands, travel within Chuuk is difficult. Access to the outer islands by boat can take up to 2 days. Commuting to the outer islands is also available by small plane. There are 2 small airstrips on Te, the Southeast outer island group and on Onun, the Northwest outer island groups. The *State of Kosrae* is the only state consisting of a single island. There are 5 coastal community clusters at the island's periphery; all except one are connected by paved roads. The one without a paved road is accessible by boat. The *State of Pohnpei* is made up of the island of Pohnpei - the largest island in the FSM, a few lagoon islands and eight smaller outer islands with a total landmass of about 262 square miles. Commuting to the outer islands is also available by small plane. There are 3 small airstrips on three of the closer outer island groups. Two of the farthest away islands of Nukuoro and Kapingamarangi do not have airstrips and are accessed by ship. The *State of Yap* is the westernmost part of FSM. Yap proper has four community clusters, connected by roads, waterways and channels. In addition, Yap has 78 outer islands, 22 of which are inhabited, stretching nearly 600 miles east of Yap proper. Because of the vast expanse of water between islands, travel within Yap is difficult. Commuting to the outer islands is also available by small plane and there are 3 small airstrips on three of the eastern outer island groups of Ulithi, Fais and the furthest one being Woleai, located in the central region of the Yap outer islands.

On the main islands of the States of Pohnpei, Chuuk and Yap, paved roads are making transport easier. However, the outer islands can mainly be reached by cargo ship, with visits to each of the inhabited

outer islands for the delivery of supplies and visits by health personnel as scheduled but depending on the availability of fuel and/or engine problems.

The total of number of telephone subscribers was 11,687 in 2005, increasing from 9,981 in 2001. About 65% (7,551) of the telephone subscribers were residential lines, 12% government subscribers and the remaining 23% business subscribers. The number of subscribers to fax and the Internet also increased from 499 to 590 in the above period. The number of Internet subscribers increased significantly from 1,115 in 2001 to 1,709 in 2005 (2005 FSM Statistical Bulletin).

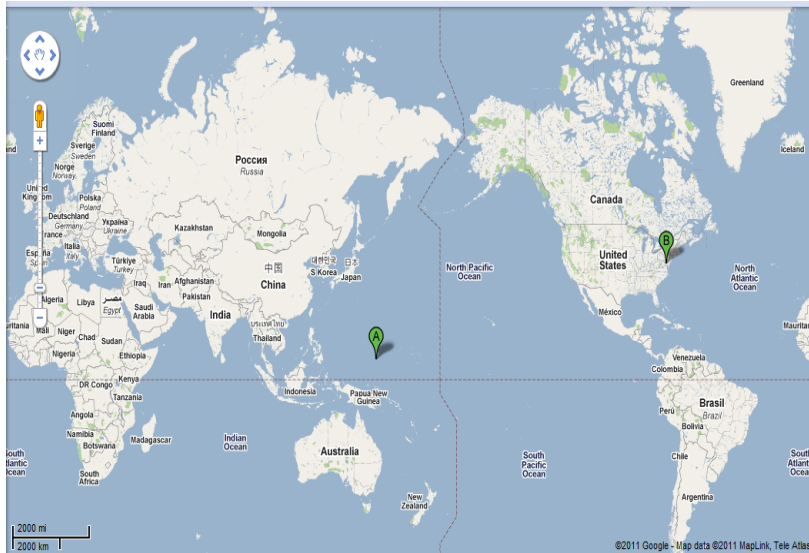
The islands are interconnected by shortwave radiotelephone (used mostly for government purposes), satellite (Intelsat) ground stations, and some coaxial and fiber-optic cable; cellular service is available on Kosrae, Pohnpei, and Yap. Unfortunately, frequent power outages have made communications through the internet or by facsimile difficult. Also, no electricity exists in many of the outer islands. Communication to the outer islands by solar powered radios is a recent development to Yap and is in the process of being established in Chuuk (Department of Health and Social Affairs).

The FSM National Government has a minimum wage of \$2.35 per hour at an 80 hour bi-weekly work schedule and each of the four FSM states have their own minimum wage amount and bi-weekly work schedule. Pohnpei State Government is \$2.00 minimum hourly wage at a 80 hour bi-weekly work schedule, Yap State Government is \$1.60 minimum hourly wage at a 80 hour bi-weekly work schedule, Chuuk State Government is \$1.25 minimum hourly wage at a 80 hour bi-weekly work schedule and Kosrae State Government is \$1.42 minimum hourly wage at a 64 hour bi-weekly work schedule.

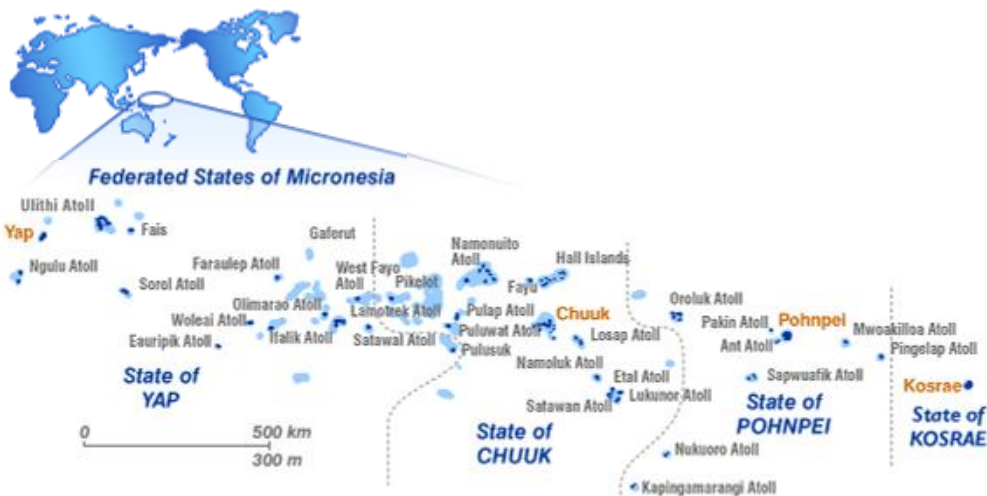
FSM has a constitutional government in free association with the United States. The president is both the chief of state and head of government. The Cabinet includes the vice president and the heads of the eight executive departments. The president and vice president are elected by Congress from among four senators at large for a four-year term (eligible for a second term). The latest election was held on May 2011; the next election is slated for May 2015. The legislative branch is comprised of a unicameral Congress with 14 seats; 4 senators serve four-year terms, with one elected from each state. The remaining 10 senators are elected from single-member districts delineated by population to serve two-year terms. Members of Congress are elected by popular vote. Elections for four-year term seats were last held March 2011 (next to be held March 2015); elections for two-year term seats were last held March 2011 (next to be held March 2013).

The judicial system is made up of the FSM Supreme Court and four state courts. The National Constitution is the basis for all legal authority and decision-making. The legislative and institutional framework of FSM includes both National and individual State constitutions, with each of the four States functioning as semi-autonomous governments (Mace, 1999).

FSM participates in various organizations of the United Nations, and is a member of the G-77 and the Secretariat of the Pacific Community (SPC). It is party to a number of international treaties relevant to the areas of interest of the SEOW, including the Single Convention on Narcotic Drugs (accession: 29 April, 1992), the WHO Framework Convention on Tobacco Control (ratification: 28 June 2004), and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (accession: 04 October 2004).



Map of the world showing the distance between the FSM (A) and Washington DC, USA (B) of which is almost halfway around the world.



Map of the Federated States of Micronesia

Source: http://p.vtourist.com/518425-Map_of_Micronesia-Federated_States_of_Micronesia.gif

FSM has withstood the incursion of multiple cultures since the late 1800s from Spain, Germany, Japan, and then the United States that have led to social and economic changes. Recently, the FSM local market's increased reliance on a cash economy has required a greater number of citizens to earn cash to buy school books for children and basic services, such as transportation. These changes have resulted in a more nuclear and less extended family structures and new gender roles.

The 2000 FSM Census of Population and Housing published in December 2002, provides evidence of the differences and similarities across the FSM states that will impact the initiation of the *SPF SIG Micronesia* project.

- The clear majority (at least 85%) of people living in each FSM state identified as indigenous to that state;
- More than 90% of citizens of each state describe the state's native language as their most commonly used language and, while English is the official language, it is considered our second language and is used in schools and government. The percentage of people who speak English averages 57%, with a low of 40% on Chuuk and a high of 75% on Kosrae;
- A high percent (averaging 49%) of FSM citizens over 25 years of age do not have a high school diploma;
- The unemployment rates are high, ranging from 9% on Kosrae to almost 48% on Pohnpei.
- Concurrently, an average of 56.75% reported no income on the 2000 Census questionnaire;
- The job market for agriculture, forestry, fishing and quarrying has severely diminished with the following industries now employing the most workers: Public Administration; Education; and Wholesale/ Retail Trades.

The demographic information contained in Figure 1 (FSM Social and Economic Characteristics), documents the population total and majority ethnicity of each FSM state and provides a snapshot of each state's economic conditions.

Figure 1: FSM Social and Economic Characteristics

	Chuuk	Kosrae	Pohnpei	Yap	Total FSM
Population (% of total FSM population)	53,595 (50%)	7,686 (7%)	34,486 (32%)	11,241 (11%)	107,008 (100%)
Ethnicity	Chuukese/ Mortlockese: 95%	Kosraen: 94.2%	Pohnpeian: 76%	Yapese/Yap Outer Islands: 85.5%	100%
Median Annual Income (only for those reporting income)	\$785/ individual \$2,793/family	\$3,446/ individual \$7,565/family	\$3,319/ individual \$6,379/family	\$3,368/ individual \$6,489/family	\$1,489/ Individual \$4,640/family
Unemployment rate	34%	9.3%	47.9%	27.6%	22%
Percent reporting no income	68%	52%	53%	54%	56.8%
Percent in purely subsistence work	42.8%	5.7%	25%	37.2%	28.4%
Percent over 25 years old without high school diploma	54%	53%	57%	35.8%	63.4%
Median Age	18.5 years old	19 years old	18.9 years old	20.9 years old	18.9 years old
Percent under 21 years old	56%	54%	55%	51%	55%
Average Persons per Family	7.8 persons	7.2 persons	6.3 persons	5.7 persons	7.0 persons

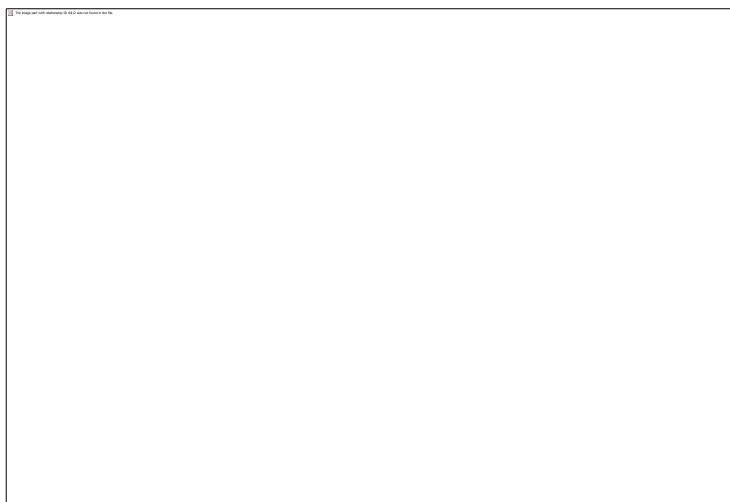
Source: FSM Census 2000

- **SPF-SIG MICRONESIA**

In November of 2008, the President of the FSM, His Excellency Manny Mori, and the Department of Health and Social Affairs submitted a proposal to the US Department of Health and Human Services and was granted \$6,383,030 for five years, beginning from 2009 to 2014 and has a budget cycle from July to June of each year. Funding for SPF SIG will be provided to the FSM National Government and will then be provided to the state governments and NGO's and/or Government Programs to implement the SPF activities. The SPF SIG Project is housed within the SAMHSA unit of the department's organizational chart and is subject to existing protocol of the department. It is also a supplement to the existing SAMH prevention program.

The intent of this SPF-SIG Micronesia is to create a sustainable infrastructure with institutionalized policies and practices to prevent and/or reverse the current trend toward unhealthy risk-taking behaviors, especially substance abuse. The NGO's and/or Government Programs that will be identified as sub-recipients of the SPF funding will use the Strategic Prevention Framework to identify and implement evidence-based prevention strategies and program models that target the strategic priority areas, individuals, groups, and environmental change and that are specifically adapted to each local culture and linguistic group in all four FSM states of Yap, Chuuk, Pohnpei and Kosrae.

The completion of the *Strategic Prevention Framework (SPF)* process will effectively develop the infrastructure of the national government to fund the four states to deliver their state prevention programming and addressing state specific priority risk and protective factors. As a result, prevention knowledge and skills will have been threaded into each FSM state guided by the *SPF 5 Step Process*.



The strategic prevention framework is based on six principles. These six principles are as follows:

1. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent mental and behavioral disorders, support resilience and recovery and prevent relapse.
2. Prevention is prevention is prevention.
3. Common risk and protective factors exist for many substance abuse and mental health

problems. Good prevention focuses on these common risk factors that can be altered.

4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention services.
5. Systems of prevention services work better than service silos.
6. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts

The Strategic Prevention Framework (SPF) Five Step Process as shown in the picture above is described as follows:

The SPF process includes five steps:

STEP 1 – Assessment

- Formation of an Epidemiological Workgroup
- Collaboration with advisory groups (SPF SIG Advisory Council)
- Collection of epidemiological data
- Analysis of epidemiological data
- Development of problem statements
- Identification of potential geographic target areas and populations
- Assessment of readiness, external factors, and potential barriers to success
- Assessment of organizational, fiscal, and leadership capacity
- Assessment of cultural competence
- Analysis of service gaps

STEP 2 – Capacity

- Creation of sustainable partnerships
- Introduction of training and education to promote readiness, cultural competence, leadership, and data collection, monitoring, and evaluation capacity
- Meetings and workshops with key stakeholders, NGO's, and service providers

STEP 3 – Statewide Strategic Plan

- Planning meetings and strategy development sessions
- Strategic Goals, Objectives, and Performance Targets
- Logic Models
- Draft Strategic Plan
- Creation of State data collection, monitoring, and evaluation plan and identification of measures

STEP 4 – Implementation

- Select and implement of evidence-based policies, programs, and practices (guided by needs assessments findings and problem analysis of causal factors)
- Strategies must be evidence based-

- Federal Model Program List
- Peer reviewed journal with proven effectiveness
- Documented effectiveness

STEP 5 – Evaluation

- Consultation and collaboration with evaluation team
- Process evaluation
- Collection of required outcome data
- Outcome evaluation
- Review of policy, program, and practice effectiveness
- Development of recommendations for quality improvement

FSM SPF-SIG PREVENTION PLAN

This FSM SPF-SIG Prevention Plan generally contains identified substance consumption and consequence problems with two selected prevention priorities using the *Strategic Epidemiological Outcome Workgroup's (SEOW) or Epi Workgroup's 2009 Report*, entitled "*FSM Substance Abuse Epidemiological Profile*". Other data were provided by the State Departments of Health Services, State Public Safety, and other agencies from the FSM states to determine the prevailing rate and levels of each type of drug/substance use and abuses in the FSM. Included in this plan are several photos taken on the consequences of alcohol consumption in the FSM.

This plan also explains the process and criteria as addressed by the Epi Workgroup and finally agreed upon by the FSM SPF SIG Advisory Council in identifying the priority areas. The final Strategic Prevention Plan will eventually be a comprehensive plan that encompasses a nationwide planning model with approaches and outcomes for which the SPF-SIG Advisory Council and staff strongly feel would assure equitable distribution of resources and implementation of best-practices as well as innovative program design to assure effectiveness and efficiencies of services to the priority identified population (under the age of 21).

More than 50% of the total population is under 21 years of age and therefore, the two determined national priorities of *Underage Drinking and Driving (past year) and, Underage Current Drinking (past 30 days)* are two critical priorities for all of the Federated States of Micronesia supported by epidemiological data (see *needs assessment & priority setting sections of this plan on the description of how FSM arrived at these priorities*).

It is part of the formation process of this strategic prevention plan that it needs to be general enough to encompass and address the problems and needs of all the four different states in their own specific ways and circumstances. *Yap*, has tiny islands spread across a wide stretch of distance of which commuting to the outer islands is by small plane (3 small airstrips) or ship to all other groups of islands depending on availability of fuel and/or problems of the plane/ship in general. Communication between the islands is by CB radio. *Yap* also has two extremely distinct cultures and languages with a caste-system. *Chuuk* has one main language with very many distinct dialects. It also has a lot of islands in the Chuuk lagoon of

which commuting to the main island is by boat. The lagoon is still referred to as "Truk Lagoon" and is one of the largest enclosed lagoons in the world, circled by 140 mile long barrier reef, and covering an area of 832 square miles. There are also a lot of outer islands beyond the lagoon. Communication is also by CB Radio. *Pohnpei* has 6 island groups of which require commuting by ship/plane and with 3 airstrips while the two most remote islands of Nukuoro and Kapingamarangi lack airstrips and travel depends on field trip ship service. Further, availability of fuel and/or mechanical problems of the plane/ship in general limit frequency of outer island service. Communication is also by CB Radio. Each of the 6 island groups speaks a different language and on the main island we have two levels of the Pohnpeian language (one for the traditional high ranking people and elders and the other for everyday communication among peers). *Kosrae* unlike the other FSM states, only has one island and does not require commuting by ship and plane but will require boat rental to get to one village that does not have vehicle access. *Kosrae* is also noted to have a very effective Christian community Influence. Each state will also identify the risk factors specific to each FSM state and these risk factors will assist them with addressing the two priorities.

The national focus is based on coordination and collaborative efforts between and among the states. Prevention services will be improved by building a prevention system with a formal mechanism for national/state level coordination and data-informed decision making on substance abuse policy and practice.

As a result of the *SPF SIG Micronesia* project and plan:

- 1) Data collection activities will produce reliable and valid substance abuse data using a standardized surveillance system in describing the substance abuse problem, understanding the relevant risk and protective factors, prioritizing substance abuse related needs, and selecting prevention strategies.
- 2) Extensive training will result in a core group of highly skilled preventionists and increased individual, community, and national level capacity to plan for and deliver effective prevention interventions by contracting COM in assisting staff to get certified IC & RC.
- 3) Communication infrastructure will result in greater amounts of collaboration, shared resources, and shared learning in support of effective substance abuse prevention. Further, the local community college in collaboration with FSM and state level SAMHS will include training in the college public health programs to provide in country technical expertise to provide ongoing training and staff development following the grant project
- 4) The *SPF SIG Micronesia* will also build capacity, through paid staffing, extensive and well-coordinated technical assistance, and training for the selection, cultural adaptation, and implementation of a comprehensive array of evidence-based practices to reduce substance use and its associated consequences.

ASSESSMENT Step #1

1. Assessing Substance Use and Related Consequences

The FSM Epidemiological Profile resulted from the collaborative efforts of the various agencies and institutions that comprise the Federated States of Micronesia's (FSM) State Epidemiological Outcomes Workgroup (SEOW). The data contained in the FSM SEOW profile were contributed by the members of the SEOW at the FSM State and National levels. The SEOW members reviewed the SEOW's purpose and its relationship to the Strategic Prevention Framework and the National Outcome Measures. They also established a set of work procedures and developed a preliminary list of data sources and indicators.

The prevalence and character of substance use/abuse evidenced in the available reports indicates that FSM populations are at high risk for the negative physical, social, and economic consequences of substance abuse such as increased family and employment instability, crime, victimization, injury, chronic disease (including addiction), and premature death.

Despite the challenges from a lack of a consistent national surveillance system, available data provides an initial glimpse into some of the features of substance use and consequences in the Federated States of Micronesia.

PRIMARY AND SECONDARY DATA SOURCES:

The following data sources and references were used to compile data for the needs assessment in the FSM:

- FSM Epidemiological Profile: 2007-2009, Compiled & updated by FSM SEOW Group with survey data from STEPs, ATS, YRBS, and GYTS.
- Adult Tobacco Survey: 2004-2005, Kosrae & Pohnpei
- Cancer Statistics: 1999-2002, Chuuk, Kosrae, Pohnpei & Yap
- Dept. of Public Safety statistics: 2000-2004, Chuuk & FSM
- Global Youth Tobacco Survey 2nd Round: 2006-2007, FSM
- Health Behavior and Lifestyle of Pacific Youth survey: 2001, Pohnpei
- Micronesian Seminar Youth Study: 2001, FSM
- 2003 Youth Risk Behavior Survey (YRBS), Pohnpei
- 2002 World Health Organization (WHO) STEPs Pilot Survey, Pohnpei
- FSM SAMH Program Epi6 System, FSM
- FSM Office of Statistics, Budget, Overseas Development and Compact Management (SBOC), Division of Statistics. *Statistical Yearbook Federated States of Micronesia 2005*. FSM National Government, Palikir, Pohnpei, FSM, March 2006.
- FSM Department of Health, Education and Social Affairs, Non-communicable Disease Program. *It's Stepwise Approach to Non-communicable Disease Surveillance Federated States of Micronesia*. Electronic report, Pohnpei, FSM, 2002.
- FSM Substance Abuse and Mental Health Program, Web-based Minimum Dataset System (MDS), Aggregated data reports, Web-based system.

- Micronesian Seminar. *Alcohol and Drug Use in the Federated States of Micronesia: An Assessment of the Problem with Implications for Prevention and Treatment*. Report prepared under contract with the Center for Substance Abuse Treatment, Substance Abuse and Mental health Services Administration, Pohnpei, FSM, March 1997.
- Office of Health Statistics, Department of Health, Pohnpei State. "Leading causes of death, Pohnpei State, 1998-2002." Summary report, Pohnpei, 2006.

SUMMARY

The 2008 FSM Epi Profile indicates that 34.4% of students surveyed reported current alcohol use and 23.8 percent reported binge drinking. There is evidence of a low perception of risk among high school students with 50% reporting riding in a motor vehicle driven by someone who had been drinking and 16% reported having driven after drinking. Special occasions like graduations, parties and etc. lead the young people to consume alcohol and enjoy driving around with their friends.

The known related consequences of alcohol abuse are staggering: 45 percent of all suicides were occasioned by alcohol use; 50% of the causes of death were alcohol related in 2003. In 2005, alcohol related offenses accounted for at least 50% of law enforcement contacts in every FSM state. Additionally there have been increasing death rates from chronic liver cirrhosis. Five of the top ten causes of death in FSM in 2003 were alcohol related. In 2004, 14 (3.6%) of the 386 deaths in the entire FSM were due to chronic liver cirrhosis. This represents a crude death rate from liver cirrhosis of 13 per 100,000.00. Suicide consistently ranks in the top causes of mortality in FSM.

ALCOHOL CONSUMPTION DATA

New information on the extent of alcohol consumption within FSM comes from the 2008 FSM Statistical Yearbook. Overall, the value of total alcohol imports has stayed relatively unchanged. However, the value of beer and wine imports appear to be decreasing while the value of imported spirits is rising (Fig. 2). According to the 2005 FSM Statistical Yearbook, beer was among the top five imported food and beverage items, costing US\$2.976 million in 2004.

Figure 2: Imported Alcohol



Alcohol use patterns in the FSM indicate that there is a significant young population that binge drinks and that alcohol use is positively associated with crime, crashes and mortality. The major source of recent data on alcohol consumption in the FSM comes from the World Health Organization (WHO) STEPs survey and Youth Risk Behavioral Survey (YRBS) conducted in Pohnpei. It is obvious that these students were under the age of 21, and the communities consider them as “underage” or youths.

Overall, half of high school students have tried drinking alcohol, and about one in five first tried alcohol before the age of 13. About one-third have consumed alcohol in the past month. One in four has gone binge drinking within the past 30 days (Fig. 3). For both sexes, the probability of current alcohol intake is highest among the youngest age group. There is a substantial increase in the use and abuse/misuse in alcohol, tobacco and marijuana in youth and adults.

Figure 3: Alcohol use, High School students, Pohnpei 2003

	Total (%)	Male (%)	Female (%)	15 or under (%)	16-17 (%)	18 or older (%)
Lifetime alcohol use	50.5	72.1	31.1	42.3	50.3	57.4
Current alcohol use*	34.4	50.4	20.8	27.7	32.8	41.9
Age at first use before 13 years	18.3	25.2	11.0	22.1	15.5	18.6
Binge drinking**	23.8	34.7	14.1	17.5	22.6	30.4

Source: Youth Risk Behavior Survey. Pohnpei, HESA, 2003

*Current alcohol use = at least one drink of alcohol in the past 30 days

**Binge drinking = 5 or more drinks in a row, within a couple of hours, in the past 30 days

Figure 4: Current alcohol consumption within the past year among youth by State, 1997

Age range	Males %		Females %		Total %	
	10-14	15-19	10-14	15-19	10-14	15-19
FSM	2.6	32.4	0.8	5.5	1.8	19.0
Pohnpei	6.4	44.4	2.1	9.9	4.3	27.6
Kosrae	0	0	0	0	0	0
Chuuk	1.7	27.9	0	1.1	0.9	14.9
Yap	0	22.2	0	11.1	0	16.7

Source: Micronesian Seminar, 1997

TOBACCO CONSUMPTION DATA

There is no current national survey data on adult tobacco use, but information is available from the pilot survey of the WHO STEPs conducted in Pohnpei in 2002, Adult Tobacco Survey (ATS) in Pohnpei & Kosrae in 2004-2005, 2007 Global Youth Tobacco Survey (GYTS) and the 2003 YRBS. According to the STEPs survey, one in four adults in Pohnpei aged 25-64 smokes tobacco. Overall, adult males have double the smoking rate of adult females. They have longer overall exposures to tobacco smoke since an earlier age. However, among younger adults, female smokers are starting to smoke tobacco as young as males.

Figure 5: Tobacco by Percentage

Findings	Pohnpei	Kosrae
Ever-smokers (%)	43.4%	46.9%
Chew tobacco with betel nut (%)	42.1%	61.8%
Want to quit smoking (%)	n/a	77.0%
Support a tobacco tax increase (%)	33.2%	70.0%
Desire a quit line service (%)	49.6%	77.0%
Support a ban on chewing tobacco with betel nut in public transport	70.1%	n/a

Source: Kosrae & Pohnpei Adult Tobacco Survey: 2004-2005

Figure 6: Adult Smoking in the States & Other Pacific Jurisdictions

	Males	Females	Total
US Ave.*	20.2%	16.5%	18.3%
Kentucky*	26.3%	24.2%	25.2%
Guam*	33.3%	21.3%	27.4%
FSM**	42%	21%	31.6%
AMS**	49%	29.7%	39.4%
RMI**	38.8%	7.0%	23.4%
PALAU***	---	---	17%

Source: BRFSS 2008 Data
WHO STEPS Data

Figure 7: Youth Smoking in the FSM

	Ever smoked cigarettes, percent (CI)	Initiated smoking < age 10, percent (CI)	Current cigarette smoker, percent (CI)	Currently use other tobacco products, percent (CI)	Ever chewed betel nut, percent (CI)	Used tobacco with betel nut, percent (CI)
FSM	45.6 (41.4 - 49.8)	24.3 (21.0 - 28.0)	28.3 (23.9 - 33.2)	37.0 (32.2 - 42.1)	61.4 (56.4 - 66.4)	47.6 (44.0 - 51.2)
Male	56.2 (49.7 - 62.6)	26.3 (21.8 - 31.3)	36.9 (29.9 - 44.5)	41.8 (34.6 - 49.3)	67.0 (60.4 - 73.7)	52.6 (46.0 - 59.1)
Female	34.7 (29.9 - 39.7)	20.5 (14.9 - 27.5)	19.8 (15.9 - 24.5)	32.1 (27.3 - 37.4)	55.6 (49.9 - 61.3)	43.5 (40.1 - 47.0)

- 2 out of 5 boys and 1 out of 5 girls in FSM currently smokes.
- 1 in 4 smokers started before the age of 10 years.
- Over 60% of youth have chewed betel nut, and nearly half used tobacco with betel nut.

Youth Data Sources:

- GYTS (2007) – all 4 States
- YRBS Pilot (2003) – Pohnpei
- Healthy Behavior and Lifestyle of Pacific Youth Survey (2001) – Pohnpei
- SYNAR – all 4 States

OTHER DRUGS CONSUMPTION

While there is limited data regarding the use of other drugs (e.g. marijuana, cocaine, heroin, inhalants) there is evidence that these drugs are available and used, especially by adolescents and young adults. According to the 1997 Micronesian Seminar study, about 8% of individuals 15 years and older had smoked marijuana in the past 12 months. Males were much more likely to smoke marihuana than females in all the states. It is observed that smoking marijuana is increasing among the youths and adults. Other illicit drugs data is not available in the FSM.

The highest rate of marijuana use is among adults aged 20-44 years old and Youth Risk Behavior Survey (YRBS) data suggests that 25% have tried marijuana; One in 10 Pohnpeian high school students reported

inhalant, heroin and methamphetamine use on the 2003 YRBS (Fig 8).

Figure 8: Current percentage of Other Illicit Drugs among High School Students

Substance Used	Percentage
Current Marijuana users	14.6%
Current Inhalant users	10.3%
Current Cocaine users	5.5%
Lifetime Marijuana use	24%
Lifetime Inhalant use	15.4%
Age at first use <13 years	10.4

Source: 2003 YRBS

Substance Used	Male	Female
Weekly Marijuana use	10.9%	9.4%
Weekly glue sniffing	2.6%	2.2%

Source: Health Behavior and Lifestyle of Pacific Youth Survey (HBLPY) – Pohnpei 2001

The data was captured in the 2003 and 2001 surveys on the current use, weekly use and lifetime use on other illicit drugs among high school students in Pohnpei. The students initially started to use these drugs when they were less than 13 years up to more than 18 years old.

CONSEQUENCE DATA

A review of the causes of mortality in the FSM from 1993 to 2003 reveals that four out of the top 5 causes of death are alcohol and tobacco-related---diseases of the circulatory system, cancer, diseases of the respiratory system and endocrine diseases (chiefly diabetes). Altogether, these four tobacco-related diseases comprise 65.4% of all deaths in the FSM for the year 2003.

I. Mortality

Six out of the top 10 causes of mortality from 1998-2002 were tobacco related, accounting for 53.9% of all deaths (Figure 9).

Figure 9: Leading Causes of Death, 1998 - 2002

	Number	Percent of all deaths
Total deaths	741	100.0
Heart disease*	151	20.4
Stroke*	73	9.9
Cancer*	68	9.2
Chronic obstructive pulmonary disease (COPD)*	62	8.4
Sepsis	59	8.0
Pneumonia*	31	4.2
Accidents	31	4.2
Diabetes mellitus*	13	1.8
Cirrhosis	10	1.3
Suicide	10	1.3
All other deaths	233	31.4

**Causes of death -Tobacco related*

In 2004, 14 (3.6%) of the 386 deaths in the entire FSM were due to chronic liver cirrhosis. This represents a crude death rate from liver cirrhosis of 13 per 100,000.00. Suicide consistently ranks in the top causes of mortality in FSM.

Five of the top ten causes of mortality in FSM in 2003, comprising approximately 45% of all deaths, were alcohol-related (Fig. 10).

Figure 10: Leading causes of death, FSM, 2003

	Number	Percent of all deaths
Total deaths	427	100.0
Heart disease*	114	26.7
Endocrine (mostly Diabetes)	60	14.0
Cancer*	53	12.4
Respiratory Diseases (COPD)	52	12.2
Infectious and parasitic diseases	36	8.4
Genitourinary diseases	19	4.4
Digestive diseases*	17	3.9
Ill-defined syndromes	17	3.9
Suicide*	13	3.0
Perinatal causes	10	2.3
Accidental injuries*	9	2.1

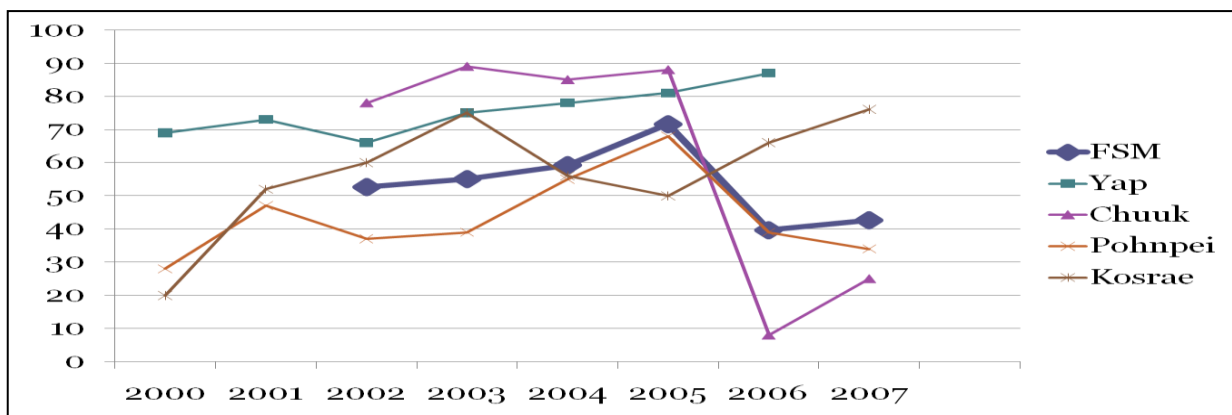
**Causes of death -Alcohol related*



II. Crimes & Offenses

Alcohol contributed to over half of all reported criminal offenses nationally. The proportion of alcohol-related offenses appears to be increasing over time for all States except Pohnpei from 2006 to 2007. In 2004-2005, 421 traffic accidents were reported in the entire federation of which 52% are alcohol related. Ninety six of these traffic accidents resulted in minor injuries and two resulted in fatalities. Eighty one (19%) involved youth aged 12-19.

Figure 11. Alcohol related offenses by Sate, 2000-2007

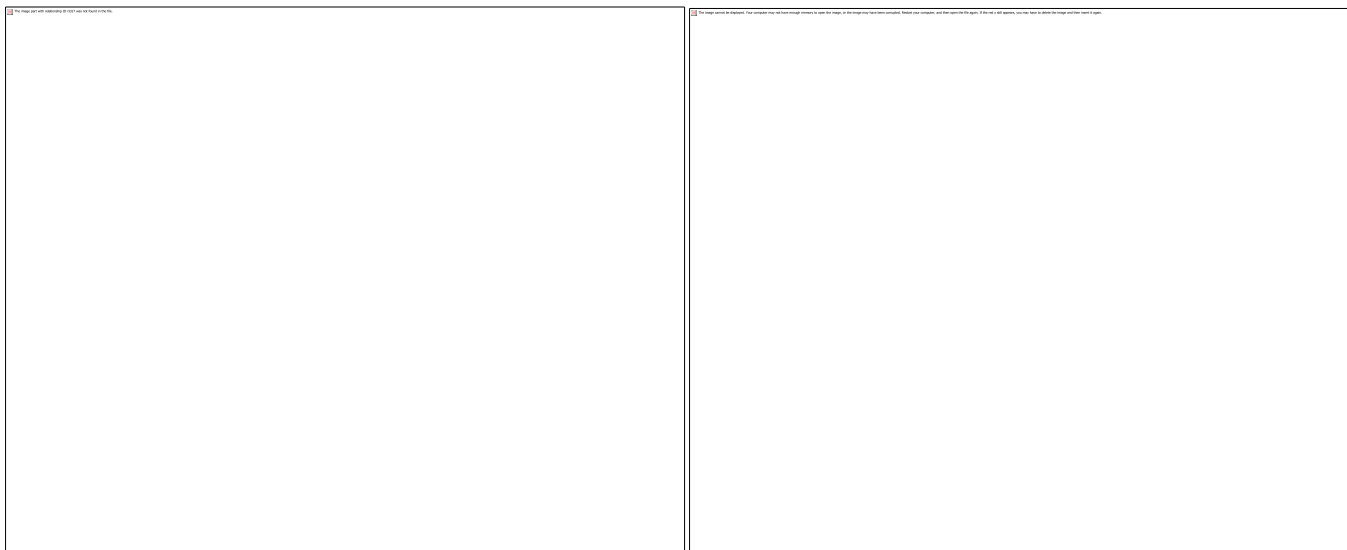


Source: 2008 FSM Statistical Yearbook, Dept. of Public Safety Data

III. Littering the Environment

Littering of empty alcohol bottles, cans and broken glass is a problem in the communities. It was also an issue needs to be considered and resolved by the prevention programs before it will reach a point that will jeopardize the lives of people in the communities. Due to the large amount of contributed empty alcohol bottles and cans in the ocean, the ecosystem, particularly essential fish breeding mangrove areas, are at risk. This signals a warning to the small islands in the FSM nation.

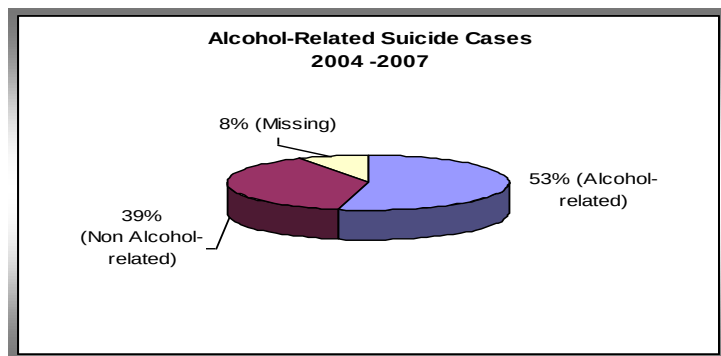
Figure 12: Environmental impact on the consequences of alcohol consumption



The known related consequences of alcohol abuse are staggering: 53 percent of all suicides in 2004 to 2007 were occasioned by alcohol use; 45% of the causes of completed suicide deaths were alcohol related. More than 60% of suicide cases in the FSM were users of tobacco, alcohol and other illicit drugs. Approximately three fourth of the completed suicides were substance abuse users.

There were incomplete data collected from State SAMH program staff on suicide cases in 2005 and also in the late 2007. Obviously, the expectation on alcohol-related suicide cases is still increasing in the four FSM States.

Figure 13: Suicide Data



Source: FSM SAMH Epi Data System

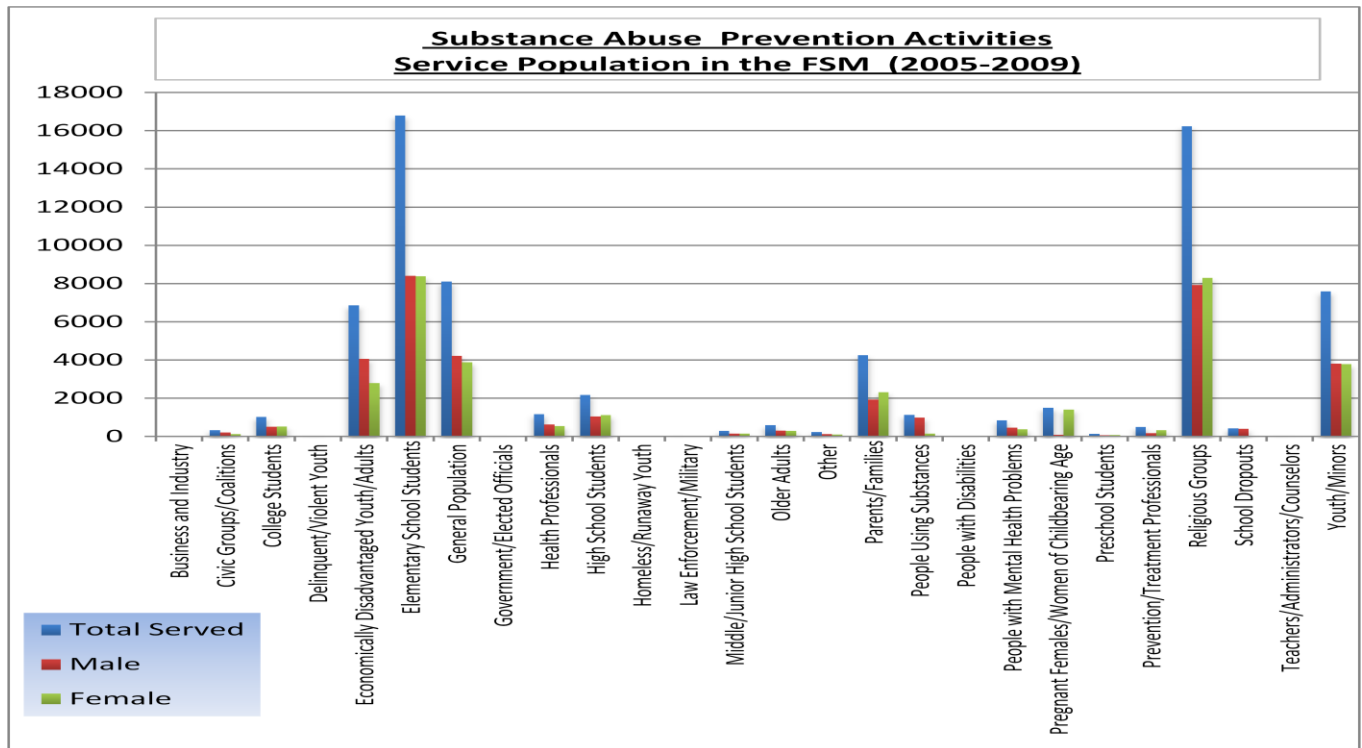
Figure 14: Completed and Attempted Suicides

Year	No. of Completed Suicide	No. of Attempted Suicide
2004	16	11
2005	5	0
2006	16	2
2007	10	2
Total	47	15

Source: FSM SAMH Epi Data System

DATA GAPS

The FSM SEOW completed a Data Gap Analysis Plan which concluded that FSM has no established surveillance system for drug and alcohol consumption indicators (*See Appendix A for the Data Gap Analysis Plan*). Separate surveys funded by various agencies have been conducted whenever funding has been available in the past, without an overall plan to guide and coordinate individual survey efforts. The Centers for Disease Control (CDC) Youth Risk Behavior Survey (YRBS) and the World Health Organization (WHO) STEPS adult surveys have been implemented in select FSM states to measure substance use issues among youth and adults. The 2003 YRBS survey data from Pohnpei will provide a baseline data point for the time series evaluation design, with data on 30-day substance use and age of first substance use, two of the required NOMs. In 2002, FSM participated in a pilot implementation of the WHO STEPS adult survey in Pohnpei state, and repeated the survey again in 2004 in Chuuk. Focusing on established risk factors, including substance use, that determine major disease burden, the WHO STEPS adult survey collects data on tobacco use and 30 day use of alcohol, which may be used for NOMs reporting.



Source: FSM MDS-web based system

The above chart shows the service population in the FSM on Substance Abuse prevention Activities from 2005 to 2009. Majority of the service population served were Elementary School Students, Religious Groups, Youth Minors and the General population. It was obvious that the highest population served (Elementary School Students) were being targeted to prevent the tendency of using alcohol in the youngsters' future life.

2. Assessing the System (Capacity & Infrastructure)

The current national-level prevention capacity and infrastructure in the FSM in terms of personnel, resources and prevention systems is as follows:

- a) *Personnel:* FSM has 5 current staff at the National level to carry out the SPF Process. They include the Secretary of the Department of Health and Social Affairs who is also the Project Director and oversees the operation of the grant and funds, including the assignment of the national team to include the SAMH Program Administrator, a Project Manager, a Finance Manager, and a Data Manager. (See Appendix B for Overview of Project Staff) SPF SIG Micronesia also receives contracted services from an Epidemiologist, Project Evaluators and the College of Micronesia, FSM. (See Appendix C for SPF Contractor information)
- b) *Resources:* All the Federal Health Programs are centrally located at the FSM Department of Health and Social Affairs (DHSA) where the Secretary of the Department encourages sharing of

program level information among the managers to help promote awareness, collaboration and resources like transportation, technology and communication. Human Resources are also shared in times of need as described and requested to the Secretary of DHSA. *(See Appendix D for SPF Collaborating Organizations and Partners)* The SPF SIG Micronesia Office is housed within the Office of the FSM SAMH and is equip with computers, telephones, internet, fax, copying machine and printers. The SPF SIG Office does not have a vehicle to use and is in town, several miles away from the FSM Department of Health and Social Affairs but transportation is shared by other programs when possible.

- c) *Prevention System:* Currently the existing prevention system operates out of the FSM Department of H&SA located in Pohnpei, the capital state of the FSM. The current existing national staffs provide guidance, direction and the monitoring of all prevention related funds that are distributed or allocated to the four states under the direction and guidance of the Secretary of H&SA. The national staffs work closely with all national programs and partner in providing services and leveraging recourses to the four states to help them to be successful in their efforts.

The SPF SIG staffs have been trained on the SAPST to understand the concept of substance prevention and also wrote this SPF Prevention Plan and will provide direction to the states on the 5 step process. Continued technical assistance will be received on specific areas as requested from West RT, the Epidemiologist and Pima and will then assist the state staffs and sub-recipients.

FSM has an existing SEOW that is committed to creating and sustaining regular data collection that result in quarterly reports of findings on youth and adult substance use and related behaviors and integrating the data into a comprehensive resource management system housed at FSM SAMH with the SPF Data Manager. The SEOW will collaborate to ensure that systems are in place for regularly collecting and analyzing data on identified substance abuse consumption and consequences, as well as indicators related to important intervening variables. As part of their plan to address documented data gaps, the FSM SEOW will assist to implement and update data on surveys in each of the FSM state.

The FSM also has many partners committed to the project in the following ways, to: 1) provide leadership in the successful implementation of the SPF SIG Micronesia; 2) participate in all data collection, reporting and analysis activities of the project as outlined in the Needs Assessment.

FSM also has the capacity for data collection, reporting and analysis activities of the SPF prevention projects. The SPF Evaluator and Epidemiologist will assist the SPF Data Manager and provide training to the state staffs to improve on data collection, reporting and analysis activities. The training will also include other information necessary to understand evaluation and using the different reporting systems (CLI, MDS) and using the web-based system for the cross-site data reporting.

The FSM Data Manager will ensure that all reports are submitted and sent out on a timely fashion in the CLI, PLI and GLI. Data on the MDS provided by sub-recipients will be cross checked for accuracy and completeness by the Data Manager.

With constant power outages in the state, all these above processes and activities become even more challenging. The time difference between the FSM and Washington, DC compounds these challenges even more when certain documents are required to be submitted at a certain time or webinars to be provided of which occur usually at 3, 4 or 5 in the morning in the FSM one full day prior (FSM Pohnpei, Monday at 9:00am would be USA DC, Sunday at 6:00pm).

The current state-level prevention capacity and infrastructure in FSM in terms of personnel, prevention systems, coalitions or NGO's and resources is as follows:

- a) *Personnel:* For the SPF SIG Project, FSM states have five 5 current staffs at each of their local levels to carry out the SPF Process. They include the Director of the Department of Health Services, the Chief, Division of Public Health, the SPF Project Coordinator, the Community Liaison and a SEOW Data Clerk. (*see Appendix B for Overview of Project Staff*)
- b) *Resources:* All the Federal Health Programs are housed at the State Departments of Health Services and sharing of the resources like transportation, technology and communication is encouraged. Human Resources are also shared in times of need as described and requested to the Director's of Health Services in each state therefore, should the state SPF Projects need assistance, the State Director's of Health can inform other program staffs to provide assistance. (*See Appendix D for SPF Collaborating Organizations and Partners*) The SPF SIG state office is housed within the state SAMH office and is equip with two computers, a copy machine, a type writer, telephones and internet but share SAMH's fax and other program's vehicle at the present time.
- c) *Prevention System:* The FSM SAMH Programs provide prevention services but very limited due to funding. FSM does not have coalitions but has several existing NGO's that currently provide community prevention work in their respective localities to help bring awareness to the communities about the dangers of substance use and abuse. Some of the NGO's include Micronesian Seminar, Women's Groups, Youth and Church Groups.

Collaboration among the Health Programs and staffs within each of the FSM states is directed by their respective Health Directors. These Directors have the authority to assign duties and responsibilities within their departments. They also have the responsibility to oversee all federal funds including prevention funds allocated to their respective states.

The state SPF SIG staffs have been trained on the SAPST to understand the concept of substance prevention. Continued technical assistance and training will be provided to the state staffs and sub-recipients on a quarterly basis or as requested.

There are also the existing SEOW state level members of which include the state SEOW Data Clerk who assists to update data on substance use and related violations in each of the FSM states including hospital alcohol related encounters at the emergency room, out-patient and admissions and school data of substance use related suspensions or drop outs from schools. Each state also has its own local partners who are committed to helping with the success of the project. The existing SEOW is committed to creating and sustaining regular data collection that result in quarterly reports that are submitted to the SPF Data Manager at the national level. As part of their plan to address documented data gaps, the state Data Clerk will ensure that data is collected on a timely fashion and reported on a quarterly basis and will assist in conducting survey's as informed.

The FSM states capacity to participate in data collection, reporting and analysis activities of their respective prevention projects is limited but will receive training and technical assistance from the FSM Data Manager with the help of the Epidemiologist and Evaluator as soon as the projects kick off to improve on the above stated three activities and other activities including understanding the principals of evaluation; collecting reliable process and outcome data; collecting NOMs data at the community level; creating/adapting pre-post program survey & other surveys as needed; using the different reporting systems (CLI, PLI and MDS) and using the web-based system for the cross-site data reporting. Data that will be collected from the sub-recipients on the CLI will be forwarded to the SPF SIG Data Manager for online input on the PMRTS.

State SAMH Program staff is collecting data, reporting and providing analysis activities of their respective prevention projects but NGO's have very little capacity and would also be involved in this training and technical assistance.

Community Readiness Survey

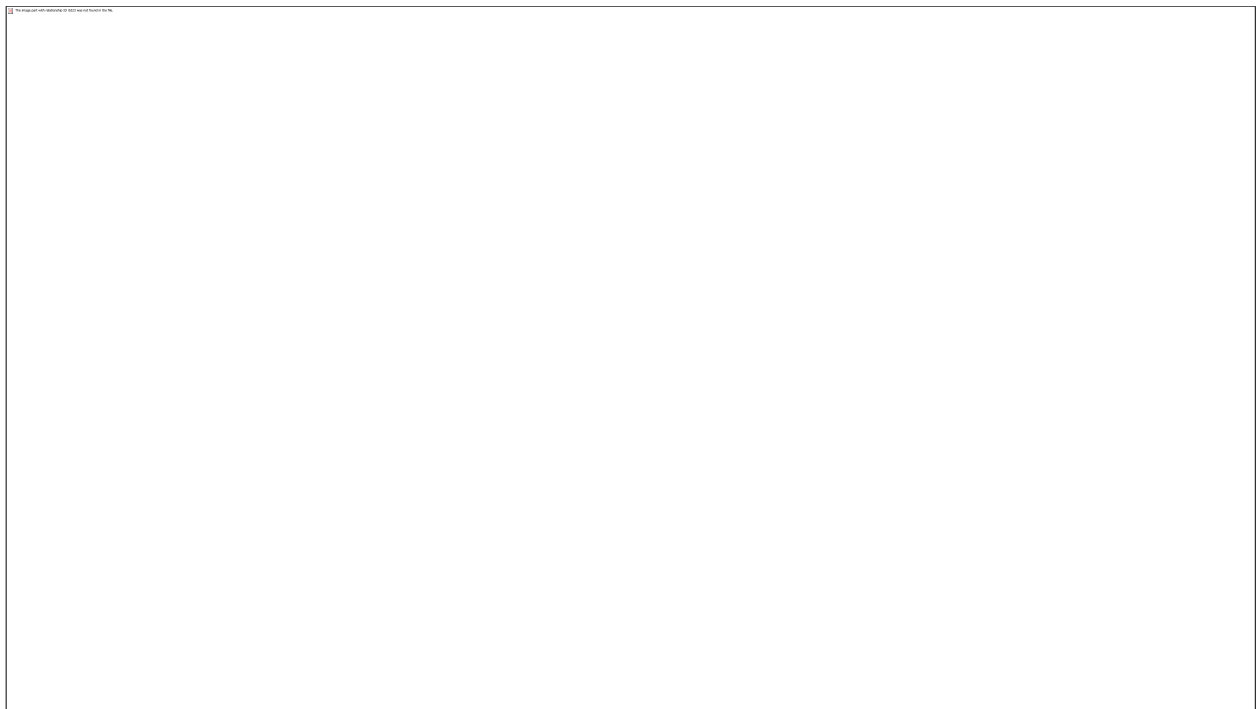
Following the assessment on Substance Use and Related Consequence, a Community Readiness Survey was conducted early 2010 in the four FSM states that looked at five modules (Community awareness of existing substance abuse prevention efforts, Leadership, Community Climate, Community knowledge about Substance abuse and Resources for prevention intervention) for readiness of the community on Substance abuse prevention.

Based on the result of the Community Readiness Survey that addresses substance abuse in the FSM, the result from the four States were obvious in Figure 15. Chuuk and Pohnpei were in the early stage of readiness which is the preplanning phase, and Yap is already preparing to do the outreach work on substance abuse prevention in their communities. However, Kosrae with its smaller population is fast to reach the stabilization level and also the furthest along the community readiness model. *(See Appendix E for full report on the Community Readiness Survey).*

Figure 15. Level of Readiness



Figure 16. Percent of Respondents who believe that the following substances of abuse are tolerated within their respective communities



The following are the existing Types of Services and Populations served in the Federated States of Micronesia as reported in the FSM Minimum Data Set (MDS). These Substance Abuse prevention services were carried out mostly by the FSM Substance Abuse & Mental Health programs including the NGO's and other health programs.

Inventory of Existing Services

<i>SERVICE TYPE</i>	<i>SERVICE POPULATION</i>	<i>SUBSTANCE ADDRESSED</i>	<i>CURRENT RESOURCES</i>
<i>ATOD-Free Social/Recreational Events</i>	Elem. & High school students, youth groups	Betel nut, Alcohol, Tobacco & Marijuana	- All State SAMH Programs - Ships & Hoops (NGO)program -State Cancer programs -Public Health programs
<i>Classroom Educational Services</i>	Elementary & High School students	Betel nut, Alcohol and Smoking tobacco & other illicit drugs	- All State SAMH Programs - Micronesia Bound
<i>Community Services</i>	Youth groups, religious groups & General population	Alcohol, Marijuana and Tobacco	- All State SAMH Programs - Ships & Hoops program - State Cancer programs - Public Health programs
<i>Employee Assistance Programs</i>	SA & MH consumers	Tobacco & Alcohol	- All State SAMH Programs
<i>Health Promotions</i>	Students , general population	Alcohol & Tobacco	- All State SAMH Programs - State cancer programs - Pubic Health programs
<i>Parenting/Family Management Services</i>	Parents and SA& MH consumers	Alcohol, Marijuana & Tobacco	- All State SAMH Programs - Public Health programs
<i>Prevention Assessment and Referral</i>	Substance abuse users, drop out youths	Alcohol	- State SAMH Programs - State Court
<i>Speaking Engagements</i>	General population, Students and Youth groups	Alcohol, Tobacco, Betel nut and Marijuana	- All State SAMH Programs - Ships & Hoops program - Public Health programs - State cancer programs
<i>Student Assistance Programs</i>	Elementary & High School students, religious youth groups	Alcohol, Tobacco, Betel nut and Marijuana	- All State SAMH Programs - Yap SEED - Public Health programs
<i>Youth/Adult Leadership Functions</i>	Religious groups, High school students, Teachers & College students	Alcohol, Tobacco and other illicit drugs	- All State SAMH Programs - Ships & Hoops program - Public Health programs

3. Criteria and Rationale for SPF-SIG Priorities

As a result of the FSM 2010 Epi workgroup Workshop that was conducted in January 2010, twenty two consumption and seven consequence indicators were selected based on data availability and reliability (See Appendix F - Summary of indicators). These identified indicators were used for the prioritization process that the Epi workgroup and Advisory council did during the week of October 25-29, 2010.

FSM identified the following criteria to be used to prioritize consumption and consequence indicators in the four FSM states.

CRITERIA

- **Size & Magnitude** – Can explore the basic question, “How big is the problem?” Magnitude – can be described as absolute numbers, frequency of occurrence or rates of substance used.
- **Seriousness** – based on assessments of urgency, severity, economic loss, and involvement of others.
- **Community concern** - May include a focus on the current levels of awareness, concern, and interest at the public, and organizational levels to support addressing a particular substance abuse issue.
- **Political Will** - Focus on the political level of acceptability and support associated with addressing the substance abuse issue by the political leaders.
- **Changeability** – based on the potential for change in substance abuse problem occurrence over the next five years.
- **Service Availability** – the availability of human, institutional, or financial resources (e.g., number of agencies that can provide resources and expertise, the level of commitment of community groups, possibility of continued funding, etc.) as well as the commitment of these resources.

On October 26, 2010, the FSM Epi workgroup assessed the selected indicators according to the criteria above. All of the indicators were scored according to each criterion from one (1) being the lowest and five (5) the highest. The exception was service availability where high service available being provided in the community was given the low score – one (1) and the low service availability was given high score of five (5).

During the prioritization process, each Epi workgroup member was given a prioritization table (see below) to do an honest scoring for each of the indicator. Then the members were convened in their particular states groups of Chuuk, Kosrae, Pohnpei and Yap and worked out on the average total scores for the indicators by their respective state (*See Appendix G for Final Priority Average Scores by State & FSM*). As a result of the four states effort, all the average total scores for the indicators were summed up and came up with the final scores for the FSM nation.

Table 1 below demonstrates the overall average scores for the top consumption and consequence indicators.

Table 1 : Average Prioritization Results for Top Six Consumption and Consequence Indicators							
	<i>Scoring: 1 – 5 1=Low, 5=High</i>	<i>Scoring: 1 – 5 1=Low, 5=High</i>	<i>Scoring: 1 – 5 1=Low, 5=High</i>	<i>Scoring: 1 – 5 1=Low, 5=High</i>	<i>Scoring: 1 – 5 1=Low, 5=High</i>	<i>Scoring: 1 – 5 1=High, 5=Low</i>	<i>Total</i>
<i>Indicator</i>	<i>Size & Magnitude (prev. & size of pop.)</i>	<i>Seriousness / Severity</i>	<i>Community Concern/</i>	<i>Political Will</i>	<i>Changeability</i>	<i>Service Availability</i>	
Drinking & Driving Ages: 20 & under	4.4	4.4	3.9	3.4	4.7	3.4	24.1
Current drinking Ages: 20 & under	4.4	4.4	4.1	3.5	4	3.2	23.7
Ever used tobacco with betel nut Ages: 13-15	4.5	4.6	4.1	3.4	3.8	3	23.6
<u>CONSEQUENCES</u>							
% of alcohol-related motor vehicle crashes	4.6	4.5	3.9	3.3	3.8	2.7	23.1
% of alcohol-related crimes	4.3	4.3	4	3.2	4.2	2.6	22.6
Tobacco-related mortality	4.6	4.7	3.9	3.2	3.6	2.3	22.4

After the Epi workgroup scored and ranked all the indicators they focused their attention on the top three priority consumption indicators #1 Drinking and driving, (age group 20 and under) #2 Current drinking, (age group 20 and under) and #3 Ever used tobacco with betel nut (age group 13 to 15) and three consequence areas (#1 Percentage of alcohol-related motor vehicle crashes, #2 Percentage of alcohol-related crimes and #3 Tobacco-related mortality). The Epi Workgroup presented their findings the next day to the Advisory Council for consideration and vote. Several Epi workgroup members are also advisory council members which facilitated the process. A thorough discussion occurred at the

Advisory Council with questions to the Epi Workgroup to assist in narrowing their focus to the area that would be targeted by the SPF SIG project.

4. Description of SPF-SIG Priorities

The Advisory Council and Epi Workgroup members all agreed that each area was of major concern in the FSM, but the Advisory Council made their final decisions based upon the indicator(s) with the highest scores: 1) **Underage Drinking and Driving (past year)** and 2) **Underage Current Drinking (past 30 days)** with the understanding that at the present time there is no specific program that would address these problems in the FSM. Additionally, because of the fact that the two top consumption problems and two top consequence problems (alcohol-related motor vehicle crashes and alcohol-related crimes) were both related to underage drinking, the Advisory Council decided that two priorities Underage Drinking and Driving (past year) and Underage Current Drinking (past 30 days) were justified.

CAPACITY BUILDING Step # 2

There are 25 individuals identified to run the SPF SIG Micronesia. SPF-SIG has 11 funded staffs (3 national level staff and 8 state level staff) and fourteen (14) in-kind. (*see Appendix B for Overview of Project Staff*) The three national SPF-SIG staffs include the Project Manager, the Financial Program Manager and the Data Program Manager to manage the SPF-SIG project throughout the FSM States. The role of the National SPF-SIG staff is to build a SPF-SIG workforce at the national and state levels to implement the identified priorities in the strategic plan and to coordinate the sub-recipients to have effective prevention measures to reduce the number of youths who are associated with underage drinking and drinking and driving. The national SPF-SIG staffs have strong background in their fields where they are capable to manage the project but will need some technical assistance in the specific skill areas required to provide good management. They are housed at the FSM Substance Abuse & Mental Health Office and supervised by the SAMH Program Administrator and the Project Director. The work performance has been reviewed and guided by the Administrator and the Project Director to make sure everything is complied with the Federal Regulations and following the process of the SPF-SIG project.

The SPF-SIG Advisory Council and members of the SEOW are in place and ready to take further action. As part of the workforce development, the SPF-SIG contracted two experts, Dr. Cuboni, the Epidemiologist to assist the improvement of the SPF-SIG data gathering, analyzing the data and provide trainings and Lisa Teyechea from PIMA as the Evaluator will be responsible to evaluate the SPF-SIG activities.

Western RTS has been very helpful in providing technical assistance to the staff, advisory council and members of the SEOW to improve their knowledge and skills on the process of the SPF-SIG, roles and responsibilities. Telephone conferences, internet communication and webinar training were also

available and given to SPF-SIG Staff. Micronesia SPF-SIG has a strong workforce team ready to move forward to implement the SPF-SIG project and extend it to the state levels.

The National SPF-SIG hired two staff members from each of the four FSM States which include the Project Coordinator and the Community Liaison to begin formulating the SPF-SIG project by gathering data, working with the local SAMH advisory council, discussing with the community leaders about the purpose of the SPF-SIG project and coordinating the SPF-SIG prevention activities in collaboration with the current SAMH prevention staff. The two State SPF-SIG staffs are currently housed at the State SAMH office sharing the facilities and all the existing resources. The State SAMH offices are under the supervision of the Chief of Public Health and all matters need to go through this individual before the approval by the State Director of Health Services. States SAMH offices are adjacent to the State Hospitals to share the facilities, communication, transportation and human resources. The SPF-SIG project will strengthen the gaps at the state levels to improve the prevention activities.

1. Areas Needing Strengthening

a) Prevention workforce: FSM only has four Prevention fellows that completed the one year training and this training has in depth training on the SPF process. To successfully implement the SPF, both the national and sub-prevention workers need to increase their knowledge and skills related to prevention.

Although we have set up the workforce staff from the national and the states to implement the SPF-SIG project, there is still a need to learn as they are not familiar with all the details of the SPF-SIG and the sub-recipient NGO's most especially will need to have a thorough training on the process of the five steps, purpose of the SPF-SIG and the importance of data as it relates to evaluation and outcome of the prevention activities to be able to carry out the priorities to reduce the use of alcohol.

b) National, State, and NGOs Prevention Staff: Not all the staff members have been formally trained on the SPF. Many staff at all the levels working on the SPF will need formal, in- depth training on the SPF Process as well as the requirements of the cooperative agreement and reporting mandates. We see the environmental strategy is much more appropriate to train all the staff as we see fit to reduce the use of alcohol on the islands.

Knowledge of Evidence Based strategies is also lacking in the FSM and therefore would require technical assistance to the staffs. First to the national staffs and then, the national staffs will assist the state staffs to provide the information to state partners requesting for this SPF funding.

c) Technology: The SPF national level and the states level staff all have their desk top computers and lap top are connected to the internet for communication. However, the NGO sub-recipients may need computers to communicate to the national staff, do the research to improve their skills and knowledge and join webinar trainings as it is an effective tool to use since the islands are far apart. There is a need for all the SPF staff to learn of how to use the webinar to improve their

knowledge and skills on the SPF-SIG implementation. Due to the power problems that some FSM states experience, the problem of internet connection and telephone communication is a problem and these are areas where the SPF project will supplement the funding to improve the problems in order to improve the services.

d) Infrastructure: The states and sub-recipients prevention staffs do not have adequate office space.

FSM and Sub-recipients – Level Activities

The national SPF will address and build capacity in the following ways:

a) Prevention workforce: Currently, FSM has a cadre of experienced SAPST trainers that the National SPF staff can call upon to offer this introductory –level training periodically to new prevention workers including one from COM FSM who will also offer this training. Second, FSM will partner with the COM-FSM to offer a semester-long Substance Abuse Prevention course. This course will be offered at least once in each state every other year. Finally, FSM will continue to offer tailored technical assistance to their SPF sub-recipients by bringing them together for training, through webinar and telephone conference. SPF national staff will also visit the states and provide technical assistance on a quarterly basis to assist the state staff and sub-recipients with activities that need improvement. COM FSM also has the technological capacity to offer distance learning opportunities across the FSM and will assist in meeting ongoing training needs. On-line courses will also be available and encouraged for prevention staffs to take to assist them with passing the IC&RC examination to become certified substance prevention specialists.

b) National, State, and NGO Prevention Staff: Members of the National SPF-Staff and National SPF Advisory Council who are knowledgeable about the SPF will provide in-depth training on the SPF to other National and sub-recipient SPF and prevention staff. The College of Micronesia-FSM (COM-FSM) also has an experienced SAPST trainer who will also provide this training to the states. Other trainings will be provided by Pima and the SPF Epidemiologist and will include the cooperative agreement requirements, and reporting requirements. West RT will also be providing continuing technical assistance when requested especially with regards to the risk factors and evidence based interventions

c) Technology: Since the SPF staffs are housed at the FSM and State SAMH offices, the availability of the internet and telephone are available to assist the National, State and the Sub-recipients. Due to the power problems that some FSM states experience, the problem of internet connection and telephone communication is a problem and these are areas where the SPF project will supplement the funding to improve the problems in order to improve the services. Cell phones, one per sub-recipient and national will be considered as a way of improving communication.

d) **Infrastructure:** FSM SPF national and States will continue to share the existing offices, to reduce the cost and to collaborate on the resources, knowledge and skills. The existing states offices need minor renovation and expansion to accommodate the SPF staffs. The SPF project will assist in purchasing vehicles and boats for the SPF staff to coordinate training activities have on site visits to the sub-recipients. The boats and vehicle will remain at the SPF Offices and will be shared with the sub-recipients on a scheduled log out basis to assist the sub-recipients to provide their services to the remote villages and islands.

- 2) **Role of the SEOW workgroup:** The FSM Epidemiological Outcomes Workgroup (SEOW) will continue to have data training once a year to the members, collecting data from the various agencies and to work with the FSM SPF-SIG Advisory Council on the situation of alcohol consumption and its consequences. The SEOW will conduct a population survey to capture the NOMs and the community profile for the FSM States. The FSM Epidemiologist will be responsible to design and analyze the data collection and survey when completed. The epi profile will be updated each year to educate the leaders and the community on the use of alcohol and its consequences.

The SEOW workgroup have received some training on the 5 steps to be able to carry out their responsibility over the SPF process. The SEOW workgroup will receive training and continue technical assistance from the SPF Data Manager, Epidemiologist and Evaluator. They will also be involved in the COM FSM substance prevention trainings that will be held in each state.

The SEOW will collaborate to ensure that systems are in place for regularly collecting and analyzing data on identified substance abuse consumption and consequences, as well as indicators related to important intervening variables. As part of their plan to address documented data gaps, the FSM SEOW will assist to implement and update data on surveys in each of the FSM states; to help create a mechanism at both the national and state levels in the systematic collection, analysis, and reporting processes; and will also work to help improve the accuracy and comprehensiveness of the overall information system.

The SEOW team in each state will collect the data based on the new or existing tools/instruments that will be designed and developed by PPP and FSM's SPF-SIG Epidemiologist.

Data that have been collected and will continue to be collected from the State Departments, need to be set up to be consistent and uniform to assist with the tracking of progress through an MOU which will be set up by the epidemiologist and SPF staff. The inputting of data in the system will be done by either the state SEOW data clerk or the state SPF community Liaison officer.

PLANNING Step #3

1. Planning Model

The Equity Planning Model is believed to be the best model for SPF SIG Micronesia because, as its name implies, it dictates equitable distribution of funds across all sub-State communities of which in the FSM would be all four states of Chuuk, Kosrae, Yap and Pohnpei. The equity model is also explained

indicating that variations might adjust the amount of money provided by overall population so that funds are allocated on a per capita basis. This variation will be based on the priority population as a whole in all four states (under the age of 21 years) giving each state an opportunity to be able to reduce the priority problems of Underage Drinking and Driving (past year) and, Underage Current Drinking (past 30 days). The priorities of the nation had also been decided upon based on the overall nationwide underage drinking use patterns and related consequences thus suggested the appropriateness of an equity model. Each of the four state governments that make up the FSM is autonomous and distinct in culture but will work collaboratively in developing a systemic ongoing monitoring system addressing each states consumption consequence patterns and to track progress of the priority problems, detect trends and use such information to direct resources as needed.

- The Highest Contributor Planning Model would use the Nation's overall number of priority problem cases as the metric for comparing State entities and therefore it is unlikely that smaller population states will get funded. The FSM has four States with a diverse population distribution therefore; this model would not work due to the lack of state-level data.
- The Highest Rate Planning Model (often referred to as highest need) would direct funding to the states with the highest rate vis-à-vis the priority substance use pattern or substance-related consequence. This model, the absolute number of people affected is not the focus. Rather the extent of the problem across state's is expressed relative to each state's population (rates) are compared. This model, due to lack of consumption and consequence data compiled throughout the four FSM States, (profiles for each state) to be able to identify the needs across the nation, this model cannot work.
- The Hybrid Planning Model combines the highest contributor and the highest rate approaches into a planning model and concentrates funding in hot spots defined by both numbers and rates and the FSM does not have the appropriate data for both number and rates by state.
- The Highest Contributor Planning Model would use the Nation's overall number of priority problem cases as the metric for comparing State entities and therefore it is unlikely that smaller population states will get funded. The FSM has four States with a diverse population distribution therefore; this model would not work due to the lack of state-level data.
- The Stratified Planning Model could have been a choice in FSM of which the substance prevention infrastructure is comprised of regional entities that have historically played a significant role in planning and administration, and where a high emphasis is placed on preserving that structure but the only reason that it was not chosen is because it was explained that if a State commits to making some type of allocation within each region *before it considers the more substantive issues related to data-guided allocation planning*, then this approach can be described as a regionally stratified planning model. SPF SIG Micronesia will distribute funds based on a per capita basis of the priority population throughout Micronesia of which was collected via the census national survey and substance data collection improvement is one of our main goals so that data can be collected appropriately, placed in one area and will be able to

be monitored and tracked so that future plans, decisions and policy making is made with documented data to back it up.

2. Sub-recipient Activities

Within this funding allocation, the National SPF staff will assist the state staff and both funded NGO's and state level program sub-recipients with each step of the SPF process to be complied with by the states. Each state will ensure that sustainability and cultural competence are taken into consideration in the SPF five step prevention plan process.

The intent of this SPF Strategic Plan is to create a sustainable infrastructure to prevent and/or reverse the current trend toward unhealthy risk-taking behaviors, especially substance abuse with reference to the national priorities of alcohol.

The state SPF staffs will have the opportunity to review the national strategic prevention plan to help them develop their own state specific strategic plans. Using data gathered during the Needs Assessment and guided by the SPF SIG science-based model, each state will then develop their own state specific strategic prevention plans addressing the identified priorities. All funded applicants will use the Strategic Prevention Framework to identify and implement evidence-based prevention strategies and program models that target individual, group, and environmental change and that are specifically adapted to each state.

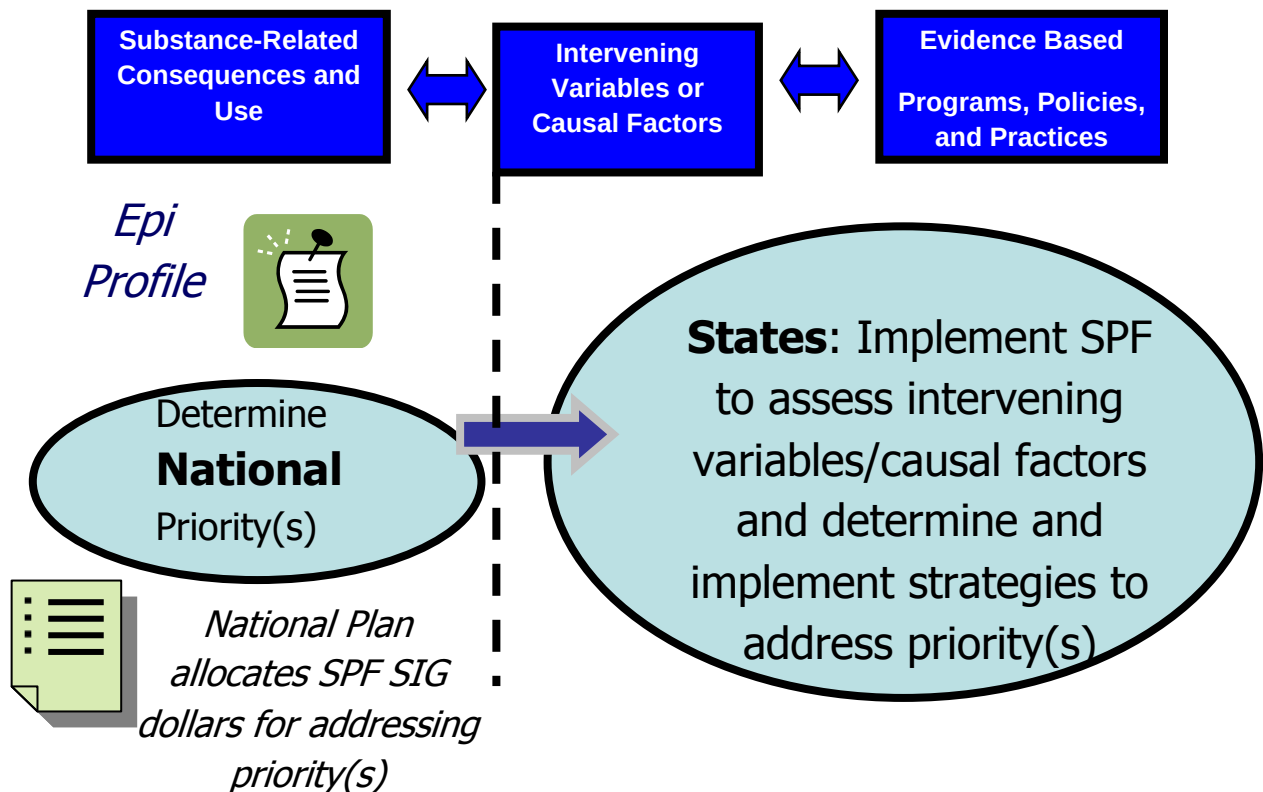
Each state will work with the national Epidemiologist and Data Manager to complete their own needs assessment to determine the risk factors in their own states that contribute to the two indentified priorities. The NGO's will also be brought in to assist in this needs assessment process. Each state will then select the risk factors that contribute most to the two priority areas and develop the best programs, strategies and activities that address these priorities.

An Evidence Based Intervention (EBI) sub-committee has been established at the national level to help review these programs, strategies and activities and the national SPF Project Manager will provide guidance and direction to help the states in this process. The state staff will ensure that the individual funded programs, strategies and activities in each state are not duplicative but are complementary to each other.

Based on the selected SPF-SIG Priorities that had been reviewed by the SPF-SIG Advisory Council and staff in the SPF-SIG Prevention Plan Meeting that was held from October 25th to 29th 2010, the following draft national logic model was created but a final document will be determined once the state plans are in place:

FSM Logic Model – Draft 1

Consequences	Consumption Patterns Prioritized	Risk Factors, Casual Factors, Intervening Variables	Programs, Strategies, Practices & Approaches
Alcohol related crimes (entire population)	1. Underage Drinking and Driving (ages 20 and under)	To be determined by each state (community) Examples: - Lack of enforcement - Low neighborhood attachment - Community norms favorable to drug use - Conflicting norms and laws - Friends who use	To be determined by each state (community) Examples: - Law enforcement - Environmental strategies - Peer to peer
Alcohol related motor vehicle crashes (entire population)	2. Underage Drinking (ages 20 and under)		
Alcohol related liver cancer (adults)			
Alcohol related mortality (entire population)			



Pima Prevention Partnership will develop a process evaluation plan to support the national staff and state level SPF Coordinators and Liaison's work in monitoring of the SPF work in the states and this will insure that everything is done appropriately with regards to the evaluation that will be performed on the project.

Each of the FSM States will develop a strategic plan using the 5 Step Process (Assessment, Capacity, Planning, Implementation and Evaluation) based on the National Plan and each states epi profiles that will address the risk factors that contribute to the two national priorities.

State NGO's and/or Government Programs will submit RFA proposals that will be submitted to each individual state SAMH Advisory Council to weed out RFA's with unrelated purposes and/or strategies and the SPF Advisory Council EBI subcommittee will review the RFA's and make recommendations to the main SPF Advisory Councils. At the present time, there are 4 existing State SAMH Advisory Council's and each of these Councils include faith members, women group members, Youth group members and traditional members. These are the essential groups necessary to assist with the reviewing of RFA's and to recommend the RFA's by priority to the state Governors and on to the Secretary of the Department of Health and Social Affairs whom will forward them to the National SPF SIG EBI workgroup and National SPF SIG Advisory Council for final recommendations back to the Secretary of the DHSA.

An overall national survey will also be done on the NOM's and health indicators to ensure that the SPF improves on the existing data system and secures a sustainable reporting system that provides reports on a timely basis as required.

3. Allocation approach

The SPF-SIG funding will be distributed to the FSM States using an equity planning model with variations of per capita of the priority population and through the submission of SPF-SIG grant applications. FSM State Government Programs and NGOs are eligible to apply for each of the four state SPF-SIG grant share's as shown on page 42 and applications will be reviewed based on merit as scored using the sub-recipient criteria.

The FSM will determine which potential sub-recipients are "high need" based on consequence and consumption data identified as the two priorities for the FSM and as described to be the risk factors for each state.

The FSM will also determine which potential sub-recipients will receive SPF funding through a process of reviewing applications. This funding allocation will also allow each state to provide the same opportunity for all NGO's to apply for funding and will work closely with the state SPF staffs in aligning their planned proposals and describe strategies to address the national priorities, insure that all projects, practices, policies and strategies are also culturally appropriate and not duplicated.

The criteria established by the FSM SAMH Office will be used by the State SAMH Advisory Council and the SPF Advisory Council to review the applications. Each of the five steps will be scored and assigned points based on merit of which would also include merit of each individual activity/strategy. Each of the activities/strategies would be based on the risk factors determined to be addressed in each of the four state plans on the two set priorities addressing the total priority population Funds will also be allocated based on where the gaps in services are. The applicants with the highest scores addressing the criteria's provided will be given the SPF funding. *(See Appendix H for Sub-recipient Criteria)*

The total amounts combined for all RFA's per state should not exceed the funding allocation amount already determined in the budget formula below (*EBP Implementation: second to the last row*) based on the priority population to address the two identified priorities of Underage Drinking and Driving (past year) and Underage Current Drinking (past 30 days). The State's SPF staffs with the help of the national SPF staffs will be responsible to provide guidance on the state's grant application(s) and the applications submitted by the NGO's.

The following is a budget breakdown by state according to the priority population in the FSM. Each States SPF staff will finalize a state strategic prevention plan and provide necessary information to the state's SPF SIG applicants so that the planned strategies are aligned with the two priorities for the nation, culturally appropriate to the individual state and sustainable after the SPF Funding is gone. A meeting will be held with all interested sub-recipient applicants to explain the criteria for the funding application and explain the importance of addressing the strategies with cultural appropriateness.

Monies collected for citations given out to offenders of state laws of selling drinks to underage youths will be placed into a government account to sustain the activities after the SPF funds are gone.

SPF-SIG Budget Breakdown by State According to Population, Year 3 Evidence Based Program Implementation					
Categories	Chuuk	Pohnpei	Yap	Kosrae	Total
Population base	53,595	34,486	11,241	7,686	107,008
% of population	50%	32%	11%	7%	100%
Population under 21 yrs.	24,743	17,635	5,056	3,249	50,683
% of state pop. Under 21 yrs.	49%	35%	10%	6%	100%
Community Coordinator	\$20,000.00	\$20,000.00	\$20,000.00	\$20,000.00	\$80,000.00
Community Liaison	\$15,000.00	\$15,000.00	\$15,000.00	\$15,000.00	\$60,000.00
SEOW Data Clerk	\$7,141	\$7,141	\$7,141	\$7,141	\$28,564
Inter-State T/A and monitoring Travel	\$16,440	0	\$16,440	\$16,440	\$49,320.00
SAMH/SPF Advisory Council	\$2,400.00	\$2,400.00	\$2,400.00	\$2,400.00	\$9,600.00
Institutional Training Assistance (COM FSM)	\$53,148.50	\$53,148.50	\$53,148.50	\$53,148.50	\$212,594.00
SPF Sub-Recipient external T/A	\$27,371.66	\$0.00	\$27,371.66	\$27,371.66	\$82,115.00
SEOW (Epidemiologist T/A)	\$9,452.00	\$9,452.00	\$9,452.00	\$9,452.00	\$37,808.00
EBP Implementation	\$257,311 (49%)	\$183,793 (35%)	\$52,512 (10%)	\$31,507 (6%)	\$525,123 (100%)
TOTAL					\$1,085,124.00

Source: FSM 2000 Census with 2011-12 SPF Budget

The existing State Substance Abuse & Mental Health Advisory Council in each state will review the applications and make recommendations to the State Governors. The State Governors will then forward the applications to the Secretary of the Department of Health and Social Affairs who will present them to the SPF Advisory Council. The Evidence Based sub-committee of the SPF Advisory Council will be involved in this process to ensure that programs, strategies and activities are evidence based. The Evidence Based Intervention (EBI) sub-committee will review and make recommendations to other SPF Advisory Council members who will then make final recommendation of sub-recipients for the Secretary's final approval.

4. Implications of Funding Model

The implications of this allocation process on reducing consumptions and/or consequences throughout the FSM are paramount. Although the total amount given to each state may be different, it is based on priority population which in the eyes of each FSM state is fair and justifiable. This method also allows each state to provide the same opportunity for everyone to apply for funding.

This allocation approach will allow FSM national staff to provide services to all of the four FSM states and will enable the FSM to reduce the identified priority areas using the appropriate evidence based strategies more than other allocation models as described on page 37. This approach will not only improve the capacity of the existing SPF Project and new sub-recipients in all four states but will be sustainable after the end of the SPF funding.

Another reason that other allocation methods will not work is because of the lack of data as described in the data gaps and this allocation approach will enable SPF to improve on the data gaps through technical assistance to all four states. (*See Appendix A for the Data Gap Analysis Plan*) At the present time, although most of the data in the FSM Profile are from Pohnpei, the same priorities have been chosen by the other 3 states SEOW members using visual observations on the problems of drinking in their respective states. These two priorities are identified to be known to all Micronesians that they are truly problematic in all four (4) states and were identified as such at the SEOW and SPF Advisory Council meeting to choose the priorities of the nation in October of 2010. Data is there to be collected but will require capacity building and guidance to help improve on their capabilities to do the work appropriately.

In the FSM, historically and politically, all funding received and disseminated in the FSM has been accepted at the national level through the FSM President and Congress and is normally distributed by population if not specified and justified to be used for a specific purpose. The SPF funds will be distributed to all the four states based on the equity approach with a funding variation of per capita of the priority population to show the significance of SPF to the nation when addressing the two priorities.

If the FSM does not receive funding for all the four states, it would not only be politically difficult to explain but difficult to show the significance of the SPF Project to the nation as a whole giving every state an opportunity to address the two priorities in each state.

Community collaboration and involvement is also important to effectively promote the SPF Process in addressing the two set priorities for the nation therefore, NGOs are an effective asset to creating change.

IMPLEMENTATION Step #4

1. National Required Activities

The SPF SIG Micronesia Project will be implemented at the National and States levels in accordance with the five (5) steps of the Strategic Prevention Framework process outlined below. (*See Appendix I for the Implementation of SPF Plan*)

The national SPF SIG Micronesia project staff will provide support, training, and consultation to each of the four states. The national SPF SIG Micronesia project staff will also provide capacity building and data monitoring at the State level and will be housed with the Department of Health and Social Affairs under the umbrella of the SAMH Program. A National Survey will also be done on the NOM's and SPF Indicators at the state level to help support the reporting requirements for SPF SIG Micronesia. The SPF SIG Micronesia national staff will work closely with the state staff to ensure that the surveys are done appropriately and reports are provided on a timely manner.

2. State Required Activities

The state SPF SIG Micronesia project staff will provide support, training, and consultation to all applying for SPF funding. At the state level, the SPF SIG Micronesia project will use each state's Substance Abuse and Mental Health Office to establish high functioning community NGO's charged with completing the *SPF* process. The SPF SIG Micronesia project SPF process will complement the traditional structure, culture, and history of FSM society. In fact, the flag of the Federated States of Micronesia shows that although each state is composed of a diversity of cultures over many miles of ocean, they are joined, not separated, by the sea.



A needs assessment will be done in each state to determine the risk factors for the set national priorities to assist the states with determining the appropriate strategies to use. A national NOMS Survey will also be done in all four (4) FSM states to insure the reporting of the NOMS are done appropriately and on a timely fashion. Pima Prevention Partnership (PPP), SPF Evaluators and the SPF Epidemiologist will train the SEOW team so that they understand the protocols and requirements of reporting and what is needed and set up to be reported. Monthly reporting will be required to be submitted by the Project Coordinators and on to the FSM Project Manager of which will include data reports compiled by the state SEOW Data Clerks to the Data Manager monthly. Once activities are all set up and running well, monthly reports will no longer be necessary but quarterly reports will be required to be submitted to the Project Manager. This is to ensure that all processes, activities, and decisions are recorded and reported to the SAMH Administrator/Manager once every quarter. All reports will be due on the 5th of the following month after the reporting period (monthly/quarterly). The national staff will meet quarterly on the 15th or working day before the 15th to plan, update, and

review progress on the implementation plan for the FSM. Each of the FSM State Coordinator's and Community Liaison's will work with the funded SPF SIG recipients and will immediately put into place methods for recording SPF recipients process, activities, and decisions. Quarterly progress updates will be submitted to the state Coordinators and disseminated to the state SAMH Advisory Council members and to the FSM SPF Manager, then to the SAMH Administrator and to the Secretary of the Department of Health and Social Affairs.

The SPF SIG Micronesia Project will ensure that selected Government and NGO prevention providers (state level) implement programs that are evidence-based and culturally competent, and have proven effective in addressing the identified priority with similar populations. This process will develop necessary infrastructure to ensure an institutionalization of evidence-based practice in providing prevention programming throughout FSM.

The College of Micronesia (COM FSM) is a key partner member in the SPF Advisory Council and will be contracted to provide a one semester course in Substance Abuse Prevention to all the existing SPF staffs in the FSM including all the sub-recipients and other substance prevention staffs at the state level to assist with the successful implementation of the project. This course will be offered twice per year, one campus per semester and will cover two states per year. This same course will also be offered at the national campus for students to take as an elective in the AS in Public Health. Additional courses will be developed and added to the public health program curriculum to allow Public Health Training Program (PHTP) majors or others to complete a concentration in Substance Abuse Awareness and prevention. COM-FSM courses and training will be developed to align with the IC&RC certification. Courses developed can be delivered either as a credit bearing course or as part of a non credit continuing education series of trainings target to the needs of workforce. For ongoing sustainability, COM-FSM will identify faculty counterparts to work alongside the project West RT trainers in order be able to continue offering both the SAPST training and institutionalize the training and support capacity beyond the SPF-SIG program at the end of the grant period. COM FSM also has the technological capacity to offer distance learning opportunities across the FSM to assist in meeting ongoing training needs. COM-FSM can also provide tutoring and workshops for Current SPF and SAMH staffs who are also encouraged to take on-line courses to help prepare them to take the IC&RC examination to become certified prevention specialists.

COM FSM will collaborate with the state SPF staff and will provide the SAPST one week training to the staff in the two states that will not be included in the Substance Prevention course during the first year and to other SPF Advisory Council members and partners who would like to take it. The other two states will then be provided with the SAPST training the following year.

COM FSM will also develop and translate substance prevention leaflets into the different languages in the FSM and will disseminate these to all school campuses in the FSM to be given out to the students that are within the priority population (under the age of 21).

COM FSM will also include their state campus counselors in the SPF training activities so that they may be able to provide substance prevention education to students within their respective state campuses.

EVALUATION Step #5

The Federated States of Micronesia have contracted with Pima Pacific Partnership (PPP) to conduct the project's evaluation. PPP has significant experience utilizing the SPF model and in working with Pacific Jurisdictions to assist in the monitoring and evaluation of a variety of mental health, prevention, and treatment programs. PPP was contracted to conduct evaluation activities for a number of reasons; some of which include: 1) the lack of local capacity to conduct comprehensive and rigorous evaluation activities, 2) an identified need to develop local capacity in which the third-party evaluator will assist with to develop, and 3) the desire of utilizing a third-party evaluator to provide a more objective review and analysis of the evaluation process.

The project's evaluation is designed to measure both process and outcome measures of the SPF SIG Micronesia throughout the five years at both the National and State levels. The evaluation of the SPF SIG Micronesia will focus on the following five (5) components: 1) assist in the development of a National/State data collection surveillance system, 2) assessment of infrastructure developments; including the implementation of the five (5) SPF steps, 3) tracking of project goals and objectives, 4) develop state capacity to collect data, and 5) data collection of the National Outcome Measures (NOMs) in collaboration with the U.S. National Cross-site evaluators. All of the five (5) components will be addressed at both National and State levels.

In order to effectively evaluate the SPF SIG Micronesia project and assess impacts as a result of SPF SIG, tools will need to be developed to address the lack of data and data gaps that is prevalent in the Federated States of Micronesia. Where appropriate, these tools will be utilized in conjunction with U.S. Federal Cross-site tools to collect relevant data at the National and State levels. Project data collected will be used to facilitate data-driven decisions at National and State levels.

SPF SIG Micronesia will utilize the U.S. Federal reporting requirements to monitor and evaluate the project with a centralized focus of measuring progress at all levels (National and State) on the stated priorities: Underage Drinking and Driving and Underage Current Drinking.

1. National-Level Surveillance, Monitoring, and Evaluation Activities

The process and outcome evaluation at the National level will include the collection of the U.S. federally required NOMs to assess project impacts and progress towards SPF SIG Micronesia's goals and objectives. The following NOMs will be included in the evaluation:

- **NOM 1:** Abstinence from drugs/alcohol
- **NOM 2:** Increase/employment or Stay in School
- **NOM 3:** Decreased criminal justice involvement
- **NOM 4:** Increased access to services (number of persons served by age, gender, race, and ethnicity)
- **NOM 5:** Increased social support/social connectedness
- **NOM 6:** Cost-effectiveness

- **NOM 7:** Use of evidence-based programs and practices

The project will utilize the U.S. National cross-site tools such as the Grantee Level Instrument (GLI) and Community Level Instrument (CLI) to monitor the progress of the project's goals and objectives. These tools will also be used as part of the project's overall evaluation to assess impacts as a result of implementation of the SPF SIG project. The use of these tools includes building the capacity to: strengthen data collection, understand the data collection tools, and utilize web-based data systems.

In addition, monitoring and evaluation tools will be developed to track project progress in the areas of: infrastructure development, SPF implementation, and goals/objectives.

2. State-Level Surveillance, Monitoring, and Evaluation Activities

The process and outcome evaluation at the State levels will include the collection of the U.S. federally required NOMs (where appropriate) to assess progress of goals at those levels. The evaluation of the project will also include the implementation of the CLI and Participant Level Instrument (PLI) with states funded through SPF SIG Micronesia. The use of these tools will include building states capacity to: collect local data, understand the data collection tools, and utilize web-based data systems.

Monitoring and evaluation tools will also be developed to track project progress in the areas of: infrastructure development, SPF implementation, and goals/objectives that will support the National level evaluation efforts.

States funded through SPF SIG Micronesia will be asked to follow an evaluation structure for data collection and comply with U.S. Federal evaluation requirements. The national project staff will work closely with each state and funded non-government or government programs to tailor specific indicators in order to most effectively assess local project impacts. This includes evaluation tools specific to state programs or policies being developed at the state level. Data collection at the State levels will support and complement the data being collected for the National level evaluation.

Assessing Project Impacts

SPF SIG Micronesia priority areas: Underage Current Drinking and Underage Drinking and Driving will be monitored regularly to assess changes in the reduction of underage alcohol use and underage drinking/driving. Data collected at the State levels will be coordinated and shared at the National level to inform overall project progress. All data collected will be reported back to National, State, and Community stakeholders for their use in their assessments, capacity building, planning, and implementation efforts.

Throughout the five years, on-going feedback on the project's progress will be provided to SPF SIG Micronesia project stakeholders for continuous program improvements. Additionally, the evaluation team will provide an annual report that will report on the project's progress in each of the five (5) SPF steps and achievement of its goals and objectives.

CROSS-CUTTING COMPONENTS AND CHALLENGES

When addressing FSM culture and socioeconomic factors through the SPF SIG Micronesia project the most current research reveals that successful, culturally appropriate, effective substance abuse prevention programs and materials for Pacific Islanders require a community to community, village-level understanding of the geographic, ethnic, racial, cultural, economic, social, religious, and linguistic diversity (Jakim, 2006; NAPAFAASA 2005; Grunbaum, J.A., 2000). The geographic, linguistic, and cultural diversity frames the design of the SPF SIG Micronesia and informs the levels and dimensions of inclusion on decision-making bodies as well as the processes of implementation, especially at the state level. The FSM state will work together strategically to foster the principles of cultural competency and sustainability throughout the SPF process. Each eligible SPF SIG funded sub-recipient, through the SPF process will generate strategies to select prevention interventions that will be on a face-to-face individual and group level prevention interventions. Language - there are eleven major indigenous languages spoken in the FSM: Yapese, Ulithian, Woleaian, Chuukese, Pohnpeian, Kosraean, Nukuoro, Moakiloa, Pingelapese, Ngetikese and Kapingamarangi; and Religious beliefs where Roman Catholicism is heavily practiced in Yap (83%) and Congregationalism is heavily practiced in Kosrae and where Catholicism is practiced by about 50% of Chuukese and Pohnpeians.

SPF SIG Micronesia has identified two priorities to address for the nation and both are relate to underage Drinking. More than 50% of the total population is under 21 years of age and therefore, the two determined national priorities of Underage Drinking and Driving (past year) and, Underage Current Drinking (past 30 days) are two critical priorities for all of the Federated States of Micronesia supported by epidemiological data.

FSM's SPF SIG Micronesia project has been designed to insure that the capacity and infrastructure built including any outcomes achieved will be sustained after SPF funds are no longer available by ensuring that the following steps are met: 1) The President, national departments, state Governors, state departments and state NGOs, and faith-based organizations will be heavily involved in the SPF by ensuring that prevention programming is assimilated into government, church and community-sponsored activities; 2) Key national and state stakeholders will convene to build a advocacy network that will support programs and strategies with appropriate resources; 3) The systems-integration that will allow public agencies to better leverage existing prevention, social service and health care dollars; 4) the unified focus of fundraising and program efforts by sub-recipients to help sustain prevention programs in schools and island communities; and 5) The increased capacity of communities to discuss specific problems affecting youth and families and for key community leaders to advocate for local resources needed to sustain prevention programs.

The challenges anticipated in applying a "need-based" allocation process, rather than allocating money the way it is typically allocated that is historically and politically known to be by population would be political resistance and would require justification in explaining the SPF SIG Micronesia five step process prevention plan and how this allocation method would make a difference. Another challenge anticipated would be developing a systemic ongoing monitoring data collection system to track progress

of the priority problems, detect trends and use such data to direct resources as needed. Another challenge when we begin to implement the plan would be monitoring sub-recipient activities and progress to ensure compliance due to distance. (*See appendix J for SPF SIS Micronesia Project Timeline*)

Because the FSM is comprised of four states with markedly different population characteristics (i.e., language, ethnicity, culture) requiring ongoing attention to applying cultural consciousness and competence in terms of program design and delivery, the SPF Plan will address all of the above to ensure the success of the project. The Advisory Council will ensure that program activities and services are provided in a manner consistent with best practices in cultural competence and will check participant perceptions of project competence; *Language*: Bi-lingual staff, the local language and English, have been the hiring preference. Training/technical assistance sessions will employ “talk-back” processes in relevant local languages. Written materials will be written in English and translated into all major Micronesian languages. *Literacy*: Written materials will be completed in English and major Micronesian languages. Staff will be available to all participants to read written materials aloud and the project will utilize interpreters for non-English and non-Micronesian speaking individuals.

As a result of the *SPF SIG Micronesia* project with respect to sustainability: 1) Data collection activities will produce reliable and valid substance abuse data using a standardized surveillance system in describing the substance abuse problem, understanding the relevant risk and protective factors, prioritizing substance abuse related needs, and selecting prevention strategies. 2) Extensive training will result in a core group of highly skilled preventionists and increased individual, community, and national level capacity to plan for and deliver effective prevention interventions by contracting COM in assisting staff to get certified IC & RC. 3) Communication infrastructure will result in greater amounts of collaboration, shared resources, and shared learning in support of effective substance abuse prevention. Further, the local community college in collaboration with FSM and state level SAMHS will include training in the college public health programs to provide in country technical expertise to provide ongoing training and staff development following the grant project 4) The *SPF SIG Micronesia* will also build capacity, through paid staffing, extensive and well-coordinated technical assistance, and training for the selection, cultural adaptation, and implementation of a comprehensive array of evidence-based practices to reduce substance use and its associated consequences.