



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Marshall Islands**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The RMI will comply with the Assurances and Certifications as stated. The appropriate Assurances and Certifications--non-construction program, debarment and suspension, drug free work place, lobbying, program fraud, and tobacco smoke--that accompany this guidance can be access from the the guidance in the State's MCH program's central office.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Means of Public Awareness:

The Ministry of Health has put more effort to have the public be more involved in the MCH programs and reviewing the grant application. For FY 2009, public announcements were made for the public for any comments and input regarding any issues in the grant application. Copies of the MCH Block Grant Application were made available at the MCH office at the Primary Health Care, including other information that any interested person (s) may had wish to comment/input regarding the grant application. In addition to this, distribution of the draft report for comment on the report and to hear additional views (by phone-calls/writing/other means of communication) regrading the RMI MCH Block Grant Application for the FY 2009.

The RMI (V7AB) is also used to broadcasting the announcement (radio station) where most of the people on the outer islands have access to it. They can hear the announcement on the air that is being announced from 6:00AM to 11:30Night daily seven days a week. Public announcement is also made during the Council of Children with Special Health Care and Education Needs meeting twice annually. Furthermore, where to call for more information was being provided to the public. For more information concerning the application, please call MCH program at the Primary Health Care at the Ministry of Health: (692) 625-3355/ (Ex.: 2123)/7007/455-6941; or visit the MCH office during regular working hours and days (Monday through Friday), (8:00 am to 5:00 pm).

Public Comments/Questions:

The public made comments on Component C, Children with Special Health Needs. Because, most families can not afford the cost for medical bills, and if possible these children be received services without free charged. For some patents/care takers expressed their concerned regarding cost the medical equipments or other supplies as needed for these children for their daily used, such as glasses, hearing aids, wheel chairs, etc.. They also expressed the needs for the service providers to make more afford to make home visits more often or on regular basis. Parents think that the service staff is not enough to provide and that the number of staff providing the direct services for the CSHCN be increased.

Responses:

Some of the responded to the concerned were make, such as for those children whom the families really can not afford the hospital deposit fee of \$5.00 per visit to the doctor to seek medical care, espically those coming from the outer islands, the program is billed with required deposit fee. The program has taken step in strengthening the collaboration between the program and other agencies within the Ministry, including other government ministries for better utilization of equipments for those children in needs, such as, wheel chairs for example. The MCH program has also made arrangement with the medical record to submit on monthly basis any documentation (if any) for any CSHCN Out-patient service cost and the program will then take care of the charges. The program has also provide medical equipments for those CSHCN who are in need and have no means of paying, for example, wheel chair.

The program continues to seek assistance from other service agencies, for example hearing aids, or glasses, and others.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

//2009/ During the year, the process of reviewing data and assess the programs and services within the Ministry continued. The Bureau of Health Planning continued to provide data on all RH/MCH programs and services for the senior staff. Reviewing and making recommendations shows that lack of information about the interventions and goals of the MOH's is limited. Furthermore, community participation and preventive services are recommended in order to reach all population groups including those of the MCH. Based on these recommendations and the reviewing of date from previous years the RMI MCH has selected priorities as stated in the last needs assessment submitted with application for FY 06-07.

*//2009//*The Ministry of Health continues to review data and assess the needs year around. Steps have been taken to ensure that data requirements in the MCH Block Grant and the Ministry are met. The new Ministry of Health Information System is soon to be completed, and we hope to generate more required and accurate from this new Information System. While this new Information System is still not complete yet, we continue relay on the old information system.

Updates will be used to make appropriate adjustments in activities such as plan development, funding , quality assurance and standards development. Updates will also be used for reporting and budget development. The new Information System will allow better depth, breadth, and quality, as well as the identification and use, of new date resources.

III. State Overview

A. Overview

In the fifty years since the end of World War II, two principle trends have occurred in the population of the Marshall Islands: rapid growth and continuing urbanization. The Marshall Islands has a very young growth and growth population. While somewhat more than 30% of the Marshallese people live in a semi-subsistence mode in the rural atolls and islands of the nation, the majority of the population in the two population centers at Majuro and Ebeye. No change//2008//
12009/No change./2009//

***The Republic of the Marshall Islands is situated in the Central Pacific Ocean between 4 degrees and 14 degrees North and 160 degrees and 173 degrees East in almost two parallel chains of 31 Atolls and Islands. The Eastern Ratak (Sunrise) with 15 Atolls and Islands and the Western Ralik (Sunset) having 16 Atolls and Islands. The total number of islands and islets is about 1,225. No change./2008//
/2009/No change./2009//***

Each atoll consists of a ring of islets encircling a deep water lagoon. The islets are interconnected and surrounded by a coral reef. None of these low-lying land areas have an elevation greater than ten feet above sea level. Two of the atolls--Majuro and Kwajalein--have become crowded urban centers, while the outer atolls remain rural in character and are known as "outer islands." No change./2008//
12009/No change./2009//

***Majuro Atoll is the most highly developed area in the nation and has several high schools, a community college, an 80 bed hospital and a developing infrastructure of electrical distribution, fresh water reservoirs and sewerage disposal. The atoll is thirty miles long. The widest islet measures about half a mile from ocean to lagoon. As the national capital, Majuro is home to an expanding population, estimated to be 61,215 at projected population 2004, and is the site of most public, commercial and industrial development. With a land area of 3.75 square miles, Majuro Atoll has a population density of 29,488. Much of the population is crowded into the "downtown" administrative and commercial center at the eastern end of the atoll. No change./2008//
/2009/No change./2009//***

Ebeye, a small island within Kwajalein Atoll, is the only other urban center in the Marshall Islands. The urbanization of Ebeye commenced in the late 1940s with the Department of Defense, with the relocation of Marshallese people from northern atolls that were affected by the US Nuclear Testing Program (1946-1958) and with 1964 opening of the Kwajalein missile testing range by the US Army. With commencement of the missile testing program, families living in the central area of Kwajalein Atoll --known as the Mid-Atoll Corridor--were relocated to Ebeye. In addition to its high birth rate, the population of Ebeye continued to grow over the years as people from throughout the Marshall Islands (and elsewhere in Micronesia/other countries) were attracted to job opportunities at the nearby military base. On Ebeye Island, more than 11,000 people reside on a land area of .12 square mile. Housing substandard and extremely crowded. While a new 38 bed hospital, currently opened that replace a dilapidated older facility, health problems are numerous and may be attributed, in part, to overcrowding and an inadequate water supply. Kwajalein Atoll is the largest atoll in the world, with a lagoon area of 839.3 square miles. The total land area of the Kwajalein islets comes to 6.33 square miles. No change./2007//
/2009/No change./2009//

The rural outer islands comprise the remainder of the Marshall Islands/ Scattered over great expanses of the Pacific Ocean, population in separate communities range from 50 to 800 persons. The outer islands constitute a diminishing proportion of the population of the nation.

With few exceptions, between noncontiguous islets of an atoll can only be taken by canoe or motorboat/ Meals are cooked on open fires or single-burner kerosene stoves. The government field trip ships travel to each outer island every two or three months bringing passengers, medical and education supplies and trade goods. Income for residents of the outer atolls is generated primarily from the sale of copra (dried coconut) and handicrafts. No change./2008//
/2009/No change./2009//

***In the outer islands, medical care is available at dispensaries staffed by health assistants who maintain radio contact with the Majuro or Ebeye hospitals for instruction and guidance. Other than a public school on Jaluit Atoll, another public school completed at Wotje Atoll and a private, church-affiliated high school at Ailinglaplap Atoll. there are no secondary education facilities in the outer islands. No change./2008//
/2009/No change./2009//***

Each of the twenty-four inhabited outer islands has an airstrip. Several of the larger atolls have more than one airstrips. Emergency medical evaluation are accomplished by small and larger aircraft or, at islands where the airstrips have been closed for repair, by field trip ship. Medical evacuation by air can only take place by daylight since the outer island airstrips do not have landing lights. Medical evacuation by ship to the hospitals in Majuro or Ebeye can take as long as two days, depending upon distance and sea conditions. Patients in the outer islands requiring specialized care not available at Majuro or Ebeye would be routed through Majuro or Ebeye before referral to Honolulu. The outer island dispensaries and the hospitals at Majuro and Ebeye are owned and operated by the RMI Ministry of Health. There are no private health care providers in the Marshall Islands.
No change./2008//
/2009/No change./2009//

People travel from Majuro and Ebeye to the outer atolls on a 24-Seat Dornier managed the Air Marshall Islands and on government-owned field trip ships that commute between atolls once a month. A small boat that is highly dependent on fuel supplies, available, people walk during low tides on the exposed coral reefs between the islands in order to reach the airstrips. It takes more than 24 hours to travel by ships and more than an hour and half by plane to the farthest island.
No change./2008//
/2009/No change./2009//

The total population of the Marshall Islands is estimated at 63,579. More than 50% of the population is under 15 years of age. The average growth rate of 3.6% is the highest in the Pacific. Currently, more than 60% of the population resides in the two urban centers. The remaining 40% reside in the outer atolls. Delivery of health care services to a dispersed population in the RMI is cumbersome.
/2007/The projected population of the Marshall Islands is slightly increasing. In 2006, the projected population has increase from 63,579 to 65,814./2008//
/2009/ Migration has the biggest impact on contemporary population growth in the RMI, as we can see from international migration statistics for the RMI, 1990 - 2006, that recently became available, and which have not factored into any projections in the 1990s. this is the sole reason our projections provide you with a RMI population total of around 52,338 - which is considerably lower than the figures of 62,000 currently floating about. We have used an annual net migration total of - 1,500 for 1999-2001, and then dropping it to -850, which corresponds to the annual net migration total between 2002 - 2006./2009//

B. Agency Capacity

The Constitution of the Marshall Islands designates the Ministry of Health and Environment (MOHE) as the "state" health agency. The MOHE is the only legislative authorized agency that provides health care services to the people of the Marshall Islands.
/2007/ The Ministry of Health and Environment (MOHE) has changed. MOHE is now Ministry of

Health (MOH). This was being done to transferred Enviroment from the Ministry to RMI Environemtn Protection Agency (RMI EPA). This has been allowing more public access to information and better coordination and collaboration between MOH and EPA in terms of clean and healthier enviroment.

No chnage.//2008//

/2009/No change.//2009//

The Bureau of Primary Health Care (PHC) is one of the five major bureaus within the Ministry of Health. It is reponsible for all preventive and primary care and the Division of Public Health is one of the five and the largest with five program areas. No change.//2007//

/2009/There are three Bureaus that provide direct health care services in the country: 1) The Bureau of Majuro Atoll Health Care (MAHCS), 2) The Bureau of Kwajalein Atoll Halth Care Services (KAHCS), and 3) The Bureau of Outer Islands Health care (OIHCS). Primary Health Care is classified under Majuro Atoll Health Care Services.//2009//

The MCH/CSHCN Program is not a separate agency. It is one of the programs in Public Health. The nurses and medical staff implement all clinical, follow-up and community outreach programs for all areas in Public Health. The MCH/CSHCN Program provide health care services for mothers, children, infant,adolescents and their families in the RMI. There are currentlt 22 nurses who implement all clinical services for public health programs, seven medexes (physical assistants), a medical director and an OB-GYN who are assigned to Public Health.

Seven (7) of the public health staff receives support salaries from the MCH Block Grant. The same seven staff (nurses, medexes/physicians) also travel to the outer atoll to implement the programs and services in Public Health. No change.//2007//

No changed.//2008//

/2009/The MCH/CSHCN is one the components within Reproductive Health. There are eight nurses, three OBGYNs, and five support staff receiving salaries from the program.//2009//

Oral Health is being one of the MCH/CSHCN program services that receive support from the MCH program in terms of services for pregnant women and children, including the schools and all MCH population. Due to shortage of trained dental health care providers, the MCH/CSHCN program is in the process of hiring two additional dental assistant to assit in the MCH dental services, and to expand its services into the communities.

No change.//2008//

/2009/Hiring of two dental providers have been implemented, and more out reach activities into the schools and into the communities are going on.//2009//

The overall health care system in the Republic consists of two hospitals in the two "urban" centers of Majuro and Ebeye, and 57 health centers in the outer atolls. The main hospital on majuro is a 80-bed facility, and Ebeye has a 25-bed hospital. Both facilities mainly provide primary and secondary care with very limited tertiary care. Patients who need tertiary care are referred to hospital in Honolulu or the Philippines. The Bureau of Primary Health Care within the Ministry of Health also offers a full range of preventive and primary care programs in the two main hospitals.

No change.//2008//

/2009/No change//2009//

The MCH and CSHCN have been intergrated into one program. This allows for more efficient use of scarce human resources and better collaboration and coordination of services in MCH. The RMI MCH/CSHCN program provides and coordinates the full spectrum of preventive and primary health care services for mothers, infants, children and adolescents both in the hospitals setting and the health centers. The services include prenatal and high-risk prenatal care clinics, postpartum care, and well childcare that includes immunization, high-risk pediatric clinics, school health program, coordination of family planning services, and the coordination of care for children with special health care needs.

No change.//2007//

No changed.//2008//

/2009/MCH/CSHCN have been placed within Repriducitve Health. This further allows for more efficient use of scarce human resources and better collaboration and coordination of services in MCH.//2009//

For several years, one of the priorities of the MOH was to develop an effective health information system. The Ministry is currently hired a new Health Planner. The Ministry has received technical assistance to modify its Health Management Information System (HMIS) in order to improve its capabilities to collect and use data to improve health care services. The Ministry has established a HMIS Committee and Working Group to review all forms and other documents that will enhance the HMIS. All programs in the Ministry have already started using the revised forms for recording and reporting of data which are being collected and channeled to the Bureau of Health Planning and Statistics. Staff training on the use of the revised froms is completed.

No change.//2007//

No cahnged.//2008//

/2009/No change.//2009//

While data and information systems have improved in the past year, this improvement has occurred primary within the urban health care settings. There is still a need to improve the data collection from the health centers int he outer atolls. The HMIS Committee has revised the recording/reporting froms, which will enable the health providers in the health centers to collect essential data and statistics. In addition to the encounter forms used by health facilities in the urban centers, a monthly form was developed to ensure that reports are regularly submittedf to the Office of Outer Islands as underreported by agencies within the Government due to inadequacy of reports submitted from the health centers. Therefore, mechanisms have been developed to improve the reporting of the number of births, deaths and encounters for all clinical and preventive services provided in the outer atolls.

No change.//2007//

Up-date./2008/ A new data and information system is almost done where all data computers will be link for access data more easily when needed from other programs within the Ministry of Health.

/2009/The New data and information system is still in the process of completion.//2009//

The Health Management Information System (HMIS)

The HMIS is a computerized database to handle all health and health-related data in the MOH. Based on the File Maker Pro software, it was designed to be a user friendly and menu diven system that can be used to monitor the progress of various health program, meet the reporting requirements of US Federal Grants, WHO, and other external agencies.

No change.//2007//

/2008/Health Mangangement Information System is on the way for completion.

/2009/The new Health Manangement Informaiton System is almost done.//2009//

The HMIS has four goals that aim to meet the information needs in the RMI. The first goal is to support the expand role of Primary Health Care. The Ministry believes that by implementing a wide range of effective and sustainable PHC programs, we can significantly reduce disease burden. Therefore data management and monitoring PHC is critical. The second goal is to provide accurate, consistent, and timely reports on the broad range of health services and programs offered by the MOH. These reports can also assist health manangers in decision making. The third goal is to provide the MOH with a wider range of information on the personnel and financial resources that are available. This will assist in the health planning for the future. The fourth goal is to ensure that the HMIS is a sustainable system that can be used to provide timely and accurate data for managers tasked with policy making decisions.

No change.//2007//

No change.//2008//

/2009/No change.//2009//

The HMIS database is divided into five modules: Medical Records, Public Health and Epidemiology, Referrals, Finance and Personnel, and Benefits, Monitoring and Evaluation (BME).

The main purpose of the Medical Records modules is to accurately record a patient's life and medical history. This information will be useful for clinical providers in treating the patients and to health service managers responsible for health planning, supervision and evaluation of health services.

No change.//2007//

No change.//2008//

1. Medical Records

The main focus of HMIS activities so far has been on the Medical Records component since it was where most of the data collected had to be consistent and able to accommodate all the curative and preventive care departments who see patients.

No change.//2007//

/2008/ It will be shifting to the new Information System.

/2009/No change.//2009//

Therefore, a comprehensive encounter form was developed.

The Encounter Form

The Outpatient encounter form contains the patient's name, medical record number, encounter date, date of birth, age gender, atoll of residence, type of visit, and the health provider's name. A list of diseases classified by their International Classification of Diseases 9th Edition (ICD-9) codes, procedures, and referral destinations are listed in boxes for the health provider to complete.

No change.//2007//

/2009/No change.//2009//

The encounter form was originally designed for the hospital's outpatient activities. In collaboration with the HMIS Working Group, which comprised of the Secretary of MOHE, the Assistant Secretary, PHC, and various departments and programs directors, the original encounter form was modified and the name changed to "MOHE Encounter Gorm" to reflect the number of departments for which this form was redesigned. While it resembles the format of the original for, there have been numerous changes and modifications. The International Classification of Diseases, 9th Edition (ICD-9) was used to standardize and classify patient findings. Sections of the form have also been rearranged to address the needs of each department.

No change.//2007//

No change.//2008

/2009/No change.//2009//

The MOH Encounter Form is also being used in the Outer Islands and complemented with a monthly report form to be sent to majuro each month by the Health Assistants. The MOH Encounter already includes categories related to cancer screening and treatment. Combined with the patient's medical chart, the Encounter Form will assist both the clinician and the Ministry's data management and surveillance efforts.

No change.//2007//

No change.//2008//

/2009/No change.//2009//

Public Health and Epidemiology

The Public Health and Epidemiology components do not have a standard form (excluding those for Births and Deaths) and relies on the monthly reports sent by each department to the Planning Office. While some data can be obtained from the Planning Office, a form, which lists specific data categories, was designed for selected public health departments. This format will enhance monthly data reporting to the Planning Office and provide HMIS with the necessary information to assist in documenting vital and other health-related statistics. The data will enhance the data collected from public health and medical records. As part of the cancer screening and early detection program coordinator's duties, a monthly report will be sent to the Office of Planning and Statistics to ensure that the data is collected and appropriately disseminated.

No change.//2007//

No change.//2008

/2009/No change.//2009//

The Referral component will be essential to determining the incurred costs for overseas referrals. Like the MOH Encounter Form, patient information will also be included. The module's primary objectives are to document the amount spent on each type of referral. The patient and financial information can be used for long term planning. Through this module, the number of cancer related referrals to tertiary hospitals in the Philippines or Honolulu and cancer related deaths that occur overseas are documented.

No change.//2007//

/2009/No change.//2009//

Finance and Personnel

The Finance and Personnel Module was designed to provide the MOHE with a system that identifies financial information available and utilized by the Ministry. A Five-Year Budget Planning Model and Program Budget Allocation Program designed with the assistance of MOH staff is being implemented to ensure that the services we provide are sustainable.

No change.//2007//

No change.//2008//

/2009/No change.//2009//

Benefits, Monitoring, and Evaluation (BME)

The objective of the BME module is to ensure the accuracy and relevance of the data we generate. In addition, the module is intended to provide a series of indicators to monitor and evaluate the efforts undertaken by MOH staff. We will be able to see which health programs or services have had the most impact and which need refinements.

No change.//2007//

No change.//2008//

/2009/No change.//2009//

Training and Professional Development

The ministry and donor agencies fund the continuing education and training of public health staff. The assistant secretary or program directors assign the personnel who attend training programs. The training has been in various formats like workshops, seminars, and certificate programs or academic programs.

No change.//2007//

/2009/No change.//2009//

Evaluation Plan

Monitoring and evaluation duties will be assigned to the individual program managers and directors and to the Bureau of Health Planning and Statistics. In the process of monitoring and evaluating the implementation of activities for the grant, the Health Management Information

System is being tailored to address the needs of a database that will be flexible to collect epidemiological data that can be used as a tool for investigations and policy making decisions. Monthly reports from the various programs will provide significant data on the health services being provided and the types of cases seen in the clinical and public health offices. Data such as morbidity and mortality number of cases seen involving fever, cases of diarrhea, number of chronic diseases like high blood pressure and diabetes will assist the Bureau of Health Planning and Statistics in identifying potential contributors to an outbreak. Preventive measures can then be taken to minimize the number of cases.

No change./2007//

nO CHANGE./2008

/2009/No change./2009//

A formal evaluation will be done through the HMIS's Benefits, Monitoring and Evaluation module (BME). This module will complement other evaluation and monitoring tools that may be proposed by the Ministry's technical committee. The following table lists some of the measures that will be included in the BME.

No change./2007//

nO CHANGE./2008

/2009/No change./2009//

These measures were selected to assist the Secretary of Health, Assistant Secretaries, department managers, program coordinators, and the Health Planning and Statistics Bureau in developing contingency, staffing, and organizational plans to ensure that the MOH will have the means to collect and analyze data for tracking the National and Jurisdictional performance Measures.

No change./2007//

nO CHANGE./2008//

/2009/No change./2009//

C. Organizational Structure

The Government of the Marshall Islands has a parliamentary system. Thirty-three senators are elected to the Nitijela (congress) every four years, and from the Nitijela, a president is elected. The Presidential-appointed members of the Cabinet exercise all executive functions of the Government of the Marshall Islands. The Ministry of Health (MOH) is one of nine governmental agencies instituted under the Government of the Marshall Islands.

No change./2007//

no CHANGE./2008//

/2009/No change./

The head of the MOH is an elected senator and a member of the President's Cabinet. The Minister exercises authority for health on behalf of the Cabinet, and he/she is responsible for the development of policies for the Ministry with recommendations from the Secretary of Health, on the other hand, is appointed as the "permanent" head of the Ministry. The Secretary of Health is responsible for daily management and administration of the Ministry and reports directly to the Minister of Health.

No change./2007//

No change./2008//

/2009/No change./2009//

The MOE has five major Bureaus:

1. Bureau of Primary Health Care
2. Bureau of Majuro Hospital Services
3. Bureau of Health Planning and Statistics
4. Bureau of Kwajalein Atoll Health Care Services

5. Bureau of Administration, Personnel and Finance

/2008/

The MOH has Three Bureaus and 3 Major Offices:

- 1) The Bureau of Majuro Atoll Health Care Services (MAHCS),
- 2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS),
- 3) The Bureau of Outer Islands Health Care Services (OIHCS),
- 4) Office of Administration, Personnel and Finance
- 5) Office of Health Planning and Statistics
- 6) Office of Medical Referral Services.//2009//

With the exception of the Bureau of Health Planning and Statistics that is headed by the National Health Planner, an Assistant heads each bureau. All Assistant Secretaries and the National Health Planner report directly to the Secretary of Health.

/2009/The Health Planner has been transferred to Ministry of Internal Affairs to be the Secretary of this Ministry. No new Health Planner yet.//2009//

The Bureau of Primary Health Care where the MCH program and CSHCN program is based, is further divided into six divisions:

1. Division of Public Health
2. Division of Human Services
3. Division of Population, Family Health & Health Promotion
4. Division of Reproductive Health (MCH/CSHCN/Family Planning/Adolescent Health)
5. Division of Outer Islands Health Centers
6. Division of Dental Services

/2009No change.//2009//

A director who reports directly to the Assistant Secretary for Primary Health Care heads each of the division. In the Division of Public Health, there are four program areas in which the MCH/CSHCN program is one. The Assistant Secretary for PHC is responsible for the daily management and supervision of programs carried out under the Title V program in each of the divisions.

No change.//2007//

/2008/In the Division of Reproductive Health, there are two program areas in which the MCH/CSHCN is one. Due to the changes in the organization structure of the Ministry, the Division of Primary Health Care (which MCH/CHSN is under) is now directly under the management of Assistant Secretary for Bureau of Majuro Atoll Health Care Services//2008//

/2008/Maternal and Child Health/Children with Special Health Care Needs/Family Planning/Adolescent Health have been integrated into one Division, which is now called the Reproductive Health Clinic, which is under the Division of Primary Health Care. This allows for more efficient use of scarce human resources and better collaboration and coordination of services in both programs.

/2009/No change.//2009//

An attachment is included in this section.

D. Other MCH Capacity

Twenty-two nurses in Public Health implement all the clinical and primary health care for all program areas in Public Health. These same nurses travel to the outer islands in addition to

supervising their assigned health zone in Majuro. The nurses must also work on weekends to do cold chain monitoring for vaccines stored in the Public Health clinics and to immunize all newborn babies in the Majuro Hospital with BCG and Hepatitis B vaccines when necessary. The nurses are not compensated for the times they work during weekends. Furthermore, the nurses are the only ones trained in the cold chain monitoring of the vaccines and are responsible for packing them to be sent to the outer atolls on weekends. Seven of the public health staff (nurses, medexes/physicians/dental assistants/health educators) receives support salaries from the MCH Block Grant. These same 7 health care providers provide the service delivery to the MCH population throughout the Republic.

No change.//2007//

//2009//Three additional Reproductive Health (RH) Nursing staff have been hired and this makes it to 10 nurses providing direct Reproductive Health Services for Majuro and outer islands as well as providing staff support for Ebeye RH service delivery. /2009/

Response to Comment:

Six providers receive salaries from the MCH Block Grant (MCH OBGYN, Health Educator, Dental Assistant, Nurses). The rest of the program providers receive salaries from other funding.

E. State Agency Coordination

The Ministry of Health and Environment, being the only "state" agency that provides health care services in the Republic, realizes the significance of collaborating with other agencies in the implementation of services to the communities./2007/ Change from Ministry of Health and Environment (MOHE) to Ministry of Health (MOH).//2008//

/2009/No change./2009//

Since the MCH/CSHCN is one of the programs in Public Health, services are effectively coordinated among the staff in Public Health, who also provides services for other program areas. The MCH/CSHCN program also coordinates with other divisions in the Bureau of Primary Health Care, such as the Mental Health Program, Alcohol & Substance Abuse Prevention Program, Vocational Rehabilitation and Social Work. For community outreach purposes, MCH/CSHCN coordinates with the Health Education and Promotion Unit, the Nutrition Unit and the Family Planning Program. These services have been expanded that other programs provide services to the MCH/CSHCN population have included.

No change.//2007//

/2009/The MCH/CSHCN is one of the Division of Reproductive Health components, services are effectively coordinated among the staff in Reproductive Health./2009//

//2009//The MCH/CSHCN and Family Planning have integrated into one Division which is the Reproductive Health for better utilization of services. RH service has expanded its service delivery with two addition clinics sites on Majuro, Laura Health Center and Youth to Youth In Health clinics. Coordination and collaboration between RH and other programs and agencies are all on-going.

The MCH/CSHCN coordinator is also a member of the Inter-Agency Leadership Council which coordinates with all agencies that provide services for children with special health care needs. Through a Memorandum of Understanding, the members of the Inter-Agency coordinate services for all CSHCN and adults who have special needs. The members of the Inter-Agency Council include: Special Education Program in the Ministry of Education, Health Start Program, College of Marshall Islands, Majuro Atoll Local Government, Kwajalein Atoll Local Government, Women in Development Office in the Ministry of Internal Affairs, and the programs in the Ministry of Health such as the Mental Health Program, Vocational Rehabilitation and Social Work. This Inter-Agency meets on a

quarterly basis.
No change./2007//
/2009/No change./2009//

The Core Committee in the MOH carries out coordination of community awareness on primary health care activities and programs. The MCH Coordinator chairs the Core Committee with other member from Nutrition Program, Hospital Services, Adolescent health, Health Promotion, Family Planning and the Human Services programs. All the international and national health events are coordinated by the Ministry's Core Committee in collaboration with the RMI Inter-Agency Council and the National Population Coordinating Committee. The Core Committee in the MOH carries out coordination of community awareness on primary health care activities and programs.
 No change./2007//

/2009/ No change./2009//

Some of the activities conducted during the year organizing and participating in the annual World TB Day, National Health Month that coincided with World Day (Annually), Breast Feeding Week, World Diabetes Day, World Food Day, World Population Day, Immunization Week. World AIDS Day, and the National Week for the Disabled. The same activities also conducted during the year as our annual activities.

No change./2007//
/2009/These activities are conducted on an annual basis./2009//

Response: Laura Health Center is on regular staff receiving salary from the MCH Block Grant. While on a weekly regular basis, one OBGYN or CNM, and one RH Nurse join him and full RH service is being provided, such as Prenatal clinic, women/male health clinic, FP and other RH services is provided.

F. Health Systems Capacity Indicators
Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	357.1	595.3	239.3	235.2	233.3
Numerator	314	527	213	214	210
Denominator	8792	8853	8900	9100	9000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
/2009/ The data system has been improved over the past, but still needs to be improved to capture better date regarding this HSC. There is a development of new information system should be implmented this year, therefore, data base on age break down on this HSI will be reported in the next reporting cycle.

//2009//The data system is still in the process of development and hopefully by the end of this year should be able to implemented the new system.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1584	1650	1578	1585
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Not applicable to the RMI since RMI does not have Medicaid.

Notes - 2006

Not applicable to the RMI since we do not have Medicaid.

Notes - 2005

Not Applicable for the RMI since no Medicaid.

Narrative:

This is not applicable to the RMI since we do not have Medicaid. Under of the Compact of Free Association with the U.S.A., RMI is not eligible for Medicaid.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1251	1584	1650	1578	1585
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

RMI does not Have SCHIP.

Notes - 2006

Not applicable to the RMI since RMI does not eligible for SCHIP.

Notes - 2005

It does not apply for the RMI.

Narrative:

Not applicable to the RMI since RMI does not have SCHIP. Data shown here is being collected throughout the year.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	34.5	17.7	18.4	30.9	78.6
Numerator	432	280	302	486	1238
Denominator	1251	1584	1643	1573	1575
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

Beginning with the 2007 annual report, the Pacific Basin Jurisdictions may have changed to the World Health Organization (WHO) standard rather than the Kotelchuck Index to report indicator data for HSCI04. The WHO standard recommends as essential that pregnant women make four prenatal care visits.

Notes - 2006

This is estimated, since the it is based only on Majuro Clinic log book and prenatal entry data.

Narrative:

The new data system that is in the process of developing and hope to be implemented by the end of this year would improve the our data collection and reporting. This data system will be used by the state Health Service. With the staff of three hired under the SSDI grant improvement has shown when we look at the data outcome

Response: Most of the data reported is being from Majuro as stated in the Grant Application. The RMI has not started the WHO standards, it is planned to start with the new 5 years Assessment with a base line

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
--	-------------	-------------	-------------	-------------	-------------

Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	22052	22281	23906	25574	2557
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

RMI does not have Medicaid Program.

Notes - 2006

Not applicable to the RMI since RMI does not have Medicaid Program.

Notes - 2005

Not Applicable for the RMI since it does not apply in RMI.

Narrative:

RMI does not have Medicaid Program/Not applicable to the RMI.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	7207	7619	7619	8121	8121
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

RMI does not have EPSDT.

Notes - 2006

Not applicable to the RMI since RMI does not eligible to EPSDT.

Notes - 2005

Not applicable to the RMI since RMI is not eligible under the Compact of Free Association with the U.S.

Narrative:

No t applicable to the RMI since RMI is not eligible for EPSDT.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1251	1548	1625	1720	1720
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

RMI does not have SSI. Data is based on 2006.

Notes - 2006

Not applicable to the RMI since RMI does not have SSI.

Notes - 2005

Not applicable to the RMI since it does not have SSI.

Narrative:

RMI does not eligibel for SSI ,/Not applicable to the RMI.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	other	0	70	70

Notes - 2009

Birth record/log book and birth certificicates.

Narrative:

Not applicable to the RMI since is not eligible under the Compact of Free Association with the U.S.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05	YEAR	DATA SOURCE	POPULATION
----------------------	-------------	--------------------	-------------------

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	other	0	37	37

Notes - 2009

Medical Records.

Narrative:

Not applicable to the RMI since is not eligible for medicaid care under the Compact of Free Association with the U.S.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	0	80.4	80.4

Notes - 2009

Prenatal charts Delivery charts and medical records.

Narrative:

Not applicable to the RMI since RMI does not eligible under the Compact of Freely Association with the U.S.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is	2007	other	0	80.4	80.4

greater than or equal to 80% [Kotelchuck Index]					
---	--	--	--	--	--

Notes - 2009

Prenatal records.

Narrative:

Not applicable to the RMI since RMI does not have medicaid care therefore data between medicaid and non-medicaid can not be compared

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	

Notes - 2009

RMI does not eligible to Medicaid.

Notes - 2009

RMI does not eligible for SCHIP.

Narrative:

Not applicable to the RMI since is not eligible under the Compact of Free Association with the U.S.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range to) (Age range to) (Age range to)		
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range to) (Age range to) (Age range to)		

Notes - 2009

Not applicabl to the RMI.

Notes - 2009

Not applicable to the RMI.

Narrative:

Not applicable to the RMI since RMI does not eligible under the Compact of Free Association with the U.S.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	

Notes - 2009

Not applicable to the RMI.

Notes - 2009

Not applicable to the RMI.

Narrative:

Not applicable to the RMI since is not eligible under the Compact of Free Association with the U.S.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
	2	Yes

Annual linkage of birth certificates and newborn screening files		
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

The RMI MCH program coordiantes and collaborates with the Health Information System. Our data system has been imprived over the past but still needs to be improved. The RMI does not have PRAMS data for mothers is being collected at our prenatal clinics, out reach/outer islands, and Ebeye clinics.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2009

Narrative:

Steps has been taken to have access to information whose dealing with the youth organizations and the youth programs throughout the Republic. The program staff in collaboration with the Internal Affairs and Youth to Youth in Health and Ministry of Education formed as a "Mobile" team and do outreach activities as well providing health education regarding youth behavior. Data on this HSC will be ready and reprot in the next reporting cycle.

IV. Priorities, Performance and Program Activities

A. Background and Overview

*//2009/ Based on health data collected by the MCH Program, the RMI MCH/CSHCN has selected the same priority needs in which some of them has been selected from the last year's needs. These priority needs have been selected to improved the health status of mothers, infants, children, youths in the RMI in all four of the services described in the pyramid. //2009//*The RMI has selected to continue with last year's priority needs.

B. State Priorities

These are all indicators that the MCH program and services must challenge each year.

Direct Health Care Services:

B. State Priorities

*//2009// Base on health data collected by the MCH Program the RMI MCH/CSHCN has selected the same priority needs mostly as last year's needs but with some additional areas of needs. These priority needs have been selected to improved the health status of mothers, infants, children, youths in the RMI in all four of the services described in the pyramid. //2009//*RMI has selected to continue with the same priority needs as last year's.

1. To reduce infant mortality rates.
2. To reduce the rates of teenager pregnancy.
3. To Increase the rates of prenatal visits during the first half of pregnancy.
4. To reduce neonatal mortality and morbidity.
5. To increase access to preventive services for women who are at risk for cancer. essential data and statistics on how the Ministry can improve programs and services.
6. To reduce the rates of sexually transmitted diseases among women of child-bearing age. coordination of services between agencies for CSHCN.
7. To strengthen the Health Information System to provide essential data to strengthen health care services focusing on preventive services.
8. To improve accessibility to the MCH/CSHCN services for children 0-21 and their families.
9. To improve preventive services for school children in dental care, immunization, and nutrition.
10. To strengthen screening programs on hearing to infants and young children.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	0	0	0	0	0
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1584	1512	1650	1578	1585
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	10	15	20	25	30

Notes - 2006

This PM#1 is not applicable to the RMI since newborn has not implemented yet. But it is estimated that 175 have been provided screening as stated in this PM.

Notes - 2005

The data indicated here is estimated.

a. Last Year's Accomplishments

PM#1 is not applicable to the RMI since there is no newborn screening program yet. But, in some cases new borns are requested to be tested and blood is then sent out the testing where there is no test tools to be used. Sending blood test off islands is only being done upon requested by the doctors, and it is not very common (around once or twice monthly) and for those very sick newborns.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This is not applicable to the RMI since RMI does not have mandated newborn screening program yet.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Although, there is not no newborn screening program in place yet, a routine general screening is an on-going for the newborn. New born are examined by the doctor on call at time of delivery and the physical exam, other than the routine exam, further testing is order by the baby's doctor. Routine exam continue by the attending doctor or on call, continue refer to CSHCN if indicated for follow-up and monitoring. For those very sick newborns and need blood tests, then the blood is sent off islands to Honolulu for testing.

c. Plan for the Coming Year

In the first half of next FY 2009, plan to develop and a newborn screening program for the Ministry. To continue with the routine new born exam until an official newborns screening program is in place.

Response

The MCH Program is looking at using the block grant to develop a newborn & hearing screening in the next grant cycle. Palau's model has been reviewed and the next will be development of the screening plan.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	9	9	9	9	9
Annual Indicator	100.0	100.0	100.0	90.8	100.0
Numerator	308	361	395	395	445
Denominator	308	361	395	435	445
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The MCH/CSHCN program has met this National Performance Measure by conducting 10 more additional follow-up visits with parents and families on those CSHCN in collaboration with the public health teams and zone nurses. The Core Committee has developed an on going list of specific questions for both clients and families that will help the service providers plan care that is needed for their children with special health care needs. MCH/CSHCN program continues similar activities during training and community outreach follow-up with clients and community awareness on MCH programs and activities. The MCH program continues to focus more on the community as a whole.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of screening element/mechanism to identify child with special health care needs.	X			
2. Monitoring services as stated in the MCH protocol for CSHCN so that these children can receive the care needed.	X			
3. On-site training of the health care providers on issues concerning CSHCN.	X			
4. Outreach activities such as home visits, zonal, outer atolls trips and screening for CSHCN.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMI MCH/CSHCN program continues to provide medical health care services to all the children and families who have been identified and confirmed to have some sort of disabilities/or disabilities. Continue to screen and referral of clients to the pediatricians or the physician on call, and an on-going collaboration with medical staff in the two urban centers who provide services for all infants and children in the Marshall Islands. Provides routine screening to identify and referral have been an on-going after delivery, well-baby, and community out reach activities, inducing out islands visits. Strengthening the coordination and collaboration between the Ministry of Health and Ministry of Education by join effort to provide more service access and as well as parents/families participate more in decision making for their children. Evaluation and monitoring for justification is being done by asking questions to find out if their needs have been met.

c. Plan for the Coming Year

Continue in the development plan for a screening tool for a better identification of these children, such as a guideline or criteria. Establish a better communication and collaboration between providers, as agencies. This plan should be completed by the end of the second quarter 2009.

Response:

There is survey/questions in place and it is used for each family responses to satisfaction of services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	308	361	395	435	445
Denominator	308	361	395	435	445
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

This performance maintains its level at 100%. The Ministry of Health being the "state" health agency, provides medical health care services to all residents throughout the State Hospitals on Majuro and Ebeye in the Division of Public Health. Infant and children who have been identified were referred to the pediatricians or the physician on call who became their primary physician for the referred cases. RMI continues to maintain the NPM at 100% in involving all CSHCN and families in their daily medical care at homes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to do home base care/visits to evaluate and monitoring of clients.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH/CSHCN program continues to collaborate with medical staff at the hospitals in providing health services to all infants and children. Every child in the RMI is considered as having a "medical home". Continues to screen and identify infants and children for any disability conditions and refer to the service. Continues to collaborate with medical staff in two urban centers in providing health care services to all infants and children. Continues to provide services for these children and families on a home base care.

c. Plan for the Coming Year

The MOH being the "state" health agency, provides medical health care services to all residents throughout the State Hospitals on Majuro, and Ebeye. The MCH/CSHCN will continue to

collaborate with the medical staff in the two urban centers in providing health care services to all infants and children. Continue to maintain at 100% these children with the present as having "medical home" for of them. RMI will continue to provide the services for the CSHCN and families at homes.

Response: RMI classified home as medical homes for any children with special health care needs.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	86	90	95
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	308	361	395	435	445
Denominator	308	361	395	435	445
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

This Performance Measure remains the same as last year. The Republic of the Marshall Islands health insurance policy covers all Marshallese. Medical services are provided to all residents from the Ministry of Health, which includes in two hospitals in the urban centers and the health centers in the outer atolls (the MCH population is included). This remains at 100% coverage with the Marshall Islands health insurance policy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to identify those children who are at risk to provide the service free of charge.		X		
2.				

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMI MCH/CSHCN provides medical health care services. This is universal health coverage for all citizens and residents in the RMI. The RMI MCH/CSHCN continues to focus on efforts to screen all children to identify CSHCN and refer to CSHCN program. CSHCN program provides service to these clients free of charge. This is an on-going policy for the RMI that includes the MCH/CSHCN population.

c. Plan for the Coming Year

2009 Performance Objective: 100%

Planned Activities: There is universal health care coverage for all citizens in the RMI. The Ministry will continue to focus on efforts to screen all children in order to have children identified with special health care needs and refer them to the CSHCN program. The MCH/CSHCN program will continue to coordinate ,and collaborate with public health outreach team, zonal nurses, and other agencies providing services for these children and families to improve service delivery care for these children and their families. RMI will continue to maintain the service at its present level.

Response: Numerator was corrected

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	85	90	95
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	308	361	395	435	445
Denominator	308	361	395	435	445
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Annual Performance Objective: 100% The RMI MCH/CSHCN program continues to provide services and receive referral cases/reports from those families of CSHCN or the community through the health workers/health assistants assigned in that community. The MCH/CSHCN continues to provide services , such as nutrition counseling, oral hygiene, etc.) for those CSHCN and families in the community. CSHCN service is available on the community base where clients and families are being refer to and also get the refer to the MCH/CSHCN program at the MOH.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. . Identify and refer of clients t the pediatricians or the physician on call.		X		
2. Identify and refer of clients to the pediatricians or doctor on call.		X		
3. Collaborate with medical staff in the hospitals who provide health services for all infants and children.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMI does not have actual community-based system yet. However, those families report to the health workers/health assistant who is assigned to that community. Those families of CSHCN have access to information and services which are then referred to the MCH/CSHCN program. Better communication has been established between the MCH base and the clients. A direct telephone line has bee established and with clients and families have better access to program without charged. In addition, they can have also to the program through internet with a direct line free of charged. With these services being available, families have more access to service and they are more organized and centralized to use them easily. MOH continues to utilized the Health Centers for the outer islands and the two main centers (Majuro & Ebeye) to make these services at community base level.

Response: All families have access to communication. They use phones in Majuro, Ebeye, and some of the outer islands, most of them do not have access to internet, but radio (CBs) is always available in the dispensaries on the outer islands and is means of communication to the outer islands.

c. Plan for the Coming Year

The RMI MCH/CSHCN program will continue to provide services and receive referral cases/reports from those families of CSHCN or the community through the health workers/health assistants assigned in that community. The MCH/CSHCN will continue to provide services , such as nutrition counseling, oral hygiene, etc.) for those CSHCN and families in the community. The program will continue to maintain the access to community base service at local level for 2009.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	9	9	9	91	91
Annual Indicator	64.9	77.6	83.5	94.3	54.2
Numerator	200	280	330	410	241
Denominator	308	361	395	435	445
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	93	95	98	98	98

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Annual Performance Objective: 10%

Accomplishment: The RMI MCH/CSHCN program collaborates with the Ministry of Education in making transition of children/youth with special health care needs. The MCH/CSHCN program referred 5 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools. RMI has met this NPM at more than 50%. On going collaboration and coordination between CSHCN Coordinator, and the Ministry of Education with the strong support from the CSHCN/Education Council makes has a very strong support the service.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with Ministry of Education to prepare these youth		X		

for further education or even get a job.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Annual Performance Objective: 10%

Accomplishment: The RMI MCH/CSHCN program collaborates with the Ministry of Education in making transition of children/youth with special health care needs. The MCH/CSHCN program referred 6 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools. Meetings on quarterly regular basis to bring up any issues regarding the transition period to prepare these children.

c. Plan for the Coming Year

2009 Performance objective: 15%

Planned Activities: The MCH/CSHCN program will continue to collaborates and coordinates with the Ministry of Education. Maintain that contact with Ministry of Education and the parents community members at the present level.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	60	65	73
Annual Indicator	57.0	49.5	61.0	72.0	95.0
Numerator	1984	1435	925	1152	1524
Denominator	3480	2899	1516	1600	1605
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	95	95	95	95	95

a. Last Year's Accomplishments

Performance objective: 15%

For FY 2007, the immunization fully coverage for 2 years has been improved from 72% in FY

2006 to 79% om FY 2007. Data has shown that the immunization for 2 year old has been improving compare to the previous years. The immunization staff, including public health staff has taken steps to further provide the immunization coverage for children at age 2. More home visits with the zone nurses, including the outer islands trips.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to do outreach activities to be able to do follow-up and up-to-date of immunization records.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The zone nurses continue to do outreach in the communities, visits the outer islands to provide immunization for the children who reside on these islands/atolls, and daily immunization clinics at public health on both Majuro, and Ebeye on Kwajalein Atoll. Public awareness on the importance to have their children complete their immunization series by age 2 years old, for example using mass media, radio spots, local newspaper, etc.

c. Plan for the Coming Year

2009 Annual Performance Objective: 75%

Planned Activities: The RMI will continue to intensify its immunization coverage rate during community outreach activities (zone activities), outer islands trips/visits, and the public health clinics. These nurses will continue to work closely with the health assistants in the outer islands/atolls, including the public health teams. Continue to increase the immunization rate by reaching out into the community on a regular basis, and continue to do public awareness using mass media.

Response: No comment

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	150	125	100	100	100
Annual Indicator	162.9	167.3	47.4	36.2	46.9

Numerator	258	253	93	71	93
Denominator	1584	1512	1961	1961	1985
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	95	90	85	85	85

Notes - 2007

Denominator is from ages 15-19 years old. Based on new EPPSO RMI Projected Population, 15-17 is not available.

Notes - 2006

Denominator is from ages 15-19 years old. Based on new EPPSO RMI Projected Population, 15-17 is not available.

Notes - 2005

Denominator for 2005 was an estimate. Data is not available with the new EPPSO RMI Population Projection. Denominator is from female ages 15-19 years old.

a. Last Year's Accomplishments

Annual Performance Objective: No more than 175 per 1,000

Accomplishment: In the past, the data for this performance measure could not be specified since the age group in the particular category included teenagers 15 through 19. For FY'07, there was total number of 278 teenage pregnancy. Data for this performance measure has shown that teenage pregnancy is slightly increasing and it is still high and there is still a need to improve the services. In comparison, for FY 2007, the total number of teen pregnancy was 278 while in FY 2005 it was 299. Therefore, in FY 2007 the teen pregnancy is lower compare to FY 2005. More afford has put into reaching the youth in the community, in the high schools, and 10 more additional fairs have been done on teen pregnancy. Collaboration and partnership with the Youth to Youth in Health has a strong part in making this difference. The family planning based at the Youth to Youth in Health building has been re-activated and now it is operating on regular basis and staff by a regular family planning GN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue its effort to decrease the rate of teen pregnancy in the RMI by improving health education and promotion activities for youths.		X		
2. Conduct more training in the community, including traditional leaders on issues regarding health promotion and family planning.		X		
3. Coordinate and collaborate with the Youth to Youth In Health to continue its effort in strengthen the Reproductive Health Clinic		X		

located at the Youth to Youth in Health Base.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Decrease in the rate of teenager pregnancies is a challenge for the RMI to improve and promote health education activities for youths. Improving barriers that inhibit accessibility to family planning services for youths by expanding services into the community and to the public. Conduct training for the community leaders on the issues presented in the National Population Policies. The Youth to Youth in Health provides family planning counseling at the Youth clinics in Majuro and more youth site visits to the outer atolls in collaboration with the Community. The Reproductive Health/Family Planning clinics continue at the Youth to Youth in Health site on regular basis. One family planning nurse (A.S. Level) is based at this clinic site so that the family planning services will be available at all regular times. Clinic hours has been expanded from the 5:00pm to 7:00pm and this is give more access for those teen in schools or staying far from the clinics.

c. Plan for the Coming Year

2009 Annual Performance Objective: No more than 150 per 1,000

Planned Activities: The RMI will continue to focus its effort to decrease the rate of teenager pregnancies in the coming year by improving health education and promotion activities for youths, and conduct more training for community leaders on the issues presented in the National Population Policies. More activities on health promotion and family planning will target to meet the needs of youths in the RMI. The Youth to Youth in Health will continue its effort to add one more youth clinic in the rural areas in the urban center(Ebeye) and more youth in the outer atolls in collaboration with the Community. Continue to expand the clinics hours at the Youth to Youth in Health and increase the number of clinic days for Laura Health Care Center to provide more access for the teen who live far from the main health services.

Response: There are challenges as to services for FP is not that easy to female seeking services from male provider since almost is related to each other, and some they leave far from the service/clinics and maybe do not have the means to pay for transportation.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	65	70	80	80	85
Annual Indicator	54.9	87.1	77.9	82.6	82.6
Numerator	1161	1842	1643	1743	1743
Denominator	2115	2115	2110	2110	2110
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	90	95	95	95	96

a. Last Year's Accomplishments

Annual Performance Objective: 80% of the proportion of 8-9

Accomplishment: It is slightly lower the denominator for the performance since we were not able to do outreach to the outer islands for more than seven months since the plans (Air Line of the Marshall Islands) has been having mechanical problems. During the FY 2007, the program was able to provide services mostly on Majuro. In FY 2007, the Number of school children examined for dental was 1365, and 1355 teeth sealed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach to provide health education to the students who are the third grade. Provide education for parents who attend clinics on issues concerning oral health.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As part of the school sealant program, staff provide dental education for the elementary schools that they visit. Oral Health services is being also provided for the schools in the outer islands/atolls during the outer islands visits. Outreach activities continue on a regular basis for the schools, and into the community. Continues with outer islands trips using field trip ship or the plane if available.

c. Plan for the Coming Year

2009 Performance Objective: 80% of the proportion of children ages 8-9

Planned Activities: Increase health education of oral health in the schools by using posters, educational materials on oral health. Implementation of school sealant program in the outer islands. Continue to expand oral health services for the by addition 100 more Elementary School children.

Response: 9 Transportation remains a challenge to us, if there is no plane we go a field trip ship or charter boat which cost so much because of cost fuel has gone up almost \$7 per gallon. If we run into one or more of the problems, it is very difficult to reach the outer islands to provide the services on a timely basis.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	9	9	9	9	9
Annual Indicator	3.1	15.3	13.6	4.5	17.8
Numerator	1	5	3	1	4
Denominator	32355	32654	22128	22128	22447
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	8	7	6	5	4

Notes - 2005

With the new EPPSO RMI population demographics, population projection for 2005 is not available. We just estimated the figure for the denominator

a. Last Year's Accomplishments

Annual Performance Objective: No more than 5 per 10,000

Accomplishment: There were documented deaths to children 1-14 due to motor vehicle crashes in FY 2007. Data shows that the objective was met, however, it remains one of our concerned due to more children and more vehicles and small space for planing.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the outreach health education for parents, the public on importance of safety (example, school cross-walks/car seat belt, etc.).			X	
2. Better coordination with public safety and providers who provide safety in the schools or any public places.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMI has been able to keep the rates of children in this age group at no more than 5/1,000 for death caused by motor vehicles for the past year. Our health education and promotion activities continue to address this issue to ensure that no deaths caused by motor crashes occur. There is school law in place to that any must stop when crossing the roads.

Response: The seat belt law is not enforced

c. Plan for the Coming Year

2009 Annual Performance Objective: No more than 5 per 100,000

Planned Activities: The RMI will continue to provide public awareness through health education and promotion. Our health education and promotion activities will continue to address this issue to ensure that no deaths caused by motor vehicle crashes occur. Continues to coordinate with the Ministry of Public Safety for the safety of children using the cross-walks.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				70	75
Annual Indicator			99.5	97.1	97.1
Numerator			1093	2009	2009
Denominator			1099	2069	2069
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	98	98	98	98	98

a. Last Year's Accomplishments

The MCH in collaboration with the Health Education and Promotion, Core Community and the Breast Feeding Policy Committee continue to develop and distribute educational materials, provide nutrition counseling during prenatal clinics, conduct presentations during prenatal clinics and the maternity ward with mothers, and continue health promotion outreach in the communities and through mass media. Staff in the Health Education continue to provide information on breast feeding issues on a weekly regular radio program. In FY 2007 the percentage of women who breast-feed their babies up to 6 months has been more than 95%., which shows improvement, but still needs to improve.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the outreach health education for the reproductive age in the community, including parents, youth groups, woman's organizations, etc.			X	
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continues to provide health education regarding the importance of breast feeding in the first 6 months of life. Continues to promote breast feeding advantages using radio spots, newspaper, outreach, including outer islands activities. Enforce breast feeding policy/baby friendly hospital.

c. Plan for the Coming Year

2009 Annual Performance Objective: 80% in early postpartum

Planned Activities: The MCH will continue to collaborate with the Health Education and Promotion Unit, Core Community and the Breast Feeding Policy Committee in development of educational materials, and will continue to provide nutrition counseling during prenatal clinics. Also, continue to conduct presentation during prenatal clinics and at the maternity ward with mothers. The MCH program will continue health promotion outreach in the communities and through mass media. Breast Feeding policy will be reminded and discuss with members of the Community Leaders Committee during community outreach and during training in the the urban centers. Staff in the Health Education will continue to discuss breast feeding on the a weekly health education radio program.

Response: Hearing screening is planned and the implementation is planned for next grant cycle (we need one ENT).

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	0	0	20	25	30
Annual Indicator	13.1	11.4	16.1	19.2	15.6
Numerator	208	172	261	301	241
Denominator	1592	1512	1625	1568	1548
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	35	40	45	45	45

a. Last Year's Accomplishments

This performance is not applicable to the RMI since screening for hearing impairment is not conducted in the hospitals. However, it is estimated that 19.2% of the new-born are screened for some hearing (routine) problem.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate and coordinate more with the doctors in the delivery units and also those who attend to that delivery at the point in time.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This performance is not applicable to the RMI since screening for hearing impairment is not conducted in the hospitals. Continue to do complete examination before discharge from the hospitals

c. Plan for the Coming Year

This National Performance Measure is not applicable to the RMI. The newborns are not screened for hearing impairment before hospital discharge. Development of an hearing test screening to be implemented no later than the end of FY 2009.

Response: No Comment

Performance Measure 13: Percent of children without health insurance.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	0	0	0	0	100
Annual Indicator	0.0	0.0	100.0	100.0	100.0
Numerator	0	0	22128	22128	22447
Denominator	32355	32654	22128	22128	22447
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

The actual number shown here is based on the new population projection for RMI. 2007

a. Last Year's Accomplishments

Annual Performance Objective: 0%

Accomplishment: The RMI health insurance policy covers all Marshallese. Medical services are provided to all residents from the Ministry, which includes the two hospitals in the urban centers and the health centers in the outer atolls.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to identify these children to bring them into the program.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continues and maintains the RMI policy that covers the whole RMI population.

Response: RMI health insurance policy covers all Marshall Insurance

c. Plan for the Coming Year

2009 Annual Performance Objective: 0%

Planned Activities: The Ministry of Health will maintain the policy that covers medical insurance for the whole RMI population.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	10
Annual Indicator			0.0	4.2	4.2
Numerator			0	250	250
Denominator			5993	5993	5993
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	15	15	20	25	26

a. Last Year's Accomplishments

This is not applicable to the RMI since there is not Medicaid Program. However, it is estimated that 4.2% is being receiving some sort services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate on regular basis with those service providers that provide some sort of services related to this NPM.	X		X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This Performance Measure is not applicable to the RMI since the RMI is not eligible for the Medicaid Program. However, plan to continues to provide assistance for the clients as well more collaboration between the MCH and community in partnership.

c. Plan for the Coming Year

This Performance Measure is not applicable to the RMI since the RMI is not eligible for the Medicaid Program. Continue with the present activities.

Response: Check out OPD/PH for Growth Monitoring

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					100
Annual Indicator				2.5	2.5

Numerator				40	40
Denominator				1578	1585
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	2	2	2	2	2

Notes - 2005

Not applicable to the RMI since data for smoking pregnant women during the last 3 months of pregnancy is not being collected.

a. Last Year's Accomplishments

In 2007, smoking for pregnant women during the last three of pregnancy in very low, which is around 1-2% the total pregnant women. This is good sign for good health during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing with the current identification of pregnant women who smoke during pregnancy.			X	
2. Provide counseling during prenatal clinics on the dangers of smoking in pregnancy.	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Counseling on smoking during pregnancy is being provided during prenatal 1st visit for all pregnant women who come into 1st prenatal booking. Information on smoking in pregnancy is also taught during outreach activities/health fairs in the community.

c. Plan for the Coming Year

Plan for the coming year is to continue provide the importance information on smoking during pregnancy for the women using radio spots, local newspaper, etc.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	15	15	9	9	8
Annual Indicator	26.8	133.3	46.8	218.4	215.3
Numerator	2	10	3	14	14
Denominator	7454	7501	6409	6410	6502
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	200	200	190	190	190

Notes - 2005

Denominator for 2005 is estimated. With the new EPPSO RMI Projected Population, 2005 data is not available.

a. Last Year's Accomplishments

Accomplishment: There were 2 out of 4 documents completed suicides in this age group (15-17 years old respectively) in 2007. Data has shown that there is an improving in reduction in number of suicide, and increasing of participation in alcohol/drug treatment program. Health education and promotion campaigns on mental health and suicide prevention have been expanded to the schools and community groups such as the churches, and youth groups.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide outreach activities into the schools, youth groups, including parents, church groups, and community.	X		X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Follow-up with participants to the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. Health Education and the program on Alcohol and Substance Abuse Prevention conduct training with youths, community groups. Educational issues is being provided through radio program and interview on alcohol, substance abuse and

suicides. Close monitoring and evaluation on the rate of suicides in each community is being through the year in order to meet the needs of each community.

c. Plan for the Coming Year

2009 Annual Performance Measure: Decrease by 2 from the current rate

Planned Activities: The MCH program will put efforts in collaborating with the Division of Human Services to follow-up with participants of the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. The Health Education and the program on Alcohol and Substance will collaborate to conduct more trainings with youth groups, community groups, parents, church groups, and the schools. More educational materials will be developed and the media will be utilized more in radio spots, radio programs and interviews on alcohol, substance abuse and suicides prevention. Close monitoring and evaluation on the rate of suicides in each community will be expanded throughout the year in order to meet the needs of each community.

Response: Yes, mental health issues are being addressed in the education.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	0	0	0	0	0
Annual Indicator	1.2	0.9	0.6	0.6	0.6
Numerator	19	13	10	9	10
Denominator	1592	1512	1650	1578	1585
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1	1	1	1	1

Notes - 2005

Not applicable to the RMI since only two urban centers that provide all health care throughout the Republic.

a. Last Year's Accomplishments

High risk deliveries are referred to the two main centers, one in Majuro and the other is located in Ebeye on Kwajalein Atoll. In two main hospitals, all care are being provided, otherwise, if a newborn is in bad condition, then he/she is referred out the Country for further medical care. For 2007, there was no documented case of maternal death due to high risk pregnancy, however, any high risk identified are being referred to the urban centers for further evaluation and management/care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Early identification of risk pregnancies and refer for further medical evaluation and close monitoring be the doctors.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Early identification of risk factor in early pregnancy and refer to either one the two main hospitals for close evaluation and monitoring. Early screening in the 1st prenatal booking. Risk assessment based on high risk scoring and referral to OB-GYNs.

c. Plan for the Coming Year

Continue with the present activities. Early booking for early identification of any high risk conditions and refer.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	60	62	45	50	55
Annual Indicator	27.3	21.5	18.7	31.1	78.7
Numerator	432	325	309	491	1248
Denominator	1584	1512	1650	1578	1585
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	80	80	80	85	85

Notes - 2005

Data for 2005 is only for Kwajalein and Outer Islands. There was no data available for Majuro Atoll for this year.

a. Last Year's Accomplishments

The data has shown that there is an improvement in prenatal 1st visit compare to 2006 was 68.8, while in 2007, it has increased to 80%. The Reproductive Health staff, including MCH/FP nurses have been taken steps to reach out into the community, including the outer islands trips to

expand the delivery of services into the community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide more public awareness through increasing outreach fairs into the community, collaborate and partner with the youth groups, parents, community, and the public at large.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Outer Islands trips on a quarterly basis. Out reach into the community, and collaboration between the RH staff and public health, and also partnership with the private sectors, including woman's organizations and the youth groups in the community.

c. Plan for the Coming Year

To increase by 5% from present in 2009. Continue the present activities.

D. State Performance Measures

State Performance Measure 1: *Percentage of mothers who receive nutrition and family planning counseling during prenatal care*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				100	100
Annual Indicator	100.0	100.0	92.1	80.5	88.3
Numerator	1251	1584	1520	1271	1400
Denominator	1251	1584	1650	1578	1585
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012

Annual Performance Objective	100	100	100	100	100
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Notes - 2007

Data shown here is based only on Majuro clinics.

a. Last Year's Accomplishments

Annual Performance Objective: 90% of pregnant women during the first booking/entry into prenatal care.

Accomplishment: During FY 2007, this objective was met with 90.2% . Data has shown that there is improvement, but there is still a needs to improve. All pregnant women who enter into prenatal for the first booking/registration receive counseling on nutrition and family planning. Counseling and registration on nutrition and family planning are also being provided in the follow-up upon delivery and again when the mother comes back for postpartum clinic.

Response:

Women also receive services from male, but this is challenge because of they might me related to each other that makes it difficult to seek medical attention from a male.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In-service continuing education in nutrition and family planning for public health nurses , family planning staff for better counseling for the MCH population.			X	
2. Counseling on family planning/nutrition is also being provided during postpartum clinics. X	X			
3. Nutrition counseling is being provided for mothers attending prenatal clinics	X			
4. One pejrson from health education provide counseling on nutrition and family planning for women referral.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities: These activities are being carried out as routine part of the prenatal protocol, counseling on nutrition and family planning are provided for all pregnant mothers attending prenatal clinics during first visit which is a part of the interview during booking/registration for entry into prenatal care. It is also provided in the follow-up upon delivery and again during postpartum

Response:

Continuing education for nurses is being done through the Ministry of Health's Continuing Education program in the Ministry, and is also being done by going off islands for short or long terms trainings.

c. Plan for the Coming Year

Performance Measure: 90%

Planned Activities: The nurses in the Reproductive Health/Public Health will be up-date in skills through in-service in nutrition and family planning to be able to provide better counseling to all pregnant women who come to the prenatal clinics and the health zones. While it is anticipated that counseling on nutrition and will not be provided to all pregnant women in the outer atolls because of the cultural barriers. Plans are being develop to increase the coverage as much as possible. A protocol has been implemented to ensure that pregnant women are counseled on nutrition and family planning for those referred from the prenatal clinic. Diabetes and hypertension will also be added to the counseling schedule on pregnancy.

Response: Few years ago, the Ministry recruited female and trained on islands for health assistants for the outer islands. Education the public continues to provide public awareness about health and the importance to come forward and talk openly about their own health.

State Performance Measure 2: *The birth rate(per 1,000) for teenagers age 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				20	15
Annual Indicator	32.1	30.3	47.4	36.2	46.9
Numerator	258	253	93	71	93
Denominator	8040	8363	1961	1961	1985
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	10	10	5	5	4

Notes - 2007

Denominator for 2005 was an estimate. Data is not available with the new EPPSO RMI Population Projection. Denominator is from female ages 15-19 years old.

Notes - 2006

Denominator for 2005 was an estimate. Data is not available with the new EPPSO RMI Population Projection. Denominator is from female ages 15-19 years old.

Notes - 2005

Denominator for 2005 was an estimate. Data is not available with the new EPPSO RMI Population Projection. Denominator is from female ages 15-19 years old.

a. Last Year's Accomplishments

During the FY 2007 has slightly increased, however, it is lower compare to FY 2005 which was more than 64%. The health, social and economic burdens directly associated with teen pregnancies, has been be aggressively stressed and conveyed to assist in reversing the current status. More than 10 community health fairs have been done for the childbearing women focusing reproductive health, including teen pregnancy and this was also done for more than 5 schools and churches youth to increase their level of understanding on issues concerning teen pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health education for the teenagers, schools, high	X			

school drop-out, and the parent education regarding teen pregnancy.				
2. Provide counseling for the teenagers to increase their level of understanding about teen pregnancy.			X	
3. Provide information for youth in the community regarding teen pregnancy.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Trainings has been established and is an on-going to train and re-train the new Reproductive Health staff, Health Assistants, parents, and other health providers on issues concerning reproductive health, and family planning, including teen pregnancy. Health education is being provided for the public to increase the awareness on issues concerning teen pregnancy through Marshall Islands News Paper, radio announcements, and visiting into the communities.

c. Plan for the Coming Year

Continues to improve the outreach health education in collaborating with the health education staff, public health staff, and other health care providers in increase public awareness. The reproductive health outreach activities is to be reestablished to reach out for the teenagers who are not in schools. Strengthen the community outreach activities and site visits to the outer islands to reach out for the teen population.

Response: Yes, the FP clinic sites both have privacy that service is being provided one-on-one basis. The provide access to the services to the schools, and the public so they have better access to the services than in the past.

State Performance Measure 3: *The Percentage of pregnant women who receive prenatal care during the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					70
Annual Indicator			18.7	31.1	78.7
Numerator			309	491	1248
Denominator			1650	1578	1585
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	73	75	75	85	85

Notes - 2007

Data shown here is based only on Majuro clinics.

Notes - 2005

Data for 2005 is only for Kwajalein and Outer Islands. There was no data available for Majuro Atoll for this year.

a. Last Year's Accomplishments

During FY'07, the MCH program was able to accomplished 80.4% compare to FY 2006 68.8% of prenatal first visit during the 1st trimester. It has been shown that more pregnant seeking care during the first three months of pregnancy. The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the public awareness regarding the important of prenatal care

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. . This SP will be reported with the National performance Measure #18.	X			
2. SPM was discontinued since it deplicate a NPM.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the public awareness regarding the important of prenatal care. Clinics hours continue as well as other prenatal routines activities. Also, the reproductive health clinics have been expanded to include two additional clinics with one of them extended clinic hours from 5:00pm regular normal working hour to 7:00pm to provide more access to the MCH clients to the service.

c. Plan for the Coming Year

To continues present activities, and continue expand the MCH services to include more women childbearing age. To Provide more excess to prenatal care by visiting the communities on a regular basis.

Response: No comment

State Performance Measure 4: *The percentage of high risk pregnant women who are identified and are referred to special prenatal services*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				100	95
Annual Indicator	11.2	25.4	12.8	14.2	27.2
Numerator	146	298	145	144	245
Denominator	1309	1175	1136	1013	900
Is the Data Provisional or Final?				Final	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	90	85	80	80	80

Notes - 2007

There is different notice in data here since it is focused only on Majuro clinics.

a. Last Year's Accomplishments

Annual Performance Objective: 40% of pregnant women

Accomplishment: During the FY 200, 27.2% was accomplished. More high risk pregnant women seeking early prenatal care are identified early and placed in the high risk special care.

Improvement is still needed that the number of prenatal clinics have not been only increased from once a week to four full days a week, but expansion of hours from 8:00am to 5:00 pm at he base clinic. This is being done to allow the pregnant women for better excess to the MCH clinics.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening of high risk pregnant women during the 1st trimester.	X			
2. Public awareness mainly to focus on women of childbearing age on early prenatal care.	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On-going screening with the OBGYN being seen and examined pregnant women early in their first bookings. This is being done to identify any high risk pregnant women in their pregnancies. Early identification of high pregnant women continues to provide service needed based on condition.

c. Plan for the Coming Year

Continues the present activities so that more pregnant women will be able to access the services. Collaborate and coordinate more with the public health zone nurses to identify any pregnant women during early pregnancy.

Response: No comment

State Performance Measure 5: *The number of women who are screened for cervical cancer.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective				100	100
Annual Indicator	82.7	98.1	96.7	64.2	69.3
Numerator	1034	1431	1596	1013	1099
Denominator	1251	1458	1650	1578	1585
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Data here reflects on Majuro clinics.

a. Last Year's Accomplishments

Accomplishment: In 2007 a total of.....1099 pap smears were taken at the prenatal clinic at Majuro. This is an improvement over the past, however, there is still a need to improve the services provided in this area, especially to do follow-up after the pap smears are done. Education on the importance of annual/regular pap-smear test, including on how to perform self-breast exams.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach into the community, especially toward the women of childbearing age to educate them on cervical cancer.			X	
2. Educating the women of childbearing age on importance to have an annual pap smear test.			X	
3. Provide pap smear screening during prenatal 1st visit, outreach trips to the outer islands.			X	
4. Follow-up of clients with the zone nurses.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities: Taking pap smears during the first visit for all pregnant women attending prenatal clinics continues. Providing cancer screening during women's health clinics, and provide cancer screening during outreach visits to the outer islands by the public health teams. Activities in regard to educating the child-bearing women ages on issues concerning cancer in women, including cervical cancer are being carried out on all clinic sites.

c. Plan for the Coming Year

Performance Objective: Increase by 25%

Planned Activities: The MCH/CSHCN program will review/revise its protocol on cancer screening particularly on cancer of the uterus and cervix. Pap smear screening will be conducted to its implementation in all public health clinics during outreach clinics and trips to the outer atolls. All necessary supplies will be purchased for the screening. Identified women who will need follow-up will be referred to the zonal for follow-up.

Response: No comment

State Performance Measure 6: *Proportion of children who are identified and referred to the Children with Special Health Care Needs program*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					100
Annual Indicator			100.0	100.0	100.0
Numerator			395	435	445
Denominator			395	435	445
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

This is only reflects data from Majuro.

a. Last Year's Accomplishments

Accomplishment: During the FY'07 , there was more 140 new cases identified and service is being provided. Better coordination and collaboration between MOH and MOE in providing services for these children and their families based on the needs. There is an improvement in communication between these two ministries, parents/clients, community and the service providers with the re-establishment of the Council for Children Special Health Needs and they meet on quarterly basis.

Response: Council of CSHCN

Ministry of Education/Sp.Ed., Ministry of Internal Affairs, Parents, Clients, Ministry of Health, Local Government, Community Representatives, Churches, NGOs

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of screening element/machanism to identify child with special health care needs.	X			
2. Monitoring services as stated in the MCH protocol for CSHCN so that these children can recieve the care needed.	X			
3. On-ste training for the health care providers on issues concerning CSHCN.	X			
4. Outreach activities such as home visits, zonal, outer islands and screening for CSHCN.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue to do simple screening for all new born at the public health clinics at six weeks after delivery to identify children with special health needs. Continue to coordinate with the Outer Islands Health Care System for referral of children with special health care needs to the MCH/CSHCN program.

c. Plan for the Coming Year

Develop and implement a tracking system for CSHCN for better data collection for better clients' follow-up, monitoring and evaluation.

State Performance Measure 7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				80	85
Annual Indicator	54.9	87.1	77.9	82.6	99.3
Numerator	1161	1842	1643	1743	1355
Denominator	2115	2115	2110	2110	1365
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	85	90	90	95	95

a. Last Year's Accomplishments

During the FY 2007, we accomplished 99% of third graders who received sealants, compare to 2006 which was 82.6%. Data shows that there is an improvement, but there is still needs to improve this performance

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Dental services is an on-going into the schools.			X	
2. Schools Sealent Program for both public and private schools.			X	
3. Health education is being provided during visiting the school and outreach clinics by the dental staff.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continues to increase the number of outreach into the schools. Continues this activity on regular basis and to include more schools. Continues to provide health education on oral health, including prevention aspects of it.

c. Plan for the Coming Year

Strengthen and continues to expand the dental outreach activities to includes more schools, and the community at large.

Response: No comment

E. Health Status Indicators

/2009/ According to the RMI projected population for FY 2005, there was 63,579 with 48% resides in Majuro which the capital for the Republic of the Marshall Islands, and the outer islands is 33%, in general , have a higher population growth rate compare to Kwajalein which 19%.

/2007/ The RMI projected population for 2006 is 65,814.//2007// //2009/Migration has the single biggest impact on contemporary growth in the RMI, as we can see from international migration statistics for the RMI, 1990-2006, that recently became available and which have not factored into any projections in the 1990s. This is the sole reason why our projections provide you with a RMI population total of around 52,338 ,up-date for 2007 which is lower than the figures of 62,000 currently floating about.

/2009/ The Constitution of the Marshall Islands designates the Ministry of Health (MOH) as the "state" health agency. The MOH is the only legislatively agency that provides health care services to the people of the Marshall Islands.

/2007/ No change.//2007// //2009/No change.

/2009/ The Bureau of Primary Health Care (PHC) is one of the five major bureaus within the Ministry of Health. It is responsible for all preventive and primary care programs throughout the Marshall Islands. There are six divisions with the Bureau of PHC, and the Division of Public Health is one of the five and the largest with five program areas.

/2007/ No change.//2007// //2009/There are three bureaus that provide direct health care services in the county: 1) The Bureau of Majuro Atoll Health Care Services (MAHCS), 2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS), and 3) The Bureaus of Outer Islands Health Care Services (OIHCS).

/2009/ The MCH/CSHCN Program is not a separate agency. It is one of the programs in Public Health. The nurses and medical staff implement all clinical, follow-up and community outreach programs for all areas in Public Health. The MCH/CSHCN Program provides health care services for mothers, Infants, children with special health care needs, including their families, and adolescent.

12007/ No change//2007// //2009/The MCH/CSHCN is integrated into Division of Reproductive Health. The Reproductive Health Nurses (RH) and medical staff implemented all clinical, follow-up and community outreach activities for all areas in Reproductive Health. The MCH/CSHCN Program provides health care services for mothers, infants, and children with special health care needs, including their families.

/2009/ Evaluation is being done on an annual basis after all data have been compiled by the Health Planning and Statistic at the Ministry of Health. All programs are also required to submit reports on a monthly basis for monitoring and evaluation for the program outcome.

/2007/ No change//2007// //2009/This is an on-going and is also being done on a quarterly basis.

/2009/ RMI Health Status Indicators are being evaluated annually, and also will be reported every year.

/2007/ No change.//2007// //2009/No change.

F. Other Program Activities

/2009/ The MCH/CSHCN Program is already a program area within Public Health. The nurses and medical staff in Public Health provide other preventive services in STD, family planning, non-communicable diseases, immunization, TB and leprosy as well. The MCH

coordinator is member of the MOHE Core Committee which coordinate all community awareness activities. The MCH program is also a member of the RMI Inter agency Council meets regularly to ensure continuous services is provided to all CSHCN, both in school and those who are not. The Breast Feeding Policy Committee also actively work closely with the MCH program and services in community awareness activities on nutrition and breast-feeding. The MCH program will participate fully in all community awareness and training programs preventive services to women, children, infants, youths and their families. //2009//The MCH/CSHCN Program has being integrated into Division of Reproductive Health. The RH nurses and medical/OBGYNs in Reproductive Health provide other preventive services in STDs, family planning, non-communicable diseases, immunization, TB, and leprosy as well. The Director for Reproductive Health (RH).

G. Technical Assistance

//2009/ The MCH/CSHCN program will need TA in the areas specified in the the Form 15. There are weakness in the area in the program reporting system. Data System Development and performance Indicators. TA is also essential in the evaluation for the CSHCN to ensure services provided and mechanisms for screening are implemented.

//2009//The MCH/CSHCN program is in need for TA in the areas specified on Form 15. Program for tacking of clients is highly need at the point to be able make a better assessments for better service follow-up, monitor, and evaluation of program clients.

V. Budget Narrative

A. Expenditures

//2009/ For FY 2006, the RMI spent 100% of its MCH funds. Forty five percent of the total grant award is for personnel. of the total funds for non-personnel, the RMI spent 25% on direct health care, 13% in enabling services and 7% on infrastructure building services. The allocation of the administration cost utilized 10% of its allocation. //2009// In FY 2007 the RMI MCH/CSHCN spent the MCH Block Grant fund based on the components and 30-30-10 percents accordingly.

B. Budget

Annual Budget and Budget Justification: The Block Grant funds will be used to provide and coordinate routine preventive and primary health care for mothers, infants, and children. The scope of these services includes prenatal care, including special high risk prenatal clinics; postpartum care; well baby care, including immunization; high risk pediatric clinics; school health programs; coordination of family planning services; and provision or coordination of care for children with special health care needs.

To identify children with special health care needs, initial screening of children will be performed by public health nurses at the Majuro and Ebeye Hospitals and by health assistants at the outer island dispensaries.

The Title V funding will be used to support the short term services of specialized consultants to work with children identified as having special health care needs. The specialist will be brought to the Marshall Islands to perform surgery on such children, that may include, plastic surgery and pediatric cardiology (these services are not available on island). The program will also arrange and pay for those children with special health care needs that may need to refer overseas for further medical care that are not available on island (the program pay plane tickets and stipend at while receiving medical care off islands for 2 weeks only, otherwise, the RMI Government will carry on the stay will require beyond two weeks).

Administrative Costs:

The RMI Government of has chosen to combine the administrative costs for all components of the project into a single comprehensive category for administering the block grant funds For the past decade, the RMI Government has consistently applied this approach to the administrative costs associated with the Maternal and Child Health Block Grant projects.

Administrative Cost	\$25,249
A. Personnel	\$ -0-
B. Fringe Benefits	\$ -0-
C. Travel	\$ 5,041
D. Equipment	\$ 18,000
E. Supplies	\$ 1,208
F. Contractual Services	-0-
G. Other	\$ 1,000

A breakdown of the MCHB is provided here according to the three component of the grant Budget justification follows under.

Component A: Pregnant Women, Mothers and Infants \$75,748

A. Personnel	\$ 26,795
B. Fringe benefits	\$ 2,763.16
C. Travel	\$ 15,500

- D. Equipments \$ 20,000
- E. Supplies \$ 2,000
- F. Fuel \$6,190
- G. Communication \$2,500

Component B: Children & Adolescents \$ 75,748

- A. Personnel \$ 54,125
- B. Fringe benefits \$ 4,330
- C. Travel \$ 5,500
- D. Equipment \$ 2,000
- E. Supplies \$ 1,000
- F. Contractual Serv. \$ 500
- G. Others \$ 500

Component C: Children with Special Health Care Needs \$ 75,750

- A. Personnel \$ 14,700
- B. Fringe Benefits \$ 1,176
- C. Travel \$ 39,677
- D. Equipment \$ 7,600
- E. Supplies \$ 3,521
- F. Contractual \$ 6,900
- G. Printing/Reproduction \$1,176
- H. Other \$1,000

Administrative Cost \$ 25,249

MCH Budget(State Federal Allocation) \$252,495

MCH Budget(Federal and State Block Grant Partnership) \$441,867

Total budget for FY 2005 \$1,614,891

3.1.1 Completion of Budget Forms

Detailed budget breakdowns are found in Forms 2,3,4,and 5

3.1.2 Other Requirements

For the FY 2006 budget, 48% is for salaries of personnel who provided direct services for the MCH/CSHCN program. There are 7 personnel under the MCH/CSHCN program. However, other health personnel in Public Health also provided direct health care services to the MCH population as well.

Although travel costs allocated account for 19% of the total budget for FY 2005, this allocation support the goals of the Ministry to improve preventive and primary health care services for the targeted outer islands population in MCH. Traveling within the Marshall Islands is necessary for personnel to provide health care services in support of the health assistants in the health centers. Furthermore, the identified CSHCN will need to travel to and from their own islands to the urban center for follow-up and further treatment and follow-up to Honolulu Shriners' Hospital for Children if necessary.

State Match

The total for the MCHBG application for FY 2009 is \$252,495. This amount is based on the Marshall Islands' FY 1989 Maintenance of Effort Amount of 175,745. The State Match for the MCH grant application is \$189,372.

Documentation of Fiscal Restrictions

The Republic of the Marshall Islands assures the Secretary of Health and Human Services that no more than 10% of the Title V funds will be used for administrative cost for the MCH Block Grant. The total amount will be used by the MOH Administration to: 1) attend meetings that are conducted by the MCHB and other agencies with regards to the MCH Programs and Services, 2) purchase supplies that are needed for administrative support of the MCH services such as office supplies, stamps, and other means to support communication between the funding agencies and the MOH, and 3) contractual services that are needed for the regular maintenance of office equipment used by the MOH Administration.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.