



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

**State Narrative for  
Palau**

**Application for 2009  
Annual Report for 2007**



Document Generation Date: Friday, December 19, 2008

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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**

//2007//. These documents were submitted in Grants.gov for fiscal year 2008.

### **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**

***/2009/ In fiscal Year 2007, the public input process is a continuous process which allows us to analyze data, present them to the various communities of Palau and based on their input, we organize services to meet the community needs. Throughout 2007, core staff and community collaborative partners have been doing presentations in the communities. Prior to developing the presentation, we had analyzed various data sets that became the lead topic of the presentation. Analyzed data came from the school health screening, nutrition assessment, psychosocial assessment of pregnant women, family planning practices including assessment of sexually transmitted infections, body mass indexes for all age groups and community profiles from the census including YRBS and YTS data. Risk factors were identified including identification of practices and behaviors that Ratios and relative risks were statistical measurements that we risk associations. A model presentation called "Community Engagement" was developed, reviewed and approved by the collaborative members and presented. This presentation encompasses life cycle issues that are present in Palau (infants, children, children with special health care needs, pregnant women, men and women of reproductive age). Along with this presentation, are other short presentation on bullying focusing on different audience that teaches bullying prevention. An evaluation component of this presentation has also enabled us to improve its content so that it is more relevant to Palau communities. Notifications to communities are through the offices of governors, CHC Councils, PTA's, schools and through public radios. Traditional means of community meetings notification systems are not used. The reasons being, this system is quite stratified and usually the "havenots" become the group whose opinions are not voiced.***

***From the community presentations, we capture comments and recommendations relating to services improvements. One of the main focus that has been identified from various communities of Palau relate to parenting skills, issues, and practices. Through funding from ECCS, we are organizing parenting training for the communities which most likely will happen in 2009. The improvement in our ability to capture, analyze and report health status information back to***

***the public has greatly improved our relationship with various communities and stakeholders. The following format of the "Community Engagement" is similarly used in all communities that are visited. However, due to our ability that has been built in the past, we are able to feature "community-specific" information in our presentation.***

***These inputs from the communities largely drive our National and State Performance Measures including the design of strategies and activities to be undertaken in 2009. We decided to use this method of capturing public input rather than a "public hearing" format, as in this format, no one shows up, even though it is announced through newspapers and radio. //2009//***

## 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

/2006/ To sum up needs assessment activities in this fiscal year, an epidemiologist and a statistician were hired in April of this year. In the last several months, they have assisted us in organizing data for this application and at the same time, we are organizing a "Health Status Report" which will follow the format of "U.S. Children's Health Status Report", published by MCHB/HRSA. This report will be posted on the Ministry of Health Website and will be circulated to our political audience and national leadership.

A Needs Assessment for all the MCH population is attached as part of this application.//2006//

/2008/ - The Needs Assessment Summary is attached as a component of the section "Needs Assessment".//2008//

***/2009/ In 2007, as discussed in the public input section, the needs assessment for this fiscal year followed similar process. Throughout the year, in our community engagement process, we enrolled community discussion on identified needs of the MCH population. From these discussions, the FHU aligns itself to address identified community needs. The needs assessment process also follows the community engagement process in that needs are reflective of the MCH age group. The important factor that came out of these community discussions is to increase effort in developing and improving parental skills in various health risk factors, such as:***

- ***obesity/nutrition/physical activity for all age groups,***
- ***psychosocial issues in pre adolescent years,***
- ***relationship of obesity to other health risk factors such as bullying, depression and suicidal ideation,***
- ***hypertension and diabetes and their relationship to risk factors of increased glucose and protein in the urine,***
- ***vision and hearing as they relate to academic performance in school***
- ***including substance use and their effects on health.***

***FHU MCH Program in collaboration with its community partners and collaborators have developed community training materials that in the next year will be used in providing parental education and training in the communities. Within the collaborative groups, non-health members are being oriented and trained to be community educators. Key staff in the program will take part as professional support to the community educators. To sum up, needs assessment activities in this fiscal year has improved with an added staff in epidemiology and statistics. Throughout the year, they have worked to organize data for this application and at the same time this has enabled our presence in the community to be more evidence and best practice based. One other area of need that we still need to establish in FHU MCH Program is the research activity that will enable us to understand the health of pregnant women and their influence of the health of their infant. This is a project that will undertake in the coming years. //2009//***

### III. State Overview

#### A. Overview

//2004// - Health services in the Republic of Palau continues to be heavily subsidized by the Government. However, a great proportion of this budget goes into funding of secondary and tertiary medical services. Almost all funding that goes into supporting Title V-MCH basic services are derived from U.S. Federal and other bi-lateral and multi-lateral sources. Below is Budgetary Distribution by Level of Care

Health Budget as a Percentage of Total National Budget	11.2%
Per Capita Expenditure on Health)	\$339
% of household earning less than \$2,500 per anum (Poverty)*	15% 11%
% of household earning less than \$5,000 per anum (Economically Vulnerable)*	10%
MOH Expenditure on:**	
Medical Referral (N=130) = \$6,153	
Hospital Admissions (N=2,900) = \$1,482	
Primary, Preventive & Promotive Services (N=100,000)	= \$9

#### Available services by Level of care

Under the most recent organizational structure of the Ministry of Health, Bureau of Public Health, the Maternal and Child Health Programs is under the direct management of the Chief of the Division of Primary Health Care. This division has two Administrators, Administrator of Preventive Services and Administrator of Primary Health Care Services. MCH is in a unique position in that in relation to administrative matters, the program receives its directives from the Administrator of Preventive Services and on more programmatic and service delivery wise, it is directed under the Administrator of Primary Health Care Services.

Based on this organizational chart, MCH Program provides direct services such as Prenatal and Postnatal care, Childhood Immunization Program, Gynecological and Cancer Screening Services, and Well-child services. In relation to other necessary services to improve health care for mothers and children, MCH collaborates with other divisions within the Bureau of Public Health and the Bureau of Clinical Services to provide these services. These services include mental health, dental services, promotive health services such as communicable disease prevention, nutrition education and general health education services. It also collaborates with the Bureau of Clinical Services in relation to hospital-based services such as delivery, pediatric services, and specialty and tertiary medical services. MCH Also collaborates with Head Start Program and the Ministry of Education in the provision of children's promotive health services.

#### Health Resources and Distribution by Level of Care:

The Ministry of Health receives its revenue from annual congressional appropriations from the Olbiil Era Kelulau. In accordance with traditional usage of health budget, population based services such as those provided by the Bureau of Public Health receives the least amount of revenue. At least three fourths (3/4) of the Bureau's budget for implementation of preventive and primary health care programs and services come from external sources through US Federal Grants, WHO funding and other multi and bi-lateral sources. As evident in the above analogy, local revenue that supports health care have their most concentration on hospital and tertiary medical services. MCH direct services, being part of the Division of Primary Health Care under the Bureau of Public Health competes for local resources that funds primary health care. Looking at the above chart, it is the \$.9 million dollars that supports close to 100,000 encounters each year.

Available Primary and Preventive Services in the Family Health Unit (Title V-MCH Program) - All service sites.

- Preventive/Promotive Activities
- Childhood Immunization
- Prenatal Services
- Birthing/Parenting Activities
- Postpartum Services
- Women's Health Services
- Family Planning
- Well-baby Services
- CHSCN Services
- Home Health & Geriatric Serv.
- Behavioral Health Services
- PH Clinics

Available specialties and sub-specialties in Family Health Unit:

- Physicians (Pediatrician/ObGyn)
- Interns/Residents (General Practice)
- Nurse Practitioners (Women's Health)
- Nurses
- Social Workers
- Health Educators
- Nutritionists
- Counselors
- Lab Technicians
- X-Ray Technicians
- Clerks
- Psychiatry (referral basis)

Hospital Based Services =

- Delivery
- Pediatric Services - hospital based
- Audiology/ENT Services
- Specialty Clinics
- Emergency Medical Services
- Urgent Care Services
- Medical Records
- Data Management
- Financing/Finance Management

Tertiary Medical Care

- Medical Referral
- Intensive Care services
  - for pediatric, Adolescents and women
- Tripler Army Med. Center
- Philippine Hospitals

//2007// - Under infrastructure initiative to enable the Family Health Unit/MCH Program to improve its services to its population, the following initiatives have been initiated:

- Universal Newborn Hearing Screening and as an offshoot of this initiative, hearing screening for older children have also improved to better screening/treat middle ear diseases.

- Universal School-based Health Screening - Children in schools (both private and public) are screened annually for general health, mental health and substance use problems. Intervention are provided through referral to specialized services in the Hospital, Behavioral Health Department and through home visitation. We have also revised our well-baby services requirements to screen annually from age 3 years old until school entry.
- We are screening for prenatal and post natal depression. Treatment and intervention are also provided onsite or through referral. In recent "Schizophrenia" studies of the Palauan population, Palauans are 2 to 3 times more at risk for this mental health problem than the rest of the world population.
- We have begun a school-based substance use intervention program. This is a new initiative that begun just a few months ago. We will be able to report on its progress in the next grant cyce.
- The FHU/MCH Program is partnering with HIV/AIDS and Breast and Cervical Cancer Screening Program on the formulation of a male health program. Most likely this program will be integrated with on-going health program for the MCH population, however, discussion on more community-based initiative has been core in our discussion.
- There is an initiative to integrate important cultural values in our school readiness program for early childhood. This is a much larger initiative that has been undertaken by an interagency collaborative group. In recent discussion, the adolescent and early childhood collaborative would like to merge and create a larger group that will play an advisory role for the MCH program. This is good as the program grows and mature, to invite more community participation in its effort to respond to community needs.
- Under the Adolescent Health Collaborative, we have partnered with all the schools in the republic, both public and private to work on ways that health and physical activity classes can be merged in terms of delivery. This has been going on for the last two years, and the next scheduled activity will be to work with classroom teachers in integrative lesson planning process whereby both curriculum are integrated into daily lesson plans.

## **B. Agency Capacity**

//2004// - The Republic of Palau's Family Health Unit implement the Maternal and Child Health Program. Services in this Unit comprised of services geared toward Family well-being including but not limited to Women and men of reproductive age group such as Obstetrics and Gynecology for women and male health primary and preventive services, Prenatal Services, Postnatal and reproductive health services (male/female), Well Child Services for infants, children, which includes immunization, and services for children with Special Health Needs. Services for adolescent is provided in collaboration with the School Health program that is part of the Primary Care Division. As part of the School Health improvement, a school-based clinic which opened in 1999 within the campus of the only public High School in Palau. This clinic is within walking distance for student at the Palau Community College who makes frequent use of this facility. An additional clinic was opened in Harris Elementary School in 2001. Behavioral Health Services are accessed on an as-needed basis. Family Health Unit is becoming a strong partner in Adolescent health services. The Unit also worked in partnership with Milad'I Dil and implemented a pilot hotline service in 2004. We also have created an Adolescent Health Collaborative Program as another component of of Family Health Unit programs. We hired a coordinator and have worked to implemented many school based preventive and promotive activities. The coordinator also works as a part time counselor/social worker in the schools and the community. She also works with the Office of Probation with those children who comes in contact with the law and requires intervention. A Family Health Care Coordinator who was hired in 2002 has continued to work to improve our services for families and especially children. We also implemented PRAMS-like survey in 2003 and in 2004 our results were assesed. Based on these results we h ave implemented birthing and parenting classes for expecting mothers and their

husbands/partners. This class is one of the way we are implementing programs that targets at specific health risk factors, in this instance to have a positive influence on the poor birth outcome of specifically Palauan women. We are also working with elementary schools, private kindergarten and the Head Start Program to develop early care concept that intruduces and prepares children for school entry. All the schools, private and public are partnering with us in this endeavour. Also through the results of the PRAMS-like survey, we also implemented psychological/mental health evaluation of our prenatal and postnatal mothers. We partnered with the Division of Behavioral Health to provide a referral link for our moms and their families. We have 2.5FTE counselors/social workers on our staff who provide onsite/home care of our moms. Referrals for psychiatrist to visit homes are made when it becomes necessary.

Behavioral Services are now provided within the Clinic in conjunction with mental/behavioral health screening. Dental screening services for Prenatal and Well-child services are provided on-site by a permanently assigned dental nurse. Mothers and children who are found to require services are then referred to Dental Clinic for appropriate services, free of charge.

//2005// - We continue with last years activities in additon in 2005 we completed the 2004-2005 PRAMS-like surve and are now analyzing the result. We were fortunate to obtain a medical /epidemiology student from the University of Washington who is now assessing our data. Preliminary indication points very important factors that will assist us in our planning and program strategies and activities.

//2006// - Major accomplishments in this year are completion of School Health Screening and the Pregnancy Risk Assessment (PRAMS-like) surveillance. Results of these two monitoring have been completed. They are now being looked at, however two main things that are coming out of these surveillance systems are as follows: Pregnant women residing in extended family system tend to have babies who, for one reason or another, tend to stay in hospital longer than normal. In areas of adolescent health, adolescents who are sexually active tend to have higher risk for suicide ideation and attempt. At this stage of data analysis and program development, we are now providing counseling for these students and are looking deeper into the risk identified in the PRAMS-like surveillance system. We have also identified two staff from the Phillipiens to fill the post of MCH Epidemiologist and Bio-statistician who can be compensated within the funding level that we currently have. These are necessary component of the staffing scheme for the Family Health Unit that for the first time, we are now trying to fill. We have never had an empideologist as a core staff in the staffing pattern of Palau Public Health System. We are now trying to fill post that will provide management capacity to implement evidence-based programs for the MCH population.

//2007// - We have hired an epidemiologist and a statistician from the Phillipines. The cost of hiring these two key staff from the Phillipines is much lower than hiring similar posts from the United States. This is a strategy we have undertaken so that the dollar value of our grant monies is stretched. We also have begun the newborn hearing screening and a report is attached as part of this report.

### **C. Organizational Structure**

//2004//Title V Maternal and Child Health Program is administered and implemented by the Palau's Ministry of Health, Bureau of Public Health under the Division of Primary and Preventive Services.

The Family Health Unit which operationalizes the Title V MCH program is under the Division of primary and Preventive Services; one of the four divisions under the Bureau of Public Health. The Family Health Unit Administrator oversees the unit vision and mission as they relate to the health of all MCH population including the health of Palauan families and male of reproductive age group. Presently, the administrator works under the direct supervision of the Chief of the Division

of Primary and Preventive Health Services. A nurse practitioner supervises the daily supervision of clinic staff and works under the supervision of the Public Health Nurse Supervisor who is under the Office of Nursing Management. The FHU Administrator, Clinic Supervisor and the Public Health Nurse Supervisor MCH Coordinator work in collaboration with other divisions in the Bureau of Public Health to assure that services, programmatic and ministerial responsibilities to the health of the MCH population are continued in a manner that is acceptable to the public and the policy of the Palau Government. At the same time, the FHU Administrator is responsible for the preparation of annual grant application and annual report and other administrative functions. The division chief and the director are responsible for program policy development.

The Bureau of Public Health is one of the two bureaus under the Ministry of Health and is headed by the Minister of Health. The Minister of Health is appointed by the President of the Republic of Palau.

//2005// - The attached organizational chart explains the restructuring that has taken place in Family Health Unit which administers the Title V MCH Grant. This restructuring opens the Unit to be more life cycle, family oriented in its services, and has developed internal capacity to be more evidence based in its program planning process. The organization chart has been approved by the Ministry of Health management. In so doing, it has opened many discussions on the importance of Family health and MCH program. At this point the development of the Unit's 5 year strategic plan has encouraged inter-program discussion and strategy planning on methods whereby the various programs can contribute to the improvement of health within the life cycle model and therefore feed into providing services for the MCH population. This is a positive result of several years of promoting the development of Family Health and MCH program to the point where it is now more understood and appreciated by many programs within the Ministry of health and also the community.

From discussions during the recent FHU Conference, a need was posed by many that there is need to develop a community collaborative/advisory group for FH Programs. This is an indication that the community is getting better acquainted with the program and therefore see the importance of strengthening it.

//2006// - In 2006, the Ministry of Health adopted a vision (Healthy Palau in Healthful Environment) and mission statement that pushes the issue of Family Health/MCH Population to be one of the core components of its mission. In fact the second and third component of the Mission statement are " promote health and social welfare and protect family health and safety". This is the first time in the ministry that the term has appeared in its mission statement.

//2007// Not much change have occurred in the Unit, however, we have really strengthen our activity in data analysis capacity building. The Ministry of Health have decided to integrate all information system which include the Unit's information systems. With this integration, changes are occurring in the last two years, which have not provided us the know-how to organize our systems. The recently hired statistician from the Philippines is also a programmer. She is assisting us in re-establishing our databases/structure/reports and etc. She also will be responsible to re-train our staff in the system.

***/2009/ Title V Maternal and Child Health Program is administered and implemented by the Palau's Ministry of Health, Bureau of Public Health under the Division of Primary and Preventive Services.***

***The Family Health Unit Administrator oversees the unit vision and mission as they relate to the health of all MCH population including the health of Palauan families and male of reproductive age group. A nurse practitioner supervises the daily supervision of clinic staff and works under the supervision of the Public Health Nurse Supervisor who is under the Office of Nursing Management. The FHU Administrator, Clinic Supervisor and the***

**Public Health Nurse Supervisor works in collaboration with other divisions in the Bureau of Public Health to assure that services, programmatic and ministerial responsibilities to the health of the MCH population are continued in a manner that is acceptable to the public and the policy of the Palau Government and the Title V MCH Grant legal mandate. The Bureau of Public Health is one of the two bureaus under the Ministry of Health and is headed by the Minister of Health. The Minister of Health is appointed by the President of the Republic of Palau. The attached organizational chart explains the current structure of Family Health Unit. This structure created a service area that is more life cycle, family oriented in its services, and has developed internal capacity to be more evidence based in its program planning and implementation process. The organization chart has been approved by the Ministry of Health management. In so doing, it has opened many discussions on the importance of Family health and MCH program.**

**The Ministry of Health adopted a vision ("Healthy Palau in Healthful Environment") and mission statement that pushes the issue of Family Health/MCH Population to be in the forefront of its mission. In fact the second and third component of the Mission statement are "promote health and social welfare" and "protect family health and safety". This is the first time in the ministry that the term has appeared in its mission statement. The FHU/MCH Program further expands and focus its roles by adopting of a mission statement that says "...responsible for improving the health of the MCH population through provision of comprehensive public health services"**

**Discuss how the reflection of evidence-based process in the organizational structure:**

**Attached is the current FHU Organizational Chart that will provide additional information on the structure of the Unit. //2009//  
An attachment is included in this section.**

#### **D. Other MCH Capacity**

//2004// - The Ministry of Health receives its revenue from annual congressional appropriations from the Olbiil Era Kelulau. In accordance with traditional usage of health budget, population based services such as those provided by the Bureau of Public Health receives the least amount of revenue. At least three fourths (3/4) of the Bureau's budget for implementation of preventive and primary health care programs and services come from external sources through US Federal Grants, WHO funding and other multi and bi-lateral sources. As evident in the above analogy, local revenue that supports health care have their most concentration on hospital and tertiary medical services. MCH direct services, being part of the Division of Primary Health Care under the Bureau of Public Health competes for local resources that funds primary health care. Looking at the above chart, it is the \$.9 million dollars that supports close to 100,000 encounters each year.

//2004// Other capacities ingrained in the Palau Family Health Unit, is the ability to work with other external agencies, ngo's to broaden the coverage of the MCH program. In this year, the Unit worked with the Ministry of Community and Cultural Affairs to develop a National Policy on Youth. This document contains many issues that requires the Ministry of Health, specifically the FHU to work collaboratively outside the boundaries of the MOH. The Unit also took the initiative this year to develop a collaborative Memorandum of Agreement with 17 agencies outside of MOH to create an Adolescent Health Collaborative. From this agreement, Palau High School have agreed to provide the Unit a space to house an Adolescent Health Program, along with the Division of Behavioral Health. The program will be supervised by the Chief of the Division of Behavioral Health and will work to address needs of individual students/families including group work and counseling services. From this site in the Palau High School, we will also extend our services to other schools and communities. Another initiative undertaken by the Unit is the development of

Policies and Procedures for the Unit. This process began last year, however, we being asked to complete the Manual for the whole life cycle. The basic parts of it for implementation of prenatal, post natal and well baby services have been completed and implemented in the 3 other super dispensaries, however, the remaining parts are being completed for implementation in the next fiscal year. The Unit also completed a Mental Health Screening tool, in collaboration with the Division of Behavioral Health. We began implementing this tool on July in our prenatal and post natal clinics. We are using the tool to identify pregnancy and post-pregnancy related depression and begin to help people before they become life long problems of women in Palau.

//2005// Other capacity building initiatives worth mention is the neonatal genetic screening. We began discussion on this issue late last years with the University of the Philippines, and to date, we have not finalized agreements. Although this has taken a long time to firm, we feel that it is a worthy initiative and will continue to see that it is established. Intermarriages between Filipinos and Palauans is increasing. With some neonatal genetic disorders being more prevalent in the Philippines, it is to our advantage to see that this initiative is established in Palau. The Newborn Hearing Screening has also been implemented and we have begun screening newborns prior to hospital discharge for hearing problems. In our State priorities we also indicated the need to continue screening up to 2 years of age and probably even beyond to assure that Otitis Media related hearing problems do not develop into life problems that will prevent children from entering schools, hinder their learning process and even become a burden to their growth into adulthood.

//2006// - The staffing pattern for FHU/MCH program has remained same over the last years. The program as mentioned in other sections of this document is managed (administratively/programmatically) by Berry Watson. However, in the last several months, due to retirement and staff vertical moves in the Office of Nursing, a newly appointed Nurse Practitioner has taken over the clinic management. the Program has been offering services in the remote areas through the super-dispensary systems. The Program has also contracted parents of children and youth with special health care needs to conduct surveys and in the near future, we will be hiring a part time parent advocate for CHSCN. As mentioned earlier also, the Program is under the Division of Primary and Preventive Health Services. This division has not had a leadership since its inception and therefore, the Program reports directly to the Director of the Bureau of Public Health.

//2007// - //2006// - Palau continues to work with the University of the Philippines, National Newborn Genetic Screening Program. We need to organize the transporting/sending of blood (contaminated product) in commercial planes that crosses borders of nations. We are at the last stage of this agreement and see the resolution of this formality in 2007. We will be able to begin this screening toward the end of 2007.

In the last 2 years we began psychosocial and mental health screening of pregnant women with intervention and follow-up. The school health screening also identifies children with risk factors and provides intervention through referrals, site-intervention and follow-up care.

Newborn hearing who failed the test: 13  
Total newborn screened prior to discharge: 130

Update on the Genetic Screening: An agreement has been signed already between the Family Health Unit/MCH and the University of the Philippines Genetic Screening Program for the latter to do the screening. In this agreement, specimens will be sent to the University by FHU/MCH. However, we are just waiting for the compliance with the shipment/cargo policies to start the genetic screening.

In the School-based health screening initiative - major issues continue to be substance abuse, mainly tobacco and depression. This is a concern as the Palauan population are high risk for schizophrenia. Main issues in physical health relates to higher percentage of children in the

overweight/obese stage. For this particular issue, we have two initiatives with the schools. These initiatives are health/pe collaboration whereby classroom teachers in both classes are being helped to be able to integrate both topics. Another initiative is classroom BMI initiative. Under this initiative, all classrooms of Palau (both private and public) will have scales, bmi charts and bmi tables. Teachers in classrooms will be assisted to be able to weigh children, convert weights/heights into bmi and finding bmi in the table and translate the bmi into the chart. The teachers will work with each child in the classroom to understand this process. Another initiative in the screening is the urine test for protein, glucose and occult blood and we do this through urine dipstick on-site. We are finding that we have a rate that is much higher than developed nations such as Japan. Through these information, we will be able to tailor intervention programs more appropriately.

***/2009/ At least three fourths (3/4) of FHU MCH funding come from external sources through US Federal Grants, WHO funding and other multi and bi-lateral sources. These funds supports population based services including some direct services. Local revenue that supports health care have their most concentration on hospital and tertiary medical services. MCH direct services, being part of the Division of Primary Health Care competes for local resources. Other capacities ingrained in the Unit, is the ability to work with other external agencies, NGO's to broaden the coverage of the MCH program. The Unit has taken the lead in implementing both Newborn Hearing and Genetic Screening. We have organized and conducted a training on hearing screening and intervention with our other neighbors of FSM and RMI. We also conduct an annual training of teachers in the area of health and Physical Education as a strategy for improving the BMI status of Palau children. We have presented papers in regional conference on the status of obesity and health risk factors in children. Two papers have been submitted for editorial review for publication. One is on health status of pregnant women in Palau (from Palau Prams-like survey) and the other paper is on schizophrenia and adopted children. The second paper is a collaborative project between key FHU staff and Palau Youth Project. Because Otitis Media related hearing problems is very high in Palau, it is in our next year plan to do an in-depth study on it for the region. This plan is part of our regional collaboration in the UNHSI Grant for 2009.***

***Within our adolescent health collaborative, we will be training classroom teachers to monitor students' BMI. Under this initiative, all classrooms of Palau (both private and public) will have scales, BMI charts and BMI tables. Teachers in classrooms will be assisted to be able to weigh children, convert weights/heights into BMI and finding BMI in the table and translate the BMI into the chart. The teachers will work with each child in the classroom to understand this process. Another initiative in the screening is the urine test for protein, glucose and occult blood and we do this through urine dipstick on-site. We are finding that we have a rate that is much higher than developed nations such as Japan. Many tools have been created and used as part of health status monitoring and as tools for the continuum of care for MCH population. These tools follows as part of this document.***

***The Palau FHU/MCH Program have invested over many years to develop its capacity. However, because of our isolation and smallness of our population, and insufficiency of personnel qualification, we are always faced with problems of finding and retaining staff such as epidemiologists, statisticians, pediatricians, obstetricians who are committed to stay in Palau and build the local professional infrastructure/capacity. These problems will continue to haunt us and therefore, we need to build the capacity with LOCAL people in mind, as this is the only sub-population that will have permanency in Palau, while the other sub-population is a mobile population, with professionalism, movement outside of Palau is almost guaranteed.***

***As a part of developing our staff, 2 FHU staff participated in the Fiji School of Medicine online Epidemiology Course. One of these staff has been encouraged to complete an MPH in Epidemiology, while we continue to source funding for her schooling, she is completing an MPH Certificate in MCH at the University of Hawaii, John Burns School of Medicine.***

***Newborn Screening implementation took place in 2008 and with current plan for information development, we foresee this program integrated with the CSN/High Risk (Medical Home), Hearing Screening and the development of Birth Defect Surveillance System. These are new development that we have initiated with completion in 2008-2009.//2009//***

***An attachment is included in this section.***

## **E. State Agency Coordination**

//2004// - In addition to what has been mentioned in other sections of this document, we also partner with the Primary Health Care Program and have made our services available to all primary health care centers in the north and south islands of Palau. These services are available in 4 super dispensaries; 3 located in the north island of Babeldaob and one located in the south island of Peleliu. This southern dispensary is responsible for the islands of Angaur, Peleliu and the southwest islands of Hatohobei and Sonsorol. Because these last two mentioned islands are over 300 miles across vast open ocean, field trips are conducted 4 times a year to the islands for delivery of necessary health services. There is also a nurse who is permanently assigned to these islands who provides routine primary health care on a daily basis. Services in the northern super dispensaries are provided on a weekly basis through visits to the remote villages. These services are additional activities we have implemented along with already existing primary health care services in these communities.

//2006// - This year we expanded our agency coordination in adolescent health, early childhood capacity and infrastructure building initiatives. Under these two initiatives we are implementing systems change to improve and expand community-based and individualized services for pregnant women, infants and children. Including in these initiatives is promote legislations and regulatory measures that will safeguard preventive health and primary health care for children and adolescents during the kindergarten, primary and secondary school years. Through initiatives between CAP, NCD, FH and Behavioral Health, community education on substance use and their effects are taking grounds. The school health assessment have provided us information that we are now sharing with each individual states on the status of health of the children in their respective states. We also partner with State Incentive Grant to develop community resiliency to substance use and abuse and to make available individualized intervention program for those who desire it.

//2007// - For this year, we are choosing to report on each of the MCH population:

- Infants and Children - in the past we have met with clinicians to discuss issues relating to infant mortality rate. These discussion have identified key factors in clinicians practice which may have worked to lower and begin the downward trend in infant mortality.

- Children with special health care needs - Not much change have been implemented, however, the concept of "Medical Home" has been adopted for all children, women and pregnant women services. In this process, all high risk clients are managed in the "Medical Home"

- Adolescents - We are making an indept analysis of the YRBS to identify the risk factors and causitive factors relating to the risk factors. Services are being organized not only for the general population but targeting individual clients and also in the "Medical Home". NGO support from Japan are being targetted for technical assistance and other supports toward the BMI school initiative and the school health screening.

- Pregnant Women - Conversion to BMI measurements to better understand the weight problems as indicated in the PRAMS-like survey. Continuation of psychosocial screening and intervention.

- Women of Reproductive Age Group - Decentralization of STI and HIV screening and conversion of these screening to dipstick based screening will enable us to better address needs of these population including male.

## F. Health Systems Capacity Indicators

### Introduction

Please refer to attachment for all Health Systems Capacity Indicators.

**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	96.0	73.1	44.0	14.6	28.9
Numerator	21	11	6	2	4
Denominator	2187	1504	1363	1374	1385
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

//2008/ - In 2007 there were 271 admissions for Upper Respiratory Infections in all age groups. 4 children with a discharge diagnosis of Asthma in the under 5 age group were admitted to the hospital with discharge diagnosis of Asthma. When compared with 2006, there is an increase in cases, however, we believe that the health system has improved dramatically so that many cases are handled in the Out Patient and Urgent Care to avoid hospital admissions.

### Notes - 2006

In 2006, there were only 2 cases of asthma that are below five (5) years old admitted at the Belau National Hospital. This brings the rate at 14.5 per 10,000 population in this age group. This is lower than the goal of 25 per 10,000 in the Healthy People 2010 Objectives.

What this rate also means is that children in Palau received quality preventive care. With the intensive health promotion and education, patients and primary care givers have likely modified their behaviors and improved access to health care such that only very few of children with asthma require hospitalization. As primary care givers understand Asthma, it is likely that preventive behaviors could have been adopted like choice of food, control of the environment etc.

This rate can also be an alternate indicator of access to medicines of children since asthmatic patients. Without medications, those with asthma are likely to develop Acute Exacerbation or one of the complications - Status Asthmaticus -requiring hospitalization.

Tracking of the number of asthmatic patients in this age group admitted at the hospital is done with the database of the Medical Department.

**Narrative:**

//2007// - Data reported under this measure reflect hospital discharge/summaries for Medical Ward/Pediatric Section. It seems to indicate a decrease in asthma hospitalization in under 5 years olds, however, we may need to review urgent care and emergency room admissions as there is a general feeling that this is increasing.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0	0.0	0.0	0.0	
Numerator		0	0	0	
Denominator		259	317	259	
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**

//2008/ - Although Palau does not participate in the Medicaid Program, Well-baby Services are provided routinely with scheduled childhood immunization. Therefore, there are well-baby clinic at 2 wks after birth, 3 moths, 6 months and 12 months during the first year of life.

These well baby services include but not limited to physical and developmental assessments. Health education with parents on various topics from breastfeeding, childhood nutrition, child development stages are also done during these well-baby services.

**Notes - 2006**

Palau does not participate in the Medicaid Program.

**Narrative:**

//2007// - This indicator does not apply to Palau as we do not have Medicaid Program. However, Palau has a well-baby clinic with periodic health screening including immunization program. Data from assessment of immunization indicate a coverage of over 98%. This means that a child in this age group in Palau is also seen for periodic health screening annually.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0	0.0	0.0	0.0	
Numerator		0	0	0	
Denominator		259	311	259	
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**

//2008/ - Palau does not participate in the SCHIP, however, please refer to HSCI 02 for clarification on well-baby services.

**Notes - 2006**

Palau does not participate in the SCHIP Program.

**Narrative:**

//2007// - Palau does not have State Childrens Health Insurance Program (SCHIP), however we have well-baby services that have routine health screening.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	29.8	42	30	27.8	22.9
Numerator	94			72	64
Denominator	315			259	279
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**

//2008/ - 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. Reviewing the initiation and the number of prenatal visits of the 279 mothers who had live births in 2007, 22.9% (n=64) had Kotelchuck Index of equal to or greater than 80%. This represents the Adequate and Adequate Plus Kotelchuck Index which was calculated based on the month prenatal care begins and adequacy of the prenatal care visits. The underlying assumption is that the earlier the initiation, the earlier the identification of health and pregnancy-related problems. On the other hand, the ACOG recommended number of visits ensures determination of the progress of pregnancy. Thus, adequacy of prenatal care is achieved which improves on pregnancy outcomes including reduction of infant mortality. The current Kotelchuck Index of 22.9% of  $\geq 80\%$  is low. Of this number, 36% began prenatal services in the first trimester. This is a challenge to the MCH Program to improve on. There are reasons to believe that the situation can be reversed since the fundamentals in delivery of care are in place. Palau's health system allows it to reach to far areas through a decentralized health care and the spread of the Dispensaries outside the capital of Koror. Intensive community campaigns put high premium on family health including pregnancy. Access to health care is directed by policies within Palau that care should be made available to those who are in need of it. In the next coming year,

the hiring of another OB-Gynecologist who is more community-based would improve greatly the care of pregnant women.

Notes: Revisions were made in the computation of expected prenatal visits. On the old computation, expected number of visits per pregnancy was based on the assumption of 40 weeks Age of Gestation (AOG) which is 14 visits, while in the revised computation, expected number of prenatal visits was based on the actual AOG. For example: initiation of Prenatal began in the 23rd week of pregnancy, total number of visits is 4, and AOG is 35 weeks. In the first computation, with the assumption of AOG of 40 weeks, expected number of visits is 9. This results to the percentage of prenatal visit at 44.4% (4/9). In the revised computation, AOG of 35 weeks has an expected number of prenatal visits of 13, and with the initial visit at 23 weeks, there are 5 missed visits. So the expected number of prenatal visits is 8 (13-5). This results to the percentage of prenatal visit at 50% (4/8). Revisions in computation resulted to an increase in the percentage of Intermediate Care from 20.1% to 20.8% and a decrease in the percentage of Inadequate Care from 57% to 56.3%.

**Notes - 2006**

Reviewing the initiation and the number of prenatal visits of the 259 mothers who had live births in 2006, 27.8% (n=72) had Kotelchuck Index of equal to or greater than 80%. This represents the Adequate and Adequate Plus Kotelchuck Index which was calculated based on the month prenatal care begins and adequacy of the prenatal care visits. The underlying assumption is that the earlier the initiation, the earlier the identification of health and pregnancy-related problems. On the other hand, the ACOG recommended number of visits ensures determination of the progress of pregnancy. Thus, adequacy of prenatal care is achieved which improves on pregnancy outcomes including reduction of infant mortality.

The current Kotelchuck Index of 27.8% of =80% is low. This is a challenge to the MCH Program to improve on. There are reasons to believe that the situation can be reversed since the fundamentals in delivery of care are in place. Palau's health system allows it to reach to far areas through a decentralized health care and the spread of the Dispensaries outside the capital of Koror. Intensive community campaigns put high premium on family health including pregnancy. Access to health care is directed by policies within Palau that care should be made available to those who are in need of it. In the next coming year, the hiring of another OB-Gynecologist who is more community-based would improve greatly the care of pregnant women.

**Notes - 2005**

The figure reported is a projection. We are now trying to extract this information from the PRAMS-like survey. We will have the actual data during the review process.

**Narrative:**

//2007// - Source of data is PRAMS-like survey, however, we also did chart audit to verify continued low participation. This is in spite of intensive community education and therefore as mentioned in other parts of this document, it may be necessary for us to incorporate these educational issues in the wellness services for women.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
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**

//2008/ - Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Medicaid is not available in Palau.

**Notes - 2006**

Medicaid is not available in Palau.

**Notes - 2005**

See Form 17 Notes.

**Narrative:**

//2007// - No Medicaid and SCHIP programs in Palau.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0	0	91.6	0	0
Numerator			480		
Denominator			524		
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**

//2008/- The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.

Palau does not have Medicaid Program. This indicator cannot be reported. However, there is an annual School Health Screening Program that also includes dental screening, referral and follow-up. In 2007, 1365 children from Headstart, 1st, 3rd, 5th, 7th, 9th, and 11th grades were assessed for dental caries/cavities. 35% of all these children were found to have caries/cavities on at least 1 tooth. All these children were referred to the Division of Dental Health for care.

**Notes - 2006**

Palau does not have Medicaid Program. This indicator cannot be reported. However, there is an annual School Health Screening Program that also includes dental screening, referral and follow-up.

**Notes - 2005**

//2005// - See Notes on Form 17 notes.

**Narrative:**

//2007// - Dental screening is part of school health screening. We collaborate with the division of dental services for referrals to treatment and sealants. In the last two years, there has been a backlog of referrals. There is a need to improve relations with the dental services so that treatment and sealant activities can be improved.

**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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0	0	53.2	0	0
Numerator			160		
Denominator			301		
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**

//2008/-Palau does not have State SSI Program. We cannot report on this indicator. However, in 2006 there were a total of 757 children with special health care needs. Under current service system, children with special needs who require rehabilitative services are provided care by the special education program, however, the Belau National Hospital rehabilitative services unit provide consultation services to special education on a case by case basis.

**Notes - 2006**

Palau does not have State SSI Program. We cannot report on this indicator. However, in 2006 there were a total of 757 children with special health care needs. We could not determine proportion of those who needed and received rehabilitative services.

**Notes - 2005**

//2005// - This is a number of children with special health care needs who are receiving special education program. However, at this time, I have no way of knowing, how many of these children receive rehabilitation services. Palau's CSHCN program does not provide direct rehabilitative services. These services are provided through a referral system to agencies or department within the Ministry of Health or the Ministry of Education that provides these services, free of charge.

**Narrative:**

//2007// - There is no SSI program in Palau and therefore rehabilitative services for CHSN is absorbed by Special education program and the government of Palau through Belau National Hospital's Physical Therapy/Rehabilitative Services and the Bureau of Public Health Home Health Services.

**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	matching data files	0	9	9

**Notes - 2009**

//2008/-About 0.4% (1/279) of the live births is classified as Very Low Birth Weight or weighing less than 1500 grams. 8.6% (25/259) of live births are classified as Low Birth Weight or weighing 1500 – 2500 grams. A total of 9.0% of the live births are low birth weight.

Note: Palau does not have Medicaid. Health care support is generally from the government, multi and bilateral funds and some out-of-pocket expenses of patient/s or their families.

**Narrative:**

//2007// - It is in our plan to look at this indicator as it relates to the health status of pregnant moms in terms of substance use patterns, pre weight and during pregnancy weight gains, psychosocial issues pre and during pregnancy. There are information coming out of the psychosocial assessment of prenatal and post natal services that we need to look at. They maybe good information that will refocus us on the next needs assessment

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

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
Infant deaths per 1,000 live births	2007	matching data files	0	7.2	7.2

**Notes - 2009**

//2008/ - In 2007, Palau does not have Medicaid program.

**Narrative:**

//2007// - Infant mortality has been decreasing since 2004/2005. Discussions with clinicians, prenatal clinic staff has taken place. This process has been set for all infant and fetal deaths. From these discussions we can begin to address clinical and non-clinical practices that may influence this indicator. Public Health Infant Mortality Review continues to be a process that needs to be agreed upon as a health system in Palau.

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

INDICATOR #05	YEAR	DATA SOURCE	POPULATION
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<b>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>			<b>MEDICAID</b>	<b>NON-MEDICAID</b>	<b>ALL</b>
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	0	33.3	33.3

**Notes - 2009**

//2008/ - In 2007, Palau does not have medicaid program.

**Narrative:**

//2007// - No Medicaid in Palau or any other poverty or indigent health programs in Palau.

**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])*

<b>INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>	<b>YEAR</b>	<b>DATA SOURCE</b>	<b>POPULATION</b>		
			<b>MEDICAID</b>	<b>NON-MEDICAID</b>	<b>ALL</b>
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	0	22.9	22.9

**Notes - 2009**

//2008/ - In 2007, Palau does not have medicaid program.

**Narrative:**

//2007// - The adequacy of prenatal care has been low in spite of extensive community education. We may need to integrate these activities in wellness services for men and women.

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

<b>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.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2007	200
<b>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.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>

Infants (0 to 1)	2007	
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**Notes - 2009**

//2008/ -In 2007, Palau does not have medicaid program. The current census information indicate that 90.4% of the population fall below 200% poverty guidelines (US).

**Notes - 2009**

//2008/-Palau does not have Medicaid, SSI and SCHIP programs.

**Narrative:**

//2007// - No Medicaid and SCHIP programs in Palau.

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

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 14)	2007	200 200 200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range to ) (Age range to ) (Age range to )		

**Notes - 2009**

//2008/ - In 2007, Palau does not have medicaid program.

**Notes - 2009**

//2008/-Palau does not have Medicaid, SSI and SCHIP programs.

**Narrative:**

//2007// - No Medicaid and SCHIP programs in Palau. However, a free health screening in the schools and well baby services are available free of charge. Palau MCH Program has a very intensive recruitment that begins from prenatal to birth.

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

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2007	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>

Pregnant Women	2007	
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**Notes - 2009**

//2008/ - Palau does not have medicaid program.

**Notes - 2009**

//2008/-Palau does not have Medicaid, SSI and SCHIP programs.

**Narrative:**

//2007// - No Medicaid and SCHIP programs in Palau. However, a free health screening in the schools and well baby services are available free of charge. Palau MCH Program has a very intensive recruitment that begins from prenatal to birth. After delivery in the hospital, each mom and baby are given a post natal and well baby appointments two weeks after delivery.

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

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

**Notes - 2009**

**Narrative:**

//2007// - Palau MCH Program participates in policy development process through call for recommendations on proposed legislations that affect the MCH population. It is also part of the strategic planning process of the Bureau of Public Health.

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

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	No
School Health Screening and Intervention	3	Yes
Youth Tobacco Survey	3	No

**Notes - 2009**

//2008/-FHU-MCH does not have direct access to YRBS and YTS data. Although when requested, general analyzed data are always provided.

//2008/- FHU-MCH have direct access to School Health Screening and Intervention data. We do the survey, make and update the database, and do the analysis.

FHU-MCH does not have direct access to YRBS and YTS data. Although when requested, general analyzed data are always provided.

**Narrative:**

//2007// - The school health screening data are available in the attached report which we have analyzed substance use patterns of adolescents. This report is attached as part of this document.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

//2004// - Five Year Performance Objective

For the most part, the five year performance objectives remained the same. For those where adjustment were made, the explanations are provided in the notes section.

#### State "Negotiated" Five Year Performance Measures

Palau chose to keep the ten negotiated performance measures that were adopted last year. Although there were changes in the priority listing, it did not warrant changing the state negotiated performance measures.

#### Development of State Performance Measures

//2004//In our Family Health Conference that was recently held in June, The Bureau of Public Health decided to retain Performance Measures established in 2000 for the next five years. As mentioned earlier in other sections of this document, changing our service delivery model to be more community and family-based, resonated in this conference. Attendants of the conference's most noted comment was that the health indicators of our nation "are indicators of solutions" that people resort to doing. The problems are usually are the underlying factors that causes the indicators to appear as they are and that the health system, in order to understand these 'underlying problems, must be ingrained in communities/families lives.

#### Discussion of State Performance Measures

//2004//A detailed listing is provided on the negotiated performance measure table. The Negotiated Performance Measure that addresses families has been made the first measure in the order of its importance. Discussion on each of the measure is also provided in the progress report section of this application. There are no significant changes to be explained in this section.

#### Five Year Performance Objectives

Again, performance objectives are presented on Form 11 and explanations are provided as needed in the notes. A few of the performance objectives had to be revised and in this instance the explanation is provided in the notes.

//2005// - We continue to use the annual Family Health Conference as a medium for identifying and prioritizing our health issues. In this conference, working groups for each age group are convened to identify objectives, health priorities and strategies to address these issues. In this conference, community members are invited to attend, discuss, prioritize and developing strategies to address these problems. The result of this exercise makes up the content of the Palau's 5 Year Strategic Plan. This plan will soon be finalized and will include in it as partners many programs within the Ministry of Health and other community partners. Also during this conference a consensus and a desire was reached by the community members, that an Advisory body will be organized to assist the Unit on its program and policy activities.

//2007// - The state performance measures remain as they are. We will retain these measurements until the next needs assessment in 2009.

**B. State Priorities**

//2004// Palau will maintain the SNPM for another year. In 2005 we will change as indicated by the Needs Assessment.

LIST OF PALAU MCH PRIORITY NEEDS  
FISCAL YEAR 2004

1. To implement a national neonatal hearing screening, diagnostic and treatment as component of Family Health Unit Services.
2. To implement a national neonatal genetic screening, diagnostic and treatment services.
3. To reduce the use of tobacco among children and adolescents.
4. To reduce the rate of depression among adolescents and yougn adults.
5. To reduce the rate of death of children under 24 years of age.
6. To reduce the prevalence of obeisity among children under 14 years of age.
7. To implement a community educator program in all communities of Palau.
8. To reduce the percentage of pre-term delivery to no more than 2 by 2010
9. To provide physical examination to all school children from grades 1 - 12th and to refer those with risk factors for appropriate intervention
10. To improve the quality of care and care coordination for children with special health care needs.

//2005// - We will continue to carry over these priority needs for 2007. However, slight changes were made for #1, 2, and 5 to be more concrete and more reflective of a statement of objectives. Please refer to Form\_\_\_\_\_ for details of these change. During the FHU conference, injury as a cause of death of children, adolescents and young adults appeared as one of the most pressing health issue in Palau. Priority 4 and 5 were developed as a link this this health issue.

//2007// - Refer to the report in the attachment.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	100	100	90	92	95
Annual Indicator	100.0	88.8	0.0	0.0	0.0
Numerator	312	230	0	0	0
Denominator	312	259	317	259	279
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	97	99	99	99	99

**Notes - 2006**

Palau has not started with actual genetic screening.

An agreement has been signed between the Family Health Unit/MCH and the University of the Philippines Genetic Screening Program for the latter to do the genetic screening. In this agreement, specimens will be sent to the University by FHU/MCH. However, we are just waiting for the compliance with the shipment/cargo policies to start the genetic screening.

**Notes - 2005**

//2005// - We are in the process of finalizing arrangement/agreements with the University of the Philippines Newborn Genetic Screening Program. We will tap this program for this activity as it is cost effective. We are confident that by fiscal year 2007 it will have been implemented

**a. Last Year's Accomplishments**

Palau finalized and approved the contract with the University of the Philippines Newborn Screening Center. This contract includes supplies for screening, courier services in Manila, and notification through email and phone for immediate intervention. Because of this relationship with the center, we have been given an opportunity for Asia Pacific Regional training and conferences.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Finalized the contract with the University of the Philippines.				X
2. Obtained supplies				X
3. Finalized contract with air courier				X
4. Trained staff on blood spot collection, packaging and transporting.				X
5. Develop standard operating protocols				X
6. Conducted trial run with courier				X
7. Implemented in mid-June 2008				X
8.				
9.				
10.				

**b. Current Activities**

We began sending specimens beginning mid June 2008. In preparation for this, we conducted training for staff on blood spot collection. We also developed a process protocol, oriented staff on this process and in addition we trained staff on IATA regulations and requirements. We have worked with DHL to contract for air courier services between Palau and the Philippines. We have been assured that the courier services will guarantee timely pickup and delivery to avoid spoilage of specimens.

**c. Plan for the Coming Year**

Palau will be able to report data for this measurement next year.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	50	55	73	75	78
Annual Indicator	50	72.8	72.8	90.3	90.3
Numerator		219	219	65	65
Denominator		301	301	72	72
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	81	84	87	88	92

**Notes - 2007**

//2008// We use data reported in 2006 to populate this table. The survey is conducted every two years. The Children with Special Health Care Needs Survey in 2007 showed that 90.2% (65/72) of primary care givers (family members) expressed that the doctors and other health care service providers have “always” and “some of the time” addressed issues and concerns of their children. This is the overall average of the seven items that were asked from the family members to measure their satisfaction with the care given to them. All the items had scores greater than 80%. There is great improvement in the satisfaction compared with last year’s 72% average percentage of their satisfaction.

**Notes - 2006**

The Children with Special Health Care Needs Survey in 2007 showed that 90.2% (65/72) of primary care givers (family members) expressed that the doctors and other health care service providers have “always” and “some of the time” addressed issues and concerns of their children. This is the overall average of the seven items that were asked from the family members to measure their satisfaction with the care given to them. All the items had scores greater than 80%. There is great improvement in the satisfaction compared with last year’s 72% average percentage of their satisfaction.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

As reported in 2006, this is one of the best performing care components for Children with Special Health Care Needs.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>
-------------------	---------------------------------

	DHC	ES	PBS	IB
1. System of care has been in place for over 15 years				X
2. Semi monthly meetings on care management and home visitations	X			
3. The medical card for CSHCN is no longer date limited				X
4. Continued to provide transportation services to CHSCN when requested		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The interagency collaborative (medical home) for CSN has been ongoing for over a decade. It is a permanent system of care within FHU and its other community/agency partners.

**c. Plan for the Coming Year**

Services will be on going and towards the end of 2008, another assessment will be conducted. Results from this assessment will lead the plan for 2010.

**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	50	55	33	35	37
Annual Indicator	0	30.9	30.9	57.7	57.7
Numerator		93	93	41	41
Denominator		301	301	71	71
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	40	50	55	60	60

**Notes - 2006**

In terms of coordination, 57.8% (average proportion of the four items under the item of coordination) of the family members of children with special health care needs expressed a score of 4 and 5 (in a scale of 5; with 1=poor and 5=excellent). This is the proportion of family members who were satisfied in terms of coordination and comprehensiveness of care. There were four (4) domains to measure this particular question. The overall rating of the coordination (4a) received the low score (50%) and doctor's communication with other health care providers (4c) received the highest (66.7%) agreement of receiving coordinated care. This year's average score is higher (57.8%) than in 2006.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

Services will be on going and towards the end of 2008, another assessment will be conducted. Results from this assessment will lead the plan for 2010.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We presented the result of SLAITS-like survey to FHU staff and doctors/nurses				X
2. Training topics were developed based on this meeting				X
3. Conducted training on case management/care coordination				X
4. Conducted training on communication				X
5. Identification of coordinator for Palau SSDI Project/coordinator for CSHCN				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2008, we have conducted several trainings to address this component of care for CSN. One was on care coordination and case management process. We had a consultant from the University of Guam who came to Palau and provided a 4-day consultancy on this training. Another training was on communication and customer service. Both of these trainings were open to all collaborative members from, within and outside of the Ministry of Health.

**c. Plan for the Coming Year**

Services will be on going and towards the end of 2008, another assessment will be conducted. Results from this assessment will lead the plan for 2010.

**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	15	17	20
Annual Indicator	0	13.0	13.0	10.6	10.6
Numerator		39	39	11	11
Denominator		301	301	104	104
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	11	12	13	14	15

**Notes - 2007**

//2008// - Of the families who took part in the Children with Special Health Care Needs Survey (n=104), 11 (10.6%) of them claimed to have insurance. In this insurance, 91% expressed that they are able to buy medicines with it.

While there is only a small proportion of families covered with private insurance, in Palau primary health care is a fundamental right. MCH services are for free particularly among those children identified as having special health care needs. At average, the families would have an annual income of US\$14,900 (CHSN Survey, 2007). A little over than half (59.6%) have more than one income earner per household. This gives also assurance that the family can supplement the necessary health needs of their child.

**Notes - 2006**

Of the families who took part in the Children with Special Health Care Needs Survey (n=104), 11 (10.6%) of them claimed to have insurance. In this insurance, 91% expressed that they are able to buy medicines with it.

While there is only a small proportion of families covered with private insurance, in Palau primary health care is a fundamental right. MCH services are for free particularly among those children identified as having special health care needs. At average, the families would have an annual income of US\$14,900 (CHSN Survey, 2007). A little over than half (59.6%) have more than one income earner per household. This gives also assurance that the family can supplement the necessary health needs of their child.

**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 indicator as reported last year was also very low. We expected it to be low as health care services for children with special needs are heavily subsidized by the government of Palau.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Palau government assumes 80% of Health Care costs for CHSCN				X
2. The medical card for CSHCN is no longer date limited				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

We expect similar pattern on this indicator unless there is a drastic change in the health care laws of Palau.

**c. Plan for the Coming Year**

Services will be on going and towards the end of 2008, another assessment will be conducted. Results from this assessment will lead the plan for 2010.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	50	55	36	38	40
Annual Indicator	0	34.9	34.9	57.7	57.7
Numerator		105	105	41	41
Denominator		301	301	71	71
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	60	62	64	67	69

**Notes - 2007**

//2008/ - This section also reflects the same items under the care coordination. 57.7% of the families expressed that the services are coordinated in a way that helps their children access these services, and again, since this survey is conducted every 2 years, we use last years' data to prepopulate this table.

**Notes - 2006**

This section also reflects the same items under the care coordination. 57.7% of the families expressed that the services are coordinated in a way that helps their children access these services.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

As reported last year, this was also a low performing indicator in the care components of CSN services. This is because there are not many non-government supported services for CSN in Palau.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. We standardized CSHCN semi monthly clinics in the rural			X	

areas				
2. Identified a physician who is responsible for these clinics.				X
3. Identified transport support for these semi monthly clinics		X		
4. Conduct clinics as scheduled				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

As reported in performance measure 3, when we conducted the trainings in 2007 and 2008, we opened them to our collaborative partners. This is to strengthen collaboration so that services can be streamlined and practices improved at different sites.

**c. Plan for the Coming Year**

Services will be on going and towards the end of 2008, another assessment will be conducted. Results from this assessment will lead the plan for 2010.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective			32	34	36
Annual Indicator	0	29.9	29.9	76.7	76.7
Numerator		90	90	56	56
Denominator		301	301	73	73
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	78	80	82	84	85

**Notes - 2007**

//2008/ - fAt average, 76% of family members agree that they have doctors and they always have health care access. These questions reflect the level of access to the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence. About 97.3% (71/73) of family members of children with special health care needs said that they never had delay in health care consult nor gone without health care for their child. Also, 55.4% (41/74) expressed that their child has a regular doctor or nurse. The low proportion of family members agreeing that their child has a regular doctor could also be explained by the fact that a child with special health care needs could also be referred from one doctor or health professional to the other including the stakeholders in the schools and communities.

**Notes - 2006**

At average, 76% (56/73) of the family members agree that they have doctors and they always have health care access. These questions reflect the level of access to the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence. About 97.3% (71/73) of family members of children with special health care needs said that they never had delay in health care consult nor gone without health care for their child. Also, 55.4% (41/74) expressed that their child has a regular doctor or nurse. The low proportion of family members agreeing that their child has a regular doctor could also be explained by the fact that a child with special health care needs could also be referred from one doctor or health professional to the other including the stakeholders in the schools and communities.

**Notes - 2005**

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

**a. Last Year's Accomplishments**

As reported last year, this was a good performing care component. However, in re-assessing the information, the component of this care which was low was in the area of identified health care provider for the child. The access to care and availability of care was at 97% but previously mentioned care component was 55%. This reflects that the characteristic of the Palau medical home design. In this design, there are several pediatricians, nurses, and social workers who are part of this medical home. Therefore, any child with special need can access quality care at any time and place.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assessed components of transition that was part of the SLAITS-like survey.				X
2. Identified components of transition care that was the least performing component				X
3. Conducted staff meetings regarding "medical home" design				X
4. Concurrence of the staff team that we will continue with the design but improve on coordination between staff				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Similar process was practiced in 2008 as this is Palau's model of medical home for children with special needs.

**c. Plan for the Coming Year**

Services will be on going and towards the end of 2008, another assessment will be conducted. Results from this assessment will lead the plan for 2010.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	99	99	99	100	100
Annual Indicator	98.7	95.9	99	97.9	95
Numerator	308	462		333	
Denominator	312	482		340	
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

### Notes - 2007

//2008/ - In 2007, the immunization registry and tracking show that HIB was missed at 15 months for majority of missed immunization. This vaccine cannot be administered after 15 months and therefore in 2007, we see the rate come down as compared to previous years.

### Notes - 2006

Children in Palau received their immunization from the Well-baby clinic or in the Dispensaries. In 2006, the total clients in the registry totaled 340 (3 years old). At average, the percentage of 35 month old who received immunization was 98% (333/340). The following are the breakdown of immunization: DTaP-4 (100%), IPV-3 (97%), MMR-2 (96%) and Hep-3 (97%).

Data is taken from the Division of Primary and Preventive Services which pool all data from the Well-Baby Clinic and the Communicable Disease Unit.

### Notes - 2005

This figure is reported by the Well-child services clinic which is responsible for immunization prior to school entry (0 - 5 years olds)

### a. Last Year's Accomplishments

In 2007, our immunization performance decline as compared to previous years. Our assessment indicate that the cause of this decline was on HIB vaccine. This vaccine has a timeline not exceeding 15 months of age. Most children who were not immunized for HIB had exceeded this age limit and therefore based on the CDC guidelines, they could not be followed up. The rate for immunization for 2007 for the age group of 19-35 months old was 95%.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Assessed immunization coverage from the tracking and registry databases				X
2. Identified vaccine that had the lowest coverage which was HIB.				X
3. Reviewed the findings with clinic staff and Immunization Program				X
4. a. Assessed immunization coverage from the tracking and registry databases Revisited immunization protocols with staff				X

5. Provide transportation services for home visitation and immunization follow-up		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

This year, through the efforts of CDC funded immunization program, we will be implementing a new database that will assist us in immunization assessment and follow-up. We foresee this new process improving our indicator for 2008 reporting year.

**c. Plan for the Coming Year**

We expect to have improved this indicator through changes in data collection, assessment and follow-up.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	17	15	13	11	10
Annual Indicator	11.8	9.5	11.1	7.6	6.5
Numerator	5	4	5	10	3
Denominator	422	422	449	1322	459
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	6.4	6.2	6	5.8	5.6

**Notes - 2007**

//2008/ - About 5.0% (n=14) of the total pregnancies in 2007 are from teenage mothers. Of these, one (1) was 16 years old and two (2) were 17 years old. This brings the 15-17 ASFR at 6.6 per 1,000 women in the said age bracket. An increase is observed in 2007 compared to 2006 at 2.2. The three-year moving average is 7.6 per 1000 for teenagers aged 15 through 17 years. Expanding the assessment of the ASFR to 15-19 years old, this has slightly dropped from 18.6 to 18.4 per 1000 women in 2006 and 2007, respectively. An age-specific fertility rate of 18.4 is lower compared with the same rate in the industrialized countries at 24 (Fertility and Contraceptive Use, Unicef Statistics, Unicef, 2007).

The denominator is a population projection for this age group(female), based on the Republic of Palau 2005 Population Census

**Notes - 2006**

This computes for the three-year moving average from 2004-2006.

Pregnancy during adolescent years tends to be unintended and premature. It is also associated with greater risks of dying in pregnancy and complications during delivery. Consequences are also dire because babies born to teenagers run a higher risk of low birth weight, serious long term disability. Having a child during teenage years also limits girls' opportunities for better education, jobs and income. These are strong reasons for Palau's commitment to the most vulnerable group of 15-19 years old.

About 5.4% (n=14) of the total pregnancies in 2006 are from teenage mothers. Of these, one (1) was 17 years old. This brings the 15-17 ASFR at 2.2 per 1,000 women in the said age bracket. A swift decrease is observed in 2006 compared to last year at 11.1. The three-year moving average is 7.6 per 1000 for teenagers aged 15 through 17 years.

Expanding the assessment of the ASFR to 15-19 years old, this has dropped from 30.8 to 18.6 per 1000 women in 2005 and 2006, respectively. An age-specific fertility rate of 18.6 is lower compared with the same rate in the industrialized countries at 24 (Fertility and Contraceptive Use, Unicef Statistics, Unicef, 2007).

**a. Last Year's Accomplishments**

In 2007, there were 3 under 17 pregnancies which brings the 3-year moving average rate for Palau to 7.6 per 1000. The overall teen pregnancy (19 and under age group) was 14 which was representative of 5% of all births. The actual pregnancy rate for this age group was 2.5 per 1000. We have used the 3-year moving average to report on this measurement as occurrences is less than 6.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School Health screening and intervention identified sexually active youth and provided counseling and family planning			X	
2. Continued to provide family planning services and reproductive health counseling to adolescents through the school health program			X	
3. Incorporating reproductive health in the comprehensive services for youths.				X
4. Provided community education on reproductive health as part of the Community Engagement for Early Childhood Community Program				X
5. Participate in the Youth Forum to discuss amongst other topics, reproductive and sexual health			X	
6. Establish partnership with HIV/AIDS Program to improve community based services at the Palau Community College campus in evenings				X
7.				
8.				
9.				
10.				

**b. Current Activities**

This year, the school health program through the adolescent health collaborative continues to advocate and provide services to assure healthy reproductive health for Palau's children. Included in activities for 2008 are provision of on-site reproductive and sexual health counseling, provision of family planning services, health screening/intervention/referrals/follow-ups and

through the Strengthening Project. This project aims to improve health of children through improving health and PE programs in schools. Through this initiative, health and PE teachers are assisted to look at health and PE as integrated subjects. Areas of health that are addressed in this initiative are wellness issues such as physical activity, nutrition, mental, behavioral and emotional health, substance abuse, sexuality and reproductive health. FHU also supports summer camps for children. In these summer camps, FHU incorporate health learnings which becomes part of the summer camps activities. Through this supports, FHU is assisting community NGO to develop culturally appropriate models of intervention for Palau youths.

**c. Plan for the Coming Year**

In 2009, we want to be able to assess the effective of the following initiatives within FHU: School Health Screening and Intervention; Strengthening Project; and Summer Camps. We will work with the community NGO to document the model of community based intervention that is being incorporated in their summer camp. We will work with Palau YRBS to further analyze the YRBS data to provide us information on risk factors that influences children's sexual practices and their reproductive health.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	99	99	83	85	87
Annual Indicator	81	81	53.9	41.5	87.1
Numerator			132	136	155
Denominator			245	328	178
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	90	93	93	93	94

**Notes - 2007**

//2008/- In 2007, this is the first time that Palau has reached its target in the last five years. FHU partners with the Division of Oral Health to continue to improve this measure. In the school health screening, the cavities rate for 3rd graders was 60%. This indicates that extensive work need to continue to lower the percentage of caries. Another partnership is through ECCS and the Association of Governors to assure that all schools in Palau will have classroom sinks for the purpose of improving oral health and personal hygiene issues of school aged children.

**Notes - 2006**

A total of 41.5% (136/328) of the third grade children received protective sealants (Note: this denominator includes those Grade 3 students who may not need protective sealants). Overall, there are 328 third grade children but only 92% (n=302) of them underwent dental screening by the Dental Unit. Of those who were screened, 69.2% (209/302) required sealants. In actuality, there are a higher proportion of Grade 3 students who received protective sealants, about 65% (136/209) from among those who required sealants.

The Dental Unit of the Ministry of Health conducts yearly screening among children. This is also complemented with the School Health Screening Program of the Bureau of Public Health through the Family Health Unit. A yearly health and psycho-social screening is done that includes screening for dental caries. Any child who has dental problems is referred to the Dental Unit. Group and individual counseling is also done by the Public Health Social Workers on varied issues including dental hygiene and care. In the 2006 School Health Screening, 18.8% (213/1131) of the students (Grades 3, 5, 7, 9 & 11) had dental caries. The mean number of dental caries was 0.5. In 2006 alone, a total of 162 referrals to the dental unit was done (School Health Screening, 2006).

Access to screening, diagnosis and management (care) are well in placed in Palau thru the Dental Unit. There are also on-going oral health promotion and preventive activities. Collaboration is very strong from and among key stakeholders like the Dental Unit, Bureau of Public Health, Schools, parents, students and the communities.

**Notes - 2005**

//2005// - This is the number of children who were screened and those who were referred for dental problems ranging from caries to decay and other dental problem during the national school health screening. This screening covered all schools of the Republic of Palau. We were unable to obtain specific numbers for sealants on permanent tooth molar.

**a. Last Year's Accomplishments**

In 2007, the percentage of third graders with at least one molar tooth sealed was 87%. There were 264 third graders screened and 178 were found to need sealant. Out of this 178, 155 children had at least 1 molar tooth sealed. From the school health screening, we find that 60% of third graders have at least 1 dental caries/cavity.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted oral health screening as part of the School Health Screening and intervention			X	
2. Identified 3rd graders who required sealant and refer to Oral Health Division for preventive dental care			X	
3. Identified 3rd graders with dental caries/cavities to Oral Health Division for treatment			X	
4. Collaborate with Oral Health Division to further improve the identification, referral and intervention process				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

For this year, FHU will increase collaboration effort with the Division of Oral Health. Since dental health screening is part of the School Health Screening, it is important for the Division of Oral Health to increase their effort in preventive dentistry for children.

**c. Plan for the Coming Year**

For this coming year, we will work with the Association of Governors to build sinks outside each classrooms for the purpose of on-site tooth brushing and hand washing. FHU will improve

collaboration and integrate activities with the Division of Oral Health to improve preventive dental care for children.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
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	3912	3912	4789	4836	4875
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0	0	0	0	0

**Notes - 2007**

//2008/ - No deaths were recorded caused by motor vehicle among children aged 14 years and younger.

The risk for motor vehicle accidents in the recent Youth Risk Behavior (2007) Survey, about 14.6% (84/572) of the respondents claimed to have driven a car or other vehicle when they had been drinking alcohol. The School Health Program has individual and group counseling on Alcohol, Tobacco and Other Drugs among the in-school students. In addition, many other programs in Palau such as the "Stop Tobacco Use Now" and the "Gen NOW" Projects of the Division of Behavioral Health have been very actively promoting the reduction of use of alcohol and tobacco in the community. FHU and the CHC with their community engagement activities are also working to increase community capacities to lessen the use and risk of tobacco and alcohol.

**Notes - 2006**

No deaths were recorded caused by motor vehicle among children aged 14 years and younger.

The risk for motor vehicle accidents could be likely. In the recent Youth Risk Behavior Survey, about 14.6% (84/572) of the respondents claimed to have driven a car or other vehicle when they had been drinking alcohol. However, the School Health Program has individual and group counseling on Alcohol, Tobacco and Other Drugs among the in-school students.

**Notes - 2005**

//2005// - There were no MVC related deaths for this age group in 2005.

**a. Last Year's Accomplishments**

In 2007, there were no deaths related to motor vehicle crashes for this age group.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>
-------------------	---------------------------------

	DHC	ES	PBS	IB
1. Integrated injury prevention in School Health Program through collaboration with Emergency Health Program			X	
2. Provided community-based education on bullying prevention in schools and communities targeting children, parents and school personnel.				X
3. Collaborate with Ministry of Justice on monitoring of injuries				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

### b. Current Activities

Continue to increase injury prevention efforts with Emergency Health Program and the Ministry of Justice so that Palau's do not die due to motor vehicle crashes.

### c. Plan for the Coming Year

Continue to increase injury prevention efforts with Emergency Health Program and the Ministry of Justice so that Palau's do not die due to motor vehicle crashes. Increase lobbying efforts with the Belau National Congress to pass the seat belt law. This has passed the second reading but has not been signed into law.

**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				60	65
Annual Indicator			48.7	58.7	52.4
Numerator				54	33
Denominator				92	63
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	56	60	64	68	72

#### Notes - 2007

//2008/ Comparison of Breastfeeding Practice among Mothers who Gave Birth from Years 2003 - 2007.

Among those mothers who delivered in 2007 and participated in the PRAMS-like survey, 96.5% breastfed their babies. Of those who breastfeed, 44.1% breastfed for 6 months or more while those who breastfed within the first six months was slightly higher at 52.4%. There is a decrease

compared with 2003-2004 (46.4%) and 2005/2006 (58.7%). There is a slight decrease of mothers who did not breastfeed in 2007 (3.2%) compared with 2005/2006 (3.3%), still the proportion of babies being breastfeed is very high. The proportion of those mothers who breastfeed their babies is 96.9% from years 2003-2007.

**Notes - 2006**

Since the number of mothers who participated in the PRAMS-like survey is low for each year, years 2003 and 2004 were combined together. The same holds true with 2005 and 2006.

Among those mothers who delivered in 2005 and 2006 and participated in the PRAMS-like survey, 96.7% breastfed their babies. Of those who breastfeed, 58.7% had it for 6 months or more. There is a moderate increase compared with 2003/2004 (51.3%). While there is a slight increase of mothers who did not breastfeed in 2005/2006 (3.3%) compared with 2004/2005 (2.9%), still the proportion of babies being breastfeed is very high. The proportion of those mothers who breastfeed their babies is 97% from years 2003-2006.

**Notes - 2005**

//2005// - This figure is obtained from PRAMS-like survey, which went up from last year figure of 27%. The 48.7% represent those women who exclusively breastfeed up to 6 months.

**a. Last Year's Accomplishments**

In 2007, the overall coverage exclusive breastfeeding was 52.4% In addition, those who exclusively breastfeed in excess of 6 months was 44.1%. The proportion of those mothers who breastfeed their babies is 96.9% from years 2003-2007.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Connected nutrition and breastfeeding care from prenatal (public health) to delivery (hospital care) through reassignment of nutritionist and counselors				X
2. Developed home-based follow-up care as part of the system of care mentioned above.	X			
3. Continued to implement exclusive breastfeeding in the post partum ward of the Belau National Hospital				X
4. Incorporated breastfeeding and its benefits in the ECCS community engagement activities			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2008, we have strengthened the hospital-to-home care for postpartum mothers. This care is to assure that once breastfeeding is initiated after birth that it continues in the home as well. Breastfeeding counseling is also initiated in the prenatal clinic to delivery.

**c. Plan for the Coming Year**

Continue efforts in the past. An emerging issue that we will have to do an in-depth investigation on is the relationship of breastfeeding and jaundice. There are anecdotal evidence that there is a relationship, however, we have not studied this emerging health issue.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	0	0	0	98	99
Annual Indicator	0.0	0.0	0.0	50.2	81.4
Numerator	0	0	0	130	227
Denominator	312	259	311	259	279
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	85	87	89	91	95

**Notes - 2007**

//2008/ - There were a total of 279 live births in 2007. Of these newborns, 81.4% (n=227) were screened for hearing using the Otoacoustic Emission test prior to discharge. About 86.3% (196/227) passed the test and 13.7% (31/227) failed in both or either ears.

Among the 31 newborns who failed the OAE test, three (3) or 9.7% (3/31) were tested in only one ear, 25.8% (8/31) newborns failed on both ears. 64.5% (20/31) newborns were tested on both ears and failed the test on either ear.

No infants were tested on the Auditory Brainstem Response Test. However, at 3 months follow-up in the well-baby services, all infants who failed the initial test at births, all passed the OAE and ABR. Therefore, no baby was found to have congenital deafness in 2007.

**Notes - 2006**

There were a total of 259 live births in 2006. Of these newborns, 50.1% (n=130) were screened for hearing using the Otoacoustic Emission test prior to discharge. About 90% (117/130) passed the test and 10% (13/130) failed in both or either ears. At least one newborn OAE test only in one ear but passed it. Another 25% (65/259) infants born in 2006 underwent screening 1 month or more after hospital discharge. Overall, a total of 195 (75.2%) infants had hearing screening. Among newborns who failed in the hearing screening, re-test were done during follow-up.

The hearing screening officially started in March 1, 2007 after the purchase of the equipment and the training of the health staff (one pediatrician and two ENT nurses). There were two skills-building training, one in Tripler Army Medical Center in Hawaii and in Palau during the delivery of the equipment. From the time that the OAE was done up to December 31, 2006 there were 214 live births. Thus, the actual proportion of newborns screened prior to discharge is 60.7% (130/214). If the other infants who were screened after discharge will be included, the overall proportion of infants who underwent OAE is 91.1% (195/214).

About 6 infants had Auditory Brainstem Response Test and passed.

**Notes - 2005**

//2005// - Palau began newborn hearing screening in March 2006. We will be able to report on this PM in 2007.

**a. Last Year's Accomplishments**

In 2007, 86% of the babies born were screened for hearing. All those who were screened passed either the initial or follow-up screening. The initial screening is performed in the neonatal unit and follow-up screening performed in the two-weeks well baby clinic at FHU. The test that are performed are OAE and ABR.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish neonatal unit policy for hearing screening prior to hospital discharge of newborns				X
2. Required all babies to be screened			X	
3. Tripler Army Medical Center Audiology Department continue to conduct annual training for staff				X
4. Conducted screening for older children as part of Palau's strategy to decrease otitis media related hearing loss			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

For 2008, we are purchasing additional testing machines that will be located in the well baby clinics. The purpose of this additional equipment is to avoid equipment movement from hospital to public health. We are finding out that when there is constant movement of these high technology/delicate equipment, it causes breakage and recalibration. Sending them out of Palau for repairs can be very costly to the program.

**c. Plan for the Coming Year**

In 2009, we want to assure that all babies born at Belau National Hospital are screened at or prior to 1-month evaluated by 3 months and begin to receive intervention no later than 6 months of age, for those babies who are found to have congenital hearing problem. We also want to make sure that we continue to screen for hearing problems in older children as Otitis Media is a leading cause of hearing loss in Palau.

**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	0
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0	0	0	0	0

**Notes - 2007**

//2008/ - While there is only a small proportion of Palauans who are covered with private health/medical insurance, the government heavily subsidizes health care. From pregnancy onto delivery all prenatal services are provided free of charge. Newborn Screening to FHU's well-baby services including school based health screening and intervention are also provided free of charge. Services for Children with special health care needs are heavily subsidized with minimal fee for medication (\$6-\$10) for prescription. Medical Home activities for CSN are also not charged. On the other hand, hospitalization is made affordable through a sliding fee and no Paluan who requires hospitalization is denied of it.

In strengthening access, the amendments introduced in the Constitution had made primary health care (as with education) as a fundamental right of every Paluan. The implementing law for it is currently being addressed. On the other hand, there is ongoing initiative in the Bureau of Public Health to adopt changes in the current public health laws to incorporate this amendment in the constitution. The Family Health Unit takes an active part in this process of change.

**Notes - 2006**

While there is only a small proportion of Paluans who are covered with private health/medical insurance, the government heavily subsidizes health care. Thus, it can be said that every child in Palau is covered with social insurance. Generally, basic preventive services are free of charge. These services include those under the Family Health/MCH Program. Children with special health care needs identified in the interagency collaborative process also receive services free of charge. On the other hand, hospitalization is made affordable through a sliding fee and no Paluan who requires hospitalization is denied of it.

In strengthening access, the amendments introduced in the Constitution had made primary health care (as with education) as a fundamental right of every Paluan. The implementing law for it is currently being addressed. On the other hand, there is ongoing initiative in the Bureau of Public Health to adopt changes in the current public health laws to incorporate this amendment in the constitution. The Family Health Unit takes an active part in this process of change.

**Notes - 2005**

//2005// - refer to form 11 notes.

**a. Last Year's Accomplishments**

In 2007, as reported in previous years, all services provided by FHU are free of charge. This is because the government of the Republic of Palau subsidizes 80% of health care cost. The other 20% is met through external funding sources such as MCH Title V Program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All services provided by FHU/MCH Program are provided free of charge			X	

2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

For 2008, same process is reported for this year. There is no expectation for change unless the Republic of Palau amends its constitutional provision for "free or subsidized health care".

**c. Plan for the Coming Year**

In 2009, same process is reported for this year. There is no expectation for change unless the Republic of Palau amends its constitutional provision for "free or subsidized health care".

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				10	8
Annual Indicator					
Numerator					
Denominator					
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.					Yes
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	6	4	2	2	2

**Notes - 2007**

//2008/ - No data can be supplied in this item since Palau doesn't have a WIC program. Although Palau doesn't have the WIC program, there are several things that we do like routine care for infants and children, Well-baby clinic that are part of the WIC program.

In 2006, Palau adopted changes to begin BMI measurements in this age group. These information are charged in the medical records, however, at this point, we have not electronically implemented collection of these indicators and therefore cannot report on it. At the same time, in the annual health screening for children over the age of 5, BMI information are collected, analyzed, and reported.

**Notes - 2006**

No data can be supplied in this item since Palau doesn't have a WIC program.

Although Palau doesn't have the WIC program, there are several things that we do like routine care for infants and children, Well-baby clinic that are part of the WIC program.

**Notes - 2005**

//2005// - We are unable to report this measure for 2005. We are now updating our service manuals to require BMI measurement for this age group. We will be able to report on this measure in 2007 reporting period.

**a. Last Year's Accomplishments**

In 2007, although Palau doesn't have the WIC program, there are several things that we do like routine care for infants and children, Well-baby clinic that are part of the WIC program. For children under ages 2-5, BMI measurement became required in 2007 as part of charting, however it is not being captured in the encounter information and for this reason we are unable to report it.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Changed measurement from "height-and-weight" to "BMI" in the Well Baby clinic				X
2. Charting in medical records adopted				X
3. Routine collection, analysis, and reporting of BMI for older children				X
4. Developed and implemented a "Palau BMI Calculator" to be used in clinics and health screenings				X
5. Incorporated hypertension percentiles in the "Palau BMI Calculator"				X
6. Conducted staff orientation on the use and interpretation of BMI and hypertension results from the calculator				X
7.				
8.				
9.				
10.				

**b. Current Activities**

For 2008, the same process reported for 2007 is reported for this year.

**c. Plan for the Coming Year**

For 2009, we would like to incorporate BMI measurement as part of the encounter data so that we can report on this measure next year. BMI measurement is part of information captured in the school health screening and therefore we can account for BMI for older children but not the younger ones.

**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				13	10
Annual Indicator				50.0	57.4
Numerator				16	39
Denominator				32	68

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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	55	53	50	47	45

**Notes - 2007**

//2008/ - If we take into account mothers who gave birth in 2007, only 68 of them were interviewed (PRAMS-like Survey) from a total of 279 mothers who had live births. Of these, 57.4% (39/68) continued to smoke during the period of pregnancy. This is higher than in 2006 at 50.0% (16/32 [1 missing data]) and lower in 2005 at 66.7% (42/63 [2 missing data]).

In years 2007, there were 68 mothers who were interviewed at post-natal phase (generally after six months from delivery). A face to face interview was done using the PRAMS-like Survey Interview Schedule. About 66.2% (43/65 [1 missing data]) smoked cigarette in the past twelve months prior to pregnancy. When probed further whether the smokers/chewers change the frequency of cigarette use during their most recent pregnancy, 57.4% (39/68) continued smoking. Among mothers who smoked, 5.9% (4/68) quit from smoking cigarette during their most recent pregnancy. On the other hand, a large proportion of those who continue to smoke decreased (60.5%) maintained (20.9%) or increased (9.3%) their frequency of smoking. In years 2007, the proportion of mothers (57.4%) who continued to smoke is less compared with 2005-2006 at 61.1% but more compared with 2003-2004 at 55.5%.

During the pre-natal visits, cessation of cigarette use either by smoking or chewing betel with cigarette is an important component of the counseling. This area requires an intensive and innovative strategy to curb the problem of cigarette use during pregnancy.

**Notes - 2006**

The data is culled from the PRAMS-like survey covering the periods of 2003-2006. With reference to the timing of smoking, the specific question in the PRAMS-like survey did not indicate the last three months of pregnancy. Rather, the question referred to smoking during the most recent pregnancy.

If we take into account mothers who gave birth in 2006, only 33 of them were interviewed from a total of 259 mothers who had live births. Of these, 50.0% (16/32 [1 missing data]) continued to smoke during the period of pregnancy. This is lower than in 2005 at 66.7% (42/63 [2 missing data]).

In years 2005-2006, there were 98 mothers who were interviewed at post-natal phase (generally after six months from delivery). A face to face interview was done using the PRAMS-like Survey Interview Schedule. About 69.5% (66/95) smoked cigarette in the past twelve months prior to pregnancy. When probed further whether the smokers/chewers change the frequency of cigarette use during their most recent pregnancy, 61% (58/95 [3 missing data]) continued smoking. Among mothers who smoked, 10.8% (7/65 [1 missing data]) quit from smoking cigarette during their most recent pregnancy. On the other hand, a large proportion of those who continue to smoke decreased (46.2%) maintained (32.3%) or increased (10.8%) their frequency of smoking. In years 2005-2006, the proportion of mothers who continued to smoke is more (61%) compared with 2003-2004 at 55.5%.

During the pre-natal visits, cessation of cigarette use either by smoking or chewing betel with

cigarette is an important component of the counseling. This area requires an intensive and innovative strategy to curb the problem of cigarette use during pregnancy.

**Notes - 2005**

//2005// - On this measure, we are unable to report on tobacco use at 6-7 months pregnancy age. This question was not part of our PRAMS-like survey and so data for this is not available. However, we did ask a question whether or not the mother changed her tobacco use during the pregnancy.

One reponse option was "I quit using tobacco during my pregnancy". The rate of reponse for this question was 13.2%. We are using this response rate as our baseline in projecting for the next 4 years.

We will include a question in the next PRAMS that will measure this new NPM.

**a. Last Year's Accomplishments**

In 2007, PRAMS-like Survey Interview Schedule, 66.2% smoked cigarette in the past twelve months prior to pregnancy. When probed further whether smokers/chewers change the frequency of cigarette use during their most recent pregnancy, 57.4% continued smoking. Among mothers who smoked, 5.9% quit from smoking cigarette during their most recent pregnancy. On the other hand, a large proportion of those who continue to smoke decreased (60.5%), maintained (20.9%), or increased (9.3%) their frequency of smoking. In years 2007, the proportion of mothers (57.4%) who continued to smoke is less compared with 2005-2006 at 61.1% but more compared with 2003-2004 at 55.5%.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to incorporate tobacco use education in prenatal care clinics			X	
2. Monitor usage information through PRAMS-like survey				X
3. Publicize PRAMS-like survey results through public media, local and regional meetings and publications				X
4. Assess the level of participation in the PRAMS-like survey				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

For 2008, we will continue to monitor this performance measure in the Palau PRAMS-like survey. Although the percentage is still very high, there is a slight decrease since we began monitoring it in 2004. We partnered with the University of Washington student and had drafted an article which has been submitted to Pacific Health Dialogue for publication. This draft article is now under editorial review.

**c. Plan for the Coming Year**

For 2009, we will continue to monitor this performance measure in the Palau Prams-like survey. Although the percentage is still very high, there is a slight decrease since we began monitoring it in 2004. In 2009, the nurses and social workers in the clinic will be responsible to conduct this survey as a means to improve client participation.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	0	0	0	0	0
Annual Indicator	0.0	0.0	68.4	67.8	0.0
Numerator	0	0	1	1	0
Denominator	1550	1177	1462	1474	1486
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0	0	0	0	0

**Notes - 2007**

//2008/ - In its commitment to address psychosocial issues that leads to suicide of young people, Palau, through FHU's school-based health screening and intervention monitors risk factors for suicide. Among the screening questions pertain to depression, traumatic experiences, suicide ideation and suicide attempt including access to counselor or therapist. If students are known to have any psycho-social problems, the Public Health Social Workers initiate counseling or make referral to appropriate units like the Behavioral Health or School Health Clinic. On the other hand, the Ministry of Education also conducts the Youth Risk Behavior Survey every two years that also deals on psychosocial issues similar to the School Health Screening Program. Both the School Health Screening and the YRBS also helped program implementers in designing strategies and activities to respond to the problems of the youth.

In the 2007 School Health Screening, 7.7 % of children reported to have suicide ideation and 32% of those who had ideation have attempted suicide. Interventions either through on-site and follow-up from school health program and through referrals were done.

In 2007, there was one case of suicide who was a 14-year old female.

**Notes - 2006**

There was one 16 year old female who committed suicide in 2006.

Palau is committed to address the health and psychosocial needs of children particularly the vulnerable 15 – 19 years old. Death from suicide is unnecessary as it is preventable. As part of its commitment in this area, the Bureau of Public Health through the Family Health Unit conducts a yearly screening (as part of the School Health Program) among in-school children specifically grades 1, 3, 5, 7, 9 and 11. Among the screening questions pertain to depression, traumatic experiences, suicide ideation and suicide attempt including access to counselor or therapist. If students are known to have any psycho-social problems, the Public Health Social Workers initiate counseling or make referral to appropriate units like the Behavioral Health or School Health Clinic. On the other hand, the Ministry of Education also conducts the Youth Risk Behavior Survey every two years that also deals on psychosocial issues similar to the School Health Screening Program. This survey measures the success of the interventions among the youth regarding suicide ideation and suicide. Both the School Health Screening and the YRBS also

helped program implementers in designing strategies and activities to respond to the problems of the youth.

In the 2005 School Health Screening, 3.7% (42/1131) attempted suicide. Proper interventions through counseling and referrals were done.

**a. Last Year's Accomplishments**

In 2007, there were no suicide deaths in this age group. In the School Health Screening, out of the 104 (7.7%) students who claimed that they thought of killing themselves, 32.0% (33/104) have said that they have attempted killing themselves. For those students who responded positive to this question, proper interventions through counseling and referrals were done. Another source of data for suicide is the Palau YRBS. In 2007, 29% of YRBS respondents claimed that they seriously considered suicide and 10% had attempted where medical intervention was provided. The discrepancy of suicide data between YRBS and School Health screening are several: (1) school health screening begins at 1st grades, with odd grades being screened and screening is for all schools of Palau, (2) YRBS is only conducted for the central public schools and not the schools in the rural areas and faith-based schools. Other factors that may influence suicide pattern in children is Bullying which continues to be high. Because of this indication, we had begun with anti-bullying campaigns in schools, and the wider communities (parents and teachers). In 2007, bullying in children was 27% which is 2% higher than 2006. The Use of alcohol in adolescent years is also high with 36% in the last 30 days (YRBS).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Incorporation of Mental And Behavioral Health Education in School Health Program				X
2. Partnership with Behavioral Health in staff training				X
3. Collaborated with Behavioral Health Division in developing and delivering community engagement modules within the ECCS community activities				X
4. Analyzed School Health Screening results and utilizing data to redirect program strategies to address mental and behavioral health issues through referrals, follow-ups and community education				X
5. Collaborate with the Ministry of Education to improve services to schools			X	
6. Conducted bullying prevention education to students in all schools of Palau			X	
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2008, We think that all these factors contribute to suicide ideation and attempt. The Palau YRBS is another source for us to identify what contributes to this performance measure, however, we have not been successful in getting the authorization to be able to analyze this data set further.

**c. Plan for the Coming Year**

For 2009, we will continue to negotiate with the Ministry of Education to allow us to work on this dataset to identify contributing factors to suicide and suicide ideation.

**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)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	0	0	0	0	0
Annual Indicator	0	0	0.0	0.0	0.0
Numerator			0	0	0
Denominator			317	259	279
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0	0	0	0	0

**Notes - 2007**

//2008/ - Palau has no Level III facility. The Belau National Hospital, the biggest hospital in the republic, does not have a Neonatal Intensive Care Unit for babies with very low birth weight or complications. Generally, the newborns are taken cared of at the Nursery which is able to respond to general care for neonates. While the facility is not equipped to respond to newborns weighing less than 1,500 grams, historically the hospital is able to care and support for babies weighing less than 1500 grams and those with some complications.

In the 2007 calendar year, one (1) baby was born weighing 1,500 grams and less (Very Low Birth Weight). About 8.6% (24/279) of live births are classified as Low Birth Weight or weighing 1500 – 2500 grams. One other mother who had a historical pattern of high risk was sent to the Philippines to birth her baby. The baby was born in November 2007 and remained in the hospital for 4 months prior to coming to Palau.

**Notes - 2006**

Palau has no Level III facility. The Belau National Hospital, the biggest hospital in the republic, does not have a Neonatal Intensive Care Unit for babies with very low birth weight. Generally, the newborns are taken cared of at the Neonatal Care Unit which is able to respond to general care for neonates. While the facility is not equipped to respond to newborns weighing less than 1,500 grams, historically the hospital is able to care and support for babies weighing less than 1500 grams and those with some complications.

In the 2006 calendar year, no baby was born weighing 1,500 grams and less (Very Low Birth Weight). Overall, about 9.6% (25/259) of live births are classified as Low Birth Weight or weighing 1500 – 2500 grams.

**Notes - 2005**

//2005// - There were 9 LBW and 8 VLBW infants in 2005. They were cared in our neonatal unit and none were referred for care in NICU outside of Palau. This remains our practice and there is considering our management and political climate in Palau, there will not be policy or regulatory measures to change this practice. There is a general concensus within our leadership that if a child born inside of Palau cannot serve at the level of neonatal care we have, then the

government-supported health system will not assist in the survival of that infant. It will be left to the parents and the family to access care outside of Palau if they so desire.

**a. Last Year's Accomplishments**

In 2007, Palau has no Level III facility. The Belau National Hospital, the biggest hospital in the republic, does not have a Neonatal Intensive Care Unit. Generally, the newborns are taken care of at the Nursery which is able to respond to general care for neonates. While the facility is not equipped to respond to newborns weighing less than 1,500 grams, historically the hospital is able to care and support for babies weighing less than 1500 grams and those with some complications. In the 2007 calendar year, one (1) baby was born weighing 1,500 grams and less (Very Low Birth Weight). About 8.6% (24/279) of live births are classified as Low Birth Weight or weighing 1500 -- 2500 grams.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to provide neonatal care for all newborns at the level of care of Belau National Hospital			X	
2. Provided medical referral opportunity for a high risk mom to have a safe delivery and management in the Philippines through the Palau Medical Referral Program	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

For 2008, one high risk pregnancy was referred to the Philippines prior to 6 months for necessary medical care. The mother was able to safely deliver her baby and returned to Palau. As noted earlier, hospitals in the Philippines are tertiary hospital sites for neonatal intensive care.

**c. Plan for the Coming Year**

For 2009, Palau would want to upgrade neonatal basic equipment and tools such as incubators, infant monitors, and bilirubin lights/blankets as we are seeing increase in numbers of jaundice in newborns.

**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	44.3	51.3	37	45	52
Annual Indicator	29.8	30.1	61.2	25.5	33.3
Numerator	93	78	194	66	93
Denominator	312	259	317	259	279
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
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	36	42	46	50	54

**Notes - 2007**

//2008/ - Of the 279 live infants born to mothers in 2007, 33.3% (n=93) had their first prenatal visits during the first trimester. About 4.3% (n=12) had no records of prenatal visits in the Encounter Forms. This data is taken from the Prenatal Registry at the Medical Records and the Encounter Forms. At the same time, we had 3 moms who gave births without prenatal care and accessed birthing/delivery services through emergency room. An issue of hospital cost is appearing to be a barrier to proper care for pregnant women and this may have an impact of the health of the mother and the baby.

**Notes - 2006**

Of the 259 mothers who gave birth in 2006, 25.5% (n=66) had their first prenatal visits during the first trimester. About 5.4% (n=14) had no records of prenatal visits in the Encounter Forms. This data is taken from the Prenatal Registry at the Medical Records and the Encounter Forms.

On the other hand, the PRAMS-like survey of those mothers who recently gave birth in 2005-2006, would show that 75.5% of them had their first prenatal visits on or before 12th weeks AOG. This proportion is higher compared to 2003-2004 (65.1%).

**Notes - 2005**

//2005// - The data for 2005 were derived from the PRAMS-like survey for 2004-2005. We have decided to analyze our data every two years due to the smallness of our population.

**a. Last Year's Accomplishments**

In 2007, 33.3% of infants were born to women who had their first prenatal visits during the first trimester. About 4.3% (n=12) had no records of prenatal visits in the Encounter Forms. This data is taken from the Prenatal Registry at the Medical Records and the Encounter Forms. On the other hand, the PRAMS-like survey of those mothers who recently gave birth in 2007 would show that 79.0% of them had their first prenatal visits on or before 12th weeks AOG. This proportion is higher compared to 2003-2004 (65.1%) and 2005-2006 (75.5%).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Integrated prenatal care education in the ECCS community engagement activities				X
2. Through ECCS collaborative, FHU delivered the "community engagement" module to all states of Palau			X	
3. Monitored prenatal care appropriateness through the PRAMS-like survey and chart audits.				X
4. Implemented changes in the Birth Certificate to enable us to capture accurate information for this measure next year				X
5. Addressed timely encoding of birth certificate data				X
6. Developed Tagalog translated materials for prenatal care		X		
7.				
8.				

9.				
10.				

**b. Current Activities**

For 2008, this measurement will continue to be monitored in the birth certificates and the PRAMS-like survey.

**c. Plan for the Coming Year**

For 2009, because of our declining PRAMS-like survey participants, the nurses in the clinic will begin administering this survey. This process will begin in July 2008 and in January 2009, the survey will be administered at three months postnatal care. Calculation of this measure will be captured from the birth certificate as assessment and improvement of service providers' activities on the Birth Certificate are being addressed.

**D. State Performance Measures**

**State Performance Measure 1:** *Percent of 0-2 years of age who test positive for hearing defects that receive further evaluation and treatment*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				100	100
Annual Indicator				0.0	0.0
Numerator				0	0
Denominator				130	227
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0	0	0	0	0

**Notes - 2007**

//2008/ - In 2007, there 31 newborns who failed the initial screening, however, when re-screened at 2 weeks and 3 months, all these newborns passed OAE and/or ABR.

We conducted a regional training on newborn hearing screening. Our counterparts from the 3 jurisdictions, RMI, FSM and Palau participated in this training. In the training we went over the etiology of hearing problems in the pacific and how Micronesia (Palau, FSM and RMI) compare to other pacific islands. We also introduced participants to the hearing screening equipment in Palau and they went through the process of using the equipment on newborns.

**Notes - 2006**

With the Universal Hearing Screening, majority of newborns in Palau were tested prior to discharge. When the baby fails in the exam, a re-test is done. The same baby is also referred to a specialist. Only 130 of the newborns were tested. Of these, 13 failed and followed up for treatment.

**Notes - 2005**

Palau will be able to report on this PM in 2007 as our program was just implemented in 2006

**a. Last Year's Accomplishments**

As reported under national performance no. 12, Palau has established this neonatal screening program. All data requirements have been reported under the national performance measure.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish neonatal unit policy for hearing screening prior to hospital discharge of newborns				X
2. Required all babies to be screened			X	
3. Tripler Army Medical Center Audiology Department continue to conduct annual training for staff				X
4. Conducted screening for older children as part of Palau's strategy to decrease otitis media related hearing loss			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

As an added resource to improve data management for newborn screening program, Palau submitted a grant application to CDC for EHDI funding. This funding source if awarded to Palau will enable us to improve data collection, monitoring, analysis and reporting. It will also enable us to use these information in further program improvement and strategies to lessen the risk of newborn and young children's hearing loss.

**c. Plan for the Coming Year**

We plan to hire a newborn screening technician. This staff will be in charged with the collection of specimen and testing, data management, and report development for the program including the FHU. We also plan to improve data management and skills of staff who are involved in newborn screening.

**State Performance Measure 2: *Percentage of newborns screened positive for genetic disorder who receive further evaluation and treatment***

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				0	0
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

**Notes - 2007**

//2008/ - In 2007-2008 we had to set-up a system in place for implementation of this screening program. Included in this system set-up, was to assure that we comply with IATA regulations on air shipment of biological products. We also trained our staff in the blood spot collection process, drying and packaging for air shipment. We have also contracted with DHL as the air courier for the blood spots and by June 15, 2008, Palau will begin screening for 5 congenital genetic disorders.

**Notes - 2006**

No screening has been done yet.

At this stage, there is already an agreement with the University of the Philippines Newborn Genetic Screening Program - where the genetic testing will be done. However, we are still thrashing-out problems related to cargo and shipment. With the requirements on handling of specimens, the government of Palau through the Family Health Unit and the cargo based in Palau are still complying with the international policies.

**Notes - 2005**

//2005// - Palau is developing its genetic screening program at this time. We will work with the management of the Ministry of Health to assure that children who are identified for genetic problems, will receive similar benefits in the Medical Referral Program. This is a tertiary medical treatment program for Palau and at this time, 95% of its clientele are adults with non-communicable disease related illnesses.

**a. Last Year's Accomplishments**

As reported under national performance no. 1, Palau implemented this program recently. We have completed all management and administrative requirements for the implementation of newborn genetic screening. These activities included finalizing contract with UP, working with CDC to identify and understand IATA requirements for transporting of blood spots across country borders, developing in-house protocols on collection, storage/processing, and transportation.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Finalized the contract with the University of the Philippines.				X
2. Obtained supplies				X
3. Finalized contract with air courier				X
4. Trained staff on blood spot collection, packaging and transporting.				X
5. Develop standard operating protocols				X
6. Conducted trial run with courier				X
7. Implemented in mid-June 2008				X
8.				
9.				
10.				

**b. Current Activities**

As reported under national performance no. 1, we implemented the program in June of this year.

**c. Plan for the Coming Year**

Palau will be able to report data on this requirement.

**State Performance Measure 3:** *Percent of adults women of reproductive age group whose BMI is over 27 are identified and provided on-site education and referred for weight management 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				60	65
Annual Indicator				0	0
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	70	75	80	85	90

**Notes - 2007**

//2008/ - Starting this year (2007), process and forms are being put in place to get the BMI of women in reproductive age. Thus, we could not report any data on the weight of women in reproductive age at this time. However, it is worth to mention that there is heightened information and education campaign in terms of weight reduction, proper diet and exercise. This was primarily brought about by the World Health Organization's finding that Palau is one of the countries with high obesity. This is an initiative that FHU and community advocacy program will partner to establish in 2009.

**Notes - 2006**

Starting this year (2007), process and forms are being put in place to get the BMI of women in reproductive age. Thus, we could not report any data on the weight of women in reproductive age at this time. However, it is worth to mention that there is heightened information and education campaign in terms of weight reduction, proper diet and exercise. This was primarily brought about by the World Health Organization's finding that Palau is one of the countries with high obesity.

**Notes - 2005**

FHU will work with Community Advocacy Program to improve their data gathering and reporting so that we can report on this measure. At the same time, we will organize systems of support for these women to receive appropriate intervention if they so desire.

The importance of this SPM is that in the two years data analysis of our PRAMS-like survey over 60% of women responded that the reason they did not enter prenatal care in the first trimester was that they did not know they were pregnant. At the same time, the Community Assessment of 2003 shows that 67% of adults (ages 15 and up) were either in the overweight or obese status.

It is generally thought that maybe the weight issue of women is affecting the menstrual cycle which lead women to not be aware that they are pregnant

**a. Last Year's Accomplishments**

Palau was able to implement certain activities relating to this objective in 2007. These objectives include staff of FHU to work as collaborative members of other Public Health Programs. One such program is the NCD Program. Activities that staff were involved in include participation in advisory councils for Head-start, Nutrition committee in NCD and trainings of teachers in Private and Public Schools on BMI measurements.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with other programs.				X
2. Implement BMI measurement in FHU clinics.			X	
3. Developed BMI calculator				X
4. Collection and monitoring of BMI in children and adolescents.				X
5. Conducted staff orientation on the use and interpretation of BMI and hypertension results from the calculator				X
6.				

7.				
8.				
9.				
10.				

**b. Current Activities**

FHU MCH Program works with Palau NCD Program. This year, FHU staff conducted trainings for Health and PE teachers for all schools of Palau on BMI measurement and the use of tables and charts. We also trained teachers and mentors for the Palau LEEP Program. Generally, BMI measurement is now understood in the general population. We are now using it in most of our clinics and the community activities.

**c. Plan for the Coming Year**

We will work with other programs in the Ministry of Health to commonly use BMI as standard measurement. By next year, we will work to establish common collection of BMI information so that we can begin to report on an annual basis. One such way that we can establish common collection of this data is further develop capabilities of the "Palau BMI Calculator" that was established and used since 2007.

**State Performance Measure 4:** *Percent of children in 1st to 12th grade who receive annual health screening*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				60	70
Annual Indicator			51	52.6	68.7
Numerator				1131	1365
Denominator				2150	1987
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	80	90	100	100	100

**Notes - 2007**

//2008/ - In 2007, for Family Health Unit/MCH, an annual school health screening is done. In 2005, it covered all grade levels. In 2007 those who were screened were 1st, 3rd, 5th, 7th, 9th and 11th grade levels only. In this reproductive health to 238 students; General Hygiene to 804 students, Alcohol, Tobacco and other Drugs to 450 students and education on screening, 1365 (68.7%) students were screened for health, psycho-social and substance abuse. At that particular period, there were a total of 3975 students in Palau in the odd grade levels. Primarily, this screening intends to identify those with health and psychosocial problems and provide immediate care or referral to appropriate agencies. With the results of the screening, the FHU/MCH was able to provide education on nutrition and physical activities to 841 students; Bullying to 445 students. Individual counseling was also given to 149 individuals. Also, 1209 students were referred to different health units at the National Belau Hospital for further diagnosis and management.

The denominator is a projected enrollment population for the grades screened in 2007.

The denominator for 2006 was edited to reflect population for the grades screened.

**Notes - 2006**

For the Family Health Unit/MCH, an annual school health screening is done. In 2005, it covered all grade levels. However, starting 2006 those who were screened were 3rd, 5th, 7th, 9th and 11th grade levels only. In this screening, 1131 students were screened for health, psycho-social

and substance abuse. At that particular period, there were a total of 4,300 students in Palau in the odd grade levels. Primarily, this screening intends to identify those with health and psychosocial problems and provide immediate care or referral to appropriate agencies. With the results of the screening, the FHU/MCH was able to provide education on nutrition and physical activities to 342 students; reproductive health to 61 students; General Hygiene to 378 students, Alcohol, Tobacco and other Drugs to 347 students and education on Bullying to 306 students. Individual counseling was also given to 239 individuals. Also, 757 students were referred to different health units at the National Belau Hospital for further diagnosis and management.

Starting this school year (2007-2008), the screening will now include Grade 1.

**Notes - 2005**

//2005// - 51% of school age children were provided health screening in 2005 from the School Health Program. This is another initiative we began last year to identify children with health, social, behavioral, mental health related problems and provided intervention when indicated.

**a. Last Year's Accomplishments**

In 2007-2008 school calendar year, the annual school health screening was conducted to all odd grades in both public and private schools. A total of 1365 students in grades 1, 3, 5, 7, 9, 11th were screened for health, psychosocial, and substance use. The purpose of The annual school health screening is to identify students with medical and psychosocial problems and provide immediate intervention and referrals to appropriate care. Health education and interventions were also provided on site during the school screening. Interventions that were provided after the screening includes health education on nutrition, physical activity, substance use, reproductive health, and mental health, and bullying. Individual counseling and group therapy were also provided to students and families needing services. Students needing medical care were referred to appropriate specialist and clinics at the hospital

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened all odd grades from both public and private schools			X	
2. Trained staff (both public health and counselors) on psychosocial interviewing skills				X
3. Analyzed data and present results to MOH and MOE management, all schools, PTA's, community collaborative groups and ECCS community engagement.				X
4. Trained PE and Health teachers from all schools on BMI and ways it can be intergrated as activities in both classes				X
5. Trained PE teachers on health integration into PE using "TOPS" model				X
6. Collaborate with the University of Tokyo to improve screening process that will enable us to identify risks for kidney disease, hypertension and diabetes				X
7.				
8.				
9.				
10.				

**b. Current Activities**

FHU/School Health continues to provide follow up care and interventions in the schools. Adolescent Collaborative group met earlier this year to discuss the upcoming 2008-2009 school year and discussions on enhancement of current system of care is ongoing. With the addition of one social worker/counselor to the PE team, all public health social workers are assigned to all

schools. Schools to identify staff to be the focal point of contact where social workers can communicate on a regular basis with. This process will ensure that all services to schools are well coordinated on a timely basis. Annual training focusing on interviewing skills and data collections of screening information are ongoing.

A BMI calculator and software measuring hypertension stages was developed at end of last year and will be utilized this coming school year screening.

**c. Plan for the Coming Year**

Head Start Screening will be integrated with the regular school health screening. Head Start working with FHU in revising PE form. Annual School Screening will continue to cover odd grades 1, 3, 5, 7, 9, 11th. Discussion on developing and integrating various screening tools measuring specific psychosocial issues are ongoing. Tools will be developed and used in the upcoming school year. A new data system capturing intervention and prevention activities have been developed and will be utilized this coming year to capture all intervention and prevention activities relating to the school health screening. Ongoing trainings for clinicians and social workers and staff involve in the school health screening will continue. Such trainings will focus on interviewing skills and data collection techniques. Trainings on immediate interventions on screening site will be conducted.

**State Performance Measure 5: *The rate of depression for adolescents ages 11 - 19.***

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				13	11
Annual Indicator			149.9	77.8	65.6
Numerator			365	88	46
Denominator			2435	1131	701
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	60	55	50	45	40

**Notes - 2007**

//2008/ - In 2007, The School Health Screening showed that 41 per 1000 children (n=55) felt depressed out of 1349 that answered the question. For the group of 11-19, the rate of depression is more prominent than the pre-adolescent age.

**Notes - 2006**

The School Health Screening, 2006 showed that 78 per 1000 children (n=88) felt depressed among the 1131 screened. About 40.5% of the youth who participated in the YRBS, 2006 felt sad or hopeless. The rate is higher in females than in males with 46.4% and 33.6%, respectively.

Profile of individuals who committed suicide from 1999 to 2004 has shown that 16-20 years old ranked fourth among the age groups with highest cases of suicides (n=7) in Palau . Data representing the in-school youth of Palau have shown that 30.4% of the students had seriously considered attempting suicide with females having higher rate at 38% compared to males at 33.6%.

A qualitative study was done by UNICEF in the Pacific to appreciate the motivations behind suicide among the youth. Among the themes that were extracted from the study participants were the absence of persons to confide with about their problems and the anxiety that goes with the inability to meet the goals and the value systems between traditional with "modern" culture.

However, the YRBS, 2006 also identified that 15.5% of the youth will seriously consider attempting suicide if they thought they had shamed themselves or their family.

**a. Last Year's Accomplishments**

Depression and other components of psychosocial issues are part of the the School Health Screening. Children are screened and if they are found to have existing psychosocial health issues, they are then referred for further evaluation and intervention or are provided care counseling on-site.

Conducted health education in the schools. Topics included social skill buildings -- resiliency factors and coping skills ( problem solving skills, decision making, conflict management, stress management, self esteem, peer pressure, communication)

Provided trainings to teachers and school staff in social skill development and coping skills.

Faith base partnership- adolescent support services in private schools (office assigned )

Conducted peer mentor trainings on social skill building

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened and identified student with depression			X	
2. Provided individual counseling to students	X			
3. Group therapy/focus groups conducted			X	
4. Family therapy provided to students and families	X			
5. Conducted health education in the schools			X	
6. Provided trainings to teachers and school staff in social skill development and coping skills.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Agency collaboration/NGO- activities with external partners. Trainings and health education to help teens to learn effective ways of coping with depression. Topics and techniques include: relaxation exercises, social skills (problem solving skill, decision making skill, peer pressure, goal setting, stress management communication, pleasant activities and actions, changing negative thinking, and problem-solving. Instructional methods that include discussions, role-playing exercises and class room work assignments.

Provided trainings to teachers and parents on social skill development.

Health education in the schools : social skill building, resiliency factors

Counseling training for teachers and school staff

Peer mentoring trainings

Integrated social skill development in all youth summer camps

Continued individual counseling to students/family therapy

**c. Plan for the Coming Year**

To conduct trainings for parents to understand their children's depression. It will also facilitate parents' providing support for the strategies their children will learn in coping with depression. Trainings will also be designed to help reduce the level of conflict between parents and teenagers by teaching effective communication and problem-solving skills.

Counseling Trainings for teachers and school staff that focuses on how to recognize symptoms of depression and ways to help children cope with depression. Trainings will also focus on communication skills and building resiliency factors.

Faith base-strengthen partnership with faith base/ provide ongoing trainings on depression and other psychosocial issues. Identify staff from each faith base as the focal point of contact.

Continue to support youth activities ( school awareness, summer camp, mentoring programs for youth) promoting emotional& mental health)

Continue community outreach --include parents and teachers in these efforts.

**State Performance Measure 6:** *The percentage of children and adolescents ages 18 and under who report using (smoke and/or chew) tobacco products in the past 30 days.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				39	37
Annual Indicator			41	258.2	
Numerator				292	
Denominator				1131	
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	35	33	31	29	28

**Notes - 2007**

//2008/ - In 2007, we are reporting information from the 2007 YRBS. This percentage is pre-calculated and therefore, we do not have numbers for the numerator and the denominator. The trend of tobacco use in this population has been consistent for about 10 years now. Even with this pattern, there is a slight decrease from 2006.

**Notes - 2006**

The School Health Screening in 2006 showed that 258 (n=292) per 1000 students admitted to use of nicotine. In the 2006 YRBS, 37% (n=180) of those who participated in the study claimed to have smoked during the past 30 days. Of those who smoked, 61.1% (n=111) started smoking before reaching Grade 13.

To address the problem of smoking, the screening is closely coordinated with the Behavioral Health Division who runs the Youth Tobacco Cessation Clinic. Also, the Public Health Social Workers of the FHU/MCH provide education, individual and group counseling on substance abuse including cigarette use.

**Notes - 2005**

//2005 - The rata of tobacco use is derived from Qunestion 36 of the Palau YRBS for same year. This questions asks about use of tobacco produce at once in the past 30 days.

**a. Last Year's Accomplishments**

Substance use including Tobacco is part of the School Health Screening. Children who are substance users are provided targeted individual counseling and group therapy which are conducted at schools and school clinics. Health education focusing on tobacco prevention in the schools and the cessation programs and life skill curriculum are provided in collaboration with STUN.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened and identified students with tobacco use			X	
2. Provided targeted individual counseling	X			
3. Group therapy conducted at schools and school clinics			X	
4. Health education focusing on tobacco prevention in the schools			X	
5. Developed cessation package to train social workers				X
6. Developed Life skill curriculum to supplement cessation program				X
7. Collaborate with STUN in disseminating information				X
8.				
9.				
10.				

**b. Current Activities**

Substance use including Tobacco is part of the School Health Screening. Children who are substance users are provided targeted individual counseling and group therapy which are conducted at schools and school clinics. Health education focusing on tobacco prevention in the schools and the cessation programs and life skill curriculum are provided in collaboration with STUN. Also provided training to service providers on cessation program at school, training of teachers and parents and working with SIG, NCD and Community Coalition against Substance Use to expand community presence on substance use and tobacco cessation.

**c. Plan for the Coming Year**

For 2009, we will pilot Cessation at School Health including the implementation of relapse prevention program. We will also work with STUN on Youth Tobacco Survey to continue prevention and intervention services in the schools. We will develop initiatives/activities focusing on refusal skills, self esteem, problem solving, coping skills. Another initiative for next year is to work with school PTA's in strengthening prevention and intervention services in the schools and including training of student peer mentors on delivering prevention messages in the schools.

**State Performance Measure 7: *Percent of pregnant women entering prenatal care 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				67	72
Annual Indicator			62	25.5	33.3
Numerator				66	93
Denominator				259	279
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	36	39	42	45	48

**Notes - 2007**

//2008/ - In 2007, First trimester initiation of prenatal care accounted 33.3% (n=93) of the 279 women who gave birth. The trend in this measure has been consistently low despite extensive community work to improve it and because of this trend, we have revised our next 5-year performance objective to reflect this low performance.

**Notes - 2006**

First trimester initiation of prenatal care accounted 25.5% (n=66) of the 259 women who gave birth in 2006 (Please refer to Performance Measure Number 18).

**Notes - 2005**

//2005// - This measure is derived from the PRAMS-like survey of 2005.

**a. Last Year's Accomplishments**

We reported data requirements on this state measure under national performance measure no. 18. In 2007, Palau used it as a state measure because of its continued historically low performance and the critical need to realize improvement on it.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Integrated prenatal care education in the ECCS community engagement activities				X
2. Through ECCS collaborative, FHU delivered the "community engagement" module to all states of Palau			X	
3. Monitored prenatal care appropriateness through the PRAMS-like survey and chart audits.				X
4. Implemented changes in the Birth Certificate to enable us to capture accurate information for this measure next year				X
5. Addressed timely encoding of birth certificate data				X
6. Developed Tagalog translated materials for prenatal care		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

We have been researching in the WHO website for further increasing our knowledge on this measure. Because changing requirement for the Pacific jurisdictions, we will be using this requirement as a baseline for data calculation. However, we will continue to calculate the Kotelchuck Index as a comparative reference.

**c. Plan for the Coming Year**

We will continue with the activities we are currently doing and in 2009 reporting year, we will show the result of the work we are doing now.

**State Performance Measure 8: Percent of Pre-term delivery**

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
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Annual Performance Objective				6	5
Annual Indicator			7.5	10.8	9.0
Numerator			24	25	25
Denominator			319	231	279
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	4	3	2	2	2

**Notes - 2007**

//2008/ - In 2007, there were 8.6% (n=25) of mothers who gave birth less than 37 weeks AOG and 91.4% gave birth at 37 weeks AOG or more. Prematurity increases neonatal mortality. Thus, the direction to reverse the high premature delivery is intended to have better neonatal and also maternal outcomes. At the same time, a focus on the prematurity will bring about review more frequently than the maternal mortality review which Palau has never had since no maternal death has occurred in the recent past.

**Notes - 2006**

There were 10.8% (n=25) of mothers who gave birth less than 37 weeks AOG and 89.2% gave birth at 37 weeks AOG or more. Prematurity increases neonatal mortality. Thus, the direction to reverse the high premature delivery is intended to have better neonatal and also maternal outcomes. At the same time, a focus on the prematurity will bring about review more frequently than the maternal mortality review which Palau has never had since no maternal death has occurred in the recent past.

Only 231 mothers were investigated as to AOG at birth since the other mothers had missing data.

**a. Last Year's Accomplishments**

There were 8.6% (n=25) of mothers who gave birth less than 37 weeks AOG and 91.4% gave birth at 37 weeks AOG or more. Pre-maturity increases neonatal mortality. Thus, the direction to reverse the high premature delivery is intended to have better neonatal and also maternal outcomes. At the same time, a focus on the pre-maturity will bring about review more frequently than the maternal mortality review which Palau has never had since no maternal death has occurred in the recent past.

Only 278 mothers were investigated as to AOG at birth since the other mothers had missing data. One (1) newborn had missing data on AOG.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Chart and Birth Certificate review				X
2. Establishment of baseline information for Palau				X
3. Provided counseling and tobacco use cessation in the prenatal clinic, home visitation and referrals especially in the prenatal high risk clinics.			X	
4. Because of the low participation in the PRAMS-like survey, the post- natal clinic nurses will begin implementing the survey on July 1, 2008				X
5.				
6.				
7.				
8.				
9.				

10.				
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**b. Current Activities**

We provide Tobacco Use Cessation and Psychosocial counseling and intervention in the prenatal clinic. Follow-up care for high risk moms is also part of our clinic activities. Our continued concern is despite of these activities, the Palau PRAMS-like survey continue to show a high rate of Tobacco use during pregnancy.

Psychosocial issues during pregnancy also show about 10% rate last year. We do not know, at this time, whether or not these two factors have an influence in our population of pregnant women in relation to preterm births.

**c. Plan for the Coming Year**

Increase research activity so that we can understand the risk factors that maybe influencing preterm delivery in our population.

**State Performance Measure 9:** *Percent of parents/caretakers who report that their children with special healthcare needs receive quality health care*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				40	50
Annual Indicator			31	90.3	90.3
Numerator				65	65
Denominator				72	72
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	91	91.5	92	92.5	93

**Notes - 2007**

//2008/ - For 2007, we are reporting similar data that was reported in 2006. Palau conducts its SLAITS-like survey every two years and data generated from this survey are used to populate data requirements for Title V Grant specifically on areas of children with special health care needs.

**Notes - 2006**

The Children with Special Health Care Needs Survey in 2007 showed that 90.2% (65/72) of primary care givers (family members) expressed that the doctors and other health care service providers have “always” and “some of the time” addressed issues and concerns of their children. Among the following issues with regard the doctors and other health care providers were: spent enough time with their child (93%); listened to you regarding your child’s health/medical problems (91.7%); been sensitive to your family’s values and traditions (84.3%); Given you enough information about your child’s condition (88.9%); discussed with you concerns relating to your child’s health (88.7%); showed you how to care for your child (93.1%); and Made you feel like an important partner in your child’s care (91.5%).

**Notes - 2005**

//2005// - This figure is derived from the 2005 SLAITS-like survey we conducted for children with special health care needs and their parents and care takers. This care component was one of the weakest in our system of services for CHSCN. One of our plan for the coming year is to hire a parent advocate/coordinator who will work with us to improve care for this special population.

**a. Last Year's Accomplishments**

The Children with Special Health Care Needs Survey in 2007 showed that 90.2% (65/72) of primary care givers (family members) expressed that the doctors and other health care service providers have "always" and "some of the time" addressed issues and concerns of their children. Among the following issues with regard the doctors and other health care providers were: spent enough time with their child (93%); listened to you regarding your child's health/medical problems (91.7%); been sensitive to your family's values and traditions (84.3%); Given you enough information about your child's condition (88.9%); discussed with you concerns relating to your child's health (88.7%); showed you how to care for your child (93.1%); and Made you feel like an important partner in your child's care (91.5%).

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct the SLAITS-like survey				X
2. Analyze and report data to clinical staff including collaborative partners.				X
3. Provide transportation services to and from clinics to parents and their children upon request		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

We monitor this care component for CSHCN every two years. At the end of this calendar year, we will again survey clients and parents of CSHCN.

**c. Plan for the Coming Year**

Updates on this measure will be provided and if continues to perform good, we will remove it as a state performance measure.

**E. Health Status Indicators**

Indicator Number Description Detail Sheet

- 01A The percent of live births weighing less than 2,500 grams. [View](#)
- 01B The percent of live singleton births weighing less than 2,500 grams. [View](#)
- 02A The percent of live births weighing less than 1,500 grams. [View](#)
- 02B The percent of live singleton births weighing less than 1,500 grams. [View](#)
- 03A The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger. [View](#)
- 03B The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes. [View](#)
- 03C The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes. [View](#)
- 04A The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger. [View](#)
- 04B The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger. [View](#)

04C The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. View

05A The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia. View

05B The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia. View

//2005/ - These indicators have led us to implement more intensive strategies to address health issues in the MCH population. Based on these information, we have strengthened our collaborative activities with other stakeholders. We also have improved systems of care through available systems development grants and have used these funding to improve services both in public health and hospital-based care. We also have initiated change in delivery of health services at the program level so that they can increase support to high risk clients of family health such as PIH and GD. Partnership with behavioral health has improved the unit's capacity to deal with many psychosocial issues of the MCH population and intervention are designed to be more focused on the individual and his/her environment, be it social or physical.

The infant mortality rate in the past years have also encouraged us to begin and initiate discussion and improvement in services through IMR Review process to identify gaps in services and seek ways to correct them.//2005//

//2007/ - We have compiled all these indicators including others that are specific to Palau and will present these information in a report that will be published and posted in the Ministry of Health Website. The report will also be circulated amongst the political and other leaderships of Palau. The Title V MCH Grant information requirements, once compiled have mainly met most of the health indicators that are necessary in reporting of the nation's health status. We are hoping to post these reports prior to the end of the year.//2007//

***//2009/ 1. The Infant Mortality over 2 decades of monitoring has shown active decrease. In this period of time, it has decreased to 1/3 of its' late 80's and early 90's level. While it has decreased over time, we are finding emerging factors that puts it at risk of reversing if we are not diligently work to make sure that it continues to remain low.***

***2. Maternal Mortality -- There has not been an occurrence of true Maternal mortality since 1993. In review of our data, there is a "related" maternal mortality that occurred in 2006. This death was due to uterine cancer. The mother chose to carry the baby to full term and delivered through cesarian birth, however passed away around 6 months after birth. The death was due to the complications of the cancer.***

***3. Child Death Rate -- while the above two indicators have more or less been controlled, the child death rate of under 24 years olds have been on the increase to the point now that in 2006 and 2007, 89% of all deaths to children were preventable in nature. These deaths were crashes due to alcohol or drowning due to alcohol. A third of them were suicides, that when investigated, have depression (contributing factor) due to familial and relationship problems as an issue. //2009//***

## **F. Other Program Activities**

//2004// -HU also works with other programs such as HIV/AIDS to assure that pregnant women are counseled and encouraged to receive HIV testing. We attain over 95% HIV screening of our pregnant moms. We also work with the Division of PRimary Health Care to assure that FHU services in Superdispensaries are delivered in quality manner through training of dispensary nurses. We also have assigned a WHNP to each superdispensary to work with the dispensary nurse to assure quality of care for all our services. The CSHCN/High Risk Clinic has increased to twice a week and we are now deliberating on increasing the CSHCN/High Risk Assessment

Team Review to twice a month to assure compliance to our Guidelines which calls for at least 2 assessment each year for each child in the database. We have also met with two communities in the north island to introduce staff and services to their areas and hear community concerns to our services and ways that we can improve on them.

FHU also works to maintain the MOU for CSHCN assure that collaboration and databases continue. We think that unless we continue these activities, it will fall through the crack. Because of this MOU, we work with other agencies and NGO's to promote disability issues, lobby for passage of legislations that will improve the conditions of disability especially children with disabilities in Palau. We have worked in the past to change legislations, influence agency policies and services and initiate infrastructure changes that eventually benefits all people.

FHU continue to work with MOHMIS to assure that the information system is changed to accommodate information needs of the Title V MCH Block Grant. This is an on-going process and that we will continue to be a major player in the process.

//2007// - Most of our collaborative activities have been developed to look at the larger "health" issues of the various mch population and although these are not generally measured under any of the measurements, they are ways we use to establish working relationships with agencies that can influence policies, working regulations so that there can be change to directly influence the results of performance measures and health indicators. At the policy level and regulatory level, reports that we are proposing to publish and circulate will educate stakeholders in this arena so that they can be knowledgeable and active partner in the health and well being of the nation.

## **G. Technical Assistance**

//2004// - TA is requested to support the FHU Administrator to present at a national or regional forum our science-based activities, from service implementation, monitoring/evaluation to initiating change to address identified health issues.

//2007// - TA is requested to cover 2-day honorarium of FH Administrator present results of school-health screening relating to BMI and 24-hour diet recall of Palau children in the October Micronesian Medical Association Conference in Guam. This is on the return trip from the Partnership Meeting in Washington D.C., and therefore, no other costs is requested.

Another TA is the continued training of key staff in adolescent health development in Palau.

//2009// - Palau will require a TA on program evaluation.

## V. Budget Narrative

### A. Expenditures

//2005// - Funds from Title V MCH Program were used to fund salaries of key staff including 1.0FTE professional staff who continues to improve services standards, guidelines, policies and procedures. This process is necessary for establishment of official baseline requirements for our services so as we expand to other clinic sites, similar standards, guidelines and p&p's will be used along the way. They have been completed as implemented, however, as new requirements are put into programs, these documents must be edited to reflect these changes. As a continuation of our efforts to improve our services, the guidelines have undergone reviews by WHO and an Initiative program for physicians supported by the University of South Pacific Fiji School of Medicine. We continue to adopt recommendations from these two sources and will in 2006 finalize our edits for approval from the Ministry of Health's management. Funds were also used to support infrastructure and capacity building developments that were necessary in developing and implementing the national adolescent health collaborative. Out of this collaborative a 5 year strategy was developed to guide the work of this collaborative and the Bureau of Public Health in working to improve adolescent health services. Additionally, the school-based physical examination is also a result of this collaborative.

The staff also include 1FTE pediatrician who work with the the Unit in the Well-child services and services for children with special health care needs. Monies are also used to support traveling of program staff to attend national and regionally required meetings/conferences. We also use monies for routine supplies in the clinics and offices. Monies were also used to support the development, implementation and analysis of both the SLAITS-like and PRAMS-like surveys including the development and implementation of the birthing and parenting education classes. This initiative is a collaborative activity between the Unit, the Community Advocacy Program and the Palau Community College. Additional monies were used for routine office supplies and phones, faxes and e-mail and internet.

//2007/ - Key MCH staff funded under Title V is the Pediatrician who work in the general population services including services for children with special health care needs. Part of her work in community education program and systems development including capacity building initiative with partners to increase their knowledge and skills in children's health and children with special health care needs issues. Major expenditures of program funds relate to data management/development and capacity to collect, analyze and report on health status information including informing stakeholders on emerging health issues of the mch population. Another major expenditures is on travel of staff to attend program required meetings/conferences and workshops outside of Palau.

***/2009/ After review of year to year expenditure reports there was no significant expenditure variation. It is important to note that the minor variations seen on the expenditures report are sometimes caused by the allocation process, in which approved federal funds are translated to local budget allocation requirements. This process consists of further allocation of awarded funds to more detailed & specific sub accounts. For instance, funding allocated for "Others" budget item is further allocated based on sub accounts supporting each cost items under this category, i.e. communications and etc. Sometimes, this process seems to increase or decrease line item totals, however this doesn't have a significant effect or variation to the overall expenditure.***

***Major expenditures of program funds continue to relate to key MCH staffs, who continue to work in the general population services including services for children with special health care needs. Other areas of expenditures relate to data management and the capacity to collect, analyze and report on health status information including informing stakeholders on emerging health issues of the target population; and the expenditures for***

*staff to attend program required meetings/conferences and workshops.  
//2009//*

**B. Budget**  
*/2009/*

**MATERNAL & CHILD HEALTH SERVICES**  
**FY'09 Budget Narrative & Justification**

**Personnel.....\$94,000**

*Funds requested for this category will be used to pay for key program staff. These staff including personnel who support program data systems, public health nurses who are charged with enabling/population based services such as well-baby, prenatal and post natal services. Included is a cost of .5 FTE Pediatrician who supports interagency collaborative clinic activities for Children with Special Needs.*

**Fringe Benefits.....\$11,280**

*Fringe Benefits cost is a standard rate at 12% of the Personnel cost. It is broken down to 6 and 6% for both Pension Plan and Social Security or (\$94,000 x 12% = \$11,280)*

**Travel.....\$16,000**

*Travel monies are needed to enable key staff to attend required meetings/conferences. These budgeted meetings/conferences are AMCHP, MCH Partnership Meeting and the Annual Grant Review Meeting in Hawaii including the Annual MCH Coordinators Meeting in Hawaii. Additional funds are will also be used CSN parent representatives to the Pacific Interagency Leadership Conference in CNMI. This parent will be a co-presenter with SSDI Project Coordinator on the result of the Palau SLAITS-Like Survey. We will also use monies under this category to support inter-island travel to support the development of our service decentralization process. We envisage this process to continue for the next several years, until we are confident that services can be sustained by skilled personnel in these remote service sites.*

**Equipment.....\$4,753**

*We are requesting monies for equipment to support data systems upgrade to meet the growing program data needs. We will also use some of the monies to provide minor equipment that will enable us to provide quality prenatal and well-baby services in the remote service sites.*

**Supplies.....\$2,000**

*Funds are requested under supplies to support routine supplies that support our data system capacity development and improvement.*

**Contractual.....\$6,132**

*Under this category, we request monies to be used for a consultant to assist us in assessing data for the BRFSS development and implementation in Palau. FHU/MCH Program will partner with the Division of Behavioral Health's State Incentive Program to implement the BRFSS. This survey will provide the program with key behavioral patters and health risk factors that the program must address. This is another initiative of the program to partner with other agencies and share cost in initiatives that can enable the*

*program to become more evidence based.*

*Others.....\$17,500*

*Communications: \$1,000*

*Funds under this category will be used to support communication costs such as telephones, faxes, e-mail and internet access.*

*Trainings: \$2,500*

*Funds requested for this category is needed for training activities on case management/care coordination and communication.*

*Meetings: \$2,500*

*Funds requested for this category is needed to conduct annual meetings for Family Health Unit staff and meetings with non-health stakeholders of comprehensive family health services improvement. These meetings will allow us to acquire public comments and evaluations on existing services so that we may be able to meet grant requirements for "Public Comments/Review". Additionally, Program will use these public comments and evaluation to alter/change services to meet the public's needs and demands.*

*Fuel/POL: \$1,500*

*Funds requested under this category will be used for POL that is needed for outreach activities to communities and also for home visitations for children with special healthcare needs.*

*Administrative Costs: \$10,000*

*Administrative cost is estimated at 6.59% of total funds requested or ( $\$151,665 \times 10\% = \$10,000$ ).*

*Total Amount Requested.....\$151,665 //2009//*

## **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.