Maternal and Child Health Services
Title V Block Grant

State Narrative for MARSHALL ISLANDS

Application for 2007
Annual Report for 2005

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Table of Contents

I. General Requirements ... 4
A. Letter of Transmittal ... 4
B. Face Sheet ... 4
C. Assurances and Certifications ... 4
D. Table of Contents ... 4
E. Public Input ... 4
II. Needs Assessment ... 5
III. State Overview ... 6
A. Overview ... 6
B. Agency Capacity ... 7
C. Organizational Structure ... 10
D. Other MCH Capacity ... 11
E. State Agency Coordination ... 11
F. Health Systems Capacity Indicators ... 12
Health Systems Capacity Indicator 01: ... 12
Health Systems Capacity Indicator 02: ... 13
Health Systems Capacity Indicator 03: ... 13
Health Systems Capacity Indicator 04: ... 14
Health Systems Capacity Indicator 07A: ... 14
Health Systems Capacity Indicator 07B: ... 14
Health Systems Capacity Indicator 08: ... 15
Health Systems Capacity Indicator 05A: ... 15
Health Systems Capacity Indicator 05B: ... 16
Health Systems Capacity Indicator 05C: ... 16
Health Systems Capacity Indicator 05D: ... 16
Health Systems Capacity Indicator 06A: ... 17
Health Systems Capacity Indicator 06B: ... 17
Health Systems Capacity Indicator 06C: ... 18
Health Systems Capacity Indicator 09A: ... 18
Health Systems Capacity Indicator 09B: ... 19
IV. Priorities, Performance and Program Activities ... 21
A. Background and Overview ... 21
B. State Priorities ... 21
C. National Performance Measures ... 21
Performance Measure 01: ... 21
Performance Measure 02: ... 22
Performance Measure 03: ... 23
Performance Measure 04: ... 25
Performance Measure 05: ... 26
Performance Measure 06: ... 27
Performance Measure 07: ... 29
Performance Measure 08: ... 30
Performance Measure 09: ... 31
Performance Measure 10: ... 32
Performance Measure 11: ... 33
Performance Measure 12: ... 35
Performance Measure 13: ... 36
Performance Measure 14: ... 37
Performance Measure 15: ... 37
Performance Measure 16: ... 38
Performance Measure 17: ... 40
Performance Measure 18: ... 41
D. State Performance Measures ... 42

State Performance Measure 1: ... 42
State Performance Measure 2: ... 44
State Performance Measure 3: ... 45
State Performance Measure 4: ... 45
State Performance Measure 5: ... 46
State Performance Measure 6: ... 48
State Performance Measure 7: ... 48
E. Health Status Indicators ... 49
F. Other Program Activities ... 50
G. Technical Assistance ... 50
V. Budget Narrative ... 51
A. Expenditures ... 51
B. Budget ... 51
VI. Reporting Forms-General Information ... 54
VII. Performance and Outcome Measure Detail Sheets ... 54
VIII. Glossary ... 54
IX. Technical Note ... 54
X. Appendices and State Supporting documents ... 54
A. Needs Assessment ... 54
B. All Reporting Forms ... 54
C. Organizational Charts and All Other State Supporting Documents ... 54
D. Annual Report Data ... 54

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.
An attachment is included in this section.

C. Assurances and Certifications

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

The Ministry of Health will make more effort to have the public be more involved in the MCH programs and reviewing the grant application. For FY 2007, public announcements are made for the public for any commonent and input regarding any issues in the grant application. Copies of the MCH Block Grant Application are made available at the MCH office at the Primary Health Care, including other information that any interested person (s) may wish to comment/input regarding the grant application. In addition to this, discribution of the draft report for comment on the report and to hear additional views (by phone-calls/writing/other means of communication) regrading the RMI MCH Block Grant Application for the FY 2007. Furthermore, where to call for more information is being provided to the public. For more information concerning the application, please call MCH program at the Primary Health Care at the Ministry of Health: (692) 625-3355/3399 (Ex.: 2123); send e-mail at davidh@ntamar.net or visit the MCH office during regular working hours and days (Monday thru Friday), (8:00 am to 5:00 om).
An attachment is included in this section.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

In the fifty years since the end of World War II. two principle trends have occurred in the popualtion of the Marshall Islands: rapid growth and continuing urbanization. The Marshall Islands has a very young growth and growth population. Whilde somewhat more than 30% of the Marshallese people live in a semi-subsistence mode in the rural atolls and islands of the nation, the majority of the populaion in the two population centers at Majuro and Ebeye.

The Republic of the Marshall Islands is situated in the Ceteral Pacific Ocean between 4 degrees and 14 degrees North and 160 degrees and 173 degrees East in almost two parallel chains of 31 Atolls and Islands. The Eastern Ratak (Sunrise) with 15 Atolls and Islands and the Western Ralik (Sunset) having 16 Atolls and Islands. The total number of islands and islets is about 1,225.

Each atoll consists of a ring of islets encircling a deep water lagoon. The islaets are inerconnected and surrounded by a coral reef. None of these low-lying land areas have an elevation greater htan ten feet above sea level. Two of the atolls--Majuro and Kwajalein--have become crowded urban centers. while the outer atolls remain rural in character and are known as "outer islands."

Majuro Atoll is the most highly developed area in the nation and has several high schools, a community college, an 80 bed hospital and a developing infrastructure of electirical distribution, freash water reservoirs and sewerage disposal. The atoll is thirty miles long. The widest islet measures about half a mile from ocean to lagoon. As the national capital, Majuro is home to an expanding population, estimated to be 61,215 at projected population 2004, and is the site of most public, commercial and industrial development. With a land area of 3.75 square miles, Majro Atoll has a populaiton density of 29,488. Much of the population is crowded into the " downtown" administrative and commercial center at the eastern end of the atoll.

Ebeye, a small island within Kwajalein Atoll, is the only other urban center in the Marshall Islands. The urbanizatrion of Ebeye commenced in the late 1940s with the department of Defence, with the relocation of Marshallese people from northern atolls tha twere affected by the US Nuclear Testing Program (1946-1958) and with 1964 opening of the Kwajalein missile testing range by the US Army. With commencement of the missile tesing program, families living in the central area of Kwajalein Atoll --known as the Mid-Atoll Corrideor--were relocated to Ebeye. In addition to its high birth rate, the population of Ebeye continued to grow over the years as people from throughout the Marshall Islands (and elsewhere in Micronesia/other contries) were attracted to job opportunities at the nearby military base. On Ebeye Island, more that 11,000 people reside on a land area of .12 square mile. Housin gis substandard and extremely crowded. Whild a new 38 bed hospital, currently opened that replace a delapidted older facitlity, healt problems are numerous and may beattributed, in part, to overcrowding and an inadequate warer supply. Kwajalein Atoll is the largest atoll in the world, with a lagoon area of 839.3 squares miles. The total land area of the Kwajalein islets comes to 6.33 square miles.

The rural outer islands comprise the remainder of the Marshall Islands/ Scattered over great expanses of the Paicific Ocean, population in separate communities range from 50 to 800 persons. The outer islands constitute a diminishing proprotion of the polulation of thenation. With few exceptions, between noncontiguous islets of an atoll can only be taken by canoe or motorboat/ Meals are cooked on open fires or single-burner kerosene stoves. The government field trip ships travel to each outer island every two ot three months bringing passengers, medical and education supplies and trade goods. Income for residents of the outer atolls is generated primary from the sale of copra (dried coconut) and handicrafts.

In the outer islands, medical care is available at dispensaries staffed by health assistants who maintain radio contact with the Majuro or Ebeye hospitals for instruction and guidance. Other

than a public school on Jaluit Atoll, another public school completed at Wotje Atoll and a private, church-affiliated high school at Ailinlaplap Atoll. there are no secondary education facilities in the oute islands.

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

Prople travel from Majuro and Ebeye to the outer atolls on a 24-seater Dornier managed the Air Marshall Islands an don government-owned field trip ships that commute betwee atolls once a month. A small boat that is highly depedent on fuel supplies, available, people walk during low tides on the esposed coral reefs between the islands in order to reach the airstrips.

The total population of the Marshall Islands is estimated at 63,579. More that 50% of the population is under 15 years of age. The average grwoth rate of 3.6% is the highest in the Pacific. Currently, more than 60% of the population resides in the two urban centers. The remaining 40% reside in the outer atolls. Delivery of health care services to a dispersed population in the RMI is cumbersome.

B. Agency Capacity

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

The Bureau of Primary Health Care (PHC) is one of the five major bureaus within the Ministry of Health. It is reponsible for all preventive and primary care and the Division of Public Health is one of the five and the largest with five program areas.

The MCH/CSHCN Program is not a separate agency. It is one of the programs in Public Health. The nurses and medical staff implement all clinical, follow-up and community outreach programs for all areas in Public Health. The MCH/CSHCN Program provide health care services for mothers, children, infant,adolescents and their families in the RMI. There are currentlt 22 nurses who implement all clinical services for public health programs, seven medexes (physicial assistants), a medical director and an OB-GYN who are assigned to Public Health.
Seven (7) of the public health staff receives support salaries from the MCH Block Grant. The same seven staff (nurses, medexes/physicians) also travel to the outer atoll to implement the programs and services in Public Health.

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

The overall health care system in the Republic consists of two hospitals in the two "urban" centers of Majuro and Ebeye, and 57 health centers in the outer atolls. The main hospital on majuro is a 80-bed facility, and Ebeye has a 25-bed hospital. Both facilities mainly provide primary and secondary care with very limited tertary care. Patients who need tertiary care are

referred to hospital in Honolulu or the Philippines. The Bureau of Primary Health Care within the Ministry of Health also offers a full range of preventive and primary care programs in the two main hospitals.

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

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

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

The Health Management Information System (HMIS)

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

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

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

The main purpose of the Medical Records modules is to accurately record a patient's life and medical history. This information will be useful for clinical providers in treating the patients and to

health service managers responsible for health planning, supervision and evaluation of health services.

1. Medical Records

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

Therefore, a comprehensive encounter form was developed.

The Encounter Form

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

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

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

Public Health and Epidemiology

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

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

Finance and Personnel

The Finance and Personnel Module was designed to provide the MOHE with a system that

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

Benefits, Monitoring, and Evaluation (BME)

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

Training and Professional Development

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

Evaluation Plan

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

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

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

C. Organizational Structure

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

The head of the MOH is an elected senator and a member of the President's Cabinet.
The Minister exercises authority for health on behalf of the Cabinet, and he/she is responsible for the development of policies for the Ministry with recommendations from the Secretary of Health,

on the other hand, is appointed as the "permanent" head of the Ministry. The Secretary of Health is responsible for daily management and administration of the Ministry and reports directly to the Minister of Health.

The MOE has five major Bureaus:

1. Bureau of Primary Health Crae
2. Bureau of Majuro Hospital Services
3. Bureau of Health Planning and Statistics
4. Bureau of Kwajalein Atoll Health Care Services
5. Bureau of Administration, Personnel and Finance

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

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

1. Division of Public Health
2. Division of Human Services
3. Division of Population, Family Health & Health Promotion
4. Division of Adolescent Health
5. Division of Outer Islands Health Centers
6. Division of Dental Services

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

An attachment is included in this section.

D. Other MCH Capacity

Twenty-two nurses in Public Health implement all the clinical and primary health care for all program areas in Public Health. These same nurses travel to the outer islands in addition to superviseing their assigned health zone in Majuro. The nurses must also work on weekends to do cold chain monitoring for vaccines stored in the Public Health clinics and to immunize all new-born babies in the Majuro Hospital with BCG and Hepaitis B vaccines when necessary. The nurses are not compensated for the times they work during weekends. Furthermore, the nurses are the only ones trained in the chold chain monitoring of the vaccines and are responsible for packing them to be sent to the outer atolls on weekends. Seven of the public health staff (nurses,medexes/physicians/dental assistants/health educatiors) receives support salaries from the MCH Block Grant. These same 7 health care providers provide the service delivery to the MCH population throughout the Republic.

E. State Agency Coordination

The Ministry of Health and Environment, being the only "state" agency that provides health care services in the Republic, realizes the significance of collaborating with other agencies in the implementation of services to the communities.The Ministry of Health, being the only 'state' agency that provides health care services in the Republic, realizes the significance of collaborating with other agencies in the implementation fo services to the communities.

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

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

The Core Committee in the MOH carries out coordination of community awareness on primary health care activities and programs. The MCH Coordinator chairs the Core Committee with other member from Nutrition Program, Hospital Services, Adolescent health, Health Promotion, Family Planning and the Human Services programs. All the international and national health events are coordinated by the Ministry's Core Committee in collaboration with the RMI Iner-Agency Council and the National Population Coordinating Committee. The Core Committee in the MOH carries out coordination of community awareness on primary health care activities and programs.

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

F. 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	2001	2002	2003	2004	2005
Annual Indicator	0	237.4	357.1	595.3	239.3
Numerator		207	314	527	213
Denominator		8719	8792	8853	8900
Is the Data Provisional or Final?				Final	Provisional

Notes - 2003

Data for Health Systems Capacity Indicator #01 will be reported as soon as it become available.

Narrative:

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

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	0	0	0.0	0.0	0.0
Numerator			0	0	0
Denominator			1	1584	1625
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Not Applicable for the RMI since no Medicaid.

Notes - 2004
This is not applicable to the RMI since we do not have Medicaid.

Notes - 2003
This is not applicable to the RMI since we do not have Medicaid.

Narrative:
For that the RMI does not eligible for the Medicaid under the Compact of Free Association with the U.S., data on this HSC is not available. The denominator shown is the state data that is being collected throughout the year.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	0	0	0.0	0.0	0.0
Numerator			0	0	0
Denominator			1251	1584	1625
Is the Data Provisional or Final?				Final	Final

Notes - 2005
It does not apply for the RMI.

Notes - 2004
Not apply for the RMI.

Notes - 2003
RMI does not eligile for SCHIP under the Compact of Free-Association with the US.

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

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0	35.9	34.5	17.7	20.9
Numerator		449	432	280	340
Denominator		1251	1251	1584	1625
Is the Data Provisional or Final?				Final	Final

Notes - 2004
This is an estimate since actural number is not available.

Notes - 2003
This is only an estimate since data is not available.

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

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	NaN	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	0	21859	22052	22281	23906
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Not Applicable for the RMI since it does not apply in RMI.

Notes - 2004
The RMI does not eligible for Medicaid.

Notes - 2003
This NPM is not applicable to the RMI since is not eligable for the NPM #14.

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

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0	0	0.0	0.0	0.0

Numerator			0	0	0
Denominator			7207	7619	7619
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Not applicable to the RMI since RMI is not eligible under the Compact of Free Association with the U.S.

Notes - 2004
See notes on Form 17.

Notes - 2003
See note for Form 17.

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

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	0	0	0.0	0.0	0.0
Numerator			0	0	0
Denominator			1251	1548	1625
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2005
Not applicable to the RMI since it does not have SSI.

Notes - 2004
See notes on Form 17.

Notes - 2003
See notes on Form 17.

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

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

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2005	payment source from birth certificate	0	6.2	6.2

Notes - 2007
RMI does not have Medicaid.

Narrative:
Not applicable to the RMI, since RMI does not eligiblel for Medicaid.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2005	payment source from birth certificate	0	32	32

Notes - 2007
RMI does not have Medicaid.

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

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	0	66.2	66.2

Notes - 2007
RMI does not have Medicaid.

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

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	payment source from birth certificate	0	20.9	20.9

Notes - 2007
RMI does not have Medicaid.

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2005	100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	100

Notes - 2007
RMI does not have Medicaid. Therefore this does not applicable to the RMI since data is not being collected.

Notes - 2007
RMI does not have SCHIP.

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 4)	2005	100

(Age range 5 to 9) (Age range 10 to 14)		100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 14)	2005	 100 100 100

Notes - 2007
RMI does not have Medicaid. RMI does not collected data for this HSI. Therefore, this only an estimate.

Notes - 2007
RMI does not have Medicaid.

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2005	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	100

Notes - 2007
RMI does not have Medicaid. No data available since RMI does not eligible for this HSI.

Notes - 2007
RMI does not have SCHIP.

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

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

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES	3	Yes

Annual linkage of infant birth and infant death certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2007

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

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

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	1	No

Notes - 2007
Data is not available.

Data will report during the next cycle.

Narrative:
Steps has been taken to have access to information whose dealing with the youth organizations and the youth programs throughout the Republic. The program staff in collaboration with the Internal Affairs and Youth to Youth in Health and Ministry of Education formed as a "Mobile" team

and do outreach activities as well providing health education regarding youth behavior. Data on this HSC will be ready and reprot in the next reporting cycle.

IV. Priorities, Performance and Program Activities
A. Background and Overview
Based on health data collected by the MCH Program, the RMI MCH/CSHCN has selected the same prioity needs in which some of them has been selected from the last year's needs. These priority needs have been selected to improved the healh status of mothers, infants, children, youths in the RMI in all four of the services described in the pyramid.

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

Direct Health Care Services:

B. State Priorities
Base on the Needs Assessment presented, the RMI MCH/CSHCN has selected the same priority needs mostly as last year's needs but with some additional areas of needs. These priority needs have been selected to improved the health status of mothers, infants, children, youths in the RMI in all four of the services described in the pyramid.

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

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	0	0	0	0	0
Annual Indicator	NaN		0.0	0.0	0.0
Numerator	0		0	0	0
Denominator	0		1584	1512	1625
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

Notes - 2004
Not applicable to the RMI since no mandatory new born screening in place yet.

Notes - 2003
Not applicable for the RMI since new born screening does not perform.

a. Last Year's Accomplishments
This National Performance Measure is not applicable to the RMI since metabolic screening is not performed.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
This National Perofrmance Measure is not applicble to the RMI since metabolic is not performed.

c. Plan for the Coming Year
This National Measure Perofrmance is not applicable to the RMI since metablic screening is not performed.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	9	9	9	9	9
Annual Indicator	8	100.0	100.0	100.0	100.0
Numerator		308	308	361	395
Denominator		308	308	361	395
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9	9	9	9	8

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
The MCH/CSHCN program has met this National Performance Measure by conducting 14 more additional follow-up visits with parents and families on those CSHCN in collaboration with the public health teams and zone nurses. The Core Committee has developed an on going list of specific questions for both cliients and families that will help the service providers plan care that is needed for their children with special health care needs. MCH/CSHCN program continues similar activities during training and community outreach follow-up with clients and community awareness on MCH programs and activities. The MCH program continues to focus more on the community as a whole.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continues to improve its effort in coducting follow-up visits with parents and families of those CSHCN				X
2. Develop plans for the CSHCN and their families to learn more about the MCH programs and services.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The RMI MCH/CSHCN program contiues to provide medical health care services to all the children and families
who have been identified and confirmed to have some sort of disabilities/or disabilities. Contiues to screen and referral of clients to the pediatricians or the physician on call, and an on-going collaboration with medical staff in the two urban centers who provide services for all infants and children in the Marshall Islands. Provides routine screening to identify and referral have been an on-going after delivery, well-baby, and community out reach activities, incuding out islands visits.

c. Plan for the Coming Year
Identify a key person to develop and implement a screening tool for a better identification of these children, such as a guideline or criteria. Establish a better communication and collaboration between providers, as agencies. This plan should be completed by the end of March 2007.

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	2001	2002	2003	2004	2005
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	100	100	308	361	395
Denominator	100	100	308	361	395
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	0

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
This performance maintins its level at 100%. The Minisistry of Health being the "state" health agency, provides medical health care services to all residents throughout the State Hospitals on Majuro and Ebeye in the Division of Public Health. Infant and children who have been identified were referred to the pediatricians or the physician on call who became their primary physician for the referred casess.

Table 4a, National Performance Measures Summary Sheet

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

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

c. Plan for the Coming Year

The MOH being the "state" health agency, provides medical health care services to all residents throughout the State Hospitals on Majuro, and Ebeye. The MCH/CSHCN will continue to collaborate with the medical staff in the two urban centers in providing health care services to all infants and children. Continue to maintain at 100% these children with the present as having "medical home" for of them.

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	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	100	100	100	100	86
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	100	308	308	361	395
Denominator	100	308	308	361	395
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	95	95	95	95

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
This Performance Measure remains the same as last year. The Republic of the Marshall Islands health insurance policy covers all Marshallese. Medical services are provided to all residents from the Ministry of Health, which includes in two hospitals in the urban centers and the healh centers in the outer atolls (the MCH population is included)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provides medical health care services to all the MCH popuation throughout the Republic.		X		
2. Identify and refer of clients to the pediatricians or the physician call.		X		
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
The RMI MCH/CSHCN provides medical health care services. This is universal healh coverage for all citizens and residents in the RMI. The RMI MCH/CSHCN continues to focus on efforts to screen all children to identify CSHCN and refer to CSHCN program.

c. Plan for the Coming Year
2007 Performance Objective: 100%
Planned Activities: There is universal health care coverage for all citizens in the RMI. The Ministry will continue to focus on efforts to screen all children in order to have children identified with special health care needs and refe them to the CSHCN program. The MCH/CSHCN program will continue to coordiante ,and collaborate with public health outreach team, zonal nurses, and other agencies providing services for these children and families to improve service delivery care for these children and their families.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	0	100	100	100	85
Annual Indicator	NaN	100.0	100.0	100.0	100.0
Numerator	0	308	308	361	395
Denominator	0	308	308	361	395
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	95	95	95	95

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Annual Performance Objective: 100% The RMI MCH/CSHCN program continues to provide services and receive referral cases/reports from those families of CSHCN or the community through the health workers/health assistants assigned in that community. The MCH/CSHCN continues to provide services , such as nutrition counseling, oral hygine, etc.) for those CSHCN and families in the community.

Accomplsihment: The RMI does not have actual community-based system yet. However, those families report to the health workers/health assistant who is assigned to that community. Those families of CSHCN have access to information and services which are then referred to the MCH/CSHCN program. Better communication has been establiched between the MCH base and the clients. A direct telephone line has bee established and with clients and families have better eccess to program without chargedf. In addition, they can have also to the program thru internet with a direct line free of charged. With these services being available, families have more access to service and they are more orgainzed and centeralized to use them easily.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

The RMI MCH/CSHCN program continues to provide services and receive referral cases/reports from those families of CSHCN or the community through the health workers/health assistants assigned in that community. The MCH/CSHCN continues to provide services , such as nutrition counseling, oral hygine, etc.) for those CSHCN and families in the community.

c. Plan for the Coming Year

2007 Annual Performance Objective: 100%

Planned Activities: The RMI MCH/CSHCN program will continue to improve its services in the commmunity so that families of those children with special health care needs will have a better access to services to use them easily.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**

Annual Performance Objective	0	9	9	9	9
Annual Indicator	NaN	90.9	64.9	77.6	83.5
Numerator	0	280	200	280	330
Denominator	0	308	308	361	395
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	91	91	93	95	98

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Annual Performance Objective: 10%
Accomplishment: The RMI MCH/CSHCN program collaborates with the Ministry of Education in making transition of children/youth with special health care needs. The MCH/CSHCN program referred 5 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate with Ministry of Education to prepare these youth for further education or even get a job.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Annual Performance Objective: 10%
Accomplishment: The RMI MCH/CSHCN program collaborates with the Ministry of Education in making transition of children/youth with special health care needs. The MCH/CSHCN program referred 5 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools.

c. Plan for the Coming Year
2007 Performance objective: 15%
Planned Activities: The MCH/CSHCN program will continue to collaborates and coordinates with the Ministry of Education,

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	90	90	90	90	60
Annual Indicator	42.0	59.7	57.0	49.5	70.1
Numerator	4222	2233	1984	1435	2249
Denominator	10053	3742	3480	2899	3209
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	65	73	75	80	85

a. Last Year's Accomplishments
Accomplishment: This Performance was not met. The result from the immunization campaign has shown that 93% of coverage for measles alone for the whole country. Documentations have also shown that 47.53% of children completed/received DPT4, OPV3, Hep.B3, MMR1, and BGC. This is shown that there is an improvement in the immunization coverage compare to the past which was only 42%. This has also shown that still improvement has to be made to bring up the % for our immunization fully coverage. The combination of the distances between outer islandws, migrations of families from the islands, limited storage facilities for the vaccines, and weak information in the place, have contributed to the low coverage in the outer islands.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
The zone nurses continue to do outreach in the communities, visits the outer islands to provide immunization for the children who reside on these islands/atolls, and daily immunization clinics at

public health on both Majuro, and Ebeye on Kwajalein Atoll.

c. Plan for the Coming Year
2007 Annual Performance Objective: 85%
Planned Activities: The RMI will continue to intestify its immunization coverage rate during community outreach activities (zone activities), outer islands trips/visits, and the public health clinics. These nurses will continue to work closely with the health assistants in the outer islands/atolls, including the public health teams.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	175	175	150	125	100
Annual Indicator	182.9	165.5	162.9	167.3	184.0
Numerator	280	207	258	253	299
Denominator	1531	1251	1584	1512	1625
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	95	90	85

Notes - 2003
For NPM #08, the RMI age group is 15-19, therefore data is reported based on the RMI age group.

a. Last Year's Accomplishments
Annual Performance Objective: No more than 175 per 1,000
Accomplishment: In the past, the data for this performance measure could not be specified since the age group in the particular category included teenagers 15 through 19. For FY'05, there was total number of 299 teenage pregnancy. Data for this performance measure has shown that teenage pregnancy is still high and there is still a needs to improve the services.

Table 4a, National Performance Measures Summary Sheet

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

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

b. Current Activities
Increase in the rate of teenager pregnancies is challenge for the RMI to improve and promote health education activites for youths. Improving barriers that inhibit accessibility to family planning services for youths by expanding services into the community and to the public. Conduct training for the community leaders on the issues presented in the National Population Policies. The Youth to Youth in Health provides family planning counceling at the Youth clinics in Majuro and more youth site visits to the outer atolls in collaboration with the Community. To reactiviate all out reach activities that have been inactive for more than two years.

c. Plan for the Coming Year
2007 Annual Performance Objective: No more than 150 per 1,000
Olanned Activities: The RMI will continue to focus its effort to decrease the rate of teenager pregnancies in the comming year by improving health education and promotion activities for youths, and conduct more training for community leaders on the issues presented in the National Population Policies. More activities on health promotion and family planning will target to meet the needs of youths in the RMI. The Youth to outh in Health will continue its effort to add two more youth clinics in the rural areas in the urban centers and more youth chapter in the outer atolls in collaboration with the Community.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	55	60	65	70	80
Annual Indicator	8.5	24.3	54.9	87.1	77.9
Numerator	857	2526	1161	1842	1643
Denominator	10053	10395	2115	2115	2110
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	85	90	95	95

Notes - 2004
This is an estimate for 2004. It will be adjusted in the next reporting cycle.

a. Last Year's Accomplishments
Annual Performance Objective: 95% of the proportion of 8 to 14
Accomplishment: The RMI did not meet the objective for the year. However, during the FY'03, the School Dental Health Program examined(grades 1,2,6 &7), and 70.37% of the children received sealants. This shown that there is an improvement compare to the past which was only 49%.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
As part of the school sealant program, staff provide dental education for the elementary schools that they visits. Oral Health services is being also provided for the schools in the outer islands/atolls during the outer islands visits.

c. Plan for the Coming Year
2007 Perforamnce Objective: 80% of the proportion of children ages 8 and 14
Planned Activities: Increase health education of oral health in the schools by using posters, educational materials on oral health. Implementation of school sealant program in the outer islands. The MCH/CSHCN will give two additional dental assistances with salaries in order to provide/expand oral health services for more school 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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	5	30	9	9	9
Annual Indicator	16.0	9.1	3.1	15.3	12.2
Numerator	5	2	1	5	4
Denominator	31285	21859	32355	32654	32724
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9	9	8	7	6

a. Last Year's Accomplishments
Annual Performance Objective: No more than 5 per 10,000
Accomplishment: There were no documented deaths to children 1-14 due to motor vehicle crashes in the past. While other causes of deaths such as malnutrition, pheumonia, congenital health diseases and drowing are more common. However,vehicle related accidents is still a concern considering the rising number in this age and the number of vehicles in the Marshall Islands. During FY'04, 5 deaths and four deaths in FY'05 due to other causes as stated above rather than motor vehilce crashes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Expand the outreach health education for parents, the public on importance of safety (example, cross road)			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The RMI has been able to keep the rates of children in this age group at zero for death caused by motor vehilces for the past year. Our health education and promotion activities continue to address this issue to ensure that no deaths caused by motor crashes occur.

c. Plan for the Coming Year
2007 Annual Performance Objective: No more than 5 per 100,000
Planned Activities: The RMI will continue to provide public awareness through health education and promotion. Our health education and promotion activities will continue to address this issue to ensure that no deaths caused by motor vehicle crashes occur.

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	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					99.5

Numerator					1093
Denominator					1099
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	70	75	80	85	90

a. Last Year's Accomplishments
Annual Performance Objective: 95% in early postpartum
Accomplishment: The National Performance was met. The RMI has increase its percentage of mothers who breastfeed their babies upon hospitals discharge from 98% to 100%. The percent of mothers who continue to breastfeed their babies up to six months has also increased from 95% to 96.8%. This is shown that there has been improvement on health education concerning issues on breastfeeding awareness.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand the outreach health education for parents, the public on importance of safety (example, cross road)			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MCH in collaboration with the Health Education and Promotion, Core Community and the Breast Feeding Policy Committee continue to develop and distribute educaitonal materials, provide nutrition counseling during prenatal clinics, conduct presentations during prenatal clinics and the maternity ward with mothers, and continue health promotion outreach in the communities and through mass media. Staff in the Health Education continue to provide information on breast feeding issueson a weekly regular radio program.

c. Plan for the Coming Year
2007 Annual Performance Objective: 80% in early postpartum
Planned Activities: The MCH will continue to collaborate with the Health Education and Promotion Unit, Core Communittee and the Breast Feeding Policy Committee in development of educational materials, and will continue to provide nutrition counseling during prenatal clinics. Also, continue to conduct presentation during prenatal clinics and at the maternaity ward with mothers. The MCH program will continue health promotion outreach in the communities and through mass media. Breast Feeding ploicy will be remined and discuss with members of the Community

Leaders Committee during community outreach and during training in the the urban centers. Staff in the Health Education will continue to discuss breast feeding on the a weekly health education radio program.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	0	0	0	0	20
Annual Indicator	NaN	13.4	13.1	11.4	16.1
Numerator	0	187	208	172	261
Denominator	0	1392	1592	1512	1625
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	30	35	40	45

Notes - 2004
For 2004, data reported here has been estimated since rountine hearing new born screening is not actural performed.

Notes - 2003
This NPM is not applicalbe to the RMI since is not performed.

a. Last Year's Accomplishments
This is not applicable to the RMI since screening for hearing impartment is not conducted in the hospitals.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Teach parents on how to identify babies at risk of heaving hearing discharge				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This performance is not applicable to the RMI since screening for hearing impairment is not conducted in the hospitals.

c. Plan for the Coming Year

This National Performance Measure is not applicable to the RMI. The newborns are not screened for hearing impairment before hospital discharge.

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	**2001**	**2002**	**2003**	**2004**	**2005**
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	31285	21859	32355	32654	32724
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

a. Last Year's Accomplishments
Annual Performance Objective: 100%
Accomplishment: The RMI health insurance policy covers all Marshallese. Medical services are provided to all residents from the Ministry, which includes the two hospitals in the urban centers and the health centers in the outer atolls.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contiue with the present activities concern				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Ministry of Health continues to focus its efforts on screening of all children and have those children identified with special health care needs refer to the CSHCN program.

c. Plan for the Coming Year
2007 Annual Performance Objective: 100%
Planned Activities: The Ministry of Health will continue to focus on screening of all children in

order to have the identified with special health care needs be referred to the CSHCN program.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					0.0
Numerator					0
Denominator					5993
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

a. Last Year's Accomplishments
This is not applicable to the RMI since there is not Medicaid Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. This is not applicable to the RMI since we do not have Medicaid				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This Performance Measure is not applicable to the RMI since the RMI is not eligible for the Medicaid Program.

c. Plan for the Coming Year
This Performance Measure is not applicable to the RMI since the RMI is not eligible for the Medicaid Program

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	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					

Notes - 2005
Not applicable to the RMI since data for smoking pregnant women during the last 3 months of pregnancy is not being collected.

a. Last Year's Accomplishments
This NPM was not met since RMI does not collect data for pregnant women during the last months of preganncy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the present activities with improving the pregnancy outcome	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Counseling on smoking during pregnancy is being provided during prenatal 1st visit for all pregnant women who come into 1st prenatal booking.

c. Plan for the Coming Year
Plan for the coming year is to look at the last three of pregnancy instead of the first three months of pregnancy.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	15	20	15	15	9
Annual Indicator	30.7	82.5	26.8	133.3	39.5
Numerator	2	6	2	10	3
Denominator	6507	7276	7454	7501	7600

Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9	8	8	5	4

Notes - 2003
There were 17 documented complete suicide cases for the RMI for FY 2003. Out of this number only 2 for 15-19 age group, there more among the older ages.

a. Last Year's Accomplishments
Accomplishment: There were only 2 documents completed suicides in this age group (15-17 years old respectively) in 2003 compare to 2002 which was also 2 document completed suicides in the same age group. There were 11 document completed suicides in this age (15-25 years old respectively)in 2003 compare to 2002, there were 6 document completed suicides in this age group. It has been long recognized that alcohol and other forms of substance abuse increasing that most of these completed suicide cases have been related to alochol abuse. Health education and promotion compaigns on mental health and suicide prevention have been expanded to the schools and community groups such as the churches, and youth groups.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Seminar in the community, with youth groups on issues concerning suicide prevention.		X		
2. Education/public awareness utilizing a seekly radio program in collaboration with the Youth To Youth In Health and Health Promotion.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Follow-up with participants to the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. Health Education and the program on Alcohol and Substance Abuse Prevention conduct training with youths, community groups. Educational issues is being provided through radio program and interview on alcohol, substance abuse and suicides. Close monitoring and evaluation on the rate of suicides in each community is being through the year in order to meet the needs of each community.

c. Plan for the Coming Year

2007 Annula Performance Measure: 50% decrease from the current rate
Planned Activities: The MCH program will put efforts in collaborting with the Division of Human Services to follow-up with participants of the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. The Health Education and the program on Alcohol and Substantce will collaborate to conduct more trainings with youth groups, community groups, parents, church groups, and the schools. More educational materials will be developed and the media will be utilized more in radio spots, radio programs and interviews on alcohol, substance abuse and suicides prevention. Close monitoring and evaluation on the rate of suicides in each community will be expanded throughout the year in order to meet the needs of each community.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	0	0	0	0	0
Annual Indicator	NaN	1.6	1.2	0.9	0.0
Numerator	0	22	19	13	0
Denominator	0	1392	1592	1512	1625
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

Notes - 2005
Not applicble to the RMI since only two urban centers that provide all health care throughout the Republic.

Notes - 2004
This is an estimated since the RMI does not have any infants
facilities for high risk deliveries and neonates.

Notes - 2003
This is not applicable to the RMI since there is no facilities for high deliveries and neonates.

a. Last Year's Accomplishments
Accomplishment: This National Performance Measure is not applicable to the RMI since there are no facitities capable of providing specialized services for very low birth weigh infants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue with present care	X			
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
This particular measure is not applicable since there are no health facilities for high risk deliveries and care management in the RMI.

c. Plan for the Coming Year
This performance measure is not applicable since there are no health facilities for high-risk deliveries and care management in the RMI.

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	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	55	57	60	62	45
Annual Indicator	29.3	63.9	27.3	21.5	66.2
Numerator	449	799	432	325	1076
Denominator	1531	1251	1584	1512	1625
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50	55	60	65	70

Notes - 2004
This shown for 2004 is based on Majuro clinics only.

Notes - 2003
This data is for Majuro clinics only.

a. Last Year's Accomplishments
Accomplishment: This performance measure was met. During FY'05 66.2% is comparatively higher than previous year (FY'04 was 32.0%)for the first trimester. The percent of first visit to the prenatal clinic during the second trimester is high at 44% percent compare to 28 percent during the first trimester. Getting the pregnant mother for prenatal during the first trimester remains a challenge. The Comprehensive Perinatal Care Program remains to a core priority of the bureau as reflected in the activities including the aggresive health education and promotion campaigns on the importance of perinatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. In-service training in nurition and family planning for public helath nurses to be able to provide counseling for the MCH population				X
2. Counceling on family planning/nutrition is also being provided during postpartum clinics.				X
3. Nutrition counseling is being provided for mothers attending prenatal clinics.				X
4. One person from health education provides couseling on nutrition and family planning for women refer				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Health Education and Promotion Unit Program remains to a Core Committee in providing health promotion activities on community awareness. The nurses continue to provide community outreach with the traditional leaders to follow-up with pregnant mothers at home who have not come in for prenatal care. Coordination with traditional leaders to inform their people to access prenatal care, espically during the first trimester. On going education program campaigns on the radio, newspaper on prenatal care. Delivery in the hospital fee is being inform by the hospital staff during their first trimester as an incentive.

c. Plan for the Coming Year

Planned Activities: The Health Education and Promotion Unit in collaboration with the zonal nurses and Core Committee will intersify their health promotion activities on community awareness. Nurses will be providing more outreach into the community with the

D. State Performance Measures

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			100.0	100.0	92.1
Numerator			1251	1584	1496
Denominator			1251	1584	1625
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments
Annual Performance Objective: 90% of pregnant women during the first booking/entry into prenatal care.
Accomplishment: During FY 2005, this objective was met with 92.1% . All pregnant women who enter into prenatal for the first booking/registration receive counseling on nutrition and family planning. Counseling and registation on nutrition and family planning are also being provided in the follow-up upon delivery and again when the mother comes back for postpartum clinic.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In-service training in nurition and family planning for public helath nurses to be able to provide counseling for the MCH population.				X
2. Counceling on family planning/nutrition is also being provided during postpartum clinics.				X
3. Nutrition counseling is being provided for mothers attending prenatal clinics				X
4. One person from health education provides couseling on nutrition and family planning for women refer				X
5.				
6.				
7.				
8.				
9.				
10.				

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

c. Plan for the Coming Year
Performance Measure: 90%
Planned Activities: The nurses in the Reproducative Health/Public Health will be up grade in skills through in-service in nurtition and family planning to be able to provide better counseling to all pregnant women who come to the prenatal clinics and the health zones. While it is anticipated that counseling on nutrition and will not be provided to all pregnant women in the outer atolls because of the cultural barriers. Plans are being develop to increase the coverage as much as possible. A protocol has been implemented to ensure that pregnant women are counseled on nutrition and family planning for those referred from the prenatal clinic. Diabetes and hypertenson will also be added to the counseling schedule.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			32.1	30.3	33.6
Numerator			258	253	299
Denominator			8040	8363	8900
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	20	15	10	10	5

a. Last Year's Accomplishments
During the FY 2005 has increased compare to FY 2004. The health, social and economic burdens directly associated with teen pregnancies, should be aggressively stressed and conveyed to assist in reversing the currect status. Two forums have been done for, one for the girls, and one for the boys (teenagers) to increase their level of understanding on issues concerning teen pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide health education for the teenagers, schools, high school drop out, and the parents education of teen pregnancy.				X
2. Provide counseling for the teenagers in increase their level of understading about teen pregnancy.				X
3. Provide them with information regarding teen pregnancy.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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

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

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					

a. Last Year's Accomplishments
During FY'05 there the MCH program was able to accomplished 66.9% of prenatal first visit during the 1st trimester compare to FY'04 which was 27.3%. It has been shown that more pregnant seeking care during the first three months of pregnancy. The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the pulbic awareness regarding the important of prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This State Performance will be reproted with the National Performance Measure #18				
2. This State Performance Measure was discontuned since it deplicate a NPM.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Home visits continue, including the outer islands trips where they actually do one on one counseling on issues regarding pregnancy. Continues the daily prenatal clinics where pregnant women are seen and examed by an OBGYN and also screen for any risk factors that might affect the pregnancy. Where any risk condition is identified they're referred to a special high risk clinic which is being done on different day once week.

c. Plan for the Coming Year
PLan: To continues present activities, and expand the MCH services to include more women childbearing age. T Provide more excess to prenatal care by visiting the communities on a regular basis.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			11.2	25.4	12.8
Numerator			146	298	145
Denominator			1309	1175	1136
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	95	90	85	80

a. Last Year's Accomplishments
Annual Performance Objective: 40% of pregnant women
Accomplishment: This State Performance Measure was met. During the FY 2005, a total of 1136 pregnant women were screened, and 145 out of this number were identified as high risk on the 1st visit to the prenatal clinics and were referred to additional prenatal services in collaboration with the hospitals. Improvement is still needed that the number of prenatal clinics have been not only increased from once a week to four full days a week, but expansion of hours from 8:30am to 5:00 pm while in the past only from 8-11:30 in the morning five days a week. This is being done to allow the pregnant women for better excess to the MCH clinics.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities
On-going screening with the OBGYN being seen and examed pregnant women early in their first bookings. This is being done to identify any high risk pregnant women in their pregnancies.

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

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			82.7	98.1	98.2
Numerator			1034	1431	1596
Denominator			1251	1458	1625
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments
Accomplishment: In 2005, a total of......1596 pap smears where taken. This is an improvement over the past, however, there is still a need to improve the services provided in this area, espically to do follow-up after the pap smears are done. Education on the importance of annual/regular pap-smear test, including on how to perform self-breast exams.

Table 4b, State Performance Measures Summary Sheet

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

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

c. Plan for the Coming Year
Performance Objective: Increase by 25%
Planned Activities: The MCH/CSHCN program will review its protocol on cancer screening paticularly on cancer of the uterus and cervix. Pap smear screening will be conducted to its implementation in all public health clinics during outreach clinics and trips to the outer atolls. All necessary supplies will be purchased for the screening. Identified women who will need follow-up will be referred to the zonal for follow-up.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					

a. Last Year's Accomplishments
Accomplishment: During the FY'05, there was more 50 new cases identified and service is being provided. Better coordination and collaboration between MOH and MOE in providing services for these children and their families based on the needs. There is an improvement in communication between these two ministeries, parents/clients, community and the service providers with the re-esblishment of the Council for Children Special Health Needs and they meet on quaterly basis.

Table 4b, State Performance Measures Summary Sheet

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

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

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

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			54.9	87.1	77.9
Numerator			1161	1842	1643
Denominator			2115	2115	2110
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	85	90	90	95

a. Last Year's Accomplishments
During the FY 2005, the RMI is still trying to improve this performance. It slightly lower in compare to FY 2004. RMI has expanded its outreach to increase the number of children who are in the thrid grades.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities
Continues to increase the number of outreach into the schools. Continues this activity on regular basis and to include more schools.

c. Plan for the Coming Year
Strengthen and continues to expand the dental outreach activities to includes more schools.

E. Health Status Indicators

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

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

The Bureau of Primary Health Care (PHC) is one of the five major bureaus within the Ministry of Health. It is responsible for all preventive and primary care programs throughout the Marshall

Islands. There are six divisions with the Bureau of PHC, and the Division of Public Health is one of the five and the largest with five program areas.

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

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

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

F. Other Program Activities

The MCH/CSHCN Program is already a program area within Public Health. The nurses and medical staff in Public Health provide other preventive services in STD, family planning, non-communicable diseases, immunization,TB and leprosy as well. The MCH coordinator is member of the MOHE Core Committee which coordinate all community awareness activities. The MCH program is also a member of the RMI Interagency Council meets regularly to ensure continous services is provided to all CSHCN, both in school and those who are not. The Breast Feeding Policy Committee also actively work closely with the MCH program and services in community awareness activities on nutrition and breast-feeding. The MCH program will participate fully in all community awareness and training programs preventive services to women, children, infants, youths and their families.

G. Technical Assistance

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

V. Budget Narrative
A. Expenditures
For FY 2005, the RMI spent 100% of its MCH funds. Fourty five percent of the total grant award is for personnel. Of the total funds for non-personnel, the RMI spent 25% on direct health care, 13% in enabling services and 7% on infracture building services. The allocation of the administration cost utilized 10% if its allocation.

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

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

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

Administrative Costs:

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

A. Personnel $ -0-
B. Fringe Benefits $ -0-
C. Travel $ 4,000
D. Equipment $ 18,000
E. Supplies $ 1,208
F. Contractual Services -0-
G. Other $ 1,000

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

Component A: Pregnant Women, Mothers and Infants $189,000
A. Personnel $ 69,168
B. Fringe benefits $ 5,580
C. Travel $ 16,000
D. Equipments $ 46,000
E. Supplies $ 52,000

Component B: Children & Adolescents $ 141,811
A. Personnel $ 54,125
B. Fringe benefits $ 4,330
C. Travel $ 25,000
D. Equipment $ 10,000
E. Supplies $ 19,900
F. Contractual Serv. $ 7,000
G. Others $ 3,000

Component C: Children with Special Health Care Needs $ 73,574
A. Personnel $ 14,700
B. Fringe Benefits $ 1,176
C. Travel $ 39,677
D. Equipment $ 7,600
E. Supplies $ 3,521
F. Contractual $ 6,900

Administrative Cost $ 25,249
MCH Budget(State Federal Allocation) $252,495

MCH Budget(Federal and State Block Grant Partnership) $441,867
Total budget for FY 2005 $1,614,891

3.1.1 Completion of Budget Forms

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

3.1.2 Other Requirements

For the FY 2005 budget, 48% is for salaries of personnel who provided direct services for the MCH/CSHCN program. There are 7 personnel under the MCH/CSHCN program. However, other health personnel in Public Health also provided direct health care services to the MCH population as well.

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

State Match

The total for the MCHBG application for FY 2005 is $252,495. This amount is based on the Marshall Islands' FY 1989 Maintenance of Effort Amount of 175,745. The State Match for the MCH grant application is $189,372.

Documentation of Fiscal Restrictions

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

the MOH, and 3) contractual services that are needed for the regular maintenance of office equipment used by the MOH Administration.

VI. Reporting Forms-General Information

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

VII. Performance and Outcome Measure Detail Sheets

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

VIII. Glossary

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

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

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

C. Organizational Charts and All Other State Supporting Documents

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

D. Annual Report Data

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