



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

**State Narrative for
Marshall Islands**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

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

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The RMI will comply with the Assurances and Certifications as stated. The appropriate Assurances and Certifications-

-non-construction program, debarment and suspension, drug free work place, lobbying, program fraud, and tobacco

smoke--that accompany this guidance can be access from the the guidance in the State's MCH program's central office.//2013//

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; published January 2012; expires January 31, 2015.

E. Public Input

Fiscal Year 2013

Means of Public Awareness:

The Ministry of Health has put more effort to have the public be more involved in the MCH programs and reviewing of the grant application. For FY 2013, public announcements were made for the public for any comments and input regarding any issues in the grant application. Copies of the MCH Block Grant Application were made available at the MCH office at the Ministry, including other information that any interested person (s) may wish to comment/input regarding the grant application. In addition to this, distribution of the draft report for comment on the report and to hear additional views (by phone-calls/writing/other means of communication) regarding the RMI MCH Block Grant Application for the FY 2013.

The government radio station (V7AB) broadcasted the announcement where most of the people especially in the outer islands have access to it. They can hear the announcement that is aired from 6:00AM to 11:30 PM/ 7 days a week. Public announcement is also made during the Council of Children with Special Health Care and Education Needs meeting twice annually. Furthermore, where to call for more information was provided to the public. For more information concerning the application, please call MCH program at the Ministry of Health: (692) 625-3355 (Ex.: 2123)/625 7007/455-8334; or visit the MCH office during regular working hours (Monday through Friday)/ (8:00 am to 5:00 pm).

Public Comments/Questions:

The public made comments on Component C, Children with Special Health Care Needs. Because most families can't afford the cost of medical bills, they asked if the services for the CSHCN are free. Some patients and care takers expressed their concern regarding cost of the medical equipments and supplies needed for these children in their daily use, such as glasses, hearing aids, wheel chairs, etc... They also expressed the need for the service providers to make more home visits or on a regular basis. Parents think that the services provided are not enough. Parents ask to increase the number of staff providing the direct services for the CSHCN.

The MCH has been coordinated with MOH Accounting Department to refer any disabled children who come to seek medical care from out-patient department (OPD) to the program. If they have already confirmed by the children doctors from Majuro Hospital and they are being registered into the program and the outpatient fee of \$5.00 per visit is then paid out from the program on a monthly basis. The account department prepares a billing on monthly basis if any children seen at OPD.

Public comments/questions:

The public, specifically the parents, presented their comments and questions concerning CSHCN services. They would like to see in the future consultants /doctors who could come to RMI to provide special services/care, such as cardiac service, hearing problems screening, eye screening, and other services for disabled conditions. For those with children with mental delay and unable to move one part or the whole body, special providers is needed. They think that short term service and doctors should be provided to the children where it is needed. They commented to hire service coordinator, including at least one staff so that they could spend more time in providing the care that is really needed for the clients, such as, counseling and training the parents/care takers on helping their children to be able do something in their lives. Parents need someone that has more time to train them on how to be more effective as parents to take care of their children with special health care needs. Some of the children can't move without assistance, family can't afford to pay for the equipments needed to help their children.

Responses: The MOH has hired more pediatricians as well as internist doctors from (PI). These doctors are now seeing and identifying and confirmed more children with health care needs. These children are then refer to the MCH program for further work-up, follow-up, and refer to visiting teams, such as, Shriners Outreach Team for further medical evaluation and care. Some of these children are being sent off island (mostly to Shrienrs Hospital in Honolulu) for surgery, TAMC if cleft palate, or the PI, if service is not available on island. For the children whose families can't afford the hospital fee of \$5.00 per visit to seek medical care, especially those coming from the outer islands, the program is billed with the required hospital fee. The program has taken steps in strengthening the collaboration between the program and departments within the Ministry and other government ministries for better utilization of equipments for those children in need, such as, wheel chairs for example. The MCH program has also made arrangement with the medical record to submit CSHCN's outpatient service cost on monthly basis. The program will take care of the charges. The program has also provided medical equipments for the CSHCN who are in need with no means of paying, for example, wheel chair. For hearing loss, "the project on newborn hearing screening has established and on-going.

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

The Ministry of Health still has a strong partnership with Youth to Youth in Health (YTYIH), Women United Together in the Marshall Islands (WUTMI), KIJLE, and other NGOs. MCH Program conducts clinic in YTYIH providing Family Planning and Women's Health Clinic. We partner with the local NGOs when conducting community activities.

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2011/ There was no formal Needs Assessment conducted to evaluate the service provided to the MCH population. However, based on an assessment conducted by the MOH utilizing data from the Health Planning and Statistics Office, it is clear that MCH service and primary health care services must be further improved in order to improve the health status of the MCH population. Surveys were done and analyzed. Based on the results, the RMI has selected the same state "Negotiated" Measures that will address the four layers of the pyramid, namely direct health care services, enabling services, population-based services and infrastructure building services. Additionally, the selected "negotiated" measures will further support the Core Public Health Services outcome measures.

For the RMI MCH Up-coming Needs Assessment, the plan will for MOH with KUMITI Committee with coordinate with the National Planning (EPPSO) to review the both Health Information System and the RMI National Census. The population survey has just been done lately, with survey, and other mechanism being used to obtain the National Censuses.

Our biggest challenge is our new Information System (MHIIS) is still in progress. We are targeting to complete the implementation by 2010. We have implemented some of the modules. The Public Health Information System under the umbrella of MHIIS, where in Reproductive Health Module is included, is expected to be completed by 2010. The MCH program continues to receive data from the MOH Health Information System that the MOH has been using. Updates will be used to make appropriate adjustments in activities such as plan development, funding, quality assurance and standards development. Updates will also be used for reporting and budget development. The MHIIS will allow in-depth and quality data.

There is a plan to bring the new system in the Ebeye Hospital after the completion of implementation in Majuro. For 2010, we will be working on the plan. //2011//

/2012/ One of our major weakness was the 5 year need assessment. RMI submitted the need assessment after the MCH Block Grant review in 2010. Need Assessment was reviewed and was provided technical assistance to follow the requirements of MCH Block Grant. Berry Moon Watson provided this technical assistance in May 2011. From the technical assistance, we revised our Form 14:

Form 14 for Year 2011 State Priority Needs

1. To reduce the rates of sexually transmitted diseases among women of child bearing age
2. To reduce the maternal mortality rate.
3. To reduce the infant mortality rate.
4. To increase the percentage of teenage (15-17 years old) acceptors of modern contraception.
5. To increase the percentage of mothers who breastfeed their newborns at 12 months after delivery.
6. To increase the percentage of mothers who receive nutrition counseling during prenatal care.
7. To increase the number of women who are screened for cervical cancer.
8. To increase the percentage of mothers who access prenatal care in the first trimester of pregnancy.
9. To decrease overweight and obese school children by 5% yearly.
10. To Improve accessibility to the MCH/CSHCN services for children 0-21 and their families.

Objectives were provided to address the priority needs identified. //2012//

//2013//

There is no change in our need assessment that was submitted in 2011.

//2013//

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

In more than fifty years since the end of World War II, two principle trends have occurred in the population of the Marshall Islands: rapid growth and continuing urbanization. The Marshall Islands has a very young growth and growth population. While somewhat more than 30% of the Marshallese people live in a semi-subsistence mode in the rural atolls and islands of the nation, the majority of the population are living in the two most populated areas at Majuro and Ebeye. The Marshall Islands consists of 29 atolls and five major islands, which form two parallel groups - the "Ratak" (sunrise) chain and the "Ralik" (sunset) chain. The Marshallese is of Micronesian origin. The matrilineal Marshallese culture revolves around a complex system of clans and lineages tied to land ownership.

//2013/ No change.//2013//

Each atoll consists of a ring of islets incircling a deep water lagoon. The islets are interconnected and surrounded by a coral reef. None of these low-lying land areas have an elevation greater than ten feet above sea level. Two of the atolls, Majuro and Kwajalein have become crowded urban centers. While the outer atolls remain rural in character and are known as "outer islands". Majuro Atoll is the most highly developed area in the nation and has high schools, a community college, an 101 bed hospital and a developing infrastructure of electrical distribution, fresh water reservoirs and sewerage disposal. The atoll is thirty miles long. The widest islet measures about half a mile from ocean to lagoon. As the national capital, Majuro is home to an expanding population and site of most public, commercial and industrial development. With a land area of 3.75 square miles, Majuro Atoll has a population density of 29, 488. Much of the population is crowded into the "downtown" administrative and commercial center at the eastern end of the atoll. Ebeye, a small island within Kwajalein Atoll, is the only other urban center in the Marshall Islands. The urbanization of Ebeye commenced in the late 1940s with the Department of Defence, with the relocation of Marshallese people from northern atolls that were affected by the Nuclear Testing Program (1946-1958) and with 1964 opening of the Kwajalein missile testing range by the US Army. With commencement of the missile testing program, families living in the central area of Kwajalein Atoll--known as the Mid-Atoll Corridor--were relocated to Ebeye. In addition to its high birth rate, the population continued to grow over the years as people from throughout the Marshall Islands (and elsewhere in Micronesia/other countries) were attracted to job opportunities at the nearby military base. In Ebeye, more than 11,000 people reside on a land area of .12 square mile. Housing is substandard and extremely crowded. Ebeye has a 45 bed hospital which replaced the dilapidated older facility. Health problems are numerous and may be attributed, in part, to overcrowding and an inadequate water supply. Kwajalein Atoll is the largest atoll in the world, with a lagoon area of 839.3 square miles. The total land area of the Kwajalein islets comes to 6.33 square miles.

//2013/ No change.//2013//

The rural outer islands comprise the remainder of the Marshall Islands, scattered over great expanse of the Pacific Ocean. Population is separate communities ranging from 50-80 persons. The outer islands constitute a diminishing proportion of the population of the nation. With few exceptions, between non contiguous islets of an atoll can only be reached by canoe or motor boat and meals are cooked on open fires or single-burner kerosene stoves. Income for residents of the outer atoll 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. There are elementary and high school public schools in Jaluit and Wotje and there are 2 private high schools in Aerok

Ailinglaplap and Maloelap Atoll.

//2013/ No change.//2013//

Each of the twenty-four inhabited outer islands has an airstrip. Several of the larger atolls have

more than one airstrips. Emergency medical evaluation are accomplished by small and larger aircraft or, at islands where the airstrips have been closed or repair, by field trip ship. Medical evacuation by air can only take place by daylight since the outer island airstrips do not have landing lights. Medical evacuation by ship to the hospitals in Majuro or Ebeye can take as long as two days depending upon distance and sea conditions. Patients in the outer islands requiring specialized care not available at Majuro or Ebeye would be referred to the Office Medical Referral Services for off island referral to Honolulu or Manila. The outer island dispensaries and the hospitals at Majuro and Ebeye are owned and operated by the RMI Ministry of Health. There is only one private clinic in the Marshall Islands.

/2013/ No change./2013//

People travel from Majuro and Ebeye to the outer islands using Dornier aircraft managed by the Air Marhsall Islands and non government-owned field trip ships that commute between atolls once a month. A small boat that is highly dependent on fuel supplies available. Also, people walk during low tides on the exposed coral feefs between the islands in order to reach the airstrips.

The total population of the Marshall Islands is estimated at 54,065 in 2009. More than 50% is under 19 years of age. The average growth rate of 3.6% is the highest in the pacific. Currently, more than 60% of the population resides in the two urban centers. The remaining 40% resides in the outer island atolls. Deliver of health care services to a dispersed population in the RMI is cumbersome.

/2013/ No change./2013//

The Marshall Islands has an area of 1,826 square kilometers and is composed of two coral atoll chains in the Central Pacific. The Marshall Islands is a parliamentary democratic, consitiutionally in free association with the United States if America. It has a developing agrarian and serviceoriented economy.

/2013/ No change./2013//

/2012/ The RMI Estimated Population in 2010 is 54,439. More than 50% is under 20 years of age. The average growth rate of 3.6% is the highest in the pacific. Currently, more than 60% of the population resides in the two urban centers. The remaining 40% resides in the outer island atolls. Deliver of health care services to a dispersed population in the RMI is cumbersome.

/2013/ No change./2013//

In 2011, the Ministry of Health bought a boat that will bring Mobile Teams to the Outer Islands to provide health services to the community.

//2012//

/2013/ The new boat is called Ejmour II. Besides the local plane, we now have Ejmour II to bring the Public Health services to the Outer Islands. In FY2011, we have provided services for 18 islands for 29 trips using Ejmour II.

//2013//

In 2012, the Ministry of Health has implemented the plan to bring Mobile Teams to the Outer Islands to provide health services to the community. This includes Maternal and Child Health services.

/2013/ On-going./2013//

B. Agency Capacity

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

There are three Bureaus that provide direct health care services in the country: 1) The Bureau of Majuro Atoll Health Care Services (MAHCS), 2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS), and 3) The Bureau of Outer Islands Health care (OIHCS). In each bureau, there is a Division of Primary Health Care. The DPHC in each bureau will handle the preventive and primary health care services to the population covered by the Bureau.

/2013/ No change./2013//

The MCH/CSHCN Program is not a separate agency. It is one of the programs in each bureau under the Division of Primary Health Care. With this organization lay out, the MCH program in KAHCS and OIHCS coordinate and submit report to the main MCH program which is in Majuro. 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. The MCH/CSHCN is one the components within Reproductive Health. There are eight nurses, three OBGYNs, and five support staff receiving salaries from the program.

/2013// There are seven nurses with A.S. Degree Level, one of them is also a CNM. There is also other supportimng staff: one Health Educator, one Counselor, one Dental Assistant, one OBGYN, one Medical Officer (MO), and one Program Manager/Director. With the total of 13 program staff, six of them continue to receive salaries from the program./2013//

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

/2013/ Activities continue./2013//

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 101-bed facility, and Ebeye has a 45-bed hospital. Both facilities mainly provide primary and secondary care with very limited tertiary care. Patients who need tertiary care are referred to hospitals in Honolulu or the Philippines. The Division 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.

/2013/ No change./2013//

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

/2013/ Activities continue./2013//

For several years, one of the priorities of the MOH was to develop an effective health information system. The Ministry is currently looking for a qualified Health Planner. The Ministry has received technical assistance to modify its Ministry of Health Integrated Information System (MHIIS) in order to improve its capabilities to collect and use data to improve health care services. The

Ministry has established a MHIIS Committee and Working Group to review all forms and other documents that will enhance the MHIIS. 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 Office of Health Planning and Statistics. Staff training on the use of the revised forms is completed.

/2013/ No change.//2013//

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 in the outer atolls. The MHIIS Committee has revised the recording/reporting forms, 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 submitted to the Office of Outer Islands as under reported 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.

/2013/ No change.//2013//

Currently, a new data and information system is in the development and implementation stage where all computers will be link to access databases more easily. While the new information is still not completed yet, the MOH continues to use the previous system which is a computerized database. Therefore, still the MOH is able to access data on Maternal and Child Health for program use purposes.

The Health Management Information System (HMIS)

The HMIS is a computerized database to handle all health and health-related data in the MOH. Based on the File Maker Pro software, it was designed to be a user friendly and menu driven 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.

Health Management Information System is on the way for completion.

The new Health Management Information System is almost done. In 2006, the Ministry of Health acquired a customized system for the Ministry and named it as Ministry of Health Integrated Information System. Initially, the system comprises of Vital Records Information System, Hospital Information System, Public Health Information System, and Management Information System. For the 1st phase of the system, the target is to implement in Majuro. Upon completion, we will expand to Ebeye and Outer Islands. Although our overall progress is 20% on the new system, we have our old systems in Majuro, Ebeye, and Outer Islands that captures the daily activities of the Ministry. We are looking forward to 100% implementation in Majuro by next year.

In 2008, a new system was added to the our Integrated System. We started then development of Medical Referral Information System. We added this system to the existing contract to upgrade our existing medical referral access system. In 2009, we implemented the system and received a good review. The system aims to record the transactions in patient care and financial of the RMI Medical Referral to Honolulu, Manila, and Taiwan.

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 managers 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 New Health Information System will be continued with the same goals stated above. 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.

There are 5 systems comprising the Ministry of Health Integrated Information System. They are Vital Records Information System, Hospital Information System, Public Health Information System, Management Information System, and Medical Referral Information System.

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 referral 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 Form" to reflect the number of departments for which this form was redesigned. While it resembles the format of the original form, 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 encounter form is still being used. The MOH Encounter Form is used in the Majuro Hospital, Ebeye Hospital and Outer Islands Health Centers and complemented with a monthly report form to be sent to Majuro each month by the Health Assistants. The MOH Encounter already includes categories related to cancer screening and treatment. Combined with the patient's medical chart, the Encounter Form will assist both the clinician and the Ministry's data management and surveillance efforts.

Public Health and Epidemiology

The Public Health and Epidemiology components do not have a standard form (excluding those for Births and Deaths) and relies on the monthly reports sent by each department to the Planning Office. While some data can be obtained from the Planning Office, a form, which lists specific data categories, was designed for selected public health departments. This format will enhance monthly data reporting to the Planning Office and provide HMIS with the necessary information to assist in documenting vital and other health-related statistics. The data will enhance the data

collected from public health and medical records. As part of the cancer screening and early detection program coordinator's duties, a monthly report will be sent to the Office of Planning and Statistics to ensure that the data is collected and appropriately disseminated.

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

Finance and Personnel

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

Benefits, Monitoring, and Evaluation (BME)

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

Training and Professional Development

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

Evaluation Plan

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

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

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

Monitoring and Evaluation are being done using outcome from data.

Even though the MOH data/information is in used, it is still a challenge for RMI. MOH is looking forward to overcome this challenge in early 2010, where data/information would be fully completed and on-going.

/2012/ In 2011, the Ministry of Health headed by the Secretary of Health met to revise the organization structure. Currently, there are three Bureaus that provide direct health care services in the country: 1) The Bureau of Majuro Atoll Health Care Services (BMAHCS), 2) The Bureau of Kwajalein Atoll Health Care Services (BKAHCS), and 3) The Bureau of Primary Health Care Bureau (BPHC). Aside from the 3 Bureaus, there are 2 offices under the Secretary of Health namely Office of Health Planning, Policy, and Statistics and Office of Administration, Personnel, and Finance. BMAHCS handles the management of Majuro Hospital and Medical Referral Services. BKACHS manages Ebeye Hospital and Primary Health Care of Kwajalein Atoll. BPHC manages the National Primary Health Care and Outer Island health care services.

The National MCH Program is under the BPHC. With this organization lay out, the MCH program in BKAHCS coordinate and submit report to the national MCH program. The nurses and medical staff implement all clinical, follow-up and community outreach programs for all areas in Public Health. The MCH Program provides health care services for pregnant women, mothers, infants, children, adolescents, men and women of reproductive age group, and children with special health care needs in the RMI. There are eight nurses, one OBGYN, and five support staff receiving salaries from the program.

Our new Health Planner assumed his position in the Office of Health Planning, Policy and Statistics this year. Installation, implementation, and maintenance of different modules of the Ministry of Health Integrated Information System are still ongoing. 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 OHPS. OHPS is responsible for technical support, data collection, data analysis, and reporting.

There are 5 systems comprising the Ministry of Health Integrated Information System. They are Vital Records Information System, Hospital Information System, Public Health Information System, Management Information System, and Medical Referral Information System.

Vital Records Information System: System for the Birth, Death, Fetal Death certificates. As of now, the birth and death certificates are not linked together. But we are applying for the SSDI grant this year. One of our objectives is to link the birth and death certificate.

Hospital Information System: This system will manage all hospital based systems like Laboratory, Radiology, Medical Records, Pharmacy, Outpatient and Inpatient.

Public Health Information System: This system will handle public health databases.

Management Information System consists of Inventory Management System, Biometric Time and Attendance system, Personnel system

Medical Referral Information system consists of Basic Referral and Supplemental Referral modules.

Monitoring and Evaluaton Plan

Currently, the program managers submit their own template of reporting the Office of Health Planning, Policy, & Statistics for data collection, analysis, and reporting. But OHPPS is working on a monitoring and evaluation template for all the Bureaus and Offices to use for centralized and

uniform collection and analysis.

There are a lot of challenges that we experience and still we are facing now in the implementation of maintenance of MHIIS.

//2013// Using National Public Health Improvement Initiative Grant, we will connect Ebeye Hospital to the Vital Records Information System (VRIS). We always have a challenge with late submission, missing birth, death and fetal death certificate from Ebeye Hospital. With the implementation of VRIS in Ebeye, we will be able to have real time data entry. The main server is in Majuro.

This year, we will also implement the WebIZ (Immunization Information System) in Ebeye Hospital. The main server is in Majuro. Currently, Ebeye Immunization Program is using a standalone system. With the implementation of WebIZ, Ebeye Immunization Coordinator can enter real time data and print out Immunization Card on time.

We have also started the implementation and training for Laboratory Management Information System in Majuro Hospital Laboratory. Before the end of the year, all Laboratory staff can access, enter, and print results from the Laboratory System. We are still looking for funding to implement the same system to Ebeye Hospital.

In 2011, the National Comprehensive Cancer Control Program with the physicians and consultants from University of Hawaii created a national screening guidelines for Cervical, breast and colorectal cancer screening. In 2012, we will have training on VIA for cervical cancer screening. We will implement a system that captures the cancer screening. We have a cancer registry wherein only diagnosed cancer patients are entered and monitored. But with the new system that we will implement, it will track all screening that we will have for breast, cervical, and colorectal.

For BMI Screening in school, we are going to use a newly developed School Health database. It is still in development stage but will go along with the BMI screening we are conducting.

Using the SSDI funding, we are working on a comprehensive tracking system for MCH program that follows the life course model for prenatal services, well-baby, children's health screening, school health screening. We will work out on a system wherein we can get better information from the Outer Islands. It is a challenge to implement an information system in the Outer Islands. 80% of our health assistants in the Outer Islands have limited computer skills. We will use wavemail system for them to send information using a template that is easy for them to understand and enter data.

Other systems are still on going. //2013

C. Organizational Structure

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

//2013/ No change.//2013//

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.

//2013/ System continues.//2013//

The MOH has Three Bureaus and 3 Major Offices:

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

//2013/ No change.//2013//

With the exception of the Office of Health Planning and Statistics which is headed by the Health Planner, an Assistant Secretary heads each bureau. All Assistant Secretaries and the Health Planner report directly to the Secretary of Health. It is a challenge for the MOH without an Health Planner to assist with statistics issues. Plan has taken place to hire a new Health Planning as soon as he/she is identified.

Each bureau have the Division of Primary Health Care. The objective is to better serve the population covered by each bureau on their primary health care needs.

Bureau of Majuro Atoll Health Care Services is composed of 6 divisions:

1. Division of Ancillary Services
2. Division of Primary Health Care
3. Division of Clinical Services
4. Division of Nursing Services
5. Division of Support Services
6. Division of Health Information and Management

Bureau of Kwajalein Atoll Health Care Services is composed of 4 divisions:

1. Division of Curative Services
2. Division of Health Management Information system
3. Division of Primary Health Care
4. Division of Support Services

Bureau of Outer Islands Health Care Services is composed of 2 divisions:

1. Division of Clinical and Training
2. Division of Primary Health Care *//2010//*

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

1. Reproductive Health
2. Immunization Program
3. Health Promotion and Disease Prevention Unit
4. Comprehensive Cancer Program
5. Mental Health and Social Services

6. Communicable Diseases: TB, Leprosy, STD/HIV,

A director who reports directly to the Assistant Secretary heads each of the division. The directors are responsible for the daily management and supervision of programs carried out under the Title V program in each of the divisions.

Reproductive Health Clinic (RHC) handles the MCH/CSHCN program. Between the bureaus, MHACS' MCH/CSHCN program work as the main contact point, provides the funding, plans the program's activities, and apply, supervise, and reports the grants. The Director of RHC in MHACS collaborates and coordinates the activities between Majuro, Ebeye, and Outer Islands. The staffs of RHC in MHACS are also the staff of RHC in OIHCS.

The Assistant Secretaries are responsible in the management and supervision of programs within their bureau.

In the Reproductive Health Clinic, there are three programs which are MCH/CSHCN, Adolescent Health, and Family Planning.

/2013/ Women's Health Clinic has merged into Reproductive Health/Maternal and Child Care.//2013//

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

Adolescent Reproductive Health has merged out into Youth to Youth In Health Program which is an NGO. The purpose is to allow more efficient use of scarce human resources and better collaboration and coordination of services in between Youth to Youth In Health and Reproductive Health at the Ministry of Health.

/2013/ There is MOU between Ministry of Health and the Youth to Youth in Health taht has been signed for better utilizing of human resources and manpowers for a better service delivery in the Republic.//2013//

/2012/ Since 2010, the Ministry of Health has been conducting meetings on re-organizing the MOH structure. The Secretary of Health sees this as a way to better coordinate and implement services. In May 2011, the new organization structure has been implemented.

Previously, we have 3 bureau and 3 offices.

- 1) The Bureau of Majuro Atoll Health Care Services (BMAHCS),
- 2) The Bureau of Kwajalein Atoll Health Care Services (BKAHCS),
- 3) The Bureau of Outer Islands Health Care Services (BOIHCS),
- 4) Office of Administration, Personnel and Finance
- 5) Office of Health Planning and Statistics
- 6) Office of Medical Referral Services

In May 2011, the MOH has 3 Bureaus and 2 Major Offices:

1. The Bureau of Majuro Atoll Health Care Services (BMAHCS),
2. The Bureau of Kwajalein Atoll Health Care Services (BKAHCS),
3. The Bureau of Primary Health Care Services (BPHC),
4. Office of Administration, Personnel and Finance (OAPF), and
5. Office of Health Planning, Policy, and Statistics (OHPPS)

With the exception of the Office of Health Planning, Policy, and Statistics which is headed by the Health Planner, an Assistant Secretary heads each bureau and office. All Assistant Secretaries

and the Health Planner report directly to the Secretary of Health. For four years, the OHPPS don't have a Health Planner. But in May 2011, a senior management staff was appointed as the Health Planner. He has been working for a long time in the Ministry of Health and has a vast experience in health planning.

Bureau of Majuro Atoll Health Care Services is composed of 4 divisions:

1. Division of Ancillary Services
2. Division of Clinical Services
3. Division of Nursing Services
4. Division of Support Services

BMAHCS is managing the Majuro Hospital.

The Bureau of Primary Health Care is the National Primary Health Care Program. It manages MCH Program, Non Communicable Disease, Communicable Disease, Health Promotion, Immunization, and Outer Islands Health Care Services.

The Bureau of Kwajalein Atoll Health Care Services consists of:

1. Division of Curative Services
2. Division of Health Management Information System
3. Division of Primary Health Care
4. Division of Support Services

BKAHCS served the Kwajalein Atoll. Division of Primary Health Care in BKAHCS is also reporting to the BPHC.

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

1. MCH Program
2. Immunization Program
3. Health Promotion and Disease Prevention Unit
4. Community Health
5. Lifestyle Diseases; Diabetes, Heart Disease, Comprehensive Cancer Control Program, Nutrition & Physical Activity.
6. Oral health
7. Mental Health and Social Services
8. Communicable Diseases: TB, Leprosy, STD/HIV

A director who reports directly to the Assistant Secretary heads each of the division. The directors are responsible for the daily management and supervision of programs carried out under the Title V program in each of the divisions.

Department of MCH Program consists of the following divisions:

1. Children with Special Health Care Needs
2. Reproductive Health
3. Women's Health
4. New Born Hearing Screening
5. Well baby and Maternal Support
6. Child and Adolescent Health
7. Immunization Program
8. Family Planning

MCH Program is headed by a director that manages and coordinates activities in Majuro,

Kwajalein, and Outer Islands. MCH Program Director acts as the main contact point, provides the funding, plans the program's activities, and applies, supervises, and reports the grants. The Director of RHC in MAHCS collaborates and coordinates the activities between Majuro, Ebeye, and Outer Islands.

//2013/ No change.//2013//

Adolescent Reproductive Health has merged out into Youth to Youth in Health Program which is an NGO. The purpose is to allow more efficient use of scarce human resources and better collaboration and coordination of services in between Youth to Youth in Health and MCH Program at the Ministry of Health. //2012// No changed//**2013/**

//2013/ NO change.//2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

There are 9 nurses in MCH Program that implement all the clinical and primary care programs. These nurses travel to the Outer Islands in addition to supervising their assigned clinic and zones in Majuro and Ebeye, Kwajalein. These nurses also worked on weekends to provide MCH Program services, such as Reproductive Health, Family Planning and Children with Special Health Care Needs in the two expanded clinics. Expanded clinics are located at Youth to Youth in Health and at the Laura Health Center. The same nurses provide the program service delivery to the MCH population throughout the Republic.

There are 2 nurses, 1 OB-GYN, 1 Health Educator, 1 Mental Health Counselor, and 1 Dental Assistant being paid out from the MCH Block Grant.

Aside from the nurses working in the MCH program, the staff is collaborating in other programs like Immunization Program, Well Baby Clinic, Laboratory staff, Radiology, Pediatricians, health assistants, mental health, health promotion and disease prevention unit, health planning and statistics office and other public health programs.

In providing the necessary required data needed for the completion of the grant, the program collaborated with the Office of Health Planning, Policy, and Statistics (OHPPS) and Economic Policy, Planning and Statistics Office through the IT Director of OHPPS.

//2012/ In the SSDI application that we are submitting this year, the IT Director of OHPPS will be assigned as the SSDI Coordinator which will work closely with the MCH Program Director.

//2013/No change.//2013//

The RMI SSDI grant application approved, and the IT Director of OHPPS is assigned as the SSDI Coordinator.

//2013/ //2013// There are seven nurses with A.S. Degree Level, one of them is also a CNM. There is also other supportimng staff: one Health Educator, one Counselor, one Dental Assistant, one OBGYN, one Medical Officer (MO), and one Program Manager/Director. With the total of 13 program staff, six of them continue to receive salaries from the program.

IT Director as the Program Manager for SSDI work closely with MCH Program Manager. //2013//

E. State Agency Coordination

The Ministry of Health, being the only "state" agency that provides health care services in the Republic of the Marshall Islands, recognized the significance of collaborating with other agencies in the implementation of service to the communities.

/2013/No change./2013//

Since the MCH Program services are effectively coordinated among the staff in Public Health, who also provides services for other program areas. The MCH/CSHCN service also coordinates with other divisions in the Bureau of Primary Health Care, such as the Mental Health Programs, Alcohol & Substance Abuse Prevention Program, and Social Worker, STD/HIV Program. For community outreach purposes, MCH Program coordinates with Health Education and Promotion Program. These services have been expanded that other programs provide services to the MCH/CSHCN population.

/2013/ No change./2013//

MCH Program consists of services that serves the need of pregnant women, mothers and infants, Children and adolescents, Children with special health care needs, Men and Women of Reproductive Age Group. MCH Program has expanded its services with two additional clinics sites on Majuro. Laura Health Center and Youth to Youth in Health clinics are the currently expanded clinics of MCH Program. The MCH/CSHCN service also coordination and collaboration between other programs within the Ministry of Health, other government agencies, such as Ministry of Education, Ministry of Internal Affairs, and NGOs, such as Youth to Youth in Health, Women's Organizations.

/2013/ No change./2013//

The Ministry of Health Core Committee (KUMITI) carries out coordination of community awareness on primary health activities and programs. The committee consists of department heads in the Ministry of Health. All the international and national health events are coordinated by the Ministry's Core Committee in collaboration with the RMI Inter-Agency Council and the National Population Coordinating Committee.

/2013/ Coordiantion and Collaboration continue./2013//

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

/2013/ On going./2013//

Some of the activities conducted during the year:

1. Organizing and participating in the annual World TB Day,
2. National Health Month,
3. Breast Feeding Week,
4. World Diabetes Day,
5. World Food Day,
6. World AIDS Day
7. World Cancer Day
8. World Population Day,
9. Immunization Week.
10. World AIDS Day, and the
11. National Week for the Disabled. The same activities also conducted during the year as

our annual activities.

Some of the activities conducted during the year.

1. Cancer Corlation clebrated the annual regonization of those who have gone to rest and those women suffering from cancer.
2. Participated in the Youth to Youth In Health Fairs
3. Organization and participating in the annual World TB Day.Bresat Feeding Week
4. National Health Month
5. Breast Feeding Week
6. World Diabetes Day
7. World Food Day
8. World AIDS Day
9. World Cancer Day
10. World Population Day
11. Immunization Week
12. National Disabled Week

13. Women's Week

Laura Health Center is on regular staff receiving salary from the MCH Block Grant. While on a regular weekly basis, one OBGYN or CNM, and one MCH Program Nurse join the health assistant and full Reproductive Health (RH) service is being provided, such as prenatal clinic, women/male health clinic, FP and other RH services. The Youth to Youth in Health clinics are held three times a week to provide RH/MCH services for the youth up the 25 years of age.

/2013/ Activities continue.//2013//

F. Health Systems Capacity Indicators

F. Health Systems Capacity Indicators

Introduction:

The Ministry of Health (MOH), Vital Statistics under the Office of Health Planning, Policy and Statistics is responsible in registering birth and death events occurring in the hospital, health centers, at home, and anywhere within the Marshall Islands. The Vital Statistics department will collect information to complete and birth and death certificate. Completed birth and death certificate will be forwarded to Ministry of Internal Affairs for final registration. If the is birth registered after a year of the birth date, it is considered late registration. The parents or guardian will have to secure a court order to register the birth certificate. For the late registration, Ministry of Internal Affairs will handle the completion and registration of the certificate.

/2013/ On going.//2013//

Our Health Information System is still in the implementation. As of now, we are using the new and old system to gather data.

//2012/ RMI Oral Grant has faced out//2013//. However, continuation of this activities with other fundings

Health Systems Capacity Indicators 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 2006 2007 2008 2009 2010

Annual Indicator

Numerator

Denominator

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average

cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final? Provisional Provisional

Narrative:

The Ministry of Health Integrated Information System is in the development and implementation stage. Public

Health where Reproductive Health (MCH/CSHCN/Family Planning data is included but is not yet done. Hopefully by

the end of 2010, they system will be fully implemented, so that better data will be available.

Currently, the

Ministry of Health is still utilizing the Health Information System that has been using over the past years. In FY

2009 the number of children with asthma been hospitalized has gone up due to better collection of information

and reporting.

/2013/ Data is being provided in the Performances.//2013//

/2012/ The number of children hospitalized for asthma was collected from 2 main hospitals, Majuro Hospital and Ebeye Hospital. Currently, the HIS for two hospitals are not connected. Each hospital used different system. With the MHIIS (Ministry of Health Integrated Information System), we will have one system. As of 2011, we are still implementing the HIS in Majuro Hospital. As soon as the system in Majuro Hospital is implemented and manageable, we will continue implementation to Ebeye Hospital.

We didn't get the SSDI for the past 5 years. But for this year, we are going to apply for it and looking forward to better manage the needed data for the MCH Block Grant. //2012//

Health Systems Capacity Indicators 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 2006 2007 2008 2009 2010

Annual Indicator

Numerator

Denominator

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final? Final Final

Notes - 2010

RMI don't have Medicaid. Denominator is population for less than 1 year old.

Notes - 2009

Not applicable to the RMI since RMI don't have Medicaid.

Notes - 2008

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

Narrative:

This is not applicable to the RMI since we do not provide have the Medicaid program. Under of the Compact of Free Association with the U.S.A. RMI is not eligible. However, in FY 2009, the MCH program provided services for 1652 babies less than one year old in the RMI. Denominator came from the EPPSO's population estimate of April 2009.

/2012/ This is not applicable to the RMI since we do not have Medicaid program. //2012//

Health Systems Capacity Indicators 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 2006 2007 2008 2009 2010

Annual Indicator

Numerator

Denominator

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final? Final Final

Notes - 2010

RMI doesn't have SCHIP. Denominator is based on less than 1 year old population from EPSSO Population Estimate of April 2009.

Notes - 2009

RMI doesn't have SCHIP. Denominator is based on less than 1 year old population from EPSSO Population Estimate of April 2009.

Notes - 2008

RMI doesn't have SCHIP.

Narrative:

RMI does not have SCHIP. However, in FY 2009, the MCH program provided services for 1,652 babies less than one year old in the RMI. Denominator came from the EPPSO's population estimate of April 2009.

/2012/ RMI don't have SCHIP. Source for the denominator is Population Estimate from EPPSO, April 2009. //2012//

Health Systems Capacity Indicators 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 2006 2007 2008 2009 2010
Annual Indicator

Numerator

Denominator

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final? Final Final

Narrative:

The new data system that is in the process of developing and hope to be completed by the end 2010, this would improve the our data collection and reporting.

The Maternal and Child Health Program continues to increase the number of mothers entry into prenatal care in the first trimester. One expanded prenatal clinic in addition to the base clinic has been established at Laura Health Center located in Majuro. The new site gives more access to not only the mothers, but also all MCH population who are unable come to the main clinic due to cost of transportation or other reasons.

/2012/ The prenatal clinic scheduled the pregnant mothers more frequently if they missed their check up in the 1st trimester.

Data source for this HSCI is from the MCH Program, Prenatal Clinics and Vital Statistics Office. We are improving our Prenatal Database to easily get this needed data. With the SSDI grant application, we can support the data quality checking of the prenatal database. //2012//

Health Systems Capacity Indicators 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 2006 2007 2008 2009 2010

Annual Indicator

Numerator

Denominator

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final? Final Final

Notes - 2010

RMI don't have Medicaid Program.

Notes - 2009

RMI don't have Medicaid Program.

Notes - 2008

RMI don't have Medicaid Program.

Narrative:

RMI don't have Medicaid Program. Not applicable to the RMI.

Although RMI don't have Medicaid program, children in the RMI received services that is covered under the RMI

Basic Insurance. Sometimes the MCH Block Grant supports in paying for medication.

/2012/ No update. //2012//

Health Systems Capacity Indicators 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 2006 2007 2008 2009 2010

Annual Indicator

Numerator

Denominator

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final? Final Final

Notes - 2010

RMI don't have Medicaid Program.

Notes - 2009

RMI don't have Medicaid Program.

Notes - 2008

RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the

population by single age. We have population data for ages 5-9. So for the age 6 to 9 years old, we estimated it based on the 5-9 years old data.

Narrative:

Not applicable to the RMI since RMI is not eligible for EPSDT. RMI don't have EPSDT. However, it is estimated that more than 50% received some sort of dental care during the year.

/2012/ Not applicable to the RMI.

We provide dental examination to 6-9 years old. For Majuro Dental Clinic, there are 388 out of 1145 children age 6-9 years old that underwent dental examination in 2010. While in 2008 and 2009, there were 334 out of 1057 and 366 out of 1161 children underwent examination respectively. //2012//

Health Systems Capacity Indicators 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 2006 2007 2008 2009 2010

Annual Indicator

Numerator

Denominator

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final? Final Final

Notes - 2010

RMI is not eligible.

Notes - 2009

RMI is not eligible.

Notes - 2008

RMI is not eligible.

Narrative:

RMI does not eligible for SSI. Not applicable to the RMI.

/2012/ No update //2012//

Health Systems Capacity Indicators 05A: Percent of low birth weight (< 2,500 grams)
INDICATOR #05

Comparison of health systems 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) 2010 other 13.5 13.5

Notes - 2012
RMI don't have MEDICAID.

Narrative:
RMI does not have Medicaid Program. Not applicable to the RMI.
Although RMI don't have Medicaid program, children in the RMI received services that is covered under the RMI
Medical Insurance. Sometimes the MCH Block Grant supports in paying for medication.

/2012/ RMI is not eligible to Medicaid. In 2010, there was 186 LBW out of 1,396 live births in the country //2012//.

Health Systems Capacity Indicators 05B: Infant deaths per 1,000 live births
INDICATOR #05
Comparison of health systems 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 2010 other 22 22

Notes - 2012
RMI don't have MEDICAID.

Narrative:
RMI is not eligible to Medicaid. There are 28 infant deaths per 1,000 live births based on the death certificate for
FY 2009.

/2012/ RMI is not eligible to Medicaid. There are 22 infant deaths per 1,000 live births based on the death certificate for 2010.

Total number of infant death is 31 and the total number of live births is 1396. IMR - 22 per 1,000 live births.
//2012//

Health Systems Capacity Indicators 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
INDICATOR #05
Comparison of health systems 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 2010 other
39.8 39.8

Notes - 2012
RMI don't have MEDICAID.

Narrative:

RMI is not eligible under the Compact of Freely Association with the U.S.

Although RMI does not have Medicaid, we provide prenatal services in the Reproductive Health Clinics in the hospitals and health centers. In 2009, the number of prenatal visits into the 1st trimester is slightly lower than 2008 that was 961, it is believed that has do with the decreased in number of births in 2009. Over the years, Marshallese people have been migrating out the country to seek better education and work.

/2012/ RMI don't have Medicaid.

Although RMI don't have Medicaid, we provide prenatal services in the Reproductive Health Clinics in the hospitals and health centers. In 2010, there was a decrease of 37% on pregnant women entering care in the First Trimester. This is attributed to the lack of OB-GYN in Majuro where 68% of total live births were delivered. Currently, Majuro only has 1 OB-GYN. Majuro Hospital is in the process of hiring 2 OB-GYN this year. With the SSDI grant application, we will hire data specialist that will help us in data entry to relieve the nurses from administrative work. Nurses can concentrate in going out to the community to zone out pregnant women.

//2012//

Health Systems Capacity Indicators 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 systems 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]) 2010 other 54.4 54.4

Notes - 2012

RMI don't have MEDICAID.

Narrative:

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

/2012/ RMI don't have Medicaid.

For 2010, there is a decrease of 22% for pregnant women with prenatal visits of greater than or equal to 80%.

This is attributed to the lack of OB-GYN in Majuro where 68% of total live births were delivered. Another reason is

that pregnant women missing their visits in the 1st Trimester of pregnancy.

Currently, Majuro only has 1 OB-GYN. Majuro Hospital is in the process of hiring 2 OB-GYN this year. With the SSDI grant application, we will hire data specialist that will help us in data entry to relieve the nurses from administrative work. Nurses can concentrate in going out to the community to zone out pregnant women.
//2012//

Health Systems Capacity Indicators 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) 2010
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) 2010

Notes - 2012

RMI don't have Medicaid.

Notes - 2012

RMI don't have SCHIP.

Narrative:

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

Based on the Federal Guideline on poverty level, most of our population falls under the guideline.

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

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

Medicaid Children

(Age range to)

(Age range to)

(Age range to)

INDICATOR #06

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

Medicaid Children
(Age range to)
(Age range to)
(Age range to)

Notes - 2012

RMI don't have Medicaid.

Notes - 2012

RMI don't have SCHIP.

Narrative:

Not applicable to the RMI. RMI don't have Medicaid.

Based on Federal Guideline on poverty level, most the our population falls under this guideline.

/2012/ No update. //2012//

Health Systems Capacity Indicators 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 2010

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 2010

Notes - 2012

RMI don't have Medicaid.

Notes - 2012

RMI don't have SCHIP.

Narrative:

Not applicable to the RMI. RMI is not eligible under the Compact of Free Association with the U.S.
Eventhough, RMI does not eligible for Medicaid and SCHIP programs, Maternal and Child Health Program served
1517 new borns in 2009.

/2012/ Not applicable to the RMI. RMI is not eligible under the Compact of Free Association with the U.S. //2012//

Health Systems Capacity Indicators 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

Annual linkage of infant birth and infant death certificates 2 Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files 1 No

Annual linkage of birth certificates and WIC eligibility files 1 No

Annual linkage of birth certificates and newborn screening files 3 No

REGISTRIES AND SURVEYS

Hospital discharge survey for at least 90% of in-State discharges 2 No

Annual birth defects surveillance system 2 No

Survey of recent mothers at least every two years (like PRAMS) 1 No

Notes - 2012

Narrative:

The MCH program coordinates with other programs within the Ministry and other governmental agencies to have access to policy and program relevant information.

All mothers served under Title V received relevant information. RMI Title V has protocols and guidelines and define all the services provided under Title V and how they can access these information. Providing the information that necessary for the program use are not always available on a timely manner, and it remains a challenge for the program.

/2012/ Currently, our annual data linkages and registries and surveys are on average. We have our Vital Records Information System that process the birth and death certificates. But what is lacking is the linkage of birth certificate to death certificate.

But with the SSDI grant application, we can work on our weaknesses on data linkages and surveys. //2012//

Health Systems Capacity Indicators 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) 2 No

Notes - 2012

MOH has to get information from other agency outside the Ministry, such as Ministry of Internal Affairs, Youth Service.

Data from Youth to Youth In Health, etc.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Based on health data collected by the MOH MCH Program in collaboration with EPPSO, the RMI MCH/CSHCN has selected these priority needs in which some of them have been selected from the last year's needs. This priority needs have been selected to improve the health status MCH Population in the RMI in all four of the services described in the pyramid. The RMI has selected to continue with last year's priority needs.

//2013/ The Maternal and Child Health conducted its Five (5) Years Needs Assessment in 2011 in collaboration with Office of Health Planning, Policy and Statistics-Ministry of Health, Early Childhood at the Ministry of Education, and other NGOs, such as, Youth to Youth In Health.//2013
//

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 health data collected by the MCH Program the RMI MCH/CSHCN has selected the same priority needs mostly as last year's needs but with some additional areas of needs. These priority needs have been selected to improved the health status of mothers, infants, children, and 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 morbidity.
5. To increase access to preventive services for women who are at risk for cancer.
- essential data and statistics on how the Ministry can improve programs and services.
6. To reduce the rates of sexually transmitted diseases among women of child-bearing age.
- coordination of services between agencies for CSHCN.
7. To strengthen the Health Information System to provide essential data to strengthen health care services focusing on preventive services.
8. To improve accessibility to the MCH/CSHCN services for children 0-21 and their families.
9. To improve preventive services for school children in dental care, immunization, and nutrition.
10. To strengthen screening programs on hearing to infants and young children.

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

Direct Health Care Services:

//2012//

1. To reduce the rates of sexually transmitted diseases among women of child bearing age

2. To reduce the maternal mortality rate.
3. To reduce the infant mortality rate.
4. To increase the percentage of teenage (15-17 years old) acceptors of modern contraception.
5. To increase the percentage of mothers who breastfeed their newborns at 12 months after delivery.
6. To increase the percentage of mothers who receive nutrition counseling during prenatal care.
7. To increase the number of women who are screened for cervical cancer.
8. To increase the percentage of mothers who access prenatal care in the first trimester of pregnancy.
9. To decrease overweight and obese school children by 5% yearly.
10. To Improve accessibility to the MCH/CSHCN services for children 0-21 and their families.

//2012//

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	2007	2008	2009	2010	2011
Annual Performance Objective	0	10	15	0	0
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1591	1526	1517	1396	1487
Data Source		Medical Record	Medical Record	Medical Record	Medical Record
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

RMI does not have Metabolic Newborn Screening Program due to inadequate availability of facilities. However, blood test for any newborn found to have problems or special conditions is sent to off island laboratory (DLS - Honolulu) for testing.

Notes - 2010

RMI does not have Metabolic Newborn Screening Program due to inadequate facilities. However, blood test for any newborn found to have problems or special conditions is sent to off island laboratory in Honolulu for testing.

Notes - 2009

RMI does not have Metabolic Newborn Screening Program due to inadequate availability of facilities. However, blood test for any newborn found to have problems or special conditions that place

him/her on special condition and needs special blood test then blood test is sent off island (Honolulu) for testing.

a. Last Year's Accomplishments

2011

RMI does not have Metabolic Newborn Screening Program due to inadequate availability of facilities. However, blood test for any newborn found to have problems or special conditions that place him/her on special condition and needs special blood test then blood test is sent off island (Honolulu) for testing. (continues)

RMI does not have Metabolic Newborn Screening Program due to inadequate availability of facilities. However, blood tests for any newborn found to have problems or special conditions that place him/her on special condition and needs special blood test then blood test is sent off island (Honolulu) for testing.

a. Last Year's Accomplishments

Currently, RMI don't have Metabolic Newborn Screening Program due to inadequate availability of facilities. However, blood test for any newborn found to have problems or special conditions that place him/her on special condition and needs special blood test then blood test is sent off island (Honolulu) for testing.

RMI does not performed blood tests on site for newborn screening yet, but coordination and collaboration with our laboratory continues so that perhaps in 2013 we will be able to provide this type of blood testing.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. RMI don't have Metabolic Newborn Screening Program due to inadequate availability of facilities.			X	
2. If there is a need, blood test for any newborn found to have problems or special conditions then blood test is sent off island to Honolulu Laboratory for testing.				X
3.				
4.				
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b. Current Activities

Currently, RMI don't have Metabolic Newborn Screening Program due to inadequate availability of facilities. However, blood test for any newborn found to have problems or special conditions that place him/her on special condition and needs special blood test then blood test is sent off island (Honolulu) for testing. RMI utilizes Laboratory in Hawaii for sending test samples.

c. Plan for the Coming Year

RMI looks forward to develop and implement Newborn Screening for Metabolic Screening.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	1487					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	0	0.0	0	0	0	
Congenital Hypothyroidism (Classical)	0	0.0	0	0	0	
Galactosemia (Classical)	0	0.0	0	0	0	
Sickle Cell Disease	0	0.0	0	0	0	
New Born Hearing Screening	995	66.9	0	0	0	

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	2007	2008	2009	2010	2011
Annual Performance Objective	9	100	100	50	55
Annual Indicator	100.0	100.0	45.0	52.2	55.5
Numerator	445	461	206	253	286
Denominator	445	461	458	485	515
Data Source		MCH program survey.	MCH program survey.	MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	60	62	65	67	70

Notes - 2009

New survey tool was implemented in 2009.

a. Last Year's Accomplishments

2011:

1. 55.5% of CSHCN families are satisfied with the services they receive.
2. More parents involvement in the program service that shows better coordination among service and clients.
3. Better communication between service providers and clients that parents visited the clinics whenever they want or need advise regarding their child's care/health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 55.5% of CSHCN families are satisfied with the services they receive.	X			
2. More parents involvement in the program service that shows better coordination among service and clients.				X
3. Better communication between service providers and clients that parents visited the clinics whenever they want or need advise regarding their child's care/health.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2011:

1. Outreach services and community outreach, including outer island visits continues for finding new CSHCN and follow up of activities and care.
2. Teach family members in caring for their child at home.
3. Screening services to identify children with special health needs.
4. Coordinate with Ministry of Education and refer of those who need to enter Special Education.
5. Refer to Human Services those who need counseling for cases that affect mental disabilities and child abused.
6. Provide monitoring and evaluation services for these children and families on a quarter basis.

c. Plan for the Coming Year

1. Continues to do outreach to make site visits to the clients' home.
2. Teach family members in caring for their child at home.
3. Continue screening services to identify children with special health care needs.
4. Continues to coordinate with Ministry of Education and refer of those who need to enter Special Education.
5. Refer to Human Services those who need counseling for cases that affect mental disabilities/or abuse.
6. Continue provide monitoring and evaluation services for these children and families on a quarter basis.

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	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	50	100
Annual Indicator	100.0	100.0	45.0	100.0	0.0
Numerator	445	461	206	485	0
Denominator	445	461	458	485	515
Data Source		MCH program survey.	MCH program survey.	MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

Based on definition of medical home, RMI don't have a medical home. We provide health care to CSHCN in the hospitals, health centers and also by house to house visits.

Notes - 2010

RMI considered medical home as their own home where they are being provided healthcare by the MCH Staff.

Notes - 2009

Results from program survey.

a. Last Year's Accomplishments

RMI don't have a medical home based on the national standard for medical home. We provide services in their home by house to house visit by mobile team. Mobile team can provide immunization, counseling and initial health care. But if patients need comprehensive care, they are referred to the Hospital and Health Centers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. RMI don't have a medical home based on the national standard for medical home.				X
2. We provide services in their home by house to house visit by mobile team. Mobile team can provide immunization, counseling and initial health care. But if patients need comprehensive care, they are referred to the Hospital and Health Centers.	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

RMI don't have a medical home based on the national standard for medical home. We provide services in their home by house to house visit by mobile team. Mobile team can provide immunization, counseling and initial health care. But if patients need comprehensive care, they are referred to the Hospital and Health Centers.

c. Plan for the Coming Year

RMI don't have a medical home based on the national standard for medical home. We provide services in their home by house to house visit by mobile team. Mobile team can provide immunization, counseling and initial health care. But if patients need comprehensive care, they are referred to the Hospital and Health Centers.

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	2007	2008	2009	2010	2011
Annual Performance Objective	95	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	445	461	458	485	510
Denominator	445	461	458	485	510
Data Source		MCH Program	MCH Program	MCH Program	MCH Program

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

RMI Basic Health Care Insurance provide 100% coverage.

Notes - 2010

RMI Basic Health Insurance provide 100% coverage.

Notes - 2009

Results from program short survey.

a. Last Year's Accomplishments

Under RMI Government health insurance, everyone is covered under RMI Basic Health Plan for Medical Care.

RMI continued its relationship with Shriners Hospital. CSHCN are presented to Shriners for medical referral. If Shriners Hospital won't be able to support the medical needs, RMI has a basic referral system. Physicians presented cases to Medical Referral Committee for them to assess if the patient is eligible for medical referral to Honolulu or Philippines. Medical Referral Committee meets every Wednesday.

RMI is not able to determine those who have private insurance since no clients private health insurance reported.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Under RMI Government health insurance, everyone is covered under RMI Basic Health Plan for Medical Care.				X
2. CSHCN are presented to Shriners for medical referral.				X
3. If Shriners Hospital won't be able to support the medical needs, RMI has a basic referral system. Physicians presented cases to Medical Referral Committee for them to assess if the patient is eligible for medical referral to Honolulu or Philippines.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2011:

The RMI continued to provide medial insurance to all Marshallese citizens.

c. Plan for the Coming Year

2013, The RMI will continue provide health insurance to all Marshallese citizens.

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	2007	2008	2009	2010	2011
Annual Performance Objective	95	100	100	50	55
Annual Indicator	100.0	100.0	45.0	52.2	55.9
Numerator	445	461	206	253	288
Denominator	445	461	458	485	515
Data Source		MCH program survey.	MCH program survey.	MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	60	60	65	65	70

Notes - 2009

In 2009, the RMI collected information on NPM #05 by conducting a questions/survey to 458 parents and out off this number, 206 (45%) of the total parents satisfied with the existing service for their children. The RMI continues to seek other possible ways to improve it service to children and families with disabilities by doing more outreach or home visits to follow up with families to identify their needs.

a. Last Year's Accomplishments

2011:

1. Quarterly site visits for those children and families who reside on the outer islands through Outreach Mobile Team.
2. Twenty four atolls were visited for follow-up with CSHCN in coordination with health assistants at Outer Islands Health Centers. We also provide on-site training for the health assistants on caring for CSHCN and how guide them on referral system.
3. Services is being coordinated among the MCH Program Service, Ministry of Education, and

Outer Islands Health Care System in monitoring and evaluation for these children, and better access to service.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Quarterly site visits for those children and families who reside on the outer islands through Outreach Mobile Team.	X		X	
2. Twenty four atolls were visited for follow-up with CSHCN in coordination with health assistants at Outer Islands Health Centers. We also provide on-site training for the health assistants on caring for CSHCN and how guide them on referral system.	X		X	
3. Services is being coordinated among the MCH Program Service, Ministry of Education, and Outer Islands Health Care System in monitoring and evaluation for these children, and better access to service.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2011:

1. Quarterly visits to outer islands.
2. Provide on-site training for health assistants residing on these atolls/islands.
3. Coordinate and collaborate with MOH, MOE, other government agencies and NGOs.

c. Plan for the Coming Year

2013:

1. We will continue our activities from 2012 to 2013.
2. Strengthen our CSHCN program.

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	2007	2008	2009	2010	2011
----------------------	------	------	------	------	------

Performance Data					
Annual Performance Objective	91	93	95	65	70
Annual Indicator	54.2	60.7	61.1	61.1	55.9
Numerator	241	280	280	280	288
Denominator	445	461	458	458	515
Data Source		MCH program survey.	MCH program survey.	MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	60	65	70	75	80

a. Last Year's Accomplishments

2011:

1. Three of these children were referred to Special Education for further their education.
2. Two service providers' trainings done to strengthen the service delivery for these children and families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Three of these children were refer to Special Education for further their education.				X
2. Two service providers trainings done to strengthen the service delivery for these children and families.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. On-gong coordination and collaboration with Ministry of Education (MOE), so that the CSHCN can ready for higher education.
2. Increase by additional 2 trainings for service providers and parents of CSHCN for sign language and speech.

c. Plan for the Coming Year

2013:

1. Continue sign language training to improve communication between service providers and clients and families.

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	2007	2008	2009	2010	2011
Annual Performance Objective	73	95	95	95	95
Annual Indicator	82.0	88.1	89.0	84.1	71.2
Numerator	1649	1728	1621	1381	1207
Denominator	2010	1961	1821	1643	1695
Data Source		Immunization Logbook	National Immunization Program	National Immunization Program	National Immunization Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	80	80	85	85	90

Notes - 2011

There were 1,695 registered 19 to 35 months children into our Immunization System. Out of the 1,695 registered 19 to 35 months children, there were 1,207 fully immunized.

a. Last Year's Accomplishments

2011:

RMI National Immunization Program have been continuously providing services. In 2011, the

Immunization Rate was 71.2 % of 19-35 months received full immunization. There was a decrease in coverage by 15% in 2011.

There were 24 Atolls visited in 2011. But due to transportation and lack of staff to provide quarterly services to Outer Islands, Immunization program can only visit the atolls once or twice a year. By November and December, the boat can't travel to Outer Islands due to rough sea. MOH uses its own boat or hire public boat to drop outreach mobile team from one Atoll to another. Air Marshall Islands experience technical problems most of the time. AMI is not reliable.

IT Department and Immunization Program conducted an data assessment for 19-35 months for 2011. We have updated our Immunization Information System. There are an estimated 200 children that we need to find the location.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Immunization Rate was 71.2 % of 19-35 months received full immunization.			X	X
2. We have visited 24 Atolls in 2011 to provide immunization services.	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2011:

1. Daily Immunization Walk in clinic.
2. Outreach clinics for better access to service.
3. Up-date immunization status by increasing numbers of outer islands trips, home visits, as well as community outreach asite from regular quarterly trips to provide and up-date immunization service.
4. Catch up campaign has been implemented this year from 7 years old below.
5. MOH is utilizing its own boat for transporting public health outreach teamsto these outer islands which is alternative to reach the Outer Islands.

c. Plan for the Coming Year

2011:

1. Continue with existing activities.
2. Provide Health Fairs and up-date children with their immunization vaccines.

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	2007	2008	2009	2010	2011
Annual Performance Objective	100	95	46	28	30
Annual Indicator	44.9	39.5	28.8	32.9	45.2
Numerator	92	79	52	60	85
Denominator	2050	2000	1803	1826	1882
Data Source		Health Planning.	Office of Health Planning & Statistics, MOH	Office of Planning, Policy, and Statistics	Office of Planning, Policy, and Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	40	40	38	38	38

Notes - 2011

There were 85 birth occurrence for 15-17 years old in RMI.

Majuro : 68

Ebeye: 11

Outer Islands: 6

Notes - 2009

Data for 15-17 years old female population came from EPPSO's Population Estimate of April 2009.

a. Last Year's Accomplishments

2011:

Teen pregnancy slightly increased. With this increased, more effort has taken place to decrease this problem.

MCH program like family planning services is included in the Outreach Mobile Team that visited 24 Outer Islands.

MCH Program provides family planning services in the public health clinic, health centers, and Youth to Youth in Health.

We also collaborated with women's organization for health talks about available family planning services and teen pregnancy.

We participated in health talks including teen pregnancy and family planning in different public events.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Program provides family planning services in the public health clinic, health centers, and Youth to Youth in Health.	X			
2. We also collaborated with women's organization for health talks about available family planning services and teen pregnancy.				X
3. MCH program like family planning services is included in the Outreach Mobile Team that visited 24 Outer Islands.	X			
4. We participated in health talks including teen pregnancy and family planning in different public events.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. More outreach activities into the community to reach for the youth who do not attend schools.
2. Hold Health Fairs in the community to talk about teen age pregnancy.
3. Outreach mobile visits to provide family planning services throughout the country.
4. Collaborate with the private and public schools for health talks/lectures about family planning services available and disadvantages of teen pregnancy.

c. Plan for the Coming Year

2013:

1. Continue the 2012 activities to 2013..
2. Strengthen the partnership with NGOs, youth groups, and faith based, etc.

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	2007	2008	2009	2010	2011
Annual Performance Objective	85	90	85	70	75
Annual Indicator	64.2	85.3	68.4	70.5	75.1
Numerator	1355	1800	512	589	638
Denominator	2110	2110	748	835	849
Data Source		MOH	Dental Program	Dental Program	Dental Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	77	77	79	79	81

Notes - 2011

Dental Program have visited 9 elementary schools.

Notes - 2009

We don't have dental hygienist in Ebeye in FY 2009, so school dental services was provided by limited staff in staff so it was a challenge for Ebeye staff, plan to increase trained dental staff for is currently in place. Also, we encountered problems in our local airline. Most of the time, flights were cancelled due to airplane problem so dental services to outer islands slowed down in 2009 and due to transportation problem, NPM #09 was slightly lower than 2008, but this covered the RMI data.

a. Last Year's Accomplishments

Data shown improvement, but there is still need to bring up our number of children third grade, to receive protective sealants on at least one permanent morlar tooth.

We have provided protective sealants to 638 third grade students. Proper tooth brushing and nutrition education has been provided.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We have provided protective sealants to 638 third grade students.	X			
2. Proper tooth brushing and nutrition education has been provided.	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012

1. Continue to school outreach for the third grader.
2. Education on oral health in the school hand book.
3. Oral Health screening at school entry.
4. Hold public education to give more access of oral health information to public.

c. Plan for the Coming Year

2013:

1. Continue with existing activities.
2. Enforce complete dental check up before entry into schools third graders.
3. Continue outer islands trips to reach the school in the outer islands.
4. Strengthen 3rd grade dental visit by partnership with the schools for clinic visits or dental mission visits

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	2007	2008	2009	2010	2011
Annual Performance Objective	9	8	9	8	8
Annual Indicator	18.5	9.2	8.9	0.0	0.0
Numerator	4	2	2	0	0
Denominator	21597	21839	22582	22752	22877
Data Source		Medical Record.	Health Planning Office	Office of Health Planning, Policy, and Statistics	Office of Health Planning, Policy, and Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	7	7	6	6	6

a. Last Year's Accomplishments

2011:

Data shows improvement that RMI was able to achieved zero death. The Public Safety enforces the seat belt law. There is also road block every weekends to check on drunk drivers, seat belt violation and other road violation

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Public Safety enforces the seat belt law.			X	
2. There is also road block every weekends to check on drunk drivers, seat belt violation and other road violation			X	
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. Parents education on child safety.
2. Coordination with public safety for children safety on the road.
3. Collaborate with Disease Prevention and Health Promotion Unit for advertisement in newspaper, radio and tv on RMI road laws and regulations. We will also include public safety in our health talks.

c. Plan for the Coming Year

2013:

1. Continue to maintain at zero death by coordination with Public Safety, Schools, and MCH Program for all children 14 years and younger safety.

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	2007	2008	2009	2010	2011
Annual Performance Objective	75	98	98	93	90
Annual Indicator	91.9	93.1	92.3	87.4	90.2
Numerator	1644	1608	1781	1188	1317
Denominator	1788	1727	1930	1359	1460
Data Source		Nutrition Program	Nutrition Program	Well Baby Clinic	Well Baby Clinic
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016

Annual Performance Objective	92	92	92	92	92
------------------------------	----	----	----	----	----

a. Last Year's Accomplishments

Our well baby clinic continues to provide services to 2 years old children. We provide immunization, growth monitoring, nutrition and counseling during our well baby clinic. During the counseling, the mothers are encouraged to continue breastfeeding and provide nutrition baby food.

A Baby Friendly Hospital Initiative and Growth Monitoring workshop was conducted in 2011. There were 35 attendees. Consultants from Fiji and Philippines under WHO and UNICEF conducted the workshop. Staff from Majuro, Ebeye, and Outer Islands attended the workshop that was held in Majuro. Out of this training, a Baby Friendly Hospital Initiative Committee has been re-established to conduct the activities that were proposed during the training. Check list of activities includes:

1. Finalizing the policy
2. Training: training of 86 staff, training for community support group which involve men participants, training of mothers on proper breastfeeding, feeding, and pain control
3. Antenatal and Post Natal: awareness of the initiative during the prenatal.
4. Labor Ward: Initiation of breastfeeding within 30 minutes, initiate feeding and kangaroo care for preterm and special infants.
5. Post Natal: Educate on Express, cup, spoon feed to mothers and their companion, Educate Position and attachment to mothers and their companion, Refer all mothers to support group member, Educate mother on exclusive Breastfeeding for 6 months, Discourage formula milk feed in the ward, No advertisement in the ward,

This initiative will bring the mothers, father, the community, and Ministry of Health work together to provide health care for infants. Our aim is to have healthy children and low infant deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Our well baby clinic continues to provide services up to 2 years old children. We provide immunization, growth monitoring, nutrition and counseling includes encouraging breastfeeding.	X	X		
2. A Baby Friendly Hospital Initiative and Growth Monitoring workshop was conducted in 2011.				X
3. Baby Friendly Hospital Initiative Committee has been re-established to conduct the activities that were proposed during the workshop.				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Our well baby clinic continues to provide services to 2 years old children. We provide immunization, growth monitoring, nutrition and counseling during our well baby clinic.

1. The Baby Friendly Hospital and Breastfeeding Initiative Committee will continue the training of 86 staff, training for community support group which involve men participants, training of mothers on proper breastfeeding, feeding, and pain control
2. The committee is working on finalizing the Baby Friendly Hospital and Breastfeeding Initiative
3. Implementation of activities for Baby Friendly Hospital and Breastfeeding Initiative.
- 4 MCH Staff and Disease Prevention and Health promotion unit will collaborate for health education materials that will be used for health fairs to give more information on benefits of breastfeeding, proper nutrition, and healthy lifestyle.
5. Collaborate with community groups for their activities to reach MCH population on breastfeeding, proper nutrition, and healthy lifestyle.
6. With the SSDI grant, we are developing a life course performance metrics that will assist in measuring progress in incorporating life course principles into RMI-MCH systems of care for the MCH populations which include pregnant women from the start of their pregnancy.

c. Plan for the Coming Year

2013:

1. Continue the 2012 activities to 2013.
 - a. Well baby clinic is ongoing.
 - b. Continue Baby Friendly Hospital and Breastfeeding Initiative training.
 - c. Continue to implement of Baby Friendly Hospital and Breastfeeding Initiative policy.
 - d. Continue implementation of activities for Baby Friendly Hospital and Breastfeeding Initiative
 - e. MCH Staff and Disease Prevention and Health promotion unit will collaborate for health education materials that will be used for health fairs to give more information on benefits of breastfeeding, proper nutrition, and healthy lifestyle.
 - i. Collaborate with community groups for their activities to reach MCH population on breastfeeding, proper nutrition, and healthy lifestyle.
2. With SSDI grant, MCH Program will train key staff in Life Course Model. We will conduct workshops to orient and

develop staff skills in life course model. This life course model will help us in our patient management.

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	2007	2008	2009	2010	2011
Annual Performance Objective	30	35	35	40	50
Annual Indicator	0.0	0.0	0.0	46.3	66.9
Numerator	0	0	0	647	995
Denominator	1591	1526	1517	1396	1487
Data Source		Medical Record.	MCH	New Born Hearing Screening	New Born Hearing Screening
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes		
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	55	55	60	60	60

Notes - 2011

The data for the new born hearing screening is Majuro Hospital only. We haven't started our new born hearing screening in Ebeye Hospital.

Notes - 2010

New Born Hearing screening was started in May 2010 at Majuro Hospital only. In 2011, New Born Hearing Screening will be available in Ebeye Hospital.

Notes - 2009

RMI don't have newborn hearing screening test in 2009. We just started our newborn hearing screening in May 2010. However, after the starting of the newborn health screening program in late May 2010 and July 15, 2010, there was 64 Majuro Hospital births that only 55 of the births occurred in this period were screened for hearing problem. More data and information will be provided with FY 2011 reporting cycle.

a. Last Year's Accomplishments

2011:

The Newborn Hearing Screening was implemented for the first time in Majuro Hospital. In 2011, we have provided 995 received new born hearing screening before discharge from Majuro Hospital.

We have encountered a lot of challenges in implementing our new born hearing screening. In

2011, we were supposed to implement the New Born hearing screening in Ebeye Hospital. But unfortunately, Ministry of Finance who handles our grant funding failed to submit federal financial report on time which lead to restriction in draw downs. Procurement of supplies has also been a challenge. This impede the implementation of the new born hearing screening. Our consultant from University of Hawaii came and worked on a solution so that we can overcome our challenges. We worked on a contract with them so they can help in the implementation. But, our contract with University of Hawaii was pending for review in Attorney General's Office and Ministry of Finance for months.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We have provided 995 received new born hearing screening before discharge from Majuro Hospital.	X			
2. We have contracted technical assistance from University of Hawaii to help us in the implementation of New Born Hearing activities.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. Continue to conduct hearing Screening Tests for all babies born at Majuro Hospital before discharge.
2. Follow-up if missed the test before discharge at home within 1 week.
3. Work closely with our TA in University of Hawaii.

c. Plan for the Coming Year

2013:

1. Continue with existing activities with funds on hand.
2. Complete the contract with University of Hawaii in the three years project period.
3. Expand service to Ebeye Hospital.
4. Train Ebeye Hospital staff on new born hearing screening.

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	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	2	1	1
Annual Indicator	2.0	2.0	1.9	1.9	1.9
Numerator	500	500	500	500	500
Denominator	25050	25000	26259	26488	26748
Data Source		Health Planning.	Health Planning	Office of Health Planning, Policy & Statistics	Office of Health Planning and Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	1	1	1	1	1

Notes - 2009

In April 2009, the Economic Planning and Statistics Office released Population Estimate which is categorized in single age. 500 children of non-Marshallese reside in RMI. The RMI Universal Insurance Policy, all Marshallese are covered under this policy. However, this policy does not cover out-patient care, including medication costs, that means, it covers for all medical cost if a person is being referred out of island for medical treatment or care and has approved under the MOH Referral Guideline (if services/care/treatment is not available on island).

a. Last Year's Accomplishments

1. RMI maintained its Basic Health Insurance Plan for Marshallese population reside in the RMI.
2. Those with other medical health insurance is not known, because maybe none of came into the clinics for medical care during this period.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. RMI maintained its Basic Health Insurance Plan for Marshallese population reside in the RMI.				X
2.				
3.				
4.				

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

b. Current Activities

2011:

1. RMI Government requires that all government employee contribute certain percentage of base salary every pay-period.

c. Plan for the Coming Year

2013:

1. Continue with present activities/plans.

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	2007	2008	2009	2010	2011
Annual Performance Objective	10	15	0	0	0
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	5993	6117	6217	6301	6353
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

RMI is not eligible for WIC.

Notes - 2010

RMI is not eligible for WIC, therefore RMI report 0 for this NPM.

Notes - 2009

Under the Compact with the U.S.A., RMI does not eligible for WIC, therefore RMI report 0 for this NPM.

a. Last Year's Accomplishments

2011:

RMI does not eligible for WIC under the Compact of Free Associate with the U.S.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. RMI does not eligible for WIC under the Compact of Free Associate with the U.S				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

RMI does not have WIC Program, since it is not eligible under the Compact with the US.

c. Plan for the Coming Year

2013:

RMI does not have WIC under the Compact with the United States.

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	2007	2008	2009	2010	2011
Annual Performance Objective	100	2	2	2	2
Annual Indicator	2.5	2.6	2.7	2.0	2.0
Numerator	40	40	41	28	29
Denominator	1591	1526	1517	1396	1487
Data Source		Medical Records	MCH	MCH Program	MCH Program
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	2	2	2	2	2

Notes - 2009

In the last three months of pregnancy, data is being collected as part of the prenatal interview, so based on results from data collected, it was estimated that less than 3% still smoke at this stage. Counseling on dangers of smoking on both mother and her baby is provided for mother throughout her pregnancy and also at postpartum (6 weeks after delivery).

a. Last Year's Accomplishments

During prenatal clinics, MCH Program provided counselling on the dangers of smoking in pregnancy for both mothers and baby.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide counselling during prenatal clinics on the dangers of smoking in pregnancy for both mothers and baby.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. Provide health education regarding smoking in pregnancy during all MCH clinics, outreach, outer islands trips.
2. Provide information to the high schools regarding smoking.
3. Collaborate with Disease Prevention and Health Promotion Unit to advertise the dangers of smoking especially to pregnant women and the baby inside her womb.

c. Plan for the Coming Year

2013:

1. Continue to provide health education on smoking once monthly to the high schools, including school drop-outs.

2. Make educational materials available to the public on smoking.

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	2007	2008	2009	2010	2011
Annual Performance Objective	8	200	20	20	20
Annual Indicator	15.2	31.7	65.0	0.0	48.4
Numerator	1	2	4	0	3
Denominator	6568	6319	6152	6107	6202
Data Source		Health Planning.	Health Planning	Office of Health Planning, Policy & Statistics	Office of Health Planning, Policy & Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	40	40	30	30	30

Notes - 2011

There were 3 males who committed suicide by hanging. 2 are from Majuro and 1 from the Outer Islands. 2 - 19 years old and 1 - 16 years old.

Notes - 2009

RMI data shown here is based on per/1,000 total population 15-19 years old since RMI population in this age group is less than 10,000 as indicated in this NPM. RMI reported that only 4 suicide ages 15-19 were completed in 2009.

a. Last Year's Accomplishments

2011:

1. Data shows that there were three suicide death among youth ages 15-19 in the RMI. Human Services and Mental Health program have provided counseling to the family who were left behind.
2. More coordination and collaboration between health education and community, especially the youth and schoold drop-out.
3. Human Services and Mental Health program have provided health talks regarding suicide and family support.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. There were three suicide death among youth ages 15-19 in the RMI. Human Services and Mental Health program have provided counseling to the family who were left behind.	X			
2. Human Services and Mental Health program have provided health talks regarding suicide and family support.			X	
3. More coordination and collaboration between health education and community, especially the youth and schoold drop-out.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2011:

1. Outreach to provide counseling skills to the health providers reside in the outer islands.
2. Lectures in the high schools on suicide.
3. Use media (weekly radio/Marshall Islands New Paper) for information on suicide.

c. Plan for the Coming Year

2013:

1. Continue with present activities.
2. Include 4 additional training for youth, consisting of 25 participats to suicide issues and other issues related to suicide.

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	2007	2008	2009	2010	2011
Annual Performance Objective	0	1	1	60	65
Annual Indicator	0.0	0.0	0.9	1.5	1.1
Numerator	0	0	3	4	4

Denominator	12	18	350	267	355
Data Source		Health Planning.	Office of Health Planning & Statistics, MOH	Office of Health Planning, Policy & Statistics	Office of Health Planning, Policy & Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	2	2	2	1	1

Notes - 2011

We only have 2 hospitals which handles high risk deliveries.

Notes - 2010

RMI considered the two Urban Center of Majuro and Ebeye high risk facility. These urban centers have better equipments, trained staff, to provide high risk deliveries, and they are also considered, high risk facility.

Notes - 2009

RMI considered the two Urban Center of Majuro and Ebeye high risk facility. These urban centers have better equipments, trained staff, to provide high risk deliveries, and they are also considered, high risk facility. In 2009 on 17 babies were considered Very Low Births and 10 of this number (17) delivered at high risk facility.

a. Last Year's Accomplishments

2011:

The VLBW are from teenage mothers. We provide counseling after delivery regarding breastfeeding, proper nutrition, proper recuperation management, immunization, and family planning services available. The RH/MCH clinics have continued and expanded to included two more clinic sites for Majuro. These two clinic sites are to provide more and better access to the MCH services.

RMI don't have a high risk facility for deliveries and neonates. But data we entered are based on high risk mothers which deliver VLBW on our hospital. We are managing high risk pregnancy even though our hospital is not a high risk facility. Our Labor Ward prepares crash cart filled with medicine and supplies needed to provide service to high risk pregnancy. Labor Ward also alert Supervisor Nurse and Maternity Ward for high risk deliveries,

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We provide counseling after delivery regarding breastfeeding, proper nutrition, proper recuperation management, immunization, and family planning services available.	X			
2. Our Labor Ward prepares crash cart filled with medicine and supplies needed to provide service to high risk pregnancy.				X
3. Labor Ward also alert Supervisor Nurse and Maternity Ward for high risk deliveries,				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. Maintain RH/MCH existing expanded clinic sites.
2. Provide MCH information to the four public high schools in the RMI.
3. Continue to provide service to high risk pregnancy.
4. Continue to provide proper counseling.

c. Plan for the Coming Year

2013:

1. Carry on the existing activities.

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	2007	2008	2009	2010	2011

Annual Performance Objective	55	80	75	65	50
Annual Indicator	79.9	70.5	63.3	39.8	34.3
Numerator	1272	1076	961	556	510
Denominator	1591	1526	1517	1396	1487
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	50	55	60	65	70

Notes - 2009

The % of 1st visit was slightly lower in 2009 this maybe due to births decreasing and pregnancy women migrating out off the country.

a. Last Year's Accomplishments

We didn't meet our annual performance objective.

Pregnant mothers come in their second or third trimester. We did a radio spot regarding the benefits of prenatal care especially on the 1st trimester and availability of services. Our MCH Staff conducted outreach activities in Majuro, Ebeye, and Outer Islands.

We have provided full prenatal care services to pregnant mothers like STD/HIV testing, nutrition, counseling and laboratory tests.

We need to be more active in working with the community to promote early prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We did a radio spot regarding the benefits of prenatal care especially on the 1st trimester and availability of services.	X			
2. Our MCH Staff conducted outreach activities in Majuro, Ebeye, and Outer Islands.			X	
3. We have provided full prenatal care services to pregnant mothers like STD/HIV testing, nutrition, counseling and laboratory tests.	X		X	
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

2012:

1. MCH Nurses actively go out to the community to encourage women to attend prenatal clinic on their 1st trimester.

2. Before the end of the year, we will conduct pregnancy management training. With our outreach mobile visits to the Outer Islands, our MCH Nurses will continue to provide guidance and assistance to the health assistants for proper pregnancy management and referral of patients.

3. MCH Program will actively partner with Disease Prevention and Health Promotion Unit and community groups for health education on proper pregnancy management and benefits of prenatal care on the 1st trimester.

4. Regular radio call with Outer Islands Health Centers for follow up on the enrollment of pregnant women especially in the 1st Trimester of pregnancy.

5. With the SSDI grant, we are developing a life course performance metrics that will assist in measuring progress in incorporating life course principles into RMI-MCH systems of care for the MCH populations which include pregnant women from the start of their pregnancy.

c. Plan for the Coming Year

2013:

1. We will continue our activities from 2012 to 2013.
 - a. MCH Nurses actively go out to the community to encourage women to attend prenatal clinic on their 1st trimester.

 - b. Before the end of the year, we will conduct pregnancy management training. With our outreach mobile visits to the Outer Islands, our MCH Nurses will continue to provide guidance and assistance to the health assistants for proper pregnancy management and referral of patients.

 - c. MCH Program will actively partner with Disease Prevention and Health Promotion Unit and community groups for health education on proper pregnancy management and benefits of prenatal care on the 1st trimester.

 - d. Regular radio call with Outer Islands Health Centers for follow up on the enrollment of pregnant women especially in the 1st Trimester of pregnancy.

e. With the SSDI grant, we are developing a life course performance metrics that will assist in measuring progress in incorporating life course principles into RMI-MCH systems of care for the MCH populations which include pregnant women from the start of their pregnancy.

2. With SSDI grant, MCH Program will train key staff in Life Course Model. We will conduct workshops to orient and develop staff skills in life course model.

3. Develop assessment tool for current services being provided -- identify strengths and weaknesses

D. State Performance Measures

State Performance Measure 1: *To reduce the rates of sexually transmitted diseases among women of child bearing age*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					5
Annual Indicator		3.5	4.8	5.0	11.2
Numerator		227	336	421	413
Denominator		6511	7058	8434	3694
Data Source		Office of Health Planning, Policy, & Statistics			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	10	7	5	5	5

a. Last Year's Accomplishments

The STD Program conducted testing in the Public Health Clinics in Majuro and Ebeye. For Health Centers in the Outer Islands, outreach mobile team visited 24 Atolls. Outreach mobile team consists of different program in Public Health such as Immunization, STD/HIV, TB, Leprosy, MCH/Reproductive Health/Family Planning, Diabetes/Hypertension and Laboratory Services. There are 2 ways to reach Outer Islands; by local airplane and boat/ship. It is very expensive to conduct Outer Islands Outreach Mobile Visit. We make sure that the services or programs are complete whenever we mobilize teams.

In 2011, there are 413 positive female cases from 15-44 years old. A total of 3,694 tests were done.

Below is the details of the 413 cases:

Syphilis: 106 cases/821 tests

Gonorrhea: 37 cases/394 tests

Chlamydia 239 cases/396 tests

HIV: There were 1672 tests. There were 5 HIV female patients. They were diagnoses from previous years. We included these 5 patients in the count of positive female in child bearing age.

Hepatitis B: 26 cases/411 tests.

Each positive case is treated and counseled. Contact tracing was also conducted for their partner/s. We conduct mandatory tests pregnant women attending prenatal clinics, TB patients, high school and college students, and medical clearance for employment.

Our Public Health Nurses and STD Physicians provide counseling and health education for positive and negative patients that come in the clinic and mobile team visits.

Disease Prevention and Health Promotion Unit provided health education in the community, schools, and churches.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. STD/HIV Screening for child bearing age - We conduct mandatory tests pregnant women attending prenatal clinics, TB patients, high school and college students, and medical clearance for employment. Self referral for testing was also tested.	X			
2. Our Public Health Nurses and STD Physicians provide counseling and health education for positive and negative patients that come in the clinic and mobile team visits.	X	X		
3. Contact tracing of partners for positive cases	X			
4. Provided Health education in the community, schools, and churches		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

Our aims for this SPM:

- a. To provide treatment as soon as possible to those who are tested positive.
- b. To provide counselling and health education for prevent spreading of STD/HIV
- c. To decrease or eliminate infant death and stillbirth caused by STD/HIV.

Activities for 2012:

1. We will continue to conduct mobile team visits to the Outer Islands to regularly tests females and their partners for STD/HIV.
2. We are still providing regular clinic in Youth to Youth in Health. Reproductive Health and Family Planning services are offered in the MCH Clinic in Youth to Youth in Health. With this program, we are able to reach the teenagers and adolescents who are shy to go to the regular clinic in Public Health.
3. Partner with Disease Prevention and Health Promotion Unit to provide media campaign on STD/HIV testing and prevention.
4. Collaborate with community groups for any activities that we can provide STD/HIV awareness.

c. Plan for the Coming Year

2013:

Continue with the current activities.

1. We will continue to conduct mobile team visits to the Outer Islands to regularly tests females and their partners for STD/HIV.
2. We will still provide regular clinic in Youth to Youth in Health. Reproductive Health and Family Planning services are offered in the MCH Clinic in Youth to Youth in Health. With this program, we are able to reach the teenagers and adolescents who are shy to go to the regular clinic in Public Health. Refer all patients that need updated STD/HIV Testing.
3. Partner with Disease Prevention and Health Promotion Unit to provide media campaign on STD/HIV testing and prevention.
4. Collaborate with community groups for any activities that we can provide STD/HIV awareness.

State Performance Measure 2: *To reduce the maternal mortality rate*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					0
Annual Indicator		0.0	2.6	1.4	1.3
Numerator		0	4	2	2
Denominator		1526	1517	1396	1487
Data Source		Office of Health Planning,			

		Policy & Statistics	Policy & Statistics	Policy & Statistics	Policy & Statistics
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

In FY2011, there were 2 maternal deaths. The 1st case was a 34 years old that died because of disseminated intravascular coagulation and amniotic fluid embolism. Second is a 43 years old that died because of amniotic fluid embolism with term pregnancy. In FY 2010, we have 2 maternal deaths. Post partum hemorrhage and retained placenta are the causes of death for the two maternal deaths. One died in Majuro Hospital which is a 23 year old pregnant woman and the other one died in Outer Islands which is a 35 year old pregnant woman. In FY 2009, we have 4 maternal deaths. Preeclampsia, post partum hemorrhage, obstructive labor and gestational hypertension are the causes of these 4 maternal deaths.

a. Last Year's Accomplishments

2011:

In FY2011, there were 2 maternal deaths. The 1st case was a 34 years old that died because of disseminated intravascular coagulation and amniotic fluid embolism. Second is a 43 years old that died because of amniotic fluid embolism with term pregnancy. The two maternal deaths happen in Majuro Hospital. QA Nurse and Chief Nurse conducted meetings with Labor Ward and Maternity Ward for corrective actions. QA nurse conduct survey quarterly to assess the services of Labor and Maternity Ward in providing patient care.

We have provided prenatal care to 1,374 pregnant mothers out of 1,487 births.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We have provided prenatal care to 1,374 pregnant mothers out of 1,487 births.	X			
2. QA Nurse and Chief Nurse conducted meetings with Labor Ward and Maternity Ward for corrective actions.				X
3. QA nurse conduct survey quarterly to assess the services of Labor and Maternity Ward in providing patient care.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

In the last five years, the RMI have maternal deaths which were preventable. Priority will be placed on improving the health care of pregnant women to avoid maternal death. Detection of high risk pregnancy will be increased.

1. All Maternal and Child Health clinical staff will have training on high risk pregnancy management.
2. All high risk pregnant women will be enrolled in the High Risk clinic and managed appropriately.
3. MCH Nurses actively go out to the community to encourage women to attend prenatal clinic on their 1st trimester.
4. Before the end of the year, we will conduct pregnancy management training. With our outreach mobile visits to the Outer Islands, our MCH Nurses will continue to provide guidance and assistance to the health assistants for proper pregnancy management and referral of patients.
5. MCH Program will actively partner with Disease Prevention and Health Promotion Unit and community groups for health education on proper pregnancy management.
5. Regular radio call with Outer Islands Health Centers for follow up on high risk pregnancy referrals.
6. With the SSDI grant, we are developing a life course performance metrics that will assist in measuring progress in incorporating life course principles into RMI-MCH systems of care for the MCH populations which include pregnant women from the start of their pregnancy.

c. Plan for the Coming Year

2013:

1. We will continue our activities from 2012 to 2013.
 - a. All Maternal and Child Health clinical staff will have training on high risk pregnancy management.
 - b. All high risk pregnant women will be enrolled in the High Risk clinic and managed appropriately.
 - c. MCH Nurses actively go out to the community to encourage women to attend prenatal clinic on their 1st trimester.
 - d. We will continue to conduct pregnancy management training. With our outreach mobile visits to the Outer Islands, our MCH Nurses will continue to provide guidance and assistance to the health assistants for proper pregnancy management and referral of patients.
 - e. MCH Program will actively partner with Disease Prevention and Health Promotion Unit and community groups for health education on proper pregnancy management.
 - f. Regular radio call with Outer Islands Health Centers for follow up on high risk pregnancy referrals.
2. With SSDI grant, MCH Program will train key staff in Life Course Model. We will conduct workshops to orient and develop staff skills in life course model.

3. Develop assessment tool for current services being provided -- identify strengths and weaknesses

State Performance Measure 3: *To reduce the infant mortality rate*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					24
Annual Indicator		30.8	25.7	22.2	22.9
Numerator		47	39	31	34
Denominator		1526	1517	1396	1487
Data Source		Office of Health Planning, Policy & Statistics			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	22	20	18	16	15

Notes - 2011

In FY2011, there were 24 infant deaths in Majuro, 3 infant deaths in Ebeye, and 7 infant deaths in the Outer Islands. The top 5 leading cause of death for infant deaths are premature, malnutrition, pneumonia, asphyxia/sepsis, and gastroenteritis/drowning.

a. Last Year's Accomplishments

2011:

For this year, we have 22.9 infant deaths per 1,000 live births. Based on our annual performance objective, we have met our objective. But we still have high infant mortality rate.

Prematurity is the leading cause of infant death. Other causes of infant deaths are pneumonia, milk aspiration, congenital abnormalities, malnutrition, birth asphyxia, sepsis, anemia, Meningococemia, and congenital heart disease.

The IMR remains high. Prematurity is one of the causes of infant mortality which is linked to the health of the mother. In 2011, we have initiated the presumptive treatment of Chlamydia for prenatal users and their partners. There were 318 clients received this treatment in Ebeye STD Program in collaboration with MCH Clinic . Majuro MCH Program and STD Program will start the presumptive treatment in 2012. Training for staff in Majuro was initiated in 2011.

All pregnant women receive nutritional education from our OB-GYNs and MCH nurses. We still don't have a certified nutritionist. For Majuro, we only have 1 OB GYN that handles the prenatal clinic. We have provided prenatal care to 1,374 pregnant mothers out of 1,487 births. Well baby clinic is ongoing. Dental services, immunization, nutrition education, growth monitoring, and physical exams were included in the Well Baby Clinic. In the Maternity and Pediatric wards, breastfeeding is highly recommended.

A Baby Friendly Hospital Initiative and Growth Monitoring workshop was conducted in 2011. There were 35 attendees. Consultants from Fiji and Philippines under WHO and UNICEF conducted the workshop. Staff from Majuro, Ebeye, and Outer Islands attended the workshop that was held in Majuro. Out of this training, a Baby Friendly Hospital Initiative Committee has been re-established to conduct the activities that were proposed during the workshop. Check list of activities includes:

1. Finalizing the policy
2. Training: training of 86 staff, training for community support group which involve men participants, training of mothers on proper breastfeeding, feeding, and pain control
3. Antenatal and Post Natal: awareness of the initiative during the prenatal.
4. Labor Ward: Initiation of breastfeeding within 30 minutes, initiate feeding and kangaroo care for preterm and special infants.
5. Post Natal: Educate on Express, cup, spoon feed to mothers and their companion, Educate Position and attachment to mothers and their companion, Refer all mothers to support group member, Educate mother on exclusive Breastfeeding for 6 months, Discourage formula milk feed in the ward, No advertisement in the ward,

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We have initiated the presumptive treatment of Chlamydia for prenatal users and their partners. There were 318 clients received this treatment in Ebeye STD Program in collaboration with MCH Clinic .	X			
2. Majuro MCH Program and STD Program will start the presumptive treatment in 2012. Training for staff in Majuro was initiated in 2011.				X
3. All pregnant women receive nutritional education from our OB-GYNs and MCH nurses.	X			
4. We have provided prenatal care to 1,374 pregnant mothers out of 1,487 births.	X			
5. A Baby Friendly Hospital Initiative and Growth Monitoring workshop was conducted in 2011.				X
6. Baby Friendly Hospital Initiative Committee has been re-established to conduct the activities that were proposed during the workshop.				X

7. Well baby clinic is ongoing. Dental services, immunization, nutrition education, growth monitoring, and physical exams were included in the Well Baby Clinic.	X			
8.				
9.				
10.				

b. Current Activities

2012:

1. Chief Nurse and Asst. Chief Nurse for training and development continuously provide assistance and guidance with Labor, Maternity and Pediatric ward for improved health care in their respective wards to avoid infant deaths.
2. All MCH staff, Labor Ward, Maternity Ward, Pediatric Ward, and Health Assistants will have training update on pregnancy management, delivery, and new born management.
3. Well baby clinic is ongoing as well as post-partum clinic.
4. Currently, 2 Perinatal Committee meetings have been held to discuss perinatal issues and infant death causes. Committee is composed of OB-GYN, Maternity and Labor Ward staff, Pediatricians, and MCH staff.
5. Baby Friendly Hospital and Breastfeeding Initiative Committee will start its community training this year.
6. Baby Friendly Hospital and Breastfeeding Initiative will finalize the policies within the year.
7. Implementation of activities for Baby Friendly Hospital and Breastfeeding Initiative
8. MCH Staff and Disease Prevention and Health promotion unit will collaborate for health education materials that will be used for health fairs and school tour regarding teen pregnancies and the effect on infant mortality rate
9. Continue to provide immunization.
10. With a CDC funding, we will implement a vital records information system in Ebeye Hospital that is connected in the main server in the Ministry of Health in Majuro. This will help us in the challenges that we face in submission of late birth and death cert.

c. Plan for the Coming Year

2013:

1. Continue the 2012 activities to 2013.
 - a. Chief Nurse and Asst Chief Nurse for training and development continuously provide assistance and guidance with Labor, Maternity and Pediatric ward for improved health care in their respective wards to avoid infant deaths.
 - b. All MCH staff, Labor Ward, Maternity Ward, Pediatric Ward, and Health Assistants will have training update on pregnancy management, delivery, and new born management.
 - c. Well baby clinic is ongoing as well as postpartum clinic.
 - d. Continue Baby Friendly Hospital and Breastfeeding Initiative training.
 - e. Implementation of Baby Friendly Hospital and Breastfeeding Initiative policy.
 - f. Implementation of activities for Baby Friendly Hospital and Breastfeeding Initiative
 - g. MCH Staff and Disease Prevention and Health promotion unit will collaborate for health education materials that will be used for health fairs and school tour regarding teen pregnancies and the effect on infant mortality rate
 - h. Continue to provide immunization.

i. Collaborate with community groups for their activities to reach MCH population on proper management of infant and healthy lifestyle.

2. With SSDI grant, MCH Program will train key staff in Life Course Model. We will conduct workshops to orient and develop staff skills in life course model. This life course model will help us in our patient management.

State Performance Measure 4: *To increase the percentage of teenage (15-17 years old) acceptors of modern contraception*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					30
Annual Indicator		1.9	3.4	2.3	2.0
Numerator		72	124	86	77
Denominator		3717	3677	3736	3871
Data Source		Office of Health Planning, Policy, & Statistics	Office of Health Planning, Policy, & Statistics	Office of Health Planning, Policy, & Statistics	MCH Program/OHPPS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	10	10	15	15	20

a. Last Year's Accomplishments

2011:

We still have low users of contraceptives on 15-17 years old.

Family Planning Clinics in Ebeye, Majuro and Health Centers in the Outer islands provide family planning services.

Youth to Youth in Health coordinates in our MCH Office in reaching the teenagers. MCH Program have a regular clinic at Youth to Youth in Health. MCH Nurses and Physician provide counseling and contraceptives to youth visiting the clinic.

Condoms are also available in all hotels, Youth to Youth in Health, restaurants, bars/clubs, health centers, and family planning clinics for free.

With the low outcome of users, we are looking into problem in recording and reporting. Our main system is in Majuro. Ebeye Family Planning Clinic and Health Centers in the Outer Islands send

their records to Majuro for data entry. But there is always delay in submission especially in Outer Islands Health Centers. We are going to address this problem in 2012.

We have also provided health education in the school concentrating on teen pregnancy and family planning.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Clinics in Ebeye, Majuro and Health Centers in the Outer islands provide family planning services.	X			
2. Youth to Youth in Health coordinates in our MCH Office in reaching the teenagers. MCH Program have a regular clinic at Youth to Youth in Health. MCH Nurses and Physician provide counseling and contraceptives to youth visiting the clinic.	X	X		
3. Availability of condoms in all hotels, Youth to Youth in Health, restaurants, bars/clubs, health centers, and family planning clinics for free.	X			
4. We have also provided health education in the school concentrating on teen pregnancy and family planning.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. Well baby clinic is ongoing.
2. Baby Friendly Hospital and Breastfeeding Initiative Committee will start its community training this year.
3. Baby Friendly Hospital and Breastfeeding Initiative will finalize the policies within the year.
4. Implementation of activities for Baby Friendly Hospital and Breastfeeding Initiative
5. MCH Staff and Disease Prevention and Health promotion unit will collaborate for health education materials that will be used for health fairs regarding the advantages of breastfeeding, proper nutrition, and healthy lifestyle.

c. Plan for the Coming Year

2013:

1. We will continue to implement our activities from 2012 to 2013.
 - a. Coordinate outreach activities with the zone nurses in Majuro and Ebeye.
 - b. We are bringing Family Planning services to the Outer Islands through Outreach Mobile Visits. In every Outreach Mobile visits, MCH Program is included. We bring supplies of contraceptives to the Outer Islands. Our MCH staff work with the health assistants for coordination and update of family planning services.
 - c. We will provide lectures in all public high schools and 2 private high schools. This project will be a regular event. Strengthen our school health activities.
 - d. We will continue to provide access of family planning services to teenagers through Youth to Youth in Health Clinics and Laura Clinic.
 - e. Maintain proper recording and reporting. We will provide regular trainings and meetings to assess our progress, success and challenges.
 - f. We will continue to collaborate with Disease Prevention and Health Promotion Unit for the awareness of Family Planning services and status and risk of teen pregnancy. We will work with Youth to Youth in Health to reach the youth population by creating a play and radio spots about teen pregnancy and available family planning services that the Ministry of Health provides.

State Performance Measure 5: *To increase the percentage of mothers who breastfeed their newborns at 12 months after delivery.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					82
Annual Indicator		84.1	80.2	80.6	82.0
Numerator		483	369	311	493
Denominator		574	460	386	601
Data Source		Well Baby Clinic	Well Baby Clinic	Well Baby Clinic	Well Baby Clinic
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	82	85	85	87	87

a. Last Year's Accomplishments

Our well baby clinic continues to provide services to 2 years old children. We provide immunization, growth monitoring, nutrition and counseling during our well baby clinic.

A Baby Friendly Hospital Initiative and Growth Monitoring workshop was conducted in 2011. There were 35 attendees. Consultants from Fiji and Philippines under WHO and UNICEF conducted the workshop. Staff from Majuro, Ebeye, and Outer Islands attended the workshop that was held in Majuro. Out of this training, a Baby Friendly Hospital Initiative Committee has been re-established to conduct the activities that were proposed

during the training. Check list of activities includes:

1. Finalizing the policy
2. Training: training of 86 staff, training for community support group which involve men participants, training of mothers on proper breastfeeding, feeding, and pain control
3. Antenatal and Post Natal: awareness of the initiative during the prenatal.
4. Labor Ward: Initiation of breastfeeding within 30 minutes, initiate feeding and kangaroo care for preterm and special infants.
5. Post Natal: Educate on Express, cup, spoon feed to mothers and their companion, Educate Position and attachment to mothers and their companion, Refer all mothers to support group member, Educate mother on exclusive Breastfeeding for 6 months, Discourage formula milk feed in the ward, No advertisement in the ward,

This initiative will bring the mothers, father, the community, and Ministry of Health work together to provide health care for infants. Our aim is to have healthy children and low infant deaths.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Our well baby clinic continues to provide services up to 2 years old children. We provide immunization, growth monitoring, nutrition and counseling includes encouraging breastfeeding.	X	X		
2. A Baby Friendly Hospital Initiative and Growth Monitoring workshop was conducted in 2011.				X
3. Baby Friendly Hospital Initiative Committee has been re-established to conduct the activities that were proposed during the workshop.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Our well baby clinic continues to provide services to 2 years old children. We provide immunization, growth monitoring, nutrition and counseling during our well baby clinic.

1. The Baby Friendly Hospital and Breastfeeding Initiative Committee will continue the training of 86 staff, training for community support group which involve men participants, training of mothers on proper breastfeeding, feeding, and pain control
2. The committee is working on finalizing the Baby Friendly Hospital and Breastfeeding Initiative

- 3. Implementation of activities for Baby Friendly Hospital and Breastfeeding Initiative.
- 4 MCH Staff and Disease Prevention and Health promotion unit will collaborate for health education materials that will be used for health fairs to give more information on benefits of breastfeeding, proper nutrition, and healthy lifestyle.
- 5. Collaborate with community groups for their activities to reach MCH population on breastfeeding, proper nutrition, and healthy lifestyle.
- 6. With the SSDI grant, we are developing a life course performance metrics that will assist in measuring progress in incorporating life course principles into RMI-MCH systems of care for the MCH populations which include pregnant women from the start of their pregnancy.

c. Plan for the Coming Year
2013:

- 1. Continue the 2012 activities to 2013.
 - a. Well baby clinic is ongoing.
 - b. Continue Baby Friendly Hospital and Breastfeeding Initiative training.
 - c. Continue to implement of Baby Friendly Hospital and Breastfeeding Initiative policy.
 - d. Continue implementation of activities for Baby Friendly Hospital and Breastfeeding Initiative
 - e. MCH Staff and Disease Prevention and Health promotion unit will collaborate for health education materials that will be used for health fairs to give more information on benefits of breastfeeding, proper nutrition, and healthy lifestyle.
 - i. Collaborate with community groups for their activities to reach MCH population on breastfeeding, proper nutrition, and healthy lifestyle.
- 2. With SSDI grant, MCH Program will train key staff in Life Course Model. We will conduct workshops to orient and develop staff skills in life course model. This life course model will help us in our patient management.

State Performance Measure 6: *To increase the percentage of mothers who receive nutrition counseling during prenatal care.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	100	100	75	80	96
Annual Indicator	79.9	70.5	100.0	95.3	92.4
Numerator	1272	1076	1537	1309	1374
Denominator	1591	1526	1537	1373	1487
Data Source		RH Clinics	RH Clinics	RH Clinics	RH Clinics
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	93	93	95	95	96

a. Last Year's Accomplishments

2011:

There were 1,487 births that occur in 2011. 92.4% of them receive nutrition counseling. Nutrition counseling is part of the prenatal care that we are providing the pregnant mothers. Currently, we don't have a certified nutritionist. Our MCH Nurses and Physicians provide the nutrition counseling. For those attending prenatal care, they were given nutrition counseling. The remaining 7.6% that gave birth didn't visit the prenatal clinics during their pregnancy.

For Health Centers in the Outer Islands, outreach mobile team visited 24 Atolls. Outreach mobile team consists of different program in Public Health such as Immunization, STD/HIV, TB, Leprosy, MCH/Reproductive Health/Family Planning, Diabetes/Hypertension and Laboratory Services. There are 2 ways to reach Outer Islands; by local airplane and boat/ship. It is very expensive to conduct Outer Islands Outreach Mobile Visit. We make sure that the services or programs are complete whenever we mobilize teams. MCH Program included in the mobile team collaborates with the health assistants to gather the pregnant women for prenatal care during the visits. MCH Program also provides additional information to health assistants on proper nutrition. Upon checking high risk pregnancy, health assistants were advised to refer patients to the 2 main hospitals for delivery.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. There were 1,487 births that occur in 2011. 92.4% of them receive nutrition counseling.	X			
2. For those attending prenatal care, they were all given nutrition counseling.	X			
3. For Health Centers in the Outer Islands, outreach mobile team visited 24 Atolls. MCH Program included in the mobile team collaborates with the health assistants to gather the pregnant women for prenatal care during the visits.	X		X	
4. MCH Program also provides additional information to health assistants on proper nutrition.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. We will continue to provide nutrition counseling and healthy lifestyle to all pregnant women.

2. MCH Nurses are working with the community to bring pregnant women to the prenatal clinic as early as possible.
3. MCH Program is included in the Outreach Mobile Team visits to the Outer Islands to provide prenatal services and other MCH services.
4. We are working with the Outer Islands program for the training on MCH services of health assistants that come to Majuro for site visits.
5. MCH Program will collaborate with Disease Prevention and Health Promotion Unit for health education materials that we can publish in the newspaper and announce in the local radio program.

c. Plan for the Coming Year

2013:

1. We will continue the activities from 2012 to 2013.
2. In the life course model training, prenatal care and nutrition will be included in the training session.
3. We will strengthen our prenatal services to have a better outcome of bringing pregnant women in their 1st trimester.

State Performance Measure 7: *To increase 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	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	30	35	20
Annual Indicator	9.9	20.2	20.7	18.8	14.2
Numerator	1153	2351	2624	2391	1807
Denominator	11594	11642	12685	12690	12690
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	16	20	28	30	33

a. Last Year's Accomplishments

2011:

Pap smear test is our national standard for cervical cancer screening. The MCH Program provides pap smear testing in the Reproductive Health/Prenatal/Family Planning/Women's Health Clinic in Majuro and Ebeye. For Health Centers in the Outer Islands, outreach mobile team visited 24 Atolls. Outreach mobile

team consists of different program in Public Health such as Immunization, STD/HIV, TB, Leprosy, MCH/Reproductive Health/Family Planning, Diabetes/Hypertension and Laboratory Services. There are 2 ways to reach Outer Islands; by local airplane and boat/ship. It is very expensive to conduct Outer Islands Outreach Mobile Visit. We make sure that the services or programs are complete whenever we mobilize teams.

All pregnant women that attended the prenatal clinic received pap smear test. We have a good outcome with this MCH population. Under the 177 Primary Health Care Program which has a separate funding to provide services to the four atolls that were affected by the nuclear testing, they discontinue the Women's Health program temporarily because they have achieved their objective in testing the child bearing age in the 4 atolls. They will continue the Women's Health in 2013 or 2014. They have endorsed all patients that have abnormal pap smear which some of them turned out to be cervical cancer. With the discontinuation, it contributes to the decrease of pap smear test in 2011.

The RMI National Comprehensive Cancer Control Program (NCCCP) has established National Standard for 3 Cancers that we are prioritizing for cancer screening. One of the cancer is cervical cancer.

Below is the national standard information:

Core:

1. Screen with VIA (Visual Inspection with Acetic Acid)
2. Screen every 2 years between age 21-50 or 3 years after vaginal intercourse, which ever comes first
3. Referral for Pap test after abnormal lesions detected with VIA (until treatment with cryotherapy available)

Expanded:

1. Screen with VIA and treat with abnormal lesions with cryotherapy (single visit or two-step).
2. Ages 21-50, or 3 years after vaginal intercourse, which ever comes first, at least every 2 years

Desirable: Screen with Pap test

1. Screen every year between ages 21-50 or 3 years after vaginal intercourse, which ever comes first
2. Screen every 5 years after 3 consecutive normal test results
3. No further screening for:
 - a. Women age > 60 if no abnormal test in the preceding 10 years
 - b. Women with total hysterectomy if indication for removal was not related to treatment of cervical dysplasia
 - c. HPV DNA Testing

The NCCCP is working with University of Hawaii and CDC for the planning of a VIA training for Outer Islands Health Centers. VIA is a cost effective testing that can be easily done in the Outer Islands.

For those who have found with abnormal pap smear, they are referred to the Women's Health Clinic in Majuro and Ebeye. If found pap smear is found to be cancerous, the physician handling

the patients present patients to Medical Referral Committee. Medical Referral Committee assess the patients and refer to tertiary care in the Philippines or Tripler Hospital in Hawaii. If patients are referred using the Basic Referral, they will be given free health care including an escort that will take care of them.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH Program provides pap smear testing in the Reproductive Health/Prenatal/Family Planning/Women's Health Clinic in Majuro and Ebeye	X			
2. We also provided pap smear testing in the Outer Islands through the Outreach Mobile Team.	X			
3. All pregnant women that attended the prenatal clinic received pap smear test.	X			
4. The RMI National Comprehensive Cancer Control Program (NCCCP) has established National Standard for cervical cancer screening.			X	X
5. The NCCCP is working with University of Hawaii and CDC for the planning of a VIA training for Outer Islands Health Centers.				X
6. For those who have found with abnormal pap smear, they are referred to the Women's Health Clinic in Majuro and Ebeye.	X			X
7. If found pap smear is found to be cancerous, the physician handling the patients present patients to Medical Referral Committee for possible off island referral to a hospital capable of treating cervical cancer.				X
8.				
9.				
10.				

b. Current Activities

2012:

1. Continue to provide and perform pap smear tests for women in child bearing age, women beyond child bearing age up to 60 years old and as needed in the MCH Clinics in Majuro, Ebeye and Outer Islands.
2. The VIA training the trainers will be conducted this year. The NCCCP is bringing health assistants from the Outer Islands. Consultants are coming in August. The trained staff will provide training for those who won't be able to attend the training in August. This is funded through the cancer program grant.
3. MCH Program will collaborate with Disease Prevention and Health Promotion Unit and NCCCP for awareness on cervical cancer screening.
4. We will also collaborate with women's group for the improvement of number of women coming into the clinics for cervical cancer screening.

c. Plan for the Coming Year

2013:

1. We will continue with our activities from 2012 to 2013.
2. We will continue the VIA training for those who didn't attend on the 1st training in 2012.
3. Implement VIA training in the Health Centers.
4. Strengthen Cervical Cancer Screening. Implementation of National Cancer Screening guidelines.

State Performance Measure 9: *To decrease overweight and obese school children by 5% yearly.*

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					40
Annual Indicator		0.0	0.0	0.0	11.0
Numerator		0	0	0	222
Denominator		1	1	1	2019
Data Source		School Health	School Health	School Health	School Health
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	30	25	20	15	10

Notes - 2011

We have visited 5 schools and assessed 2,019 school children. BMI Screening in school started in 2011. There are more schools to cover.

Notes - 2010

This is a new State performance. We will conduct the BMI testing this coming school year.

Notes - 2009

This is a new State performance. We will conduct the BMI testing this coming school year 2011-2012.

a. Last Year's Accomplishments

Nutritional Health Status of Schoolchildren in Ebeye FY2011

On this fiscal year, comprehensive nutritional assessments were done on the school children by the Pediatrician.

Anthropometrics can be sensitive indicators of health, growth, and development in infants and children.

Anthropometrics is the single most universally applicable, inexpensive method available to assess the size, proportion, and composition of the human body. Meanwhile, it has now been well-established that the Body Mass

Index (BMI) is the most appropriate variable for nutritional status assessment among adolescents. All 2044

students were assessed for under-nutrition using the Waterlow Classification, while only 2019 of the 2044 were included in the BMI percentile assessment.

**BMI PERCENTILE NUTRITIONAL ASSESSMENT OF SCHOOLCHILDREN
FY2011 (By Percentage)**

Number of Children Assessed	Boys: 1040	Girls: 979	Total: 2019
Underweight (< 5th Percentile)	Boys: 5%	Girls: 2%	Total: 4%
Normal BMI (5th to 85th Percentile)/Healthy Weight	Boys: 86%	Girls: 84%	Total: 85%
Overweight or Obese (> 85th Percentile)	Boys: 9%	Girls: 14%	Total: 11%
Obese (> 95th Percentile)	Boys: 2%	Girls: 5%	Total: 2%

Around 4% of the students are underweight using BMI percentile -- that's 81 undernourished students. On the other hand, around 11% of the students are overweight with 2% of them obese -- that equates to 182 overweight and 40 obese children.

In 2011, Ebeye School Health Program conducted physical examination (PE) on 2,044 students out of the 2,064 total enrollees in Ebeye's 7 major schools. This comprised 99.03% of the targeted students for fiscal year 2011.

Five of the seven schools have 100% coverage rate. Through the annual physicals, acute and chronic health problems of the students are better addressed. On fiscal year 2011, 20.10% of students examined have essentially normal PE findings compared to 16.60% from the previous year. The three most common abnormal PE findings for the past three years remained basically the same: dental caries, cervical lymphadenopathies, and skin infections. Those with dental caries were referred for dental consultation. Minor skin infections, conjunctivitis, oral sores, ear infections, common colds, and respiratory tract infections were prescribed medications. Foreign bodies in the ear were likewise removed by the school physician. On this fiscal year, hundreds of students with dermatologic and ENT problems were referred during the Canvasback Mission for care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. There were 2019 of 2044 Ebeye students that undergo BMI Screening	X			
2. In 2011, Ebeye School Health Program conducted physical examination (PE) on 2,044 students out of the 2,064 total enrollees in Ebeye's 7 major schools.	X			
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

1. With collaboration with Disease Prevention and Health Promotion Unit and Taiwan Health Center, we are conducting BMI Screening in public and private schools in Majuro.
2. For the Outer Islands, MCH staff will work with the school teachers to conduct BMI Screening.
3. Disease Prevention and Health Promotion Unit is implementing the Health Promoting School. Health Promoting School projects coordinates with the principal on banning junk foods in the school canteen.
4. Ebeye Primary Health Care Service continues to implement its school health program.

c. Plan for the Coming Year

2013:

1. We will strengthen our school health program in Majuro and Outer Islands. For Ebeye, we will continue and improve the school health services that Ebeye Primary Health Care Services are providing.
2. Collaborate with Ministry of Education on the implementation of Healthy Promoting School, BMI screening, increase physical activity, and pres
3. We will conduct Life Course Model Training wherein proper nutrition and healthy lifestyle are included. We will include Ministry of Education on this training.

State Performance Measure 10: *To improve accessibility to the MCH/CSHCN services for children 0-21 and their families.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					90
Annual Indicator		83.9	86.9	84.5	79.2
Numerator		387	398	410	408
Denominator		461	458	485	515
Data Source		MHC Program	MHC Program	MHC Program	MHC Program
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	82	82	85	85	85

a. Last Year's Accomplishments

2011:

RMI provided health care services to 408 CSHCN and their families by giving them better access to MCH/CSHCN services through clinical services and outreach services. Outer Islands Health Assistants who extended their responsibilities to include services to CSHCN and their families. With these small islands (atolls) and islets far apart and distance from each other, it is difficult to reach them on times. These underlying atolls and islets can be reach only by field trip ships and take more than 24 hours to arrive on the farthest atoll of Ujelang located in the Ralik Chain in the RMI/ or plane by Air Marshall Islands (AMI). Not all the outer islands have air strips so most of

these information have been collected from Majuro, Ebeye, and most of the outer islands, but not all of them.

We have provided screening for any disabilities, follow up and monitoring of condition. We continue to provide service. We have referred 11 CSHCN patients to Shriners' Hospital, Tripler Hospital, and Philippines Hospital. All orthopedic CSHCN patients received service from Shriners' Hospital. Cleft Palate were referred to Tripler Hospital and Philippines Hospital.

Shriners' physicians and nurse came in September 2011 to provide screening for old and new patients. MCH Staff prepared the patients and other information prior to their visits.

For those referred to Shriners' and Tripler Hospital, they need to submit medical clearance for complete physical exam. If patients found to have TB or PPD test positive, they are referred to TB program for medical care and evaluation. Once TB program cleared out the patients, processing of referral starts again.

MCH Program Manager regularly communicates with Shriners' Hospital for patients referred, to be referred, and on going cases in the islands.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. RMI provided health care services to 408 CSHCN and their families by giving them better access to MCH/CSHCN services through clinical services and outreach services.	X			
2. Outer Islands Health Assistants who extended their responsibilities to include services to CSHCN and their families.	X			
3. We have referred 11 CSHCN patients to Shriners' Hospital, Tripler Hospital, and Philippines Hospital. All orthopedic CSHCN patients received service from Shriners' Hospital. Cleft Palate were referred to Tripler Hospital and Philippines Hospital.	X			
4. Shriners' physicians and nurse came in September 2011 to provide screening for old and new patients. MCH Staff prepared the patients and other information prior to their visits.	X			
5. MCH Program Manager regularly communicates with Shriners' Hospital for patients referred, to be referred, and on going cases in the islands.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. Provide more access services for those CSHCN and families who reside on the outer islands and far from the two urban centers.
2. Provide CSHCN services during outreach clinics.
3. Provide CSHCN screening on an annual bases by off islands visiting team (e.g. Shriners), etc.

c. Plan for the Coming Year

2013:

1. Carry-on presently existing activities.
2. Increase number of site visits for follow-up from quarterly to six times yearly.
3. Develop and implement mini survey to find out the present satisfaction status.

State Performance Measure 11: *To increase the percentage of mothers who access prenatal care in the first trimester of pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					50
Annual Indicator		70.5	63.3	39.8	34.3
Numerator		1076	961	556	510
Denominator		1526	1517	1396	1487
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	50	55	60	65	70

a. Last Year's Accomplishments

We didn't meet our annual performance objective.

Pregnant mothers come in their second or third trimester. We did a radio spot regarding the benefits of prenatal care especially on the 1st trimester and availability of services. Our MCH Staff conducted outreach activities in Majuro, Ebeye, and Outer Islands.

We have provided full prenatal care services to pregnant mothers like STD/HIV testing, nutrition, counseling and laboratory tests.

We need to be more active in working with the community to promote early prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. We did a radio spot regarding the benefits of prenatal care	X			

especially on the 1st trimester and availability of services.				
2. Our MCH Staff conducted outreach activities in Majuro, Ebeye, and Outer Islands.			X	
3. We have provided full prenatal care services to pregnant mothers like STD/HIV testing, nutrition, counseling and laboratory tests.	X		X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2012:

1. MCH Nurses actively go out to the community to encourage women to attend prenatal clinic on their 1st trimester.
2. Before the end of the year, we will conduct pregnancy management training. With our outreach mobile visits to the Outer Islands, our MCH Nurses will continue to provide guidance and assistance to the health assistants for proper pregnancy management and referral of patients.
3. MCH Program will actively partner with Disease Prevention and Health Promotion Unit and community groups for health education on proper pregnancy management and benefits of prenatal care on the 1st trimester.
4. Regular radio call with Outer Islands Health Centers for follow up on the enrollment of pregnant women especially in the 1st Trimester of pregnancy.
5. With the SSDI grant, we are developing a life course performance metrics that will assist in measuring progress in incorporating life course principles into RMI-MCH systems of care for the MCH populations which include pregnant women from the start of their pregnancy.

c. Plan for the Coming Year

2013:

1. We will continue our activities from 2012 to 2013.
 - a. MCH Nurses actively go out to the community to encourage women to attend prenatal clinic on their 1st trimester.
 - b. Before the end of the year, we will conduct pregnancy management training. With our outreach mobile visits to the Outer Islands, our MCH Nurses will continue to provide guidance and assistance to the health

assistants for proper pregnancy management and referral of patients.

c. MCH Program will actively partner with Disease Prevention and Health Promotion Unit and community groups for health education on proper pregnancy management and benefits of prenatal care on the 1st trimester.

d. Regular radio call with Outer Islands Health Centers for follow up on the enrollment of pregnant women especially in the 1st Trimester of pregnancy.

e. With the SSDI grant, we are developing a life course performance metrics that will assist in measuring progress in incorporating life course principles into RMI-MCH systems of care for the MCH populations which include pregnant women from the start of their pregnancy.

2. With SSDI grant, MCH Program will train key staff in Life Course Model. We will conduct workshops to orient and develop staff skills in life course model.

3. Develop assessment tool for current services being provided -- identify strengths and weaknesses

E. Health Status Indicators

Introduction

The Republic of the Marshall Islands (RMI) population estimate for 2009 is 54,065 based on the document released by Economic Policy, Planning, and Statistics Office as of April 2009. They considered the increase of migration out of Marshall Islands which was not calculated in the 1999 census.

//2012//

The Republic of the Marshall Islands (RMI) population estimate for 2011 is 54999 based on the document released by Economic Policy, Planning, and Statistics Office (EPPSO) as of April 2009. They considered the increase of migration out of Marshall Islands which was not calculated in the 1999 census.

In 2011, EPPSO conducted the RMI Census. They haven't released the result of the census. So for this reporting period, we will still use the estimated population that they released in April 2009.

//2012//

F. Other Program Activities

Public Health nurses implement all the primary health care programs for the Ministry. These same nurses travel to the outer islands in addition to supervising their assigned health zones in Majuro and Ebeye.

Immunization nurses must also work on weekends to do cold chain monitoring for vaccines stored in the Public Health clinics, receive shipments and to continue their zoning. The nurses are not compensated for the times they work during weekends. Furthermore, the nurses are the only ones trained in the cold chain monitoring of the vaccines and are responsible for packing them to be sent to the outer atolls on weekends.

Public health nurses work with the diabetes clinic, tb clinic, leprosy clinic, well baby clinic, and STIs clinic.

G. Technical Assistance

*/2013/ The MCH/CSHCN program will need TA in the areas specified in the the Form 15. There have been delayed with not cleared on the actual funds for MCH program, including Fiscal Year differences as well as utilizing of the MCH Block Grant Funds from our Ministry of Finance. The program is still having problem as to utilizing of this funds. The program suggested that there is need of TA regarding administration on MCH Block Grant and maybe it would be best if this TA come from HRSA staff managing the grant/2013/ ./2013//
//2013//*

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	252495	252495	252495		252495	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	189372	189372	189372		189372	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	441867	441867	441867		441867	
8. Other Federal Funds <i>(Line10, Form 2)</i>	1038724	1038724	971724		1154081	
9. Total <i>(Line11, Form 2)</i>	1480591	1480591	1413591		1595948	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	108907	108907	108907		108907	
b. Infants < 1 year old	86274	86274	86274		86274	
c. Children 1 to 22 years old	141811	141811	141811		141811	
d. Children with	79625	79625	79625		79625	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	25250	25250	25250		25250	
g. SUBTOTAL	441867	441867	441867		441867	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	0		0		65357	
c. CISS	0		50000		50000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		614349		0	
i. CDC	641349		0		641349	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
30+FP	297375		297375		297375	
CSAP	100000		10000		100000	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	123973	123973	123973		123973	
II. Enabling Services	90000	90000	90000		90000	
III. Population-Based Services	125250	125250	125250		125250	
IV. Infrastructure Building Services	102644	102644	102644		102644	
V. Federal-State Title V Block Grant Partnership Total	441867	441867	441867		441867	

A. Expenditures

The RMI Maternal and Child Health Services spent 100% of its funds. Forty nine percent of the total grant award was for personnel, RMI spent 20% on direct health care, 11% in enabling services and 10% on infrastructure building services. The allocation of the administration cost utilized is 10%. The RMI MCH/CSHCN spent the MCH Block Grant fund based on the components and 30-30-10 percent accordingly.

/2013/No change./2013//

B. Budget

Annual Budget and Budget Justification: The Block Grant funds will be used to provide and coordinate routine preventive and primary health care for mothers, infants, and children. The scope of these services includes prenatal care, including special high risk prenatal clinics;

postpartum care; well baby care, including immunization; high risk pediatric clinics; school health programs; coordination of family planning services; and provision or coordination of care for children with special health care needs.

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

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

Administrative Costs:

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

Administrative Cost \$25,249

- A. Personnel \$ -0-
- B. Fringe Benefits \$ -0-
- C. Travel \$ 20,000
- D. Equipment \$ -0-
- E. Supplies \$ -0-
- F. Contractual Services -0-
- G. Other \$ 5,249

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 up to 1 yr. \$75,749

A. Personnel \$ 39,600

A total of \$39,600 is budgeted for the continued support of the Program Director, and one MCH dental assistant. The program requires skilled and well-trained health profession staff to improve the delivery services to its target population throughout the Republic.

B. Fringe benefits \$ 4,356

A sum of \$4,356 has been set aside for fringe benefits to cover contributions to the Marshall Islands Social Security System, the national health care system insurance and other benefits to staff. The RMI Government fringe benefits are calculated as a rate of 11% of the total base salary.

C. Travel \$ 15,000

A sum of \$15,000 has been set aside to cover travel costs for the program director to attend the MCHB required, including travel that are within the program scope.

D. Equipments/computer \$ 7,134

A sum of \$7,134 has been set aside to cover purchase cost for a new computer to replace the old one that is no-longer function. It will be used to support the existing program data base system.

E. Supplies \$ 2,000

It is requested in the amount of \$2,000 to cover the cost for program daily operation needs, such as office supplies, computer needs.

Fuel \$2,659

Due to the rising of fuel cost, the amount of \$3,659 has been budgeted to cover the fuel for the program's vehicle to continue providing outreach services to the program population in the community in Majuro.

G. Communication \$2,000

H. Other Cost = \$3,000

It is requested in the

Component B: Children & Adolescents \$ 75,749

A. Personnel \$ 54,440

A total of \$54,440 has been budgeted for personnel to support for 1 health educator, 1 dental assistant, 2 nurses at AS Degree level and 1 counselor to continue the program service delivery for the MCH population throughout the Republic.

B. Fringe benefits \$5,988

A total of \$5,988 has set aside for fringe benefits to cover contribution to the Marshall Islands Social Security System, the national health care system insurance and other benefits to staff.

C. Travel \$6,526

This amount of \$6,526 is requested to cover domestic travel for the program staff to visit the outer islands to provide the service delivery to the MCH population reside in the outer islands.

D. Equipment/computer sets \$3,855

A total of \$3,855 has been budgeted to cover a computer set to replace the old one that is no longer in used. It is a need to replace this for the program data base/information system. This includes, all the needs to put up this new computer.

E. Supplies \$ 1,000

It is budgeted in the amount of \$1,000 to cover office supply cost, including other costs that maybe concerned the program daily operational needs.

F. Communication \$2,000

It is budgeted in the amount of \$2,000 to cover the communication cost, including other cost that may concern the program communication, such as phone, fax, e-mail, international call, cell cards, or replacement of office phone as needed.

G. Others \$ 1,940

This is budgeted in the amount \$1,940 to cover other costs need for the program use, such as maintenance/or repaired of program vehicle to keep it in good condition, and other related needs.

Component C: Children with Special Health Care Needs \$ 75,749

A. Personnel \$ 16,820

A sum of \$16,820 to is budgeted to support for 1 Coordinator for CSHCN (AS Degree level) to be able to provider the service better and to improve planning, mointoring and evaluation for component C (CSHCN).

B. Fringe Benefits \$ 1,850

A total of \$1,850 to cover the fringe benefits for the 2 component C (CSHCN) staff.

C. Travel \$ 48,955

- International = \$43,955

It is budgeted in the of \$43,955 to cover international travel for CSHCN, including one family escort outside the Republic for further medical care if the case is not able receive needed medical care or surgery on island. The case must present to the RMI Medical Ref. Committee and approve before proceed with any paper work-up.

- Demostic Travel = \$5,000 to cover the travel and per diem cost to bring patient and 1 family escort for each patient from the outer islands.

D. Equipment \$500

It is set aside in the amount of \$500 to support those CSHCN that really can not afford for equipments to help them in their daily activities, such wheel chairs, etc.

E. Medical Supplies \$ 200

It is requested in the amount of \$200 to cover the cost for supply for CSHCN, such as dressing supply, etc.

F. Commuicationl \$ 2,000

A sum of \$1,000 is budgeted to cover the service communication, such as phone, fax, e-mail, phone/and cell card that necessary to make the communication between CSHCN service coordinator/program director, and clients opens at all time to give more access to get services.

G. Fuel \$2,000

Due to increasing of fuel cost, it is requested here in the amount \$2,000 to cover fuel cost to be used for CSHCN service delivery in the RMI.

H. Printing \$200

It is budgeted in the amount of \$200 to cover the printing cost the translation of phamplet for CSHCN and family used.

I. Other \$3,224

A total amount of \$3,224 is budgeted to cover the cost for boat charter for CSHCN as needed as transportation/or boat charter is needed to bring them the where there is air strips to catch the plane to Majuro or Ebeye. To cover all other costs related to the service in terms of rental, this include car rental to be used during screening and outside consultants visiting to bring or transport clients from and back to their homes.

Administrative Cost \$ 25,249

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

MCH Budget(Federal and State Block Grant Partnership) \$441867

Total budget for FY 2013 \$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 FY2013 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 2013, 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 2013 is \$252,495 This amount is based on the Marshall Islands' FY 1989 Maintenance of Effort Amount of 175,745. The State Match for the MCH grant application is \$189,372.

Documentation of Fiscal Restrictions

The Republic of the Marshall Islands assures the Secretary of Health and Human Services that no more than 10% of the Title V funds will be used for administrative cost for the MCH Block Grant. The total amount will be used by the MOH Administration to: 1) attend 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 MCH 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.