Marshall Islands State Action Plan Table 2027 Application/2025 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Improve postpartum care and 12-week follow-up.	By FY2030, achieve ≥85% documented postpartum visits within 12 weeks through Marshall Islands Information System (MHIS) / Immunization Information System (WebIZ) across Majuro, Ebeye, and the Neighboring Islands.	Strengthen Postpartum Follow-Up tracking through MHIS/WebIZ to record visits Conduct community outreach for postpartum women through Zone Outreach Unit (ZOU) visits and the Reproductive Health clinic visits.	ESM PPV.1 - Percent of postpartum women recorded in MHIS/WebIZ as having a clinic visit within 12 weeks after delivery.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Increase cervical cancer screening among women ages 21–65 years.	By FY2030, at least 80% of RH clinics and outreach missions will submit quarterly cervical cancer screening service reports.	Integrate cervical cancer screening into routine RH and outreach services Strengthen reporting and data systems for cervical cancer screening	SPM ESM 3.1 - Percent of RH clinics and outreach missions reporting cervical cancer screening services quarterly.	SPM 3: Percent of women ages 21–65 years who received cervical cancer screening (Pap smear or HPV-DNA test) in the reporting year.	
Expand oral health services in pregnancy and early childhood.	By FY2030, at least 40% of pregnant women will receive a dental health screening or preventive service during pregnancy.	Integrate preventive oral health services into routine antenatal care for pregnant women in Majuro, Ebeye, and Neighboring Islands.	ESM PDV-Pregnancy.1 - Percent of pregnant women receiving a dental health screening or preventive service (clinic-based or through outreach).	NPM - Preventive Dental Visit - Pregnancy	**Linked NOMs:** Women's Health Status Children's Health Status
Improve postpartum care and 12-week follow-up.	By FY2030, achieve ≥85% documented postpartum visits within 12 weeks through Marshall Islands Information System (MHIS) / Immunization Information System (WebIZ) across Majuro, Ebeye, and the Neighboring	Strengthen postpartum follow-up systems and service delivery to ensure timely 12-week visits are provided and documented across Majuro, Ebeye, and the Neighboring Islands.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Percent of postpartum women who attend a clinic visit within 12 weeks	**Linked NOMs:** Maternal Mortality Infant Mortality

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	Islands.				
Perinatal/Infant Health					
Increase immunization and newborn care in the Neighboring Islands	By FY2030, at least 50% of infants from NIs will complete their 2-month immunizations by 8 weeks of age.	Use WebIZ and MHIS to track and follow up on immunization completion with the support of the Registry Data Unit (RDU). Conduct ZOU outreach visits to deliver immunization to children who missed follow-up appointments.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Percent of infants from Neighboring Islands (NIs) who received all recommended 2-month immunizations by 8 weeks of age.	
Expand access to breastfeeding education and support for mothers in Majuro, Ebeye, and the Neighboring Islands	• Increase the percentage of infants ever breastfed from 55.8% (2019 MCH-JS) to ≥75% • Increase exclusive breastfeeding to 6 months from 42.3% (2018 ICHNS) to ≥65%	trengthen facility-based breastfeeding support during antenatal, delivery, and postnatal care	ESM BF.1 - Breastfeeding counseling is integrated into all ANC, delivery, and postnatal visits, with documentation in MHIS. ESM BF.2 - Percent of health facilities (Majuro, Ebeye, NI outreach clinics) routinely providing breastfeeding support as part of ANC, delivery, and postnatal services.	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality
Child Health					
Expand oral health services in pregnancy and early childhood.	By FY2030, at least 50% of children in Majuro and Ebeye combined receive oral health screening through clinic visits and outreach, with expansion to Neighboring Islands as feasible.	Provide oral health screening and fluoride treatment during clinic visits and community outreach.	ESM PDV-Child.1 - Percent of children ages 1–17 years receiving preventive oral health screening through clinic or school visits (MHIS/Oral Health records).	NPM - Preventive Dental Visit - Child	**Linked NOMs:** Tooth decay or cavities Children's Health Status CSHCN Systems of Care

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			Inactive - *ESM PDV-Child.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.*		
Increase immunization and newborn care in the Neighboring Islands	By FY2030, at least 80% of planned NI immunization outreach missions will be completed and entered into WebIZ within 1 month of the mission.	Strengthen immunization outreach planning, delivery, and data reporting for Neighboring Islands to improve childhood vaccination coverage.	ESM VAX_Child.1 - Percent of planned NI immunization outreach missions completed and with data entered into WebIZ within 1 month of the visit.	NPM - Childhood Vaccination	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality Child Mortality Children's Health Status
Early identification and coordinated care for CSHCN	By FY2030, increase the percentage of children ages 0–17 years with a documented medical home in MHIS from the current baseline (MCH-JS 2025) to at least 50%.	Strengthen documentation and continuity of care for children across health facilities and outreach missions by embedding medical home fields into MHIS and routine child health visits.	ESM MH.1 - Percent of CSHCN identified in MHIS, ECD program registers, or Public School System Special Education registers who have a documented ongoing point of care (Majuro/Ebeye hospital or NI health facility) serving as their medical home.	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Adolescent Health					
Expand oral health services in pregnancy and early childhood.	By FY2030, increase the percentage of adolescents ages 12–17 who receive at least one preventive dental visit each year by 10%, documented in MHIS/Oral Health registers.	Integrate preventive oral health screening into adolescent health services delivered through school health programs, Youth-to-Youth clinics, and outreach missions.	ESM PDV-Child.1 - Percent of children ages 1–17 years receiving preventive oral health screening through clinic or school visits (MHIS/Oral Health records).	NPM - Preventive Dental Visit - Child	**Linked NOMs:** Tooth decay or cavities Children's Health Status CSHCN Systems of Care

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			Inactive - *ESM PDV-Child.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.*		
Improve adolescent access to sexual and reproductive health (SRH) services.	By FY2030, increase the percentage of adolescents ages 12–17 with a documented preventive medical visit from the current baseline (MCH-JS 2025) to at least 50%, using MHIS, RH clinic, and Youth-to-Youth registers as data sources.	Expand delivery and documentation of preventive adolescent health visits across clinic-based and outreach platforms, including RH and Youth-to-Youth clinics, Clinic Without Walls, and school health visits.	ESM AWV.1 - Percent of adolescent program participants (ages 12–21) receiving a documented preventive well-visit referral or completing a preventive visit through clinics, school health visits, or outreach missions. ESM AWV.2 - Percent of pregnant women receiving a dental health screening or preventive service (clinic-based, or through outreach) ESM AWV.3 - Percent of adolescent girls fully vaccinated for HPV by age 13 years through clinic and school-based services, or outreach services documented in WebIZ or RH clinic registers.	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Early	By FY2030, at least 50% of	Develop and adopt a working definition of CSHCN and medical home for	ESM MH.1 - Percent	NPM - Medical Home;	**Linked NOMs:**

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identification and coordinated care for CSHCN	identified CSHCN will have a documented medical home in Majuro, Ebeye, or NI health facilities.	the RMI context, to guide identification, tracking, and reporting. Conduct developmental screening during MCH clinic and ZOU outreach visits, recorded in MHIS and ZOU registers. Document children flagged during screening in the MHIS and ZOU registers for follow-up at future visits with the support of the RDU.	of CSHCN identified in MHIS, ECD program registers, or Public School System Special Education registers who have a documented ongoing point of care (Majuro/Ebeye hospital or NI health facility) serving as their medical home.	Medical Home_Personal Doctor; Medical Home_Family Centered Care; Medical Home_Usual Source of Sick Care	Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Cross-Cutting/Systems Building					
Improve adolescent access to sexual and reproductive health (SRH) services.	By FY2030, achieve at least 75% completion of all planned NI MCH outreach missions each year to ensure access to essential MCH services, including SRH, for adolescents and families in remote atolls.	Strengthen outreach planning, logistics, and coordination to ensure reliable delivery of MCH services in the Neighboring Islands. Action: - Ensure outreach missions include integrated adolescent SRH services (contraceptive counseling, HPV vaccination, RH education). - Track completed missions quarterly using ZOU logs and RDU verification. - Address barriers such as fuel shortages or transport breakdowns through contingency planning.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Percent of planned Neighboring Island (NI) MCH outreach missions completed in the reporting year.	