Maternal and Child Health Services Title V Block Grant

Marshall Islands

FY 2024 Application/ FY 2022 Annual Report

Created on 9/28/2023 at 9:42 AM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

REPUBLIC OF THE MARSHALL ISLANDS
OFFICE OF THE SECRETARY
MINISTRY OF HEALTH & HUMAN SERVICES
P.O. Box 16 ~ Majuro ~ Marshall Islands ~ 96960
Telephone No. (692) 625-5327 Ext: 2392/2388
Email:sechhs.rmi@gmail.com

7/27/23

HRSA Grant Application Center
ATTN: MCH Block Grant
901 Russell Avenue, suite 450
Gaithersburg, MD 20879

Dear Madam/Sir,

On behalf of the Ministry of Health and Human Services in the Republic of the Marshall Islands (RMI), MCH Program submits to your office the FY 2024 Title V Block Grant Application /FY 2022 Annual Report.

The Ministry of Health is grateful for this opportunity to provide a report on activities the program was able to provide to improve the health of mothers, children, adolescents, children with special health care needs.

Thank you for your continued support for the RMI MCH Program.

Sincerely,

Francyne W. Jacklick
Acting Secretary, MOHHS

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The mission of the Republic of Marshall Islands (RMI) Maternal and Child Health (MCH) Program is to promote and improve health and wellness of women, children, infants, children with special health care needs, adolescents, and families by providing quality preventive services. The RMI MCH Program Director manages the Title V Program, Children with Special Health Care Needs Program, and the Family Planning program. The MCH program coordinates with other Public Health (PH) programs, the States Systems Development Initiative (SSDI), as well as international partners such as, Centers for Disease Control and Prevention (CDC) United Nations International Children's Educational Fund (UNICEF), Early Childhood development (ECD), the United Nation's Population Fund (UNFPA), Early Hearing Detection Initiative (EHDI), and the World Health Organization (WHO) on program activities.

The RMI MCH is awarded $230,524.00 each year from the Title V MCH Services Block Grant. The MCH Program is among the eight programs under the Bureau of Primary Health Care Services (BPHCS), under the Ministry of Health and Human Services (MOHHS). Together with MCH state funds and other federal funds, the Title V MCH block grant is used to address RMI's priority needs, improve performance and expand systems of care for the MCH target population. Title V funds compliment the state plans in supporting healthcare for women and children by addressing gaps and priority needs which are not achieved by state funds or other federal funds. MCH continues to work with members of the MCH Needs Assessment Steering Committee to assess the impact of the strategies implemented towards addressing the priority needs of the target populations served. Focus groups discussions with the key stakeholders and selected people from the community and key in-depth interviews with the medical providers, and other program managers are also conducted to gather information in assessing the needs of the MCH target populations.

The ever-changing MCH target population demographics, emerging of new diseases, the change in health trends over-time, and the shift in program capacity influences the MCH program routine assessments of the needs of the MCH target population in RMI. In 2020, the MCH program in collaboration with Marshall Islands Epidemiology Initiative (MIEPI) and key stakeholders completed a 5-year comprehensive needs assessment which examined areas of priority and alignment between local MCH priority needs and the national Title V National Outcome Measures (NOMs) and National Performance Measures (NPMs). This assessment resulted in the identification of the NPMs in each of the five population health domains for programmatic focus over the 5-year cycle and development of State Performance Measures (SPMs) for priorities not addressed by NPMs. State priorities identified were aligned to the MOHHS wide strategic plan.

Priorities and Performance Measures Linkage

Priority	Performance Measures
Women and Maternal	
Improve women/maternal health through cancer screening, prenatal and family planning services	NPM 1: Percent of women ages 18 years through to 44 years old with a preventive medical visit in the past
	SPM 4: Percent of women ages 25-49 years old screened for cervical cancer
	SPM 6: Percent of women ages 15-44 years old who use Family planning services
Perinatal/Infant Health	
Improve perinatal/infant's health through adequate quality prenatal services and newborn screening	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months old.
	SPM 7: Percent of newborns that received the Congenital Hypothyroidism newborn screening
	SPM 8: Percent of newborn that received CMV screening.
	SPM 9: Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Child Health	
Parent-completed developmental screening tools	NPM 6: Percent of children, ages 9 months through to 35 months old, who received a developmental screening using a parent completed screening tool
	SPM 3: Increase percentage of fully immunized children ages 19 years through to –35 years old.
Adolescent Health	
Improve adolescent health through promotion of adolescent well-being and reducing teen pregnancy	NPM 10: Percent of adolescents ages 12 years through to 17 years with a preventive medical visit in the past year.
	SPM 5: Increase use of family planning services to teenagers ages 13 years though to 17 years old.
CSHCN	
Improve enrollment and special care of CSHCN through developmental screening and referrals to proper care	NPM 12: Percent of adolescents with and without special health care needs, ages 12 years through 17 years, who received services necessary to make transition to adult care.

The MCH block grant provides support to the RMI MOHHS MCH program activities through comprehensive, coordinated, and family-centered services (inclusive of children with special healthcare needs). These are also supported through decentralizing services through to the communities (clinic outreach, community awareness, family support services, case management/coordination), and transportation to and from Majuro, Ebeye and the Neighboring islands (NI) which also allows for referrals to Shriners for surgery and domestic referrals to the two main hospitals. These activities are coordinated through partnerships with local programs across systems that serve the MCH populations. Partners include Youth to youth in health, Women United together in the Marshall Islands, Ministry of Internal Affairs, Public School System and other non-profit and/or non-governmental organizations. These partnerships are critical in the MCH Bureau's efforts in expanding its reach for serving target groups and for

integrating services to support a comprehensive system of care for the women, children, and their families. With the COVID-19 pandemic, activities and services for the program were affected due to the staff being reassigned to assist in outreach activities for assessment, vaccination, and quarantine on Majuro, Ebeye and Neighboring Islands. The information submitted in the Marshall Islands Title V Block Grant Annual Report/Application reflects the efforts over the past year in implementing strategies identified in the State Action Plan to address RMI MCH Priorities across the five (5) health domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children with Special Healthcare Needs. The following is a summary of accomplishments during 2022, challenges, and plans for 2024.

Women/ Maternal Health

Priority: Improve women/maternal health through cancer screening, prenatal and family planning services.

Highlights:

- Continue partnership with Cancer Program to increase the rate of cervical cancer screening through after-hours clinics and patient navigation. Increase the number of women detected with abnormal pap smears and referred for tertiary care for immediate treatment.
- Continue to provide education and awareness of importance of annual women checkup and availability of services to the communities and faith-based organizations
- Spot checks on inventory of family planning commodities and availability of supplies and equipment for MCH services like prenatal, birth delivery, infant care and other related services in Majuro, Ebeye and Neighboring Islands.
- Dental outreach visits to Neighboring Islands in collaboration with Taiwan Health Center and ECD Program
- Distribution of safe delivery kits to the Neighboring Islands health centers.
- Availability of Prenatal via telehealth services when hospital/public health clinics were closed due to COVID-19 community transmission.
- World Cancer Awareness Month activities 182 participants Age range from: 3yrs – 60+ on the kickoff activity with a walkathon, sponsored tennis and volleyball tournaments with NCD and cancer screening of players, and Ebeye breast cancer screening,
- Cancer Summit in Majuro where all our key stakeholders and cancer coalition members attended to reflect on all the accomplishments and challenges the past five years; breakout sessions with coalition members and health providers
- No Maternal Death in 2022

Challenges:

- Socio economic reasons which affect the visitation to the services
- Due to strong cultural practices, women would resort to traditional medicine before coming for consult or even after consult with a physician.
- Limited availability of female Health Assistants in the Neighboring Island which resulted to low prenatal visits, late identification of high-risk pregnancy, and low annual screening.

Plan:

- To expand cancer screening services to the communities
- MCH One Stop Shop for domain population
- Buildup of workforce capacity by Midwifery; 15 Neighboring Islands Female health care workers; training of the Community Health care workers and continuing education for BS in Nursing

Perinatal/Infant Health

Priority: Improve perinatal/infant's health through adequate and quality prenatal services and newborn screening

Highlights:

- Counselling on importance of exclusive breastfeeding to all lactating mothers.
- Radio awareness and spots on importance of early prenatal visits are ongoing
- Distribute baby bags to mothers who attended prenatal care in their 1st trimester
- 22 solar powered freezer donations received to build the capacity of Neighboring Islands Health centers for cold chain equipment.

Challenge:

- Limited newborn screening for Neighboring Islands due to lack of equipment and trained staff
- Availability of immunization services in the Neighboring Islands is dependent on the outreach mobile visits for the 2 main islands (Majuro and Ebeye).
- The hiring of nutritionist and lactation nurse that will train the health care workers was stalled because of the closure of RMI borders which limited the capacity to bring subject matter experts.

Plan:

- Improvement of services in the NI Health Centers by providing cold chain equipment, training of health assistants on vaccination
- Partner with community-based organizations to promote and support breastfeeding practices, Baby friendly initiative projects including breastfeeding awareness and education
- Partner or seek technical assistance to update birthing hospitals SOP for delivery and management of newborns

Child Health

Priority: Improve child health through early childhood developmental screening and vaccinations/Promote child safety in the community.

Highlights:

- COVID-19 vaccinations for children are available and provided in Majuro and Ebeye. Increase number of immunization outreach visits in the Neighboring Islands through the COVID-19 vaccination campaign
- Early Childhood program supports the Parents as Teacher project under the Women United Together Marshall Islands.
- Continue to support the oral health with supplies and travel to the Neighboring Islands.

Challenges:

- Availability of immunization services in the Neighboring Islands is dependent on the outreach mobile visits for the two main islands (Majuro and Ebeye). Currently, there is no cold chain equipment in the Neighboring Islands Health Centers

Plan:

- Implement cold chain equipment system in the Neighboring Islands for storing of vaccination. Build the capacity of the health assistants to vaccinate and monitor the cold chain of the vaccines.
- Conduct community awareness on the proper immunization schedule and the benefits of immunization
- Continue to provide outreach services to improve access to services

Adolescent Health:

Priority: Improve adolescent health through promotion of adolescent wellbeing and reducing teen pregnancy

Highlights:

- Climate Change Art Seminar for high school students linking health to climate change using the medium of art to foster a deeper engagement with the issues of climate change and health.
- Youth friendly sexual reproductive health training

- Family planning supply chain management design training
- Launching of Sexual and Gender Based Violence Clinical guidelines
- No suicide and motor vehicle mortality reported.

Challenge:

- Encounter hindrances in Family Planning awareness in the school. Sexual Reproductive Health subject is not part of the curriculum.

Plan

- Development of the Comprehensive Sexual Education Curriculum
- Advocate FP services for parents' consent during PTA meetings

CSHCN

Priority: Improve enrollment and special care of CSHCN through developmental screening and referrals to proper care.

Highlights:

- Referrals from MCH clinic to Human Services for evaluation.
- Parents and Doctor sessions
- Family group session with parents with children with hearing problems

Challenges:

- Lack of specialty care of CSHCN in RMI. CSHCN are referred off island to seek specialty care and treatment which adds financial and emotional burden to the families and the government.

Plan:

- Develop transition plan in partnership with government agencies and NGOs
- Hire a CSHCN Manager that will oversee the CSHCN projects and report to the MCH Director

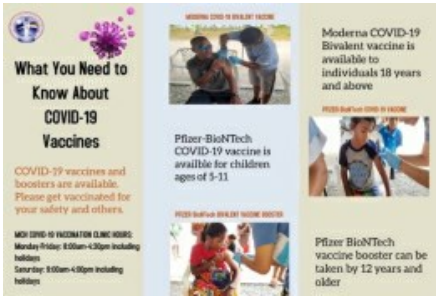
III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

The RMI MCH program receives approximately $200,000.00 from HRSA MCH Block Grant to support access to preventive and primary health care services for the population groups of:

1) preventive and primary care services for pregnant women, mothers, and infants, 2) preventive and primary care services for children and adolescents, 3) preventive and primary care for children with special health care needs. The Title V funds are allocated based on the 30/30/10 rule. A minimum of 30% of the Title V fund is allocated to provide services to Children with Special Health care Needs (CSHCN), a minimum of 30% towards services for children and adolescents and no more than 10% for state administration of funds. Together with State funds, and other additional federal funds, the Title V MCH block grant is used to address MCH priority needs, improve performance related to targeted MCH outcomes, and expand systems of care for the MCH and CSHCN populations. The RMI Title V funds compliment state funds and other funds by addressing gaps and priority needs which are not achieved by State funds or other federal dollars. Together with MCH state funds and other federal funds, the Title V MCH block grant is used to address RMI's priority needs, improve performance and expand systems of care for the MCH target population. Title V funds compliment the state plans in supporting healthcare for women and children by addressing gaps and priority needs which are not achieved by state funds or other federal funds. MCH Block Grant funds are used to support policy development, annual and five-year needs assessment activities, education and awareness campaigns, program development, implementation, and evaluation. Additionally, funds are used to support workforce development towards building capacity among MCHB staff, nurses, and partners who impact RMI Title V priorities.

III.A.3. MCH Success Story

Preparedness and Response to the State of Emergency COVID-19:

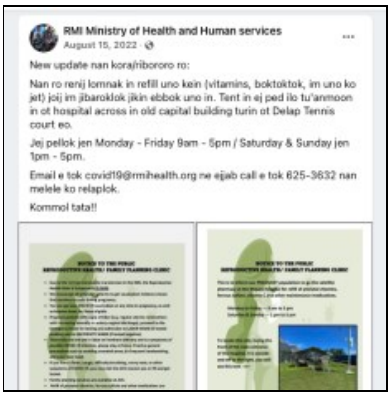


COVID-19 vaccinations increase due to: Established a vaccine taskforce; Use of media platforms for COVID-19 vaccinations awareness, social media, radio talk shows, local newspaper updates on COVID-19 vaccination dashboard; Feedback portal to enable questions and answers on COVID-19 vaccinations; Administration of COVID-19 vaccinations within the clinics and after hours, as well as through the communities from house-to-house campaigns and Neighboring Islands; COVID-19 vaccination raffle activity was rolled with cash prizes to those individuals that had their first dose of vaccination and another raffle for those who have had their second dose of vaccinations. COVID-19 vaccinations coverage by Dec 2022 Fully vaccinated for 6 months old and above: Majuro 82%; Ebeye 86%; Neighboring Islands (NI) 73%; RMI overall 81%

Response to Community Transmission of COVID-19:

The COVID-19 test-to-treat (T2T) sites were installed at several schools at Majuro Atoll and at the gymnasium on Ebeye Island.

Prenatal Clinics on Telehealth services: OBGYNs are available via phone call, text messages, emails and Facebook messenger for consultation. For pregnant mothers that needs medication, staff nurses delivered the medication to their homes. Satellite pharmacy was also available for medication pick up. Risk Communication and Community Engagement (RCCE) Team sent out mass text messages, social media postings and radio announcement on availability and access to Prenatal Services. Ebeye provided prenatal services for high-risk patients at the T2T sites, set up room for ultrasound outside Emergency Room. There were 21 deliveries; 19 out of 21 deliveries were positive with COVID-19. There was no serious complication for the mothers and the newborns. They were closely monitored for 2 days and were sent for isolation at home and advise accordingly as well. Contact tracing to all positive pregnant mothers with management and counseling was done.



III.B. Overview of the State

As a grantee of the Maternal and Child Health Services Title V Block Grant Program, the Republic of the Marshall Islands (RMI) is required to do a statewide maternal and child health (MCH) needs assessment every five years. The needs assessment process outcome is the identification of priority needs for the maternal and child population groups.

The RMI Ministry of Health and Human Services' (MOHHS) MCH Program is responsible to facilitate the needs assessment process and administers MCH grant funds. The mission statement of the Ministry is "To provide high quality, effective, affordable, and efficient health services to all people of the Marshall Islands, through a primary care program to improve the health statistics, and build the capacity of each community, family and the individual to care for their own health". To the maximum extent possible, the MOHHS pursues these goals using the national facilities, staff and resources of the RMI.

Figure 1 Map of the Republic of the Marshall Islands

The Marshall Islands are located in the Central Pacific Ocean, approximately 2,000 miles southwest of Hawaii and 1,300 miles southeast of Guam. They are comprised of 29 scattered chains of remote atolls, the Eastern Ratak (Sunrise) and Western Ralik (Sunset). The total land area is 181 square kilometers and has some 370 km of coastline (less than 0.01 percent of the total surface area). The Marshall Islands face great challenges in the delivery of basic health services. Transportation and communications are limited by the isolated nature of many of the islands and atolls. Two-thirds of the population lives on the two major urban atolls, Majuro and Kwajalein (including Ebeye Island). Population densities in some of the urban settlements exceed 28,000 people/km^2. More than half of the RMI total population lives in Majuro. The Marshallese is of Micronesian origin. The matrilineal Marshallese culture revolves around a complex system of clans and lineages tied to land ownership. RMI has an area of 1826 square kilometers and is composed of two coral atoll chains in the Central Pacific.

RMI is a parliamentary democracy, constitutionally in free association with the United States of America. It has a developing fisheries and service-oriented economy. It is mainly a Christian nation with the majority of the population being protestant followed by Catholic and other religions. The two main urban centers (Majuro and Ebeye-Kwajalein atoll) have paved roads and with piped water and a sewer system. The island of Ebeye is one of the most densely populated places in the world, only second to Bangladesh/Dakka. While the majority of the RMI population is concentrated on the two main urban centers, it is important to note that a great portion is dispersed around the many islands/atolls. This makes the provision of comprehensive health services to the entire population a challenge. However, the development of fundamental services such as health care and education have, over many decades, developed and improved in the remote islands. Health services capacity is further enhanced through provision of on-site health visits and follow-up care from the urban centers through field trips including availability of case evacuation and referrals to the central hospital. This established system is under RMI constitutional mandate, a responsibility of the Government.

Population

In FY2022, the MCH Program has served the following population:
1. Pregnant Women: 1,309
2. Infant <1 year old : 1021
3. Children from 1 to 22 years old: 3,132
4. CSHCN : 78
5 Others: 3,923

Population Demographics

In September 2021, a national census of population and housing was conducted in RMI. The RMI Census of Population and Dwellings is conducted by the country's statistics agency, the Economic, Planning, Policy and Statistics Office (EPPSO). It provides an official count of people, along with demographic and socioeconomic information at the atoll/island and community level. It is the 12th census of population to be undertaken after the first census enumeration was undertaken in the RMI in 1920.

There is 20% decrease in the total population count from the 2011 census. In 2011, there was 53,158 population while in 2021 census population is down to 42,418. Decrease in population is attributed to migration of Marshallese mostly to the USA because of job opportunities, health care and education. The Marshall Islands has a young population.

Table 1: Key Indicators, RMI 2021 Census Report

Indicator	Total	Males	Females
Total enumerated population (2021)	**42,418**	**21,728**	**20,690**
Annual rate of population change (%), 2011 to 2021	-2.23%		
Population density (people per sq. miles) - national level	605		
Kwajalein	1,546		
Majuro	6,175		
Proportion of population living in urban area (%)	78%		
Proportion of population aged under 15 years of age	34%	34%	34%
Proportion of population aged 15 to 24 years (youth aged group)	20%	20%	20%
Proportion of population aged 15 to 59 years (working age population)	60%	59%	60%
Proportion of population aged 60 years and older	6%	6%	6%
Age dependency ratio	61		
Median age (years)	22	21	22
Households			
Number of private HHs	7,123		
Average household size	5.85		
Proportion of private HHs receiving a remittance in last 12 months	11%		
Number of institutions (non-private HHs)	78		
Number of people in institutions	843		
Proportion of private HHs with piped water supply	44%		
Proportion of private HHs with access to a flush toilet	88%		
Proportion of private HHs using electricity as the main source of lighting	75%		
Proportion of private HHs with access to the internet	43%		
Proportion of private HHs with access to a mobile phone	89%		
Births and fertility			
Estimated births	704		
Crude birth rate (CBR), per 1,000 population	16.6		
Total fertility rate (TFR), per woman	3.4		
Teenage fertility rate, per 1,000 (SDG 3.7.2)	47		
Mean age at childbearing	27.6		
Mean age at first birth	21.6		
Average age at first marriage	25.6	26.5	24.8
Health and mortality			
Disability prevalence (population aged 5 years and over)	3.1%	3.3%	2.9%
Net migration			
Population who lived in a different location 1 year ago	1,088		
Elsewhere in RMI	912		
Outside the country	176		
Population who lived in a different location 5 years ago	2,456		
Elsewhere in RMI	1,700		

Indicator	Total	Males	Females
Outside the country	756		
Population who lived in a different location 1 year ago (%)	2.7		
Elsewhere in RMI (%)	2.2		
Outside the country (%)	0.4		
Population who lived in a different location 5 years ago (%)	6.7		
Elsewhere in RMI (%)	4.6		
Outside the country (%)	2.1		
Education			
School enrolment rate of 6-14 year old (% of population of same age)	93%	93%	94%
Proportion of population aged 15 years and over (%) with:			
Secondary education	62%	60%	63%
Secondary qualification (as highest grade completed)	61%	60%	62%
Tertiary education	5%	5%	4%
Tertiary qualification (as highest level completed)	5%	5%	4%
Gender parity index, Primary (GPI)	0.9		
Gender parity index, Secondary (GPI)	1.0		
Labour force (population 15+ years)			
Employed population (number)	12,297	7,774	4,523
Paid workers (number)	11,574	7,500	4,074
Subsistence workers (number)	325	295	30
Not in the labour force (number)	13,529	5,243	8,286
Labour force participation rate	50.3	62.0	38.1
Employment to population ratio	45.2	56.3	33.8
Unemployed (number) - looking for, available and willing to start work	1,371	784	587
Unemployment rate (%) - looking for, available and willing to start work	10.0	9.2	11.5
Unemployed - available and willing to start work (number)	373	172	201
Unemployed - all unemployed + subsistence workers (number)	2,008	1,162	846

Source: Economic Policy, Planning and Statistics Office, 2021

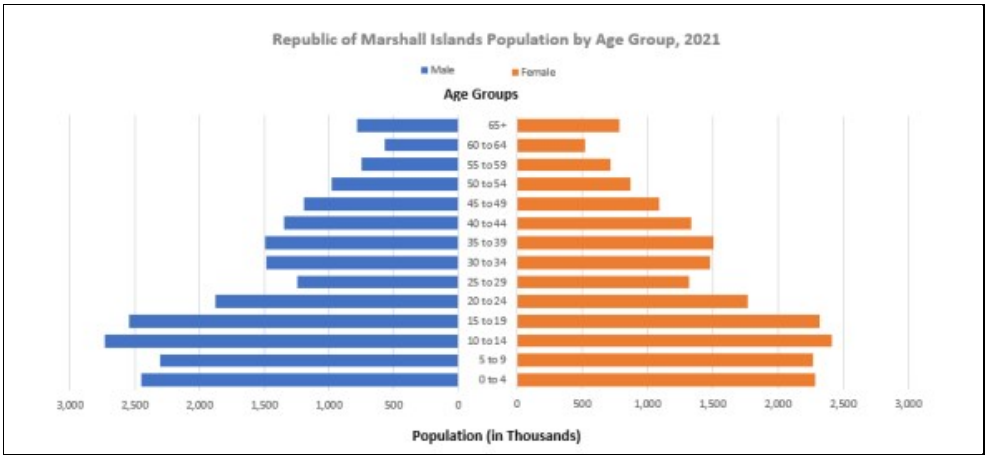


Figure 2 RMI Population by Age Group, 2021

The 3 bottom bars show the population's younger dependents (0-14 years old). In RMI this is approx. 62% of the population. This means they have a YOUTHFUL population. Only 7% are over 65 years old.

Table 2: RMI Population by Age, 2021-2025

Age	2021	2022	2023	2024	2025
Total	**42,418**	**42,320**	**42,223**	**42,126**	**42,029**
0 to 4	***4,740***	***4,729***	***4,718***	***4,707***	***4,697***
0	983	981	978	976	974
1	977	975	973	970	968
2	984	982	979	977	975
3	899	897	895	893	891
4	897	895	893	891	889
5 to 9	***4,573***	***4,562***	***4,552***	***4,542***	***4,531***
5	966	964	962	959	957
6	888	886	884	882	880
7	860	858	856	854	852
8	967	965	963	960	958
9	892	890	888	886	884
10 to 14	***5,140***	***5,128***	***5,116***	***5,105***	***5,093***
10	1,041	1,039	1,036	1,034	1,031
11	980	978	975	973	971
12	1,035	1,033	1,030	1,028	1,026
13	1,035	1,033	1,030	1,028	1,026
14	1,049	1,047	1,044	1,042	1,039
15 to 19	***4,865***	***4,854***	***4,843***	***4,832***	***4,820***
15	1,054	1,052	1,049	1,047	1,044
16	1,076	1,074	1,071	1,069	1,066

17	985	983	980	978	976
18	939	937	935	933	930
19	811	809	807	805	804
20 to 24	***3,641***	***3,633***	***3,624***	***3,616***	***3,608***
20	819	817	815	813	811
21	862	860	858	856	854
22	717	715	714	712	710
23	662	660	659	657	656
24	581	580	578	577	576
25 to 29	***2,561***	***2,555***	***2,549***	***2,543***	***2,538***
25	588	587	585	584	583
26	569	568	566	565	564
27	531	530	529	527	526
28	458	457	456	455	454
29	415	414	413	412	411
30 to 34	***2,962***	***2,955***	***2,948***	***2,942***	***2,935***
30	557	556	554	553	552
31	610	609	607	606	604
32	594	593	591	590	589
33	575	574	572	571	570
34	626	625	623	622	620
35 to 39	***3,003***	***2,996***	***2,989***	***2,982***	***2,975***
35	577	576	574	573	572
36	605	604	602	601	599
37	604	603	601	600	598
38	619	618	616	615	613
39	598	597	595	594	593
40 to 44	***2,683***	***2,677***	***2,671***	***2,665***	***2,658***
40	557	556	554	553	552
41	646	645	643	642	640
42	542	541	540	538	537
43	456	455	454	453	452
44	482	481	480	479	478
45 to 49	***2,280***	***2,275***	***2,270***	***2,264***	***2,259***
45	516	515	514	512	511
46	444	443	442	441	440
47	470	469	468	467	466
48	412	411	410	409	408
49	438	437	436	435	434
50 to 54	***1,849***	***1,845***	***1,841***	***1,836***	***1,832***
50	369	368	367	366	366
51	428	427	426	425	424
52	356	355	354	354	353
53	343	342	341	341	340

54	353	352	351	351	350
55 to 59	***1,461***	***1,458***	***1,454***	***1,451***	***1,448***
55	317	316	316	315	314
56	316	315	315	314	313
57	341	340	339	339	338
58	263	262	262	261	261
59	224	223	223	222	222
60 to 64	***1,091***	***1,088***	***1,086***	***1,083***	***1,081***
60	237	236	236	235	235
61	251	250	250	249	249
62	220	219	219	218	218
63	213	213	212	212	211
64	170	170	169	169	168
65+	***1,569***	***1,565***	***1,562***	***1,558***	***1,555***

Source: Economic Policy, Planning and Statistics Office, 2021

Table 3. *Population by Urban/Rural and atoll by sex – RMI Census 2021*

Atoll by Urban/Rural	Sex		
	Total	Male	Female
Urban / Rural area			
Total	**42,418**	**21,728**	**20,690**
Rural	9,473	4,962	**4,511**
Urban	32,945	16,766	**16,179**
Atoll / island			
Total	**42,418**	**21,728**	**20,690**
1–Ailinglaplap	1,175	599	**576**
2–Ailuk	235	117	**118**
3–Arno	1,141	619	**522**
4–Aur	317	172	**145**
5–Bikini	0	0	**0**
6–Ebon	469	260	**209**
7–Enewetak	296	159	**137**
8–Jabat	75	41	**34**
9–Jaluit	1,409	721	**688**
10–Kili	415	226	**189**
11–Kwajalein	9,789	5,096	**4,693**
12–Lae	133	69	**64**
13–Lib	156	74	**82**
14–Likiep	228	114	**114**
15–Majuro	23,156	11,670	**11,486**
16–Maloelap	395	219	**176**
17–Mejit	230	119	**111**
18–Mili	497	272	**225**
19–Namdrik	299	155	**144**
20–Namu	525	284	**241**
21–Rongelap	0	0	**0**
22–Ujae	310	153	**157**
24–Utirik	264	131	**133**
25–Wotho	88	44	**44**
26–Wotje	**816**	**414**	**402**

Source: Economic Policy, Planning and Statistics Office, 2021

Educational Attainment

With the 2021 census, there are no new information on the education on enrollment to learning institutions.

The level of educational attainment is an important indicator of the degree of development and quality of life standards achieved by countries, as reflected in many demonstrated inter-relationships between education and demographic, economic and social development. For example, educated mothers tend to have fewer and healthier children. Higher levels of education also contribute to a better qualified workforce, and better educated people also have improved chances to find employment, both domestically and overseas. It is for such reasons that education is an important development goal for Pacific island countries and their development partners.

According to the RMI 2011 Census, 42.9% of people aged 25 and over have completed high school or pursued further studies and training; an additional 47.8 % had completed primary education (19.2%) or completed some years of High school (28.6%). While this picture represents a small improvement over the situation prevailing in the late 1990s, as reflected in comparative figures of 40.1% and 45.6% respectively, the fact that (1) 28.6% of people aged 25 or older had started but not completed high school, and that (2) this proportion increased since the late 1990s (21.6%), could be seen as two major policy challenges.

The vast majority of Marshallese attends school, although many do not complete primary school and very few go on to complete secondary or higher education. Starting at age 14, attendance rates decline noticeably for all children.

Educational Attainment in the RMI, 1999 and 2011 comparison

Educational Attainment	1999		2011	
	Number	Percent	Number	Percent
No Schooling	554	3.1%	296	1.3%
Some Elementary	2003	11.2%	1747	7.9%
Elementary completed	4284	24.0%	4247	19.2%
Some high school	3858	21.6%	6317	28.6%
High School completed	4450	24.9%	5478	24.8%
Some college or higher	1419	7.9%	2008	9.1%
College or higher completed	1303	7.3%	1987	9.0%
Total	17871	100.0	22080	100.0%
Source: RMI Household Census 2011				

Enrollment Status

School enrollment has increased slightly for children aged 5-9 years to 80.1% in 2011 from 74.2% in the late 1990s and increased to 91.9% from 86.6% aged 10-14 over the same period. While showing a positive development in recent years, building on these achievements in the context of achieving education for all children, especially those that drop out due to adolescent pregnancy and reversing the recent decline in enrollment represent an important policy challenge

Enrollment Ratios by Age Group, 5-24, 1999 and 2011

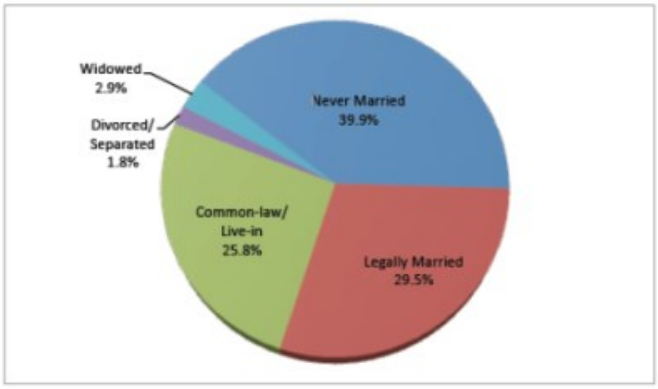
Age Enrolled	Number Enrolled		Total Persons		Enrollment Ratio	
	1999	2011	1999	2011	1999	2011
5 - 9	4,929	5,611	6,640	7,009	74.2%	80.1%
10 - 14	6,518	5,943	7,513	6,464	86.8%	91.9%
15 - 24	**4,719**	**3,601**	**10,861**	**9,473**	**43.4%**	**38.0%**

Nuptiality

Figure 3 shows the distribution of household population 12 years old and over by marital status. More than half of this population (55.4%) was married, with 29.5 percent legally married and 25.8 percent living in a common-law union or live-in status. Almost two-fifths were never married, and some 3 percent were widowed and 1.8 percent were either

divorced or separated. Over three-quarters of widowed persons were women; this is attributed to the difference in the age of spouses at the time of marriage (women tended to be younger than their spouses) and a higher life expectancy at birth for women compared to men. The percentage of widowed women increased with age as they tended to remarry less frequently upon divorce or the death of a spouse.

Figure 3 Population of 12 years old and over by marital status, RMI 2011



Health care in the RMI

In 1986 the RMI Government adopted the concept of Primary Health Care declared by the WHO in 1978. The Bureau of Primary Health Care was established to target the strengthening of preventive programs/services at the community level. The bureau is renamed the Bureau of Primary Health Care Services.

The health care system comprises two hospitals, one in Majuro and one in Ebeye and fifty-six (56) active health care centers in the outer atolls and islands. Both hospitals provide primary and secondary care but limited tertiary care. Patients who need tertiary care are referred to Honolulu, ROC-Taiwan, or the Philippines.

Health centers in the outer islands focus on the preventative, promotive and essential clinical care services. All health care centers are permanently staffed by full time Health Assistants who provide health services.

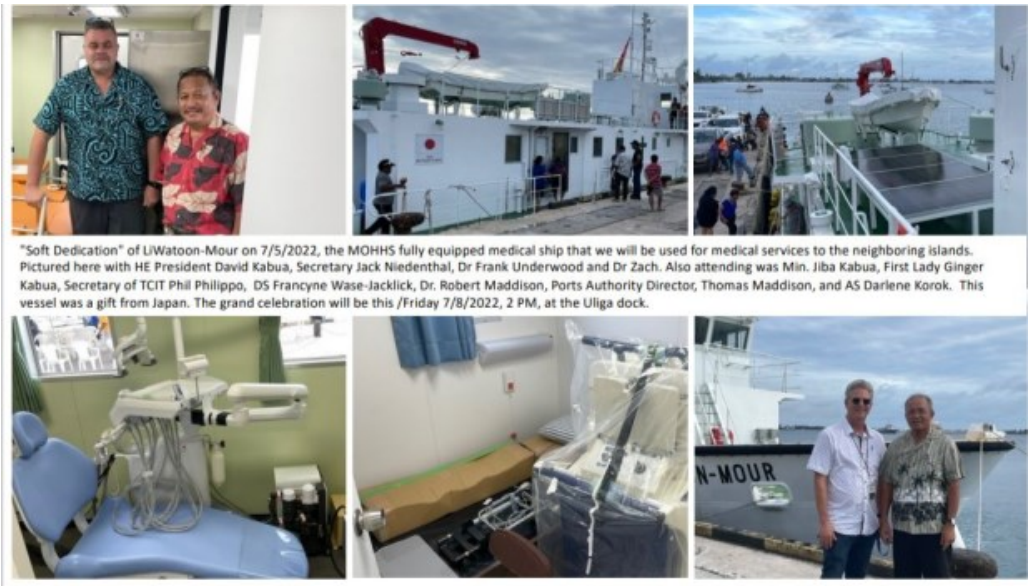
Table 4 indicates the hospital and health centers under the MOHSS. Leroij Atama Zedkeia Medical Center commonly known as Majuro Hospital and Leroij Kitlang Memorial Health Center commonly known as Ebeye Hospital are serving inpatient, outpatient, public health clinics and ancillary services. There is 56 Health Centers in RMI. 177 Health Care Program funded by US grant can hire 1 doctor and 1 health assistant in their 4 Outer Islands Clinics namely Utrik, Enewetak, Kili and Mejatto. 177 Health Care Program provides services to the people that were affected by the nuclear testing. Aside from the 177 Health Centers, Health Assistants are the health care providers in the health centers.

Public health staff conduct comprehensive outreach missions to provide preventive services to the hard-to-reach population in the Neighboring Islands (NI formerly knows as Outer Islands). Services include Family planning, cervical cancer screening, Oral health, Immunization, Leprosy screening and treatment, TB screening and treatment, NCD and STI services.

Most of the NI Health centers do not have electricity, making it a challenge for Health centers to have a cold chain storage and provide immunizations to the communities. Such services are rendered only if there are comprehensive team travel to the atolls. In 2022, we have received the requested solar freezers for the cold chain storage of vaccines. These solar freezers are donated by the Japan Government through the assistance of UNICEF. 22 out of 24 UNICEF solar freezers were distributed during the COVID-19 NI vaccination. We are still waiting for 20 solar freezers purchased by World Bank funds. Majuro Public Health Team leads will provide continuing training and plans to fully implement immunization services in NI next year, 2023.

Our health centers in the are not equipped with dental equipment, supplies and manpower. Health Assistants have limited educational background and experience to provide oral health services. Since majority of the Health Assistants are male, it's hard for women to seek care and services like family planning, cervical cancer screening and prenatal care services.

In 2022, the MOHHS received two boats from UNICEF and Government of Japan. We are still waiting for one more boat coming from World Bank which is included in the COVID-19 list of requested needs. The Public Health started using the medical boat in late 2022 to provide vaccinations, bringing in medical supplies like COVID-19 test kits, IPC supplies and other services.



"Soft Dedication" of L/Watoon-Mour on 7/5/2022, the MOHHS fully equipped medical ship that we will be used for medical services to the neighboring islands. Pictured here with HE President David Kabua, Secretary Jack Niedenthal, Dr Frank Underwood and Dr Zach. Also attending was Min. Jiba Kabua, First Lady Ginger Kabua, Secretary of TCIT Phil Philippo, DS Francyne Wase-Jacklick, Dr. Robert Maddison, Ports Authority Director, Thomas Maddison, and AS Darlene Korok. This vessel was a gift from Japan. The grand celebration will be this /Friday 7/8/2022, 2 PM, at the Uliga dock.

Title V funds supported the time of staff, travel, fuel, and supplies. PIHOA's support to train more midwives to be dispatched to the NI. ECD support with training of Female Health Aides to support Sexual and Reproductive Health Services (SRH) in the NI without Female Health Assistants. UNFPA supports a toolkit for assessing and inventory of essential medicine and SRH, and Gender based Violence (GBV) There is a major need to strengthen awareness on the importance of good oral hygiene and annual dental check.

Table 5: Health Care Locations			
MAJURO ATOLL			
• Leroij Atama Zedkeia Medical Center (Majuro Hospital) • Laura Health Center • Rongrong Health Center • Woja Health Center			
KWAJALEIN ATOLL			
• Leroij Kitlang Memorial Health Center (Ebeye Hospital) • Santo Dispensary • Ebadon Dispensary • Gugeegue Dispensary			
OUTER ISLANDS HEALTH CENTERS			
Ratak Chain 1. Aerok 2. Maleolap 3. Ailuk 4. Arno 5. Aur 6. Bikarej 7. Enejelar 8. Enejit 9. Ine 10. Jang 11. Jebal 12. Kaven 13. Kilange 14. Likiep	15. Lukonwor 16. Mejit 17. Milli 18. Nallu 19. Ollet 20. Tarawa 21. Tinak 22. Tobal 23. Tokewa 24. Tutu 25. Ulien 26. Wodmej 27. Wotje	**Ralik Chain** 1. Aerok Ailinglaplap 2. Bwoj 3. Ebon 4. Imiej 5. Imiroj 6. Jabnoden 7. Jabot 8. Jabwor 9. Jaluit 10. Lae 11. Lib	12. Loen 13. Mae 14. Majkin 15. Mejrirok 16. Namdrik 17. namu 18. Narmij 19. Toka 20. Ujae 21. Woja 22. Wotho
177 HCP Program	Department of Energy Clinic	Kumit Wellness Center	Taiwan Health Center
Majuro Clinic Ejit Clinic Kili Heakth Center Enewetak Health Center Utrik Health Center Mejatto Health Center			

Table 6: No. of Beds in the two Main Hospitals	
Hospital	No. of beds
Leroij Atama Zedkeia Medical Center (Majuro Hospital)	101
Leroij Kitlang Memorial Health Center (Ebeye Hospital)	54

Table 7: Private Clinics and Pharmacy	
Clinic Name	Location
Majuro Clinic	Delap, Majuro
Eyesight, Professional	Delap, Majuro
Medisource Pacific Pharmacy	Majuro and Ebeye

Government health funding and human resources

In a 2015 WHO study of 11 selected Pacific Island countries, the RMI had the highest government health expenditure in the last six years of period reviewed (Figure 3) . The study found RMI government funding amounted to only 40% of the necessary health expenditure for the entire population. A considerable proportion of the remaining health budget is sourced from external aid, comprising mainly of US Compact of Free Association (COFA) payments and other US federal assistance.

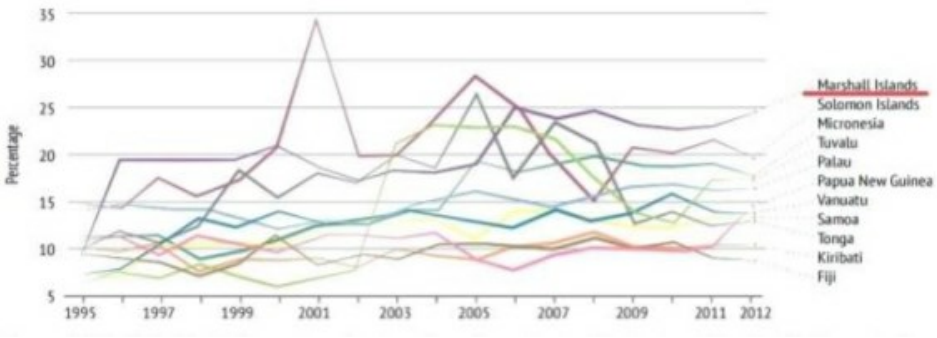
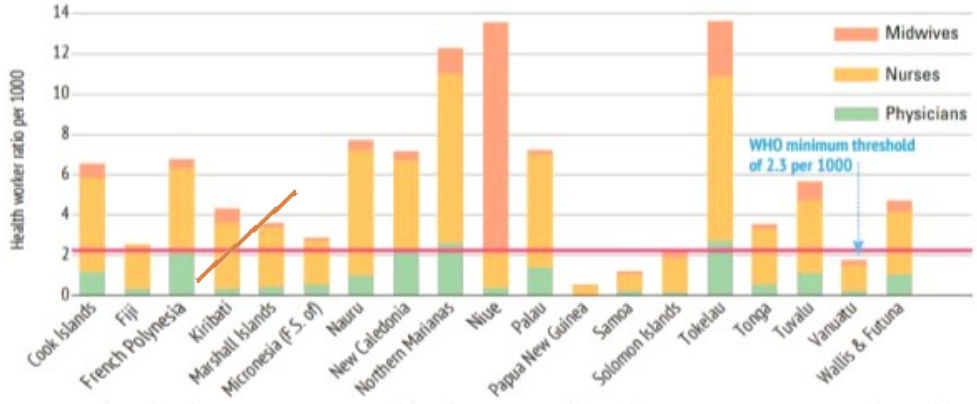


Figure 3 Government health expenditures as a percentage of total government expenditures in selected Pacific Island countries, 1995-201 2

Source: World Health Organization (WHO) Global expenditure database, 2015

Figure 4 Health workforce (doctors, nurses and midwives) per 1,000 population in selected Pacific Island countries,2015



Source: The first 20 years of the journey towards the vision of Healthy Islands in the Pacific, World Health Organization (WHO) (2015)

Communication

In 2020, MOHHS and Marshall Islands National Telecommunication Authority (MINTA) partnered through a grant to install VSAT in all the health centers in the NI. The VSAT will provide voice and data. Our plan is to be able to use the VSAT services for better communication, telehealth, access to the MHIS (Marshall Health Information System) and can provide remote training. The improvement in communication will also decrease medical evacuation that can costs from 10,000 to 15,000 per case. Specialists from Majuro and Ebeye can do an assessment first based on the information that will be submitted through email and video calls.

In 2022, 47 of the health centers have VSAT but only 8 were activated. Majority of the health centers need to install new solar power panel system to power on the IT equipment that will be installed. Through World Bank, WHO, CDC, and USAID COVID-19 funds, we purchased laptops and UPS, solar batteries, and panels that will be assigned and installed in the health centers. There are challenges in the procurement of the solar panel system which also cause delays in the implementation in NI. During the TB Mass Screening in Wotje, the TB physician and staff were able to access MHIS, update encounters and transfer images to the radiology system. The TB Mass Screening team was able to conduct hotwash calls with Majuro team to present cases and provide updates on the activities. We also encounter challenge in the VSAT connection and have to wait for NTA to assist in the troubleshooting.
Once this whole system is set, MCH program will conduct its telehealth for the Children with Special Health Care Needs, High risk pregnancy and follow up of cases. Weekly reporting of syndromic surveillance, birth and death occurrence will improve.

With the Health Informatics Department's communication plan, MOHHS purchased new HF radios to replace the old/nonfunctional radios. Satellite phones were also purchased for redundant communication. Funding was provided under CDC Crisis funds – COVID-19. CDC Epidemiology and Laboratory Capacity - COVID-19 supplemental funds and CDC Immunization funds support the communication fees to ensure communication in all the health centers are hospitals are uninterrupted.

The main challenge for communication is the high cost. Internet connection fee is very expensive in RMI. For Majuro Hospital, we pay $10,000 per month for 20mbps of connection. $600 per month in Laura Health Center and $600 for Woja Health Center to connect for internet dsl. For Ebeye Hospital, we pay $3,600 for the internet connection per month. A total of $14,800 per month for all our internet connections. International calls are $1.25 per minute. National Calls are $0.50 per minute. To use VSAT, there will be an additional cost $200/site/month for MOHHS to incur.

Transportation

Mode of transportation:

a. Majuro: Public transportation is shared taxi with minimum fee of $1.50 to maximum of $5.00. Speed boats are used to go to the small islands, 20-30 minutes ride to the nearest small islands inside Majuro.
b. Ebeye: Public transportation is a shared taxi with a minimum fee of $1.00. Speed boats are used to go to the small islands, 1 hr. ride to go to the farthest health center in Ebeye. Ebeye Hospital staff use the military plane to go to one of the islets in Ebeye to provide health care. Military base also provides military ship to bring people from Ebeye to the US Military base where Kwajalein airport is located. Marshallese working in the base is also using the ship to go to work daily.
c. Outer Islands: RMI has a government-owned ship that brings people, food, and other supplies to the NI. Within the NI, there are speed boats, bicycle and trucks to bigger atolls. Air Marshall Islands (AMI) has two planes that service the whole RMI. But it's not reliable.

For the MCH program, we usually travel by AMI. One way airfare can range from $70 on the nearest island to $400 on the farthest island. There are instances that public health outreach team including MCH staff get stranded for a day or a month if the planes are not working. We also use small boats to go to the small islands or islets in the NI. The trip to Enewetak is 4-5 days via boat, which is the farthest island. Enewetak is near Pohnpei. When the weather is bad or the ocean is too rough, we can't provide outreach visits to the NI. Recently with the donated medical boat from UNICEF, LiWatoon-Mour was able to service the NI outreach mobile trips.

Food Security

The Marshall Islands face multiple challenges. It has few natural resources, and imports by far exceed exports. Agricultural production is relatively small but important to the livelihood of people and the economy.

RMI has been severely affected by rising food and fuel costs coupled with natural disasters. The dependency on imported fuel and food has led to high inflation rates. According to the RMI Food Security Policy (FAO, 2013), the

food import in RMI goes up to 80-90% depending upon Islands. The population has seen rapidly increasing levels of food and nutrition related non communicable diseases, which impact negatively on the health system, families, and national economy.

The major constraints to food security in RMI are:

- Limited technical expertise in agriculture production with the Ministry of Resources and Development (MRD)
- Lack of improved agriculture and livestock production skills among growers
- Limited disease and pest control and surveillance capacity and practices in Agriculture production system
- Lack of food preservation/processing facilities, technologies, and skills
- Limited awareness and knowledge on nutrition
- High vulnerability to natural disasters
- High price

Early Childhood Development Program Update:

In 2019, the World Bank (WB) launched the Multisectoral Early Childhood Development (ECD) Program with the MOHHS, Ministry of Education, Sports, and Training, Ministry of Culture and Internal Affairs, and the MOFBPS. Results from the ICHN Survey conducted by UNICEF in 2017 portrayed an alarming rate of stunting in RMI. The ECD program is taking on the initiative to assist with the most vulnerable, pregnant mothers, and children 0-5 years of age. It is important to highlight the much-needed action within the first 1,000 days of a child's life for intervention.

Table 1: Health, nutrition, and child development outcomes

Maternal and Child Health Outcomes	
Infant mortality rate *(deaths per 1,000 live births)*+*(deaths per 1,000 live births)+	28
Under-5 mortality rate *(deaths per 1,000 live births)+*	34
Maternal mortality ratio *(deaths per 100,000 live births)+*	92
Low birth weight (<2,500 g), *(% last born children 0-59 months*)*	11.6
Maternal and Child Nutritional Outcomes	
Underweight *(% children 0-59 months*)*	11.7
Stunting *(% children 0-59 months*)*	35.3
Wasting *(% children 0-59 months*)*	3.6
Overweight *(% children 0-59 months*)*	3.8
Underweight/Thinness (BMI<18.5 kg/m^2), % WRA*	1.8
Overweight (BMI 25.0-29.9 kg/m^2), % WRA*	72.7
Obesity (BMI >30 kg/m^2), % WRA*	45.1
Child Development Outcomes	
Percent of children age 36-59 months developmentally on track for indicated domains	
Literacy – Numeracy	55.4
Physical	92.8
Social-Emotional	72.4
Learning	87.6
ECDI Index Score*	78.9
Literacy-numeracy: Developmentally on track if at least two of the following are true: Can identify/name at least ten letters of the alphabet, Can read at least four simple, popular words, Knows the name and recognizes the symbol of all numbers from 1 to 10. *Physical*: Developmentally on track if one or both of the following is true: Can pick up a small object with two fingers, like a stick or a rock from the ground, Is not sometimes too sick to play. *Social-emotional*: Developmentally on track if at least two of the following are true: Gets along well with other children, Does not kick, bite, or hit other children, Does not get distracted easily. *Learning*: Developmentally on track if one or both of the following is true: Follows simple directions on how to do something correctly, When given something to do, is able to do it independently.	

Sources: *UNICEF Integrated Child Health and Nutrition Survey, 2017; +MOHHS Key Performance Indicators Report, 2017; **MOHHS Annual Report, 2017; Notes: WRA: Women of reproductive age (15-49). Note: Data are subject to the usual errors associated with small sample sizes, and in the case of population data such as IMR and MMR issues associated with measurement of mortality in small populations.

Component 1 (MOHHS) aims to improve the availability and coverage of an evidence-based package of essential RMNCHN and stimulation services for the first 1,000 days (pregnant and lactating women and children up to age 2).

Adolescent girls, women of reproductive age and children aged 2-5 years will be secondary target groups, with interventions for these populations incorporated in an opportunistic manner and/or in later stages of implementation. The component seeks to both strengthen the package of services provided and alleviate supply- and demand- side barriers to the use of this package of services.
The first 2 years will focus on alleviating key pressure points to ensure adequate coverage of a revised and evidence-based package of RMNCH-N services in the Majuro/Ebeye Hospitals. Financing will focus on strengthening hospital and clinic-based service delivery in Majuro and Ebeye and filling short-term gaps in supply-side readiness in NI clinics. This immediate term measure is considered vital for preventing further deterioration of key health and nutrition outcomes. The component will also support a suite of TA activities to identify strategic shifts in service delivery to inform further scale-up beyond the initial phase.

The component has two sub-components; one aimed at strengthening stewardship and management of health administration and the other at directly strengthening service delivery. Each sub-component will have four dimensions: (a) RMNCH-N service package; (b) human resources; (c) equipment and supplies; and (d) data and information.

Implementation of activities will be financed under component 1 (MOHHS) and other components (MOCIA, MOEST, MOFBPS). While component 1 will support MOHHS in the delivery of early years-focused SBCC activities in combination with other RMNCH-N interventions, a comprehensive, cross- sectoral strategy and campaign will be developed under component 4. Sub-component 1.1 will support the development and roll-out of training, capacity building, and coaching packages required for MOHHS to effectively deliver the activities, whereas sub-component 1.2 will finance the production of materials, roll-out and delivery of the campaign through MOHHS channels.

5. **Sub-component 1.1:** Strengthening MOHHS management and stewardship capacity to deliver essential RMNCHN services. The objective of this sub-component is to strengthen the management and stewardship capacity of MOHHS to scale up access to a package of essential RMNCH-N services. Activities/inputs to be financed include:

• **Essential RMNCH-N Service Package:** The Project will finance a suite of TA activities to define an essential RMNCH-N package, assess supply-side readiness to deliver the package and recommend strategic shifts in service delivery needed to improve coverage and utilization. While many RMNCH-N interventions are underway, there is a need for MOHHS define and deliver a basic essential package of services, strengthening areas such as: maternal nutrition counselling during ANC; infant and young child feeding promotion; routine monitoring and promotion of optimal child growth and development; identification of disability and developmental delay, birth registration, etc. The component will support an assessment to define the essential RMNCH-N package and an expanded package of activities as well as accompanying operational guidelines for the essential package. A supply-side readiness assessment will be undertaken to identify frontline needs and gaps. A service delivery study will be undertaken and complemented by a Health Financing Systems Assessment to develop recommendations for sustainable, cost-effective delivery models and modalities in Majuro/Ebeye and the NI.

Human Resources: The Project will finance: a human resources mapping and needs assessment to develop a HR strategic plan focusing on the delivery of the essential RMNCH-N package; TA to develop a performance management system; the development of training and coaching packages as identified in the needs assessment. Two ECD Coordinators (national and international) will be placed within the MOHHS, who will not only be responsible for managing activities under the Ministry's mandates (as discussed under component 4), but in doing so will provide specific guidance to staff in the ministry and other implementing agencies to build capacity to work on their mandate

in the future. It is expected that the national ECD coordinator will be absorbed into the MOHHS payroll during the life of the project (approximately year 4).

• **Equipment, commodities, and supplies:** The Project will finance TA on forecasting, purchasing, procurement, and commodity management, as needed.

• **Data and information:** The Project will undertake a rapid assessment of the data needs of the MCH and RH programs to monitor RMNCH-N service utilization and outcomes as well as the existing HMIS. The assessment will be used to identify gaps in the existing HMIS that already benefit from support from Taiwan, China.

6. **Sub-component 1.2:** Enhancing delivery of essential RMNCH-N services. The objective of this sub-component is to scale up access to and coverage of a package of essential RMNCH-N services. This sub-component will support the following:

• **Human Resources:** The Project will finance contracted service delivery providers (e.g. doctors, nurses, midwives) to support MOHHS to achieve a more optimal number, distribution, skills/skills mix, and performance of health care professionals required to effectively deliver the RMNCH-N service package. This includes: (a) surge support to Majuro/Ebeye Hospitals to fill critical human resource gaps for RMNCH-N provision; (b) additional health providers to complement and assist the Health Assistants in the NI Health Centers in delivering RMNCH-N services; (c) a third-party provider to deliver training and coaching to boost provider skills and adherence to guidelines; and (d) design and roll-out of a transparent performance management system, including the associated management, supervision, and mentoring costs. Direct hire or contracting arrangements identified as appropriate by the service delivery TA will be used for (a) and (b). It is expected that contract providers will be absorbed into the MOHHS payroll during the life of the project. Therefore, the number and type of additional contract staff will be included in the annual work plan and budget, and jointly agreed between the RMI and the WB. Counterpart financing is one option that may be considered.

Equipment, commodities and supplies: The Project will finance the procurement of small equipment (including anthropometric measurement equipment), materials, pharmaceuticals/commodities, in order to meet standards of readiness to deliver the basic essential RMNCH-N package. In the first phase, procurement will be limited to filling equipment, commodity, and supplies requirements for the Majuro/Ebeye Hospitals, Laura Clinic, and NI Health Centers. Additional equipment/commodity/supply requirements may be identified in in the strategic mapping and the component can finance costs of upgrading NI Health Centers and/or equipping zone nurses, health outreach workers, mobile clinics, etc. to deliver the RMNCH-N service package. Investments in the immunization cold chain will be complementary to those financed under the Asian Development Bank’s regional immunization TA.

• **Data and Information Technology:** The Project will finance gaps in the IT system infrastructure (hardware, software, and training) to monitor RMNCH-N patient records and service utilization, manage stock, and assess performance. Enhancing the availability, quality, and use of data for decision-making will be necessary in order to translate the supply- and demand-side investments to improved health and nutrition outcomes. With support from Taiwan, China, efforts are underway to upgrade and modernize the HMIS. Development of innovative IT solutions to strengthen community outreach and service delivery may be considered at the midterm review. The Project will further support the development of a database and digital dashboards to make the information for decision-making readily available.

Table 1: Key Project Data

Project Data	US$ (millions)
Original Project Amount	US$13.00
Component 1 Total Budget	US$3.66
Closing Date	December 31, 2024

NP1: Well-women visit

ECD has been involved with minor works within the Majuro and Ebeye Hospital. One project specifically applies to the MCH One Stop Shop. With guidance from the team, the ECD project has met with program managers and hospital staff to discuss the structure and floor plan of this works. Documentation has been sent over to the World Bank for approval from the safeguard and financial management team. We hope to start renovating by October 2021.

NPM3: Risk Appropriate Care

The Milestone Passbook or newborn baby passports is set to launch in November 2021 and is currently in its final stages of approval. Translation and consultations with stakeholders have taken place to ensure consensus. Due to COVID-19 competing activities and community transmission in August 2022, the milestone passbook was not implemented in 2022.

NPM13: Preventative Dental Visit

The project has initiated discussion with partners from both MOHHS and Public School System (PSS) to roll out the dental school checkup and outreach. Early 2021, discussion took place to assist with revamping the annual school dental checkups done by the MOHHS dental team. With the support from Taiwan Health Center (THC), PSS, and MOHHS, this initiative will launch in September 2021. THC was able to give a generous donation of dental kits and ECD will assist with financial support regarding travel to Ebeye for outreach at the school's there. The main challenge is lack of funding and staff for the dental program. It is important this program can continue and reach the outer islands as a required health check up to improve overall dental health in the RMI.

The main challenge for the ECD project is lack of staffing and financial constraints caused by the COVID-19 pandemic. With only the National Coordinator on board, it has been a challenge hiring and keeping staff to implement and roll out this project. Due to the COVID-19 project, the borders have been closed and have made it harder to bring in consultants, trainers, staff, and so forth. MOHHS has been in a constant State of Emergency since August 2019, in part due to the dengue outbreak. The MOHHS has been exhausted and working tirelessly to make sure the RMI is safe and COVID-free.

State of Emergency – COVID-19

In March 2020, RMI closed its borders because of SARSCOV-2. From then on, RMI started its preparedness efforts as a country. A National Disaster Committee was created and MOHHS leads the health sector. Each government agencies (Local and National) build up its capacity to respond to COVID-19.

MOHHS strengthens its surveillance, testing capability, risk communication and community engagement, prevention, and treatment against COVID-19.

- COVID-19 vaccinations increase due to:
  - Established a risk communication and community engagement working group.
    - Increased awareness to the communities on COVID-19 symptoms, and its preventative methods.
    - Use of media platforms for COVID-19 vaccinations awareness, social media, radio talk shows, local newspaper
  - Established a vaccine taskforce.
  - Feedback portal to enable questions and answers on COVID-19 vaccinations.
  - Administration of COVID-19 vaccinations within the clinics and after hours, as well as through the communities from house-to-house campaigns.
  - A COVID-19 vaccination raffle activity was rolled with cash prizes to those individuals that had their first dose of vaccination and another raffle for those who have had their second dose of vaccinations.
- Personal Protective Equipment (PPE) training
  - The nurses within the MCH clinics were trained in PPE donning and doffing (refresher training). They were also trained in proper mask wearing as well as hand hygiene.
- Collaboration with another Government Ministry - PSS
  - The MOHHS established a COVID-19 K-12 Screening (K12CST) testing taskforce with PSS.
  - They were able implement the K12CST program within the schools which was to conduct COVID-19 screening testing through the schools for any persons on the school premises that would show signs and symptoms.
  - Before implementation, members of the K12CST would have to present to the Parents and Teachers association for awareness and questions. As well as consent for swabbing from the parents.
  - Through this program, the faculty staff are trained in PPE donning and doffing, as well as swabbing for COVID-19 symptoms on site and testing on-site

By August 8, 2022, 1st COVID-19 community transmission was confirmed. The COVID-19 response plan rolled out. We close the hospital for non-emergency services like Outpatient and public health clinics were closed. Below are highlighted activities:

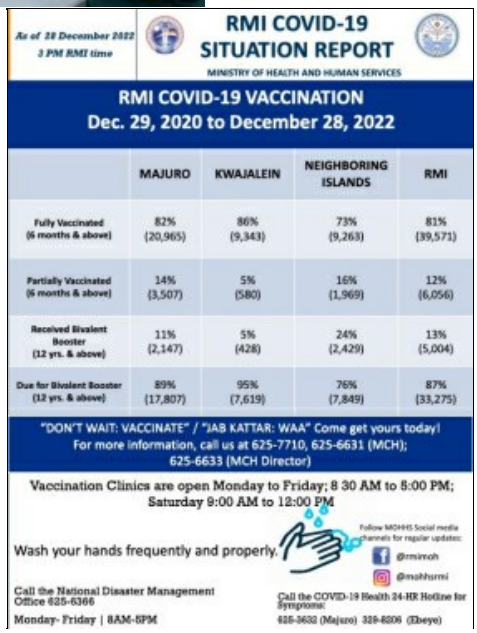
Response to COVID-19

- The COVID-19 test-to-treat (T2T) sites were installed at several schools at Majuro Atoll and the gymnasium on

Ebeye Island.

- These COVID-19 T2T sites allowed for those who wanted to get vaccinated for COVID-19 first dose, second dose or booster. Availability of staff trained, laptops, and access to internet allowed for record checking for the COVID-19 vaccinations and data entry of COVID-19 administered doses.
- PSS faculty were able to aid at the COVID-19 T2T sites.
- Mobile clinics implemented to visit those individuals within the communities that were immobile and were not able to visit the COVID-19 T2T sites.
- We received assistance from CDC, WHO, and UNICEF subject matter experts to respond to community cases of COVID-19.

The above RMI COVID-19 situation report on the left bottom illustrates the number of COVID-19 cases reported from August 8, 2022 to December 28, 2022. The stacked bar chart compares the COVID-19 cases reported and tested from the 3 main atolls Majuro, Kwajalein (Ebeye), and the NI's. As depicted in the stacked bar, there is an increase in number of



As of 28 December 2022 3 PM RMI time

RMI COVID-19 SITUATION REPORT

MINISTRY OF HEALTH AND HUMAN SERVICES

RMI COVID-19 VACCINATION
Dec. 29, 2020 to December 28, 2022

	MAJURO	KWAJALEIN	NEIGHBORING ISLANDS	RMI
Fully Vaccinated (6 months & above)	82% (20,965)	86% (9,343)	73% (9,263)	81% (39,571)
Partially Vaccinated (6 months & above)	14% (3,507)	5% (580)	16% (1,969)	12% (6,056)
Received Bivalent Booster (12 yrs. & above)	11% (2,147)	5% (428)	24% (2,429)	13% (5,004)
Due for Bivalent Booster (12 yrs. & above)	89% (17,807)	95% (7,619)	76% (7,849)	87% (33,275)

"DON'T WAIT: VACCINATE" / "JAB KATTAR: WAA" Come get yours today!
For more information, call us at 625-7710, 625-6631 (MCH); 625-6633 (MCH Director)

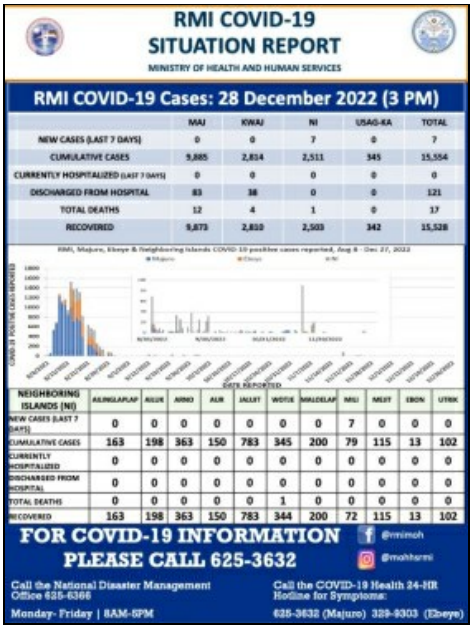
Vaccination Clinics are open Monday to Friday; 8 30 AM to 5:00 PM; Saturday 9:00 AM to 12:00 PM

Wash your hands frequently and properly.

Follow MOHHS Social media channels for regular updates:
@rmimoh
@mohhsrmi

Call the National Disaster Management Office 625-6366
Monday- Friday | 8AM-5PM

Call the COVID-19 Health 24-HR Hotline for Symptoms:
625-3632 (Majuro) 329-8206 (Ebeye)



RMI COVID-19 SITUATION REPORT

MINISTRY OF HEALTH AND HUMAN SERVICES

RMI COVID-19 Cases: 28 December 2022 (3 PM)

	MAJ	KWAJ	NI	USAG-KA	TOTAL
NEW CASES (LAST 7 DAYS)	0	0	7	0	7
CUMULATIVE CASES	9,885	2,814	2,511	345	15,554
CURRENTLY HOSPITALIZED (LAST 7 DAYS)	0	0	0	0	0
DISCHARGED FROM HOSPITAL	83	38	0	0	121
TOTAL DEATHS	12	4	1	0	17
RECOVERED	9,873	2,810	2,503	342	15,528

RMI, Majuro, Ebeye & Neighboring Islands COVID-19 positive cases reported, Aug 8 - Dec 27, 2022

Majuro Ebeye N/NI

COVID-19 POSITIVE CASES REPORTED

DATE REPORTED

NEIGHBORING ISLANDS (NI)	AILINGLAPLAP	AILUK	ARNO	AUR	JALUIT	WOTJE	MALOELAP	NIU	MILI	EBON	UTRIK
NEW CASES (LAST 7 DAYS)	0	0	0	0	0	0	0	7	0	0	0
CUMULATIVE CASES	163	198	363	150	783	345	200	79	115	13	102
CURRENTLY HOSPITALIZED	0	0	0	0	0	0	0	0	0	0	0
DISCHARGED FROM HOSPITAL	0	0	0	0	0	0	0	0	0	0	0
TOTAL DEATHS	0	0	0	0	0	1	0	0	0	0	0
RECOVERED	163	198	363	150	783	344	200	72	115	13	102

FOR COVID-19 INFORMATION @rmimoh

PLEASE CALL 625-3632 @mohtsrmi

Call the National Disaster Management Office 625-6366

Monday- Friday | 8AM-5PM

Call the COVID-19 Health 24-HR Hotline for Symptoms:

625-3632 (Majuro) 329-9303 (Ebeye)

COVID-19 cases reported and tested (rapid antigen test) in the first 2 weeks from Majuro atoll (blue color) of community transmission, then by the third week there was a decline in COVID-19 cases reported from Majuro atoll whilst testing continued. Similar pattern, also be seen with Kwajalein, whereby first case identified in the first week, and an increase in number of COVID-19 cases reported and tested shown in the second week with a decline in numbers reported by the third week. As for the NI's, the COVID-19 cases were identified in the second week of the outbreak, and this was largely due to transporting COVID-19 test kits to the NI's. Therefore, COVID-19 cases were identified and reported in the second week and by the third week onwards there was a decline in COVID-19 cases reported. On August 28th, 2022, the RNZ Pacific Correspondent (1) reported that "Johns Hopkins University, which tracks covid cases globally, reported that the Marshall Islands set a seven-day all-time record for the rate of positive cases of Covid. "But what the data also shows is a jurisdiction that is able to test, treat and provide access to healthcare," said Brostrom". Dr Brostrom continued to mention in the report that RMI had given that accessibility to the communities through the alternate care sites (later renamed to test to treat sites) that allowed to treat and manage thousands of people in the communities within a short period of time.

Key Achievements

- RMI had the highest COVID-19 vaccination coverage rate during a COVID-19 outbreak;
- Multi-sectoral approach and collaboration played an integral part during the response phase;
- Team leads and their members in respective clusters were very supportive and operational;
- Fasting procurement processing; AND
- Coordination and team-work.

TB-NCD-Leprosy Mass Screening

In 2022, the TB program was able to conduct 1 successful TB Mass Screening amidst the demands of COVID-19 preparedness activities. 3% (n=20) of 699 screened were diagnosed with Active TB. Of the 20 Active TB cases, 2 are 0-5 yrs. old, 8 cases are 6-15 yrs. old, and 10 cases are 16 yrs. old and above. There are 165 Latent TB Infection (LTBI). There were 354 18 yrs. old and above screened for NCD. 41 are pre-diabetic, 9 newly diagnosed diabetic, 67 pre-hypertension and 9 newly diagnosed hypertension. 1 newly diagnosed Leprosy (Hansen's Disease). Health Assistant in Wotje continued the TB Direct Observe Therapy (DOT) services on LTBI and Active cases.

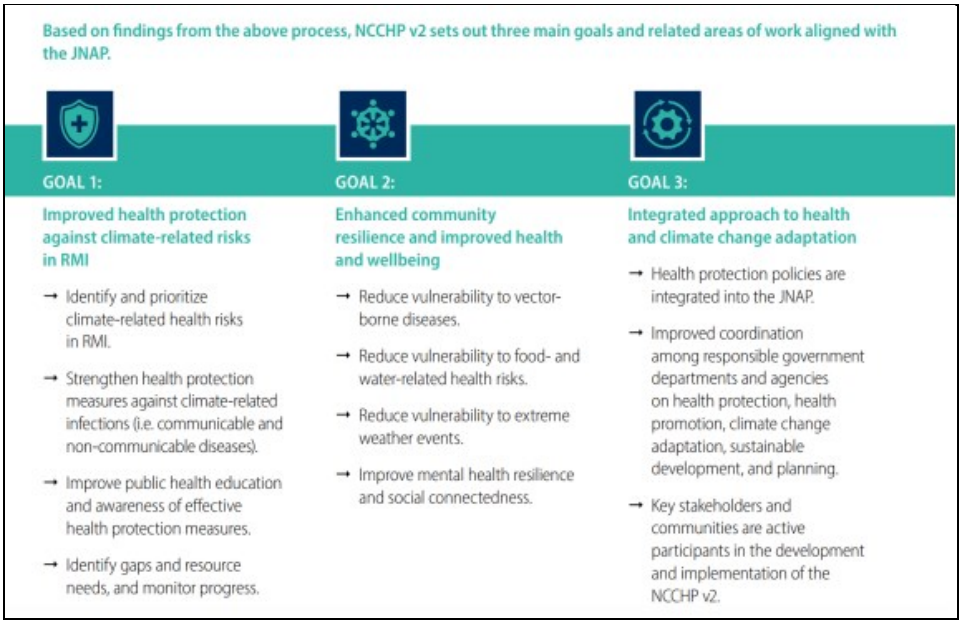
Neighboring Islands Health Care Summit 2022

The 3-day summit to focus on reviewing current NI Health Center's current status, operations, local partnership, and to establish a possible vision based on standards for NI health services. First Day will be an internal review (Pre-Summit) followed by a 2-day session that will include Marshall Islands Mayors Association (MIMA).

Meeting objectives:

- Review the status of NI health services through review of recent assessments and reports from Mayors association and MOHHS officials.
- Develop a set of appropriate standards for use in the RMI, with reference to a core domains framework for primary care services in outlying areas.
- Identify ways forward to meet standards
- Establish a strong partnership between MOHHS and NI Mayors.

RMI National Climate Change in Health Policy and Revised Action Plan



On December 8, 2022, the launching of the National Climate Change and Health Policy Revise Plan(2) took place. Importance of this policy is to address the impacts of climate change on people's health in the Marshall Islands. A number of key health issues – food and water safety and security, respiratory and vector-borne diseases, mental health, and extreme weather-related impacts – were identified as priorities. In addition, barriers to implementation of the plan, such as insufficient funding and human resources, apathy, and stigma, were highlighted. Stakeholders suggested responsible RMI agencies, strategies to manage these risks and timeframes. The strategies include increased resource allocation, educational campaigns, and continuing communication and engagement, particularly with traditional leaders, landowners, and community and faith-based groups.

Reference

RNZ Pacific Correspondent. As COVID-19 cases drop, Marshall Islands praised for “unprecedented” response. 2022.

Pacific Community, Scaling Up Pacific Adaptation, The Global Climate Change Plus Initiative. National Climate Change and Health Policy and Revised Action Plan Government of the Republic of the Marshall Islands [Internet]. 2022 [cited 2023 Jul 29]. Available from: https://gccasupa.org/wp-content/uploads/2022/11/National_Climate_Change_and_Health_Policy_and_Revised_Action_Plan_RMI.pd

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

Needs Assessment Update

COVID-19

July 2023, there are 16,098 COVID-19 cases in RMI with 17 deaths and 147 hospitalizations. 100% of 6 months and above received full COVID-19 vaccination based on the projected population from the new census of 2011. The number of fully vaccinated with COVID-19 6 months and above is 41,468 while population for 6 months and above is 41,339. 33% of the 5 years old and above received bivalent COVID-19 vaccines. We continue to provide testing and vaccinations. In 2022, preparedness and response to COVID-19 affected the implementation of activities.

Ministry of Health and Human Services Strategic Plan (MSP) 2022-20230

MSP was conducted from April to June, 2022. The Secretary, Deputies, Assistant Secretaries, Bureau Directors, and Chiefs were oriented to MSP process via an organizational meeting held before the retreats. In addition, separate meetings were held with the chiefs of each of the Bureaus falling into three retreat groups (Public Health & Primary Care; Hospital & Referral Services; Administration, Finance & Planning). Leaders of the Kwajalein Atoll Health Care Services Bureau were invited to all Bureau-level retreats. In addition to the MSP retreats, results from a Neighboring Islands Health Services Summit between MOHHS and the Marshall Islands Mayors Association (MIMA), which was held in April 2022, is included in the MSP. The scope of the MSP was limited to MoHHS strategies plus laws and policies and did not include consideration of possible changes to the RMI government health insurance plan, or insurance-supported health funds, MoHHS partners or other segments of society that affect health. Prior to each retreat staff in the respective bureaus were delegated to perform SWOT (strengths, weaknesses, opportunities, threats) analyses of their bureaus, review current endorsed (or nearly endorsed) strategic plans for categorical areas within their bureaus, and review existing laws, regulations, and policies relevant to their bureaus for presentation at their retreats. Open strategic planning discussions were held following these presentations conducted by facilitators chosen by Bureau chiefs.

Ministry of Health and Human Services Strategic Plan, 2022-2030 is our blueprint for continuous improvement over the next eight years and expands on the approaches to improving health set forth by our leaders in the RMI National Strategic Development Plan, 2020-2030. In keeping with our mission, the Plan emphasizes ways to work smarter and in closer partnership with communities to expand delivery of prevention and primary care services, which are most cost effective, to work with our policy makers to accelerate the adoption of policies to improve health, to take innovative approaches toward easing the hidden burden of red tape that compromises our effectiveness and customer service, and to raise standards of our workforce, our hospitals and our outlying health centers.

Below is the section related to MCH services:

2) Improved maternal, infant, child & adolescent health *[SDG: 3-Good Health; 10-Reduced Inequality; 16-Peace, Justice & Strong Institutions; 17-Partnerships]*	1. Improve health policy environment (policies/laws/regulations/enforcement related to MCH and adolescent care) 2. Establish standards and quality monitoring systems for hospital units 3. Improve technical management of RMI hospitals (with attention to care of maternal and pediatric conditions) 4. Decentralize primary care services (including for MCH clients) 5. Improve PH & primary care services integration across categorical programs (including MCH-related programs) 6. Improve registry data systems to enable targeted outreach for preventive services delivery (including for NCD & MH clients) 7. Engage partners & other sectors in ECD initiative (Finalize and seek endorsement for National ECD Policy & Action Plan)

The Inaugural Tole Mour Leadership Conference was held from July 19-21, in Majuro. The conference brings together the RMI Ministry of Health and Human Service's (MOHHS) Ministry Leadership Team (MLT), Bureau Leads, Senior Management Team (SLT), and partner technical assistance (TA) agencies to share strategies and resources for accelerating the shift to a more integrated and sustainable health system. This year's meeting will focus on the first year of the RMI MOHHS' Strategic Plan 2022-2030 (MSP 2022-30) and chart the way to move forward with the business practice and service delivery model innovations that the Plan calls for.

Revitalize MOHHS' efforts to implement the RMI National Strategic Development Plan 2020-2030 (NSDP) as outlined for the health sector in the RMI MOHHS MSP 2022-30, with areas of emphasis including revitalizing leadership, nurturing a more flexible and resilient workforce, elevating health equity and coverage of public health services, collaboration with community-based organizations, and improved use of digital and communications technology.

Health Information System Deliverables

The MOH HS Strategic Plan 2022-2030 calls for decentralization, integration, and data-driven approach to delivery of public health & primary care services to the RMI population. MOHHS Strategic Plan components, designed to meet these strategic goals:

Establishment of a new Zone Outreach Unit (ZOU) linked to a new Registry Data Unit (RDU). Both units will consolidate workers from across multiple categorical health programs into integrated units (zone nurses & CHOWs for the ZOU and Data officers for the RDU).

Deliverables:

- Data collection system for recording outreach visits in Majuro
- Standardized monthly reports of outreach activities and outcomes
- Enhanced registries capable of tracking patients in high risk/high needs groups in the Majuro communities
- Standardized outreach lists linked to deployment of Zone Nurses and Community Health Outreach Workers (CHOWs)
- Standard Operating Procedure (SOPs) for ZOU and RDU processes
- Action Matrix for implementation of ZOU and RDU

Establishment of Neighboring Islands Enhanced Services Support Project (NIESSP)

Deliverables:

- Data collection system for Field Officer visits to Nls**(Good to Expand)**
- Record system for tracking high risk/high needs groups in the NI community
- Analysis of costs for current system using Majuro-based staff for direct services delivery to Nls compared

with costs for NIESSP**(Good to Expand)** service delivery system

• SOPs for field trip assessment/continuing education/supportive supervision of NI staff

• SOPs to report results of field trips to PH**(Good to Expand)** programs and Outer Islands Health Care Services

• SOPs to link field trip reports to payments for NI Local Atoll Performance Agreements and for fee-for- service Maternal Health & Child Development Aides

• Action Matrix for implementation of NIESSS

On-going Needs Assessment Activities

MCH Program continues to collect and analyze data from different programs that provides services to MCH populations. Continued partnerships with Public School System, Vital Statistics, Preparedness program, Hospital services, NGOs like Marshall Islands Disable People Organization, Women United Together Marshall Islands and other agencies.

RMI 2nd MCH Jurisdictional Survey was conducted in 2021. Planning and training were conducted remotely by NORC to the same Non-Government Organization (NGO) that conducted the 2019 jurisdictional survey.

Women/Maternal Health

Between 2019 and 2021, the number of preventive medical visits among women aged 18 to 44 decreased by 40% (MCH-JS: 48.3% and 29.2%, respectively), but this decline was not statistically significant. Contrarily, although not statistically significant, outcomes like infant mortality (Vital Statistics) declined by 3% between 2019 and 2021, with a greater decline during the postnatal period (average annual percent change - AAPC-32%; $p>0.05$) compared to the neonatal period (AAPC: -5%; $p>0.05$). Additionally, between 2019 and 2021, preterm-related mortality declined significantly, by 46% (Vital Statistics). Preterm births decreased significantly by 61% (Vital Statistics); however, there was a significant increase in early term births (AAPC:42%; $p<0.05$). Other outcomes significantly increased throughout the course of the period (Vital Statistics), including neonatal abstinence (AAPC:19%; $p<0.05$), teen birth rate (AAPC:13%; $p<0.05$), and postpartum depression symptoms (AAPC: 38%; $p<0.05$).

There is no maternal death in 2022. MCH and Cancer programs continued to partner to navigate women to the after-hours Women's clinic to be able to receive cancer screening. Cervical cancer is still leading cause of death for Marshallese women.
In women aged 15 to 44, the use of family planning services dropped significantly by 5%, from 15.5% in 2017 to 12% in 2021. In 2022, the family planning users for 15 to 44 years old went down to 10%

Perinatal/Infant Health

Periods and sources to measure ever breastfed and exclusive breastfeeding trough 6 months are different. However, MCH-JS data shows a 61% significant increase of infants who are ever breastfed between 2019 and 2021 (55.8% to 90.1%, respectively), while MCH program data from 2017 and 2018 shows a significant increase (percent change PC:4%; $p<0.05$) for infants exclusively breastfed until 6 months (40.5% to 42.3%, respectively). According to Vital Statistics data, infant (AAPC: -3%; $p<0.05$) and neonatal (AAPC:-32%; $p<0.05$) mortality rates decreased even though not significantly, while SUID were only reported during 2020 (97.3 per 1,000 live births). 15% decrease on infant mortality rate from 2019 to 2022. Children aged 19 to 35 months who were fully immunized increased significantly (AAPC: 8%; $p<0.05$) between 2017 and 2021, from 46.8% to 62.7%.

Child Health

There was a 37% non-significant decline in the percentage of children, ages 1 through 17, who had a preventive dental visit in the past year between 2019 and 2021 (MCH-JS**(Good to Expand)**: 25.2% to 15.9%, respectively). Although not significant, the percentage of children, ages 1 through 17, who have decayed teeth or cavities in the past year improved by 33% during this same period (MCH-JS: 23.8% to 15.9%, respectively). Elementary schools visited by dental programs increased significantly between 2020 and 2021 (PC:31%, $p<0.05$) as did the percentage of children between the ages of 1 and 17 who received preventive dental care from a dentist (PC: 2%; $p<0.05$).

Adolescent Health

Between 2019 and 2021, there was a non-significant decline of 42% in preventive medical visits among adolescents aged 12 to 17 (MCH-JS: 45.9% and 26.6%, respectively). However, throughout the same time frame, according to Vital Statistics and the Immunization Program (WebIZ), a number of outcomes significantly improved: Teen birth rates (AAPC:13%; $p<0.05$), adolescent mortality rate (AAPC: -45%; $p<0.05$), children aged 6 months to 17 years who receive an annual influenza vaccine (AAPC: 65%; $p<0.05$), adolescents aged 13 to 17, who have received at least one dose of the Tdap vaccine (AAPC: 47%; $p<0.05$), and at least one dose of the meningococcal vaccine (AAPC: 163%; $p<0.05$). Additionally, although not statistically significant, the percentage of obese children aged 10 to 17 (AAPC: -21%; $p > 0.05$) and the rate of adolescent suicide (AAPC: -66%; $p > 0.05$) also improved. In 2022, there are no suicide and motor vehicle accidents among adolescents. On the other side, there was a significant 10% decline in the percentage of adolescents, aged 13 to 17, who had gotten at least one dose of the HPV vaccine (WebIZ). Thirteen-year-old girls' HPV vaccination coverage (ESM 10.3) has increased by 5% during 2017, however this change is not statistically significant. Teenagers 13 to 17 years old used 9% more family planning services between 2017 and 2021 (18.6% and 10.4%, respectively), however this increase was not statistically significant.

Children with Special Health Care Needs

Even though by 2019, 50% of CSHCN, aged 12 to 17, received services to help them transition to adult health care, the 2021 MCH-JS data show that 0% of the CSHCN had received these services. This indicator should be taken with care because the width of the confidence interval is >20%, or >1.2 times the estimate. The MCH-JS offers the same caution for CSHCN, aged 0 through 17, who received care in a functioning system since it reports 0% for both years. Between 2019 and 2021, there was an 11% decline in the prevalence of children diagnosed with an autism spectrum disorder, however, this decrease was not statistically significant (MCH-JS: 1.8% and 1.6%, respectively). However, this indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution Children 3 to 17 years old who were diagnosed with attention deficit /attention deficit hyperactivity disorder showed a 90% non-significant decline between 2019 and 2021 (MCH-JS: 2% and 0.2%, respectively).

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$226,000	$223,723	$228,778	$230,254
State Funds	$200,000	$2,646,295	$200,000	$2,646,295
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$426,000	$2,870,018	$428,778	$2,876,549
Other Federal Funds	$150,000	$184,125	$150,000	$47,000
Total	$576,000	$3,054,143	$578,778	$2,923,549

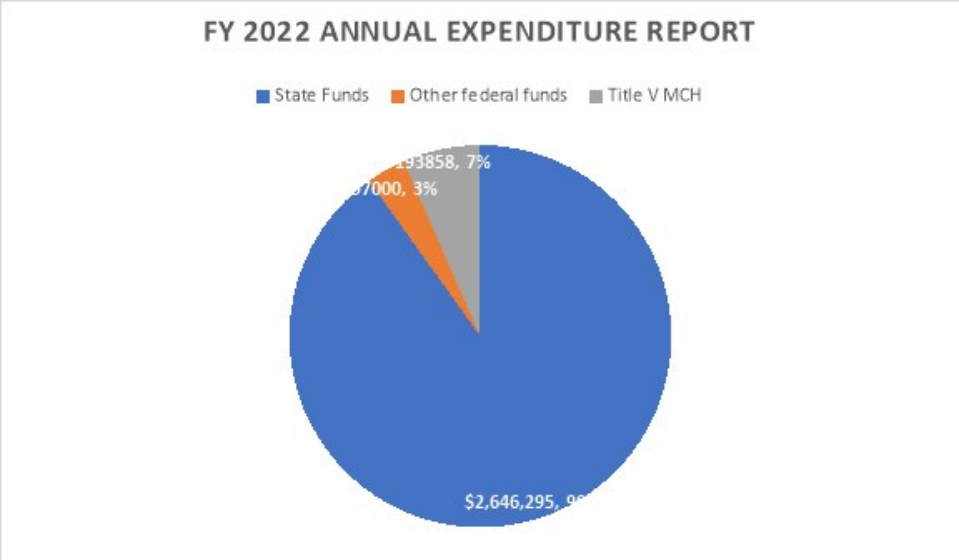
	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$229,808	$233,858	$230,524	
State Funds	$2,646,295	$2,397,695	$2,646,295	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$2,876,103	$2,631,553	$2,876,819	
Other Federal Funds	$200,000	$97,000	$97,000	
Total	$3,076,103	$2,728,553	$2,973,819	

	2024	
	Budgeted	Expended
Federal Allocation	$233,858	
State Funds	$2,646,295	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$2,880,153	
Other Federal Funds	$100,000	
Total	$2,980,153	

III.D.1. Expenditures

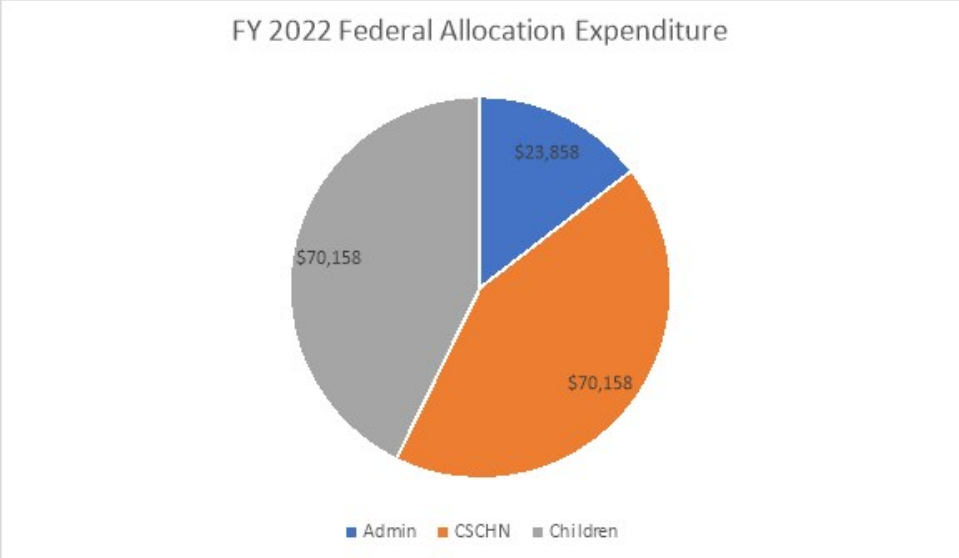
OVERVIEW OF EXPENDITURES

The mission of the RMI Maternal and Child Health Program is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The program works towards achieving these comprehensive services through the Ministry of Health and Human along with its' internal and external partnerships. In FY2022 (10/1/2021 to 9/30/2022), RMI MCH Program expended a total of $193,858.00. As of 9/30/2022, the total unobligated amount is $40,000.00. These unobligated funds are mainly for salary (vacant post), fringe benefits and employee insurance.



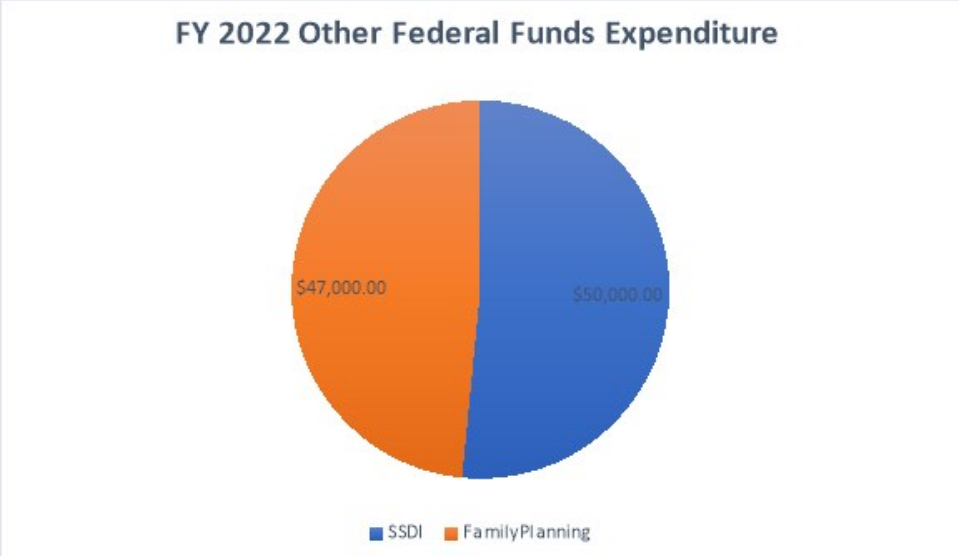
Legislative Requirements Met:

The RMI MCH program continually ensure that the program is complying with the Legislative financial requirements for the Title V Block Grant. The Ministry of Finance, Banking and Postal Services (MoFBPS) Federal Grant Coordinator provides a monthly funds status report of current funds available, encumbered, expended, and 30/30/10 percentage status report. Performance Based Budget Coordinator and Fiscal Officers at the Ministry of Health and Human Services (MOHHS) do monthly budget reconciliation with the MCH program to monitor and track expenditures to ensure compliance. Expenses are monitored and tracked at both Ministry of Health and Human Services through a database. MoFBPS is responsible to do the drawdown in PMS. The Title V legislation requires a minimum of 30% of the Block Grant funds for preventive and primary care children and a minimum of 30% for CSHCN services, no more than 10% for administrative cost.



Other Federal Funds:

The chart below provides an overview of other federal funds expended that were under the direct authority of the MCH Program Manager which are also listed in Form 2 (Family Planning and SSDI). The amount expended in FY2022 is $97,000.00



Total state match:

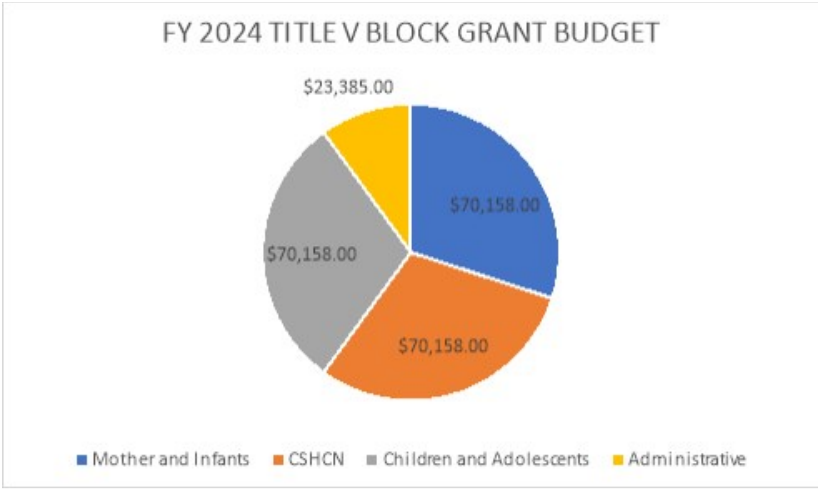
The total state matching funds in the amount of 2,646,295 was expended for FY2022. Most of the other funds were expended towards personnel salaries at the Majuro and Ebeye Hospital to provide services to the MCH population.

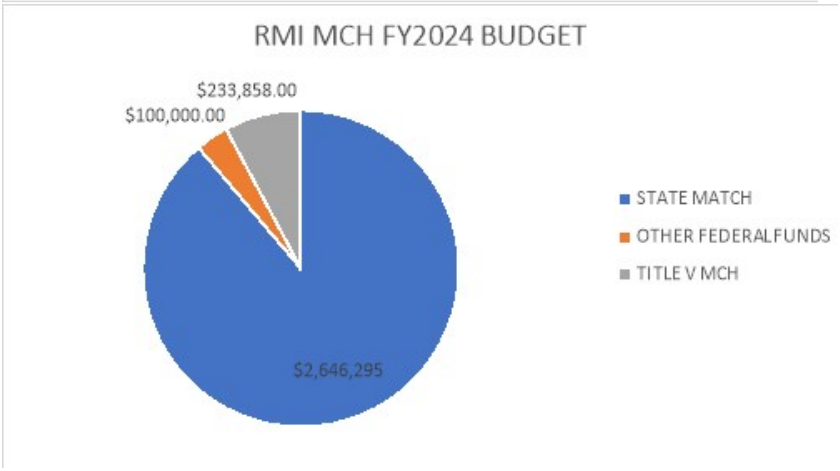
III.D.2. Budget

The mission of the RMI Maternal and Child Health (MCH) Program is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The program works towards achieving these comprehensive services through the Ministry of Health and Human along with its internal and external partnerships. FY2024 estimates a total state MCH program budget of $2,646,295.00. The MCH Program's State Action Work Plan has been developed based on the Needs Assessment and current emerging issues. Therefore, the MCH Program's State Action Work Plan determines where the MCH federal grant dollars are budgeted. The MCH grant, all Other Federal Funds, and the Total State Match, continues to align its comprehensive goals and objectives to effectively serve the MCH population. The Title V funds consist of personnel salaries, fringe benefits and insurance that support the following staffing:1 Midwife, 2 program nurses, 1 CSHCN program staff, 1 dental assistant who works closely with pregnant mothers. These personnel work not only for the MCH Program but contribute to activities that support the MCH activities. The MCH program manager is funded 100% under the Compact funds. In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Professional Services such as contractual and other costs to support the MCH Programs activities and initiatives stated on the State Action Work Plan. Funds also support MCH TA trainings and other trainings for staff that provide essential services to the MCH population. Public education and awareness costs include print, radio, local newspapers, television and social media posts on the importance of preventive screenings, annual preventive visits and prenatal care. Community awareness includes publicizing available services and programs, oral health care, breast feeding, and women's health services. Title V funds will be utilized to support the costs of pap kits, pregnancy test kits, STI reagents and other needed medical supplies. Funds are also utilized towards other costs such as overtime, domestic travels, communication, and support for medical referral of CSHCNs. The chart below provides an overview of the RMI MCH Program 2024 Budget as reported on Form 2.

Legislative Requirements Met. RMI MCH Program is committed to complying with the legislative financial requirements for Title V. The program will maintain expenditure and budget documentation for all MCH Block Grant funding allocations through the Ministry of Finance, Banking and Postal Services' accounting system The RMI MCH Program will satisfy the required match, which includes a $3 match in non-federal funds for every $4 of federal MCH Block Grant funds expended [Section 503(a)] and the maintenance of effort from 1989 [Section 505(a)(4)].

The Fiscal Year 2024 Title V Block Grant budget proposal of $233,858.00 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age was budgeted at $70,158.00 which is at 30% of the total federal award. Preventive and Primary Care for Children was budgeted at $70,158.00 which is 30% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Children with Special Health Care Needs was budgeted at $70,158.00 which is 30% of the total federal award (at least 30% of the total award to be utilized in compliance with the 30%-30% requirements). Administrative costs were budgeted at $23,385.00 which is 10% of the total direct costs of the federal grant award. The chart below provides a budget overview of the required federal allocation for the FY 24 Budget.





COVID-19 funds

Since 2022, the Ministry of Health and Human Services receives funding to support the COVID-19 preparedness and response from the following partners and it's not limited to CDC, HRSA, HHS, UNICEF, WHO, World Bank, IOM ADB, USAID, Republic of China-Taiwan, Australian Government, and New Zealand Government. The following activities were funded and not limited to:

1. Workforce Capacity
2. Laboratory Capacity
3. Communication
4. Vaccination
5. Repatriation
6. Skill building
7. Surveillance and Epidemiology
8. Risk Communication and Community Engagement
9. Reopening of Schools

10. Quarantine and Isolation facilities
11. Community testing
12. Tabletop exercises and full scall exercises

Total state match:

The total state matching funds in the amount of 2,646,295 budgeted for FY2023. Most of the other funds are still allocated to personnel salaries, utilities, medical equipment and supplies, fuel, outreach mobile visits to provide services to the MCH population.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Marshall Islands

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

III. E.2 State Action Plan Narrative overview

III.E.2.a. State Title V Program Purpose and Design

With the MoHHS' Mission Statement: "To provide high quality, effective, affordable, and efficient health services to all people of the Marshall Islands, through a primary care program to improve the health statistics and build the capacity of each community, family and the individual to care for their own health." With this mission statement in mind, each daily task, activity, and plan is in pursuant with the goal to utilize the national facilities, staff, and resources of the RMI.

Within the RMI MCH program, the mission is to promote and improve the health and well-being of women, infants, adolescents, children including children with Special Health Care Needs, and their families through the delivery of quality preventive programs and effective partnerships. Along with that purpose, the MCH Program envisions all women, infants, and children, including children with special health care needs, adolescents and their families a healthy and thriving lifestyle. The RMI MCH Program coordinates with other public health programs and stakeholders to implement health promotional and preventive activities for the women and children population. Title V funds are administered through the MCH National program and Ministry of Finance, Banking and Postal Services. The RMI National MCH workforce is housed at the MoHHS in Majuro and while other MCH workforce is housed at Ebeye, Kwajalein and at the health centers in the neighboring islands. The RMI MCH Program is designed to address the strategies identified within the RMI MCH Title V State Action Plan to provide preventive services to the MCH population. While majority of staff is funded by sources other than Title V, all contribute to the Title V mission and MCH priorities.

The following are the key staff involved in the Title V needs assessment and application processes.

MCH Program Manager: Mrs. Caroline Johnny Jibas holds an Associate of Science in Nursing. Aside from her experience in the MCH Program, Mrs. Jibas has experience working with the various Public Health Programs. She worked as a Zone nurse, TB, and Leprosy nurse before she was transferred to the MCH program. Mrs. Jibas has been involved in the Needs Assessment Activities for both the Title X Family Planning Program and Title V MCH Program in the RMI. Mrs. Jibas continues to provide guidance and input to all programs and centers in the neighboring islands. The Program Manager position is funded at 1.0 FTE through state MCH funds.

System and Data Manager: Ms. Edlen Anzures holds a Bachelor of Science from Adamson University, Philippines. She also received a post graduate certificate in Field Epidemiology from Fiji National University (FNU), and she is currently pursuing her master's degree in epidemiology. She has been involved in the Needs assessment and application process for both Family planning and MCH programs for many years. Ms. Edlen Anzures provides epidemiological support to the Title V MCH Program and assists in reviewing and making recommendations for data collection, quality improvement, and data analysis.

Title X/ MCH Family Planning Program Coordinator: Ms. Ana Valotu, stationed on Ebeye holds a Post-graduate Diploma in Obstetrics and Bachelors in Nursing from College of Medicine, Nursing and Health Sciences, Fiji National University. She is also a certified Epidemiology technician and currently pursuing her master's in epidemiology Aside from her experience in the MCH Program, Ms. Ana has experience working with Family planning program and working with Youth to Youth in Health on youth activities. Ms. Ana has been involved in numerous Needs Assessment Activities for both the Title X Family Planning Program and Title V MCH Program.

Performance based budget coordinator, Ministry of Health and Human Services: Mr. Ilaisa Daukakaka holds a Bachelor of Arts Degree in Business Administration. Mr. Daukakaka assists the MCH program in tracking of the Title V funds. Mr. Daukakaka coordinates monthly budget reconciliation with the program. He attended the financial forms training offered to RMI MCH program.

Clinicians: Dr. Ivy Clare Lapidez is an OBGYN, providing services to pregnant mothers and women and girls of reproductive age. Dr. Ivy is the clinical advisor for the OBGYNs and the chairperson for the Reproductive maternal, newborn, child and adolescent health (RMNCAH) committee. She has been involved with the needs assessment activities and application process. Dr. Mary Jane Gancio, a pediatrician and a clinical advisor providing care for newborns and children at the public health clinics and the inpatient wards. She has been involved in application process for numerous years and has been to AMCHP meetings.

MCH Clinic Supervisor: Mrs. Maypol Briand is the senior and supervisor nurse for the prenatal and gynecological clinic, she holds an AS in degree in nursing and a certificate in Midwifery. The position is funded at 1.0 FTE through

Title V funds. She's also a certified Visual Inspection with Acetic Acid (VIA) Trainer. She also has experience in Family Planning counselling and services.

MCH Clinic Nurse: MS. Eomra Lokeijak is a Nurse by profession, with an Associate Degree in nursing. Aside from MCH work, Ms. Eomra does clinical work and awareness activities in both MCH and Family Planning services at the MCH clinic. Ms. Eomra is certified in implant insertion and removal and VIA and Pap smear screening. The position is funded at 1.0 FTE through Title V funds. MCH nurse: Mr. Carlwin Aiseia is a nurse by profession, with an AS degree in Nursing. He is also a certified trainer on Family Planning and counselling. The position is funded at 1.0 FTE through Title V funds. Children with special health care needs: Ms. Johanna Rilang is a nurse by profession, with an AS degree. She is certified in VIA screening, pap smear, insertion and removal of implants. She has been to MCH/AMCHP conferences. The position is funded at 1.0 FTE through Title V funds. Dental Assistant: Ms. Kim Laidren is a dental assistant providing services and referral of pregnant women to proper treatment and care. The position is funded at 1.0 FTE through Title V funds.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Staffing Structure

The RMI MCH Program has 14 full time staff with 4 staff funded through the Title V MCH funds. The five Title V funded staff are 3 registered nurses, 1 certified midwife and 1 certified dental assistant. Nine staff of the MCH Program are funded by CHC, General Funds and other federal grants.

The MCH Program addresses the needs of the RMI MCH population complies with the varying program requirements of the MCH Title V Block Grant and links all services with other programs under the Ministry of Health and Human Services. While most of the staff is funded by sources other than Title V, they all contribute to the Title V mission and MCH priorities. For example, CDC funded immunization nurses implements the activities related to increase of complete immunization rates for 19-35 months.

Although the MCH Program is working closely with the Ministry's Human Resources and Public Service Commission to improve current workforce capacity, there is still challenges in providing specialized programs due to limited specialists and funding issues.

Recruitment & Retention

Recruitment of Ministry of Health and Human Services (MOHHS) staff including MCH program is handled through the coordination of MOHHS' Human Resources Office and Public Service Commission policies and procedures. In the last two years, there are a lot of MOHHS' staff that resigned to look for high-paying job opportunities from other government agencies, private companies or move to USA. Although the MCH funded staff are long time employees of the Ministry, our MCH activities and priorities are affected because most of our activities are collaborations with other public health and hospital-based programs.

Challenges in recruitment are, but not limited to, low salary grade, PSC's long process of recruitment and hiring, funding and availability of RMI workforce that fits at least the minimum requirements of the job description.

Every 2 years, more than 10 local nurses graduate from the nursing school at the College of the Marshall Islands. Currently, there's been a challenge with funding to hire new graduate nurses causing some nurses to apply for other fields, like local other ministries, banks and private offices. Aside from the nurses who graduate from the Nursing School, RMI, like other jurisdictions and territories, recruits a large majority of its nursing workforce from the Philippines and Fiji for specialties in midwifery, ER and ICU.

Continuing Education/Medical Education

RMI in collaboration with Taiwan established a medical program in 2016 where RMI students attend medical school in Taiwan. As of 2022, there are thirteen (13) Marshallese Doctors graduated from this program. Seven (7) had passed the Internship program and assign to the different hospital and public health programs like NCD, Reproductive Health, Pediatric Ward, Labor, and Delivery Ward, ER and etc. In 2022, 5 of the intern doctors were able to return to Majuro to start their internship program. Two of the doctors have returned to Taiwan to pursue specialty in Surgery. Our first master's degree in nursing came back and return to work in the Ministry as the Director

of Nursing Bureau. There is another nurse taking master's degree.

Workforce Capacity Training

The RMI MCH program in collaboration with other public health programs is to provide comprehensive and holistic community health services, including medical, dental, mental health and substance abuse screening, perinatal, nutrition, and family planning, all supplemented by enabling services including outreach, providing transportation.

In 2022, RMI MCH staff members took part in the following trainings:

- Minimal Initial Service package (MISP)
  The aim of the MISP framework is to contribute to reducing preventable maternal and newborn deaths, reduce the unmet needs for family planning, reduce STI/HIV transmission and reduce gender-based violence during humanitarian crisis. It was a 5-day training provided virtually by United National Population Fund (UNFPA). Participants are from Ministry of Health and Human Services staff from Majuro and Ebeye

- COVID-19 related training
  There were several trainings and presentation related to COVID-19 that were provided to the program. COVID 19 presentations, COVID-19 vaccinations, COVID-19 swabbing, IPC training, surveillance, contact tracing refresher course to staff on COVID-19.

- Spot-check Training
  Training using tablets to access a database to capture assessment of Family planning commodities at the service sites on Majuro, Ebeye and neighboring islands. UNFPA Virtual training was provided for 2 days.

- Family Planning Training
  10 days of Family Planning training provided virtually by UNFPA. Counselling techniques and commodities were the main topics, hands on training on how to insert implants, IUDs and other methods. Staff from the service sites in Majuro and Ebeye attended.

The need to build and improve the workforce for sustainability of the public health programs is imperative to improving delivery of services to the community. The shortage of local manpower impacts health service delivery in that there is a need to recruit manpower from the other countries, with a lengthy process and a high-cost package compared to local hire, since housing is provided. The program will work closely with leadership to develop competent, committed, and compassionate MCH professionals.

Workforce Enhancement Activities for Support by ECD for 2022:

- MOHHS Workforce Development Package

  Endorsed April 2022. Includes, Nurse Midwifery Program (PG Diploma in partnership with Fiji National University - FNU); Nurse Internship program (for new College of the Marshall Islands - CMI ASN nurses-continue 8 month internship that has been going for past 2 years); BSN Bridging Program (in partnership with University of Fiji), Community Health Outreach Worker program (in partnership with CMI, mainly for Majuro); Reproductive Health Worker program (to train women on Neighboring Islands which have only male health assistants to provide basic safe childbearing, basic family planning, basic antenatal and post-partum care: using United Nations Population Funds' (UNFPA) Minimum Initial Services Package training program.

  Due to community transmission of COVID-19, workforce enhancement plan implementation was delayed.

III.E.2.b.ii. Family Partnership

III.E.2.b.ii Family Partnership

The MCH Program not only partners with internal and external programs, but is striving to involve families at all levels, individually, and at the decision- making level. Family/consumer engagement is needed in advisory committees, strategic and program planning, quality improvement, workforce development, block grant development and review, materials development, and advocacy. In order to ensure that services are effectively meeting the needs of the local population, programs under the MCH have taken a collective approach towards involving families in programmatic decision making. The program in collaboration with Human Services and EHDI program involved Parents in working groups as well as play groups. This gives opportunity for parents to come together and share experiences with autistic children and children with hearing problem. One of the focuses is for training and capacity building among families as a means for strengthening meaningful family engagement.

Parent As Teachers (PAT) was established by Women United Together in the Marshall Islands (WUTMI), with this Vision: “All parents will be their child’s best first teacher. “ PAT project provides consultations on Special Education; holds 4 quarterly parental workshops/social events, participate in additional parental group sessions at elementary schools and conduct numerous home visits with its’ targeted and enrolled families.

In 2016, the MOHHS contracted Marshall Islands Epidemiology Initiative to facilitate focus groups with adolescents from RMI high schools. The focus groups were conducted with the intent to ensure that strategic and program planning are guided by family/consumer input. Surveys were also conducted throughout the communities. Moreover, for materials development, programs seek input from families who actively participate in MCH programs on items such as program brochures. Program informational materials, including those specific for the adolescent population, are reviewed by the health promotion division at the Ministry of Health and Human Services and approved by them prior to printing and distribution to the community as a mechanism for ensuring that print materials are culturally and linguistically appropriate. RMI kicked off with partnership with families group discussions concerning health of their children and will in the future engage families in decision making level.

In 2022, the MOHHS EHDI staff, behavioral health program staff and MCH program in collaboration with Public School System (PSS) and other stakeholders partnered with the families and the officers of the Marshall Islands Disabled People Organization (MIDPO) to plan the Disability Week activities in the Marshall Islands. MCH program was supported the opening ceremony to kick of the program. The MCH Director shared the Title V MCH Block Grant to MIDPO members, parents, families, and the rest of attendees including the highlights, current activities and plans of the MCH Program. Questions from the attendees on the plans for the Children with special health care needs component of the program especially and how to navigate the services provided at the Hospital and referrals from community to hospital and to off-island referrals. Program Director was able to address issues and questions.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Under the Office of Health Planning, Policy, Preparedness, Personnel, and Epidemiology (OHPPPPE), MCH Program receives the needed support on the data review, capacity, monitoring and address maternal and child health issues. MCH Program is not able to get its own Epidemiologist, but we have the Ministry's Epidemiologist that we work with.

Through the CDC Epidemiology and Laboratory Capacity grant, we have 3 Epidemiologists working for RMI MOHHs. Currently, 1 is based on Majuro, 1 on Ebeye and 1 in Honolulu, working remotely. In 2023, a monitoring and evaluation officer will join the EPI Team for better tracking of our MCH and MOHHS key performance indicators. We also have surveillance specialists and officers that are part of the EPI workforce

Epidemiologists: Jill McCready (contract ended in early 2023), Jana Matanaicake-Lum On (Majuro Epidemiologist and Acting Territorial Epidemiologist) and Josua Ligairi (Ebeye Epidemiologist)

Surveillance Team: Myciefer Takia (Vaccine Preventable Diseases Coordinator), Jason Lalimo (Surveillance Officer), Nathan Karben, Bruce Borran and Rujack Livai (Surveillance Specialist)

Vital Statistics: Brandon Alex (Data Specialist)

SSDI Director: Edlen J. Anzures

IT Coordinators/Data Modernization Lead: Nowel Delis and Etika Temo

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

State Systems Development Initiative (SSDI) support to MCH Block Grant (MCH)

The MOHHS has an office dedicated for building data capacity, assessment, planning, implementation, and reporting which work in all the bureaus of SSDI program is under the Office of Health Planning, Policy, Preparedness and Epidemiology which makes it as an advantage to link all the activities in MCH Programs. The SSDI Director is also the Health Informatics Director (used to known as IT Director) handles the MCH program information systems. For the past years, we have been building the IT infrastructure and data systems to be able to respond to the needs of MCH Programs. The SSDI program has been supporting the MCH Programs in the annual submission of MCH grant applications and reports.

SSDI grant funded two Data Encoders. One is assigned in the Vital Statistics Office who provided great assistance in updating the Vital Statistics from a 2 year-back log of data entry, filling and submission of data. Data encoder also visit Ebeye Hospital and selected Neighboring Islands Health Centers to audit the birth and death occurrence. Daily visit to Majuro Hospital Medical Records and Maternity Ward for the registration of births and deaths. They Coordinate with the Neighboring Islands Health Care Services Main Office in Majuro for the weekly call to all the 52 working health centers for birth and death occurrence. They work with the 177 Health Care Program Mission Coordinator for the birth and deaths occurrences in the 4 health centers under the program. With the funded staff, the Vital Statistics Office submitted fetal, birth and death certificates to Ministry of Culture and Internal Affairs for the certification of these registrations of vital events.

SSDI: **(12/1/2017 – 11/30/2022)**

Goal 1: Build and expand jurisdiction MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation.

- Supported the data needs of the Title V MCH Block Grant Application and Annual Report yearly submissions;
- Continue to build capacity of the MCH Program and stakeholders to improve the needs assessment process. Update of the 2021-2025 Five Years Needs Assessment including progress, challenges, and new strategies ;
- Revised and improved in the development, implementation, evaluation, and monitoring of the National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-informed Strategy Measures (ESMs) and
- Supported the MCH program needs in building its data infrastructure and information systems.

Goal 2: Provide partnership and on-site support for the development and implementation of a data collection tool/process that will enable tracking of Title V MCH Block Grant NPM data

- Working with NORC on the development and implementation of the 2nd Jurisdiction MCH Survey.

With the SSDI support in funding and technical assistance, the department continue to release the Republic of the Marshall Islands (RMI) Key Performance Indictors

The RMI Ministry of Health and Human Services (MOHHS) is responsible for improving the health status of the people of the RMI. It is essential to guide this effort with accurate, consistently measured, valid-data, and an

organized system in a way that gives a clear picture of both progress and problem areas.
Criteria for inclusion in the revised Key Performance Indicator (KPI) set included:

- Give a balanced picture of the top health priorities of MOHHS and RMI;
- Summarize overall progress rather than programmatic details;
- Use internationally recommended health and performance indicators where possible so that comparisons can be made across countries; and
- Are feasible to measure without great difficulty in the RMI.

The final set includes 36 indicators which fall into the following categories:

dDemographics, non-communicable diseases, maternal & child health, infectious diseases, resource, and administrative indicators. The KPIs were chosen to match priorities contained within the 3-year RMI MOHHS Strategic Plan (2018-2020) and designed to incorporate, where possible, indicators that are in harmony with RMI health sector commitments to the United Nations Strategic Development Goals and the Pacific Healthy Islands Framework. The intended target audience for KPI report includes the MOHHS Senior Leadership Team, Government of RMI, and partners like HRSA, CDC, WHO, SPC, and PIHOA

SSDI funding is instrumental in building RMI's improved MCH data analytics and capacity. We are expanding and addressing the data linkage of different siloed systems in RMI. We need additional resources to enhance our data systems to address health inequities, Social Determinants of Health, and to address health disparities to ensure health equity.

During the pandemic, staff funded under SSDI were given additional roles and responsibilities which includes review of documents of fishing vessels, carriers, and containers requests to enter Majuro Seaport, support the administrative staff for processing of procurements, and data entry of COVID-19 testing. RMI COVID-19 Dashboards with information on repatriation, sea and airport surveillance were developed and released under the department.

Due to the pandemic, IT consultants are unable to come and assist us in implementing the different modules under MHIS (Marshall Health Information System). Pending systems for development and implementation are Vital Records Information System and Milestones for 0-4 years old under the MCH Program. These activities are deferred to 2023.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

As the Ministry of Health and Human Services builds its health information system, MCH related systems that addressed the data needs of MCH State Priorities are included and prioritized for 2023. With the plans for the MHIS (Marshall Health Information System), Neighboring Islands Health Centers will be able to access the systems with the improvement of communication systems in each health center. Telehealth Program plan of implementation was moved to 2023.

The following systems are in development stage in 2022-2023:

1. Vital Records Information System (birth and death linkage)
2. Vital Records Information System Module for Registrar's Office at the Ministry of Culture and Internal Affairs
3. Milestones Module for 0-4 yrs old
4. Children with Special Health Care Needs Registry with link to their encounters with the providers
5. Marshall Health Information System modules: Prenatal, Women's Health, Family Planning. Labor and Delivery

We also plan to assist MCH Block Grant in Performance and Quality Improvement Initiatives driven data and workforce capacity building.

In 2023, we are planning to develop the Health Informatics Strategic Plan.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

Preparedness Program under the Office of Health Planning, Policy, Preparedness, Personnel and Epidemiology (OHPPPPE) prepares comprehensive Emergency Operation Plans. These plans are updated regularly to keep up with the emerging diseases.

Staff from MCH Programs under the Bureau of Primary Health Care Services and Kwajalein Health Care Services are activated to be part of the Labor Pool. The MCH Director will provide guidance on the active emergency but will be waiting for the assignment to be given by the Incident Commander.

During COVID-19 State of Emergency, Communicable Diseases Response Plan – COVID-19 was activated. The MCH staff were given task to assist in the COVID-19 quarantine facilities, vaccination services including travel to Neighboring islands, test to treat sites, outreach to find 50 and above population for COVID-19 testing and vaccination. In the community transmission, MCH Director managed one the test to treat sites.

MCH Director submitted MCH Program COVID-19 response plan. In this plan, Prenatal, Women and Family Planning Clinics will provide 3 months of medications like prenatal vitamin and family planning commodities. Plan to provide telehealth during COVID-19 community transmission. This plan was implemented. During community transmission and clinics were closed, the OB-GYNEs were available for consult via Facebook messengers, phone calls and text messages. If needed, the nursing staff delivers the needed medicines to their homes. Health Informatics Department provide IPads to all the doctors for their telehealth needs. They were able to log in to the MHIS (Marshall Health Information System). There was satellite pharmacy outside the hospital for pick-up of medications and all medications provided were free of charge. COVID-19 testing were free.

Emergency Operation Plan (EOP)

The current EOP doesn't have the specific plans for MCH population including person with disabilities. MCH Director met with the Preparedness Director and provided language in the EOP to include the maternal and child health population. The EOP will be revised. We will look into different sources but will use the HHS Maternal-Child Health Emergency Planning Tool Kit.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

The Marshall Islands has a well-developed/organized primary/preventive and public health system. There are two main hospitals located in the two urbanized islands in the Kwajalein (Ebeye Hospital) and Majuro (Majuro Hospital) Atolls. Including the two main hospitals, there are 49 active health centers/health clinics located in the various islands that make up the Marshall Islands. The two main hospitals serve the urban areas including the surrounding islands through referrals and medical evacuation. The two hospitals provide primary/secondary and some tertiary care. However, most tertiary care patients are referred off-islands to hospitals in the Philippines, Hawaii (Tripler Army Medical Center) and Taiwan. The health clinics in the Outer-Islands are staffed by Health Assistants who are locally trained and assigned to these clinics as primary care providers. The Marshall Islands MCH Title V program is a national program one of the key programs in the Bureau of Primary Health Care Services and provides the mandated services for the MCH population.

The 177 Health Care Program (Victims of Nuclear Fallout of Bikini, Rongelap, Enewetak, and Utrik) Clinics provide primary health care services to the four atolls affected by the nuclear testing. A primary health care physician manages the 177 Clinics. The Department of Energy has a DOE Clinic which provides medical services to the direct nuclear patients. The Diabetes Wellness Center which is managed by Canvasback Missions, in collaboration with MOHHS, demonstrates that natural foods and an active lifestyle can reduce or replace the need for diabetic medications and provides a higher quality of life for the participants. They also offer healthy food options for minimal price. Taiwan Health Center concentrates on developing health education materials and training programs primarily used in Non-Communicable Diseases (NCDs) like diabetes and helps with outreach activities, monthly missions on specialties to work at Majuro Hospital. Taiwan Health Center also work with Medical Education Committee for the internship of Medical Interns that graduated in Taiwan.

These health care services include, but are not limited to : a) clinical services in the hospitals and health center facilities and outreach activities; b) primary health care or preventive services in the hospital and health center settings, school and community compounds, house-to-house outreach; c) health promotions and educational activities, special projects with community groups; d) collection of data for the Health Information System to monitor health indicators, including monitoring and evaluation of health services and the health care systems.

In addition to the above-mentioned government sponsored health care services, there is one private health clinic and 1 private optometry practices in Majuro. All of the doctors practicing in the government and private clinics are licensed under the MOHHS' Medical Examining and Licensing Board to practice in the RMI including the medical and dental missions.

Medical Referral is handled by the Medical Referral Office. MCH program coordinated the CSHCN referral with Medical Referral Office. RMI has a national health insurance offering basic and supplemental health insurance. For Basic insurance, patient pays a) $5 for full outpatient visit which includes laboratory, diagnostics and pharmacy b) $17 for Emergency visit and c) $10 for admission. For patient with no insurance, patient pays a) $20 for full outpatient visit which includes laboratory, diagnostics and pharmacy b) $35 for Emergency visit and c) $110 for admission. To be able to receive basic referral where patients are referred to tertiary hospitals in Hawaii, Manila, and Taiwan, patients' needs to be enrolled in Basic Insurance. All Marshallese citizens are automatically under the Basic Insurance. For foreigners living and working in RMI, they need be an active member of Marshall Islands Social Security Administration with regular payment for 1 year and existing legal immigration papers.

Traditional Medicine Committee

Through a decision of the RMI Cabinet, a Traditional Medicine Working Group (TMWG) was formed in 2020 to make recommendations regarding the integration of appropriate traditional medicine/treatment into the RMI Health Care System. The TMWG conducted a preliminary desktop review of information on global best practices. This included study of the experience of integration in selected other health care systems internationally; evaluated the list of those traditional practices already observed to be used on patients in the RMI health care system; discussed most useful healing plants used in Marshallese Traditional Medicine & identified invasive (ingested) and noninvasive (topical) traditional healing treatments; and reviewed selected traditional massage therapies.

The working group also identified the complementary therapies and traditional medicine used in the Marshall Islands Health Care system over the years, particularly with respect to maternity health. The group also assessed whether this was enough information to carry out the preliminary assessment stage. At this initial and based only on information that have been obtained to date, the following conclusions are provided for consideration:

- Establishment of a Traditional Medicine Research Unit at the College of the Marshall Islands (CMI) with the primary role to:
- Identify the chemical properties of the most widely used Marshallese medical plants;
- Study how Marshallese medicines interact with western medicines;
- Undertake clinical research programs to study particular treatments and their effect in curing disease;
- Conduct clinical trials, based on research commencing with research into post-partum medicines (kōnnat and kiden) are given to women who have just given birth and the tonic made from the leaves of these trees have proven to greatly enhance the health and well-being of the new mothers.

Partnership

- Women United Together Marshall Islands
    - Patient Navigators to the Women's health clinics for cervical and breast cancer screening
- Public School System
    - Planning and implementation of Disability week program
- United Nations Population Fund (UNFPA)
    - Trainings on Contraceptive Management System (CMS), Youth Friendly Health Services Guidelines, Adolescence Sexual Reproductive Health in Emergencies,
    - Implementation of Health Facilities Readiness for Sexual Reproductive Health Assessment using Tupaia Meditrak Tool Kit
    - Cervical Cancer Policy Consultation
    - Drafting the Reproductive Maternal Neonatal Children Adolescent Health (RMNCAH) Policy
- World Bank
    - Early Childhood Development Program: Fast Cash Transfer to eligible children; Planning for workforce capacity building like midwifery training, Community Health Care Workers training, Female health aides.

Youth to Youth in Health

- Continue the "After hr" clinic
- Distribution of condoms in the community

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

III.E.2.b.v.b. Title V MCH -Title XIX Medicaid Inter-Agency Agreement (IAA)

RMI does not have Medicaid services. We have our own local insurance. All services provided by the MCH programs are free to the public.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

The following section provides report and plan narratives for Republic of the Marshall Islands (RMI) priorities, National Performance Measures (NPM), and State Performance Measures (SPM) by population domain as reflected in the 5-year plan. Changes were made to RMI's Title V priorities because of the 2020 5-year needs assessment as well as additional changes resulting from ongoing needs assessment during the pandemic.

Many activities planned for FY2021 and FY2022 were impacted by the pandemic: delayed, cancelled or changed. Our borders were closed in time of any community transmission. But our programs were affected by the pandemic. Most of the staff were re-assigned to provide workforce surge for the COVID-19 quarantine facilities, vaccination in the remote islands including house to house vaccinations, and activities related to preparedness and response.

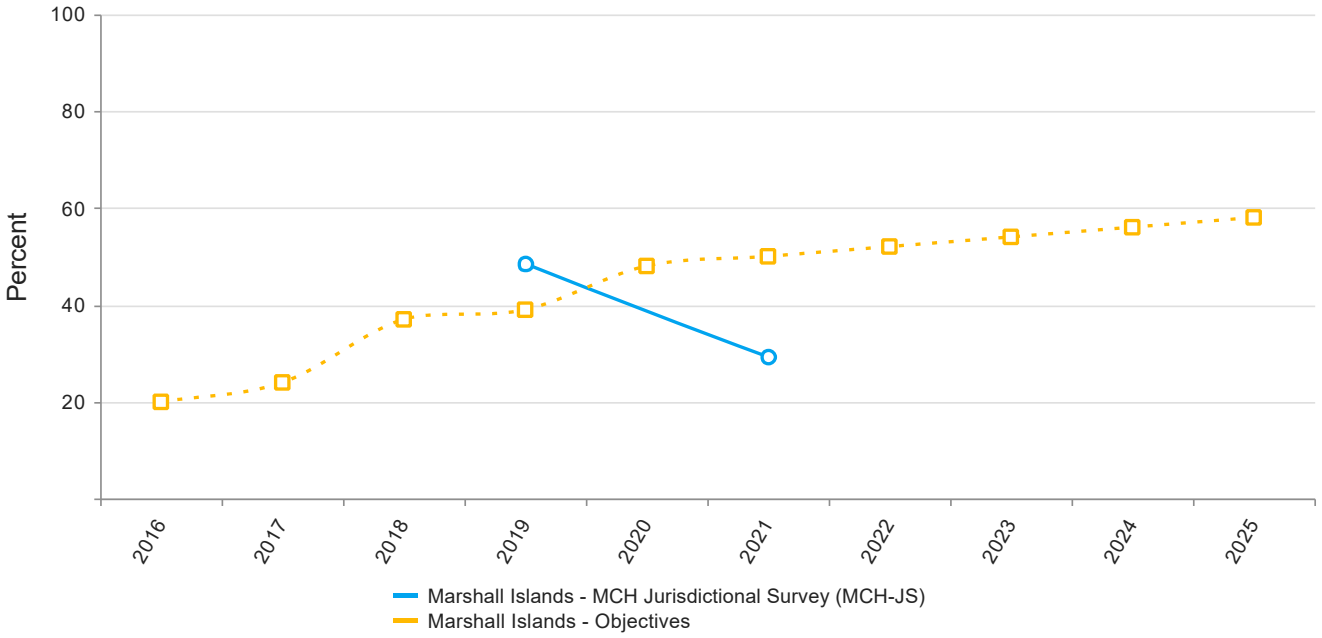
RMI's priorities discussed in this next section, by domain are listed below with the associated NPM/SPM number, the status for FY 2021 and FY2022 (new, continuing, and outgoing), and subject matter.

MCH Domain	NPM #	State Priority	State Performance Measures
Women/ Maternal Health	NPM 1	Access to coordinated, comprehensive care and services for Women before, during and after pregnancy. Cancer screening and services for Women's Health	SPM 1: Percent of Women ages 25-49 years old screened for cervical cancer. SPM 2: Percent of women ages 15-44 years old that use family planning services SPM 3: Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Perinatal/ Infant Health	NPM 3	Reduce Infant Mortality Rate	SPM 1: Training on the updated clinical guidelines and protocols for Obstetrics and Gynecological conditions
Perinatal/ Infant Health	NPM 4	Infants breastfed exclusively through six months	
Child Health	NPM 6	Parent-completed developmental screening tools	SPM 3: Increase percentage of fully immunized children ages 19 to 35 months
Adolescent Health	NPM 10	Child Oral Health Program partnership with schools Teen reproductive health and pregnancy prevention	SPM 5: Increase use of Family planning services to teenagers ages 13 to 17 years old.
Children with Special Health Care Needs	NPM 12	Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.	SPM 2: Final and endorsed readiness assessment of RMI MOHHS to handle Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program.
Cross-Cutting/ Life Course	NPM 13	Child Oral Health Program partnership with schools	

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective		48	50	52
Annual Indicator	48.3	48.3	29.2	29.2
Numerator	8,951	8,951	5,743	5,743
Denominator	18,513	18,513	19,682	19,682
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	37	39	48	50	52
Annual Indicator	37.7				
Numerator	3,733				
Denominator	9,896				
Data Source	MCH Program				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives			
	2023	2024	2025
Annual Objective	54.0	56.0	58.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	15
Annual Indicator			10.8	37.5
Numerator			103	386
Denominator			958	1,030
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	25.0	30.0

ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1	2
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Cancer Program	Cancer Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	3.0	3.0	5.0

ESM 1.3 - Percent of women booked for prenatal visit in first trimester

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	22
Annual Indicator			18.7	25.8
Numerator			179	260
Denominator			958	1,006
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	24.0	26.0	28.0

ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	12
Annual Indicator			0	6
Numerator			0	60
Denominator			958	1,006
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	14.0	16.0	18.0

State Performance Measures

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	11	13	13	12	14
Annual Indicator	10.9	13.4	10.8	13.4	10.1
Numerator	856	892	917	1,146	679
Denominator	7,849	6,644	8,529	8,529	6,719
Data Source	MCH Program	MCH Progam	MCH Program	MCH Program	MCH Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	16.0	18.0	20.0

SPM 2 - Percent of women ages 15-44 years old that use family planning services

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	18	20	16	15	16
Annual Indicator	16.8	14.5	11	12	13
Numerator	1,984	1,773	1,353	1,479	1,261
Denominator	11,790	12,255	12,271	12,301	9,715
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17.0	18.0	19.0

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		37	33	35	37
Annual Indicator		31.1	34.9	36.4	39.1
Numerator		372	359	368	399
Denominator		1,198	1,028	1,010	1,021
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	39.0	41.0	43.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 1	
Priority Need	
Access to coordinated, comprehensive care and services for Women before, during and after pregnancy	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By July 2025, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 58% (Baseline: 2019 MCH Jurisdictional Survey data 48.3%)]	
Strategies	
Promote well-woman visit through health education, awareness and campaign.	
Continued partnership with Cancer Program, HIV/STI Program and other Public Health programs	
Development and implementation of comprehensive one-stop shop well-woman essential services	
Strengthen Prenatal and post partum services	
ESMs	**Status**
ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.	Active
ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women	Active
ESM 1.3 - Percent of women booked for prenatal visit in first trimester	Active
ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 2

Priority Need

Cancer screening and services for Women’s Health

SPM

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Objectives

By July 2025, increase in cervical cancer screening for ages 25-49 years old to 22% (Baseline: 2019 MCH Program - 13.4%)

Strategies

Continued partnership with cancer program in screening awareness and navigation of women to the women's health clinic

Increase availability of community health centers that provides cancer screening

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 3

Priority Need

Access to coordinated, comprehensive care and services for Women before, during and after pregnancy

SPM

SPM 2 - Percent of women ages 15-44 years old that use family planning services

Objectives

Increase percentage of women ages 15-44 years old that use family planning services by 5% yearly.

Strategies

Increase public awareness of the Family Planning Services

Continue the after 5 pm Family Planning Clinic .

Improve distribution and inventory of Family Planning commodities to all health centers.

Partnership with Women based NGOs that will provide health education and navigating of women to the Family Planning Services

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 4

Priority Need

Access to coordinated, comprehensive care and services for Women before, during and after pregnancy

SPM

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Objectives

Increase number of pregnant women with prenatal visits in the First Trimester of pregnancy by 5% yearly.

Strategies

Increase awareness and health education on benefits of prenatal visits through radio, print, social media and partnership with NGOs

Collaborate with Immunization Zone Nurses to refer pregnant women to Prenatal Clinic

Implement incentive program for pregnant women that attended Prenatal Clinic at the First Trimester

Improve HIV/STI screening for pregnant women using rapid test kits.

Priority Need: Access to coordinated, comprehensive care and services for Women before, during and after pregnancy.

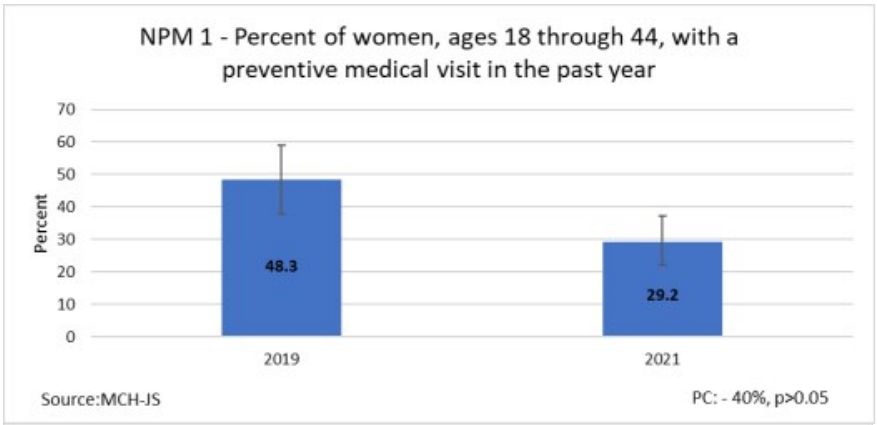
Measure	2019	2020	2021	2022	PC or AAPC	p-value
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year[1]	48.3	48.3	29.2	29.2	- 40%	p>0.05
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalization[2]	NA	19.5	29.7	20.4	52%	p>0.05
NOM 3 - Maternal mortality rate per 100,000 live births[2]	0	194.6	297	0	53%	p>0.05
NOM 4 - Percent of low birthweight deliveries (<2,500 grams) [1]	9.8	NA	13.6	15.7	39%	p>0.05
NOM 5 - Percent of preterm births (<37 weeks) [1]	21.5	NA	8.3	11.6	- 61%	p<0.05
NOM 6 - Percent of early term births (37, 38 weeks) [2]	20.8	13.4	29.4	31.1	42%	p<0.05
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths[2]	23.2	19.5	28.8	38.2	16%	p>0.05
NOM 9.1 - Infant mortality rate per 1,000 live births[2]	26.4	25.5	24.8	22.5	- 15%	p>0.05
NOM 9.2 - Neonatal mortality rate per 1,000 live births[2]	15.3	14.2	13.8	16.7	- 5%	p>0.05
NOM 9.3 - Post neonatal mortality rate per 1,000 live births[2]	9.2	10.7	2.1	5.9	- 32%	p>0.05
NOM 9.4 - Preterm-related mortality rate per 100,000 live births[2]	816.3	291.3	208.8	587.7	- 46%	p<0.05
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy[2]	0	1.6	1.9	1.6	19%	p<0.05
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations[2]	0	0	0	0	NA	NA
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females[2]	48.7	65.7	59.6	77	13%	p<0.05
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth[3]	0	1.6	2.2	1.2	38%	p<0.05

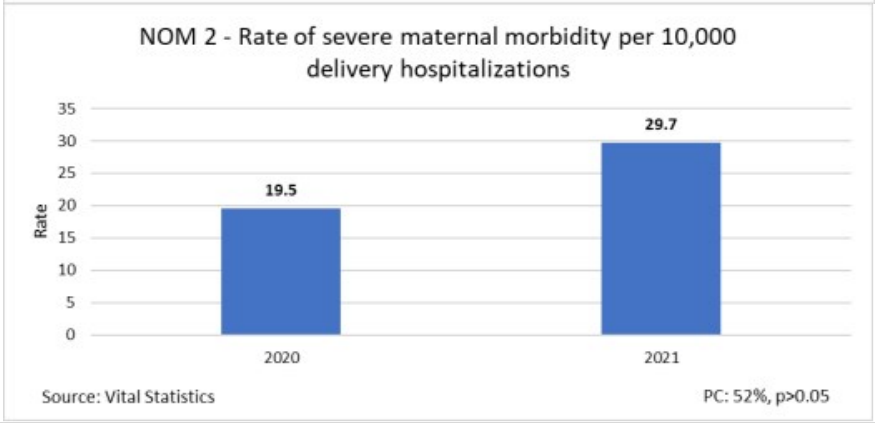
NA = Not available, PC = Percent Changes, AAPC = average annual percent change

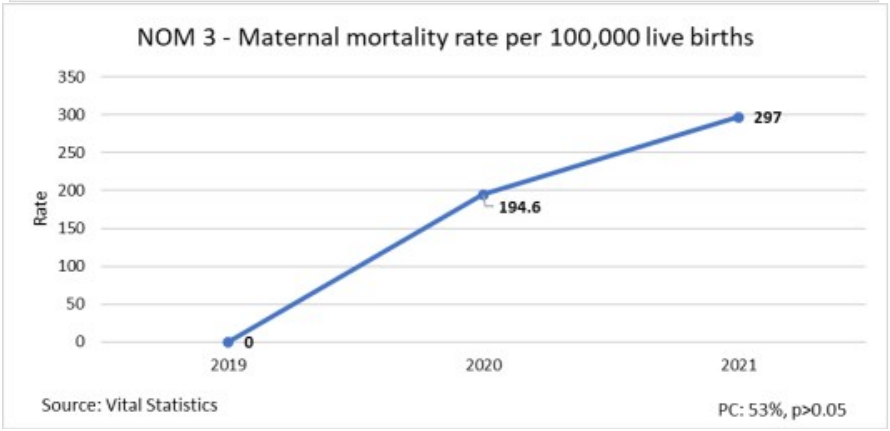
p<0.05 = statistically significant change

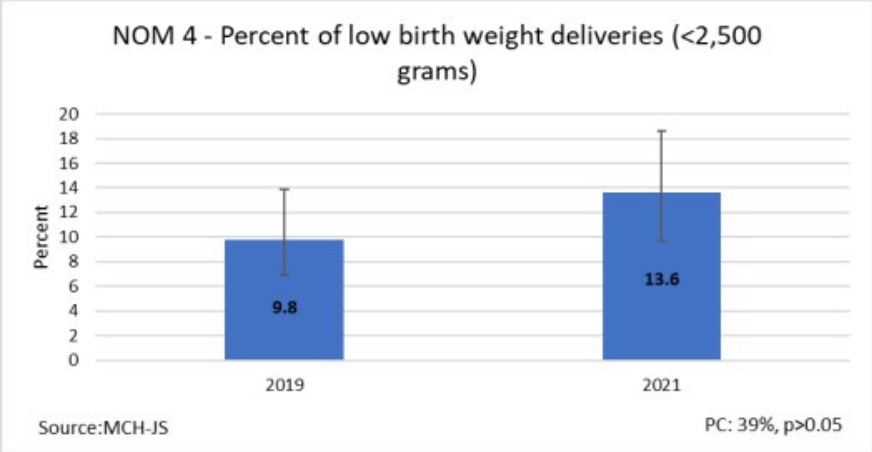
Sources: [1] MCH-JS 2019 and 2021; [2] Vital Statistics 2019-2021; [3] MCH Program 2019-2021

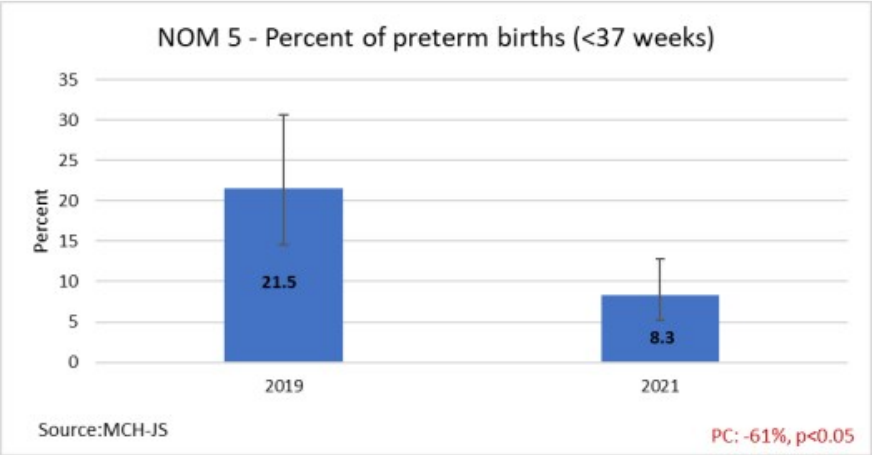
Between 2019 and 2021, the number of preventive medical visits among women aged 18 to 44 decreased by 40% (MCH-JS: 48.3% and 29.2%, respectively), but this decline was not statistically significant. Contrarily, although not statistically significant, outcomes like infant mortality (Vital Statistics) declined by 14% between 2019 and 2022, with a greater decline during the postnatal period (AAPC: -32%; p>0.05) compared to the neonatal period (AAPC: -5%; p>0.05). Additionally, between 2019 and 2021, preterm-related mortality declined significantly, by 46% (Vital Statistics). Preterm births decreased significantly by 61% (Vital Statistics); however, there was a significant increase in early term births (AAPC:42%; p<0.05). Other outcomes significantly increased throughout the course of the period (Vital Statistics), including neonatal abstinence (AAPC:19%; p<0.05), teen birth rate (AAPC:13%; p<0.05), and postpartum depression symptoms (AAPC: 38%; p<0.05).

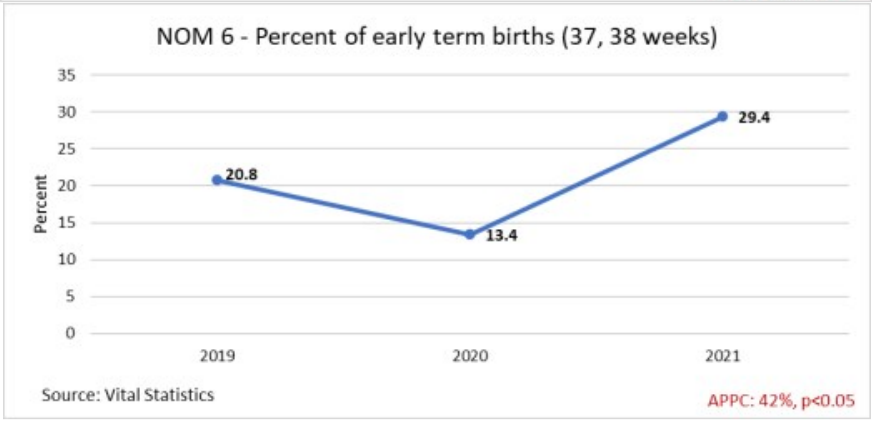


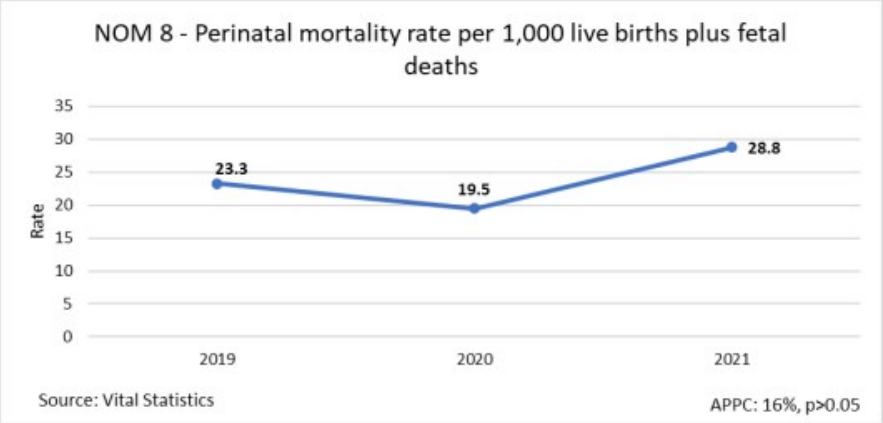


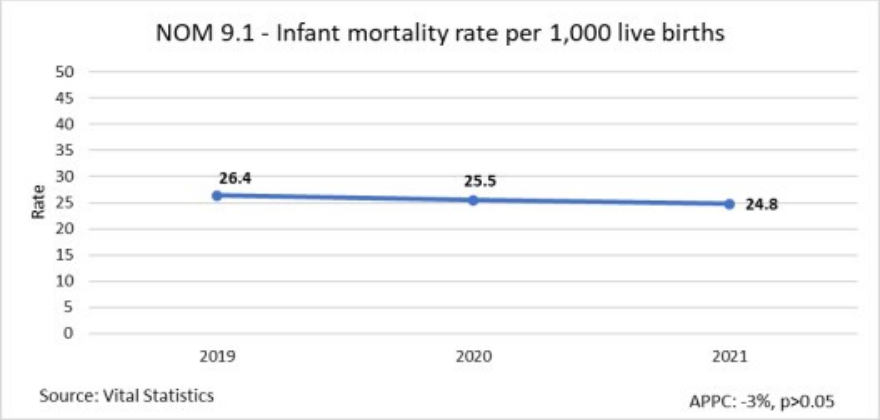


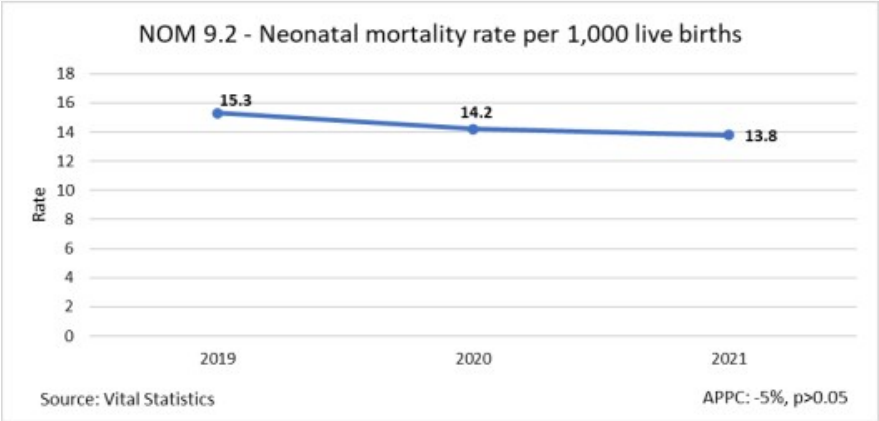

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
Percent
20
18
16
14
12
10
8
6
4
2
0
9.8
13.6
2019
2021
Source:MCH-JS
PC: 39%, p>0.05

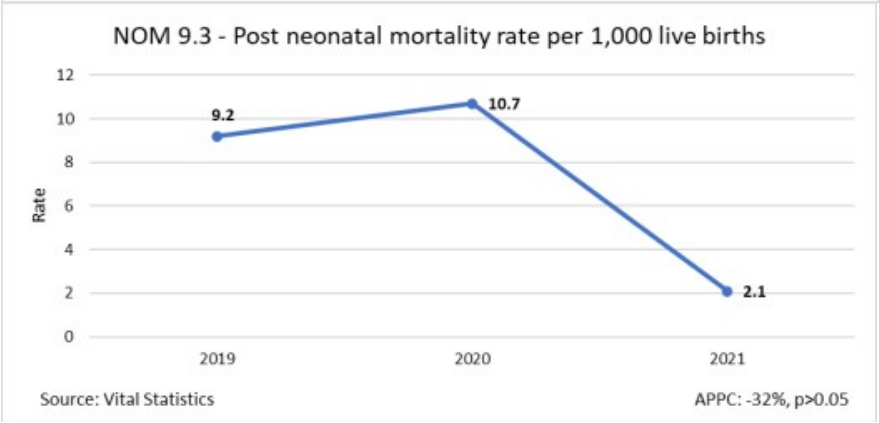

NOM 5 - Percent of preterm births (<37 weeks)
Percent
35
30
25
20
15
10
5
0
21.5
8.3
2019
2021
Source:MCH-JS
PC: -61%, p<0.05

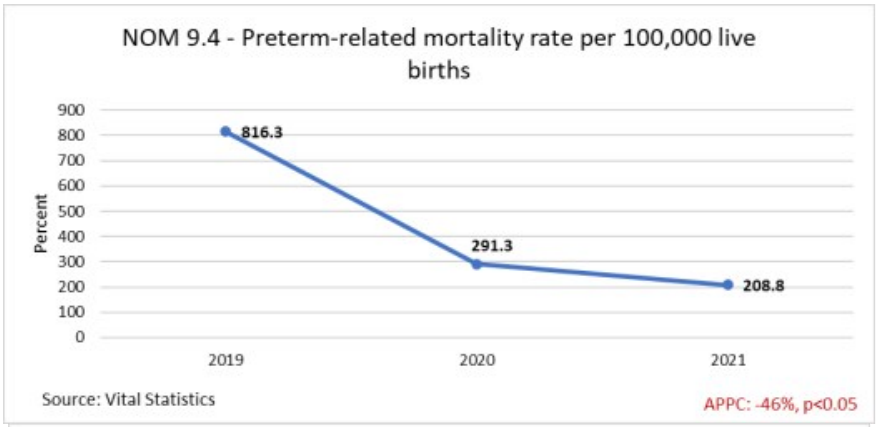

NOM 6 - Percent of early term births (37, 38 weeks)
Percent
35
30
25
20
15
10
5
0
20.8
13.4
29.4
2019
2020
2021
Source: Vital Statistics
APPC: 42%, p<0.05

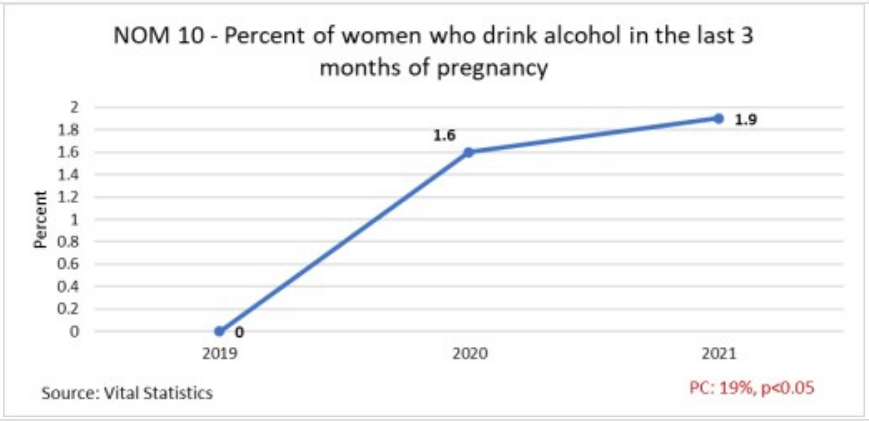

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
Rate
35
30
25
20
15
10
5
0
23.3
19.5
28.8
2019
2020
2021
Source: Vital Statistics
APPC: 16%, p>0.05

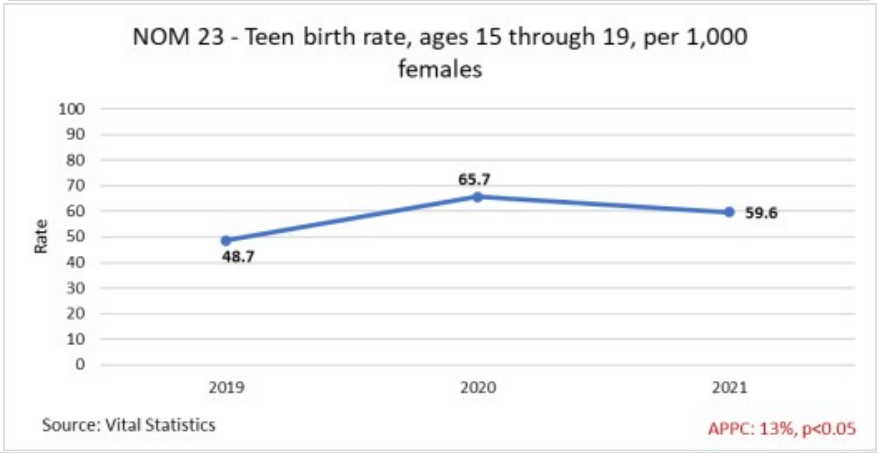

NOM 9.1 - Infant mortality rate per 1,000 live births
Rate
50
45
40
35
30
25
20
15
10
5
0
26.4
25.5
24.8
2019
2020
2021
Source: Vital Statistics
APPC: -3%, p>0.05

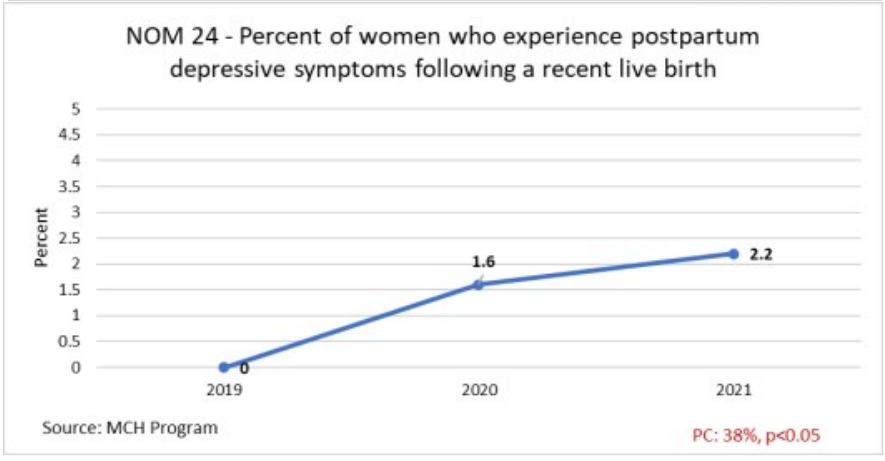

NOM 9.2 - Neonatal mortality rate per 1,000 live births
Rate
18
16
14
12
10
8
6
4
2
0
15.3
14.2
13.8
2019
2020
2021
Source: Vital Statistics
APPC: -5%, p>0.05


NOM 9.3 - Post neonatal mortality rate per 1,000 live births
Rate
12
10
8
6
4
2
0
9.2
10.7
2.1
2019
2020
2021
Source: Vital Statistics
APPC: -32%, p>0.05


NOM 9.4 - Preterm-related mortality rate per 100,000 live births
Percent
900
800
700
600
500
400
300
200
100
0
816.3
291.3
208.8
2019
2020
2021
Source: Vital Statistics
APPC: -46%, p<0.05

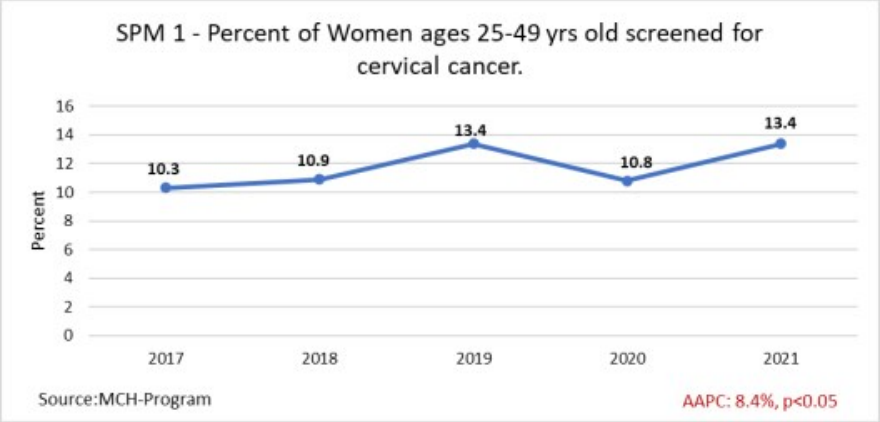

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
Percent
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
0
1.6
1.9
2019
2020
2021
Source: Vital Statistics
PC: 19%, p<0.05


NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
Rate
100
90
80
70
60
50
40
30
20
10
0
48.7
65.7
59.6
2019
2020
2021
Source: Vital Statistics
APPC: 13%, p<0.05


NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth
Percent
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
0
1.6
2.2
2019
2020
2021
Source: MCH Program
PC: 38%, p<0.05

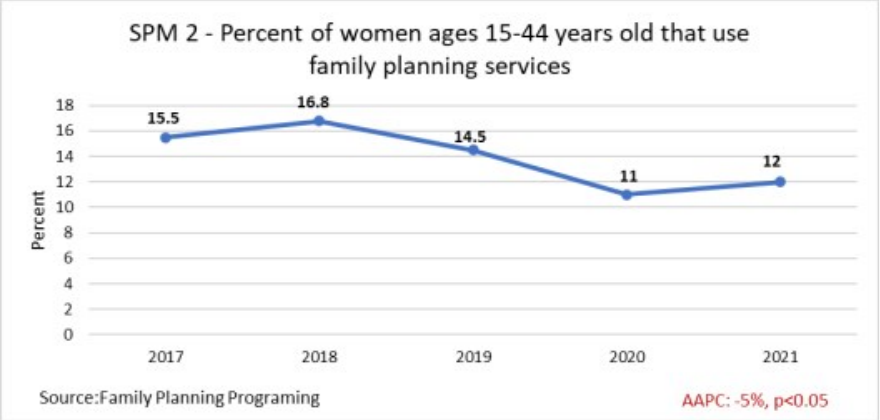
Priority Need: Cancer screening and services for Women's Health

Cervical cancer screening rates for women between the ages of 25 and 49 have increased significantly by 8%, improving from 10.3% in 2017 to 13.4% in 2021.



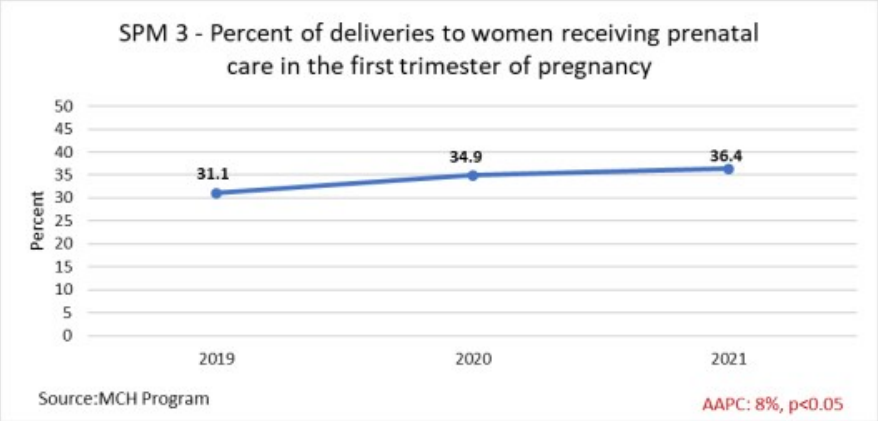
Priority Need: Access to coordinated, comprehensive care and services for Women before, during and after pregnancy

In women aged 15 to 44, the use of family planning services dropped significantly by 5%, from 15.5% in 2017 to 12% in 2021.



Priority Need: Access to coordinated, comprehensive care and services for Women before, during and after pregnancy.

The percentage of live births among pregnant women who got prenatal care in the first trimester improved significantly by 8%, from 31.1% in 2019 to 36.4% in 2021.



Highlights:

- Continue partnership with Cancer Program to increase the rate of cervical cancer screening through after-hours clinics and patient navigation. Increase the number of women detected with abnormal pap smears and referred for tertiary care for immediate treatment.
- Continue to provide education and awareness of importance of annual women checkup and availability of services to the communities and faith-based organizations.
- Spot checks on inventory of family planning commodities and availability of supplies and equipment for MCH services like prenatal, birth delivery, infant care and other related services in Majuro, Ebeye and Neighboring Islands.
- Continue the distribution of safe delivery kits to the Neighboring Islands health centers.
- World Cancer Month Awareness, February 2022
  - To kick off the month-long awareness, a walkathon happened in Majuro with 182 participants 3 years to 60+ years old.
  - There were 102 mammograms done on Ebeye Hospital on February 5-16, 2022.
  - Art Gala Fundraiser
  - Sponsored Volleyball and tennis tournament with health screening; Volleyball tournament is in partnership with College of the Marshall Islands (CMI), Women United Together Marshall Islands (WUTMI) and the Breast Cancer Society. There were eight teams that registered. NCD and cancer screening were included in the health screening with the players and organizers.

World Cancer Awareness Walkathon in Majuro

Art Night; Kids showing product of their painting

Tennis Tournament

Health Screening at the Volleyball Tournament

Art Gala Fair, 2022

Volleyball Tournament Organizers with Minister Bilimon

RMI Cancer Summit, June 15-16, 2022 Majuro

- RMI Cancer Summit was held in June 2022 in Majuro. Off-island participants and presenters joined via online conference link.
- Yearly Breast Cancer Awareness fishing tournament with cancer screening for the participants in November 2022 which is a month delayed due to funding availability.
- Community outreach for cancer screening, prenatal services, and HPV vaccination: 2 Atolls (Wotje and Ebon) were visited in 2022.

Cancer program along with WUTMI for HPV awareness

Outreach Reproductive Health Services in Wotje

- Received the new, state-of-the-art mammography unit and 3 new ultrasound machines, Mammogram was purchased from funds CDC Cancer Program, Health Care Revenue Fund, and ultrasound machines purchased Early Childhood Development grant.

Challenges:

- Socio-economic reasons which affect the visitation to the services
- Due to strong cultural practices, women would resort to traditional medicine before coming for consult or even after consult with a physician.
- Limited availability of female Health Assistants in the Neighboring Island which resulted to low prenatal visits, late identification of high-risk pregnancy, and low annual screening.

- Delay in the implementation of MCH One Stop Shop because of limited space available to move other services to create the one stop shop.
- COVID-19 Pandemic affected the implementation of activities

Plan:

- To expand cancer screening services to the communities
- MCH One Stop Shop for domain population
- Buildup of workforce capacity by Midwifery; 15 NI Female health care workers; training of the Community Health care workers and continuing education for BS in Nursing

Priority Needs: Improve women/maternal health through cancer screening, prenatal services and family planning services

Strategy: Outreach mobile visits by MCH and Family Planning Program to at least 6 Outer Islands yearly.

The program was able to visit 2 atolls to provide cervical cancer screening, breast exam and family planning services to the hard-to-reach population in the remote islands. HPV vaccination, prenatal, family planning and cancer screening were provided during these visits. Due to COVID-19 vaccination, we were not able to reach the targeted number of atolls to visit.

Program also conducted one on one counselling on the availability and importance of annual checkups, spacing of pregnancy as well as early prenatal care. High risk pregnant mothers and women with abnormal results are referred to Majuro for further examination and care. There is a challenge in the number of women seeking services with myths associated with family planning methods and fear of getting screened and knowing their results. Transportation is also a barrier to women seeking services.

Strategy: Partnership with Cancer Program in reaching out to bring women in the community and faith-based organization to avail the services of MCH program.

MCH Program continued its partnership with Cancer program resulted in improvement of services. With this partnership, MCH Block Grant supports the staff and supplies to carry out the cervical cancer screening and breast cancer screening. Cancer Program contracted the services of WUTMI (Women United together Marshall Islands) to facilitate the schedule and assistance of bringing the women in the community and faith-based organization in the MCH Clinics. Community awareness

ESM 1.3 - Percent of women booked for prenatal visit in first trimester.

We were advised to change this ESM into SPM from the last block grant review. MCH Program will address this in the next needs assessment and application cycle.

	2021	2022
Annual Indicator	18.7	25.8

In 2022, MCH Program continued to advertise the Prenatal Clinics schedule in the MOHHS FB page, newspaper, and local radio station. During the COVID-19 community transmission, prenatal service were provided via telehealth.

ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

We were advised to change this ESM into SPM from the last block grant review. MCH Program will address this in the next needs assessment and application cycle.

Women/Maternal Health - Application Year

As the MCH program continues to improve its services for women and maternal health, we also want to reward women that takes ownership of improving their own health. In this application year, we will create an incentive program to those who will meet the criteria. In example, for pregnant women that attended prenatal clinic on her 1st trimester, Majuro Hospital to waive hospital fee after delivery. We will continue to strengthen our collaborations with our partnership in providing comprehensive services.

NPM 1 Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Priority : Access to coordinated, comprehensive care and services for Women before, during and after pregnancy

By July 2025, increase the percentage of women ages 18 through 44 who had a preventive medical visit in the past year to 58% (Baseline: 2019 MCH Jurisdictional Survey data 48.3%)]

Strategies

- Promote well-woman visit through health education, awareness and campaign.
    - Create effective Information, Education and Communication (IEC) materials translated to Marshallese and other common languages in RMI.
    - Partner with Women based NGOs to promote the availability of services for well-woman visit in the two main hospitals.
    - Sponsor activities on Breast and Cervical cancer awareness.
    - Create effective videos/advertisements about prenatal and pregnancy translated to Marshallese and other common languages in RMI
    - Train more Female Health Aides to provide Sexual Reproductive Health services in the Neighboring Islands
- Continued partnership with Cancer Program, HIV/STI Program and other Public Health programs
    - MCH will continue the regular meetings with the Public Health Programs to consolidate and coordinate the activities especially with limited staffing and resources.
    - Conduct quality assurance meetings to discuss the issues like supplies, schedules and other things that might affect the availability and delivery of services.
    - To expand services to the communities, have cervical cancer screening at the health centers in Majuro, Ebeye and Neighboring Islands. Continue the after-hours clinic for cancer screening to cater the working women who cannot come to the clinic during office hours
- Development and implementation of comprehensive one-stop shop well-woman essential services.
    - Develop a one stop shop well woman essential services.
    - Availability of MCH expanded services through the MCH One Stop Shop where services like prenatal and postnatal, women's health, family planning, immunization, dental, laboratory services, and well-baby clinic
    - Create and implement SOP for this one-stop shop well-woman essential services
    - With the Senior Leadership, identify and develop a community health center that provide cancer screening and community referrals.
- Strengthen Prenatal and post-partum services
    - Make the prenatal clinics conducive for the pregnant women.

- Community Health Care Workers (CHOWs) to visit the pregnant women that missed her appointments
- Implement regular post-partum clinic schedule
- Establish a “mother’s class” to be a requirement for all expectant mothers to attend.

ESMs	Status
ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.	Active
ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women	Active

Perinatal/Infant Health

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	1
Annual Indicator	0	0	0	0
Numerator	0	0	0	0
Denominator	2	8	5	9
Data Source	MOHHS	Vital Records Information System	MOHHS	Vita Statistics
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	1.0	2.0	2.0

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator			0	0
Denominator			2	2
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	2.0	2.0	2.0

ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	100
Annual Indicator			0	0
Numerator			0	0
Denominator			2	2
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

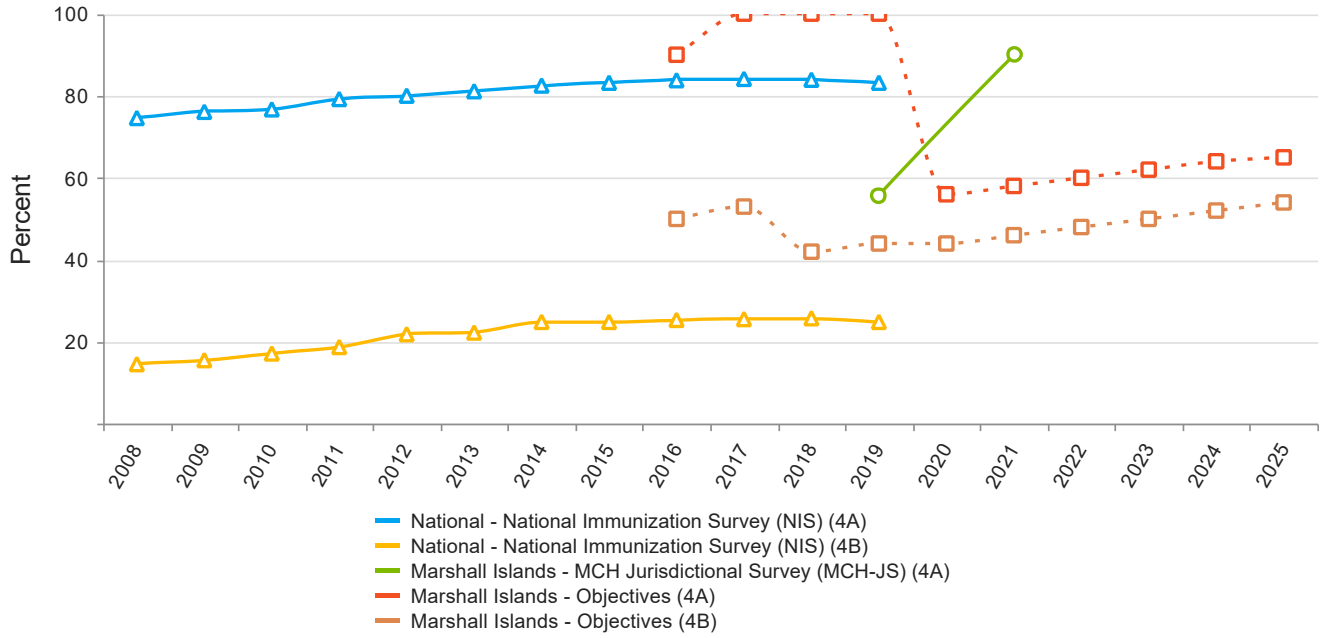
ESM 3.3 - Percent of newborn babies issued newborn baby health passbook

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	25
Annual Indicator			0	0
Numerator			0	0
Denominator			100	100
Data Source			MCH Program	MCH Program
Data Source Year			2021	200
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	35.0	40.0

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	100	56	58	60
Annual Indicator	55.8	55.8	90.1	90.1
Numerator	5,143	5,143	7,855	7,855
Denominator	9,218	9,218	8,720	8,720
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	100	100	56	58	60
Annual Indicator	100				
Numerator	989				
Denominator	989				
Data Source	RMI ICHNS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives			
	2023	2024	2025
Annual Objective	62.0	64.0	65.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	42	44	44	46	48
Annual Indicator	42.3	42.3	42.3	42.3	42.3
Numerator	373	373	373	373	373
Denominator	881	881	881	881	881
Data Source	RMI ICHNS	RMI ICHNS	RMI ICHNS	RMI ICHNS	RMI ICHNS
Data Source Year	2018	2018	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	52.0	54.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			Yes	Yes
Annual Indicator			No	Yes
Numerator				
Denominator				
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	Yes	Yes	Yes

ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	10
Annual Indicator			0	0
Numerator			0	0
Denominator			30	30
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	20.0	25.0

State Performance Measures

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	50	63	65	65	67
Annual Indicator	61.3	64.1	58.6	62.7	63.4
Numerator	995	1,014	954	1,006	987
Denominator	1,624	1,583	1,629	1,604	1,556
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	69.0	70.0	72.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Perinatal/Infant Health - Entry 1	
Priority Need	
Infants breastfed exclusively through six months	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
By July 2025, increase the percent of infants who are ever breastfed to 65% (Baseline: 2019 MCH JS 55.8%)	
By July 2025, increase the percent of infants breastfed exclusively through 6 months to 54% (Baseline: 2018 RMI ICHNS 42.3%)	
Strategies	
Strengthen workforce capacity to provide breastfeeding education and counselling.	
Partner with community-based organizations to promote and support breastfeeding	
ESMs	**Status**
ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services	Active
ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training.	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (Marshall Islands) - Perinatal/Infant Health - Entry 2

Priority Need

Reduce infant mortality rate

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

By July 2025, reduce infant mortality rate by 5% yearly (Baseline: 2108 - 27.4 Per 1,000 live births)

Strategies

Improve the capability and capacity of the birthing hospital to handle critical newborns.

Update and implement birthing hospitals SOP for delivery and management of newborns

ESMs	Status
ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures	Active
ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually	Active
ESM 3.3 - Percent of newborn babies issued newborn baby health passbook	Active

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

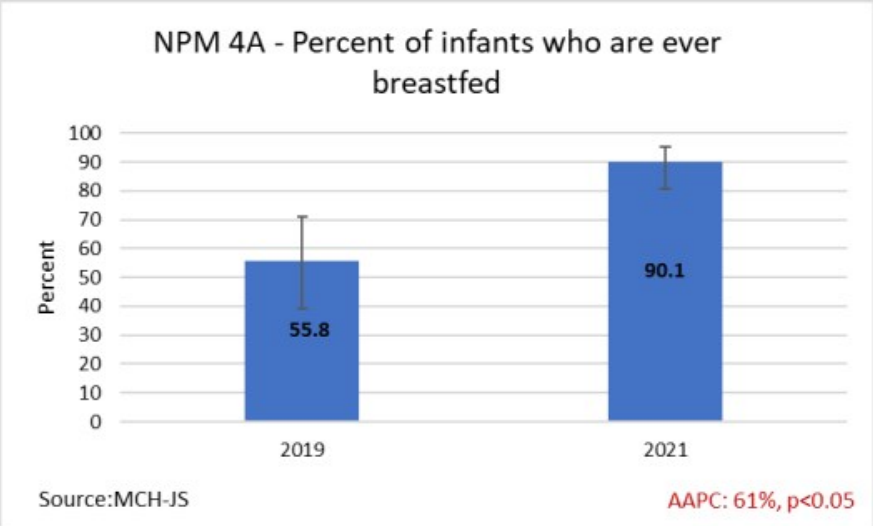
NOM 9.4 - Preterm-related mortality rate per 100,000 live births

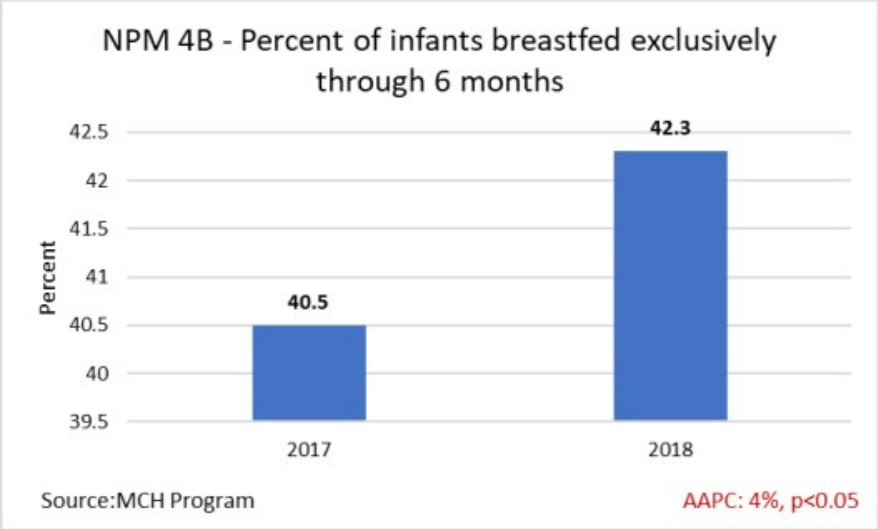
Priority Need: Infants breastfed exclusively through six months.

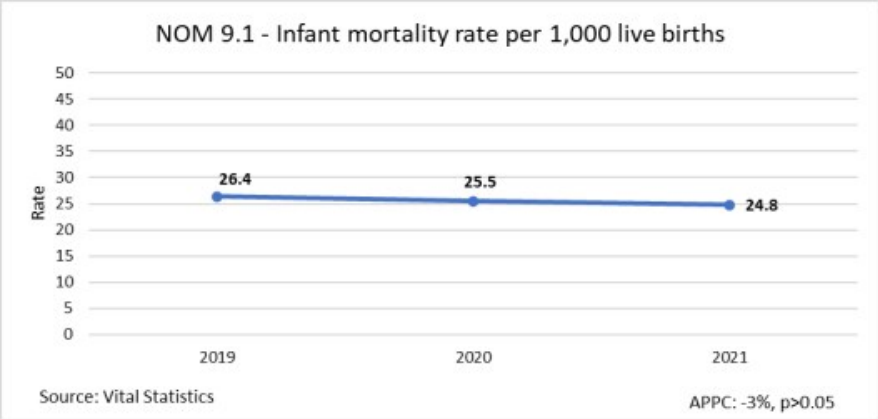
Measure	2017	2018	2019	2020	2021	2022	PC or AAPC	p-value
NPM 4A - Percent of infants who are ever breastfed[1]	NA	NA	55.8	55.8	90.1	90.1	61%	p<0.05
NPM 4B - Percent of infants breastfed exclusively through 6 months[2]	40.5	42.3	42.3	42.3	42.3	42.3	4%	p<0.05
NOM 9.1 - Infant mortality rate per 1,000 live births[3]	NA	NA	26.4	25.5	14.8	22.5	- 3%	p>0.05
NOM 9.3 - Post neonatal mortality rate per 1,000 live births[3]	NA	NA	9.2	10.7	2.1	5.9	- 32%	p>0.05
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births[3]	NA	NA	0	97.3	0	0	- 100%	p>0.05

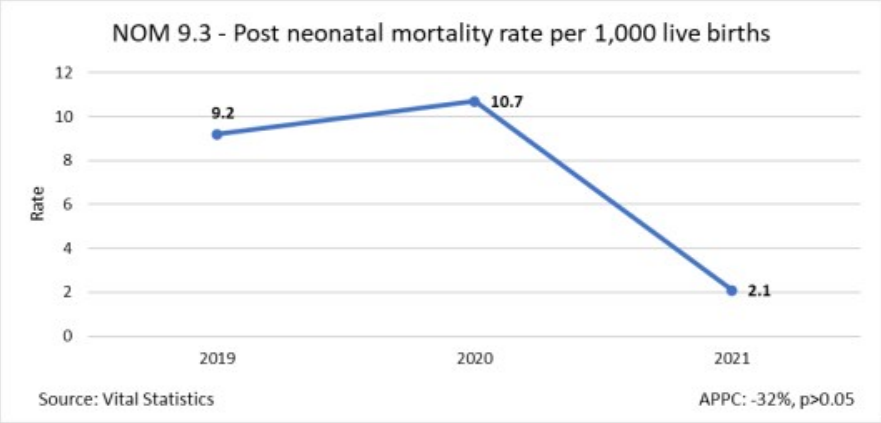
NA = Not available, PC = Percent Changes, AAPC = average annual percent change
Data for ESMs is not available for PC or AAPC analysis. Not included in table.
p<0.05 = statistically significant change
Sources: [1] MCH-JS 2019 and 2021; [2] MCH Program 2017-2021; [3] Vital Statistics 2019-2021

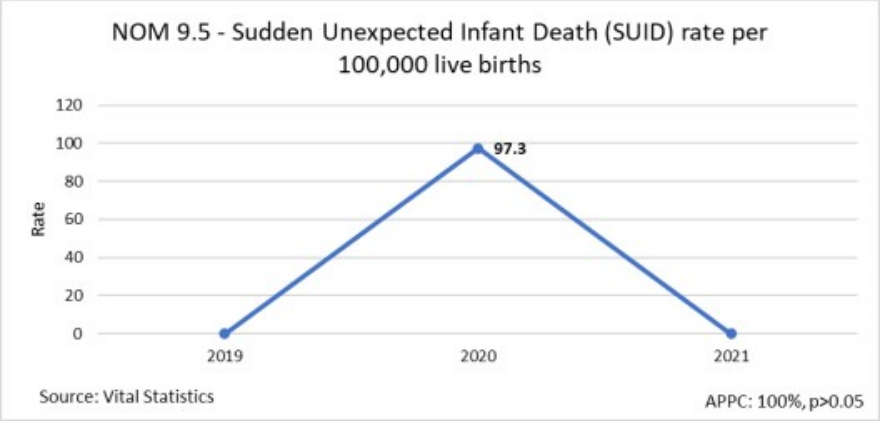
Periods and sources to measure ever breastfed and exclusive breastfeeding trough 6 months are different. However, MCH-JS data shows a 61% significant increase of infants who are ever breastfed between 2019 and 2021 (55.8% to 90.1%, respectively), while MCH program data from 2017 and 2018 shows a significant increase (PC:4%; p<0.05) for infants exclusively breastfed until 6 months (40.5% to 42.3%, respectively). According to Vital Statistics data, infant (AAPC: -3%; p<0.05) and neonatal (AAPC:-32%; p<0.05) mortality rates decreased even though not significantly, while Sudden Unexpected Infant Death (SUID) were only reported during 2020 (97.3 per 1,000 live births).




NPM 4B - Percent of infants breastfed exclusively through 6 months
42.5
42
41.5
41
40.5
40
39.5
Percent
40.5
42.3
2017
2018
Source:MCH Program
AAPC: 4%, p<0.05


NOM 9.1 - Infant mortality rate per 1,000 live births
50
45
40
35
30
25
20
15
10
5
0
Rate
26.4
25.5
24.8
2019
2020
2021
Source: Vital Statistics
APPC: -3%, p>0.05


NOM 9.3 - Post neonatal mortality rate per 1,000 live births
12
10
8
6
4
2
0
Rate
9.2
10.7
2.1
2019
2020
2021
Source: Vital Statistics
APPC: -32%, p>0.05



Highlights:

- Continued counselling on importance of exclusive breastfeeding to all mothers at the Reproductive Health clinic, maternity ward, and the Postpartum clinic.
- Community awareness: radio spots, newspaper advertisements, and social media postings on the importance of early prenatal visits and schedule of prenatal clinics are ongoing.
- Distribute baby bags to mothers who attended prenatal care in their 1st trimester
- There are 3 New ultrasound machines purchased.
- Availability of new space and ultrasound machines for prenatal and women's clinic at Laura Clinic
- We received 24 solar freezers from UNICEF. 22 of the 24 solar freezers were distributed to 22 health centers during the COVID-19 vaccination outreach visits.

Challenge:

- Due to preparedness and response to COVID-19, activities Limited newborn screening for Neighboring Islands (NI) due to lack of equipment and trained staff
- Availability of immunization services in the NI is dependent on the outreach mobile visits.
- The hiring of nutritionist and lactation nurse that will train the health care workers were stalled because of the closure of RMI borders which limited the capacity to bring subject matter experts.
- We need to improve on the breast feeding and postnatal data collection.

Plan:

- Improvement of services in the NI Health Centers by providing cold chain equipment, training of health assistants on cold chain equipment storage and handling and vaccination.
- Partner with community-based organizations to promote and support breastfeeding practices, Baby friendly initiative projects including breastfeeding awareness and education.
- Partner or seek technical assistance to update birthing hospitals SOP for delivery and management of newborns.
- Implementation of Registry Data Unit that will assist each program on data collection, reporting and analysis.

Improve perinatal/infant's health through adequate and quality prenatal services and newborn screening.

MCH Block Grant Program works closely with EHDI Program. Collaboration of work and alignment of plans are engaged to ensure that both programs don't duplicate work but able to support the needs of Infant Health.

Early Hearing Detection & Intervention (EHDI) Program

2022	MAJURO	EBEYE	TOTAL
Births	697	204	911
IP Screened	676	195	871
Deceased	12	4	14
% Complete Screening	99%	98%	98%
Referred	79	16	95
IP Passed	597	179	776
Missed	9	5	12
OP Passed	42	9	51
OP Referred	7	0	7
LTFU	29	7	36

Acronyms	
IP	Inpatient
OP	Outpatient
LTFU	Loss to Follow Up

Early Intervention is provided to all babies who have been identified with a hearing loss/deafness. These families get home visits once a week and join a playgroup also once a week. Families on Ebeye only receive weekly home visits.

Challenges

The greatest challenge has been the pandemic. The EHDI Program requires routine visits by a Pediatric Audiologist to travel to the RMI, both Majuro and Ebeye to conduct Diagnostic Evaluations on babies who failed their initial hearing screening tests. These audiological visits take place three to four times a year. Because of the pandemic the nation has been forced to close the borders EHDI program had to cancel all scheduled audiological visits for the entire year. A pediatric Ear, Nose and Throat (ENT) was scheduled to travel in June 2020 to conduct hands on training to the newly hired ENT which has been canceled due to the pandemic. With cancellation of routine visits by the itinerant audiologist, babies who failed the newborn hearing screening do not get audiological diagnostic evaluations. These babies are at risk of having a hearing loss or deafness. Hearing Screening and diagnostic equipment need periodic calibrations. With the borders closed there is no way for the equipment to be calibrated since there is no specialist on island.

Accomplishments

2022: The EHDI program collaborated World Teach deaf schoolteacher in training the program's deaf mentor who directly work with the families enrolled in the program. Although we have challenges with funding and bringing in specialty services, the program to provide the newborn hearing screening to 98% of the newborn in Majuro and Ebeye Hospitals.

Ways forward. Set up tele-audiology and tele-intervention capabilities.

Perinatal/Prenatal Services

Having healthy infants are linked to the good health of the mothers. Prenatal care services are available in the 2 main hospitals and all 60 health centers. In the health centers, service is limited wherein tests that needs laboratory confirmation are not available.

ESM 1.3 - Percent of women booked for prenatal visit in first trimester.

We were advised to change this ESM into SPM from the last block grant review. MCH Program will address this in the next needs assessment and application cycle.

	2021	2022
Annual Indicator	18.7	25.8

In 2022, MCH Program continued to advertise the Prenatal Clinics schedule in the MOHHS FB page, newspaper, and local radio station. During the COVID-19 community transmission, prenatal service was provided via telehealth.

Ensure every woman has skilled professional at delivery

99% of births in 2022 are delivered by skilled attendants like nurse, midwife, health assistant, medical assistant, and doctors. In childbearing, women need a continuum of care to ensure the best possible health outcome for them and their newborns. This includes care at the clinic before and after delivery, as well as high quality midwifery care at delivery. The risk of stillbirth and maternal deaths is reduced by about 20% with the presence of a skilled birth attendant.

Births Attended by Skilled Health Personnel, 2018-2022

	2018	2019	2020	2021	2022
Percentage of Births attended by skilled health personnel	98%	99%	99%	99%	99%

Infant Health

23 per 1,000 live births infant death in 2022 before they reach the age of 1 yr. old. Prematurity, aspiration, and pneumonia, congenital defects are the most common underlying causes of death for these infants which is the same as in 2021. This stresses the importance of Early prenatal care and good management skills during labor. The importance of exclusive breastfeeding up to 6 months is part of the counselling services at the RH clinic, maternity ward and the postnatal clinic. With the Early Childhood Development (ECD) program in place, there are plans to have BF class to pregnant mothers by a nutritionist and a trained lactation nurse. Lactation nurse will trained staff from maternity, labor and delivery and pediatric wards. But due to the closure of borders and challenge in hiring new staff, Lactation Nurse was not hired in 2022. ECD Program will continue to provide the support.

In 2019, RMI conducted survey on child health and nutrition for 0-5 yrs old. Below is the result on breastfeeding and infant feeding,

Breastfeeding and infant feeding			
MICS Indicator	**Indicator**	**Description**	**Value**
2.5	Children ever breastfed	Percentage of women with a live birth in the last 2 years who breastfed their last live-born child at any time	87.4
2.6	Early initiation of breastfeeding	Percentage of women with a live birth in the last 2 years who put their last newborn to the breast within one hour of birth	60.8
2.7	Exclusive breastfeeding under 6 months	Percentage of infants under 6 months of age who are exclusively breastfed[4]	42.3
2.8	Predominant breastfeeding under 6 months	Percentage of infants under 6 months of age who received breast milk as the predominant source of nourishment [5] during the previous day	50.9
2.9	Continued breastfeeding at 1 year	Percentage of children age 12-15 months who received breast milk during the previous day	40.5
2.10	Continued breastfeeding at 2 years	Percentage of children age 20-23 months who received breast milk during the previous day	34.2
2.12	Age-appropriate breastfeeding	Percentage of children age 0-23 months appropriately fed [6] during the previous day	39.8
2.13	Introduction of solid, semi-solid or soft foods	Percentage of infants age 6-8 months who received solid, semi-solid or soft foods during the previous day	64.2
2.14	Milk feeding frequency for non-breastfed children	Percentage of non-breastfed children age 6-23 months who received at least 2 milk feedings during the previous day	39.4
2.15	Minimum meal frequency	Percentage of children age 6-23 months who received solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum number of times or more [7] during the previous day	60.8

MCH Program is actively advocating breastfeeding inside and outside the hospitals. In the hospital, no bottle feeding is implemented but there are mothers that are not following the policy.

There are still children coming in with malnutrition. One of the needs presented by the Pediatricians is to have a feeding program. This issue on the feeding program was discussed by the leadership team. With the ECD program in place, there is a plan to have cash transfers to families with low income to support purchase nutritious food

	2017	2018	2019	2020	2021
NPM 4 - A) Percent of infants who are ever breastfed	100	100	55.8*	55.8*	90.1
NPM 4 B) Percent of infants breastfed exclusively through 6	40.5	42.3	42.3	42.3**	42.3**

*MCH JS
**Children and Nutrition Health Survey

NPM 4 A): Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is lifesaving skin to skin contact immediately after birth between the baby and the mother.

NPM 4- B) We need to strengthen our community awareness and data collection. We will be working with women's group to reach the women population and able to provide them health education on the remind them on the benefits

of breastfeeding for their children.

Perinatal/Infant Health

Priority: Infants breastfed exclusively through six months

NPM 4 A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objective:

- By July 2025, increase the percent of infants who are ever breastfed to 65% (Baseline: 2019 MCH JS 55.8%)
- By July 2025, increase the percent of infants breastfed exclusively through 6 months to 54% (Baseline: 2018 RMI ICHNS 42.3%)

Strategy:

- Strengthen workforce capacity to provide breastfeeding education and counselling.
  - Hire a lactation Nurse that will strengthen the breastfeeding capacity of the hospitals and the health centers
  - Lactation Nurse will train the staff in breastfeeding education and counselling
  - Develop the access of the workforce for proper breastfeeding tools and sites.

- Partner with community-based organizations to promote and support breastfeeding
  - Identify Women based NGOs that will assist us in promotion and campaign of breastfeeding
  - MCH Program will conduct at least 1 public awareness campaign during the Breastfeeding week.
  - During Women Conference, MCH Program will participate to promote and train women on proper breastfeeding. Program will use radio, print, and social media platforms to promote breastfeeding. Continue proving health education, promotion and demonstration to mothers on exclusive breastfeeding of infants up to 6 months, complimentary food at 6 months and to continue breastfeeding up to 2-3 years of life during their prenatal and well-baby clinic visit

Priority Need: Reduce infant mortality rate

NPM 3 Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objective: By July 2025, reduce infant mortality rate by 5% yearly (Baseline: 2108 - 27.4 Per 1,000 live births)

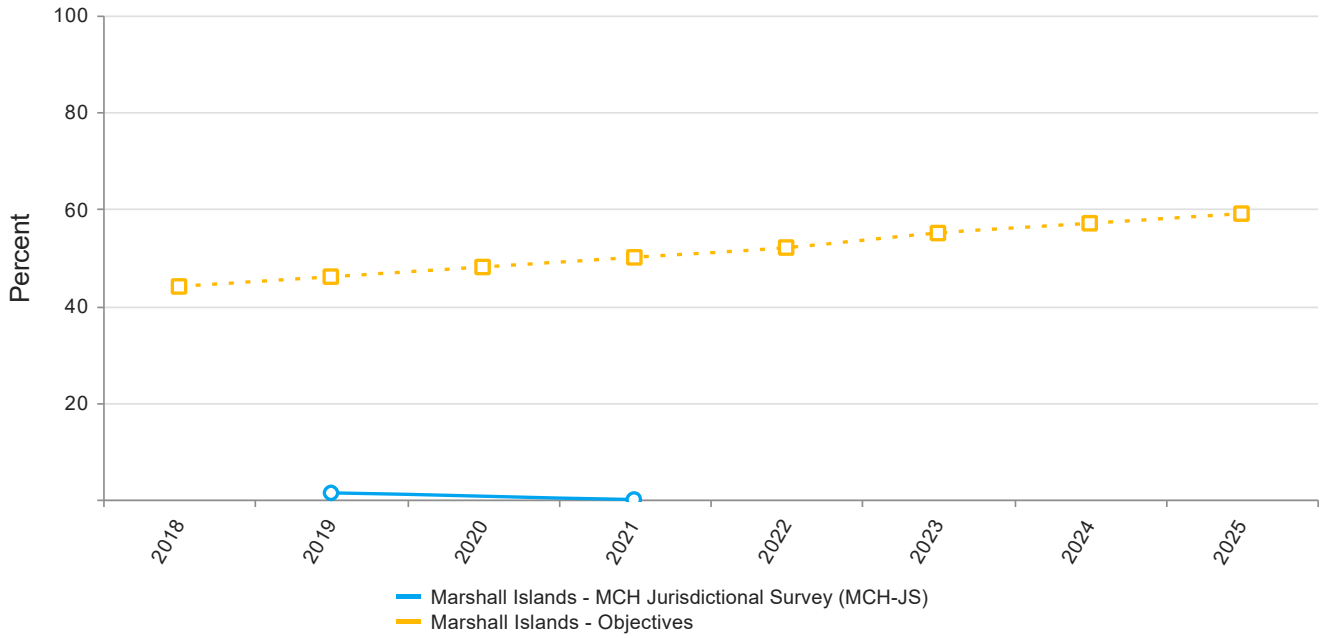
Strategy:

- Improve the capability and capacity of the birthing hospital to handle critical newborns.
  - Complete the CDC Levels of Care Assessment Tool (CDC LOCATe)
  - Develop and implement work plan to address the result of the CDC LOCATe
  -
- Update and implement birthing hospitals SOP for delivery and management of newborns
  - Update SOPs for delivery and management of newborns
  - Training and implementation of the SOPs
  - Yearly evaluation of the SOPs

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS)			
	2019	**2020**	**2022**
Annual Objective	46	48	52
Annual Indicator	1.5	1.5	0
Numerator	53	53	0
Denominator	3,619	3,619	3,829
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	44	46	48	50	52
Annual Indicator	30.8	20.6	24	20.5	22.1
Numerator	500	532	569	521	344
Denominator	1,624	2,577	2,373	2,545	1,556
Data Source	MCH Program	MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	55.0	57.0	59.0

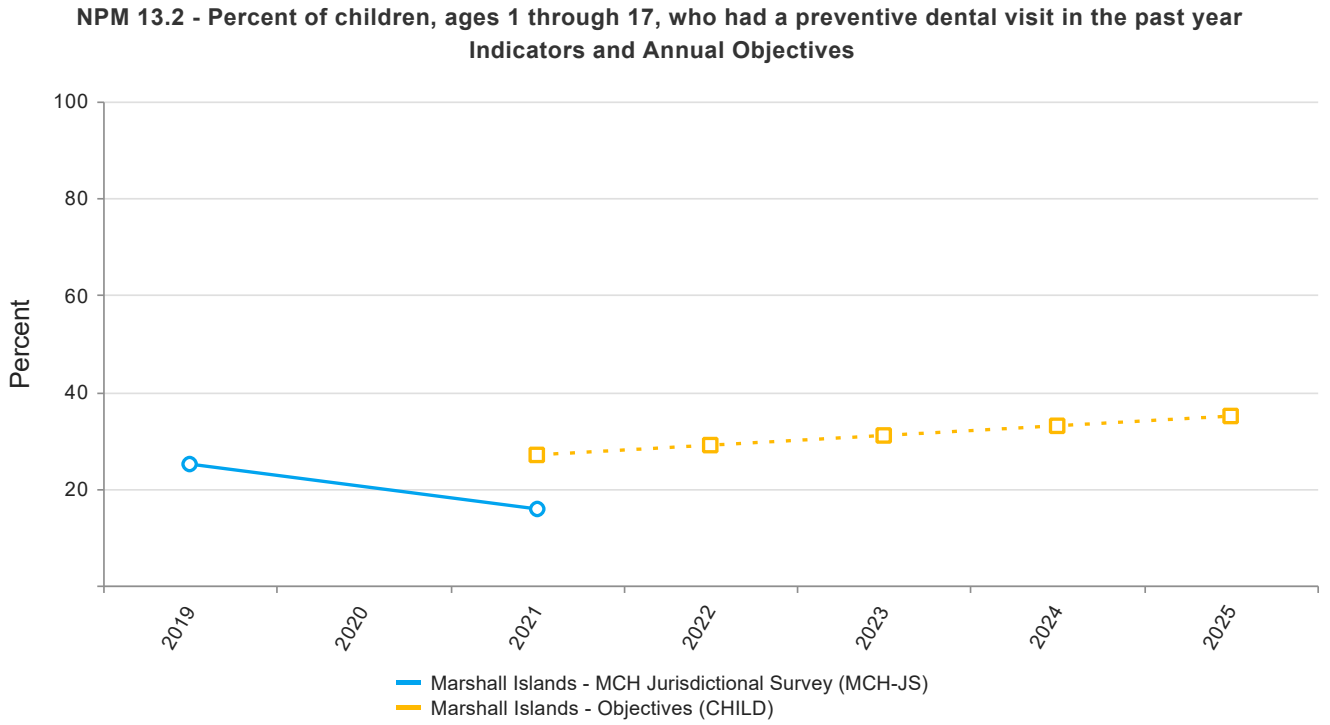
Evidence-Based or –Informed Strategy Measures

ESM 6.1 - The number of potential high risk screens referred to early intervention

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			Yes	Yes
Annual Indicator			No	Yes
Numerator				
Denominator				
Data Source			MCH Program	MCH Program
Data Source Year			FY2021	FY2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	Yes	Yes	Yes



NPM 13.2 - Child Health

Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			10	29
Annual Indicator	25.2	25.2	15.9	15.9
Numerator	5,835	5,835	3,613	3,613
Denominator	23,195	23,195	22,676	22,676
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	31.0	33.0	35.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			15	17
Annual Indicator		14.3	18.8	10.7
Numerator		16	21	12
Denominator		112	112	112
Data Source		Dental Clinics/MCH Program	Dental Clinics/MCH Program	Dental Clinics/MCH Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	19.0	21.0	22.0

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	22
Annual Indicator		20.9	21.3	20.6
Numerator		2,691	2,746	2,659
Denominator		12,889	12,889	12,889
Data Source		Dental Clinics/MCH Program	Dental Clinics/MCH Program	Dental Clinics/MCH Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	24.0	26.0	28.0

State Performance Measures

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	50	63	65	65	67
Annual Indicator	61.3	64.1	58.6	62.7	63.4
Numerator	995	1,014	954	1,006	987
Denominator	1,624	1,583	1,629	1,604	1,556
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	69.0	70.0	72.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Child Health - Entry 1	
Priority Need	
Parent-completed developmental screening tools	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By 2025, increase in referral from clinics to CSHCN registry by using the developmental screening tools	
Strategies	
Implement the new well baby clinic standardized developmental tool in the two main hospitals and all the health centers.	
Implement data system to capture and monitor developmental screening information and referrals	
Create and distribute new baby passport where monitoring of developmental tools is included.	
ESMs	**Status**
ESM 6.1 - The number of potential high risk screens referred to early intervention	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Marshall Islands) - Child Health - Entry 2

Priority Need

Child Oral Health Program partnership with schools

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By 2025, increased number of children ages 1 to 14 years old with preventive dental care services by 5% yearly

Strategies

Increase campaign and awareness on oral health hygiene and available services.

Regular outreach mobile visits to the Outer Islands

ESMs	Status
ESM 13.2.1 - Percentage of elementary schools visited by dental program	Active
ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Marshall Islands) - Child Health - Entry 3

Priority Need

Parent-completed developmental screening tools

SPM

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Objectives

To increase immunization coverage for children 19 to 35 months old by 5% yearly

Strategies

Continue to provide quality outreach mobile immunization visits to the Outer Islands

Conduct community awareness on the proper immunization schedule and the benefits of immunization

Continue to provide immunization services on Saturdays and outreach zone visits.

Child Health Annual Plan

MCH Program continuous to partner with Immunization Program and Well baby Clinic to provide services for improvement of children's health.

Priority Need: Parent-completed developmental screening tools

NPM 6 Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives: By 2025, increase in referral from clinics to CSHCN registry by using the developmental screening tools

Strategies:

- Implement the new well baby clinic standardized developmental tool in the two main hospitals and all the health centers.
    - Continue training of the staff in using the developmental tool.
    - Develop implementation plan for the other health centers.

- Implement data system to capture and monitor developmental screening information and referrals
    - Development of the system is in process to capture and monitor developmental screening and referrals. Implementation of the system in 2021 for Majuro MCH Clinic and 2022 for Ebeye MCH Clinic.
    - Develop implementation plan for the other health centers.

- Create and distribute new baby passbook where monitoring of developmental tools is included.
    - Conduct community awareness on the usage of the new baby passbook
    - Train the staff and invite stakeholders before launching the baby passbook.
    - Launch baby passbook to be used in the main hospitals and health centers
    - Develop an online capturing the information on the baby passbook
    - Evaluate the effectivity of this activity

Priority Need: Parent-completed developmental screening tools

SPM 5 Increase percentage of fully immunized children ages 19 to 35 months

- Objective: To increase immunization coverage for children 19 to 35 months old by 5% yearly

Strategies:
Immunization program will continue to provide vaccination services for complete immunization of children 9 to 35 months following the RMI National Immunization Schedule for complete immunization (4DTAP, 3HepB, 3IPV, 1HIB and 2MMR). National Immunization program has a target of visiting the atolls/islands at least twice a year. This will increase the percentage of complete immunization. We will also implement a reminder/recall report to track patients that are due and missing vaccinations. Program also will improve its timeliness and accuracy in entering the

vaccination to MIWebIZ – Marshall Islands Immunization Information System.

Implement cold chain equipment system in the Neighboring Islands for storing of vaccination. Build the capacity of the health assistants to vaccinate and monitor the cold chain of the vaccines.

Conduct community awareness on the proper immunization schedule and the benefits of immunization

MCH Program will assist the Immunization program in community awareness through print, radio, and social media platform. We will also partner with them during the Immunization Week and National Health Month in community activities like walkathon and outreach activities.

MCH Program requested for technical assistance for training in creating appropriate educational materials.

Continue to provide immunization services on Saturdays and outreach zone visits.
Immunization Program will continue to open on Saturdays to target parents that don't have time to bring their children on weekdays. Outreach zone visits will continue to reach children that failed to come to the clinic for their scheduled vaccination because of lack of transportation and financial support.

Priority Need: Child Oral Health Program partnership with schools

NPM 13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objective: By 2025, increased number of children ages 1 to 14 years old with preventive dental care services by 5% yearly

- Increase campaign and awareness on oral health hygiene and available services.
    - Develop IEC Oral Health materials that are translated into Marshallese and other common languages in RMI
    - Conduct community and school oral health awareness activities
    - Engage different platforms to disseminate IEC materials like social media posting, newspaper advertisement, radio spots and school bulletin boards.
- Regular outreach mobile visits to the Outer Islands
    - Oral Health will conduct outreach mobile visits at least 4 Atolls/Islands in a year.

Child Health Annual Plan

MCH Program continuous to partner with Immunization Program and Well baby Clinic to provide services for improvement of children's health.

Priority Need: Parent-completed developmental screening tools

NPM 6 Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives: By 2025, increase in referral from clinics to CSHCN registry by using the developmental screening tools

Strategies:

- Implement the new well baby clinic standardized developmental tool in the two main hospitals and all the health centers.
    - Continue training of the staff in using the developmental tool.
    - Develop implementation plan for the other health centers.

- Implement data system to capture and monitor developmental screening information and referrals
    - Development of the system is in process to capture and monitor developmental screening and referrals. Implementation of the system in 2021 for Majuro MCH Clinic and 2022 for Ebeye MCH Clinic.
    - Develop implementation plan for the other health centers.

- Create and distribute new baby passbook where monitoring of developmental tools is included.
    - Conduct community awareness on the usage of the new baby passbook
    - Train the staff and invite stakeholders before launching the baby passbook.
    - Launch baby passbook to be used in the main hospitals and health centers
    - Develop an online capturing the information on the baby passbook
    - Evaluate the effectivity of this activity

Priority Need: Parent-completed developmental screening tools

SPM 5 Increase percentage of fully immunized children ages 19 to 35 months

- Objective: To increase immunization coverage for children 19 to 35 months old by 5% yearly

Strategies:
Immunization program will continue to provide vaccination services for complete immunization of children 9 to 35 months following the RMI National Immunization Schedule for complete immunization (4DTAP, 3HepB, 3IPV, 1HIB and 2MMR). National Immunization program has a target of visiting the atolls/islands at least twice a year. This will increase the percentage of complete immunization. We will also implement a reminder/recall report to track patients that are due and missing vaccinations. Program also will improve its timeliness and accuracy in entering the

vaccination to MIWebIZ – Marshall Islands Immunization Information System.

Implement cold chain equipment system in the Neighboring Islands for storing of vaccination. Build the capacity of the health assistants to vaccinate and monitor the cold chain of the vaccines.

Conduct community awareness on the proper immunization schedule and the benefits of immunization

MCH Program will assist the Immunization program in community awareness through print, radio, and social media platform. We will also partner with them during the Immunization Week and National Health Month in community activities like walkathon and outreach activities.

MCH Program requested for technical assistance for training in creating appropriate educational materials.

Continue to provide immunization services on Saturdays and outreach zone visits.
Immunization Program will continue to open on Saturdays to target parents that don't have time to bring their children on weekdays. Outreach zone visits will continue to reach children that failed to come to the clinic for their scheduled vaccination because of lack of transportation and financial support.

Priority Need: Child Oral Health Program partnership with schools

NPM 13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

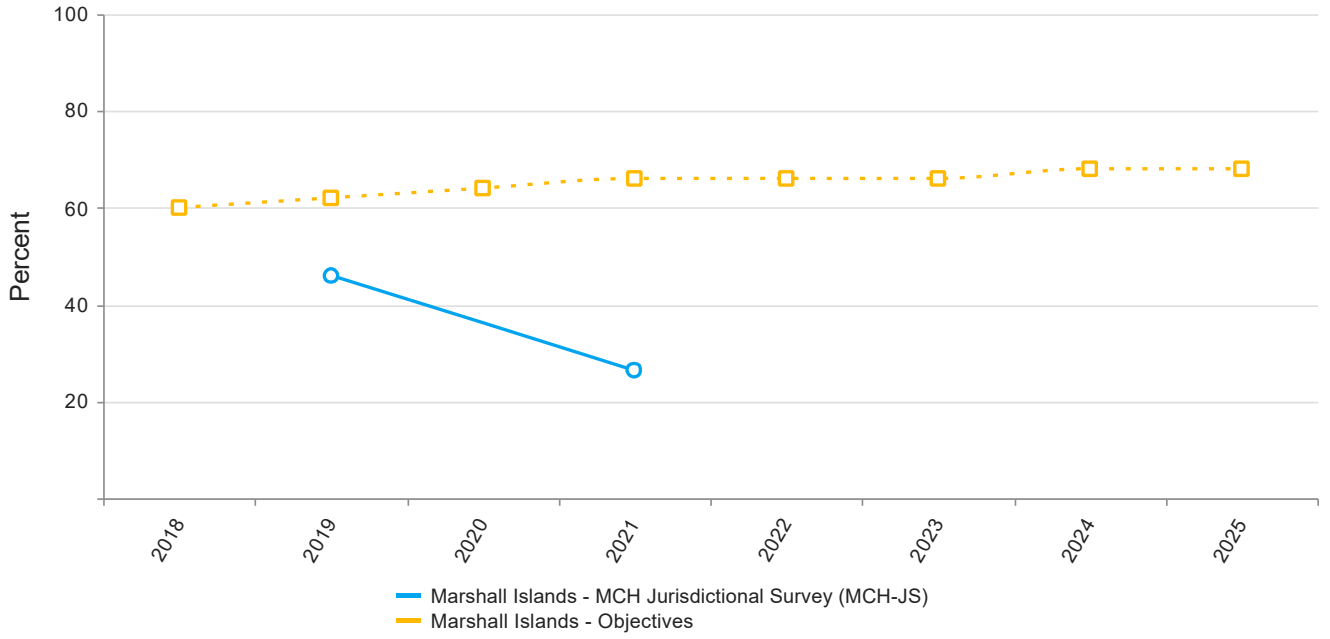
Objective: By 2025, increased number of children ages 1 to 14 years old with preventive dental care services by 5% yearly

- Increase campaign and awareness on oral health hygiene and available services.
    - Develop IEC Oral Health materials that are translated into Marshallese and other common languages in RMI
    - Conduct community and school oral health awareness activities
    - Engage different platforms to disseminate IEC materials like social media posting, newspaper advertisement, radio spots and school bulletin boards.
- Regular outreach mobile visits to the Outer Islands
    - Oral Health will conduct outreach mobile visits at least 4 Atolls/Islands in a year.

Adolescent Health

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	62	64	66	66
Annual Indicator	45.9	45.9	26.6	26.6
Numerator	2,966	2,966	1,724	1,724
Denominator	6,465	6,465	6,476	6,476
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	66.0	68.0	68.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	12
Annual Indicator			7.5	24.7
Numerator			69	241
Denominator			922	975
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	17.0	20.0

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	10
Annual Indicator			0	0
Numerator			0	0
Denominator			922	922
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

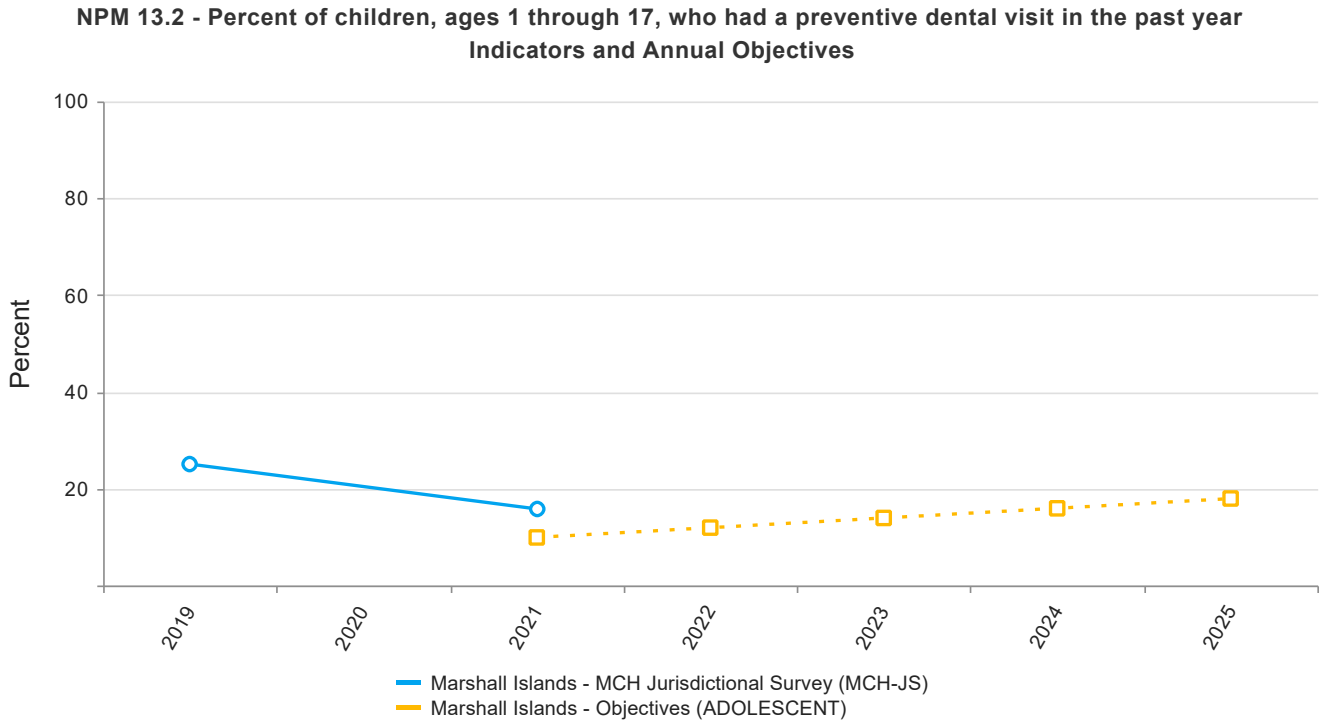
Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	20.0	25.0

ESM 10.3 - HPV vaccine coverage of girls age 13 years

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	37	39	51	35	36
Annual Indicator	36.4	49	33.3	38.3	48
Numerator	245	351	206	235	234
Denominator	673	717	619	614	488
Data Source	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program
Data Source Year	2018	2019	2020	2021	202211
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	37.0	38.0	39.0



NPM 13.2 - Adolescent Health

Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			10	12
Annual Indicator	25.2	25.2	15.9	15.9
Numerator	5,835	5,835	3,613	3,613
Denominator	23,195	23,195	22,676	22,676
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	14.0	16.0	18.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			15	17
Annual Indicator		14.3	18.8	10.7
Numerator		16	21	12
Denominator		112	112	112
Data Source		Dental Clinics/MCH Program	Dental Clinics/MCH Program	Dental Clinics/MCH Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	19.0	21.0	22.0

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	22
Annual Indicator		20.9	21.3	20.6
Numerator		2,691	2,746	2,659
Denominator		12,889	12,889	12,889
Data Source		Dental Clinics/MCH Program	Dental Clinics/MCH Program	Dental Clinics/MCH Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	24.0	26.0	28.0

State Performance Measures

SPM 4 - Percentage of teenagers 13-17 years old using Family planning services

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	20	20	13	22	24
Annual Indicator	18.8	11.8	21	19.4	16.4
Numerator	126	79	115	109	85
Denominator	6,686	6,686	5,464	5,612	5,187
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	26.0	28.0	30.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Adolescent Health - Entry 1	
Priority Need	
Child Oral Health Program partnership with schools	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
By 2025, increased preventive dental care services for adolescent 15-17 yrs old by 5% yearly	
Strategies	
Strengthen partnership with Public School System for dental services availability in public school	
Conduct community/school awareness of proper oral hygiene.	
ESMs	**Status**
ESM 13.2.1 - Percentage of elementary schools visited by dental program	Active
ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Marshall Islands) - Adolescent Health - Entry 2

Priority Need

Improve adolescent health through promotion of adolescent well-being.

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By 2025, increase HPV coverage rate for 13 years old female by 5% yearly or by 61 Per 1,000 13 yrs old female population.

Strategies

Make HPV Vaccination Routine Vaccine to 11-12 yrs old.
Strengthen HPV Vaccination messages to the community in partnership with Cancer Program
Conduct meetings with Parent and Teachers Association (PTAs) to provide awareness and health education on HPV vaccines and cervical cancer

ESMs	Status
ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year	Active
ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program	Active
ESM 10.3 - HPV vaccine coverage of girls age 13 years	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

State Action Plan Table (Marshall Islands) - Adolescent Health - Entry 3

Priority Need

Teen reproductive health and pregnancy prevention.

SPM

SPM 4 - Percentage of teenagers 13-17 years old using Family planning services

Objectives

Increase use of Family planning services between 13 - 17 yrs old by 5% yearly.

Strategies

Community awareness of Family Planning Services through radio, print, social media platforms and participate in women and youth to youth conferences

Work with the community and women's group for family planning awareness and education.

Strengthen the Family Planning Services at the Youth to Youth in Health Clinic and after dark clinic

Continue to provide family planning clinical services in Majuro, Ebeye and Outer Islands.

Family Planning commodities and counseling training to MCH nurses, Family Planning nurses and School Nurses

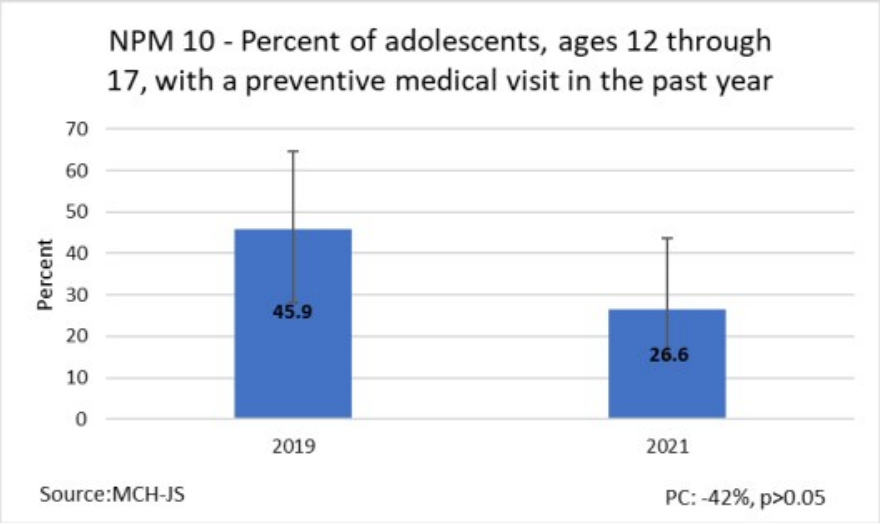
Priority Need: Improve adolescent health through promotion of adolescent well-being.

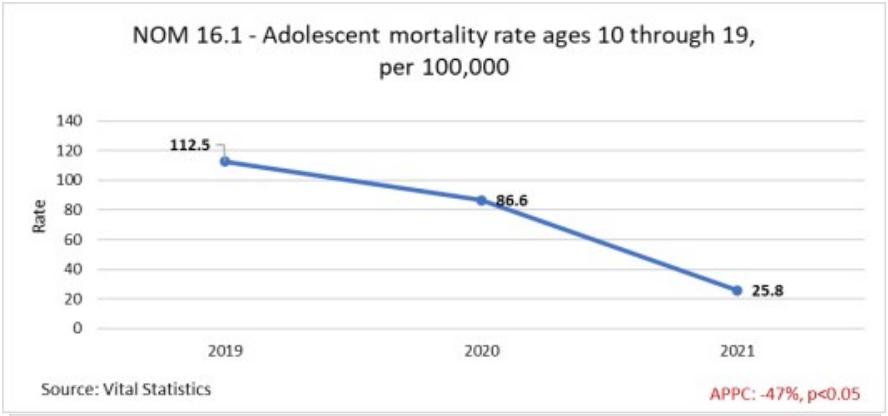
Measure	2017	2018	2019	2020	2021	2022	PC or AAPC	p-value
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year[1]	NA	NA	45.9	45.9	26.6	26.6	- 42%	p>0.05
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000[2]	NA	NA	112.5	86.6	25.8	0	- 47%	p<0.05
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000[2]	NA	NA	0	0	0	0	NA	NA
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000[2]	NA	NA	61.4	41.2	0	0	- 66%	p>0.05
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system[1]	NA	NA	0	0	0	0	NA	NA
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or Counseling[1]	NA	NA	13.4	13.4	7	7	- 48%	p>0.05
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health[1]	NA	NA	57.2	57.2	52.7	52.7	- 8%	p>0.05
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) [1]	NA	NA	18.2	18.2	14.4	14.4	- 21%	p>0.05
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal Influenza[3]	NA	NA	72.2	28.5	83	86	65%	p<0.05
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine[3]	NA	NA	49	40.3	39.3	40.9	- 10%	p<0.05
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine[3]	NA	NA	12.3	18.6	26.5	21.5	47%	p<0.05
NOM 22.5 - Percent of adolescents, ages 13 through 17,						22.9		

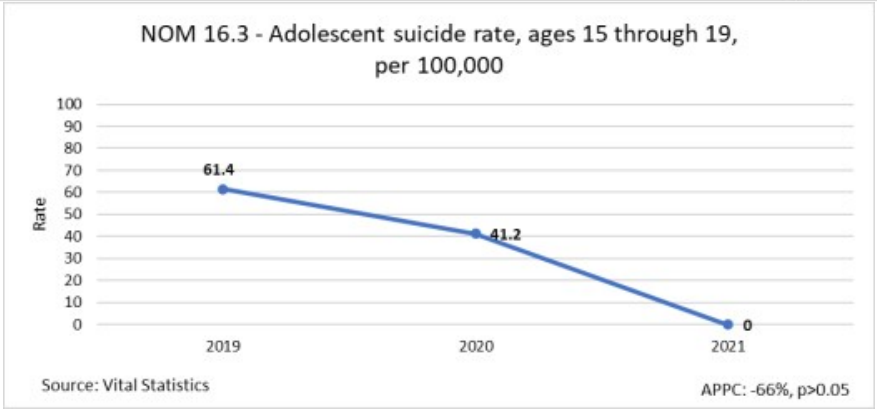
Measure	2017	2018	2019	2020	2021	2022	PC or AAPC	p-value
who have received at least one dose of the meningococcal conjugate vaccine[3]	NA	NA	15.9	15.3	30.9		64%	p<0.05
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females[2]	NA	NA	48.7	65.7	59.6	77	13%	p<0.05
ESM 10.3 - HPV vaccine coverage of girls age 13 years[3]	34.9	36.4	49	33.3	38.3	48	5%	p<0.05

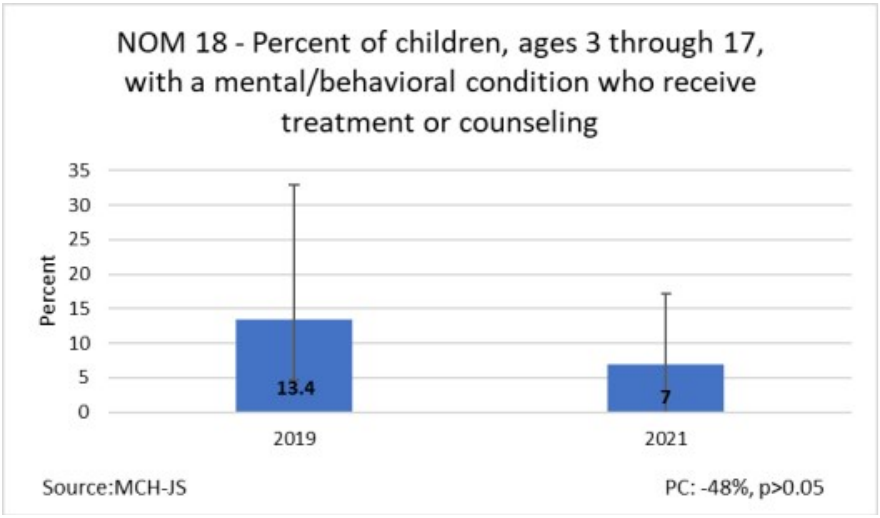
NA = Not available
p<0.05 = statistically significant change
Sources: [1] MCH-JS 2019 and 2021; [2] Vital Statistics 2019 to 2021; [3] WebIZ 2017 to 2021

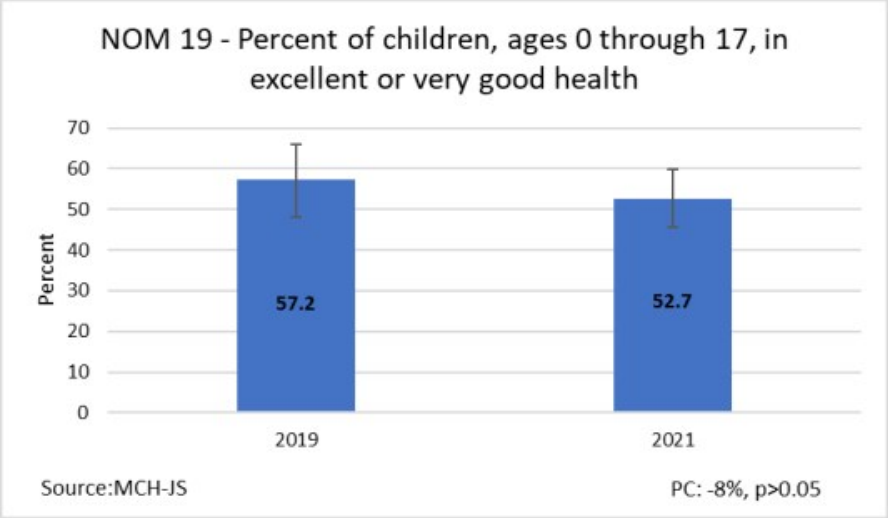
Between 2019 and 2021, there was a non-significant decline of 42% in preventive medical visits among adolescents aged 12 to 17 (MCH-JS: 45.9% and 26.6%, respectively). However, throughout the same time frame, according to Vital Statistics and the Immunization Program (WebIZ), a number of outcomes significantly improved: Teen birth rates (AAPC:13%; p<0.05), adolescent mortality rate (AAPC: -45%; p<0.05), children aged 6 months to 17 years who receive an annual influenza vaccine (AAPC: 65%; p<0.05), adolescents aged 13 to 17, who have received at least one dose of the Tdap vaccine (AAPC: 47%; p<0.05), and at least one dose of the meningococcal vaccine (AAPC: 163%; p<0.05). Additionally, although not statistically significant, the percentage of obese children aged 10 to 17 (AAPC: -21%; p > 0.05) and the rate of adolescent suicide (AAPC: -66%; p > 0.05) also improved. On the other side, there was a significant 10% decline in the percentage of adolescents, aged 13 to 17, who had gotten at least one dose of the HPV vaccine (WebIZ). Thirteen-year-old girls' HPV vaccination coverage (ESM 10.3) has increased by 5% during 2017, however this change is not statistically significant.

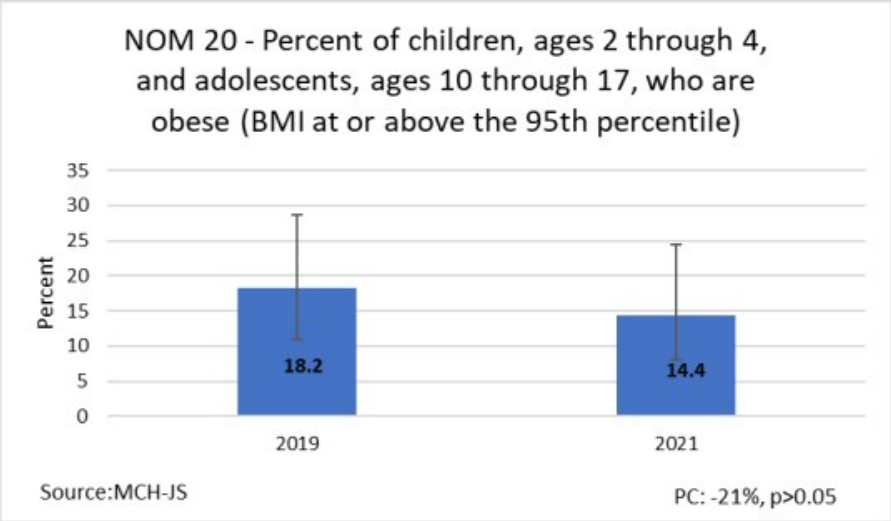


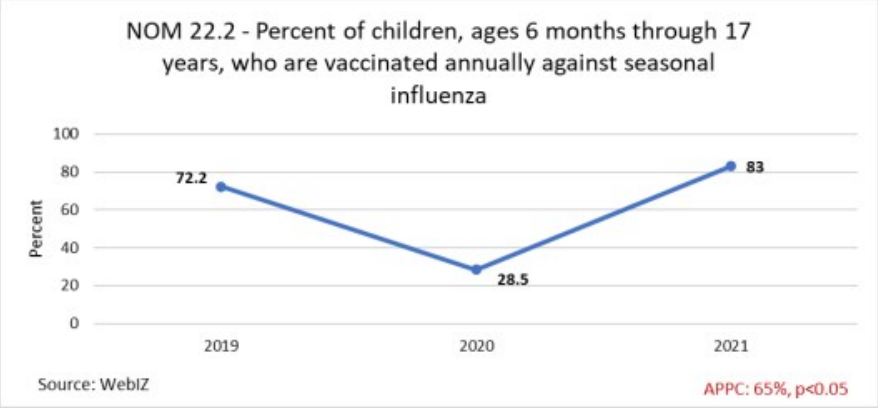

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
Rate
140
120
100
80
60
40
20
0
112.5
86.6
25.8
2019
2020
2021
Source: Vital Statistics
APPC: -47%, p<0.05

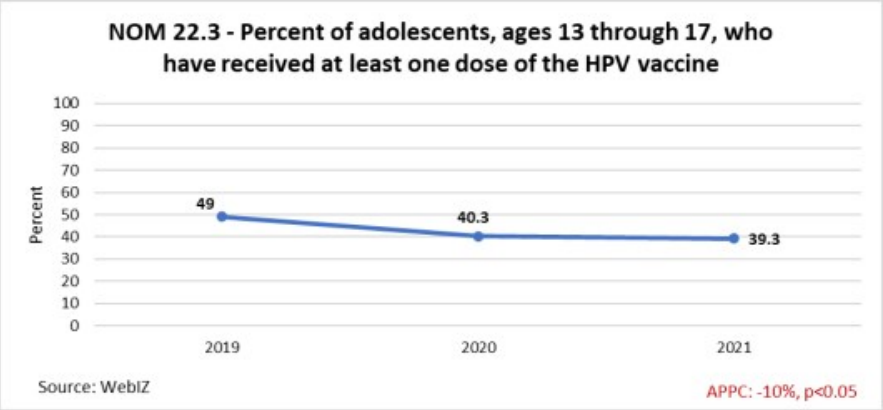

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
Rate
100
90
80
70
60
50
40
30
20
10
0
61.4
41.2
0
2019
2020
2021
Source: Vital Statistics
APPC: -66%, p>0.05

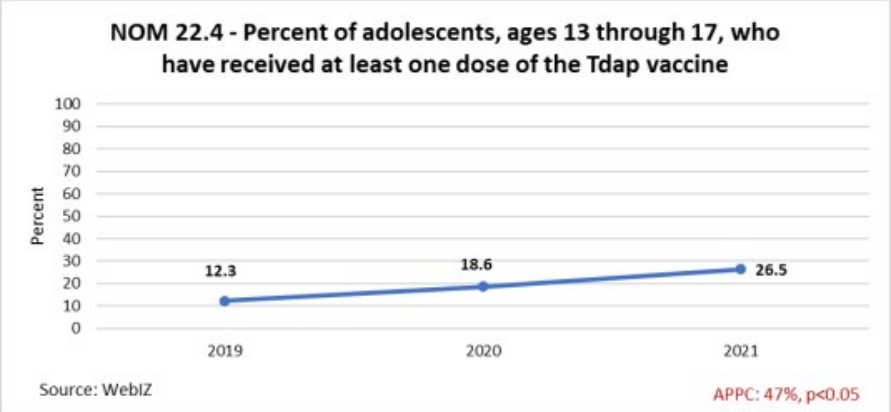

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
Percent
35
30
25
20
15
10
5
0
13.4
7
2019
2021
Source:MCH-JS
PC: -48%, p>0.05

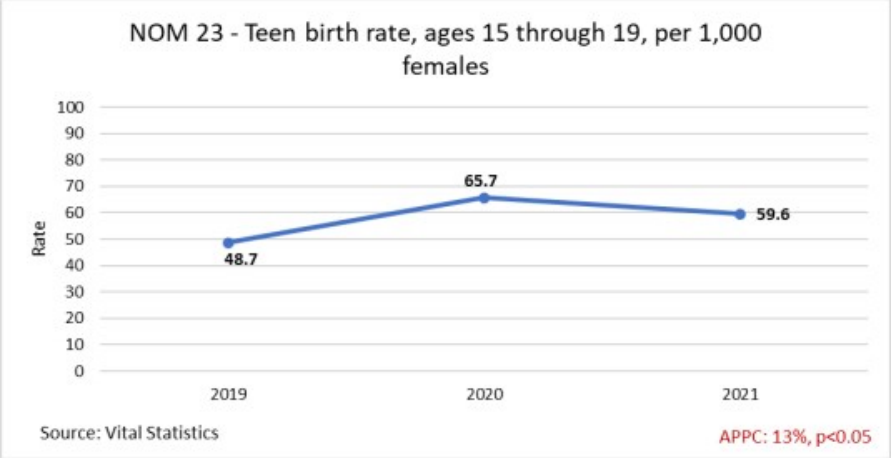

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
Percent
70
60
50
40
30
20
10
0
57.2
52.7
2019
2021
Source:MCH-JS
PC: -8%, p>0.05

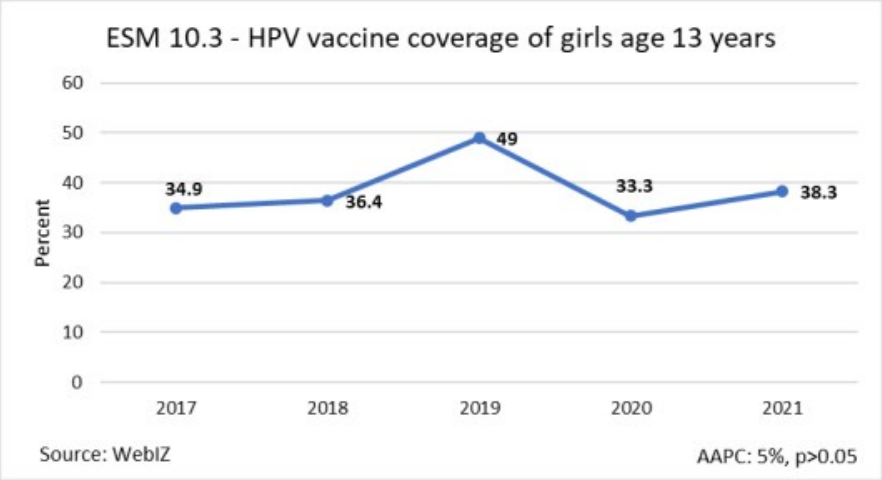

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
Percent
35
30
25
20
15
10
5
0
18.2
14.4
2019
2021
Source:MCH-JS
PC: -21%, p>0.05


NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
Percent
100
80
60
40
20
0
72.2
28.5
83
2019
2020
2021
Source: WebIZ
APPC: 65%, p<0.05


NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
Percent
100
90
80
70
60
50
40
30
20
10
0
49
40.3
39.3
2019
2020
2021
Source: WebIZ
APPC: -10%, p<0.05

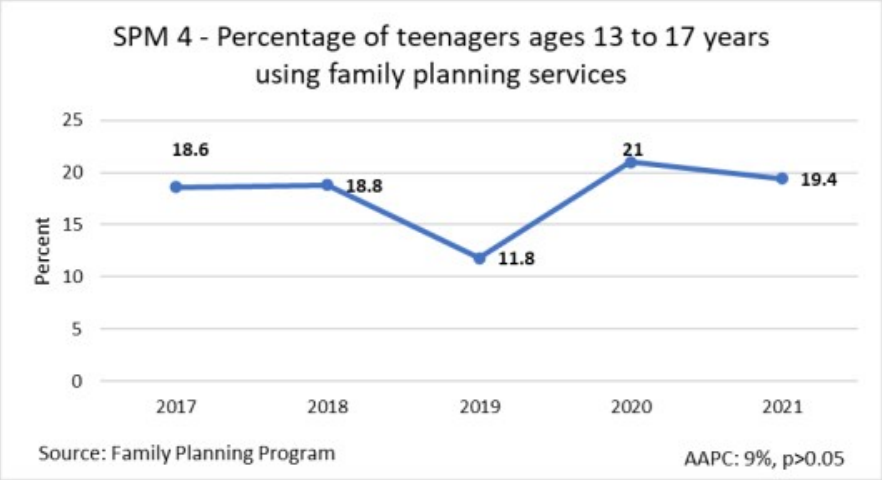

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
Percent
100
90
80
70
60
50
40
30
20
10
0
12.3
18.6
26.5
2019
2020
2021
Source: WebIZ
APPC: 47%, p<0.05


NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
Rate
100
90
80
70
60
50
40
30
20
10
0
48.7
65.7
59.6
2019
2020
2021
Source: Vital Statistics
APPC: 13%, p<0.05



Priority Need: Teen reproductive health and pregnancy prevention

Teenagers 13 to 17 years old used 9% more family planning services between 2017 and 2021 (18.6% and 10.4%, respectively), however this increase was not statistically significant.



NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Highlights:

- The Climate Change Art Seminar for high school students linked health to climate change using the medium of art. This was to foster a deeper engagement with the issues of climate change and health.

- There was youth friendly sexual reproductive health training provided.
- The implementation of the family planning supply chain management design training.
- The launch of the Marshall Islands Sexual and Gender Based Violence Clinical guidelines.
- Zero adolescent deaths ages 10 through 19 years old.

Challenge:

- There is a reluctance of the inclusion of Sexual Reproductive Health education within the school curriculum. Limits accessibility to Family Planning awareness within schools.
- COVID-19 preparedness and response were prioritized.

Plan

- To provide awareness within existing platforms between MOHHS and PSS taskforce on the inclusion of SRH education.
    - To develop a proposal on the Comprehensive Sexual Education Curriculum.
- To provide this plan through for approval to the PTA meetings as well as advocate on FP services for parents' consent during PTA meetings

In 2022, activities were deferred due to the preparedness and response for COVID-19 Pandemic. We continue provide existing services to the adolescent population.

Preventive medical visit services include eye checkup, stool and urine analysis, Immunization, TB Screening, Leprosy Screening and STI/HIV Screening. Due to limited and availability of complete services in the Neighboring Islands, preventive medical visit is only given in Majuro Hospital and Ebeye Hospital. Medical clearance is required for high school and college entry, food handlers, work clearance and visa application.

Adolescent mortality rate ages 10 through 19, per 100,000

In 2017, there are 7 deaths among ages 10 – 19 yrs. old. Underlying causes of death are the following: 2 pneumonia, 1 Congestive Heart Failure, 1 Bacterial Meningitis, 1 Drowning, 1 Post extubating acute pulmonary edema, 2 unknowns

In 2018, there are 14 deaths among ages 10 – 19 yrs. old. Underlying causes of death are the following: Endometritis: 1, Malnutrition: 1, Suicide: 2, Maternal Death: 1, Cancer: 2, Pneumonia: 2, CNS infection: 1, Blood Byscrasia: 1. Bacterial Meningitis: 1, Sepsis: 1, RHD: 1, Drowning (boat coalition): 1

In 2019, there are 3 adolescent suicide deaths due to hanging. Behavioral Health Department are engaged in providing suicide awareness activities in the schools and out of school youth. There is also an on-going drug addiction and selling in the community. This emerging problem is being addressed in the RMI Drug Task force composed of different government agencies and NGOs.

In 2020, causes of death for 10-19 years old were 2 suicides by hanging, 2 Pneumonia, 1 TB, 1 vehicular accident, 1 Dengue, 1 Cancer, 1 Congenital disease, and 1 uncial herniation. There is no vehicular accident death on 15-19 yrs. old

In 2021 and 2022, there are no suicide deaths among adolescents and motor vehicle accident.

In 2022, there are no adolescent deaths recorded.

HPV vaccinations campaign was launched by Immunization Program headed by School Immunization Coordinator. Public School System supports the campaign and endorsed it to the public schools. There is only one school that resist the promotion and vaccination of HPV due religious reason. Immunization program partnered with Cancer Program and MCH Program to be able to reach the mothers that will provide consent for HPV vaccinations.

There is a need to strengthen our activities and reach more teenagers which will eventually lower down our teen births which is 48.4 per 1,000 females ages 15-19 years old. Teen prevention pregnancy group continue to visit the high schools in Majuro, Ebeye and Outer Islands to provide presentations, counselling, and distribution of condoms. MCH Program with partnership with HIV/STI Program created and implement the Sexual Reproductive Health curriculum to one of the private school. The trained students can provide SRH talk to other students. Students are more open and comfortable talking with the same age group. Peer to peer group education to schools on Majuro and Neighboring islands.

Calculation of the Preventive visits includes: 12-17 yrs. old that visits Immunization program for vaccination (Tdap, MCV, HPV), HIV/STI screening test, Family Planning services, and prenatal services for teen pregnancy.

SPM 4 - increased use of Family planning services to teenagers ages 13 to 17 years old

	2017	2018	2019	2020	2021	2022
Increase use of Family planning services to teenagers ages 13 to 17 years old (Rate per 1,000 Teenagers 13-17 years old.)	18.6	18.8	11.8	21	19.4	16.4

MCH Block Grant Program continue to provide staff and supplies for after hrs. and Saturday clinics at the Youth to Youth in health.

MCH program partnered with STI/HIV Program to provide family planning counselling to the 13-17 years old that receive physical exam prior to school enrollment.

Adolescent Health Annual Plan

Population Domain: Adolescent Health
Priority Need: Teen reproductive health and pregnancy prevention.

SPM 4 Increase use of Family planning services to teenagers ages 13 to 17 years old

Objective: Increase use of Family planning services between 13 - 17 yrs old by 5% yearly.
Strategies:

- Community awareness of Family Planning Services through radio, print, social media platforms and participate in women and youth to youth conferences
    - Planning Program will utilize the FP IEC (Information, Education and Communication) Committee to revise old FP IEC materials and create new IEC in Marshallese, English and Chinese language.
    - MCH Program will fund the production for the radio, print, video and social media postings.
    - FP program will participate in the annual Women Conference, Youth to Youth Conference and Faith Based Conferences.

- Work with the community and women's group for family planning awareness and education.
    - MCH Program to provide funding for Women's group that will assist in the community awareness and education
    - Women's Group will assist in patient navigation to the FP services

- Strengthen the Family Planning Services at the Youth to Youth in Health Clinic and after dark clinic
    - FP services will still be available in Youth to Youth in Health and after dark clinic in Majuro. Clinic starts at 5:30 PM to 7:00 PM, Monday and Friday. The target population is the youth and patients that can't come to the FP clinic during regular clinic hours.
    - MCH program will sponsor at least 1 Youth awareness activity that will discuss Family Planning Services and annual check up visits. We will also include other youth-oriented programs in the Ministry on the awareness activity.

- Continue to provide family planning clinical services in Majuro, Ebeye and Neighboring Islands.
    - Program will ensure that FP commodities are available in all FP clinics and health centers in the Neighboring Islands.
    - Schedule community outreach and referral system. MCH Program will coordinate the community outreach with the Community Health Care Workers.
    - MCH Staff to continue providing regular FP services training to the Health Assistants in the Neighboring Islands

- Family Planning commodities and counseling training to MCH nurses, Family Planning nurses and School Nurses
    - With partnership with UNFPA, MCH Program will support the Family Planning commodities and counselling training. The training for school nurses will build capacity to provide FP services in the schools.

Priority Need: Child Oral Health Program partnership with schools

NPM 13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

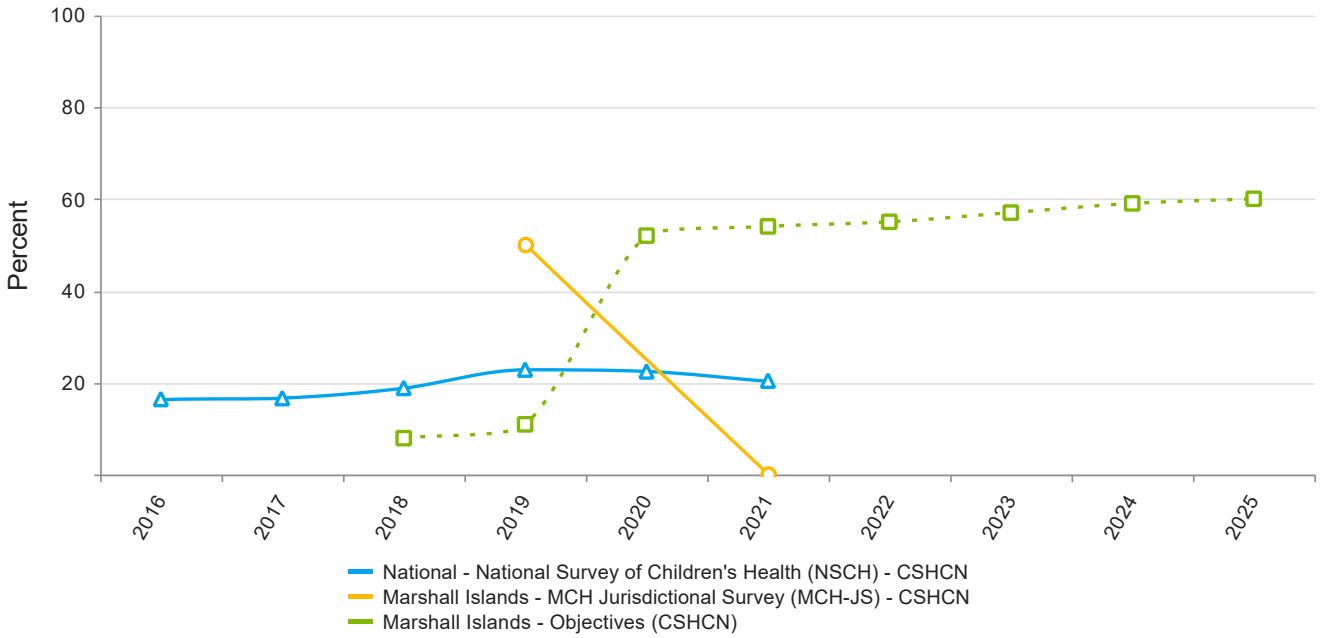
Objectives: By 2025, increased preventive dental care services for adolescent 15-17 yrs. old by 5% yearly
Strategies:

- Strengthen partnership with Public School System for dental services availability in public school
    - Ensure dental services outreach school schedule is regularly updated and submitted to Public School System
    - At the beginning of the school year, Ministry of Health and Human Services Public Health programs meet with the PTAs for awareness of PH services offered in the school.
- Conduct community/school awareness of proper oral hygiene.
    - Develop IEC Oral Health materials that are translated into Marshallese and other common languages in RMI
    - Conduct community and school oral health awareness activities
    - Engage different platforms to disseminate IEC materials like social media posting, newspaper advertisement, radio spots and school bulletin boards.

Children with Special Health Care Needs

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN			
	2019	**2020**	**2022**
Annual Objective	11	52	55
Annual Indicator	50.0	50.0	0
Numerator	176	176	0
Denominator	351	351	458
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	8	11	52	54	55
Annual Indicator	0				
Numerator	0				
Denominator	8,119				
Data Source	MCH Program				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives			
	2023	2024	2025
Annual Objective	57.0	59.0	60.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			2	5
Annual Indicator			3.4	9.5
Numerator			3	9
Denominator			89	95
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	7.0	9.0	12.0

State Performance Measures

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	50	63	65	65	67
Annual Indicator	61.3	64.1	58.6	62.7	63.4
Numerator	995	1,014	954	1,006	987
Denominator	1,624	1,583	1,629	1,604	1,556
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	69.0	70.0	72.0

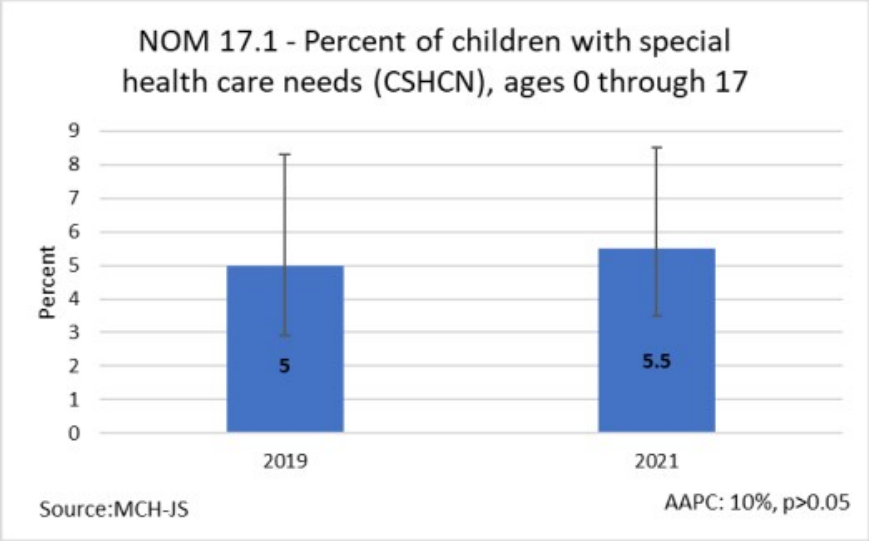
State Action Plan Table

State Action Plan Table (Marshall Islands) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.	
NPM	
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	
Objectives	
By 2025, MCH Program with partnership created and implemented the non-medical related programs for CSHCN.	
Strategies	
Develop transition plan in partnership with government agencies, NGOs and chamber of commerce	
Develop and implement clinical management guidelines for CSHCN referrals	
ESMs	**Status**
ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

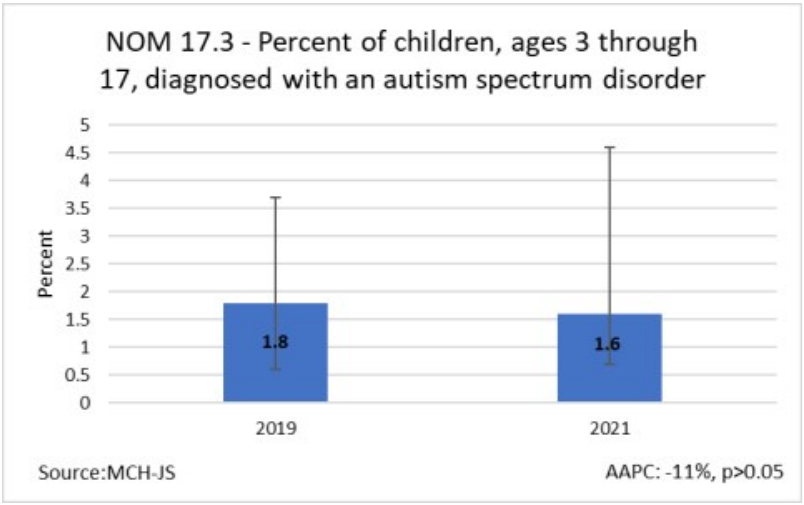
Priority Need: Develop and implement clinical management, guidelines, and registry for Children with Special Health Care Needs.

Even though by 2019, 50% of CSHCN, aged 12 to 17, received services to help them transition to adult health care, the 2021 MCH-JS data show that 0% of the CSHCN had received these services. This indicator should be taken with care because the width of the confidence interval is >20%, or >1.2 times the estimate. The MCH-JS offers the same caution for CSHCN, aged 0 through 17, who received care in a functioning system since it reports 0% for both years.

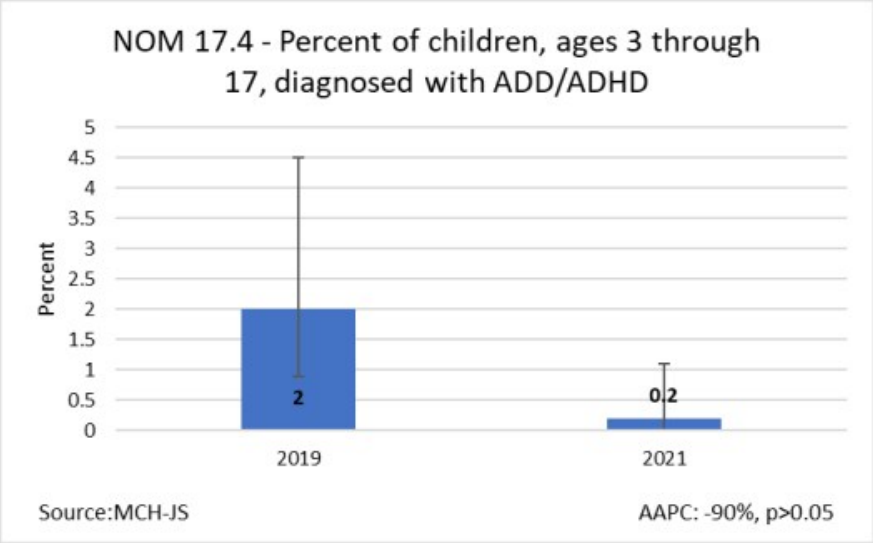
A 10% increase was observed in the prevalence of CSHCN 17 years or younger between 2019 and 2021 (MCH-JA: 5% and 5.5%, respectively) but this shift was not significant.



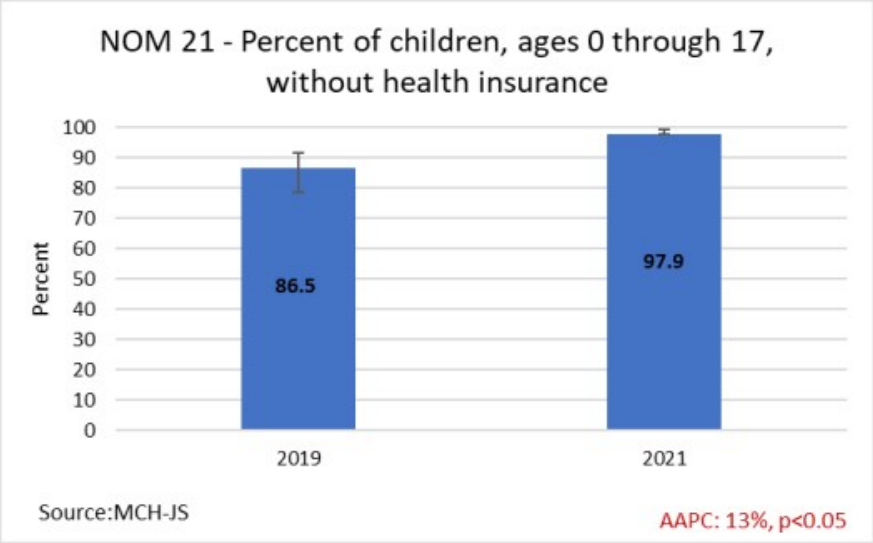
Between 2019 and 2021, there was an 11% decline in the prevalence of children diagnosed with an autism spectrum disorder, however, this decrease was not statistically significant (MCH-JS: 1.8% and 1.6%, respectively). However, this indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution.



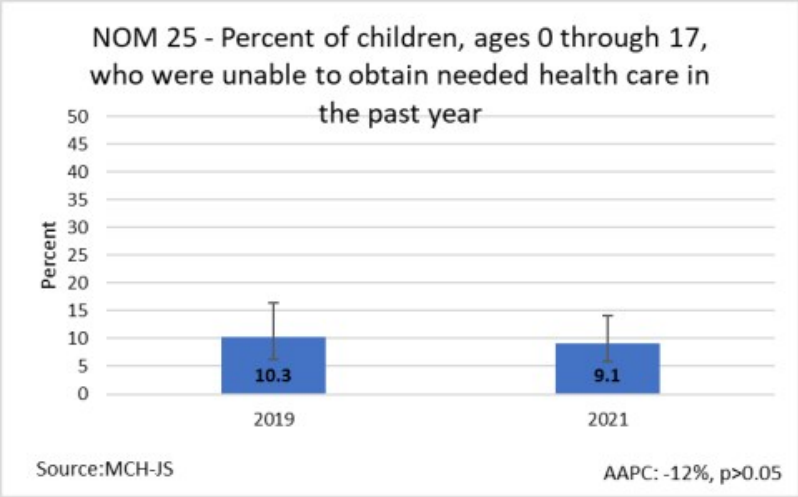
Children 3 to 17 years old who were diagnosed with attention deficit /attention deficit hyperactivity disorder showed a 90% non-significant decline between 2019 and 2021 (MCH-JS: 2% and 0.2%, respectively).



Children 0 to 17 years old without health insurance increased significantly by 13% (MCH-JS) between 2019 (86.5%) and 2021 (97.9%).



When comparing 2019 MCH-JS with 2021, there was a non-significant 12% decline in the number of children ages 0 to 17 who were unable to get the necessary medical care in the previous year (10.3% and 9.1%, respectively).



NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

	2019*	2020	2021*
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care	50		16.3

*MCH JS

2021: Result for the MCH JS is linked in the MCH BG application.

2019: Result for the MCH JS is linked in the MCH BG application.

2018: This NPM will be part of the Jurisdiction Survey to be able to get better information.

2017: this NPM will be part of the Jurisdiction Survey to be able to get better information. For 2017, no survey was done to capture this data. In 2018, we will work with Children's clinic to endorse >14 years old that needs assistance to transition to adult health care.

2016: RMI is only reporting CSHCN data - Only 10 out of the 300 identified CSHCN moved from pediatric to adult care. For RMI, Child health care services are provided from 0-14 years old. For 15 and up, the patients are referred to adult care which are in the main outpatient and public health clinics. For this measure, we have to establish a method to measure using survey if the patients know the transition in their health care.

Highlights

- Continue with immunization and deworming and Vit. A distribution to the population.
- Online training and conference for staff implementing early newborn hearing screening

- Referrals from MCH clinic to Human Services for evaluation.
- Parents and Doctor sessions
- Family group session with parents with children with hearing problems
- Continued collaboration with partners, EHDI (Early Hearing Detection Initiative), PSS (Public School System), MOCIA (Ministry of Internal and Cultural Affairs)
- Availability of data from MCH Jurisdictional Survey

Challenges:

- Need additional staff for the program to implement activities
- Weak case finding activities mainly in the neighboring islands.
- COVID-19 preparedness and response activities were prioritized.

- Lack of specialty care of CSHCN in RMI. CSHCN are referred off island to seek specialty care and treatment which adds financial and emotional burden to the families and the government

Plan:

- Develop transition plan in partnership with government agencies and NGOs
- Hire a CSHCN Manager that will oversee the CSHCN projects and report to the MCH Director

Program continue to work with Disability Group in conducting awareness activities, scheduling and referral of CSHCN.

With the COVID-19 Pandemic, MCH program developed a plan to ensure that the CSHCN's health care needs will be addressed. Telehealth program is in development which will be used as another platform to reach CSHCN population.

Children with Special Health Care Needs - Application Year

Population Domain: Children with Special Health Care Needs
Priority Need: Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.

NPM 12 Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objective: By 2025, MCH Program with partnership created and implemented the non-medical related programs for CSHCN.

Strategies:

- Develop transition plan in partnership with government agencies and NGOs

The MCH Blok Grant with support and endorsement from Ministry of Health and Human Services (MOHHS) leadership to create a task force that will manage the development of the transition plan. Regular meetings with the task force to develop the plan. MCH Block grant program to support the meetings for venue and supplies. We will create listing of services and benefits available for the CSHCN population. Draft Transition Plan will be presented to MOHHS Leadership and stakeholders.

- Develop and implement clinical management guidelines for CSHCN referrals

MCH Block Grant will organize a workshop with clinical staff and partners to develop the clinical management guidelines for CSHCN referrals by 1st quarter of 2023. Draft guidelines will be presented to the MOHHS leadership for review and endorsement before the end of 2023

Cross-Cutting/Systems Building

State Action Plan Table

State Action Plan Table (Marshall Islands) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Child Oral Health Program partnership with schools
Objectives
By 2025, increased preventive dental care services by 5% yearly
By 2025, Oral Health services visited at least 90% of the elementary and high schools in RMI
Strategies
Oral health services will conduct outreach visits to the schools yearly
Increase campaign and awareness on oral health hygiene and available services

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

The MCH Program engaged in different ways to present and gather public input. The following are the different groups that we engaged with to present the MCH Block Grant State Priorities, strategies, and annual progress report:

1. With the Mayors at the Marshall Islands Mayors Association Annual Conference
2. Women's Annual Conference by Women United Together Marshall Islands
3. Disability Awareness Week
4. World Cancer Awareness Month Walkathon
5. Breast Cancer Awareness Month Walkathon
6. Directors and managers in the Ministry of Health and Human Services – Strategic Planning
7. NCD Coalition

The executive summary is available for anyone that requested through email or pick up in the MCH Program Office.

III.G. Technical Assistance

The MCH Program needs technical assistance on the following areas:

1 FIMR:

The program needs assistance on developing a team to focus on this area. We currently have a perinatal committee which consists of program staff, maternity, and labor staff, OBGYNs. This committee conducts biannual meetings where charts are reviewed, and discussions made on how to improve services and quality patient care. No meetings in 2021 due to the pandemic. Plan to reach out to Ms. Rosemary through the project officer.

2. The program needs assistance on BSS for the Oral Health Program, TA submitted, pending due to the pandemic.

With the TA, program will be able to acquire the necessary knowledge and skills to conduct BSS in RMI. The program will be able to obtain the vital data needed thru BSS and use data as needed to formulate feasible plans to address areas. Update: Caroline Johnny-Jibas is working on the TA forms along with Dr. Dustin Bantol and Flora Nathan

3. Technical Assistance on the Financial part of the Application. This part was addressed during MCHB site visit but MCH Program Director wants to be more detailed. The 1st TA completed in April 2021. Update: The TA will be offered during the MCH Block Grant Review week in Honolulu, Sept 2023.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MCH Organization Chart.pdf

VII. Appendix

+

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Marshall Islands

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 233,858	
A. Preventive and Primary Care for Children	$ 70,158	(30%)
B. Children with Special Health Care Needs	$ 70,158	(30%)
C. Title V Administrative Costs	$ 23,385	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 163,701	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 2,646,295	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,646,295	
A. Your State's FY 1989 Maintenance of Effort Amount $ 175,745		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 2,880,153	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 100,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 2,980,153	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 229,808 (FY 22 Federal Award: $ 233,858)		$ 233,858	
A. Preventive and Primary Care for Children	$ 68,943	(30%)	$ 70,158	(30%)
B. Children with Special Health Care Needs	$ 68,943	(30%)	$ 70,158	(30%)
C. Title V Administrative Costs	$ 22,980	(10%)	$ 23,385	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 160,866		$ 163,701	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 2,646,295		$ 2,397,695	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,646,295		$ 2,397,695	
A. Your State's FY 1989 Maintenance of Effort Amount $ 175,745				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 2,876,103		$ 2,631,553	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 200,000		$ 97,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 3,076,103		$ 2,728,553	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 150,000	$ 47,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000	$ 50,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Program was not awarded for 2023-2026 cycle. No cost extension was granted to use $47000.00	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Marshall Islands

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 40,000	$ 40,000
2. Infants < 1 year	$ 30,157	$ 30,157
3. Children 1 through 21 Years	$ 70,158	$ 70,158
4. CSHCN	$ 70,158	$ 70,158
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 210,473	$ 210,473

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 900,000	$ 894,475
2. Infants < 1 year	$ 500,000	$ 449,875
3. Children 1 through 21 Years	$ 600,000	$ 530,645
4. CSHCN	$ 646,295	$ 522,700
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 2,646,295	$ 2,397,695
Federal State MCH Block Grant Partnership Total	$ 2,856,768	$ 2,608,168

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Pending salary payment, PO s and PRs will be paid off by the end of the FY	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Transfer of unused funds for vacant post and increments will be used to support program's operations	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Marshall Islands

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 70,000	$ 70,000
3. Public Health Services and Systems	$ 163,858	$ 163,858
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 233,858	$ 233,858

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 0	$ 0
3. Public Health Services and Systems	$ 2,646,295	$ 2,397,695
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 2,646,295	$ 2,397,695

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Marshall Islands

Total Births by Occurrence: 1,021 **Data Source Year: 2022**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	871 (85.3%)	95	7	7 (100.0%)

Program Name(s)
Hearing Loss

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Patient will be registered under Children with Special Health Care Needs. They will be monitored by the Pediatricians. Early Hearing Detection and Intervention Program connects with the children with hearing problems and their families. EHDI assist in the referral services and bringing in professionals like Audiologist. RMI don’t have a resident Audiologist.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2022**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Number of births for Majuro and Ebeye only : 911 Screened: 871 Died: 14 Missed: 12 Total births include Neighboring Islands: 1021; but no newborn hearing screening in NI	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: Number of births for Majuro and Ebeye only : 911 Screened: 871 Died: 14 Missed: 12	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Marshall Islands

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,010	0.0	0.0	100.0	0.0	0.0
2. Infants < 1 Year of Age	1,021	0.0	0.0	100.0	0.0	0.0
3. Children 1 through 21 Years of Age	3,647	0.0	0.0	100.0	0.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	82	0.0	0.0	100.0	0.0	0.0
4. Others	3,217	0.0	0.0	100.0	0.0	0.0
Total	8,895					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	1,767	No	1,309	100.0	1,309	1,010
2. Infants < 1 Year of Age	1,728	No	1,021	100.0	1,021	1,021
3. Children 1 through 21 Years of Age	34,371	No	20,951	23.0	4,819	3,647
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,985	No	82	100.0	82	82
4. Others	42,732	No	21,419	29.0	6,212	3,217

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**
	Field Note: Pregnant women that visited Prenatal Clinic in Majuro, Ebeye and Outer Islands.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: Infants services in MCH Clinics, house to house and outreach mobile visits. Title V supported the activities through staff time, medical supplies and training.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: 1-21 years old served in the Children's clinics, Prenatal Clinics, Women's Health and Dental Clinics.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Children with Special Health Care Needs that were given services in the reporting period.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**
	Field Note: Number reflects the unduplicated patients that come to the Women's Clinics with services but not limited to cancer screening, OB-GYNE cases, family planning services, dental services, and referrals to TB, Leprosy and STI Clinics.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: 100% served	
2.	**Field Name:**	**Pregnant Women Denominator**

	Fiscal Year:	**2022**
	Field Note: Pregnant women that visited Majuo, Ebeye and Neighboring Islands for prenatal services.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: live births in RMI.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Infants served by the program.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Served is based on the 1-21 years old that were given services by the MInistry of Health and Human Services	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**
	Field Note: Based on the1-21 years old and above 2022 projected population based on 2021 census.	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Served is based on the 1-21 years CSHCN old that were given services by the MInistry of Health and Human Services	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**
	Field Note: Registered CSHCN.	
9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**

	Field Note: 6212	
10.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2022**
	Field Note: Based on the 22 years old and above 2022 projected population based on 2021 census.	

Data Alerts:

1.	Pregnant Women Denominator is less than or equal to 90% of the Pregnant Women Reference Data. Please double check and justify with a field note.
2.	Infants Less Than One Year Denominator is less than or equal to 90% of the Infants Less Than One Year Reference Data. Please double check and justify with a field note.
3.	Children 1 through 21 Years of Age Denominator is less than or equal to 90% of the Children 1 through 21 Years of Age Reference Data. Please double check and justify with a field note.
4.	Children with Special Health Care Needs 0 through 21 Years of Age Denominator is less than or equal to 90% of the Children with Special Health Care Needs 0 through 21 Years of Age Reference Data. Please double check and justify with a field note.
5.	Others Denominator is less than or equal to 90% of the Others Reference Data. Please double check and justify with a field note.
6.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
7.	Children with Special Health Care Needs 0 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Marshall Islands

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	1,021	0	0	0	0	8	997	16	0
Title V Served	1,021	0	0	0	0	8	997	16	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0
2. Total Infants in State	1,021	0	0	0	0	8	997	16	0
Title V Served	1,021	0	0	0	0	8	997	16	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Marshall Islands

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(692) 625-7007 x2275	(692) 625-7007 x2275
2. State MCH Toll-Free "Hotline" Name	RMI MCH Program	692-625-7007
3. Name of Contact Person for State MCH "Hotline"	Caroline J. Jibas	Caroline J. Jibas
4. Contact Person's Telephone Number	(692) 625-7007 x2275	(692) 625-7007 x2275
5. Number of Calls Received on the State MCH "Hotline"		215

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Marshall Islands

1. Title V Maternal and Child Health (MCH) Director	
Name	Caroline J. Jibas
Title	MCH Program Manager
Address 1	P.O BOX 16
Address 2	
City/State/Zip	Majuro / MH / 96960
Telephone	(692) 625-7007
Extension	
Email	cjibas@rmihealth.org

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Caroline J. Jibas
Title	Program Manager
Address 1	P.O BOX 16
Address 2	
City/State/Zip	Majuro / MH / 96960
Telephone	(692) 625-7007
Extension	2275
Email	cjibas@rmihealth.org

3. State Family Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Marshall Islands

Application Year 2024

No.	Priority Need
1.	Access to coordinated, comprehensive care and services for Women before, during and after pregnancy
2.	Cancer screening and services for Women's Health
3.	Infants breastfed exclusively through six months
4.	Parent-completed developmental screening tools
5.	Reduce infant mortality rate
6.	Child Oral Health Program partnership with schools
7.	Teen reproductive health and pregnancy prevention.
8.	Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.
9.	Improve adolescent health through promotion of adolescent well-being.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to coordinated, comprehensive care and services for Women before, during and after pregnancy	Revised
2.	Cancer screening and services for Women's Health	Continued
3.	Infants breastfed exclusively through six months	Continued
4.	Parent-completed developmental screening tools	Continued
5.	Reduce infant mortality rate	New
6.	Child Oral Health Program partnership with schools	Continued
7.	Teen reproductive health and pregnancy prevention.	Revised
8.	Develop and implement clinical management, guidelines and registry for Children with Special Health Care Needs.	Continued
9.	Improve adolescent health through promotion of adolescent well-being.	Revised

Form 10
National Outcome Measures (NOMs)

State: Marshall Islands

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	30.5
Numerator	399
Denominator	1,309
Data Source	MCH Progrram
Data Source Year	2022

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	20.4
Numerator	2
Denominator	982
Data Source	Hospital Census
Data Source Year	2022

NOM 2 - Notes:

Source for number of delivery hospitalizations is Majuro and Ebeye only.

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	1,021
Data Source	Vital Statistics Office
Data Source Year	2022

NOM 3 - Notes:

No maternal deaths for this reporting period.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 3. Please review your data to ensure this is correct.

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	13.6 %	2.3 %	3,292	24,274
2019	9.8 %	1.8 %	2,389	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2022
Annual Indicator	15.7
Numerator	160
Denominator	1,021
Data Source	Vital Statistics Office
Data Source Year	2022

NOM 4 - Notes:

Majuro: 113; Kwajalein: 41; Outer Islands : 6 ; Total of 160 births with weight less than 2500 grams.

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	8.3 %	1.9 %	2,006	24,274
2019	21.5 %	4.1 %	5,225	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2022
Annual Indicator	11.6
Numerator	118
Denominator	1,021
Data Source	Vital Statistics
Data Source Year	2022

NOM 5 - Notes:

There were 8 without proper length of pregnancy. 118 births with less than 37 weeks length of pregnancy. 44 of the 118 reported low birth weight. 13 born from teen mothers.

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	31.1
Numerator	318
Denominator	1,021
Data Source	Vital Statistics
Data Source Year	2022

NOM 6 - Notes:

36 births with low birth weight;

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	318
Data Source	Vital Statistics and Labor Ward
Data Source Year	2022

NOM 7 - Notes:

All cesarean deliveries have indications. Regular deliveries are attended by midwives.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 7. Please review your data to ensure this is correct.

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	38.2
Numerator	39
Denominator	1,021
Data Source	Vital Statistics and Labor Ward
Data Source Year	2022

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	24.8		21	
2020	25.5		35	
2019	26.4		36	
2018	27.4		38	
2017	28.1		40	
2016	28.8		41	
2015	29.5		43	
2014	30.1		45	
2013	30.6		47	
2012	31.1		49	
2011	31.5		51	
2010	31.7		53	
2009	31.8		54	

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2022
Annual Indicator	22.5
Numerator	23
Denominator	1,021
Data Source	Vital Statistics
Data Source Year	2022

NOM 9.1 - Notes:

Underlying cause of infant deaths are complication of pregnancy and delivery like prematurity, sepsis, meconium stain

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	13.8		11	
2020	14.2		19	
2019	15.3		21	
2018	15.5		21	
2017	16.0		22	
2016	16.4		23	
2015	16.9		25	
2014	17.2		26	
2013	17.5		27	
2012	17.7		28	
2011	17.8		29	
2010	18.0		30	
2009	18.0		31	

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2022
Annual Indicator	16.7
Numerator	17
Denominator	1,021
Data Source	Vital Statistics
Data Source Year	2022

NOM 9.2 - Notes:

Common cause of death prematurity, sepsis and meconium stain.

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	5.9
Numerator	6
Denominator	1,021
Data Source	Vial Staitstics
Data Source Year	2022

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	587.7
Numerator	6
Denominator	1,021
Data Source	Vital Statistics
Data Source Year	2022

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	1,021
Data Source	Vital Statistics
Data Source Year	2022

NOM 9.5 - Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 9.5. Please review your data to ensure this is correct.

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	1.6
Numerator	16
Denominator	1,012
Data Source	MCH program
Data Source Year	2022

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	982
Data Source	Vital Statistics
Data Source Year	2022

NOM 11 - Notes:

No admission with neonatal abstinence syndrome.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 11. Please review your data to ensure this is correct.

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	15.9 %	2.5 %	3,610	22,676
2019	23.8 %	4.2 %	5,528	23,195

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	84.0
Numerator	7
Denominator	8,330
Data Source	Vital Statistics
Data Source Year	2022

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	10,005
Data Source	Vital Statistics
Data Source Year	2022

NOM 16.1 - Notes:

No death occurred for ages 10-19 yrs old.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 16.1. Please review your data to ensure this is correct.

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	4,865
Data Source	Vital Statistics
Data Source Year	2022

NOM 16.2 - Notes:

No death occurred for ages 15-19 yrs old.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 16.2. Please review your data to ensure this is correct.

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	4,865
Data Source	Vital Statistics
Data Source Year	2022

NOM 16.3 - Notes:

No deaths due to suicide for age 15-19 yrs old.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 16.3. Please review your data to ensure this is correct.

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	5.5 %	1.2 %	1,337	24,274
2019	5.0 %	1.3 %	1,203	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	0 %	0	0	1,337
2019	0 %	0	0	1,203

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	1.8 %	0.9 %	344	19,252
2019	1.6 %	0.7 %	308	19,810

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	0.2 %	0.2 %	31	19,252
2019	2.0 %	0.8 %	393	19,810

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	7.0 %	5.1 %	71	1,019
2019	13.4 %	6.9 %	124	923

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	52.7 %	3.6 %	12,784	24,274
2019	57.2 %	4.6 %	13,888	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2007	24.9 %	1.2 %	342	1,374

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	14.4 %	4.1 %	1,374	9,514
2019	18.2 %	4.5 %	1,728	9,514

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	97.9 %	1.0 %	23,755	24,274
2019	86.5 %	3.3 %	20,995	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	0.0
Numerator	0
Denominator	982
Data Source	WebIZ
Data Source Year	2022

NOM 22.1 - Notes:

The 7 vaccine series is not in the Immunization Schedule of RMI.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 22.1. Please review your data to ensure this is correct.

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	86.0
Numerator	17,399
Denominator	20,240
Data Source	WebIZ,
Data Source Year	2022

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	40.9
Numerator	2,124
Denominator	5,187
Data Source	WebIZ, RMI Census 2021
Data Source Year	2022

NOM 22.3 - Notes:

Denominator:2022 Projected population from 2021 census for 13-17 years old; both gender.
RMI is currently vaccinating only female for HPV. Denominator for female 13-17 years old: 2469; 2124/2469 = 86% with at least HPV vaccine for female 13-17 years old.

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	21.5
Numerator	1,115
Denominator	5,187
Data Source	WebIZ, RMI Census 2021
Data Source Year	2022

NOM 22.4 - Notes:

Denominator: 2022 Projected population based on RMI Census 2021

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	22.9
Numerator	1,189
Denominator	5,187
Data Source	WebIZ, RMI Census 2021
Data Source Year	2022

NOM 22.5 - Notes:

Denominator: 2022 Projected population based on 2021 RMI Census

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	77.0
Numerator	179
Denominator	2,324
Data Source	Vital Statistics
Data Source Year	2022

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2022
Annual Indicator	1.2
Numerator	12
Denominator	1,021
Data Source	MCH Program
Data Source Year	2022

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	9.1 %	2.1 %	2,219	24,274
2019	10.3 %	2.6 %	2,502	24,274

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Marshall Islands

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective		48	50	52
Annual Indicator	48.3	48.3	29.2	29.2
Numerator	8,951	8,951	5,743	5,743
Denominator	18,513	18,513	19,682	19,682
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	37	39	48	50	52
Annual Indicator	37.7				
Numerator	3,733				
Denominator	9,896				
Data Source	MCH Program				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	54.0	56.0	58.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Preventive medical visit for women includes papsmear/VIA screening, breast cancer screening, family planning counselling, STI/HIV Screening, TB Screening, Leprosy Screening and Immunization service (Hep B, MCV4, Flu - for immunocompromise) in Majuro Hospital, Ebeye Hospital and Outer Islands (that reported on time)

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	1
Annual Indicator	0	0	0	0
Numerator	0	0	0	0
Denominator	2	8	5	9
Data Source	MOHHS	Vital Records Information System	MOHHS	Vita Statistics
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	1.0	2.0	2.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This is a new PM. During the Needs Assessment, the stakeholders identified that our hospital need to improve its birthing and neonatal facilities.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Our hospitals is not a Level III+ Neonatal Intensive Care Unit (NICU). But we have a NICU for both Majuro and Ebeye Hospitals.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Our hospitals are not in a Level III+ Neonatal Intensive Care Unit (NICU). But we have a NICU for both Majuro and Ebeye Hospitals that takes care of very Lowe birth weight newborns. 8 out of the 9 very low birth weight newborns were born in the hospitals.	

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	100	56	58	60
Annual Indicator	55.8	55.8	90.1	90.1
Numerator	5,143	5,143	7,855	7,855
Denominator	9,218	9,218	8,720	8,720
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	100	100	56	58	60
Annual Indicator	100				
Numerator	989				
Denominator	989				
Data Source	RMI ICHNS				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	62.0	64.0	65.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is life saving skin to skin contact immediately after birth between the baby and the mother.

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	42	44	44	46	48
Annual Indicator	42.3	42.3	42.3	42.3	42.3
Numerator	373	373	373	373	373
Denominator	881	881	881	881	881
Data Source	RMI ICHNS	RMI ICHNS	RMI ICHNS	RMI ICHNS	RMI ICHNS
Data Source Year	2018	2018	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	52.0	54.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey. There are 881 children under 5 yrs old from Majuro, Ebeye and Outer Islands.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey. There are 881 children under 5 yrs old from Majuro, Ebeye and Outer Islands. This is one of RMI State Priority. MCH Program with collaboration with other programs developed a milestone passport/passbook which will enable us to measure this NPM. There will be activities laid out to improve this indicator.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey.	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data presented is from RMI Integrated Child Health and Nutrition Survey.	

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS)			
	2019	**2020**	**2022**
Annual Objective	46	48	52
Annual Indicator	1.5	1.5	0
Numerator	53	53	0
Denominator	3,619	3,619	3,829
Data Source	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	44	46	48	50	52
Annual Indicator	30.8	20.6	24	20.5	22.1
Numerator	500	532	569	521	344
Denominator	1,624	2,577	2,373	2,545	1,556
Data Source	MCH Program	MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	55.0	57.0	59.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data reported is for Majuro Only. Ebeye and Outer Islands needs more training. It was a challenge to collect and report this data because the information system needs to be updated. In 2018, the mHIS (Marshall Hospital Information System) roll out on outpatient first and plan for MCH clinic will be in 2019-2020.

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective	62	64	66	66
Annual Indicator	45.9	45.9	26.6	26.6
Numerator	2,966	2,966	1,724	1,724
Denominator	6,465	6,465	6,476	6,476
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	66.0	68.0	68.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Preventive visits: 12-17 yrs old that visits Immunization program for vaccination (Tdap, MCV, HPV), HIV/STI screening test, Family Planning services, and prenatal services for teen pregnancy. In this reporting period, we included the 12-17 yrs old with TB/Leprosy Mass Screening in Majuro.

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data			
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN			
	2019	**2020**	**2022**
Annual Objective	11	52	55
Annual Indicator	50.0	50.0	0
Numerator	176	176	0
Denominator	351	351	458
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	8	11	52	54	55
Annual Indicator	0				
Numerator	0				
Denominator	8,119				
Data Source	MCH Program				
Data Source Year	2018				
Provisional or Final ?	Final				

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	57.0	59.0	60.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
This NPM will be part of the Jurisdiction Survey to be able to get better information.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			10	29
Annual Indicator	25.2	25.2	15.9	15.9
Numerator	5,835	5,835	3,613	3,613
Denominator	23,195	23,195	22,676	22,676
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	31.0	33.0	35.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Annual Objectives			
	2023	2024	2025
Annual Objective	14.0	16.0	18.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Marshall Islands

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	11	13	13	12	14
Annual Indicator	10.9	13.4	10.8	13.4	10.1
Numerator	856	892	917	1,146	679
Denominator	7,849	6,644	8,529	8,529	6,719
Data Source	MCH Program	MCH Progam	MCH Program	MCH Program	MCH Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	16.0	18.0	20.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Population is based on the midyear population for 2020.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Denominator: 2022 Projected population from 2021 census. The cancer screening was affected by the community transmission of COVID-19. Clinics were closed for 3 weeks. When clinics open, we were prioritizing emergency and prenatal cases.	

SPM 2 - Percent of women ages 15-44 years old that use family planning services

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	18	20	16	15	16
Annual Indicator	16.8	14.5	11	12	13
Numerator	1,984	1,773	1,353	1,479	1,261
Denominator	11,790	12,255	12,271	12,301	9,715
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	17.0	18.0	19.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: In FY2020, there was delay in visiting the Outer Islands for mobile visits due to the preparedness and response activities on COVID-19 Pandemic. Staff were re-assign to manage the quarantine facilities with other Public Health staff. We plan to revisit all the active Family Planning Clinic charts to find any missing data entry, recalculating of Jadelle users and women that are in BTL.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Denominator is from the recent 2021 census with projected population for 2022. There is 24% decrease of population for 15-44 years old female in the 2021 comparing to 2011 census. Due to COVID-19 community transmission, the number of unduplicated Family planning clients decreased by 16% comparing to 2021.	

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		37	33	35	37
Annual Indicator		31.1	34.9	36.4	39.1
Numerator		372	359	368	399
Denominator		1,198	1,028	1,010	1,021
Data Source		MCH Program	MCH Program	MCH Program	MCH Program
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	39.0	41.0	43.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percentage of teenagers 13-17 years old using Family planning services

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	20	20	13	22	24
Annual Indicator	18.8	11.8	21	19.4	16.4
Numerator	126	79	115	109	85
Denominator	6,686	6,686	5,464	5,612	5,187
Data Source	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program	Family Planning Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	26.0	28.0	30.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old. Number of users: Female: 126,; Male: 0 Population: 13-17 yrs old: Female: 3,224 ; Male: 3,461 Total: 6,686	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old. Number of users: Female: 114,; Male: 1 Population: 13-17 yrs old: Female: 2,646 ; Male: 2,818 Total: 5464 Challenge: Family Planning Staff providing after hrs clinic at the Youth to Youth in Health (YTYIH) reported that Youth age 13-17 yrs old are not coming to the clinic. The previous YTYIH Administration hire young teenagers to bring other teenagers to the clinic. YTYIH lost their funding in 2019 - 2020 which affected the services.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old. Number of users: Female: 109,; Male: 0 Population: 13-17 yrs old: Female: 2,690 ; Male: 2,922 Total: 5612	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Recommendation from the last block grant review to revise SPM 4 indicator. This has been completed this application.	

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	50	63	65	65	67
Annual Indicator	61.3	64.1	58.6	62.7	63.4
Numerator	995	1,014	954	1,006	987
Denominator	1,624	1,583	1,629	1,604	1,556
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	69.0	70.0	72.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
In 2016-17, RMI has several outbreaks including mumps, Hepatitis A, and conjunctivitis. Immunization nurses were also assigned to work on the Integrated Children Household Nutrition Survey which affected their work in immunization. Immunization schedule to the Outer Islands was also affected due to some administrative requirements which prolonged the processing of travel documents.

In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%. In 2018: Majuro - 61.24%, Ebeye - 95.19% and Outer Islands - 25.6% RMI - 61.27%. In this reporting period, Immunization Program was able to achieve its annual objective. Improved data monitoring and reporting was added in the program's activity in 2018. Monthly reporting of data is included in the program's meeting which strategies for improvement were derived. Although the 90% goal for immunization rate is still far, the program will continue to provide outreach services and extended clinic hours to cater to the population that are unable to come to the clinics.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%. In 2018: Majuro - 61.24%, Ebeye - 95.19% and Outer Islands - 25.6% RMI - 61.27%. In 2019: Majuro - 67.3%, Ebeye - 95.5% and Outer Islands - 15.6% RMI - 64.1%.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: In 2020: Majuro - 63.9%, Ebeye - 84.9% and Outer Islands - 17.1% RMI - 58.6%.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: In 2020: Majuro - 65%, Ebeye - 95% and Outer Islands - 25% RMI - 63%.	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: In 2022: Majuro - 63%, Ebeye - 92% and Neighboring Islands - 33% RMI - 63%.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Marshall Islands

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	15
Annual Indicator			10.8	37.5
Numerator			103	386
Denominator			958	1,030
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	25.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1	2
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Cancer Program	Cancer Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	3.0	3.0	5.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to the Global COVID-19 Pandemic, this activity is delayed. Planning is on-going for the provision of cervical cancer screening at least to 1 health center.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Due to the Global COVID-19 Pandemic, this activity is delayed. Planning is on-going for the provision of cervical cancer screening at least to 1 health center.	

ESM 1.3 - Percent of women booked for prenatal visit in first trimester

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	22
Annual Indicator			18.7	25.8
Numerator			179	260
Denominator			958	1,006
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	24.0	26.0	28.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
We were advised to change this ESM into SPM from the last block grant review. MCH Program will address this in the next needs assessment and application cycle.

ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			10	12
Annual Indicator			0	6
Numerator			0	60
Denominator			958	1,006
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	14.0	16.0	18.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The system and process is in planning stage along with ECD project.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: We were advised to change this ESM into SPM from the last block grant review. MCH Program will address this in the next needs assessment and application cycle.	

ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator			0	0
Denominator			2	2
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The team led by Clinical Advisor created sub-committee that will review and update the SOPs with current standards of care for both maternal and infant outcomes. We have created google drive to store the library of SOPs that the program have.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to competing priority with COVID-19 preparedness and response, we were not able to complete the activities. OBGYNE updated section of SOP on COVID-19 pregnancy management and delivery.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Due to competing priority with COVID-19 preparedness and response, we were not able to complete the activities. OBGYNE updated section of SOP on COVID-19 pregnancy management and delivery.	

ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	100
Annual Indicator			0	0
Numerator			0	0
Denominator			2	2
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.3 - Percent of newborn babies issued newborn baby health passbook

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	25
Annual Indicator			0	0
Numerator			0	0
Denominator			100	100
Data Source			MCH Program	MCH Program
Data Source Year			2021	200
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	35.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to preparedness and response to COVID-19 Pandemic, the health passbook (milestone passbook) development and implementation was delayed. Committee meetings were conducted. Drafted Marshallese translation of the passbook was distributed for review. First 50 newborns will be registered to use the Milestone Passbook. the 1st 6 months will be used as a quality improvement activity to ensure that we will be able to address any problems before launching it to the health centers

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Due to preparedness and response to COVID-19 Pandemic, the health passbook (milestone passbook) development and implementation was delayed. Committee meetings were conducted. Drafted Marshallese translation of the passbook was distributed for review. First 50 newborns will be registered to use the Milestone Passbook. the 1st 6 months will be used as a quality improvement activity to ensure that we will be able to address any problems before launching it to the health centers.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Due to preparedness and response to COVID-19 Pandemic, the health passbook (milestone passbook) development and implementation was delayed. Committee meetings were conducted. Drafted Marshallese translation of the passbook was distributed for review. First 50 newborns will be registered to use the Milestone Passbook. the 1st 6 months will be used as a quality improvement activity to ensure that we will be able to address any problems before launching it to the health centers.

ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			Yes	Yes
Annual Indicator			No	Yes
Numerator				
Denominator				
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to preparedness and response to COVID-19 Pandemic, we were not able to conduct this activity. Staff's time was shared with COVID-19 vaccination activities.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: We were advised to change this ESM into % instead of a Yes/No Answer from the last block grant review. MCH Program will address this in the next needs assessment and application cycle.	

ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	10
Annual Indicator			0	0
Numerator			0	0
Denominator			30	30
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	20.0	25.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to COVID-19 and RMI borders closure, we were not able to hire the lactation nurse that will train and produce local lactation nurse.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Due to COVID-19 and RMI borders closure, we were not able to hire the lactation nurse that will train and produce local lactation nurse. This is included in the ECD work plan and will be implemented next year.	

ESM 6.1 - The number of potential high risk screens referred to early intervention

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			Yes	Yes
Annual Indicator			No	Yes
Numerator				
Denominator				
Data Source			MCH Program	MCH Program
Data Source Year			FY2021	FY2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: In planning along with ECD project.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: This ESM will be reviewed to either revise to be specific, measurable and achievable.	

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	12
Annual Indicator			7.5	24.7
Numerator			69	241
Denominator			922	975
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	17.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
We are working in the school for the full implementation of this project. We are creating flyers and video that can be distributed in the school and played during health subject.

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	10
Annual Indicator			0	0
Numerator			0	0
Denominator			922	922
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	20.0	25.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Denominator: 2 Middle Schools; 18 Secondary Schools; 2 of the secondary private schools doesn't allow discussion of STIs and Pregnancy.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to preparedness and response to COVID-19 Pandemic, we were not able to conduct this activity. Staff's time was shared with COVID-19 vaccination activities. We will work with Public School System to meet with the parents as we encounter some resistance,	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Due to preparedness and response to COVID-19 Pandemic, we were not able to conduct this activity. Staff's time was shared with COVID-19 vaccination activities.	

ESM 10.3 - HPV vaccine coverage of girls age 13 years

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	37	39	51	35	36
Annual Indicator	36.4	49	33.3	38.3	48
Numerator	245	351	206	235	234
Denominator	673	717	619	614	488
Data Source	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program	WebIZ, Immunization Program
Data Source Year	2018	2019	2020	2021	202211
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	37.0	38.0	39.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Majuro - 104, Ebeye - 81; Outer Islands - 38	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Majuro - 104, Ebeye - 81; Outer Islands - 38	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Majuro: 109; Ebeye: 47; NI: 78 Total of 234. Based on the recent 2021 census, the projected population of 13 years old female is 488. The increase in the HPV rates is attributed to the denominator with 23% decrease of 13 years old female population Recalculating 2021 with 489 female 13 years old based on recent census, the HPV Rate is 48%	

ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			2	5
Annual Indicator			3.4	9.5
Numerator			3	9
Denominator			89	95
Data Source			MCH Program	MCH Program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	7.0	9.0	12.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
We were advised to change this ESM into SPM from the last block grant review. MCH Program needs to create an ESM once this become a SPM. MCH Program will address this in the next needs assessment and application cycle.

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			15	17
Annual Indicator		14.3	18.8	10.7
Numerator		16	21	12
Denominator		112	112	112
Data Source		Dental Clinics/MCH Program	Dental Clinics/MCH Program	Dental Clinics/MCH Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	19.0	21.0	22.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Denominator - Elementary Schools: 94 schools; Secondary Schools: 18 schools	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Denominator - Elementary Schools: 94 schools; Secondary Schools: 18 schools	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Denominator - Elementary Schools: 94 schools; Secondary Schools: 18 schools. Due to community transmission of COVID-19, Dental visits in the school were suspended. Dental Staff were assigned to respond to community transmission of COVID-19.	

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			20	22
Annual Indicator		20.9	21.3	20.6
Numerator		2,691	2,746	2,659
Denominator		12,889	12,889	12,889
Data Source		Dental Clinics/MCH Program	Dental Clinics/MCH Program	Dental Clinics/MCH Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	24.0	26.0	28.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Due to the COVID-19 community transmission, services were affected. Staff was re-assigned to COVID-19 response.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Marshall Islands

SPM 1 - Percent of Women ages 25-49 yrs old screened for cervical cancer.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To increase the number of women 25-49 yrs old who have cervical cancer screening. To be able to detect early any anomalies that will lead to cervical cancer.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women, age 25-49 yrs old, who had cervical cancer screening in the calendar year **Denominator:** Number of women, age 25-49 yrs old
Data Sources and Data Issues:	RMI MOH MCH Program - Cervical Cancer Screening Database
Significance:	Cervical Cancer is the leading cause of death for Marshallese women. Cervical cancer is the most common type of cancer for female population. The Ministry of Health and Human Services address the increase of cervical cancer cases by emphasizing on the strength of prevention and early detection.

SPM 2 - Percent of women ages 15-44 years old that use family planning services
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To be able to provide full family planning services to all women 15-44 years old in Majuro, Kwajalein and Outer Islands.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of unduplicated family planning method users **Denominator:** Number of female population in RMI between 15-44 years old
Data Sources and Data Issues:	Family planning program database. Users are those using any of the following: female sterilization, male partner sterilized, oral contraceptive, IUD, hormonal implant, hormonal injections, male or female condoms, fertility awareness method, abstinence
Significance:	Family planning services prevent unplanned pregnancies which are more likely than planned pregnancies to occur in young teens, women > 35 years of age, and to women who have had a previous baby without sufficient time to recover (i.e. <1 year between births). Babies from unplanned pregnancies are more likely to be born into poverty, premature, malnourished, and have developmental disabilities. Good coverage of women with family planning services indicates that the medical system is protecting mothers and children from preventable problems.

SPM 3 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase the number of women receiving prenatal care beginning in the first trimester
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of deliveries to women who received prenatal care beginning in the first trimester of pregnancy. **Denominator:** Number of deliveries in the hospital and health centers
Data Sources and Data Issues:	Hospital Information System, Reproductive Health Information System
Significance:	Early and adequate prenatal care is vital to ensuring a healthy pregnancy. Receiving inadequate prenatal care increases the risk for complications and other adverse outcomes for both mother and baby. Early and adequate prenatal care provides the opportunity for early detection and management of complications which reduces the risk for pre-term labor and babies being born with low birth weight.

SPM 4 - Percentage of teenagers 13-17 years old using Family planning services
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease teen pregnancy.
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** Number of unduplicated female 13-17 years old family planning method users **Denominator:** No. of female 13 to 17 years old population
Data Sources and Data Issues:	Data Source: Family planning program database. Users are those using any of the following: female sterilization, male partner sterilized, oral contraceptive, IUD, hormonal implant, hormonal injections, male or female condoms, fertility awareness method, abstinence Data issues: There's a significant challenge in collecting data in the Outer Islands. The stigma and outlook of parents in family planning services for their teenage children are part of the challenges that we have to face in this measure.
Significance:	Reducing adolescent pregnancies Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities. Based on RMI's Needs assessment and strategic planning,one of RMI's priorities is decreasing teen pregnancy through providing family planning services.

SPM 5 - Increase percentage of fully immunized children ages 19 to 35 months
Population Domain(s) – Perinatal/Infant Health, Child Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase immunization coverage by 4% from previous year for children 19 to 35 months old.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 19-35 months with complete immunization **Denominator:** Number of 19-35 months children
Data Sources and Data Issues:	Data Sources: RMI National Immunization Program, WebIZ (IIS Program) Data Issues: Basic vaccine series in RMI includes: 4 DPT, 3 Polio, 3 HepB, 1 HIB, 2 MMR. Before 2016 “complete coverage” was considered to be 4 DPT, 3 Polio, 3 HepB, 1 HIB, 1 MMR. There have been substantial delays in entering data into WebIZ in the past and there are problems with the database such as duplicate records and children not known whether out of the country.
Significance:	Reduce infant and child mortality and morbidity. Prevent vaccine related diseases.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Marshall Islands

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Marshall Islands

ESM 1.1 - Percent of women program participants (18-44 years) that received education on the importance of a well-woman visit in the past year.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To ensure that women are receiving education on the importance of well-woman visits
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MCH women (including pregnant and postpartum) program participants who have received education on the importance of a well-women/preventive health visit in the reporting year **Denominator:** Number of MCH women (including pregnant and postpartum) program participants
Data Sources and Data Issues:	Will develop a collection tool and report to capture client and visit and service data.
Significance:	A well women visit is a way to make sure an individual is staying health. A well-woman visit is an excellent opportunity for counseling patients about maintaining a healthy lifestyle and minimizing health risks. Components of the visit may vary depending on the patients age, risk factors, and physician preference.

ESM 1.2 - Number of community health centers that provide cancer screening/referrals for women
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase to 5 the number of community health centers that provide preventive medical visits for women
Definition:	**Unit Type:** Count **Unit Number:** 5 **Numerator:** Number of health centers that provide preventive medical visits for women **Denominator:**
Data Sources and Data Issues:	RMI MOHHS Annual Report
Significance:	Through strong collaborative efforts, family planning campaigns and health education to include outreach to outlying communities in the RMI. The program will adopt the same strategy to provide preventive medical visits to women by increasing the number of community health centers that can provide basic preventive medical services to women such as family planning services packaged to include, STI & HIV screening, breast and cervical screening, BMI and BP checks, blood and glucose checks, dental screening, and health education and counseling.

ESM 1.3 - Percent of women booked for prenatal visit in first trimester
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To have a healthy pregnancy, newborn and postpartum condition of the pregnant women.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnant women who had at least 4 prenatal visits, with first visit in first trimester, that delivered live birth during the reporting period **Denominator:** Number of live births during the reporting period
Data Sources and Data Issues:	Clinic/Service report, Vital Statistics, Marshall Health Information System
Significance:	Having a healthy pregnancy is one of the best ways to promote a healthy birth. Getting early and regular prenatal care improves the chances of a healthy pregnancy. With regular prenatal care women can: a. Reduce the risk of pregnancy complications. b.) Reduce the fetus's and infant's risk for complications. During prenatal care, the OBGYN doesn't only discuss the pregnancy but include post-partum conditions which will prepare the pregnant women.

ESM 1.4 - Percent of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase or maintain the percentage of women receiving postpartum follow-up health care services within the first four to six weeks after delivery.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women receiving postpartum follow-up health care services within the first four to six weeks after delivery. **Denominator:** Weighted number of resident women population with a recent live birth. Denominator includes all respondents except those with missing, don't know and refused answers.
Data Sources and Data Issues:	Clinic/Service Report, Marshall Health information system
Significance:	Access to quality health care services during preconception, prenatal, postpartum and inter-conception phases for women of child bearing age is crucial for reducing adverse perinatal maternal health outcomes. The postpartum examination is a particularly important medical examination that is recommended to occur at about 4-6 weeks after delivering a baby. The checkup typically includes discussion of any problems that may have occurred during pregnancy, physical and biometric checks for elevated blood pressure and diabetes, discussions of postpartum depression symptoms, and other concerns. Postpartum follow-up visits are critical to assess women's post-delivery health and health risks, and greatly benefit current and future maternal and newborn health.

ESM 3.1 - Number of birthing hospitals re-designated with updated standard operating procedures
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Update perinatal regionalization standards and designations and implement updated performance measures for hospitals in Majuro and Ebeye.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number Birthing Facilities Re-designated with standard operating procedures **Denominator:** Total Number Birthing Facilities in the state
Data Sources and Data Issues:	Endorsed SOPs
Significance:	It is imperative for the RMI to ensure all hospitals are functioning in accordance with current standards of care for both maternal and infant outcomes.

ESM 3.2 - Percent of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To accurately identify the neonatal and maternal level of care provided at the birthing hospitals in the RMI.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing hospitals who complete the CDC Levels of Care Assessment Tool (CDC LOCATe) annually **Denominator:** Number of hospitals in the RMI
Data Sources and Data Issues:	MCH Program
Significance:	Ensuring infants are born at facilities that are equipped to meet the need of both the infant and the mother is important to improve both maternal and neonatal outcomes. The LOCATe tool is a hospital survey on obstetric and neonatal practices and services which classifies maternal and neonatal levels of care based on responses to survey questions.

ESM 3.3 - Percent of newborn babies issued newborn baby health passbook
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	To provide parents of newborn babies a passbook to monitor baby milestones, development, immunizations and clinic schedule.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of newborns issued a newborn baby health passbook annually **Denominator:** Number of births in the RMI per year
Data Sources and Data Issues:	MCH Program, Marshall Hospital Information System
Significance:	Ensure newborns are equipped with a tool to monitor their growth, development, immunization and clinic schedule.

ESM 4.1 - Percent of women provided with in-person or telephonic breastfeeding consults/support services NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of infants breastfed up to six months and increased the percent of infants exclusively breastfed.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Number of women provided with in-person or telephonic breastfeeding consults/support services **Denominator:**
Data Sources and Data Issues:	MCH Program/Clinics. We will develop the collection tool for this ESM.
Significance:	Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Moreover, promoting and/or facilitating community activities that reinforce breastfeeding may allow for more women across the state to have access to the support they need to initiate breastfeeding and continue doing so exclusively for at least 6 months.

ESM 4.2 - Number of MCH staff and community health workers attended the Certified Lactation Counselor training. NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the percent of infants who have ever been breastfed and continues until 6 months.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of MCH Staff and community health workers who attended the Certified Lactation Counselor training. **Denominator:** Total number of MCH Staff and community health workers.
Data Sources and Data Issues:	MCH Program Report.
Significance:	Receiving health education prior and during pregnancy can motivate mothers to breastfeed their babies. But an on-call staff or community health outreach worker who takes calls anytime or makes home visits to assist with mom who needs counseling and coaching through a hard time can also motivate them to keep breastfeeding.

ESM 6.1 - The number of potential high risk screens referred to early intervention
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	That 100% of high risk screens are referred to an early intervention program and our documented.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Percentage of high risk screens referred to early intervention/Part C **Denominator:**
Data Sources and Data Issues:	MCH Program, Marshall Health Information System
Significance:	Research shows that healthcare providers' knowledge of and referral patterns to early intervention services and other community services is quite low. It is important that we increase knowledge through academic detailing and other onsite outreach efforts. Specific attention will focus on ensuring that children identified at risk for developmental delays following a screen are actually linked with and receive the interventions recommended by the referring provider

ESM 10.1 - Percent of adolescent program participants (12-21 years) that received education on the importance of a well-visit in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To ensure supportive programming for well adolescent visits/preventive health care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescent program participants (12-21 years) who have received education on the importance of a well adolescent/preventative visit in the reporting year **Denominator:** Number of adolescent program participants (12-21 years)
Data Sources and Data Issues:	MCH Program, Will develop a collection tool and reporting, Marshall Health Information System.
Significance:	Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase educational awareness on sexual health (teen pregnancy and STI) to adolescents ages 12-17 years old in public schools on main islands.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of public middle and high schools visited with completed delivery of pregnancy & STI prevention program **Denominator:** Number of public middle and high schools.
Data Sources and Data Issues:	MCH Program, Outreach visit reports.
Significance:	Women who become pregnant during their teens are at increased risk for medical complications, such as premature labor, and social consequences.

ESM 10.3 - HPV vaccine coverage of girls age 13 years
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	By 2020, achieving greater than or equal to 90% HPV Coverage Rate for 13 years old girls.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # females age 13 years who received 2 doses of HPV vaccine (X 100) **Denominator:** RMI Female Population aged 13 years (projected mid-year population from 2011 census)
Data Sources and Data Issues:	Query WebIZ for females 13 years of age on the last day of the measurement year (e.g. 3/31/16 for 2016) for the denominator, and select those who have record of 2 HPV doses received for the numerator.
Significance:	Cervical cancer has been the leading cause of death in the RMI over the past 10 years; the incidence and death rates from cervical cancer are among the highest in the Pacific in RMI. HPV is the cause of most cases of cervical cancer. Effective delivery of HPV vaccine to girls before the onset of sexual activity can protect the next generation of RMI women from this terrible disease

ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Collaborate with inter-governmental agencies, business, and non-profits to provide CHSCHN with non-medical related services.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CSHCN youth registered for non-medical related services</td></tr>
<tr><td>Denominator:</td><td>Total number of CSHCN youth in the registry</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Marshall Health Information System - CSHCN Registry</td></tr>
<tr><td>Significance:</td><td>By involving business representatives on the council, it is our hope that the business community will learn more about the children and youths with special health care needs and the transition program and therefore provide them with employment opportunities.</td></tr>
</table>

ESM 13.2.1 - Percentage of elementary schools visited by dental program
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of schools visited to educate and provide preventive measures (varnish & sealant).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of elementary and high schools visited by dental program **Denominator:** Number of elementary and high schools
Data Sources and Data Issues:	Oral Health Services Monthly Reports
Significance:	Oral health is a vital component of overall health. Schools support student success by providing oral health care assessment, intervention, and follow-up for all children within the school setting. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits.

ESM 13.2.2 - Number of children ages 1-17 years receiving preventive dental care from a dentist.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase preventive dental visits among children in elementary and high schools.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of children, ages 1 through 17 who had a preventive dental visit in the past year **Denominator:** The number of children ages 1-17 enrolled in elementary or high schools.
Data Sources and Data Issues:	Oral Health Services, Marshall Health Information System
Significance:	RMI MCH Program recognize the integral role of maintaining oral health across the lifespan, beginning before a child is born and continuing until the end of life. Poor oral health impacts overall health and well-being; a child's ability to learn, grow and thrive; self-esteem; employability; and overall quality of life. The "Life Course Theory" conceptual framework points to broad social, economic and environmental factors as underlying causes of inequalities in health, with oral health being no exception. The two most prevalent oral diseases, dental caries (cavities) and periodontal (gum) disease are chronic, communicable, bacterial infectious diseases that are almost entirely preventable and manageable if detected in the early stages of the disease. Dental caries is the most common, chronic disease in children, five times more common than asthma and seven times more common than hay fever. If a child develops tooth decay at an early age, they are more likely to have a lifetime of pain and suffering from poor oral health.

Form 11
Other State Data

State: Marshall Islands

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Marshall Islands

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		
2) Vital Records Death	Yes	Yes	Daily	0	No	
3) Medicaid	No	No	Never	NA	No	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	No	No	Never	NA	No	
6) Newborn Hearing Screening	Yes	Yes	Quarterly	0	No	
7) Hospital Discharge	Yes	Yes	Daily	0	Yes	
8) PRAMS or PRAMS-like	No	No	Never	NA	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**2) Vital Records Death**
	Field Note: We are in the process of upgrading the Vital Records Information System. In the upgraded system, deaths will be linked to birth records.
Data Source Name:	**3) Medicaid**
	Field Note: Medicaid is not applicable to RMI.
Data Source Name:	**4) WIC**
	Field Note: WIC is not applicable to RMI
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: This is not a routine screening.