Maternal and Child Health Services Title V Block Grant

Marshall Islands

FY 2016 Application/ FY 2014 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Republic of the Marshall Islands
MINISTRY OF HEALTH
P.O. Box 16
Majuro, Marshall Islands 96960
Phone: (692)625-3355/3399*Fax: (692)625-3432
Email: mailynnlang@gmail.com; rmimohe@ntamar.net

July 07, 2015

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 in the Republic of the Marshall Islands (RMI), I am pleased to submit to your office the RMI Maternal and Child Health Block Grant Application FY 2016 with Annual Report FY 2014.

Further, the Ministry of Health recognizes the Maternal and Child Health Bureau for its willingness in supporting the maternal and child health care services in the Republic of the Marshall Islands. This grant will greatly augment our effort as we strive to implement a quality health care to the people of the Marshall Islands.

Should further clarification regarding the application be necessary, please contact us.

Thank you.

Sincerely,

Date: 7-7-15

Mailynn Konelios-Langinlur
Secretary of Health

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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Program Activities Related to Performance Measure

Direct Health Care Services: The RMI will continue to focus its preventive and health care services for pregnant women, mothers and children and CSHCN in the country. These health care services will be provided to the two hospitals, health centers in the outer atolls, Public Health clinics and during our community outreach and activities.

Enabling Services: MCH/CSHCN will continue to collaborate with the Health Education and Health Promotion Unit (Nutrition Unit) an Public Health Programs in conducting its community outreach and health promotion activities for women, children, pregnant women and infants both in the urban centers and the remote atolls.

Population-Based Services: The MCH/CSHCN program will strengthen its screening efforts to providing Pap smear to all women who attend the Public Health clinics and those are at risk for developing cervical cancer. This will be done in the clinics as well as during community outreach activities. The MCH/CSHCN will improve its screening efforts for children with special health care needs in additional to the coordination and referral to the CSHCN program. Additionally, the RMI will improve its dental health care service and school health programs, which will include immunization, Vitamin A distribution, and fluoride distribution, for the school children. Community outreach will continue to develop its primary health care programs to provide immunization, screening and health promotion at the community level.

Below are the Marshall Islands State Priorities:

To reduce the maternal mortality rates. (Continue)	State needs.
Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool (New)	
Increase percent of infants breastfed exclusively through 6 months (New)	
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past yea (New)	
To increase the rates of teenager 15-19 years old acceptors of modern contraceptive. (Replace)	Not duplicate with NPM.
To increase the percentage of women who screened for cervical cancer. (Continue)	Not duplicate with NPM.
To increase the number of children, ages 1 through 17, who had a preventive dental visit in the past year (New)	
To increase number of CSHN entry into the program. (New)	Not duplicate with NPM.
To increase the number of women who have a preventive medical visit (New)	
To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19. (New)	

II. Components of the Application/Annual Report

II.A. Overview of the State

A. Overview

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

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

replaced the dilapidated older facility. Health problems are numerous and may be attributed , in part, to overcrowding and an inadequate water supply. Kwajalein Atoll is the largest atoll in the world, with a lagoon area of 839.3 square miles. The total land area of the Kwajalein islets comes to 6.33 square miles.

The rural outer islands comprise the remainder of the Marshall Islands, scattered over great expanse of the Pacific Ocean. Population is separate communities ranging from 50-80 persons. The outer islands constitute a diminishing proportion of the population of the nation. With few exceptions, between non contiguous islets of an atoll can only be reached by canoe or motor boat and meals are cooked on open fires or single-burner kerosene stoves. Income for residents of the outer atoll is generated primary from the sale of copra (dried coconut) and handicrafts.

In the outer islands, medical care is available at dispensaries staffed by health assistants who maintain radio contact with the Majuro or Ebeye hospitals for instruction and guidance. There are elementary and high school public schools in Jaluit and Wotje and there are 2 private high schools in Aerok Ailinglaplap and Maloelap Atoll.

/2013/ No change.//2013//

/2015 No Change //***2015//***

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

more than one airstrips. Emergency medical evaluation are accomplished by small and 12

larger

11 aircraft or, at islands where the airstrips have been closed or repair, by field trip ship. Medical

evacuation by air can only take place by daylight since the outer island airstrips do not have

landing lights. Medical evacuation by ship to the hospitals in Majuro or Ebeye can take as long

as two days depending upon distance and sea conditions. Patients in the outer islands requiring

specialized care not available at Majuro or Ebeye would be referred to the Office Medical Referral

Services for off island referral to Honolulu or Manila. The outer island dispensaries and the hospitals at Majuro and Ebeye are owned and operated by the RMI Ministry of Health.

There is
only one private clinic in the Marshall Islands.
People travel from Majuro and Ebeye to the outer islands using Dornier aircraft managed by the
Air Marshall Islands and non government-owned field trip ships that commute between atolls
once a month. A small boat that is highly dependent on fuel supplies available. Also, people walk
during low tides on the exposed coral reefs between the islands in order to reach the airstrips.
The total population of the Marshall Islands is estimated at 54,065 in 2009. More than 50% is
under 19 years of age. The average growth rate of 3.6% is the highest in the pacific. Currently,
more than 60% of the population resides in the two urban centers. The remaining 40% resides in
the outer island atolls. Deliver of health care services to a dispersed population in the RMI is
cumbersome.
The Marshall Islands has an area of 1,826 square kilometers and is composed of two coral atoll
chains in the Central Pacific. The Marshall Islands is a parliamentary democratic, constitutionally
in free association with the United States if America. It has a developing agrarian and service oriented
economy.
/2012/ The RMI Estimated Population in 2010 is 54,439. More than 50% is under 20 years of age.
The average
growth rate of 3.6% is the highest in the pacific. Currently, more than 60% of the population
resides in the two

urban centers. The remaining 40% resides in the outer island atolls. Deliver of health care

services to a dispersed population in the RMI is cumbersome.//2012//

In 2011, the Ministry of Health bought a boat that will bring Mobile Teams to the Outer

Islands to

provide health

services to the community.

/2012/ The new boat is called Ejmour II. Besides the local plane, we now have Ejmour II to

bring

the Public Health

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services to the Outer Islands. In FY2011, we have provided services for 18 islands for 29

trips

using Ejmour II.//2012//

/2015//

Population:

The 2011 RMI Census of Population and Housing provided a national population 53,158 persons (27,243 males and 25,915 females) currently residing in RMI.

Prior to the Census, there were projections that the RMI population would have 55,000 to over 60,000 people, but due to massive outmigration in recent years, it is estimated that around 11,000 Marshallese have left the country. Annual national population growth rate of 0.4% over the past twelve years.

The MCH population makes up about 85% while the over 45-59 makes up another 11% and the over 60 is another 4%. It is a very young and large population that MCH Title V program serves.

RMI Population Estimates by Five Year Age Group

Age Group	2007		2008		2009		2010		2011	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-4	3,916	3,716	3,976	3,772	4130	3881	4141	3891	4,031	3,712
5-9	3,768	3,529	3,706	3,490	3804	3567	3813	3576	3,622	3,395
10-14	3,422	3,246	3,555	3,340	3729	3471	3801	3530	3,385	3,108
15-19	3,378	3,189	3,237	3,083	3144	3008	3121	2986	2,417	2,314
20-24	3,215	2,979	3,316	3,045	3329	3041	3277	3000	2,614	2,480
25-29	1,999	1,951	2,156	2,082	2299	2191	2448	2295	2,159	2,245
30-34	1,282	1,274	1,285	1,279	1324	1315	1379	1361	1,876	1,913
35-39	1,174	1,129	1,141	1,108	1119	1094	1074	1059	1,587	1,549
40-44	1,130	1,073	1,102	1,045	1079	1024	1045	996	1,419	1,366
45-49	1,018	1,034	1,030	1,026	1031	1013	1020	993	1,189	1,155
50-54	919	878	893	904	869	915	866	925	1,016	914
55-59	784	645	827	674	832	693	832	722	815	761
60-64	438	400	478	443	503	469	549	500	583	469
65-69	242	236	256	238	258	240	278	262	284	238
70-74	159	185	160	193	145	188	147	186	131	119
75+	177	216	180	217	148	215	147	220	115	177
Total	27,022	25,679	27,297	25,939	27,741	26,324	27,938	26,501	27,243	25,915

Source: EPPSO, RMI Population Projections, 2006-2010, 2011 RMI Household Census

Females Ages 15-44 years Population by Reproductive Age

Age Group	2007	2008	2009	2010	2011
15-19	3,215	3,099	3,008	2,986	2,314
20-24	2,346	3,056	3,041	3,000	2,480
25-29	1,915	2,101	2,191	2,295	2,245
30-34	1,614	1,310	1,315	1,361	1,913
35-39	1,437	1,134	1,094	1,059	1,549
40-44	1,230	1,061	1,024	996	1,366
Total	11,757	11,761	11,673	11,697	11,867

Source: EPPSO, RMI Population Projection, 2006-2010, 2011 RMI Household Census

Educational Attainment

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 actually increased since the late 1990s (21.6%), could be seen as two major policy challenges.

The vast majority of Marshallese attend 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%
Tota	17871	100.0	22080	100.0%

Enrollment Ratios

School enrolment 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.

Age Enrolled	Number Enrolled		Total Persons		Enrolment 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%**

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.

Nuptiality

More than half of the 12 years old and over 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.

In every age group, a higher percentage of males were never married than females, supporting the general observation that men marry later than women. In the 15–19 age group, over 95 percent of males and 88.9 percent of females in the Marshall Islands were never married. The percentage of the never married population declined significantly with age. In the 40–44 age group, less than 10 percent of males and females were never married.

RMI Health Service System

The Ministry of Health has three bureaus and two offices which are all headed by Assistant Secretaries. The three bureaus oversee the provision of care to three geographical sectors of Majuro, Kwajalein and the Outer islands. The Bureau of Majuro Atoll Health Care Service is the largest as it includes the main referral hospital in RMI and an extensive primary care division. The two offices are health planning/policy/statistics and administration /finance /personnel.

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 Kwajelien (Ebeye Hospital) and Majuro (Majuro Hospital) Atolls. Including the two main hospitals, there are additional 56 health centers/health clinics located in the various islands that make up the Marshall Islands. The two main hospitals service 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 are referred off-islands to hospitals in the Philippines and Hawaii (Tripler Army Medical Center). 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 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, Enewetok, and Utirik) Clinics provide primary health care services to the four atolls affected by the nuclear testing. A primary

health care physician manages the 177 Clinics. DOE Clinic is providing medical services to the nuclear patients under the Department of Energy. Diabetes Wellness Center which is managed by Canvasback Missions, in collaboration with MOH, to show that natural foods and an active lifestyle could reduce or replace the need for diabetic medications and provide a higher quality of life for the participants. Taiwan Health Center concentrates on developing health education materials and training programs mostly in Non Communicable Diseases (NCDs) like diabetes and also helps our outreach activities.

These health care services include, but 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 these above mentioned government sponsored health care services, there is one private clinic, one private dental clinic, and 2 private optometry services in Majuro. All of the doctors practicing in the government and private clinics are licensed under the MOH's Medical Examining and Licensing Board to practice in the RMI. //2015//

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Each Fiscal Year, the RMI MCH at the MOH, receives approximately $252,495 from the Health Resources and Services Administration (HRSA)/Maternal and Child Health Bureau (MCHB) for the MCH Services Title V Block Grant. As a grantee of Title V funds, the RMI is required to complete a statewide needs assessment every five years to identify the priority needs for the six population health domains:

1) Women/Maternal Health

2) Perinatal/Infant Health;

3) Child Health;

4) Adolescent Health;

5) Children with Special Health Care Needs (CSHCN);

and 6) Cross-cutting or Life Course.

To conduct the RMI Maternal and Child Health (MCH) Program Five Year Needs Assessment, the MOH's MCH Program staff reviewed quantitative and qualitative data to provide necessary information to assess the needs of the MCH population groups. Throughout the process, the focus was on the MOH's 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.* To the maximum extent possible, the MOH pursues these goals using the national facilities, staff and resources of the RMI.

The purpose of the needs assessment is to use the findings and recommendations to identify health priorities and improve and strengthen the MOH's Public Health and its partners' ability to respond to public health issues.

The process involved various departments and programs within the Ministry and other partners including community members to identify health priority needs and at the same time assess the capacity within the State to address these needs. This is a continuous and on-going process throughout the year as the needs may change depending on the situation(s) that may arise.

a. **Process for conducting Needs Assessment Process**

RMI Mother and Child Health and Reproductive Health Needs Assessment was conducted in September, 2014. The representative from government and non-government organizations were at the one week meeting.

List of Participants

	Name	Position and station
1	Oling Debrum	Director of Primary Health care, MOH Ebeye
2	Neir Kabua,	Cancer Prevention Coordinator, MOH, Majuro
3	Betalyna Abo,	Family Planning Nurse, Majuro, MOH
4	Yoshiko Yamaguchi	UN JPO, UNDP /GEF/SGP Coordinator
5	Silomeci Sawaqe	Nurse at Maternity Ward, MOH, Majuro,
6	Maybelline Ipil	MIEPI consultant
7	Ana V. Koliniwai	FP nurse, MOH Ebeye
8	Peter Hopkins	Youth to Youth In Health
9	Aluka Rakin	Youth to Youth In Health
10	Joni Nashion	MOH Majuro, Nursing Supervisor
11	Brooke Takala Abraham	USP, Majuro
12	Tomiko Maddison	Women United Together Marshall Islands (WUTMI)
13	Lydia Tibon	KIJLE
14	Journal Jilly	Kumit Bobrae, Majuro
15	Eomra Lokeijak	FP nurse, MOH , Majuro
16	Tauki Korean	FP nurse, MOH, Majuro
17	Rina Heben	Maternity nurse, MOH
18	Malynee Joseph	Youth to Youth In Health
19	Jacqueline Mojilong	Majuro FP nurse, MOH
20	Molly Murphy	MIEPI consultant
21	Edlen J. Anzuers	IT Department, MOH, Majuro
22	Ransen L. Hansen	Majuro-Vital Statistic, MOH
23	Helen David	Majuro FP Director, MOH
24	Dr. Helentina Garstang	RH Physician, MOH
25	Luren Loeak-Ading	Women United Together Marshall Islands (WUTMI)
26	Anjain Maddison	Ministry of Internal Affairs

The causality analysis was conducted during the needs assessment. The analysis has helped to identify the strengths and weaknesses, and other factors affecting MCH and Reproductive Health Services in RMI. The policy statements derived from the experiences from the current intervention as well as addressing of the gaps.

The overall outcomes, strategies and activities are stated toward improving health care, particularly to Reproductive Health Services.

Guidance principles and Values

The description of the values and principles are based on the following parameters:

- National ownership and country leadership
- Rights bases approach and respect for the reproductive rights for all individuals
- Gender and culturally sensitive participatory, aim to put emphasis on gender mainstream, equal opportunity to all citizen (including the marginalized) irrespective of their social status, religion, or beliefs.
- Ensuring implementation of evidence based interventions and quality in MCH and reproductive health care which includes access to services
- Multidisciplinary approach- Involve all sectors linked to health such as education, Law and Order, Justice, labor, and other disciplinary partners.

In conducting the needs assessment, the MCH Program included the following documents: 2010-2015 RMI MCH Needs Assessment, RMI MOH 3 Years Strategic Plan, and MOH's Yearly Portfolio in the process. The main aim was to cover the needs of the MCH population.

Methods for Assessing MCH Populations

The MOH established a committee to facilitate a process for ensuring stakeholder involvement in the development of the 2016 Title V Needs Assessment. The Committee included key staff from various departments and programs within the Ministry to be involved in evaluating the programs and services within the MOH, including the Reproductive Health (RH), MCH, CSHCN, and Family Planning (FP). The MCH Program also collaborated with other stakeholders from the Ministry of Education, Special Education, School Health, the Ministry of Internal Affairs, Parents' Organization, Kijle, Youth-to-Youth-in-Health, Community Leaders, Women's Organization and the RMI Interagency Council

During the year, the process of reviewing data and assessing the programs and services within the Ministry was conducted. The Office of Health Planning, Policy and Statistics continued to provide data on all RH/MCH programs and services for the senior staff to review. The Ministry used the documents listed below during the process of the needs assessment in order to evaluate the MCH program services.

1. MOH Annual Report 2012,2013
2. MOH Operation Portfolio

3. Quarterly reports from each program area
4. RMI 3 Years Strategic Plan
5. WUTMI reports
6. MIEPI Statistical Reports
7. Other related documents on RH and MCH, including CSHCN services

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II.B.2. Findings

II.B.2.a. MCH Population Needs

After the consultation from different sectors,

The areas of concerns include:

1. Maternal and Neonatal health: Antenatal, perinatal, postpartum & newborn care
2. Children with Special Health Care Needs
3. Provision of Family Planning
4. Adolescent Sexual and Reproductive Health
5. The control of STIs/HIV and on integration with other Sexual and Reproductive Health programs
6. Other gynaecological morbidities: abortions, cancer, infertility, and menopause
7. Cervical and Breast cancer
8. Gender and Reproductive Health
9. Reproductive Health Commodity Security
10. Men involvement in RH

8 National Performance Measures were chosen wherein State Priorities were linked.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The MOH is the State Health Department that, under the RMI Constitution, is the only agency that provides for high quality, accessible and affordable health care services to the population of the Marshall Islands. The Mission Statement clearly states the goal of the MOH:

"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 Ministry of Health pursues these goals using the national facilities, staff and resources of the Republic of the Marshall Islands.

The MOH is comprised of different bureaus headed by an Assistant Secretary of Health with a total of 554 staff in the urban centers, and Outer Islands and two offices. Three bureaus, namely the Bureau of Majuro Atoll Hospital Care Services (BMAHCS), the Bureau of Kwajalein Atoll Health Care Services (BKAHCS) and the Bureau of Primary Health Care Services (BPHCS) which provides direct health care service. There are two hospitals and 57 health centers. The offices are Office of Administration, Personnel, & Finance and Office of Health Planning, Policy & Statistic.

The Division of Primary Health Care has the following divisions.

- RH/MCH/CSHCN Programs – conduct prenatal, post-partum, family planning, STD screening and treatment, high-risk and CSHCN clinics.

- Immunization Program – immunize the infants, children, adolescents and adults, including pregnant women who come for prenatal care.

- Communicable Disease Program

- Tuberculosis (TB) - conduct screening and treatment for TB during clinics, visits to the schools and communities and also during prenatal clinics.

- Leprosy Program – conduct screening and treatment for TB and leprosy during clinics, visits to the schools and communities and also during prenatal clinics.

- STD/HIV Program – screening and treatment is provided in all the clinics, including prenatal and during outreach to the schools and communities in the urban center as well as those in the Outer Islands.

- Non-communicable Disease Program

    - Chronic Disease Control Program – provide treatment and screening for diabetes, hypertension, and cardiovascular in the clinics and outreach to the schools and communities, including gestational diabetes.

    - Comprehensive Cancer Program - register cancer patients, provide screening, and coordinate activities for cancer prevention and pathway to care.

- Well Baby Clinic - provide services to children like immunizations, breastfeeding, Vitamin A., deworming, counseling and nutrition.

- Health Promotion and Disease Prevention Unit - provide educational materials and sessions.They also conduct activities for promoting nutrition, physical education, and awareness for all the programs of the Ministry.

    - Human Services Program - provide services to mental health patients and rape victims.Staff members provide counseling services, medication to clients who need to have prescribed drugs, conduct home visit(s) daily to assess the needs of the clients and their families and conduct a weekly support group meeting to ensure that families receive the support necessary for increasing their confidence in taking care of their family members who have special needs physically and/or are those enrolled in the Mental Health Program.

Dental Services are one of the departments in the Ancillary Services of the hospitals. The dental services provide clinical services for all three MCH populations, dental preventive services through the school sealant program, community outreach to the Outer Islands and CSHCN.

The BMAHCS, BKAHCS, and BPHCS serve the populations of Majuro, Kwajalein, and Outer Islands, respectively. However, these three bureaus collaborate within to coordinate their programs to serve the total RMI population. Collaboration among the bureaus within the MOH is an integrated part of collaboration in providing the services, traveling to Outer Islands, patient care in the hospital and upon discharge, outreach clinics and activities both in the urban center and in the Outer Islands.

II.B.2.b.ii. Agency Capacity

/2016/There has been quick transition on MOH Management. Julia Alfred is on Administrative Leave. Mrs. Mailynn Konelios-Langinlur has been acting Secretary of Health since December 2014. Minister Phillip Muller is still our Minister of Health. On November 2015, there will be a national election, Leadership might change depending on the party that will win in the election.

Organization of the Ministry still the same. Secretary of Health is the main management of the Ministry.

As the sole provider of health systems, the Ministry of Health continues to develop its capacity in terms of workforce, health care, health information system and community/public health programs.

Improvement in Communication:

The Ministry of Health is in the process of installing 8 DAMA sites in 8 Health Centers. This is an initial project. CDC funded the project. The DAMA site will provide communication via voice and data to these health centers. We are looking forward to improvements of reporting, communication, referrals and health care.

Health Information System

The Ministry of Health continues to consolidate the systems that we have. Improvements on collection and data entry are still on going.

Immunization Program: Upgrade of the MIWebIZ Immunization Information System

EpiAnywhere: TB, STD/HIV and Leprosy Programs are using the system

Vital Records Information System: Birth, Death and Fetal Death . There will be an upgrade this year to accommodate the information on Newborn hearing screening, prenatal status

/2016//

/2015/ Mrs. Justina R. Langidrik is no longer the Secretary of Health. She moved to Chief Secretary's Office.

The Ministry of Health has a new Secretary of Health and Minister of Health. Secretary Julia M. Alfred started in June 2014. She is very supportive of the goals and activities of the MCH Program.

New Minister of Health is Honorable Phillip Muller.

There is no change the organization as this grant is being written. Previous written information is still valid and being observed.

//2015//

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

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

/2014/ There are three Bureaus that provide direct health care services in the country: 1) The Bureau of Majuro Hospital Health Care Services (MAHCS), 2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS), and 3) The Bureau of Primary Health Care Services (BPHCS). The reorganization was endorsed to Public Service Commission in April 2013. The reorganization's objective is to improve the services that MOH gives to population

for Majuro, Kwajalein
and Outer Islands. The Primary Health Care is now a national Bureau that will coordinate the programs in the all the
public health clinics, health centers, and community activities.//2014//
The MCH/CSHCN Program is not a separate agency. It is one of the programs in each bureau under the Bureau of
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Primary Health Care. With this organization lay out, the MCH program in KAHCS and OIHCS coordinate and submit
report to the main MCH program which is in Majuro. The nurses and medical staff implement all clinical, follow-up and
community outreach programs for all areas in Public Health. The MCH/CSHCN Program provide health care services
for mothers, children, infant, adolescents and their families in the RMI. The MCH/CSHCN is one the components
within Reproductive Health. There are eight nurses, three OBGYNs, and five support staff receiving salaries from the
program.
/2013// There are seven nurses with A.S. Degree Level, one of them is also a CNM. There is also other supporting
staff: one Health Educator, one Counselor, one Dental Assistant, one OBGYN, one Medical Officer (MO), and one
Program Manager/Director. With the total of 13 program staff, six of them continue to receive salaries from the MCH
program.//2013//.
Oral Health as one of the MCH/CSHCN program services that receive support from the MCH program in terms of
services for pregnant women and children, including the schools and all MCH population. Due to shortage of trained
dental health care providers, the MCH/CSHCN program is in the process of hiring one additional dental assistant to
assist in the MCH dental services, and to expand its services into the communities.
The overall health care system in the Republic consists of two hospitals in the two "urban"

centers of Majuro and
Ebeye, and 57 health centers in the outer atolls. The main hospital on Majuro is a 101-bed facility, and Ebeye has a
45-bed hospital. Both facilities mainly provide primary and secondary care with very limited tertiary care. Patients
who need tertiary care are referred to hospitals in Honolulu or the Philippines. The Division of Primary Health Care
within the Ministry of Health also offers a full range of preventive and primary care programs in the two main
hospitals.
The MCH and CSHCN have been integrated into one program. This allows for more efficient use of scarce human
resources and better collaboration and coordination of services in MCH. The RMI MCH/CSHCN program provides and
coordinates the full spectrum of preventive and primary health care services for mothers, infants, children and
adolescents both in the hospitals setting and the health centers. The services include prenatal and high-risk
prenatal care clinics, postpartum care, and well childcare that includes immunization, high-risk pediatric clinics, school
health program, coordination of family planning services, and the coordination of care for children with special health
care needs. The MCH/CSHCN have been placed within Reproductive Health. This further allows for more efficient use
of scarce human resources and better collaboration and coordination of services in MCH.
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For several years, one of the priorities of the MOH was to develop an effective health information system. The
Ministry is currently looking for a qualified Health Planner. The Ministry has received technical assistance to modify its
Ministry of Health Integrated Information System (MHIIS) in order to improve its capabilities to collect and use data
to improve health care services. The Ministry has established a MHIIS Committee and Working

Group to review all
forms and other documents that will enhance the MHIIS. All programs in the Ministry have already started using the
revised forms for recording and reporting of data which are being collected and channeled to the Office of Health
Planning and Statistics. Staff training on the use of the revised forms is completed.
While data and information systems have improved in the past year, this improvement has occurred primary within
the urban health care settings. There is still a need to improve the data collection from the health centers in the
outer atolls. The MHIIS Committee has revised the recording/reporting forms, which will enable the health providers
in the health centers to collect essential data and statistics. In addition to the encounter forms used by health
facilities in the urban centers, a monthly form was developed to ensure that reports are regularly submitted to the
Office of Outer Islands as under reported by agencies within the Government due to inadequacy of reports
submitted from the health centers. Therefore, mechanisms have been developed to improve the reporting of the
number of births, deaths and encounters for all clinical and preventive services provided in the outer atolls.
Currently, a new data and information system is in the development and implementation stage where all computers
will be link to access databases more easily. While the new information is still not completed yet, the MOH continues
to use the previous system which is a computerized database. Therefore, still the MOH is able to access data on
Maternal and Child Health for program use purposes.
The Health Management Information System (HMIS)
The HMIS is a computerized database to handle all health and health-related data in the MOH. Based on the File
Maker Pro software, it was designed to be a user friendly and menu driven system that can be

used to monitor the
progress of various health program, meet the reporting requirements of US Federal Grants, WHO, and other
external agencies.
Health Management Information System is on the way for completion.
The new Health Management Information System is almost done. In 2006, the Ministry of Health acquired a
customized system for the Ministry and named it as Ministry of Health Integrated Information System. Initially, the
system comprises of Vital Records Information System, Hospital Information System, Public Health Information
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System, and Management Information System. For the 1st phase of the system, the target is to implement in
Majuro. Upon completion, we will expand to Ebeye and Outer Islands. Although our overall progress is 20% on the
new system, we have our old systems in Majuro, Ebeye, and Outer Islands that captures the daily activities of the
Ministry. We are looking forward to 100% implementation in Majuro by next year.
In 2008, a new system was added to the our Integrated System. We started then development of Medical Referral
Information System. We added this system to the existing contract to upgrade our existing medical referral access
system. In 2009, we implemented the system and received a good review. The system aims to record the
transactions in patient care and financial of the RMI Medical Referral to Honolulu, Manila, and Taiwan.
The HMIS has four goals that aim to meet the information needs in the RMI. The first goal is to support the expand
role of Primary Health Care. The Ministry believes that by implementing a wide range of effective and sustainable
PHC programs, we can significantly reduce disease burden. Therefore data management and

monitoring PHC is
critical. The second goal is to provide accurate, consistent, and timely reports on the broad range of health services
and programs offered by the MOH. These reports can also assist health managers in decision making. The third goal
is to provide the MOH with a wider range of information on the personnel and financial resources that are available.
This will assist in the health planning for the future. The fourth goal is to ensure that the HMIS is a sustainable
system that can be used to provide timely and accurate data for managers tasked with policy making decisions.
The New Health Information System will be continued with the same goals stated above.
The HMIS database is divided into five modules: Medical Records, Public Health and Epidemiology, Referrals, Finance
and Personnel, and Benefits, Monitoring and Evaluation (BME).
The main purpose of the Medical Records modules is to accurately record a patient's life and medical history. This
information will be useful for clinical providers in treating the patients and to health service managers responsible for
health planning, supervision and evaluation of health services.
There are 5 systems comprising the Ministry of Health Integrated Information System. They are Vital Records
Information System, Hospital Information System, Public Health Information System, Management Information
System, and Medical Referral Information System.
1. Medical Records
The main focus of HMIS activities so far has been on the Medical Records component since it was where most of the
data collected had to be consistent and able to accommodate all the curative and preventive care
17
departments who
see patients.
Therefore, a comprehensive encounter form was developed.

The Encounter Form

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

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

The encounter form is still being used. The MOH Encounter Form is used in the Majuro Hospital, Ebeye Hospital and
Outer Islands Health Centers and complemented with a monthly report form to be sent to Majuro each month by the
Health Assistants. The MOH Encounter already includes categories related to cancer screening and treatment.

Combined with the patient's medical chart, the Encounter Form will assist both the clinician and the Ministry's data
management and surveillance efforts.

Public Health and Epidemiology

The Public Health and Epidemiology components do not have a standard form (excluding those for Births and

Deaths) and relies on the monthly reports sent by each department to the Planning Office. While some data can be
obtained from the Planning Office, a form, which lists specific data categories, was designed for selected public
health departments. This format will enhance monthly data reporting to the Planning Office and provide HMIS with
the necessary information to assist in documenting vital and other health-related statistics. The data will enhance
the data collected from public health and medical records. As part of the cancer screening and early detection
program coordinator's duties, a monthly report will be sent to the Office of Planning and Statistics to ensure that the
data is collected and appropriately disseminated.

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

Finance and Personnel

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

Benefits, Monitoring, and Evaluation (BME)

The objective of the BME module is to ensure the accuracy and relevance of the data we

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

Training and Professional Development

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

Evaluation Plan

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

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an outbreak. Preventive measures can then be taken to minimize the number of cases.
A formal evaluation will be done through the HMIS's Benefits, Monitoring and Evaluation module (BME). This module
will complement other evaluation and monitoring tools that may be proposed by the Ministry's

technical committee.

The following table lists some of the measures that will be included in the BME.

These measures were selected to assist the Secretary of Health, Assistant Secretaries, department managers,

program coordinators, and the Health Planning and Statistics Bureau in developing contingency, staffing, and

organizational plans to ensure that the MOH will have the means to collect and analyze data for tracking the

National and Jurisdictional performance Measures.

Monitoring and Evaluation are being done using outcome from data.

Even though the MOH data/information is in used, it is still a challenge for RMI. MOH is looking forward to overcome

this challenge in early 2010, where data/information would be fully completed and on-going.

/2012/ In 2011, the Ministry of Health headed by

the Secretary of Health met to revise the

organization structure.

Currently, there are three Bureaus that provide direct health care services in the country: 1) The Bureau of Majuro

Atoll Health Care Services (BMAHCS), 2) The Bureau of Kwajalein Atoll Health Care Services (BKAHCS), and 3) The

Bureau of Primary Health Care Bureau (BPHC). Aside from the 3 Bureaus, there are 2 offices under the Secretary of

Health namely Office of Health Planning, Policy, and Statistics and Office of Administration, Personnel, and Finance.

BMAHCS handles the management of Majuro Hospital and Medical Referral Services. BKACHS manages Ebeye

Hospital and Primary Health Care of Kwajalein Atoll. BPHC manages the National Primary Health Care and Outer

Island health care services.

The National MCH Program is under the BPHC. With this organization lay out, the MCH program in BKAHCS

coordinate and submit report to the national MCH program. The nurses and medical staff implement all clinical,

follow-up and community outreach programs for all areas in Public Health. The MCH Program provides health care
services for pregnant women, mothers, infants, children, adolescents, men and women of reproductive age group,
and children with special health care needs in the RMI. There are eight nurses, one OBGYN, and five support staff
receiving salaries from the program.
Our new Health Planner assumed his position in the Office of Health Planning, Policy and Statistics this year.
Installation, implementation, and maintenance of different modules of the Ministry of Health Integrated Information
System are still ongoing. All programs in the Ministry have already started using the revised forms for recording and
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reporting of data which are being collected and channeled to the OHPS. OHPS is responsible for technical support,
data collection, data analysis, and reporting.
There are 5 systems comprising the Ministry of Health Integrated Information System. They are Vital Records
Information System, Hospital Information System, Public Health Information System, Management Information
System, and Medical Referral Information System.
Vital Records Information System: System for the Birth, Death, Fetal Death certificates. As of now, the birth and
death certificates are not linked together. But we are applying for the SSDI grant this year. One of our objectives is
to link the birth and death certificate.
Hospital Information System: This system will manage all hospital based systems like Laboratory, Radiology, Medical
Records, Pharmacy, Outpatient and Inpatient.
Public Health Information System: This system will handle public health databases.
Management Information System consists of Inventory Management System, Biometric Time and

Attendance system,

Personnel system

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

Monitoring and Evaluation Plan

Currently, the program managers submit their own template of reporting the Office of Health Planning, Policy, &

Statistics for data collection, analysis, and reporting. But OHPPS is working on a monitoring and evaluation template

for all the Bureaus and Offices to use for centralized and uniform collection and analysis.

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

MHIIS.

//2013// Using National Public Health Improvement Initiative Grant, we will connect Ebeye Hospital to the Vital

Records Information System (VRIS). We always have a challenge with late submission, missing birth, death and fetal

death certificate from Ebeye Hospital. With the implementation of VRIS in Ebeye, we will be able to have real time

data entry. The main server is in Majuro.

This year, we will also implement the WebIZ (Immunization Information System) in Ebeye Hospital. The main server

is in Majuro. Currently, Ebeye Immunization Program is using a standalone system. With the implementation of

WebIZ, Ebeye Immunization Coordinator can enter real time data and print out Immunization Card on time.

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We have also started the implementation and training for Laboratory Management Information System in Majuro

Hospital Laboratory. Before the end of the year, all Laboratory staff can access, enter, and print results from the

Laboratory System. We are still looking for funding to implement the same system to Ebeye Hospital.

In 2011, the National Comprehensive Cancer Control Program with the physicians and consultants from University of
Hawaii created a national screening guidelines for Cervical, breast and colorectal cancer screening. In 2012, we will
have training on VIA for cervical cancer screening. We will implement a system that captures the cancer screening.
We have a cancer registry wherein only diagnosed cancer patients are entered and monitored. But with the new
system that we will implement, it will track all screening that we will have for breast, cervical, and colorectal.
For BMI Screening in school, we are going to use a newly developed School Health database. It is still in
development stage but will go along with the BMI screening we are conducting.
Using the SSDI funding, we are working on a comprehensive tracking system for MCH program that that follows the
life course model for prenatal services, well-baby, children's health screening, school health screening. We will work
out on a system wherein we can get better information from the Outer Islands. It is a challenge to implement an
information system in the Outer Islands. 80% of our health assistants in the Outer Islands have limited computer
skills. We will use wavemail system for them to send information using a template that is easy for them to
understand and enter data.

II.B.2.b.iii. MCH Workforce Development and Capacity

The MCH/CSHCN Program coordinator is a member of the Ministry of Health Core Committee which coordinate all community awareness activities. The MCH program is also a member of the RMI Interagency Council under a Memorandum of Understanding as well as parents representatives. The Interagency Council meets regular to ensure continuous services is provided to all CSHCN, both in school and those who are not.
The program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information system) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and aerial resources necessary to meet public health obligation. As program capacity setts the stage for other activities, program capacity results are closely related to the results for process, health outcomes, and risk factors.
The State Program Collaborate with other States Agencies and Private Organization. State establish and maintain

ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
The State support for communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improvement and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standard/guidelines, training, data and planning systems. Examples include needs assessment, monitoring, training, applied research, information systems and systems of care. Int he development of system of care it should be assured that the systems are centered, community based and culturally competent.

II.B.2.c. Partnerships, Collaboration, and Coordination

Family and Community Partnership

The MCH Program has established its relationship with different sectors of the community: Government, Nongovernment and Faith Based Organization. The following is our partners in the community:

Government: Ministry of Education, Ministry of Internal Affairs, Ministry of Finance, All Local Governments, Ministry of Justice, Attorney General's Office, Office of the President

Non-Government Organization: Kijle (a women group), Women United Together Marshall Islands (WUTMI), Marshall Islands Epidemiological Group, Family Support of Special Children, Cancer Survivorship Group

International: UNFPA, WHO, HRSA, CDC

Faith Based: Assembly of God, Protestant Church, Catholic Church

Our vast partnership has given us confidence and access to our population to be able to provide the health care services that the MCH program through the Ministry of Health can provide.

Programs within the Ministry of Health:

Office of Health Planning, Policy and Statistics - Vital Statistics Department, Medical Records Department, IT Department and SSDI program are under this office. We have a good partnership in developing systems, collecting and analyzing of data, and implementation of activities.

Public Health Programs: STD/HIV, Leprosy, TB, Chronic Care, Cancer Program, Dental Care, Immunization Program. We are one team in providing health care to all population. When we provide services to the Outer Islands, all programs are represented so we can give a full and comprehensive services to the atolls that we visited once or twice a year.

Medical Referral Services - Good partnership in assessing and referring our patients to Tripler Hospital, Shriners' Hospital, Hospital in the Philippines. Our coordination is doing well as we always update each other on status of patients.

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	To reduce the maternal mortality rates.	Continued	State needs.
2	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	New	
3	Increase percent of infants breastfed exclusively through 6 months	New	
4	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past yea	New	
5	To increase the rates of teenager 15-19 years old acceptors of modern contraceptive.	Replaced	Not duplicate with NPM.
6	To increase the percentage of women who screened for cervical cancer.	Continued	Not duplicate with NPM.
7	To increase the number of children, ages 1 through 17, who had a preventive dental visit in the past year	New	
8	To increase number of CSHN entry into the program.	New	Not duplicate with NPM.
9	To increase the number of women who have a preventive medical visit	New	
10	To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19.	New	

Follow the recommendation from international and regional development agencies; the government of RMI is very active in improving the safe motherhood/making pregnancy safe, family planning, healthy children and adolescents, well being of Children with Special health Care Needs, healthy lifestyle and living and other services in the country.

The causality analysis was made prior to selection of state priorities. The analysis has helped to identify the strengths and weaknesses, and other factors affecting the Maternal and Child Health and Reproductive Health

Services in RMI.

State Selected Priorities:

Selection factors that were included during the process:

1. Availability of resources and services within the islands.

2. Challenges and success of meeting the targets

3. Strategies and activities for each state priorities

4. Mapping of information, data and sources,

5. Commitment of Ministry of Health, Community and stakeholders

	Reasons
To reduce the maternal mortality rates. (Continue)	This is one of MOH Commitment in Millennium Development Goals. Reducing maternal mortality rates. The RMI has had maternal deaths which were preventable. Priority will be placed on improving the health care of pregnant women to avoid maternal death. Detection of high risk pregnancy will be increased.
Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool (New)	Early identification of developmental disorders is critical to the well-being of children and their families. MOH will be able to provide early prevention and will save and improve children's health and lead to better life.
Increase percent of infants breastfed exclusively through 6 months (New)	Exclusively breastfeed for about six months gives better growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines,protection from allergies, and reduces probability of SIDS, low rish to non communicable disease like diabetes, asthma, and risk factors like obesity, and better teeth development. It is also a bonding to the mother and newborn. For mothers, it will be a good help in her post partum recovery, family planning method. mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (New)	Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. It will also a good way to counsel them with the help of health care professional especially on the changes in their body and environment.
To increase the rates of teenager 15-19 years	This was chosen to help in the reduction of teen births and pregnancies. Currently, we haven't reached even 1/2 of our 15-19 years old population. We will provide counselling

old acceptors of modern contraceptive. (Replace)	and chooses of available family planning methods.
To increase the percentage of women who screened for cervical cancer. (Continue)	Cervical Cancer is the number one cancer in women. Every year, new cases are diagnosed even on young girls. We need to make sure our strategies and activities are working to save more women from dying of cervical cancer.
To increase the number of children, ages 1 through 17, who had a preventive dental visit in the past year (New)	We need to reach our population of 1 through 17 years old and meet their dental health care needs. Insufficient access to oral health care and effective preventive services affects children's health and education. Early dental visits will teach children the importance of oral health. Having dental care at a young age will change the perspective of children on coming to the dentist. This will become a habit to them and will not be scared of visiting the dentists.
To increase number of CSHCN entry into the program. (New)	Our program needs to improve in providing services to Children with Special health care needs. We have to visit Outer Islands more often to register childrenunder the program. We also have to improve our new born screening.There is a need to develop and implement Autism, Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) Program that will be enrolled under the program.
To increase the number of women who have a preventive medical visit (New)	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. We need to prepare a healthy woman in facing new phase in her life like pregnancy, birthing, post partum, chronic diseases. Give woman a choice on how she wants her body and mind to be healthy.
To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19. (New)	For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings. The Ministry of Health and stakeholders agreed that we need the government to create policies and laws for safe environment.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.0	25.0	30.0	40.0	45.0

NPM 2-Percent of cesarean deliveries among low-risk first births

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	30.0	25.0	25.0	23.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	90.0	90.0	95.0	95.0	95.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	60.0	70.0	80.0	90.0

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.0	20.0	30.0	40.0	50.0

NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	625.0	600.0	555.0	555.0	555.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60.0	65.0	70.0	75.0	77.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	42.0	42.0	44.0	46.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	45.0	50.0	55.0	60.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.0	37.0	40.0	42.0	45.0

The Linkage of Marshall Islands State Priorities with NPMs and NOMs was based on the assessment and discussion of the team. We considered what we can do and achieve in the next 5 years. Priorities were given strategies and activities. Challenge that we have seen is the capacity of the Ministry and partners in fulfilling the priorities due to changes of leadership, funding, policy, laws, and emerging issues like outbreaks and natural disasters.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

This section will be filled in next application.

We will discuss thoroughly on what we need to be part of the SPMs and SOMs with consideration on the events that will happen in 2015/2016 activities.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

The State Priorities has been assessed and chosen to fit the needs assessment result and action to be taken.

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
To reduce the maternal mortality rates.	1. Improve Pregnancy by making quality maternal services more available and accessible.	Ensure every pregnant woman is receive with quality antenatal care Ensure every woman has skilled professional at delivery Ensure all pregnant women are access to a comprehensive emergency obstetric care Facilitate Access and Availability of Effective Neonatal Care and Post-natal care Community awareness and participation on Maternal and Neonatal Health	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births	Percent of cesarean deliveries among low-risk first births		
To increase the percentage of women who screened for cervical cancer.	Improve quality cancer services-- women have access to screening and cancer care both in urban and rural areas of	Community advocacy, engagement and empowerment to enable access screening and detection				

	RMI	services Ensure up-skilling of hospital-based nursing and medical staff to provide quality of care to diagnosed with reproductive tract cancers Ensure supplies needed for the screenings and management is readily and sufficiently available Advocacy to member of the public, politicians, medical and nursing leaders to support the setting up screening and vaccinations services for adults and young population				
To increase the number of women who have a preventive medical visit	Increase the percentage of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy	Ensure access and availability of recommended clinical preventive services, including screening, counseling, and immunizations	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low	Percent of women with a past year preventive medical visit		

	Increase the proportion of persons who receive appropriate clinical preventive services		birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births				

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

The concept is to ensure all women receive appropriate health care throughout pregnancy and childbirth including proper nutrition and living a healthy life style during pregnancy, appropriate antenatal care, prevention of complications, early and effective diagnostics and the treatment of complications. The objective is to ensure women and infants are safe throughout pregnancy, during and after delivery.

Strengthened quality of antenatal care services at peripheral health centres and increased number of qualified midwives are needed to meet the current high demand of antenatal services. Women should be encouraged to receive antenatal services from community clinics. Facilities should be equipped to ensure private consultations and relevant screening and treatment. All facilities should have running potable water.

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREA 1: Ensure every pregnant woman is receive with quality antenatal care	1. Conduct community awareness, promote early booking of mothers before 12 weeks of gestation and mothers attend at least 4 Pre-Natal clinics before delivery 2. Promote increased male participation in antenatal, intra-partum and postnatal care 3. Promote pre-natal classes at first booking at all service deliveries 4. Conduct routine screening and treating for syphilis and STIs for all pregnant women 5. Standardise quality of antenatal care at all facilities
STRATEGIC AREA 2: Ensure every woman has skilled professional at delivery	1. Conduct training to health staffs on Emergency Obstetric Care (EMOC) 2. Provide training to traditional birth attendance on basic obstetric care 3. Promote safe delivery at health facilities by skilled health professionals 4. Provide clean delivery kits to skilled birth attendants for use in remote areas

	5. Develop clear referral system, facilitate prompt referrals of high risk cases to the main hospitals
STRATEGIC AREA 3: Ensure all pregnant women are access to a comprehensive emergency obstetric care	1. Review and standardise clinical guidelines and protocols for obstetric care 2. Ensure service deliveries are met/and comply with a basic and/or comprehensive obstetric care standards 3. Develop a system for the on-going up skilling of health care workers in emergency obstetric and neonatal competency and skills; 4. Develop quality assurance and quality improvement (QA and QI) to monitor and evaluate the practice. 5. Ensure client receive maximum benefit by strengthen communication and referral strategies amongst all levels service deliveries
STRATEGIC AREA 4: Community awareness and participation on Maternal and Neonatal Health	1. Engage communities, raising awareness and promoting Maternal and Neonatal Health 2. Conduct meeting/workshop develop a basic plan for referral for high risk cases 3. Create support network in community for women and family

Cervical, breast, and ovarian cancer are the most comment cause of premature death in women. Cervical cancer is the second most common cancer in women worldwide. (WHO, 2013)

Early diagnostic and timely management could save women life. The health services shall ensure the functioning of services are available for prevention, screening, management, and follow-up of cancers of the reproductive system among men and women.

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREAS 1: Community advocacy, engagement and empowerment to enable to access screening and detection services	1. Provide education to schools (Middle School, High School and College) education on cancer, risk factors, early screening, and availability of services in the Ministry of Health 2. Conduct comprehensive HPV Campaign in schools and local community 3. Continue community visit for cancer and prevention awareness 4. All clients should undergo cancer screenings based on the RMI National Cancer Screening Guidelines
STRATEGIC AREAS 2: Ensure up-skilling of hospital-based nursing and medical staff to provide quality of care to diagnosed with reproductive tract cancers	1. Review management guideline (screening and management) on breast, cervical and colorectal cancer by the two Cancer coalitions from Majuro and Ebeye. 2. Provide training of staff in mammogram and ultrasound 3. Develop strategy for retention of staff that has the skills to provide the services 4. Strengthen referral pathway for continuum of care. 5. Capacity trainings on management of cervical, breast, and colorectal cancer 6. Retraining of VIA Screening 7. Improve and decrease turnaround time for Pap smear and pathology reports from laboratory. 8. Incorporate HPV vaccines in the regular immunization schedule.

STRATEGIC AREAS 3: Ensure supplies needed for the screenings and management is readily and sufficiently available	1. Re-enforcement the use of inventory system • Flow of inventory • Information system 1. Create an ordering and replenishing system guidelines
STRATEGIC AREAS 4: Advocacy to member of the public, politicians, medical and nursing leaders to support the setting up screening and vaccinations services for adults and young population	1. Utilize NCD Coalition to advocate to the politicians and advisory group for support on the screening, prevention, management and treatment of cancer. 2. Collaborate with Faith Based Organization advocate to the politicians and advisory group for support on the screening, prevention, management and treatment of cancer. 3. MOH to work with its international partners to seek additional funding to support the cancer screenings and vaccination services.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20	25	30	40	45

NPM 2 - Percent of cesarean deliveries among low-risk first births

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40	30	25	25	23

Development of measures and activities will be reported on next cycle.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past yea	Improve Neonatal Outcomes by making quality Newborn services more available and accessible. Decrease the RMI low birth weight rate	Ensure every pregnant woman is receive with quality antenatal care Ensure every woman has skilled professional at delivery Ensure all pregnant women are access to a comprehensive emergency obstetric care Facilitate Access and Availability of Effective Neonatal Care and Post-natal care Community awareness and participation on Neonatal and Infant Health Ensure well baby services are available	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		
Increase percent of infants breastfed	Improve Neonatal Outcomes by	Provide well baby clinic services to all	Post neonatal mortality rate per 1,000 live births	A) Percent of infants who are ever breastfed		

exclusively through 6 months	making quality Newborn services more available and accessible.	infants Community awareness and participation on Neonatal and Infant Health emphasizing exclusive breastfeeding	Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	and B) Percent of infants breastfed exclusively through 6 months		

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREA 1: Ensure every pregnant woman is receive with quality antenatal care	1. Conduct community awareness, promote early booking of mothers before 12 weeks of gestation (1st Trimester) and mothers attend at least 4 Pre-Natal clinics before delivery 2. Promote increased male participation in antenatal, intra-partum and postnatal care 3. Promote pre-natal classes at first booking at all service deliveries 4. Conduct routine screening and treating for syphilis and STIs for all pregnant women 5. Standardize quality of antenatal care at all facilities
STRATEGIC AREA 2: Ensure every woman has skilled professional at delivery	1. Conduct training to health staffs on Emergency Obstetric Care (EMOC) 2. Provide training to traditional birth attendance on basic obstetric care 3. Promote safe delivery at health facilities by skilled health professionals 4. Provide clean delivery kits to skilled birth attendants for use in remote areas

	5. Develop clear referral system, facilitate prompt referrals of high risk cases to the main hospitals
STRATEGIC AREA 3: Ensure all pregnant women are access to a comprehensive emergency obstetric care	1. Review and standardize clinical guidelines and protocols for obstetric care 2. Ensure service deliveries are met/and comply with a basic and/or comprehensive obstetric care standards 3. Develop a system for the on-going up skills of health care workers in emergency obstetric and neonatal competency and skills; 4. Develop quality assurance and quality improvement (QA and QI) to monitor and evaluate the practice. 5. Ensure client receive maximum benefit by strengthen communication and referral strategies among all levels service deliveries
STRATEGIC AREA 4: Facilitate Access and Availability of Effective Neonatal Care and Post-natal care	1. Develop a basic comprehensive care package for new-borns and post natal mothers 2. Ensure staffs working at postnatal and new-born units are undergo regular training in new-born resuscitation and clinical assessment to recognize danger signs 3. Develop/review policies for strengthening postnatal clinic and MCH attendance 4. Ensure client receive maximum benefit by strengthen communication and referral strategies at all levels of service deliveries 5. Establishment of mechanisms for on-going monitoring and evaluation of Pediatric services

STRATEGIC AREA 5: Community awareness and participation on Neonatal and Infant Health	1. Engage communities, raising awareness and promoting Neonatal and Infant Health 2. Conduct meeting/workshop develop a basic plan for referral for high risk cases 3. Create support network in community for women and family

Perinatal/Infant Health - Annual Report

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	90.0	90.0	95.0	95.0	95.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	60.0	70.0	80.0	90.0

Development of measures and activities will be reported on next cycle.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	To increase the number of children who receive a developmental screening.	Develop Standardized Developmental Screening tool Development of Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program Community awareness on the screening tool and availability of health care services for 10 to 71 months children	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		
To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19.	Reduce hospitalizations for nonfatal injuries	Community and media awareness and health education on non-fatal injuries and first aid treatment Availability of services and supplies to accommodate hospitalization of non fatal	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

		injuries				

Child Health

Child Health - Plan for the Application Year

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREA 1: Develop Standardized Developmental Screening tool	1. Conduct research and development of Standardized Developmental Screening tool with consideration of availability of resources 2. Promote awareness to community on available services 3. Implement Developmental Screening Tool in Majuro and Ebeye
STRATEGIC AREA 2: Development of Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program	1. Ask for technical assistance in the development of program 2. Create a team that will develop and implement the program 3. Enroll confirmed cases to CSHCN Program 4. Develop capacity of workforce to provide the needed medical care for the patients
STRATEGIC AREA 3: Community awareness on the screening tool and availability of health care services for 10 to 71 months children	1. Engage communities, raising awareness and promoting on the screening tool and availability of health care services for 10 to 71 months children 2. Conduct meeting/workshop develop a basic plan for referral for high risk cases 3. Create support network in community for women and family

Child Health - Annual Report

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10	20	30	40	50

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	625	600	555	555	555

Development of measures and activities will be reported on next cycle.

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
To increase the rates of teenager 15-19 years old acceptors of modern contraceptive.	The provision of quality Family Planning services is available and accessible to the 15-19 years old and general population of RMI	Ensure that the family planning's client receives full sexual reproductive health care services Ensure counseling of clients to utilize effective and appropriate methods of contraception thereby facilitating informed choice Strengthen the community awareness of the Family planning clinic existence and services Expand and improve the FP services within the MOH and the community				
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past yea	Improve the health care services to Adolescent population	Ensure the availability of immunization vaccines and services Ensure that the family planning's	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

		client receives full sexual reproductive health care services Ensure counseling of clients to utilize effective and appropriate methods of contraception thereby facilitating informed choice Ensure that the needed mental health counseling will be provided by certified counselors Ensure that the availability of STI / HIV services	through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the			

			Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			
To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19.	Reduce hospitalizations for nonfatal injuries.	Community and media awareness and health education on non-fatal injuries and first aid treatment Availability of services and supplies to accommodate hospitalization of non fatal injuries	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

			who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Adolescent Health

Adolescent Health - Plan for the Application Year

To increase the rates of teenager 15-19 years old acceptors of modern contraceptive

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREA 1: Ensure that the family planning's client receives full sexual reproductive health care services	1. Ensure other SRH services such as pregnancy test, counselling, STI screening and treatment, cancers screening are available at all family planning clinics 2. Ensure client receive maximum benefit by strengthen communication and referral strategies at all levels of service deliveries

	3. Promote and re-enforce of best practice, ensurecomprehensive physical examination is part of the routine clinic
STRATEGIC AREA 2: Ensure counseling of clients to utilize effective and appropriate methods of contraception thereby facilitating informed choice	1. Conduct regular refresher training for the FP/RH/Maternity/PH/Dispensaries staffs and school nurses 2. Strengthen counselling of clients in selecting appropriate contraceptive methods, and ensure proper documentation are completed at all visits 3. Supply wide range of quality family planning methods at all service deliveries. 4. Improve quality of service to increase access to existing FP methods 5. Conduct regular monitoring and evaluation of services by getting feedback from clients (Provide a set of questionnaire to all the FP clients)
STRATEGIC AREA 3: Strengthen the community awareness of the Family planning clinic existence and services	1. Strengthen strategic health communication on FP to community, develop IEC materials, put up sign-board in appropriate places 2. Promote access to health services, put up an eye catching clinic schedule around the MOH 3. Conduct general public awareness through the media (radio, newspaper, channel, internet) 4. Continue to capacitate the community health workers and school health advocates of the FP clinic
STRATEGIC AREA 4: Expand and improve the FP services within the MOH and the community	1. Provide FP services at all Public Health programs (physical exams, NCD clinics, STI/HIV, and zones). 2. Provide FP services to the high risk population in the wards (maternity, delivery, and pediatric ward)

	3. Continue to provide emergency contraceptive in the ER 4. Improve the FP services at the CMI clinic 5. All FP services will be provided in the High School clinics and colleges. 6. Continue and improve the FP services in YTYIH, Laura, and Outer island dispensaries

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

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREA 1: Ensure the availability of immunization vaccines and services	1. Ensure availability of vaccine (Flu vaccine, Tdap, meningococcal conjugate vaccine, HPV) 2. Ensure access of vaccines in Hospital, Health Centers and mobile outreach services. 3. Ensure that the 12- years old are part of the high risk group for Immunization Program.
STRATEGIC AREA 2: Ensure counseling of clients to utilize effective and appropriate methods of contraception thereby facilitating informed choice	1. Conduct regular refresher training for the FP/RH/Maternity/PH/Dispensaries staffs and school nurses 2. Strengthen counselling of clients in selecting appropriate contraceptive methods, and ensure proper documentation are completed at all visits 3. Supply wide range of quality family planning methods at all service deliveries. 4. Improve quality of service to increase access to existing FP methods 5. Conduct regular monitoring and evaluation of services by getting feedback from clients (Provide a set of questionnaire to all the FP clients)

STRATEGIC AREA 3: Ensure that the needed mental health counseling will be provided by certified counselors	1. Revise the School Health Program to include mental health assessment and counselling 2. Ensure access and availability of Mental Health Services 3. Ensure capacity building of Mental Health workforce to accommodate 12-17 years old
STRATEGIC AREA 4: Ensure that the availability of STI/HIV services	1. Extend services to cover more geographical areas in the outer islands 2. Development of specific protocols/or guidelines to support integration and linkages of STI/HIV to existing RH services (and vice versa) 3. Dissemination of standard protocols and guidelines on integration and linkages between two programmes

Adolescent Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60	65	70	75	77

Development of measures and activities will be reported on next cycle.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
To increase number of CSHN entry into the program.	Improve the assessment, coverage and enrollment of CSHCN into the program to be able to provide the needed care.	Develop and implement a database system on infants who have special health care needs (SHCN) within 6 months after birth Improve service delivery for CSHCN and families and follow-up services Coordination of better referral for CSHCN to the program Development of Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREA 1: Continuation and implementation of database system on children who have special health care needs (CSHCN)	1. Continue building up the database 2. Continue to enroll CSHCN
STRATEGIC AREA 2: Improve service delivery for CSHCN and families and follow-up services	1. Continue to conduct the survey and report analysis to be able to assess the needs of CSHCN and families 2. Better coordination between CSHCN, family and the program on completing medical assessment
STRATEGIC AREA 3: Coordination of better referral for CSHCN to the program	1. Continue to coordinate with Medical Referral Services for possible referral to Tripler and other partner hospital to provide medical treatments that are not available in RMI. 2. Promote better communication between MCH Program and the health assistants to be able to provide good referral of patients. 3. Strengthen MCH Program coordination between health programs within the Ministry of Health
STRATEGIC AREA 4: Development of Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program .	1. Ask for technical assistance in the development of program 2. Create a team that will develop and implement the program 3. Enroll confirmed cases to CSHCN Program 4. Develop capacity of workforce to provide the needed medical care for the patients

Children with Special Health Care Needs - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40	42	42	44	46

Development of measures and activities will be reported on next cycle.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
To increase the number of children, ages 1 through 17, who had a preventive dental visit in the past year	To be able to provide dental services to ages 1 through 17 years old To be able to provide good oral health starting from childhood to adulthood	Ensure access and availability to oral health care, good oral hygiene, and adequate nutrition Ensure supplies needed for the screenings and sealants are readily and sufficiently available	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

To increase the number of children, ages 1 through 17, who had a preventive dental visit in the past year

STRATEGIC AREAS AND ACTIONS:

STRATEGIC AREAS	ACTIVITIES
STRATEGIC AREA 1: • Ensure access and availability to oral health care, good oral hygiene, and adequate nutrition •	1. Extend and ensure services to cover more geographical areas in the outer islands 2. Promote through media awareness on good oral health care 3. Partner with school systems to enhance knowledge on good oral hygiene, oral health care and adequate nutrition. 4. Make changes on policy to include dental visits on school entry
Ensure supplies needed for the screenings and sealants are readily and sufficiently available	1. Process necessary purchase orders to accommodate the increase of 1-17 years old clients.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	45.0	50.0	55.0	60.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.0	37.0	40.0	42.0	45.0

Development of measures and activities will be reported on next cycle.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

The MCH/CSHCN Program coordinator is a member of the Ministry of Health Core Committee which coordinate all community awareness activities. The MCH program is also a member of the RMI Interagency Council under a Memorandum of Understanding as well as parents representatives. The Interagency Council meets regular to ensure continuous services is provided to all CSHCN, both in school and those who are not.

The program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information system) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and aerial resources necessary to meet public health obligation. As program capacity setts the stage for other activities, program capacity results are closely related to the results for process, health outcomes, and risk factors.
The State Program Collaborate with other States Agencies and Private Organization. State establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
The State support for communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improvement and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standard/guidelines, training, data and planning systems. Examples include needs assessment,

monitoring, training, applied research, information systems and systems of care. In the development of system of care it should be assured that the systems are centered, community based and culturally competent.

II.F.3. Family Consumer Partnership

Family and Community Partnership

The MCH Program has established its relationship with different sectors of the community: Government, Nongovernment and Faith Based Organization. The following is our partners in the community:

Government: Ministry of Education, Ministry of Internal Affairs, Ministry of Finance, All Local Governments, Ministry of Justice, Attorney General's Office, Office of the President

Non-Government Organization: Kijle (a women group), Women United Together Marshall Islands (WUTMI), Marshall Islands Epidemiological Group, Family Support of Special Children, Cancer Survivorship Group

International: UNFPA, WHO, HRSA, CDC

Faith Based: Assembly of God, Protestant Church, Catholic Church

Our vast partnership has given us confidence and access to our population to be able to provide the health care services that the MCH program through the Ministry of Health can provide.

Programs within the Ministry of Health:

Office of Health Planning, Policy and Statistics - Vital Statistics Department, Medical Records Department, IT Department and SSDI program are under this office. We have a good partnership in developing systems, collecting and analyzing of data, and implementation of activities.

Public Health Programs: STD/HIV, Leprosy, TB, Chronic Care, Cancer Program, Dental Care, Immunization Program. We are one team in providing health care to all population. When we provide services to the Outer Islands, all programs are represented so we can give a full and comprehensive services to the atolls that we visited once or twice a year.

Medical Referral Services - Good partnership in assessing and referring our patients to Tripler Hospital, Shriners' Hospital, Hospital in the Philippines. Our coordination is doing well as we always update each other on status of patients.

II.F.4. Health Reform

Health Reform

MCH Program under the Ministry of Health provides services to all. Health Insurance covers the whole Marshallese population.

II.F.5. Emerging Issues

We will discuss on next year application.

II.F.6. Public Input

The public, specifically the parents, presented their comments and questions concerning CSHCN services. They would like to see in the future consultants /doctors who could come to RMI to provide special services/care, such as cardiac service, hearing problems screening, eye screening, and other services for disabled conditions, including Shriners' annual Outreach visit.

For those with children with mental delay and unable to move one part or the whole body, special providers is needed. They think that short term service and doctors should be provided to the children where it is needed. They commented to hire service coordinator, including at least one staff so that they could spend more time in providing the care that is really needed for the clients, such as, counseling and training the parents/care takers on helping their children to be able do something in their lives. Parents need someone that has more time to train them on how to be more effective as parents to take care of their children with special health care needs. Some of the children can't move without assistance, family can't afford to pay for the equipment needed to help their children. Responses: The MOH has three Pediatricians (1 in Ebeye Hospital and 2 in Majuro Hospital) that is to see all children on a daily basis, including CSHCN. This doctor is now seeing and identifying and confirmed more children with health care needs. These children are then refer to the MCH program for further work-up, follow-up, and refer to visiting teams, such as, Shriners Outreach Team for further medical evaluation and care. Some of these children are being sent off island (mostly to Shriners Hospital in Honolulu) for surgery, Tripler Army Medical Hospital if cleft palate, or the Philippines, if service is not available on island. For the children whose families can't afford the hospital fee of $5.00 per visit to seek medical care, especially those coming from the outer islands, the program is billed with the required hospital fee. The program has taken steps in strengthening the collaboration between the program and departments within the Ministry and other government ministries for better utilization of equipment for those children in need, such as, wheel chairs for example. The MCH program has also made arrangement with the medical record to submit CSHCN's outpatient service cost on monthly basis. The program will take care of the charges. The program has also provided medical equipment for the CSHCN who are in need with no means of paying, for example, wheel chair. For hearing loss, "the project on newborn hearing screening has been established and on-going in both hospitals.

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

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

The Ministry of Health has put more effort have the public be more involved in the MCH programs and reviewing of the grant application. For FY 2015, public announcements were made for the public for any comments and input regarding any issues in the grant application. Copies of the MCH Block Grant Application were made available at the MCH Program Office at the Ministry, including other information that any interested person (s) may wish to comment/input regarding the grant application. In additional to this, distributions of the draft report for comment on the report and to hear additional views (by phone calls, etc.) regarding the RMI MCH Block Grant Application for FY 2015.

The government radio station (V7AB) broadcasted the announcement where most of the people especially in the outer islands have access to it. They can hear the announcement that is aired from 6:00 am to 11:30 at night seven days a week. Public announcement is also made during the Council for Children with Special Health Care and Education Needs meeting twice yearly. Furthermore, where call for more information was provided to the public. For more information concerning the application, please call the MCH Program at 625-3399 (ex. 2401)/456-5773 or

stop by the MCH office during regular working yours (Monday through Friday from 8:00AM to 12:00 Noon and 1:00PM to 5:00PM.

The Maternal and Child Health Block Grant was opened for public input on the air stating June 16, 2015 to July 13, 2015, in the outreach program activities, for the individual client, family members, and care takers to submit their comments by writings, phones, or stop-by the MCH Office at the Ministry of Health. The MCH office is opened 5 days a weeks from 8am to 5pm with phones opened at these numbers: 625-33999ex.2401/2403) or mobile at 456-5773/455-6388 for comment and information.

Below are summary of the comments we received:

A.Community:

Question 1: Can the MCH BG set aside budget to purchase equipment for children who are needed of such equipment, such wheelchair, hearing aids, etc.

Replied: The MCH Program continues to coordinate with different departments like Rehabilitation Department to seek assistance for free wheelchairs and crutches and visiting medical teams that provides hearing aids, free eye glasses.

Question 2: Can MCH Program bring our children to hospital on regular basis like for rehabilitation services, regular checkup?

Currently, the program has no functioning vehicle and it is a need that the program is working on it with the MOH. Sometime, these children with special health care needs are not able to come for exercise at the MOH due to transportation problem and no means of paying for taxi or bus fares. We will work on a strategy to be able to provide this kind of service to CSHCN.

Question 3: There are times when their child visits hospital outpatient for medical reasons and if medication is prescribes then have to pay from their own packets.

Replied: CSHCN is free of charge from hospital services including medicines. Please inform the cashier that you are a CSHCN patient. We will also make a card for you to identify that your child is enroll under CSHCN program.

B. During this summer, there is a retaining for the health assistants who work in the Outer Islands/Atolls. There are 58 health assistants for these atolls. 1st group has 28 health assistants that attended. The Health Assistants bring in to the table the issues of the community in the Outer Islands as well as their challenges.

1. The Primary Health Care Mobile Team visits the Outer Islands/Atolls on quarterly bases depending on transportation availability and always a team report is submitted to the Ministry. We are requesting for the MCH/CSHCN Director to have an access to these reports so she can see the improvement and challenges in the Outer Islands

Reply: The MCH/CSHCN Director will coordinate with each mobile team leader to provide report to the program every visit to those outer atoll

1. We need a better communication between program base office and outer island health assistance to better monitoring and providing better assess for those client who reside on these atoll.

Reply: Currently, the Ministry of Health and National Telecommunication Authorization with coordination with the local government has an ongoing project called DAMA Installation Project. The DAMA Installation Project is setting up of internet and phone system in the health centers. There are 8 health centers on the 1st part of the project. This project will greatly improve the communication system between health centers and the main office. Access to education, reporting and referral system will improve.

C. Outer Island Visit

A trip to Arno Atoll, which is one the big outer atoll in the RMI with total population around 800 people, was taken place this month. The MCH/CSHCN Program Director and one program staff met with the people from one of the communities in Arno Atoll.

1. We don't receive the needed services and medicines for MCH and CHSCN. There is need to improve better and update service delivery in term on monthly, quarterly or yearly site visit to do follow-up for the clients

Reply: We will work on the improvement of the services not only in Arno but all places. We will have a regular communication through radio calls, phone calls, and possibly email to get feedback and needed services.

2. Is there a way that these children receive educational needs in terms of attending the right school based on child's needs.

Reply: The Program Director will further seek school opportunity from Ministry of Education (MOE) and will get back for respond

II.F.7. Technical Assistance

The MCH Program needs technical assistance on the following areas:

1. MCH Funds Administration:

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

2. Development of Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program

Our Human Services Program and MCH Program don't have the capability to assess, diagnose and provide treatment for AHD, ADD and ADHD. It will be really helpful if we can have an assistance in developing this program. We don't have a Psychiatrist. We have Pediatricians, Mental Health Counselors, and Mental health Nurse.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 252,495	$ 252,495	$ 252,495	$ 252,494
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 189,372	$ 189,372	$ 189,372	$ 189,372
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 441,867	$ 441,867	$ 441,867	$ 441,866
Other Federal Funds	$ 971,724	$ 924,716	$ 1,154,081	$ 1,154,081
Total	$ 1,413,591	$ 1,366,583	$ 1,595,948	$ 1,595,947

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 252,494	$ 252,494	$ 252,494	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 189,372	$ 189,372	$ 189,372	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 441,866	$ 441,866	$ 441,866	$
Other Federal Funds	$ 924,716		$ 939,824	$
Total	$ 1,366,582	$ 441,866	$ 1,381,690	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 252,494	$
Unobligated Balance	$ 0	$
State Funds	$ 189,372	$
Local Funds	$ 0	$
Other Funds	$ 0	$
Program Funds	$ 0	$
SubTotal	$ 441,866	$
Other Federal Funds	$ 0	$
Total	$ 441,866	$

III.A. Expenditures

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

III.B. Budget

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

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

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

Administrative Costs:

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

Administrative Cost $25,249

A. Personnel $ 8,025

   It is requested here in the amount to support a Program Administrative Assistant to do the daily program operation, such as, preparing of travel authorization, purchase order, answer the phone, setting up appointment for the program clients and program activities, and provide the assistance as related to the program.

B. Fringe Benefits $ 923.00

   It budgeted in the amount as shown here to cover for fringe benefits as required by RMI government at 10.5% of total salary.

   C. Travel $ 15,000

   D. Equipment $ -0-

   E. Supplies $ 1,301

   F. Contractual Services -0-

   G. Other $ -0-

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

   Component A: Pregnant Women, Mothers and Infants up to 1 yr. $75,749

A. Personnel $ 44,050

   A total of $44,050 is budgeted for the continued support of the Physician/OBGYN, and one MCH dental assistant. The program requires skilled and well-trained health profession staff to improve the delivery services to its target population throughout the Republic.

B. Fringe benefits $ 4,521

A sum of $4,521 has been set aside for fringe benefits ot cover contributions to the Marshall Islands Social Security System, the national health care system insurance and other benefits to staff. The RMI Government fringe benefits are calculated as a rate of 10.5 % of the total base salary.

C. Travel $ 10,000

A sum of $10,000 has been set aside to cover travel costs for the program director to attend he MCHB required, including travel that are within the program scope.

D. Equipment = 6,000

It is requested here in the amount as shown above for the purchase of one laptop computer, one overhead projector, and canon camera for MCH activities, such as, production of local educational program materials, over head projector to be used to provide lectures, and the laptop to be used for data, and reporting purposes, and any outreach activities in the community and outer islands/atolls.

E. Supplies $ 2,000 I

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

F. Fuel $5,000

Due to the rising of fuel cost, the amount of $5,000 has been budgeted to cover the fuel for the program's vehicle to continue providing outreach services to the program population in the community in Majuro.

A. Communication $2,000

It budgeted here in the amount of 2,000 to cover the program communication bills, such as phones, fax, including $600.00 cell cards that it is a needs for communication between program staff and program manager during outreach into the communities.

B. Other Cost = $3,178

t is requested in the cover for other cost such as car rental to do home visit for MCH clients, including CSHCN.

Component B: Children & Adolescents $ 75,749

A. Personnel $ 55,000

A total of $55,000 has been budgeted for personnel to support for 3 nurses at AS Degree level and 1 nurse-midwife to continue the program service delivery for the MCH population throughout the Republic.

B. Fringe benefits $5,777

A total of $5,777 has set aside for fringe benefits to cover contribution to the Marshall Islands Social Security System, the national health care system insurance and other benefits to staff.

C. Travel $6,000

This amount of $6,000 is requested to cover domestic travel for the program staff to visit the outer islands to provide the service delivery to the MCH population reside in the outer islands.

D. Equipment = $6,000

A total of $6,000 has been budgeted to cover a laptop, over head projector, and one camera the MCH program in Majuro. It is a needs for these equipment for development of program educational materials, do presentation during outreach activities using over head projector and a laptop computer. The laptop will also be used for the program purposes, such as writing grant, outer islands/atolls trips to do data and reporting,

D. Supplies $ 1,000

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

E. Communication $1,000

t is budgeted in the amount of $940 to cover the communication cost, including other cost that may concern the program communication, such as phone, fax, e-mail, international call, cell cards, or replacement of office phone as needed.

F. Others: $972

It is requested here in the amount of 972 to cover for boat charter to be used for client's follow up and get CSHCN from islet to main island and back.

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

A. Personnel $ 15,925

A sum of $15,925 to is budgeted to support for 1 Coordinator for CSHCN (AS Degree level) to be able to provider the service better and to improve planning, monitoring and evaluation for component C (CSHCN).

B. Fringe Benefits $ 1,673

A total of $1,673 to cover the fringe benefits for the 1 (CSHCN) coordinator at 10.5% of total salary.

I. Travel = $46,000

International travel will cover those clients and 1 family member referral out of the country for further medical evaluation where service is not available in the RMI. Domestic travel will cover travel cost and stipend for client and one family member who are being referred from outer islands/atolls to either one of two urban centers of Majuro or Ebeye, including program staff to do site visit for these clients reside on these islands/atolls.

International = $40,000

Domestic = $ 6,000

II. Medical Supplies $ 2,00 0

It is requested in the amount of $2,000 to cover the cost for supply for CSHCN, such as dressing supply, etc.

III. Communication $ 2,000

A sum of $2,000 is budgeted to cover the service communication, such as phone, fax, e-mail, phone/and cell

card that necessary to make the communication between CSHCN service coordinator/program director, and clients opens at all time to give more access to get services.

IV. Fuel $1,000

Due to increasing of fuel cost, it is requested here in the amount $1,000 to cover fuel cost to be used for CSHCN service delivery in the RMI.

V. Printing $1,000

It is budgeted in the amount of $1,000 to cover the printing cost the translation of pamphlet for CSHCN and family used.

VI. Other $6,152

A total amount of $6,152 is budgeted to cover the cost for boat charter for CSHCN as needed as transportation/or boat charter is needed to bring them the where there is air strips to catch the plane to Majuro or Ebeye. To cover all other costs related to the service in terms of rental, this include car rental to be used during screening and outside consultants visiting to bring or transport clients from and back to their homes $1,152., and $5,000 to cover car rental to do follow of CSHCN at home.

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

MCH Budget (Federal and State Block Grant Partnership) $441867 Total budget for FY 2013 $1,614,891

Completion of Budget Forms Detailed budget breakdowns are found in Forms 2,3,4,and 5 3.1.2 Other Requirements

For the FY2013 budget, 48% is for salaries of personnel who provided direct services for the MCH/CSHCN program. There are 7 personnel under the MCH/CSHCN program. However, other health personnel in Public Health also provided direct health care services to the MCH population as well.

Although travel costs allocated account for more than19% of the total budget for FY 2014, this allocation support the goals of the Ministry to improve preventive and primary health care services for the targeted outer islands population in MCH. Traveling within the Marshall Islands is necessary for personnel to provide health care services in support of the health assistants in the health centers. Furthermore, the identified CSHCN will need to travel to and from their own islands to the urban center for follow-up and further treatment and follow-up to Honolulu Shriners' Hospital for Children if necessary.

State Match

The total for the MCHBG application for FY 2016 is $252,495. This amount is based on the Marshall Islands' FY 1989 Maintenance of Effort Amount of 175,745. The State Match for the MCH grant application is $189,372.

Documentation of Fiscal Restrictions

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

MOH Administration to: 1) attend meeting that are conducted by the MCHB and other agencies with regards to the MCH Programs and Services, 2) purchase supplies that are needed for administrative support of the MCH services such as office supplies, stamps, and other means to support communication between the funding agencies and the MOH, and 3) contractual services that are needed for the regular maintenance of office equipment used by the MCH Administration.

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. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Marshall Islands

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 252,494	$ 252,494
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 75,749 (30%)	$ 75,749 (30%)
B. Children with Special Health Care Needs	$ 75,749 (30%)	$ 75,749 (30%)
C. Title V Administrative Costs	$ 25,247 (10%)	$ 25,247 (10%)
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 189,372	$ 189,372
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 0	$ 0
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 0	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 189,372	$ 189,372
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 175,745	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 441,866	$ 441,866
(Same as item 18g of SF-424)		
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	$ 0	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 441,866	$ 441,866
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 252,494
A. Preventive and Primary Care for Children	$ 75,749
B. Children with Special Health Care Needs	$ 75,749
C. Title V Administrative Costs	$ 25,249
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 189,372
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 189,372

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9. OTHER FEDERAL FUNDS

No Other Federal Programs were provided by the State on Form 2 Line 9.

Form Notes For Form 2:

None

Field Level Notes for Form 2:

None
Data Alerts: None

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

State: Marshall Islands

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 80,000	$ 50,995
2. Infants < 1 year	$ 50,246	$ 50,000
3. Children 1-22 years	$ 50,499	$ 75,749
4. CSHCN	$ 61,749	$ 75,749
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 242,494	$ 252,493
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 47,343	$ 47,340
2. Infants < 1 year	$ 47,343	$ 47,343
3. Children 1-22 years	$ 47,343	$ 47,343
4. CSHCN	$ 47,343	$ 47,343
5. All Others	$ 0	$ 0
Non Federal Total of Individuals Served	$ 189,372	$ 189,369
Federal State MCH Block Grant Partnership Total	$ 431,866	$ 441,862

Form Notes For Form 3a:

For FY 2014, it was budgeted for component C, CSHCN at $79,625 so it is reported here based on FY '14 budgeted.

Field Level Notes for Form 3a:

None

Data Alerts:

1.	Children 1 to 22 Years, Application Budgeted does not equal Form 2, Line 1A, preventive and Primary Care for Children Application Budgeted. Please add a field level note to explain.
2.	CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. Please add a field level note to explain.

Form 3b
Budget and Expenditure Details by Types of Services

State: Marshall Islands

	FY16 Application Budgeted	FY14 Annual Report Expended
II. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 184,494	$ 184,494
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 66,123	$ 66,123
B. Preventive and Primary Care Services for Children	$ 56,248	$ 56,248
C. Services for CSHCN	$ 62,123	$ 62,123
2. Enabling Services	$ 30,000	$ 30,000
3. Public Health Services and Systems	$ 38,000	$ 38,000
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		$ 14,000
Physician/Office Services		$ 80,000
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 15,000
Dental Care (Does Not Include Orthodontic Services)		$ 20,494
Durable Medical Equipment and Supplies		$ 45,000
Laboratory Services		$ 10,000
Direct Services Total		$ 184,494
Federal Total	$ 252,494	$ 252,494

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 158,748	$ 158,748
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 54,748	$ 54,748
B. Preventive and Primary Care Services for Children	$ 52,000	$ 52,000
C. Services for CSHCN	$ 52,000	$ 52,000
2. Enabling Services	$ 15,000	$ 15,000
3. Public Health Services and Systems	$ 15,624	$ 15,624
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		$ 10,000
Physician/Office Services		$ 70,000
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 13,748
Dental Care (Does Not Include Orthodontic Services)		$ 10,000
Durable Medical Equipment and Supplies		$ 50,000
Laboratory Services		$ 5,000
Direct Services Total		$ 158,748
Non-Federal Total	$ 189,372	$ 189,372

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 1,199

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing loss	816 (68.1%)	24	0	0 (0%)

1b. Secondary RUSP Conditions

None

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	816 (68.1%)	24	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Early Hearing Detection and Intervention Program:\r\n\r\nScreened by 1 month\r\nDiagnosed by 3 months\r\nEnrolled in Early Intervention Services (EIS) by 6 months\r\n\r\nBabies were screened by 1 month, diagnosed by 3 months and enrolled in EIS by 6 months. Babies who were identified with confirmed diagnosis were referred to EIS (early intervention services), Speech Pathologist and SPED program\r\n\r\nEHDI program monitored babies until 5 yrs old\r\n\r\nIf EHDI ENT Surgeon did not come within scheduled visit, EHDI program endorses babies to MCH clinic should come across Chronic Otitis Media plus other medical problems for Pediatrician management. EHDI endorses children with Special Health Care Needs to MCH Program.Program also provide pocket talkers to some of the children identified with confirmed hearing loss.\r\nEHDI visits every quarter includes Specialists such as Audiologist, ENT and EHDI Principal Investigator.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Hearing loss - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Registered new born in the EHDI program	
2.	**Field Name:**	**Hearing loss - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: 24 were recommended for evaluation. 15 is in process for evaluation, referred without diagnosis recorded 1 - refused diagnosis 8 - moved out of jurisdiction 0 - confirmed loss	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Marshall Islands

Reporting Year 2014

		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	1,217	0.0	0.0	100.0	0.0	0.0
2. Infants < 1 Year of Age	1,511	0.0	0.0	100.0	0.0	0.0
3. Children 1 to 22 Years of Age	29,800	0.0	0.0	100.0	0.0	0.0
4. Children with Special Health Care Needs	294	0.0	0.0	100.0	0.0	0.0
5. Others	0	0.0	0.0	100.0	0.0	0.0
Total	32,822					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2014**
	Field Note: Number of pregnant women is based on number of births.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: Population of <1 year old based from the 2006 projected population which didn't consider the 2011 Household Census. EPPSO needs to work with SPC on the new projected population.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2014**
	Field Note: Population based from the 2006 projected population which didn't consider the 2011 Household Census. EPPSO needs to work with SPC on the new projected population.	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Marshall Islands

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	1,204
2. Infants < 1 Year of Age	1,511
3. Children 1 to 22 Years of Age	29,800
4. Children with Special Health Care Needs	294
5. Others	0
Total	32,809

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: Source: RMI Household Census 2011. <1 year old population.	

Form 6

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

State: Marshall Islands

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	1,199	0	0	0	6	1,171	22	0
Title V Served	1,199	0	0	0	6	1,171	22	0
Eligible for Title XIX	0	0	0	0	0	0	0	0
2. Total Infants in State	1,511	0	0	0	0	1,511	0	0
Title V Served	1,511	0	0	0	0	1,511	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	1,199	0	0	1,199
Title V Served	1,199	0	0	1,199
Eligible for Title XIX	0	0	0	0
2. Total Infants in State	1,511	0	0	1,511
Title V Served	1,511	0	0	1,511
Eligible for Title XIX	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

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(692) 625-3399 x2401	(692) 625-3399 x2401
2. State MCH Toll-Free "Hotline" Name	Hellen Jetnil-David	Hellen Jetnil-David
3. Name of Contact Person for State MCH "Hotline"	Hellen Jetnil-David	Hellen Jetnil-David
4. Contact Person's Telephone Number	(692) 625-3399 x2401	(692) 625-3399 x2401
5. Number of Calls Received on the State MCH "Hotline"		1
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	hnjdavid@gmail.com	
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	none	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	none	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

Information reported here is for 2013. 2014 will be reported in the next reporting cycle.

Form 8
State MCH and CSHCN Directors Contact Information

State: Marshall Islands

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Hellen Jetnil-David
Title	Director, MCH &CSHCN Program
Address 1	P.O. Box 16
Address 2	Amata kabua Blvd.
City / State / Zip Code	Majuro / MH / 96960
Telephone	(692) 625-3399 x2401
Email	hnjdavid@gmail.com

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Hellen Jetnil-David
Title	Director, MCH CSHCN
Address 1	P.O. Box 16
Address 2	Amata Kabua Blvd.
City / State / Zip Code	Majuro / MH / 96960
Telephone	(692) 625-3399 x2401
Email	hnjdavid@gmail.com

3. State Family or Youth Leader (Optional)

Name	Molly Helkina at the Ministry of Internal Affairs
Title	Assistant Secretary
Address 1	P.O. Box D
Address 2	Uliga
City / State / Zip Code	Majuro / MH / 96960
Telephone	(692) 625-3204
Email	mollyhelkina@gmail.com

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Marshall Islands

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	To reduce the maternal mortality rates.	Continued	State needs.
2.	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	New	
3.	Increase percent of infants breastfed exclusively through 6 months	New	
4.	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past yea	New	
5.	To increase the rates of teenager 15-19 years old acceptors of modern contraceptive.	Replaced	Not duplicate with NPM.
6.	To increase the percentage of women who screened for cervical cancer.	Continued	Not duplicate with NPM.
7.	To increase the number of children, ages 1 through 17, who had a preventive dental visit in the past year	New	
8.	To increase number of CSHN entry into the program.	New	Not duplicate with NPM.
9.	To increase the number of women who have a preventive medical visit	New	
10.	To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19.	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Marshall Islands

Form Notes for Form 10a NPMs and NOMs:

None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	35.6
Numerator	427
Denominator	1,199
Data Source	MCH Program
Data Source Year	2014

NOM-1 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	9.5
Numerator	1
Denominator	1,049
Data Source	Hospital Admission
Data Source Year	2014

NOM-2 Notes:

1,049 newborns were delivered in the two main hospitals. 63 newborns were delivered in the Health Centers 87 were delivered outside the hospitals and health centers.

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	83.4
Numerator	1
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-3 Notes:

Maternal Death is a 29 year old from Majuro who has high risk pregnancy. She has gestational diabetes.

Data Alerts: None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	13.0
Numerator	156
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-4.1 Notes:

None

Data Alerts: None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.5
Numerator	6
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-4.2 Notes:

None

Data Alerts: None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	12.5
Numerator	150
Denominator	1,199
Data Source	Vital Statistics information System
Data Source Year	2014

NOM-4.3 Notes:

None

Data Alerts: None

NOM-5.1 Percent of preterm births (<37 weeks)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	39.1
Numerator	469
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-5.1 Notes:

None

Data Alerts: None

NOM-5.2 Percent of early preterm births (<34 weeks)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	13.8
Numerator	166
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-5.2 Notes:

None

Data Alerts: None

NOM-5.3 Percent of late preterm births (34-36 weeks)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	25.3
Numerator	303
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-5.3 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	19.3
Numerator	231
Denominator	1,199
Data Source	Vital Statistics information System
Data Source Year	2014

NOM-6 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM-7 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	18.9
Numerator	23
Denominator	1,217
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-8 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	10.0
Numerator	12
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-9.1 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	5.0
Numerator	6
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-9.2 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	5.0
Numerator	6
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-9.3 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	333.6
Numerator	4
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-9.4 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	1,199
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-9.5 Notes:

No reported SUID as cause of death.

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 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	1,199
Data Source	MCH Program
Data Source Year	2014

NOM-10 Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM #10. Please review your data to ensure this is correct.

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	1,049
Data Source	Hospital Admission
Data Source Year	2014

NOM-11 Notes:

1,049 newborns were delivered in the two main hospitals. 63 newborns were delivered in the Health Centers 87 were delivered outside the hospitals and health centers. There is no infant born in 2014 with a mother who abuse drugs. No reported pregnant women with drug abuse in 2014. Majuro Hospital Laboratory and Ebeye Hospital Laboratory don't have the capability to conduct the testing locally. For drug testing, we have to send it to Hawaii Diagnostic Laboratory Services.

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)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

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 12 months

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	4.4
Numerator	1,000
Denominator	22,616
Data Source	MCH Program
Data Source Year	2014

NOM-14 Notes:

The provided data is provisional. Currently, we need to adjust the reports from Dental Program for them to provide the information needed.

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	61.1
Numerator	8
Denominator	13,102
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-15 Notes:

Drowning, Moving vehicle accident, Fish poisoning, Coronary Heart Disease, Ischemic Heart Disease and pneumonia are main causes of death. Demographics: 4 female and 1 male. 5 from Majuro, 1 from Ebeye and 2 from Outer Islands.

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	17.8
Numerator	2
Denominator	11,224
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-16.1 Notes:

1st case - 14 year old male died due to electric shock injury. 2nd case - 13 years old male died due to septicemia probable meningococcemia.

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	4,731
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-16.2 Notes:

None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	4,731
Data Source	Vital Statistics Information System
Data Source Year	2014

NOM-16.3 Notes:

no suicide death reported among 15 through 19 years 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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	2.2
Numerator	525
Denominator	24,274
Data Source	MCH Program
Data Source Year	2014

NOM-17.1 Notes:

None

Data Alerts: None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	85.1
Numerator	447
Denominator	525
Data Source	MCH Program
Data Source Year	2014

NOM-17.2 Notes:

There are CSHCN in the Outer Islands that we need to visit. Outer Islands have limited resources to provide for our CSHCN.

Data Alerts: None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	19,561
Data Source	MCH Program
Data Source Year	2014

NOM-17.3 Notes:

None

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM #17.3. Please review your data to ensure this is correct.

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.0
Numerator	0
Denominator	19,561
Data Source	MCH Program
Data Source Year	2014

NOM-17.4 Notes:

Human Services Program is the main provider of treatment and counselling for mental and behavioral patients. The program is consist of certified counselors, mental health nurses, and a physician. The program is in need of a Psychiatrist that will help them improve their program and clinical diagnosis. We need to build up our system to be able to provide services on ADD/ADHD

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM #17.4. Please review your data to ensure this is correct.

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	100.0
Numerator	10
Denominator	10
Data Source	Human Services Program, Majuro
Data Source Year	2014

NOM-18 Notes:

Human Services Program is the main provider of treatment and counselling for mental and behavioral patients. The program is consist of certified counselors, mental health nurses, and a physician. The program is in need of a Psychiatrist that will help them improve their program and clinical diagnosis. All patients that are endorsed or referred to the program are being given treatment and counselling. The data is provisional. It only reflects Majuro at this time.

Data Alerts: None

NOM-19 Percent of children in excellent or very good health

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	20.6
Numerator	5,000
Denominator	24,274
Data Source	MCH Program
Data Source Year	2014

NOM-19 Notes:

The number provided is an estimation. We need to establish an assessment tool to measure the whole population of 0 through 17 years old.

Data Alerts: None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	39.7
Numerator	408
Denominator	1,029
Data Source	Marshall Islands YRBSS 2007
Data Source Year	2007

NOM-20 Notes:

Marshall Islands don't have WIC Program. The current YRBS available for Marshall Islands is 2007 survey.

Data Alerts: None

NOM-21 Percent of children without health insurance

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	1.2
Numerator	300
Denominator	24,274
Data Source	Office of Health Planning and Statistics
Data Source Year	2014

NOM-21 Notes:

RMI has a public health insurance where in all Marshallese children are covered. For the estimated 300 children, they are children of expatriate working in RMI. Their parents has an option to enroll in RMI Supplemental Health Insurance and cover the insurance of their children. Public Health Program like Immunization Program, TB, Leprosy, STD/HIV, provides free services to all children regardless of their insurance status.

Data Alerts: None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	55.8
Numerator	1,108
Denominator	1,987
Data Source	Marshall islands WebIZ - Immunization Program
Data Source Year	2014

NOM-22.1 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	38.2
Numerator	9,278
Denominator	24,274
Data Source	National Immunization program
Data Source Year	2014

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	5.4
Numerator	292
Denominator	5,414
Data Source	RMI National Immunization program
Data Source Year	2014

NOM-22.3 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	14.9
Numerator	809
Denominator	5,414
Data Source	National Immunization Program
Data Source Year	2014

NOM-22.4 Notes:

None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	15.2
Numerator	821
Denominator	5,414
Data Source	National Immunization program
Data Source Year	2014

NOM-22.5 Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Marshall Islands

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.0	25.0	30.0	40.0	45.0

NPM-2 Percent of cesarean deliveries among low-risk first births

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	30.0	25.0	25.0	23.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	90.0	90.0	95.0	95.0	95.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	60.0	70.0	80.0	90.0

NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.0	20.0	30.0	40.0	50.0

NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	625.0	600.0	555.0	555.0	555.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	60.0	65.0	70.0	75.0	77.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	40.0	42.0	42.0	44.0	46.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.0	45.0	50.0	55.0	60.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.0	37.0	40.0	42.0	45.0

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Marshall Islands

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Marshall Islands

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Marshall Islands

Form Notes for Form 10d NPMs and SPMs

None

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

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator	0.0	0.0	0.0	0.0	
Numerator	0	0	0	0	
Denominator	1,487	1,316	1,308	1,199	
Data Source	Medical Record	Medical Record	New Born Hearing Screening/ Well Baby clinic	New Born Hearing Screening/ Well Baby clinic	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: RMI does not have Metabolic Newborn Screening Program due to inadequate availability of facilities. However, blood test for any newborn found to have problems or special conditions is sent to off island laboratory (DLS - Honolulu) for testing.	
2.	**Field Name:**	**2011**
	Field Note: RMI does not have Metabolic Newborn Screening Program due to inadequate availability of facitiies. However, blood test for any newborn found to have problems or special conditions is sent to off island laboratory (DLS - Honolulu) for testing.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 NPM# 01. Please review your data to ensure this is correct.

2.	A value of zero has been entered for the numerator for year 2014 NPM# 01. Please review your data to ensure this is correct.

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

	2011	2012	2013	2014	2015
Annual Objective	55.0	60.0	62.0	65.0	67.0
Annual Indicator	55.5	46.2	65.6	73.7	
Numerator	286	238	338	387	
Denominator	515	515	515	525	
Data Source	MCH program survey.	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	100.0	0.0	0.0	0.0	0.0
Annual Indicator	0.0	0.0	65.6	58.1	
Numerator	0	0	338	305	
Denominator	515	515	515	525	
Data Source	MCH program survey.	MCH program	MCH Program	MCH Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: RMI don't have a medical home. Patients are treated in the hospital. We provide visitation at their home if needed to.	
2.	**Field Name:**	**2011**
	Field Note: Based on definition of medical home, RMI don't have a medical home. We provide health care to CSHCN in the hospitals, health centers and also by house to house visits.	

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	510	525	515	515	
Denominator	510	525	515	515	
Data Source	MCH Program	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2011**

Field Note:
RMI Basic Health Care Insurance provide 100% coverage.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	55.0	60.0	60.0	65.0	65.0
Annual Indicator	55.9	55.9	55.9	54.9	
Numerator	288	288	288	288	
Denominator	515	515	515	525	
Data Source	MCH program survey.	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	70.0	60.0	65.0	70.0	75.0
Annual Indicator	55.9	55.9	55.9	61.3	
Numerator	288	288	288	146	
Denominator	515	515	515	238	
Data Source	MCH program survey.	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	95.0	80.0	80.0	70.0	75.0
Annual Indicator	71.2	50.4	65.0	55.8	
Numerator	1,207	1,102	1,444	1,108	
Denominator	1,695	2,188	2,221	1,987	
Data Source	National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
There are 1,987 registered 19 to 35 months old. 1,108 have received appropriate immunization. RMI is divided into 3 main islands: Majuro, Ebeye, and Outer Islands. Majuro has 53%, Ebeye has 99% and Outer Islands has 34% fully immunized 19 to 35 months. The outer islands coverage has always demonstrated very low due to several reasons. 1. Health assistants are not administering immunization vaccines to the children because of unavailability of cold chain in the Outer Islands. 2. the children are frequently leaving the outer islands where they were registered and unable to tract them in time for their next shots. 3. Transportation and weather can affect the trip to the outer islands to provide immunization services.

2. **Field Name:** **2013**

Field Note:
There are 2221 registered 19 to 35 months old. 1,444 have received appropriate immunization.

RMI is divided into 3 main islands: Majuro, Ebeye, and Outer Islands. Majuro has 60%, Ebeye has 99% and Outer Islands has 57% fully immunized 19 to 35 months.

The immunization coverage rate for Majuro appears comparatively low due to data entry untimely and lateness for the three years interval. The outer islands coverage has always demonstrated very low due to several reasons. One of which is that the health assistants are not administering immunization vaccines to the children because of unavailability of cold chain in the Outer Islands. The second reason is the children are frequently leaving the outer islands where they were registered and unable to tract them in time for their next shots. Therefore, the total immunization coverage for the country appears to be very low; whereas in the actual sense, it is higher than 65%. The challenge is due to how and when the data are being entered into the data base.

Using the Outer Islands Mobile Team, the Immunization program provides vaccine activities in the islands. If the child missed one of her scheduled vaccines, the child will not be included in the calculation of complete immunization.

3.	**Field Name:**	**2011**

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

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	30.0	40.0	40.0	35.0	35.0
Annual Indicator	45.2	45.4	36.4	49.5	
Numerator	85	66	53	72	
Denominator	1,882	1,455	1,455	1,455	
Data Source	Office of Planning, Policy, and Statistics	Office of Planning, Policy, and Statistics	Office of Health Planning, Policy, and Statistics	Office of Health Planning, Policy, and Statistics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: RMI Census 2011 don't have projected population. We are using the 2011 population. This was approved by Economic, Policy, Planning and Statistics Office.	
2.	**Field Name:**	**2013**
	Field Note: RMI Census 2011 don't have projected population. We are using the 2011 population. This was approved by Economic, Policy, Planning and Statistics Office.	
3.	**Field Name:**	**2011**
	Field Note: There were 85 birth occurence for 15-17 years old in RMI. Majuro : 68 Ebeye: 11 Outer Islands: 6	

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	75.0	77.0	50.0	50.0	50.0
Annual Indicator	75.1	26.2	30.1	33.8	
Numerator	638	215	227	245	
Denominator	849	822	753	725	
Data Source	Dental Program	Dental Program	MCH Program	MCH Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**

Field Note:
Dental Program have visited 9 elementary schools.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	8.0	7.0	7.0	0.0	0.0
Annual Indicator	0.0	14.1	0.0	4.7	
Numerator	0	3	0	1	
Denominator	22,877	21,253	21,253	21,253	
Data Source	Office of Health Planning, Policy, and Statistics	Office of Health Planning, Policy, and Statistics	Office of Health Planning, Policy, and Statistics	Office of Health Planning, Policy, and Statistics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: There is no deaths to children aged 14 years and younger cause by motor vehicle crashes.	
2.	**Field Name:**	**2012**
	Field Note: Age distribution: 1 year old - 1, 3 years old - 1, and 14 years old - 1	
3.	**Field Name:**	**2011**
	Field Note: There is no case.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 NPM# 10. Please review your data to ensure this is correct.

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	90.0	92.0	70.0	74.0	78.0
Annual Indicator	90.2	62.0	80.5	81.5	
Numerator	1,317	1,028	1,213	1,115	
Denominator	1,460	1,658	1,506	1,368	
Data Source	Well Baby Clinic	Well Baby Clinic	MCH Program	MCH Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	50.0	55.0	55.0	70.0	72.0
Annual Indicator	66.9	35.1	66.9	68.1	
Numerator	995	462	877	816	
Denominator	1,487	1,316	1,310	1,199	
Data Source	New Born Hearing Screening	New Born Hearing Screening program	New Born Hearing Screening program	New Born Hearing Screening program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**

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

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	1.0	1.0	1.0	1.0	1.0
Annual Indicator	1.9	1.0	1.2	1.2	
Numerator	500	253	300	300	
Denominator	26,748	24,274	24,274	24,274	
Data Source	Office of Health Planning and Statistics	Office of Health Planning and Statistics	Office of Health Planning and Statistics	Office of Health Planning and Statistics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator	0.0	0.0	0.0	0.0	
Numerator	0	0	0	0	
Denominator	6,353	7,669	7,669	7,669	
Data Source	MCH Program	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: RMI does not have WIC under the Compact of Freely Associated with the U.S.A.	
2.	**Field Name:**	**2013**
	Field Note: RMI does not have WIC under the Compact of Freely Associated with the U.S.A.	
3.	**Field Name:**	**2012**
	Field Note: RMI does not have WIC under the Compact of Freely Associated with the U.S.A.	
4.	**Field Name:**	**2011**
	Field Note: RMI is not eligible for WIC.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 NPM# 14. Please review your data to ensure this is correct.
2.	A value of zero has been entered for the numerator for year 2014 NPM# 14. Please review your data to ensure this is correct.

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	2.0	2.0	2.0	2.0	2.0
Annual Indicator	2.0	1.9	1.9	1.9	
Numerator	29	25	25	23	
Denominator	1,487	1,316	1,316	1,199	
Data Source	MCH Program	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	20.0	40.0	20.0	0.0	0.0
Annual Indicator	48.4	0.0	0.0	0.0	
Numerator	3	0	0	0	
Denominator	6,202	6,262	6,262	6,262	
Data Source	Office of Health Planning, Policy & Statistics	Mental Health Annual Report	Mental Health Annual Report	Vital Statistics Information System	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: There is no suicide deaths in ages 15 through 19.	
2.	**Field Name:**	**2013**
	Field Note: There is no suicide deaths in ages 15 through 19.	
3.	**Field Name:**	**2012**
	Field Note: There is no suicide deaths in ages 15 through 19.	
4.	**Field Name:**	**2011**
	Field Note: There were 3 males who committed suicide by hanging. 2 are from Majuro and 1 from the Outer Islands. 2 - 19 years old and 1 - 16 years old.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 NPM# 16. Please review your data to ensure this is correct.

2.	A value of zero has been entered for the numerator for year 2014 NPM# 16. Please review your data to ensure this is correct.

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	65.0	2.0	2.0	2.0	1.0
Annual Indicator	40.0	0.0	0.0	0.0	
Numerator	4	0	0	0	
Denominator	10	17	9	6	
Data Source	Office of Health Planning, Policy & Statistics	Health Planning	Health Planning	Vital Statistics Information System	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: We only have 2 hospitals which handles birth deliveries including high risk deliveries. Our hospitals are not level III hospitals or subspecialty perinatal centers.	
2.	**Field Name:**	**2013**
	Field Note: We only have 2 hospitals which handles birth deliveries including high risk deliveries. Our hospitals are not level III hospitals or subspecialty perinatal centers.	
3.	**Field Name:**	**2012**
	Field Note: We only have 2 hospitals which handles birth deliveries including high risk deliveries.	
4.	**Field Name:**	**2011**
	Field Note: We only have 2 hospitals which handles high risk deliveries.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 NPM# 17. Please review your data to ensure this is correct.

2.	A value of zero has been entered for the numerator for year 2014 NPM# 17. Please review your data to ensure this is correct.

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	55.0	50.0	52.0
Annual Indicator	34.3	40.0	46.4	35.6	
Numerator	510	526	608	427	
Denominator	1,487	1,316	1,310	1,199	
Data Source	MCH Program	MCH Program	MCH Program	MCH Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

Form 10d

State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Marshall Islands

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

	2011	2012	2013	2014	2015
Annual Objective	5.0	10.0	6.0	5.0	5.0
Annual Indicator	11.2	6.9	8.8	8.6	
Numerator	413	232	309	301	
Denominator	3,694	3,359	3,506	3,506	
Data Source	Office of Health Planning, Policy, & Statistics	Office of Health Planning, Policy, & Statistics	Office of Health Planning	Office of Health Planning	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 2 - To reduce the maternal mortality rate

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator	1.3	0.0	0.8	0.8	
Numerator	2	0	1	1	
Denominator	1,487	1,316	1,310	1,199	
Data Source	Office of Health Planning, Policy & Statistics	MOH Annual Report	MOH Annual Report	Vital Records Information System	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: There is one maternal death which is due to pulmonary edema secondary to Chronic Hypertensive Vascular Disease. This patient was enrolled in our high-risk pregnancy clinic and has successfully delivered her baby and was discharged without complications. However, two days post-partum – she suddenly developed pulmonary edema	
2.	**Field Name:**	**2011**
	Field Note: In FY2011, there were 2 maternal deaths. The 1st case was a 34 years old that died because of disseminated intravascular coagulation and amniotic fluid embolism. Second is a 43 years old that died because of amniotic fluid embolism with term pregnancy. In FY 2010, we have 2 maternal deaths. Post partum hemorrhage and retained placenta are the causes of death for the two maternal deaths. One died in Majuro Hospital which is a 23 year old pregnant woman and the other one died in Outer Islands which is a 35 year old pregnant woman. In FY 2009, we have 4 maternal deaths. Preeclampsia, post partum hemorrhage, obstructive labor and gestational hypertension are the causes of these 4 maternal deaths.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2012 SPM# 2. Please review your data to ensure this is correct.

SPM 3 - To reduce the infant mortality rate

	2011	2012	2013	2014	2015
Annual Objective	24.0	22.0	19.0	18.0	16.0
Annual Indicator	22.9	19.8	19.8		
Numerator	34	26	26	12	
Denominator	1,487	1,316	1,310	1,199	
Data Source	Office of Health Planning, Policy & Statistics	MOH Annual Repor	MOH Annual Report	Vital Records Information System	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: In FY2013, there were 23 infant deaths. The top 5 leading cause of infant deaths are premature, pneumonia, sepsis, malnutrition, Congestive heart failure.	
2.	**Field Name:**	**2011**
	Field Note: In FY2011, there were 24 infant deaths in Majuro, 3 infant deaths in Ebeye, and 7 infant deaths in the Outer Islands. The top 5 leading cause of death for infant deaths are premature, malnutrition, pneumonia, asphyxia/sepsis, and gastroenteritis/drowning.	

Data Alerts: None

SPM 4 - To increase the percentage of teenage (15-17 years old) acceptors of modern contraception

	2011	2012	2013	2014	2015
Annual Objective	30.0	10.0	10.0	15.0	15.0
Annual Indicator	2.0	2.4	3.2	6.5	
Numerator	77	73	97	197	
Denominator	3,871	3,021	3,021	3,021	
Data Source	MCH Program/OHPPS	Family Planning Program	Family Planning Program	Family Planning Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 5 - To increase the percentage of mothers who breastfeed their newborns at 12 months after delivery.

	2011	2012	2013	2014	2015
Annual Objective	82.0	82.0	88.0	88.0	88.0
Annual Indicator	82.0	88.2	88.6	87.9	
Numerator	493	768	758	1,096	
Denominator	601	871	856	1,247	
Data Source	Well Baby Clinic	Well Baby Clinic	Well baby clinic	Well Baby Clinic	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 6 - To increase the percentage of mothers who receive nutrition counseling during prenatal care.

	2011	2012	2013	2014	2015
Annual Objective	96.0	93.0	96.0	96.0	96.0
Annual Indicator	92.4	96.0	94.5	98.7	
Numerator	1,374	1,263	1,238	1,183	
Denominator	1,487	1,316	1,310	1,199	
Data Source	RH Clinics	RH Clinics	RH Clinics	RH Clinics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 7 - To increase the number of women who are screened for cervical cancer.

	2011	2012	2013	2014	2015
Annual Objective	20.0	16.0	33.0	33.0	33.0
Annual Indicator	14.2	15.3	15.6	18.6	
Numerator	1,807	1,953	1,989	2,365	
Denominator	12,690	12,743	12,743	12,743	
Data Source	MCH Program	MCH Annual Report	MCH Annual Report	MCH Annual Report	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 9 - To decrease overweight and obese school children by 5% yearly.

	2011	2012	2013	2014	2015
Annual Objective	40.0	30.0	50.0	50.0	45.0
Annual Indicator	11.0	61.2	65.3	57.4	
Numerator	222	1,300	1,388	1,324	
Denominator	2,019	2,125	2,125	2,305	
Data Source	School Health	School Health	School	MCH Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   Our partner in conducting this activity had a change of activities in 2014. The Ministry of Health Staff conduct the health assessment as much as we can. We were not able to cover all schools.

2. **Field Name:** **2011**

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

Data Alerts: None

SPM 10 - To improve accessibility to the MCH/CSHCN services for children 0-21 and their families.

	2011	2012	2013	2014	2015
Annual Objective	90.0	82.0	82.0	85.0	85.0
Annual Indicator	79.2	84.9	86.6	85.1	
Numerator	408	450	459	447	
Denominator	515	530	530	525	
Data Source	MHC Program	MCH Program	MCH Program	MCH program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 11 - To increase the percentage of mothers who access prenatal care in the first trimester of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	55.0	50.0	52.0
Annual Indicator	34.3	40.0	46.4	35.7	
Numerator	510	526	608	427	
Denominator	1,487	1,316	1,310	1,195	
Data Source	MCH Program	MOH Annual Report	MCH Program	MCH Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

Form 11

Other State Data

State: Marshall Islands

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Marshall Islands

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table