

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

Marshall Islands

**FY 2020 Application/
FY 2018 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



Republic of the Marshall Islands
MINISTRY OF HEALTH & HUMAN SERVICES
Office of the Secretary
P.O. Box 16 Majuro, Marshall Islands 96960
Phone: (692) 625-5660/5661/3355/3399
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July 12, 2019

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), MCH Program submits to your office the RMI maternal and Child Health Block Grant Application and Annual Report.

The Ministry of Health is very much aware of the Maternal and Child Health Bureau willingness in supporting the MCH services in RMI. The technical assistance provided by your office has greatly helped the MCH program in providing services to our people.

Should you need any clarifications, please don't hesitate to contact our office and program.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jack Niedenthal', with a large flourish extending to the right.

Jack Niedenthal
Secretary of Health & Human Services

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

RMI MCH BLOCK GRANT EXECUTIVE SUMMARY

Mission statement:

The mission statement of the RMI Ministry of Health is "To provide high quality, effective, affordable, and efficient health services to all people of the Marshall Islands, through a primary care program to improve the health statistics, and build the capacity of each community, family and the individual to care for their own health". With this mission statement, the MCH Program provides, delivers and promote the wellness of women, infants, children including children with special health care needs, adolescents, and their families through high quality, effective, affordable, and efficient health services

STATE PRIORITIES

Women's /Maternal Health:

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

NPM1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objective 1: Increase number of women with preventive medical visits by 5% yearly.

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

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

SPM 4 Percent of Women ages 25-49 yrs old screened for cervical cancer.

Objective 2: Increase percentage of women ages 25-49 yrs old screened for cervical cancer by 5% yearly.

Strategy: Continue the implementation of the Cervical Cancer Screening database for data collection and reporting

Strategy: Increase public awareness of the cervical cancer including risk factors, prevention screening and treatment

Strategy: Establishment of referral system for patients with abnormal papsmear or VIA findings

SPM 6 Percent of women ages 15-44 years old that use family planning services

Objective 3: Increase percentage of women ages 15-44 years old that use family planning services by 5% yearly.

Strategy: Increase public awareness of the Family Planning Services

Strategy: Continue the after 5 pm Family Planning Clinic

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

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

Objective 4: Increase pregnant women that received dental check up by 5% yearly

Strategy: Strengthen referral of pregnant women to Dental Services

Strategy: Support the Dental Services team in providing outreach mobile visits to the Outer Islands Health Centers.

Perinatal/Infant Health:

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

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

Objective: By 2020, increase of mothers that report exclusive breastfeeding of infant up to 6 months of age by 10%

Strategy: Continue to conduct proper breastfeeding training in hospitals, clinics and health centers

Strategy: Increase community awareness on benefits of breastfeeding and proper breastfeeding

SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening

Objective: Increase the percentage of newborn screened for Congenital Hypothyroidism by 5% yearly

Strategy: Develop the clinical guidelines for Congenital Hypothyroidism newborn screening treatment and referrals.

Strategy: Coordinate with the Laboratory Department to ensure that test will be conducted and supplies are available.

Strategy: MCH Program will work with mHIS developer to include the newborn screening in the hospital information system.

SPM 8 Percent of newborn tested for congenital cytomegalovirus (CMV)

Objective: Increase the percentage of newborn screened for congenital cytomegalovirus (CMV) by 5% yearly

Strategy: Develop the clinical guidelines for congenital cytomegalovirus (CMV) newborn screening, treatment and referrals.

Strategy: Coordinate with the Laboratory Department to ensure that test will be conducted and supplies are available.

Strategy: MCH Program will work with mHIS developer to include the newborn screening in the hospital information system.

SPM 9 Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

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

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

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

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

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

Child Health:

Priority Need: Improve child health through early childhood developmental screening and vaccinations

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

Objective: By 2020, increase the number of children ages 9 through 35 months, who received developmental screening.

Strategy: Implement the new well baby clinic standardized developmental tool in the two main hospitals and all the health centers.

Strategy: Implement data system to capture and monitor developmental screening information and referrals.

Strategy: Create and distribute new baby passport where monitoring of developmental tools is included.

Strategy: Strengthen referral of children with behavioral and emotional disorder to Behavioral Health

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

Objective: Increase immunization coverage for children 19 to 35 months old by 4% yearly

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

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

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

Priority: Promote child safety in the community.

Objective: By 2020, MCH Program with community partners will conduct at least 3 community campaigns on awareness and promotion of child safety within the community

Strategy: Community and media awareness and health education on non-fatal injuries, first aid treatment and child safety against motor vehicle accidents, fall, burn, drowning, choking, and other injuries

Strategy: Work with the Public School System on child safety policies and awareness education.

Adolescent Health:

Priority Need: Improve adolescent health through promotion of adolescent well-being and reducing teen pregnancy

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

Objective: Increase HPV coverage rate for 13 years old female by 5% yearly

Strategy: Make HPV Vaccination Routine Vaccine to 11-12 yrs old.

Strategy: Strengthen HPV Vaccination messages to the community in partnership with Cancer Program

Strategy: Conduct meetings with Parent and Teachers Association (PTAs) to provide awareness and health education on HPV vaccines and cervical cancer

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

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

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

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

Strategy: Family Planning commodities and counselling training to MCH nurses, Family Planning nurses and School Nurses

Children with special health care needs:

Priority Need: Improve enrolment and special care of CHSCN through developmental screening and referrals to proper care

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

Objective: By 2020, increase number of children with special health care needs referred to proper medical management by 5% yearly

Strategy: Develop and implement the Birth Defects Registry

Strategy: Develop and implement clinical management guidelines for CSHCN referrals

ACCOMPLISHMENTS

Maternal/Women Health - The MCH continue to increase awareness on the importance of preventive screenings such as cervical cancer screening, preconception and early prenatal care. The program prioritized addressing barriers to care.

Accomplishments:

- Team established for planning of cervical cancer screening.
- After dark cervical and breast cancer screening
- Continue the cervical cancer screening to hard to reach population, women in the outer islands using VIA

- Canvasback mission team visit (OBGYN)
- 1st Cancer Summit in the Pacific Islands was held in Majuro
- Increase awareness of cancer screening provided by the Ministry

Challenges:

- Low rate of women seeking preventive healthcare.
- Limited number of trained staff for VIA screening.
- Low rate of women and men using family planning methods.
- Low rate of women seeking prenatal care during 1st trimester

Perinatal/Infant Health: Continued activities with focused on increasing promotion of breastfeeding and development of available newborn screening.

Accomplishments:

- 100% of women were given breastfeeding counselling during first booking.
- >90% of infants completed newborn hearing screening before discharge from the hospital.
- Quarterly audiology visits for referrals
- ENT mission visit to children with hearing problem
- Free hearing aid given to children.
- 98% of births in 2018 are delivered by skilled attendants
- Practice the “First Embrace” where the newborn has immediate skin to skin with the mother

Challenges

- Lack of newborn screening in Outer islands
- Lost to follow up of patients with hearing problem
- 35% of children under five are stunted
- Only 42% of children under 6 months are exclusively breastfed
- Just 30% of children are fed a minimum acceptable diet

Child Health: The MCH program in collaboration the immunization program focused on developmental screening among children and promote routine vaccinations at the clinic, schools and communities.

Accomplishments:

- Developmental screening tool developed.
- There is 31% increase of complete immunization coverage in 2018.
- Outreach visits to schools and communities.

Challenges:

- Patient migration
- Lack of reliable transportation to the Outer Islands
- Limited or lacking capability to manage vaccine storage in the Outer Islands
- Lack of awareness on importance of vaccination.
- lack of referral process for patients with developmental delays

Adolescent Health: Partnership and collaboration with Public School system and Youth to Youth in Health to improve adolescent health outcomes.

Accomplishments:

- Presentations to high schools on FP methods and STI services
- Peer to peer presentation on teenage pregnancy.
- Presentation to agencies recruiting out of school male/female on SRH, FP and STI
- Formation of HPV task group that will lead the improvement of HPV vaccination for 11-12 yrs old and inclusion of HPV vaccine as part of required immunization.

Challenges:

- Low number of teenagers coming in for FP services
- Low number of teenagers coming in for preventive annual checkups.

Children with special health care needs: Services provided for CSHCN thru collaboration with the Public school system, Early Hearing Detection and Intervention program services for Children 0-3 yrs old. Program also coordinates with Shriners Hospital.

Accomplishments:

- Collaboration with Shriners' outreach clinic for families with children who need services to be referred.
- Case management on cases seen by Shriner's mission.
- Enrollment of children for EHDl program
- MCH program partnership with Disability group

Challenges:

- Lack of specialty care on island leading to off island referrals.

Cross-cutting: The program in collaboration with the dental department provides oral preventive services to pregnant women, children in school and in the communities in the outer islands.

Accomplishments:

- All preventive services for pregnant women, children (schools/communities) are free.
- Preventive services at the schools.

Challenges:

No preventive services in the outer islands due to lack of power supply.
Less children coming in for annual oral health exam.
Less pregnant women with preventive dental visit.

Challenges in the RMI

The Marshal Islands face great challenges in the delivery of basic health services to the underserved population in

the outer islands due to limited transportation to the isolated and scattered nature of the islands and atolls. Local airline is unreliable due to mechanical problems.

Nutrition amongst children is still an issue. The survey conducted in 2017 in collaboration with UNICEF showed that 35% of children in the Marshall Islands are stunted. Exclusive Breastfeeding is still a challenge, the program will take action to teach the community on importance of exclusive breastfeeding and proper nutrition. People should also be made aware of the 1st one thousand days of life.

People mainly depended on cheaper canned goods than the vegetables, fruits and other local foods. Fresh fruits and vegetables are exported with very high prices. The high rising sea level and drought also destroy local crops which affects food security.

Even with the increase of minimum wage, it doesn't compensate the increasing cost of living in RMI. Fuel cost is at \$5.35/gal. A sack of rice is \$11.00.

RMI continue to experience outbreaks of Mumps, Hepatitis A and Conjunctivitis.

Below is a summary of the key issues related to the nutrition and health situation of children in RMI:

- 35% of children under five are stunted
- 33% of Marshallese children 6 to 59 months are anaemic
- 60% of children are Vitamin A deficient

Poor IYCF practices are major contributors to this a level of undernutrition

- Only 60% of children are breastfed within one hour of birth
- 20% of children receive pre-lacteal feeds
- Only 42% of children under 6 months are exclusively breastfed
- Just 30% of children are fed a minimum acceptable diet

Poor maternal nutrition status contributes to child morbidity and mortality

- 80% of Marshallese women are overweight and nearly half are obese
- 21% of women in RMI are diabetic
- 38% of pregnant women are anaemic

Poor WASH (Water, Sanitation, Hygiene) practices pose a threat to child development and survival

- 41% of households do not use an appropriate treatment method before consumption
- 11% of the population uses a non-improved facility or practices open defecation
- Just 56% of rural households has access to improved sanitation facilities

III.A.2. How Federal Title V Funds Support State MCH Efforts

Title V support to RMI MCH Program

Human Resources

40% of the funds are used to support the Human Resources of MCH Program to implement activities. 5 staff are currently getting paid under the program - 2 from mother and infant, 2 from children and adolescent and 1 from CSHCN component. These dedicated staffs are providing services in the clinics and outreach mobile visits.

Travel

Title V support travel for program staff and other related staff to attend mandatory technical assistance meetings, block grant review and other related conferences/training for the program for capacity building.

We were able to bring Children with Special Health Care Needs and family escort from the Outer Islands to Majuro or Ebeye for follow up and presentation to Shriners' before they can get referred to Shriners' Hospital. There were 25 CSHCN patients referred to Shriners with funding from MCH Program.

Women in the Outer Islands who are at risk with health condition like abnormal cervical cancer screening result, pregnant women with high risk pregnancy were supported for domestic travel to the main hospital where better care are given to them.

Activities

With the Title V funding, we are able to provide prenatal care, women's health, family planning, cancer screenings, children with special health care needs, dental services, and well baby clinic.

We provided continuing education on breastfeeding, 1st 1000 days of lives, nutrition, Vitamin A and de-worming, and family planning commodities. Partnership with Youth to Youth in Health and Women Together in Marshall Islands are ongoing especially on community awareness. Title V provided support on IEC materials.

Bringing MCH services to the Outer Islands where health care is limited. Specialized MCH services are delivered in the Outer Islands along with other programs like HIV/STI, Immunization Program, TB and Leprosy.

TB/Leprosy Mass Screening: MCH Program assisted the project with staff, medical and office supplies. There were 22,402 or 82% of the 27,275 Majuro population tested and interviewed for TB, Leprosy and NCD. 19,136 or 85% of the 22,402 completed their screening.

Staff in MCH Program assisted in the Nutrition-WASH (Water, sanitation, and hygiene.) Survey - Formative Research on Nutrition-WASH social norms and practices. qualitative information available to explain the underlying social and behavioral determinants associated with these practices. Report is available for sharing.

Medical and Laboratory Supplies were purchased for the program's need to serve the MCH population.

III.A.3. MCH Success Story

Success story for patient A and patient B: Extra Special

This is a success story of 2 patients, ages 11 and 8 who were referred to Shriners' Hospital in FY 2018 for surgery of the hands for extra digit and skin craft due to burn on chest and lower extremities.

CSHCN submitted the cases to Shriners' Hospital for referral. Cases were approved by Shriners' for surgery. Through CSHCN funds, MCH Program was able to support travel for patient A, Patient B and their family escorts to Shriners' Hospital to undergo surgery. After a successful surgery, patient A, who had the extra thumb removed was happy for no one will be bullying him anymore. For patient B, he now has no problems.

Success Story: Nutrition & WASH Survey in the Republic of the Marshall Islands

RMI has a better understanding of the problem on poor nutrition and underlying social and behavioral determinants associated with these practices in MCH population. The report was used in the RMI Multisectoral Early Childhood Development Project funded by World Bank.

Summary of Key Nutrition & WASH Issues

Below is a summary of the key issues related to the nutrition and health situation of children in RMI:

- 35% of children under five are stunted
- 33% of Marshallese children 6 to 59 months are anaemic
- 60% of children are Vitamin A deficient Poor IYCF practices are major contributors to this a level of undernutrition
- Only 60% of children are breastfed within one hour of birth
- 20% of children receive pre-lacteal feeds
- Only 42% of children under 6 months are exclusively breastfed
- Just 30% of children are fed a minimum acceptable diet Poor maternal nutrition status contributes to child morbidity and mortality
- 80% of Marshallese women are overweight and nearly half are obese
- 21% of women in RMI are diabetic
- 38% of pregnant women are anaemic Poor WASH practices pose a threat to child development and survival
- 41% of households do not use an appropriate treatment method before consumption
- 11% of the population uses a non-improved facility or practices open defecation
- Just 56% of rural households has access to improved sanitation facilities

Conducting comprehensive qualitative research to examine the underlying social norms, beliefs and behavioral factors that influence maternal and child feeding practices and WASH-related behaviors at the individual, family, and society levels, as well as the effects of food insecurity, will allow for the development of effective strategies to improve the status of maternal and child nutrition and health in the Republic of the Marshall Islands.

III.B. Overview of the State

Overview of the State – Republic of the Marshall Islands

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

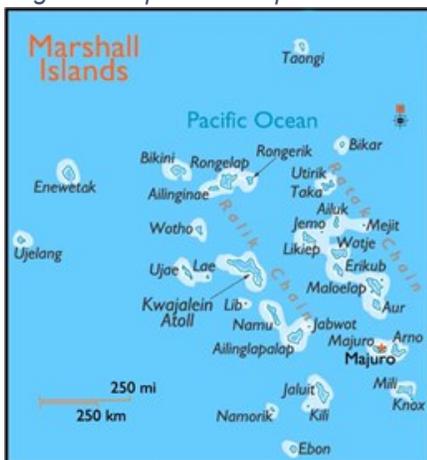
The RMI Ministry of Health and Human Services' (MOHHS – formerly known as Ministry of Health) MCH Program is responsible to facilitate the needs assessment process and administers MCH grant funds. The mission statement of the Ministry is "To provide high quality, effective, affordable, and efficient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

Geography

The Marshall Islands are located in the Central Pacific Ocean, approximately 2,000 miles southwest of Hawaii and 1,300 miles southeast of Guam. They are comprised of 29 scattered chains of remote atolls, the Eastern Ratak (Sunrise) and Western Ralik (Sunset). The total land area is 181 square kilometers and has some 370 km of coastline (less than 0.01 percent of the total surface area). The Marshall Islands face great challenges in the delivery of basic health services. Transportation and communications are limited by the isolated nature of many of the islands and atolls. Two-thirds of the population lives on the two major urban atolls, Majuro and Kwajalein (including Ebeye Island). Population densities in some of the urban settlements exceed 28, 000 people/km². More than half of the RMI total population lives in Majuro.

The Marshallese is of Micronesian origin. The matrilineal Marshallese culture revolves around a complex system of clans and lineages tied to land ownership. The Marshall Islands has an area of 1826 square kilometers and is composed of two coral atoll chains in the Central Pacific.

Figure 1 Map of the Republic of the Marshall Islands



The Marshall Islands is a parliamentary democracy, constitutionally in free association with the United States of America. It has a developing fisheries and service-oriented economy. It is mainly a Christian nation with the majority of the population being protestant followed by Catholic and other religions. The two main urban centers (Majuro and Ebeye-Kwajalein atoll) have paved roads and with piped water and a sewer system. The island of Ebeye is

considered to be one of the most densely populated places in the world, only second to Bangladesh/Dakka. While the majority of the RMI population is concentrated on the two main urban centers, it is important to note that a great portion is dispersed around the many islands/atolls. This makes the provision of comprehensive health services to the entire population a challenge. However, the development of fundamental services such as health care and education has, over many decades, developed and improved in the remote islands. Health services capacity is further enhanced through provision of on-site health visits and follow-up care from the urban centers through field trips including availability of case evacuation and referrals to the central hospital. This established system is under RMI constitutional mandate, a responsibility of the Government.

Population

The total population count of the 2011 census is 53,158; which increased only by 2,300 people since the last census in 1999. The slow growth of the population in the country is primarily caused by the emigration of the Marshallese to the United States and elsewhere. (UNFPA, 2014) The population for 2017 is 55,396. The Marshall Islands has a young population. 66% of RMI Population is less than 30 years old.

In FY2017, the MCH Program has served the following population:

1. Pregnant Women : 1,257
2. Infant <1 year old : 989
3. Children from 1 to 22 years old: 8,707
4. CSHCN : 156
- 5 Female Population 15-44 yrs old:1,984

Percentage of Populations Served by Title V

Pregnant Women Notes:

Number of pregnant women: 1,453

Population (Form 5b reference data): 1816

% served: 80%

Infant <1 year old

Number of <1 yr old with encounters for Immunization and Well baby clinic: 1,515

% served: 85%

Children 1 through 21 Years of Age

Number of children served : 11,363

Population (RMI Projected population): 34,434

% served: 33%

Children with Special Health Care Needs

Number of children served : 156

Population (registered CSHCN): 156

% served: 100%

Others

Number of population served: 1,984

Population of 22 and above (RMI Projected population): 38,323

% served: 8%

Projected Population, 2011 – 2015, EPPSO

Age Group	2011 Census Population		2012		2013		2014		2015	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-4	4,031	3,712	4048	3736	4019	3724	3958	3686	3882	3636
5-9	3,622	3,395	3688	3454	3769	3518	3850	3577	3908	3610
10-14	3,385	3,108	3472	3191	3513	3243	3522	3271	3531	3297
15-19	2,417	2,314	2480	2349	2642	2469	2854	2632	3059	2796
20-24	2,614	2,480	2507	2357	2349	2206	2187	2061	2075	1958
25-29	2,159	2,245	2177	2231	2208	2208	2236	2174	2231	2117
30-34	1,876	1,913	1864	1926	1839	1922	1811	1910	1789	1892
35-39	1,587	1,549	1589	1566	1593	1587	1598	1610	1599	1631
40-44	1,419	1,366	1422	1370	1413	1365	1400	1359	1388	1357
45-49	1,189	1,155	1207	1184	1226	1203	1244	1218	1259	1229
50-54	1016	914	1032	944	1039	972	1045	1003	1053	1034
55-59	815	761	846	796	864	809	881	816	895	825
60-64	583	469	625	521	651	572	674	621	693	664
65-69	284	238	324	269	366	301	408	334	448	371
70-74	131	119	137	118	147	129	162	147	182	169
75+	115	177	117	182	119	182	121	181	123	180
Total	27,243	25,915	27,534	26,193	27,756	26,410	27,949	26,600	28,115	26,765

Projected Population, 2016-2018, EPPSO

Age Group	2016		2017		2018		2019	
	Male	Female	Male	Female	Male	Female	Male	Female
0-4	3814	3595	3693	3480	3579	3373	3594	3387
5-9	3911	3594	3926	3618	3898	3606	3914	3621
10-14	3563	3337	3624	3393	3705	3457	3720	3471
15-19	3219	2932	3315	3025	3356	3077	3370	3090
20-24	2049	1926	2125	1975	2288	2095	2297	2104
25-29	2176	2026	2061	1900	1905	1750	1912	1757
30-34	1781	1869	1793	1846	1824	1824	1831	1831
35-39	1593	1645	1577	1650	1552	1646	1558	1653
40-44	1381	1362	1381	1377	1385	1397	1391	1403
45-49	1267	1236	1266	1237	1257	1232	1262	1237
50-54	1064	1060	1080	1083	1099	1102	1103	1107
55-59	907	840	917	862	924	890	927	894
60-64	712	697	731	719	748	732	751	735
65-69	482	411	510	455	534	501	536	503
70-74	208	194	238	220	272	248	273	249
75+	127	182	132	187	140	196	140	196
Total	28,254	26,906	28,370	27,026	28,465	27,126	28581	27237

Source: EPPSO: Economic Planning, Policy and Statistics Office

Female, age 15-44 years old Population by Reproductive Age

Age Group	2011 Census	2012	2013	2014	2015	2016	2017	2018	2019
15-19	2,314	2,349	2,469	2,632	2,796	2,932	3,025	3,077	3,090
20-24	2,480	2,357	2,206	2,061	1,958	1,926	1,975	2,095	2,104
25-29	2,245	2,231	2,208	2,174	2,117	2,026	1,900	1,750	1,757
30-34	1,913	1,926	1,922	1,910	1,892	1,869	1,846	1,824	1,831
35-39	1,549	1,566	1,587	1,610	1,631	1,645	1,650	1,646	1,653
40-44	1,366	1,370	1,365	1,359	1,357	1,362	1,377	1,397	1,403
Total	11,867	11,799	11,757	11,746	11,751	11,761	11,773	11,790	11,838
Source: EPPSO RMI Projected Population, 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 attends school, although many do not complete primary school and very few go on to complete secondary or higher education. Starting at age 14, attendance rates decline noticeably for all children.

Educational Attainment in the RMI, 1999 and 2011 comparison

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

Source: RMI Household Census 2011

Enrollment Status

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

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

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

Nuptiality

Figure 2: Population 12 years old and over by marital status, RMI: 2011

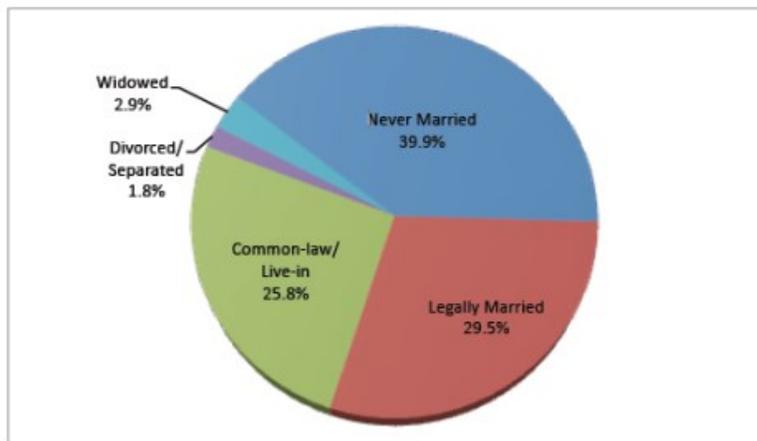


Figure 2 shows the distribution of household population 12 years old and over by marital status. More than half of this population (55.4%) was married, with 29.5 percent legally married and 25.8 percent living in a common-law union or live-in status. Almost two-fifths were never married and some 3 percent were widowed and 1.8 percent were either divorced or separated. Over three-quarters of widowed persons were women; this is attributed to the difference in the age of spouses at the time of marriage (women tended to be younger than their spouses) and a higher life expectancy at birth for women compared to men. The percentage of widowed women increased with age as they tended to remarry less frequently upon divorce or the death of a spouse.

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 Care Service System

The Marshall Islands has a well-developed/organized primary/preventive and public health system. There are two main hospitals located in the two urbanized islands in the Kwajalein (Ebeye Hospital) and Majuro (Majuro Hospital) Atolls. Including the two main hospitals, there are 60 health centers/health clinics located in the various islands that make up the Marshall Islands. The two main hospitals serve the urban areas including the surrounding islands through referrals and medical evacuation. The two hospitals provide primary/secondary and some tertiary care. However, most tertiary care patients are referred off-islands to hospitals in the Philippines 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 Division of Public Health and provides the mandated services for the MCH population.

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

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

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

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

Taiwan Health Center is services provide by the Republic of China, Taiwan. THC coordinate and manage the Taiwan Health Missions in RMI. Missions ranges from ophthalmology, orthopedic, ENT, Urology and other medical needs that the Ministry request the center. There are 3-4 missions a year provided in Majuro and Ebeye. THC is also bringing experts in diabetes, tuberculosis, parasitic and other specialists to provide training and expertise.

Wellness Center is managed by Canvasback mission with funding from the RMI Government. Wellness Center sells healthy vegetarian breakfast and lunch for an affordable price. Center also works closely with NCD Program and Community Lifestyle Program for diabetes management and education. Canvasback Mission provided two medical missions in 2018. Orthopedic and OBGYNE missions were conducted in Majuro Hospital in 2018.

Communication

Marshall Islands National Telecommunication Authority (MINTA) is the sole provider for voice and data communication. MOHHS contracted MINTA to purchase and install DAMA (Demand Assigned Multiple Access) Systems in the Outer Islands. 8 Health Centers in the Outer Islands were installed with the DAMA system from 2014 to 2015. There is a plan to install the next 10 health centers as soon as funding is approved. The DAMA sites will be used for voice and data. In 2016 and 2017, we will roll out the data collection and telehealth in the health centers with DAMA. The main challenge for communication is the high cost. Internet connection fee is very expensive in RMI. For Majuro Hospital, we pay \$10,000 per month for 20mbps of connection. \$600 per month in Laura Health Center and \$600 for Woja Health Center to connect for internet dsl. For Ebeye Hospital, we pay \$3,600 for the internet connection per month. A total of \$14,800 per month for all our internet connection. International calls are \$1.25 per minute. National Calls are \$0.50 per minute. But overall, we have better communication system compared to 5 years ago. Radio VHF connection is still our main communication in the Outer Islands. To collect information like weekly disease syndromic surveillance, birth and death occurrence and any unusual event, the Outer Islands main office in Majuro calls all 56 working health centers managed by the program in a weekly basis which is scheduled every Monday and Tuesday.

Transportation

Mode of transportation:

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

Food Security

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

The Republic of Marshall Islands (RMI) has been severely affected by rising food and fuel costs coupled with natural disasters. The dependency on imported fuel and food has led to high inflation rates. According to the RMI Food Security Policy (FAO, 2013), the food import in RMI goes up to 80-90% depending upon Islands. The population has seen rapidly increasing levels of food and nutrition related non communicable diseases, which impact negatively on health system, families and national economy.

The major constraints to food security in RMI are:

- Limited technical expertise in agriculture production with the Ministry of Resources and Development (MRD)
- Lack of improved agriculture and livestock production skills among growers

- Limited disease and pest control and surveillance capacity and practices in Agriculture production system
- Lack of food preservation/processing facilities, technologies and skills
- Limited awareness and knowledge on nutrition
- High vulnerability to natural disasters

III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

Title V support to RMI MCH Program

Human Resources

40% of the funds are used to support the Human Resources of MCH Program to implement activities. 5 staff are currently getting paid under the program - 2 from mother and infant, 2 from children and adolescent and 1 from CSHCN component. These dedicated staffs are providing services in the clinics and outreach mobile visits.

Travel

Title V support travel for program staff and other related staff to attend mandatory technical assistance meetings, block grant review and other related conferences/training for the program for capacity building.

We were able to bring Children with Special Health Care Needs and family escort from the Outer Islands to Majuro or Ebeye for follow up and presentation to Shriners' before they can get referred to Shriners' Hospital. There were 25 CSHCN patients referred to Shriners with funding from MCH Program.

Women in the Outer Islands who are at risk with health condition like abnormal cervical cancer screening result, pregnant women with high risk pregnancy were supported for domestic travel to the main hospital where better care are given to them.

Activities

With the Title V funding, we are able to provide prenatal care, women's health, family planning, cancer screenings, children with special health care needs, dental services, and well baby clinic.

We provided continuing education on breastfeeding, 1st 1000 days of lives, nutrition, Vitamin A and de-worming, and family planning commodities. Partnership with Youth to Youth in Health and Women Together in Marshall Islands are ongoing especially on community awareness. Title V provided support on IEC materials.

Bringing MCH services to the Outer Islands where health care is limited. Specialized MCH services are delivered in the Outer Islands along with other programs like HIV/STI, Immunization Program, TB and Leprosy.

TB/Leprosy Mass Screening: MCH Program assisted the project with staff, medical and office supplies. There were 22,402 or 82% of the 27,275 Majuro population tested and interviewed for TB, Leprosy and NCD. 19,136 or 85% of the 22,402 completed their screening.

Staff in MCH Program assisted in the Nutrition-WASH (Water, sanitation, and [hygiene](#).) Survey - Formative Research on Nutrition-WASH social norms and practices. qualitative information available to explain the underlying social and behavioral determinants associated with these practices. Report is available for sharing.

Medical and Laboratory Supplies were purchased for the program's need to serve the MCH population.

FY 2019 Application/FY 2017 Annual Report Update

From May 29 – June 1, 2018, MCH Program with SSDI Program support organized MCH 1st Bi-Annual Workshop.

Objectives of the Workshop:

1. MCH Block Grant Application
2. Needs Assessment
3. MCH Programs and partners 2017 update
4. Plan for 2019
5. Recommendations

Programs and partners that attended, participated and presented:

1. Vital Statistics Office
2. Immunization Program
3. Well Baby Clinic
4. Women and Maternal Health
5. Early Hearing Detection and Intervention Program
6. HIV/STI Program
7. TB Program
8. National Comprehensive Cancer Control Program
9. Maternity and Labor & Delivery Ward
10. Behavioral Health
11. Dental Services
12. Family Planning Services
13. Office of Health Planning, Policy, Preparedness and Epidemiology
14. SSDI Program
15. Ebeye MCH Program
16. Women United Together Marshall Islands
17. MIEpi – Marshall Islands Epidemiological Work Group
18. Kijle – Family oriented NGO

It was 4 days of compact and interactive agenda where each area of MCH Population Domain were discussed. A lot of success, challenges and ways forward. Unfortunately, Public School System was not able to attend due to previous commitment

Surveys conducted:

1. **Hybrid survey-** The RMI Hybrid Survey aimed to assess the prevalence of selected NCDs, risk factors, and substance use, which includes questions from validated instruments such as the BRFSS, STEPS, and National Health and Nutritional Examination Survey as well as locally developed questions as needed.

Objectives:

1. Inform the community on NCD and risk factor prevalence
2. Use these data to prioritize and tailor NCD prevention programs
3. Support further research on NCD risk and protective factors in RMI
4. Use these data to monitor progress in the fights against NCDs in RMI

Target group

Participants eligible for the RMI Hybrid survey include all RMI resident's male and female aged 18 years and over who were able to comprehend either English or Marshallese and provide consent.

Data collection

Data collection began on July 7, 2017 and ended on April 5, 2018. A total of 2869 respondents completed the survey and measurements. All interviews and measurements were performed by trained enumerators recruited by the Marshall Islands Epidemiology Prevention Initiative (MIEPI). Respondents answered questions about their alcohol and tobacco use, other substance use, dietary habits, physical activity, health access, oral health, health conditions, and cancer screening. Additionally, height and weight, fasting blood glucose, total cholesterol, and blood pressure were measured

2. **ICHNS** (Integrated Child Health and Nutrition Survey) - The principle survey design collected data on the current nutrition status of children under 5 years of age and their mothers and the key determinants of optimal nutrition status in the country at the national and urban/rural level.

The RMI ICHNS 2017 will enable stakeholders in RMI to more effectively plan, manage and monitor existing nutrition programs and determine where programmatic revision may be needed to address gaps and barriers to effective coverage. While a DHS was implemented in 2007 and a National Census in 2011, there is no updated national or sub-national representative survey that has ever been implemented to measure the prevalence of malnutrition and dietary patterns of young children and their mothers in the Republic of the Marshall Islands. The findings from the ICHNS 2017 will form the baseline for key nutrition indicators, which together with any future Demographic Health Survey conducted in RMI can provide evidence on progress towards achieving the Sustainable Development Goals. The general aim of the survey is to assess the status and influencing variables to nutrition status in under five children and their mothers in the Republic of the Marshall Islands.

The survey:

1. Examined the prevalence and identified the key determinants of stunting, overweight and wasting in young children and examine the prevalence of overweight, underweight and short stature in mothers of young children.
2. Established the current status of early child development, child functioning and child discipline practices in urban and rural children.

The survey was conducted in January 2017 to July 2017.

3. **Tuberculosis and Leprosy Mass Screening:**

1. Project Goals: HD, TB, and DM Screening for 90% of Majuro population, or 23,400 people.

2. Project Dates: Screening is projected to take place from June 2018-October 2018

- a. All Majuro adults and all Majuro children will undergo HD and TB screening.
- b. Children will get screening for HD and symptom screening for TB and a check for lymph node enlargement. If the child has lymphadenopathy or reports TB symptoms, then they will also be screened with an x-ray and a careful TB exposure history. Unless specifically requested, NCD screening will not be done on individuals under 20 years old.
- c. Adults will undergo TB symptom screen, and receive a CXR and Hansen's screen. As in Ebeye, sputum for TB will be collected if the CXR is significantly abnormal. Screening for TB will remain essentially unchanged in Majuro, including TB symptom screen and CXR for all adults, with additional TB screening for any child who reports TB symptoms. Individuals with an abnormal CXR will be asked to provide sputum (on-site collection) for rapid testing with GeneXpert in Majuro lab.

All positive TSTs are recommended to undergo latent TB infection treatment.

Findings and Recommendations:

Women/Maternal Health

In 2017, there are 69 new registered cancer patients. 44 (64%) are female cancer patients. Top 3 cancers for female population are cervical (19), breast (8), and uterine (4). For cancer deaths among female, 9 died of cervical cancer and 5 died of breast cancer. The MCH Program and partners highly recommends that this should be addressed. Early screening is the key to lower down the mortality and morbidity of female cancer deaths. In 2017, we launch the mass cervical cancer screening. It is a work in progress. Cancer Program is assisting MCH Program in bringing patients to the clinic and bringing

the clinic to the patients.

There is no increase in Family Planning users. Contraceptive prevalence rate is still at 16%. Male population is also not coming to the clinic. In 2017, there are 9 documented male users. We need to strengthen our Family Planning awareness and make sure that the services are available at all times.

Infant/Perinatal Health

Hearing screening is the main newborn screening that we have. It was recommended that we add PCR CMV-Saliva test and Congenital hypothyroidism in our newborn screening. We want to develop this area of infant health.

In 2017, 9% of 989 live births are preterm. 4 (22%) of the 18 infant deaths (or 400 per 1,000 live births) are premature. These could have been avoided. Only 33.5% of pregnant women in 2017 attended prenatal clinic at their 1st trimester. We included this area in the priority needs to give more attention. Good maternal health will benefit the babies. We will give incentives on pregnant mothers that attend clinic at 1st trimester and complete the prenatal visits.

Table 24: Infant Causes of Death, RMI, FY2017

Underlying Cause of Death	Count
Premature	5
Pneumonia	4
Sepsis	2
Asphyxia	2
Asthma	1
Congenital Heart Disease	1
Malnutrition	1
Meconium Aspiration	1
Meningitis	1
Prolonged Labor	1
Septicemia	1

Child Health

There are 9 children from 1 to 9 yrs old died in 2017. 2 deaths due to drowning, 1 vehicular accident, 1 laceration of the neck (murder), 3 malnutrition, 1 dehydration, 1 probable meningitis. Program will address this through improvement of Child Safety. We will work with partners to provide health education and awareness on non-fatal injuries, first aid treatment and child safety against motor vehicle accidents, fall, burn, drowning, choking, and other injuries

The Integrated Child Health and Nutrition (ICHNS) Survey 2017 revealed that stunting is a high public health concern in RMI with 35% of children under 5 years of age stunted and 10% of children severely stunted. The prevalence of stunting significantly increases with age and gender of the child with highest prevalence in children 12-35 months of age and boys having significantly higher prevalence of stunting (40%) compared to girls (31%, P<0.01). There was no significant difference in the prevalence of stunting by area with similar prevalence for both urban and rural areas. Child stunting is attributed to multivariate factors with the prevalence of child stunting in RMI associated with socio-economic status as well as maternal characteristics, child feeding practices, and child care practices. For this application, we will not include the activities on addressing the ICHNS survey because another survey will be conducted to assess the qualitative data of ICHNS

Adolescent Health

Teen Pregnancy is still high. In FY2017, 136 of 989 live births are from 15-19 yrs old (45 per 1,000 female age 15-19 yrs old). Program will work with partners especially Youth to Youth in Health to provide family planning services to this age group. After dark clinic will be available. Program needs to increase awareness among this age group, thru school presentations as well as community for those not in school.

FY 2018 Application/FY 2016 Annual Report Update

MCH Program conducted series of meetings with the team to update the State Priorities, needs of the program, strategy and activities. We have revised our State Priorities, objectives and strategies to make it easier to understand and achievable. We have also applied the pointers given during the review of MCH Block Grant Application.

During the meetings, MCH Director presented the 2017 Application and program update for 2015 and 2016. Out of these meetings, we have revised our State Priorities with the following:

<i>Improve women's health through preventive medical visit, cancer screening and comprehensive health care for preconception, prenatal and postpartum.</i>	Women/Maternal Health
<i>Improve perinatal/infant's health through promotion of breastfeeding, baby friendly hospital, implementation of Well Baby developmental screening, and improvement of immunization rates</i>	Perinatal/Infant Health
<i>Improve child health through early childhood developmental screening, and complete vaccinations</i>	Child Health
Promote child safety in the community	Child Health
Improve adolescent health through promotion of adolescent well-being (preventive medical visit, education on injury, suicide, drug, tobacco and alcohol use,) and reducing teen pregnancy	Adolescent Health
Improve enrollment and special care of CHSCN through developmental screening and referrals to proper care	Children with Special Health Care Needs
Improve oral health of children and women	Cross Cutting

Data and current activities for the last 5 years were presented to the team. Staff assigned in their respective domain discussed the plans for 2018. We have to prioritize activities to make sure it will be achievable, measurable and will be done in a timely manner.

Attendees:

Ministry of Health and Human Services: National Immunization Program, National Comprehensive Cancer Control Program, STD/HIV Program, Human Services, MCH Clinic Staff, SSDI Program.

Partners: Women United Together Marshall Islands, EHDI Program, Disability Group, Public School System, UNICEF

Reference: MCH Block Grant Application 2017/Annual Report 2015, MOH 3 years rolling Strategic Plan, FY2016 MOH Annual Report, EHDI 2016 Annual Report, NCCCP new 5 years grant application, SSDI Program Work Plan, Needs Assessment document

Women's/Maternal Health:

Most of the pregnant women tends to visit on their last trimester. Pregnant women from the Outer Island will have comprehensive prenatal care at their last trimester upon their arrival in Majuro where comprehensive prenatal care is available. Comprehensive prenatal care is provided in the two main hospitals which includes the following services: 1. Tests: Pap smear, GC, HIV, Hepatitis B, Syphilis and Chlamydia, blood chemistry, diabetes screening 2. individual counseling: all family planning methods, STIs/HIV, nutrition, personal hygiene, breastfeeding, 3. services: immunization, and dental. 4. Free prenatal medicines. Two OB/GYN in Majuro and 1 OB/GYN in Ebeye are providing specialty care. High risk case pregnant women are tracked and management to avoid maternal complications and death. MCH Program and National Comprehensive Cancer Control Program partnered in cervical and breast cancer screening where MOHHS engaged the churches to provide education and bring women to the hospital for their screening. We still continue to use VIA for Outer Islands cervical screening. Family Planning services are provided for free from counselling, testing and contraceptive methods.

Priority: Improve women's health through preventive medical visit, cancer screening and comprehensive health care for preconception, prenatal and postpartum.

NPM: Percent of Women with a past year preventive medical visit

Objective: By 2020, increase percentage of pregnant women with complete routine screening and treatment of Syphilis, Gonorrhea and Chlamydia by 5% yearly

Strategies:

- Conduct routine screening and testing of Syphilis, Chlamydia and Gonorrhea to pregnant women that visited prenatal clinics

- Refer pregnant women with positive Syphilis, Gonorrhea and Chlamydia screening to STI/HIV program for treatment and management

- Strengthen patient management tracking of cases.

- Strengthen coordination between MCH program and STI/HIV Program

ESM 1.1 - Percentage of women that understand the awareness talks on preconception, preventive medical visits, prenatal, post partum, healthy lifestyle and services provided by Ministry of Health

ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits

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

Objective: By 2020, increase percentage of pregnant women that had at least 4 prenatal visits by 5%

- Conduct community awareness to promote early booking of mothers before 12 weeks of gestation and mothers attend at least 4 Pre-Natal clinic visits before delivery

- Promote pre-natal classes at first booking in Prenatal Clinic

- Reminder information of prenatal visit's schedule through call, text and email.

ESM 2.1 - Percentage of pregnant women who had at least 4 prenatal visits

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

Objectives: By 2020, increase percentage of women ages 25-49 yrs old screened for cervical cancer by 5% yearly.

Strategies:

- Conduct staff capacity building through VIA training, implementation of cervical cancer screening form and training on Cervical Cancer Screening database.

- Implementation of new cervical cancer screening form in Majuro, Ebeye and Outer Islands.

- Implement Cervical Cancer Screening e-Registry.

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

Objective: By 2020, increase percentage of women ages 15-44 years old that use family planning services by 5% yearly.

Strategies:

- Conduct family planning awareness campaign in school, community meetings, women organization meetings and events, and use of social media network

- Create and distribute family planning services related videos, posters and other promotional materials in the local language.

- Make the family planning services available in women's clinics and health centers which include availability of

contraceptive method of choice in the clinics.

Improve reporting and collection of family planning services from the Outer Islands.

Perinatal/Infant Health:

The MCH Program continues to provide better care to the pregnant women through comprehensive prenatal care which has better birth outcomes and less complications at birth. Pediatricians at the MCH Clinics provides counselling to post partum mothers that come on the 1st post-natal visit. Counselling includes proper breastfeeding, available immunization, and family planning methods. This made an impact to the mothers especially on exclusive breastfeeding. Well baby clinic provides immunization, growth and weight monitoring, assessment of infant and referral to CSHCN as needed. New Born Hearing Screening is provided at the Maternity ward and follow up on the hearing screening outpatient clinic. Every quarter, an audiologist and surgeon visits and provide specialty care to identified children with hearing problems.

Priority: *Improve perinatal/infant's health through promotion of breastfeeding, baby friendly hospital, implementation of Well Baby developmental screening, and improvement of immunization rates*

NPM: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months, Objectives:

- By end of 2018, 5% increase of mothers that report exclusive breastfeeding of infant up to 6 months of age
- By end of 2018, 5% increase of mothers that report who ever breastfed their infant.
- By end of 2018, Breastfeeding policy has been endorsed

Strategies:

1. Implement Well Baby Standardized Developmental screening tool
2. Implement information system that will tract and monitor screening
3. Continue to implement the Ten Steps to Successful Breastfeeding with target of finalizing the Breastfeeding policy at the end of 2018.
4. Strengthen health education and promotion of breastfeeding.

ESM 4.1 - % of hospitals accredited as baby friendly.

ESM 4.2 - Percentage of pregnant women that where given comprehensive breastfeeding counselling during prenatal visit

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

Objectives:

1. To increase immunization coverage by 4% every year for children 19 to 35 months old.
2. Improve health education on available immunization services and benefits of immunization

Strategies:

1. Continue to provide quality outreach mobile immunization visits to the Outer Islands
2. Conduct community awareness on the proper immunization schedule and the benefits of immunization
3. Continue to provide immunization services in Majuro and Kwajalein's clinics and outreach visits.
4. Create and distribute Immunization related health promotion materials translated into Marshallese language

Child Health:

The Public Health programs provide the following services: Vitamin A, deworming, TB and Leprosy contact tracing and management, oral health in school and community, immunization in the schools and community, reproductive health services: family planning and counselling, and children's high risk clinic. For school aged children, the MOHHS coordinates activities with the Public School System

Priority: *Improve child health through early childhood developmental screening, and complete vaccinations.*

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

Objective: By 2020, increase children ages 10 through 71 months who receive developmental screening and proper care by 5% yearly.

Strategies:

- Implement Well Child Standardized Developmental Screening tool in Majuro, Kwajalein, and Outer Islands.
- Continue to train MCH Clinical Staff and Health Assistants in using the Well Child Standardized Developmental Screening Tool

ESM 6.1 - Implement a Comprehensive Developmental Screening tool for 10 through 71 months children

Priority: *Promote child safety in the community.*

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

Objective: By December 2018, the MCH Program with Public Safety will conduct at least 3 community campaign on awareness and promotion of child safety within the community.

Strategies:

- Community and media awareness and health education on non-fatal injuries, first aid treatment and child safety against motor vehicle accidents, fall, burn, drowning, choking, and other injuries
- Coordinate and create an article with Ministry of Public Safety the laws involving child safety in the community, at home and in school
- Work with the schools on child safety policies and awareness education.

ESM 7.1 - Health talks on Injury and violence prevention

ESM 7.2 - Number of community campaign on awareness and promotion of child safety within the community.

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

Objectives:

1. To increase immunization coverage by 4% every year for children 19 to 35 months old.
2. Improve health education on available immunization services and benefits of immunization

Strategies:

1. Continue to provide quality outreach mobile immunization visits to the Outer Islands
2. Conduct community awareness on the proper immunization schedule and the benefits of immunization
3. Continue to provide immunization services in the clinics and outreach visits.
4. Continue to implement RMI School Immunization Law which requires all public and private schools to enforce the immunization requirements

SPM: Final and endorsed readiness assessment of RMI MOHHS to handle Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program.

Objective: By end of 2018, the MCH Program with Human Services Department conducted a readiness assessment on the development of Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Program within the Ministry of Health and Human Services

Strategies:

- Conduct readiness assessment of the Ministry in creating this new program
- Meet with the stakeholders on the status of the readiness assessment and finalize an endorsement by the end of

Adolescent Health:

In 2016, there were 4 completed suicide from ages 15 to 19 years old. The family of the deceased were referred to Human Services Program for counselling. The Human Services Program has been coordinating health talks on suicide prevention to the Public School system and community leaders. In 2016, there was 11.11 % decrease on teen births comparing to 2015. MOHHS continue to provide free family planning services. The Ministry has a strong partnership with Youth to Youth in Health where MOHHS provide health services to the clients coming to YTYIH. YTYIH serves as a haven to youth that don't want to be stigmatized going to the Family Planning and STD/HIV Clinics in the hospital.

Priority: Improve adolescent health through promotion of adolescent well-being (preventive medical visit, education on injury, suicide, drug, tobacco and alcohol use,) and reducing teen pregnancy

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

Objective: By 2020, achieving greater than or equal to 90% HPV Coverage Rate for 13 years old girls.

Strategies:

- Work with the Ministry of Health and Human Services Senior Leadership team to make HPV Vaccination as a public health priority

- Make HPV Vaccination Routine Vaccine to 11-12 yrs old.

- Strengthen HPV Vaccination messages to the community in partnership with Cancer Program

- Meet with parents and guardians to inform the benefits of HPV Vaccination and available services

- Timeliness, Accuracy, and completeness of HPV Vaccination Data in MIWebIZ

ESM 10.2 - HPV vaccine coverage of girls age 13 years

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

Objective: By 2020, increase use of Family planning services between 13 - 17 yrs old by 5% yearly.

Strategies:

- Coordinate with the schools for awareness of family planning services which are not limited to the use of contraceptives.

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

- Strengthen the Family Planning Services at the Youth to Youth in Health Clinic.

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

Children with Special Health Care Needs

MCH Program collaborates with Early Hearing Detection and Intervention program, Public School System, and other MOHHS Programs and clinics in identifying and providing services children with special healthcare needs. Most of the cases are specialty cases that needs to be referred to off island hospitals like Shriners' and through our medical referral services. Shriners' Hospital visits Marshall Islands often to provide follow up services and to assess new cases for possible referral. Challenges in this domain are data tracking system, referrals from the Outer Islands and follow up of cases.

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

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

Objective : To have quarterly meeting with EHDl Program, Special Education, and health care providers like pediatrician, other physicians, to discuss the transition of the CSHCN adolescent to adult health care

Strategies:

- Develop and implement a database system on infants who have special health care needs
- Develop CSHCN Guidelines
- Develop and implement transition/referral of services for CSHCN to adult health care

ESM 12.2 - Percent of adolescent that moved to adult health care

Cross Cutting/Life Course:

Dental caries is still a problem in RMI especially in the Outer Islands where dental services are only provided by outreach mobile visits. Dental Department don't have its own budget. Usually, other program like MCH will provide funding for Dental Program to be part of the Outreach mobile team. We lost our funding few years ago on preventive services. We are working to apply for a new one.

Priority: *Improve oral health of children and women*

NPM: 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

Objectives:

- By 2020, to increase pregnant women that received dental check up by 5% yearly
- By 2020, to increase children 1 to 17 years old that received dental check up by 5% yearly

Strategies:

- Strengthen access to Dental Services for all Outer Islands Health Centers.
- Ensure pregnant woman will have at least one dental check up every pregnancy
- Conduct at least 1 dental outreach preventive medical visit to all elementary and high schools.
- Continue to provide weekly dental services in Laura Health Center.

ESM 13.1 - Percentage of pregnant women that received dental check up

FY 2017 Application/FY 2015 Annual Report Update

MCH Program conducted series of meetings with the team to update the State Priorities, needs of the program, strategy and activities. We have revised our State Priorities, objectives and strategies to make it easier to understand and achievable. We have also applied the pointers given during the review of MCH Block Grant Application.

During the meetings, MCH Director presented the 2016 Application and program update for 2015 and 2016. Out of these meetings, we have revised our State Priorities with the following:

Improve women's health through preventive medical visit, cancer screening and comprehensive health care for prenatal and postpartum.	Women/Maternal Health
Improve perinatal/infant's health through comprehensive prenatal care, promotion of breastfeeding, and developmental screening	Perinatal/Infant Health
Improve child health through early childhood developmental screening, and complete vaccinations.	Child Health
Promote child safety in the community	Child Health
Improve adolescent health through promotion of adolescent well-being (preventive medical visit, education on injury, suicide, drug, tobacco and alcohol use,) and reducing teen pregnancy	Adolescent Health
Improve enrollment and special care of CHSCN through developmental screening and referrals to proper care	Children with Special Health Care Needs
Improve oral health of children and women	Cross Cutting

Priority Needs and Plans

Data and current activities for the last 5 years were presented to the team. Staff assigned in their respective domain discussed the plans for 2017. We have to prioritize activities to make sure it will be achievable, measurable and will be done in a timely manner. Below are the result of the meetings and prioritization:

Women's/Maternal Health: In FY2015, only 39% of pregnant women attended prenatal care on their 1st trimester. Most of the pregnant women tends to visit on their last trimester. Pregnant women from the Outer Island will have comprehensive prenatal care at their last trimester upon their arrival in Majuro where comprehensive prenatal care is available. Out of the 1,116 pregnant women, 97% were provided with nutrition counselling. There were 3% of pregnant women who didn't have prenatal visit. The MCH Program and the Ministry of Health addressed the needs of the Women's and Maternal Health. Comprehensive prenatal care is provided in the two main hospitals which includes the following services: 1. Tests: Pap smear, GC, HIV, Hepatitis B, Syphilis and Chlamydia, 2. individual counseling: all family planning methods, STIs/HIV, recognizing signs of danger and come to hospital ASAP, nutrition, personal hygiene, breastfeeding, 3. services: immunization, and dental. 4. Free prenatal medicines. Two OB/GYN in Majuro and 1 OB/GYN in Ebeye are providing specialty care. High risk case pregnant women are tracked and management to avoid maternal complications and death. OB/GYNs, MCH Program Director and staff are engaged in the improvement plan of services and facilities. National Comprehensive Cancer Control Program headed the cervical and breast cancer screening where in the Ministry of Health engaged with the churches to provide education and bring women to the hospital for their screening. Canvasback Mission and our own OB/GYNs conducted the screening with the help of our MCH nurses. Aside from papsmear screening, we are now able to use VIA (Visual Inspection Acetic) test to screen especially in the Outer Islands. Family Planning conducted

update training on the proper use of the different methods available in RMI,

Priority: *Improve women's health through preventive medical visit, cancer screening and comprehensive health care for prenatal and postpartum.*

NPM: Percent of Women with a past year preventive medical visit

Plans include:

1. Increase awareness on preconception health visits
2. Promote annual preventive medical visit for healthy women.
3. Promote reproductive life planning
4. Continue to coordinate with the Faith Based Organization, Women's group in referring women for cancer screening
5. Promote healthy lifestyle

Perinatal/Infant Health: From 2011 Infant Mortality Rate, there was a decrease of 12.1 by FY2015. The MCH Program continues to provide better care to the pregnant women through comprehensive prenatal care which has better birth outcomes and less complications at birth. Pediatricians at the MCH Clinic provides counselling to post partum mothers that come on the 1st post natal visit. Counselling includes proper breastfeeding, available immunization, and family planning methods. This made an impact to the mothers especially on exclusive breastfeeding. Well baby clinic provides immunization, growth and weight monitoring, assessment of infant and referral to CSHCN as needed. New Born Hearing Screening is provided at the Maternity ward and follow up on the hearing screening outpatient clinic. Every quarter, an audiologist and surgeon visits and provide specialty care to identified children with hearing problems.

Priority: *Improve perinatal/infant's health through comprehensive prenatal care, promotion of breastfeeding, and developmental screening*

NPM: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months,
Plans include:

1. Implement Standardized Developmental Screening tool
2. Develop data system that will track and monitor screening and referral.
3. Implement strategies that will improve breastfeeding like "Ten Steps to Successful Breastfeeding" and "First Embrace"
4. Increase awareness on advantages of early and adequate prenatal care

Child Health: In 2015, only 58.5% of 19-35 months old received complete immunization based on the schedule. The Public Health programs provide the following services: Vitamin A, deworming, TB and Leprosy contact tracing and management, oral health in school and community, immunization in the schools and community, reproductive health services: family planning and counselling, and children's high risk clinic. For school aged children, the Ministry of Health coordinates activities with the Public School System (Ministry of Education).

Priority: *Improve child health through early childhood developmental screening and complete vaccinations.*

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

Plans include:

1. Implement Standardized Developmental Screening tool
2. Increase immunization rates (19-35 months routine vaccinations, HPV vaccinations)

Priority: *Promote child safety in the community.*

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

Plans include:

1. Community and media awareness and health education on non-fatal injuries, first aid treatment and child safety against motor vehicle accidents, fall, burn, drowning, choking, and other injuries
2. Coordinate with Ministry of Public Safety in the full implementation of motor vehicle safety laws.

Adolescent Health: In 2015, there were 2 completed suicide from ages 15 to 19 years old. The family of the deceased were referred to Human Services Program for counselling. The Human Services Program has been coordinating health talks

on suicide prevention to the Public School system and community leaders. In 2015, there was 16.67% decrease on teen pregnancy from 2014. In 2014, Ministry of Health was suspended from the Family Planning funding. We were able to receive our new funding with conditions in September 2015. But we continue to provide family planning services through the help of MCH Block Grant for staff funding and UNFPA for the contraceptives. The Ministry of Health has a strong partnership with Youth to Youth in Health where MOH provide health services to the clients coming to YTYIH. YTYIH serves as a haven to youth that don't want to be stigmatized going to the Family Planning and STD/HIV Clinics in the hospital.

Priority: *Improve adolescent health through promotion of adolescent well-being (preventive medical visit, education on injury, suicide, drug, tobacco and alcohol use,) and reducing teen pregnancy*

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

Plans include:

1. Adolescent population have access and receives comprehensive preventive medical care which includes family planning, immunization, std/hiv screening, mental health counselling
2. Community and media awareness and health education on non-fatal injuries, first aid treatment and child safety against motor vehicle accidents, fall, burn, drowning, choking, and other injuries
3. Assist in the implementation of the Youth to Youth in Health's Teenage Pregnancy Prevention project

Children with Special Health Care Needs: MCH Program collaborates with Early Hearing Detection and Intervention program, Public School System, and other MOH Programs and clinics in identifying and providing services children with special healthcare needs. Most of the cases are specialty cases that needs to be referred to off island hospitals like Shriners' and through our medical referral services. Shriners' Hospital visits Marshall Islands often to provide follow up services and to assess new cases for possible referral. Challenges in this domain are data tracking system, referrals from the Outer Islands and follow up of cases.

Priority: *Improve enrollment and special care of CHSCN through developmental screening and referrals to proper care*

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

Plans include:

1. Improve the assessment, coverage and enrollment of CSHCN into the program to be able to provide the needed care.
2. Develop and implement a data tracking system
3. Develop CSHCN Guidelines

Cross Cutting/Life Course: Dental caries is still a problem in RMI especially in the Outer Islands where dental services are only provided by outreach mobile visits. Dental Department don't have its own budget. Usually, other program like MCH will provide funding for Dental Program to be part of the Outreach mobile team. We lost our funding few years ago on preventive services. We are working to apply for a new one.

Priority: *Improve oral health of children and women*

NPM: 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

Plans include:

1. Strengthen access to Dental Department for all Outer Islands.
2. Ensure pregnant woman will have at least one dental check up every pregnancy
3. Improve referral of clients to Dental Department.

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)

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 Loek-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, Kijile, 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

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. Mailyynn 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 primarily 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

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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 module's primary objectives are to document the amount spent on each type of referral. The patient and financial information can be used for long term planning. Through this module, the number of cancer related referrals to tertiary hospitals in the Philippines or Honolulu and cancer related deaths that occur overseas are documented.

Finance and Personnel

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

Benefits, Monitoring, and Evaluation (BME)

The objective of the BME module is to ensure the accuracy and relevance of the data we generate. In addition, the module is intended to provide a series of indicators to monitor and evaluate the efforts

undertaken by MOH staff.

We will be able to see which health programs or services have had the most impact and which 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 MHIS.

//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 sets 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.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.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$252,494	\$227,247	\$252,494	\$217,698
State Funds	\$189,372	\$189,372	\$189,372	\$200,000
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$441,866	\$416,619	\$441,866	\$417,698
Other Federal Funds	\$0	\$133,649	\$0	\$150,000
Total	\$441,866	\$550,268	\$441,866	\$567,698
	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$226,608	\$204,914	\$226,276	
State Funds	\$200,000	\$200,000	\$200,000	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$426,608	\$404,914	\$426,276	
Other Federal Funds	\$224,374	\$212,229	\$134,000	
Total	\$650,982	\$617,143	\$560,276	

	2020	
	Budgeted	Expended
Federal Allocation	\$226,000	
State Funds	\$200,000	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$426,000	
Other Federal Funds	\$150,000	
Total	\$576,000	

III.D.1. Expenditures

EXPENDITURES

MCH Title V funds are used to support programs and services in linking with the state's MCH priority needs and meet the requirements of the Title V legislation.

The federal support complements the state MCH investment in which funds are used to support MCH program activities. Program monitors expenditures to ensure compliance with the legislative financial requirements, program also gets advice from PO when questions arise concerning the MCH funds. Funds under each component comply with the 30, 30, 10 requirements and are expended accordingly by monthly ledgers compiled by the Ministry of finance.

Number of MCH population served:

Pregnant women: 1,257

Not all pregnant women come to the hospital for prenatal checkup, some women in the outer islands don't come to Majuro due to lack of resources, accommodation and etc. Some women on Majuro don't come for prenatal care until the last trimester or when they're in labor, since they don't have problem there's no need to see the Doctors. There's a need for community awareness on the importance of early prenatal checkup and the program needs to expand the prenatal services to the outer islands by providing training to Health Assistants in the outer islands.

Infants <1 year of age: 989

There is a challenge in reaching all children under year of age. Not all mothers are bringing their children for follow up visit/annual checkups. For children in the outer islands, services are only provided during Public health team comprehensive visits. There's a need to provide awareness to mothers/fathers on the importance of annual checkups and immunizations. Public Health team need to increase the number of trips to outer islands each year to provide needed services to the target population.

Children 1-21 years old: 8,707

There's still a challenge in immunizing children due to migration and some parents don't bring in children for follow up immunization and checkup. Majority of adolescents only show up at the clinic for medical clearance for school entry. There's a small proportion of adolescents using FP methods. The program needs to again raise awareness on the importance of annual checks, preconception counseling and include SRH in the school's curriculum.

Children with special health care needs: 156

The program supported the travel of CSHCN and family escort to Shriners' Hospital including 2 weeks of per diem. Support the local travel for CSHCN to Majuro Hospital to meet with specialist prior to referral.

Others: 1,984

Not many women are coming in for preventive screening services and FP methods. There is a need to raise awareness on the importance of early screening, early detection and prompt treatment to save lives and the benefits of family planning methods. Program needs to increase number of trips to the outer islands to provide such services.

RMI doesn't have Medicaid, each individual is entitled to pay a \$5.00 consultation fee when seen at the hospital. However, services are free for pregnant women (prenatal vitamins, FeSO4 blood tests, dental checkup) immunization, Leprosy treatment, TB treatment, FP visits (free commodities)

Capacity Building

Off-island Training and Meetings funded by MCH Block Grant

1. MCH TA meeting, San Francisco
2. AMCHP, Kansas City
3. FP training, Kansas City
4. Increasing access to and awareness of contraception in the context of Zika preparedness, Honolulu HI
5. Sexual and reproductive health conference, Arlington, VA
6. FSM MCH WORKSHOP
7. Spring TA Meeting, Hawaii

On-island trainings and meetings partially funded through staff, supplies, local travel or venues:

1. Region IX Recurring Calls
2. Vitamin A and Deworming training
3. Well Baby Clinic New Developmental screening Form and SOP training: 27 staff from the health centers, 15 nurse practitioner students and 10 MCH/Immunization/Pediatric nurses were trained
4. Family Planning
5. First Embrace – A mother's first embrace and her baby's first breath
6. Breastfeeding training provided by UNICEF
7. Perinatal Meeting and Pacific FIMR COIN Pre-Assessment
8. MCH Program - Reproductive Health Unit and Weto in Mour: Violence Against Women and Girls Support Service (WiM) within Women United Together Marshall Islands
9. Cervical cancer screening team meetings.
10. WUTMI(Women united together in the Marshall Islands) Annual Conference
11. UNICEF Integrated Child Health and Nutrition Survey conducted.
12. Hybrid NCD Survey, 2018
13. MCH 1st Bi-Annum Workshop
14. Cancer Summit
15. VIA Training
16. MCH 101 TA
17. RH Program training.
18. MCH Pilot Survey
19. Family Planning Refresher Course Training
20. HFRSA Training (Health Facility Readiness and Service Availability).
21. HFRSA Outer Island survey.

Salary:

MCH Block Grant supports 3 nurses, 1 dental assistant

Medical Supplies:

Provides medical supplies for the prenatal and women's health clinics.

Others:

- Printing of forms and educational materials.
- Supports communication – internet, phones, and mobile pre-paid cards
- Fuel for the Family Planning truck which being used by the program for outreach visits and administrative works.
- Office and computer supplies

III.D.2. Budget

Title V support to RMI MCH Program

Human Resources

40% of the funds are used to support the Human Resources of MCH Program to implement activities. 5 staff are currently getting paid under the program - 2 from mother and infant, 2 from children and adolescent and 1 from CSHCN component. These dedicated staffs are providing services in the clinics and outreach mobile visits.

Travel

Title V support travel for program staff and other related staff to attend mandatory technical assistance meetings, block grant review and other related conferences/training for the program for capacity building.

We were able to bring Children with Special Health Care Needs and family escort from the Outer Islands to Majuro or Ebeye for follow up and presentation to Shriners' before they can get referred to Shriners' Hospital. There were 25 CSHCN patients referred to Shriners with funding from MCH Program.

Women in the Outer Islands who are at risk with health condition like abnormal cervical cancer screening result, pregnant women with high risk pregnancy were supported for domestic travel to the main hospital where better care are given to them.

Activities

With the Title V funding, we are able to provide prenatal care, women's health, family planning, cancer screenings, children with special health care needs, dental services, and well baby clinic.

We provided continuing education on breastfeeding, 1st 1000 days of lives, nutrition, Vitamin A and de-worming, and family planning commodities. Partnership with Youth to Youth in Health and Women Together in Marshall Islands are ongoing especially on community awareness. Title V provided support on IEC materials.

Bringing MCH services to the Outer Islands where health care is limited. Specialized MCH services are delivered in the Outer Islands along with other programs like HIV/STI, Immunization Program, TB and Leprosy.

TB/Leprosy Mass Screening: MCH Program assisted the project with staff, medical and office supplies. There were 22,402 or 82% of the 27,275 Majuro population tested and interviewed for TB, Leprosy and NCD. 19,136 or 85% of the 22,402 completed their screening.

Staff in MCH Program assisted in the Nutrition-WASH (Water, sanitation, and hygiene.) Survey - Formative Research on Nutrition-WASH social norms and practices. qualitative information available to explain the underlying social and behavioral determinants associated with these practices. Report is available for sharing.

Medical and Laboratory Supplies were purchased for the program's need to serve the MCH population.

III.E. Five-Year State Action Plan

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

State: Marshall Islands

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

State title v purpose and design:

The state title v purpose is to support services to improve health and well-being of the nation's mothers, infants, children and youth with special health care needs and their families.

State title v supports:

- State Title V supports travel of staff to outer islands and in communities of Majuro, Ebeye and Outer Islands to provide health education and preventive screening activities.
- Provide transportation for clients to come to Majuro for follow up with OBGYNE on abnormal pap smear and via results.
- Provide funds for off island referrals for the target population to seek medical treatment. Support weekly stipends for both client and escort.
- Establish committees under the ministry to investigate outbreaks and health problems. Provide data trends and public education on health issues
- Support salary for other staff in the ministry to implement program services on Majuro, Ebeye and outer islands.
- All medical equipment used to serve the target population in the preventive and curative side.
- Collaboration with NGOs to assist in the implementation of activities under the program.
- Development of policies, for example the school immunization law and nutrition policy at schools where no vendor is allowed to sell sweet treats to students.
- Public health laws where all food handlers should go thru the medical examination in order to cook and serve a public food, school entry medical examination, taxi drivers' medical examination on tuberculosis.
- Support related programs with clinical and office supplies.
- Support Dental program's clinic and outreach mobile visits
- Support the CSHCN interisland and off island referral

III.E.2.b. Supportive Administrative Systems and Processes

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

Workforce development/Capacity building

Changes in the Health Organization:

National MCH Program is under the Bureau of Primary Health Care Services. As the national program, MCH Director work closely with Majuro, Ebeye, Outer Islands and 177 Health Care Program on MCH program and activities.

Secretary of Health and Human Services: Late January of this year, Mr. Jack Niedenthal was appointed by the RMI Public Service Commission as the new Secretary. Secretary Niedenthal advocates the work plan and activities of the MCH Block Grant.

Deputy Secretary of Health and Human Services: Mailynn Konelios-Langinlur. Mrs. Langinlur was promoted to Deputy position in 2016. She provides advice and support to the program alongside with Public Health Medical Director. MCH Director reports directly to the Deputy on administrative functions of the program.

Public Medical Director: Dr. Tom Jack. Dr. Jack provides over all clinical advise to the MCH Program alongside the OBGYNs and Pediatricians.

Staff funded under MCH Block Grant

MCH Director: Caroline Johnny-Jibas. Caroline graduated from the College of the Marshall Islands in 1995 with an AS Degree. She started working in 1996 as a Public Health Zone Nurse before she was promoted to be the Hansen's disease program coordinator in 2011. She was transferred to MCH program as the director in April of 2016. She manages and coordinates all the activities between all clinics, health centers and stakeholders. Funded under the Compact funds.

CSHCN Coordinator: Caroline Johnny-Jibas. Currently, Caroline is the coordinator until a new one is hired. Position will be open in the next budget period. As the CSHCN Coordinator, she works closely with Pediatricians, Pediatric Ward Head Nurse, MCH nurses, EHDI (Early Hearing Detection Initiative) Program, Medical Referral Services, Public School systems and Shriner's Hospital.

Staff Nurse: Maypol Briand, Carlwin Aisea, Eomra Lokejak and Johanna Rilang,. The three staff nurses graduated with AS Nurse degree in College of the Marshall Islands. They are responsible for Women's Health Clinic, Prenatal and Post-Natal Clinic, Youth to Youth Clinic and leads MCH related outreach mobile visits. Funded under MCH Block Grant.

Dental Assistant: Kim Laidren. She overlooks pregnant women referred to the dental clinic and refer patients when further evaluation and treatment is needed. Funded under MCH Block Grant.

Staff working with MCH Program funded under different grants

Family Planning Services Staff: Tauki Korean, Jacqueline Mojilong, Whynonna Wonne and Komi Mea. These staff are paid under Title X – Family Planning Grant. Aside from their family planning activities, they are also working with the Women's Health, Prenatal and Post-Natal clinics, Youth to Youth in Health Clinic and outreach activities

Ebeye MCH Coordinator: Ana Valotu. She handles Women's Health, Prenatal and Post-Natal Clinic, and Family Planning Services in Ebeye Hospital along with 1 nurse.

OBGYNE: Dr. Meeankshi Prathak(new, started in June 2019) Dr. Ivy Claire Lapidez, Dr. Corazon Rivera, Dr. Andrea Abello. There are 3 OBGYNs on Majuro and 2 on Ebeye.

Pediatrician: Dr. Mary Jane Gancio, Dr. Menasa Baleinamau, Dr. Paz Estoesta. There are 2 Pediatricians in Majuro and 1 in Ebeye

SSDI Coordinator: Edlen J. Anzures. She graduated from Adamson University with a degree of B.S. Computer Engineering and recently finished DDM (Data for Decision Making) course under Fiji School of Medicine. She works closely with MCH Director on the activities supported by SSDI. She is also the Health Informatics Director of the Ministry of Health and Human Services.

Deputy Secretary of Health and Human Services: Francyne Wase-Jacklick. She graduated in Hawaii Pacific University with a degree of B.S. Biology and A.S. Biology in Mt. St. Mary College. She provides support in the monitoring and evaluation of the work plan of the MCH Program. Mrs. Wase-Jacklick was recently promoted to Deputy Secretary

On-island trainings and meetings partially funded through staff, supplies, local travel or venues:

- 1.Region IX recurring calls

- 2.VIA Training
- 3.Family planning refresher training (Training by UNFPA)
4. MCH 1st Biannum Workshop
5. FSM MCH workshop- Program manager was able to attend.
6. Health Facility Readiness and Service Availability (Training by UNFPA.)
7. HIV/RPR SD DUO Training-
8. Technical Assistance –Consultant visit , Dr. Jean (MCH 101)
9. AMCHP Annual Conference
- 10.MCH TA meetings
11. National Reproductive Health Annual Meeting
- 12.Follow up meetings with World Bank on activities for Early Childhood Development Project.
- 13.Outer Islands trips for Dental Health, Nurse practitioners,
- 14.TB mass screening- MCH Staff were assigned to assist at the screening sites
15. 1st Cancer Summit in the Pacific

National MCH Program under the Bureau of Primary Health Care Services aims to keep the goal of the bureau: Preventative and public health services will be efficiently maximized through a healthy islands lifestyle concept and with essential medical and administrative functions to ensure that the health and life span of various individuals, families and communities are enhanced.

The Bureau of Preventative and Public Health includes the following departments:

Outer Island Health Services

Communicable Diseases

STD/HIV

Leprosy

Tuberculosis

Non-Communicable Diseases

Diabetes

Hypertension

Cancer Control Program

Maternal and Child Health

Immunization

Behavioral Health

Health Promotions

Zone Health/Community Outreach

Administration

There is streamlining of program activities and coordination and reduction of silos to avoid duplication of efforts and over-all improvement of services for MCH population.

Improvement Plan on Workforce and Capacity Building

1. Create and implement a MCH 101 training module for new and old employees.
2. Monthly meetings on quality improvement of MCH State Action Plan
3. Continue the MCH Workshops

III.E.2.b.ii. Family 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, Public School system, Ministry of Internal Affairs, Ministry of Finance and all local governments.

Non-Government Organization: KIJLE (a women group), Weto in Mour (Women United Together Marshall Islands (WUTMI), Marshall Islands Epidemiological Group(MIEPI), Family Support of Special Children, Cancer Survivorship Group, KUMIT BOBRAE, WAM(Wann aelon in Majol)

International: UNFPA, WHO, HRSA, CDC, UNICEF, World Bank

Faith Based: Assembly of God, Protestant Church, Catholic Church and Church of latter Day saints.

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 and Human Services can provide.

Programs within the Ministry of Health and Human Services

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.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

SSDI's support to MCH Block Grant

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

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

Newly hired data encoder is assigned in MCH Program to assist in all data entry and administrative needs of the program.

SSDI : (12/1/2017 – 11/20/2022)

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

- Supported the data needs of the Title V MCH Block Grant Application and Annual Report yearly submission
- Building capacity of the MCH Program and stakeholders to improve the needs assessment process. Update of the 2016-2020 Five Years Needs Assessment including progress, challenges and new strategies.
- Revision and improvement in the development, implementation, evaluation and monitoring of the National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-informed Strategy Measures (ESMs)
- Support the MCH program needs in building its data infrastructure and information system

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

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

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

SSDI Program supported the 1st MCH Bi-Annum Workshop 2018 through technical assistance and funding. The workshop was successful. It's the 1st time that we have a workshop the is all about Maternal and Child Health. We have presenters and attendees from all areas that provide service to MCH population and partner NGOs.

SSDI program continues to assist MCH program in the development, implementation and monitoring of MCH data management. In 2017-2018, we have redesigned the databases of MCH to link Prenatal, Family Planning, Women's health and Cervical Cancer screening. We named it as Reproductive Health Information System. System continuous to develop as we find bugs and additional requirements from the program. In 2018-2019, we plan to implement the system in Ebeye MCH Program, 177 Health Care Program and Outer Islands Main Office.

Training activities in 2017 under SSDI funding (travel, supplies)

1. Excel and Power point basic and advance training of MCH Staff
2. Re-training of Ebeye Vital Statistics Staff in birth, death and fetal death data collection.
3. Data for Decision Making

Additional plan for 2018-2019 is to implement the following systems:

1. Birth Defects and Surveillance System
2. Vitamin A and De-worming data collection tool. This tool is ready but need to conduct series of training.
3. Children with Special Health Care Needs linking with Early Intervention
4. Upgrade of Vital Statistics Information System – this will be included in the mHIS (Marshall Hospital Information System) in the 3rd year of the project.

Telehealth: SSDI will support the development of Telehealth in RMI. Will work closely with our Chief of Staff and MCH Director. Shriners' Hospital schedule Telehealth calls for the Children with Special Health Care Needs prior to referral and follow up.

MCH Block Grant Application and Annual Report: SSDI will continue to support the data needs of the program, provide assistance in grant writing and implementation of the activities. Dashboard and key performance indicators will be developed and implemented.

Jurisdictional MCH Survey: SSDI Program will continue to support the development and implementation of the survey. We have conducted the pilot survey.

Plan for training and workshop:

1. SSDI Director will continue the Excel and Power point basic and advance training of MCH Staff. There is a need to do follow up training to make the staff feel comfortable in
2. Support the Data Decision Making classes for Ebeye participants.
3. MCH Program Annual Meeting in 2019.
4. Continue the Needs Assessment activities.

Jurisdiction MCH Survey

- Review, translation and update of questions
- Training of staff
- 25 surveys done
- Review of the submitted surveys



MCH 2nd Annual Spring Federal/Jurisdiction/Territory Partnership Technical Assistance Meeting

- SSDI NOFO, Carryover, Prior Approval
- MCH BG State Action Plan, NPMs, SPMs, ESMs, Access to TVIS, Budget Forms, Executive Summary
- Telehealth, STIs, PHHS BG



RMI MCH Workshop, May 27- June 1, 2018

- Program updates – MCH, Immunization, Family Planning, Cancer, STI/HIV, Preparedness, NCD, 177 Health Care Program, EHDI, WUTMI, KIJLE
- MCH BG State Action Plan





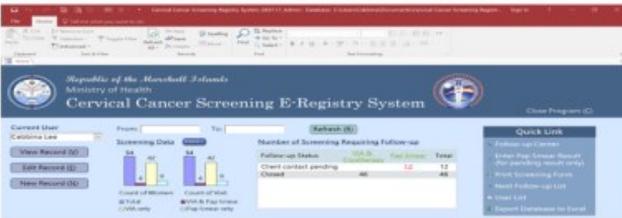
Title V MCH Block Grant Application and Annual Report, July 2018

- Supported the MCH Program in writing the grant and provided data.
- Submitted in July 2018
- Assist in creating the MCH BG Progress Presentation

Implementation of mHIS

- Marshall Hospital Information System
- Finger print and photo capture enrollment of patients
- Medical Records
- Triage
- Clinical Information System

Reproductive Health Information System



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

Majuro TB/Leprosy Mass Screening INTEL

- Manages the registration and data team
- Provide training and implementation of TB/Leprosy Mass Screening
- Set up of 4 screening sites

Reports and Application

- Quarterly Expenditures
- NCC Progress Report
- Carryover Application

Support needs of computers and printers

- Computers and printer set up in Vital Statistics, Doctor's Lounge and Outpatient Triage.



Data Collection

- 3 visits to Ebeye Hospital for Vital Statistics data collection and reconciliation.
- Weekly radio calls to Outer Islands Health Centers for data collection of birth, death, syndromic surveillance and unusual events



RMI Health Care Service System The Marshall Islands has a well-

3 SETS OF VTC EQUIPMENTS

- to support and strengthen the data capacity through training, webinars, and technical support between Majuro, Ebeye and Partners. This facilitates data collection and coordination between the islands which will improve timeliness and quality of data. This will also connects Program Managers and Epi staff to monitor and evaluate progress

Federal/State Maternal and Child Health Partnership Technical Assistance Meeting October 16 –18, 2018

- SSDI Grantee Meeting
- Peer to Peer learning and information exchange
- MCH Priority
- Leadership Training



developed/organized primary/preventive and public health system. There are two main hospitals located in the two urbanized islands in the Kwajalein (Ebeye Hospital) and Majuro (Majuro Hospital) Atolls. Including the two main

hospitals, there are 60 health centers/health clinics located in the various islands that make up the Marshall Islands. The two main hospitals serve the urban areas including the surrounding islands through referrals and medical evacuation. The two hospitals provide primary/secondary and some tertiary care. However, most tertiary care patients are referred off-islands to hospitals in the Philippines 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 Division of Public Health and provides the mandated services for the MCH population.

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

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

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

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

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

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	28.0	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	15.7	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	20	24	37
Annual Indicator	21.7	35.4	37.7
Numerator	2,150	3,605	3,733
Denominator	9,891	10,197	9,896
Data Source	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	39.0	41.0	43.0	45.0	47.0	47.0

Evidence-Based or –Informed Strategy Measures

ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		90	68	
Annual Indicator	88.3	66.1	66.8	
Numerator	233	654	661	
Denominator	264	989	989	
Data Source	Vital Statistics Department	MCH Program	MCH Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	69.0	70.0	72.0	72.0	73.0	75.0

ESM 1.3 - Percent of women ages 18 thru 44 seen at outreach mobile visits

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5.0	7.0	9.0	11.0	12.0	14.0

ESM 1.4 - Number of pregnant women with dental check up

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	53.0	56.0	59.0	61.0	63.0

State Performance Measures

SPM 4 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	20	11	
Annual Indicator	10.3	10.9	
Numerator	828	856	
Denominator	8,009	7,849	
Data Source	MCH Program	MCH Program	
Data Source Year	2017	2018	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.0	14.0	16.0	18.0	20.0	20.0

SPM 6 - Percent of women ages 15-44 years old that use family planning services

Measure Status:		Active
State Provided Data		
	2017	2018
Annual Objective	16	18
Annual Indicator	15.5	16.8
Numerator	1,825	1,984
Denominator	11,773	11,790
Data Source	Family Planning Program	Family Planning Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Women/Maternal Health - Entry 1

Priority Need

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

NPM

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

Objectives

Increase number of women with preventive medical visits by 5% yearly.

Strategies

Outreach mobile visits by MCH and FP Program to at least 6 Outer Islands yearly.
 Partnership with Cancer Program in reaching out to bring women in the community and faith-based organization to avail the services of MCH program.

ESMs	Status
ESM 1.1 - Percentage of women that understand the awareness talks on preconception, preventive medical visits, prenatal, post partum, healthy lifestyle and services provided by Ministry of Health	Inactive
ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits	Active
ESM 1.3 - Percent of women ages 18 thru 44 seen at outreach mobile visits	Active
ESM 1.4 - Number of pregnant women with dental check up	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

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

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

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

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

Priority Need

Improve oral health of children and women

NPM

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

Objectives

Increase pregnant women that received dental check up by 5% yearly

Strategies

Strengthen referral of pregnant women to Dental Services

Support the Dental Services team in providing outreach mobile visits to the Outer Islands Health Centers.

ESMs

Status

ESM 1.1 - Percentage of women that understand the awareness talks on preconception, preventive medical visits, prenatal, post partum, healthy lifestyle and services provided by Ministry of Health	Inactive
ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits	Active
ESM 1.3 - Percent of women ages 18 thru 44 seen at outreach mobile visits	Active
ESM 1.4 - Number of pregnant women with dental check up	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

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

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

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

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

Priority Need

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

SPM

SPM 4 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Objectives

Increase percentage of women ages 25-49 yrs old screened for cervical cancer by 5% yearly.

Strategies

Continue the implementation of the Cervical Cancer Screening database for data collection and reporting

Increase public awareness of the cervical cancer including risk factors, prevention screening and treatment

Establishment of referral system for patients with abnormal papsmear or VIA findings

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

Priority Need

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

SPM

SPM 6 - Percent of women ages 15-44 years old that use family planning services

Objectives

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

Strategies

Increase public awareness of the Family Planning Services

Continue the after 5 pm Family Planning Clinic .

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

Annual Report

State Priority 1: Improve women/maternal health through cancer screening, prenatal services and family planning services

Domain: Women/Maternal Health

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

Annual Objective	2016	2017	2018
Annual Indicator	21.7	35.4	37.7
Numerator	2,150	3,085	3,733
Denominator	9,891	10,197	9,896
Data Source	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018

MCH Program for Women/Maternal Health

In 2017, MCH Program worked on establishing the cervical cancer screening. We do have this service in previous years. But in 2017, with our Interim Secretary of Health, MCH Program headed the team in planning and implementing the mass cervical cancer screening. Team is composed of MCH Program, Cancer Program, SSDI Program/IT Department, Office of Health Planning, Policy, Preparedness and Epidemiology and Taiwan ICDF. Comprehensive Cervical Cancer Form was developed and implemented. The form has the history, screening, treatment, and management plan. Majuro Team was trained in using the form, information system and process. SSDI funded staff was hired to be the Data Encoder to make sure that all the screenings are entered and laboratory results are entered into the system. We have implemented this changes in August 2017

Aside from Majuro, MCH Program provided cervical cancer screening using VIA method in 4 Outer Islands (Namdrik, Mili, Maloelap and Utrik) from September to December 2017.

In 2018, there was a Canvasback Mission where 432 women where seen for papsmear in Majuro Atoll.

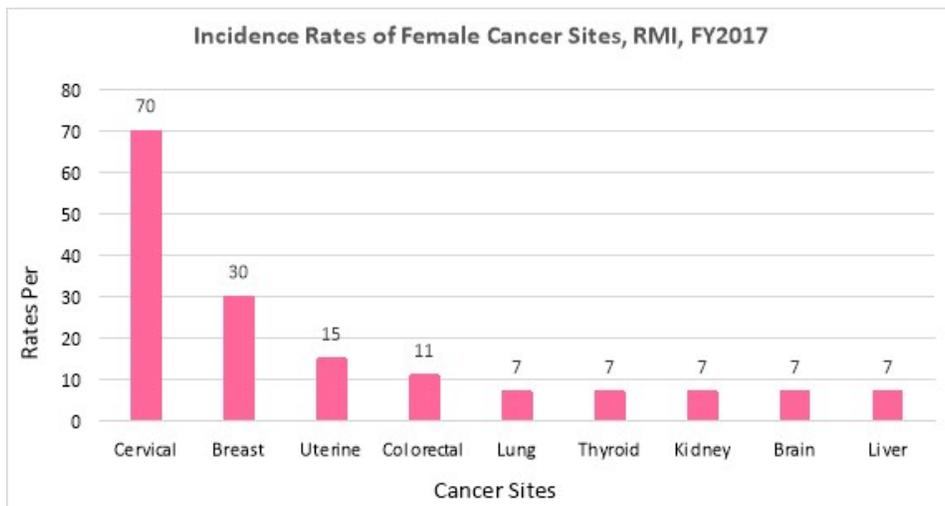
Also the MCH Program in partnership with Cancer Program strengthen the cervical cancer screening. Cancer Program through CDC grant contracted Women United Together Marshall Islands to be the patient navigators to bring the women in the community to avail the cervical cancer and colorectal cancer screening. This target the women that can't come during regular clinic hours. Women's Clinic managed by the MCH program opens its Saturday service to accommodate women that are working on weekdays and women that are hesitant to come during regular clinic hours.

SPM 4 - Percent of Women ages 25-49 yrs. old screened for cervical cancer

	2017	2018
Annual Objective	20	11
Annual Indicator	10.2	10.9
Numerator	828	856
Denominator	8,009	7,849
Data Source	MCH Program	MCH Program
Data Source Year	2017	2018

We didn't meet our annual objective for 2017. In 2018, MCH Program will implement the changed in cervical cancer screening in Ebeye MCH Program including data recording and collection. VIA method will still be used for Outer Islands outreach mobile visits. If patient is found with abnormal results, OBGYNE will provide clinical management. Patients from Outer Islands will be referred to Majuro MCH Program which will be funded by MCH Program.

During the needs assessment for this year application, the team recommended to follow the cervical cancer screening national guidelines to provide papsmear screening to 21-65 years old or VIA screening to 30-49 yrs old.



Top 3 Cancer for Female are cervical, breast and uterine. Most of the cases that are registered are in the late stage. If screened early, development of the cancer can be stopped.

Improve Pregnancy by making quality maternal services more available and accessible.

In 2017 and 2018, we have 3 OBGYNE in Majuro and 2 OBGYNE in Ebeye for MCH/Reproductive Health Services. OBGYNEs provides training to the MCH Prenatal and Post-Partum Services, Maternity Ward, and Labor & Delivery Ward. WHO initiative "First Embrace" where in newborn is immediately put into the mom's chest and arms. With the Pediatrician, breastfeeding training was also conducted.

"First Embrace" is our campaign for Early Essential Newborn care. Majuro Hospital has implemented this initiative. In the workshop planned for November 2018, Majuro OBGYNEs will have break out sessions with the Ebeye and Outer Islands participants on "First Embrace"

Prenatal Services in Majuro and Ebeye includes Tests: Pap smear, HIV/STI, blood chemistry, diabetes screening, 2) Individual counselling: family planning methods, HIV/STIs, nutrition, personal hygiene, breastfeeding, 3) services: immunization and dental. For Outer Islands, prenatal services is limited to pregnancy management, and counselling. For other services, outreach mobile visits will be the one providing the services.

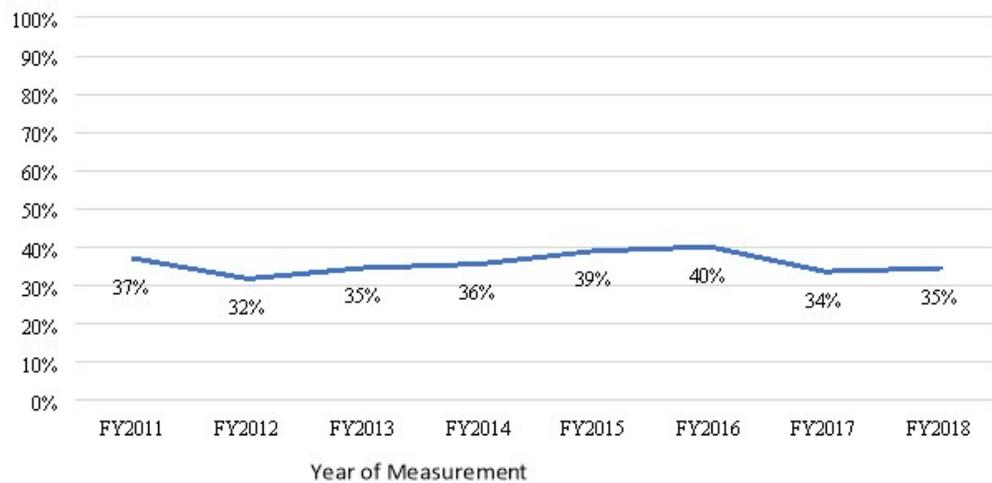
In 2017, due to the capacity of the Laboratory Department, Gonorrhea and Chlamydia testing were not provided. Zika Kits (repellent, mosquito nets, condoms, IEC materials related to Zika) are given to pregnant women on their first visit. Prenatal services and medicines are free.

In 2018, HIV/STI introduced the STD duo test.

FY2018	Majuro	Ebeye	Total	%
Sexually transmitted disease prevalence among pregnant women				
# of pregnant women who screen + for each of the following tests:				
RPR (for syphilis) +	15	5	20	2%
Chlamydia Antigen +	32	0	32	3%
Gonorrhea Antigen +	9	0	9	1%
Hepatitis B Surface Antigen +	4	14	18	2%
# of pregnant women tested for each disease	686	291	977	

Percent of Pregnant Women who attended Prenatal on the 1st Trimester, RMI, FY2011-FY2018

Family Planning Program



Contraceptive Prevalence Rate, RMI, FY2011-FY2018								
Description	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
No. of Women 15-44 yrs old that used at least one method of contraception	1,234	1,373	1,721	1,917	1,836	1,826	1,825	1,984
No. of 15-44 yrs old women	11,867	11,799	11,757	11,746	11,751	11,761	11,773	11,790
Contraceptive Rate	10%	12%	15%	16%	16%	16%	16%	16.8%
<i>Source: Family Planning Program</i>								

RMI Unduplicated Female Users Family Planning Services, 2017										
	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	>44	Total
Primary Method										
Female Sterilization	0	0	0	5	34	120	252	183	106	700
Hormonal Implant	7	28	45	121	87	77	37	21	4	427
3-Month hormonal injection	3	19	38	106	67	76	47	33	12	401
Oral Contraceptive	0	6	28	48	32	36	33	20	10	213
Female Condom	1	0	0	0	0	0	1	0	1	3
Fertility Awareness Method (FAM)	0	0	0	0	0	0	0	0	0	0
Intrauterine Device (IUD)	0	0	0	0	0	1	1	0	0	2
Abstinence	0	1	0	0	0	0	0	0	0	1
Withdrawal or other method	0	0	1	2	1	1	1	0	0	6
Total	11	54	112	282	221	311	372	257	133	1,753
No Method										
Pregnancy or Seeking Pregnancy	4	30	90	243	185	157	83	18	1	811
Other Reason	0	2	16	34	52	43	27	19	21	214
Total	4	32	106	277	237	200	110	37	22	1,025
Rely on Method										
Vasectomy	0	0	0	0	0	0	0	0	0	0
Male Condom	1	0	1	0	1	0	1	0	2	6
Total	1	0	1	0	1	0	1	0	2	6
Total Female Users of Family Planning clinic	16	86	219	559	459	511	483	294	157	2,784
Source: Family Planning Program										

Male Unduplicated Users in Family Planning Clinics, RMI, FY2018										
Primary Method	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	>44	Total
Vasectomy	0	0	0	0	0	0	0	0	0	0
Male Condom	0	0	1	1	0	0	0	0	0	2
Other Reason	0	0	0	2	0	3	2	0	0	2
Total Male Users of Family Planning clinic	0	0	1	3	0	3	2	0	0	4
Source: Family Planning Program										

Highlights for Family Planning

We still continue the After Dark Clinic at Youth to Youth in Health every Monday and Friday from 5:30 PM to 7:00 PM. During these clinics hrs., MCH/FP Staff provides Family planning services including giving contraceptives, counselling, and cervical screening. Aside from the youth, anyone who comes into the clinic will be served. With the outreach mobile visits, 5 Outer Islands were visited and provided with Family Planning Services. The MCH staff provided assistance in the TB/Leprosy Mass Screening from June to Sept 2018 which affects the travel to the Outer Islands.

Aside from the main FP clinics, services are available in Post-Partum visits and Maternity Wards. FP Services are free.

Challenges: Male population are not coming to the clinic. Women are not coming to the clinic because they don't have money for transportation. We have to bring the services to the public. We need to strengthen awareness and accessibility of the services.

Women/Maternal Health - Application Year

Women/Maternal Health Annual Plan

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

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

Objective 1: Increase number of women with preventive medical visits by 5% yearly.

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

MCH/FP Program will partner with other Public Health Programs that visit the outer islands to provide comprehensive outreach mobile visits. Comprehensive outreach mobile visits composed of Immunization Program, MCH Program, FP Program, Leprosy Program, TB Program, HIV/STI Program and NCD Program. MCH will support 6 Outer Islands outreach mobile visits to reach 18-44 years old that needs preventive medical visits.

MCH services that will be provided are Prenatal and Post Partum, Family Planning, Cervical Cancer Screening.

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

MCH Program Director has been working with Cancer Program in the RMI National Breast and Cervical Cancer Early Detection Program. Cancer Program has funding to support off-site/off-hrs clinics which will serve women that can't come to the MCH Clinics because they are working and support shipment and testing of specimen to off-island diagnostic laboratory. MCH Program will support the partnership through staff and clinics needs.

Objective 2: Increase percentage of women ages 25-49 yrs old screened for cervical cancer by 5% yearly.

Strategy: Continue the implementation of the Cervical Cancer Screening database for data collection and reporting

MCH Program, SSDI Program, and Taiwan ICDF (International Cooperation and Development Fund) Volunteer developed and implemented the Cervical Cancer Screening database in the last quarter of 2017. In 2018-2019, we plan to implement the system in Ebeye MCH Program. We will be able to track out screening, treatment and referrals.

As we continue the use of the current database, the Health Informatics Department is working with its contractor to create and develop the cancer screening module in the MHIS (Marshall Hospital Information System)

For the Outer Island screening, MCH program in the main office in Majuro will be responsible in collection and reporting.

Strategy: Increase public awareness of the cervical cancer including risk factors, prevention screening and treatment

Continue to conduct campaigns through print, radio, and social media ads to increase awareness on cervical cancer's risk factors, prevention, screening and treatment. Advocate for early screening and detection. Partner with community groups but not limited to WUTMI (Women United Together Marshall Islands), KIJLE (family-based group), and faith-based organization. Create and distribute Marshallese/English video on preventive medical screening. Meet with private owned company to include cervical cancer screening as part of their yearly medical clearance.

Strategy: Establishment of referral system for patients with abnormal papsmear or VIA findings

MCH Program will work with the Outer Islands Health Care Services Director and 177 Health Care Program administrator in creating and implementing policy for a referral system for patients with abnormal cervical cancer screening results. MCH funds will be used to support travel for women with abnormal results for follow up with OBGYNs on Majuro.

Objective 3: Increase percentage of women ages 15-44 years old that use family planning services by 5% yearly.

Strategy: Increase public awareness of the Family Planning Services

Create and distribute family planning services related videos, posters and other promotional materials in Marshallese language. Conduct family planning awareness campaign in school, community meetings, women organization meetings and events, and use of social media platform.

Strategy: Continue the after 5 pm Family Planning Clinic

Family Planning Program will re-activate the after 5 pm Family Planning Clinic at the Youth to Youth in Health. This service will target working women and other patients that don't want to come to the public health clinic but prefer to come to an offsite clinic

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

The program will collaborate with Outer Islands Health Centers for the monthly reports on clients and inventory of commodities on hand. The program will also distribute commodities to outer islands health centers on a quarterly basis through Outer Islands Health center office or through Ministry's mobile trips.

Objective: Increase pregnant women that received dental check up by 5% yearly

Strategy: Strengthen referral of pregnant women to Dental Services

MCH Program – Prenatal Clinic ensures that pregnant women are referred to Dental Services. By the end of the week, MCH program will collect information from Dental Services and enter into the Reproductive Health Information System – Prenatal Services Module. MCH Program is working with Oral health Services to improve the services and develop indicators.

Strategy: Support the Dental Services team in providing outreach mobile visits to the Outer Islands Health Centers.

MCH Program will assist Dental Services team to provide dental check up to pregnant women in the Outer Islands. We will include dental services in the Outreach mobile visits.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	28.0	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4

National Performance Measures

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

NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data			
	2016	2017	2018
Annual Objective	90	100	100
Annual Indicator	100	100	100
Numerator	1,089	989	989
Denominator	1,089	989	989
Data Source	MCH Program	MCH Program	RMI ICHNS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	50	53	42
Annual Indicator	50.3	40.5	42.3
Numerator	548	401	373
Denominator	1,089	989	881
Data Source	MCH Program	MCH Program	RMI ICHNS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.0	46.0	48.0	50.0	52.0	52.0

Evidence-Based or –Informed Strategy Measures

ESM 4.2 - Percentage of pregnant women that where given comprehensive breastfeeding counselling during prenatal visit

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	70	10	
Annual Indicator	0	58.4	
Numerator	0	734	
Denominator	1,097	1,257	
Data Source	MCH Program	MCH Program	
Data Source Year	2017	2018	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	62.0	64.0	66.0	68.0	70.0

State Performance Measures

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		48	50	
Annual Indicator	46.1	46.8	61.3	
Numerator	868	795	995	
Denominator	1,881	1,697	1,624	
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	63.0	65.0	67.0	69.0	71.0	73.0

SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	10.0	12.0	14.0	16.0	18.0

SPM 8 - Percent of newborn that received congenital cytomegalovirus (CMV) screening

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5.0	7.0	9.0	11.0	14.0	17.0

SPM 9 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	37.0	39.0	41.0	43.0	45.0	47.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Perinatal/Infant Health - Entry 1

Priority Need

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

NPM

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

Objectives

By 2020, increase of mothers that report exclusive breastfeeding of infant up to 6 months of age by 10%

Strategies

Continue to conduct proper breastfeeding training in hospitals, clinics and health centers

Increase community awareness on benefits of breastfeeding and proper breastfeeding

ESMs

Status

ESM 4.1 - % of hospitals accredited as baby friendly.

Inactive

ESM 4.2 - Percentage of pregnant women that where given comprehensive breastfeeding counselling during prenatal visit

Active

NOMs

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

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

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

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

Priority Need

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

SPM

SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening

Objectives

Increase the percentage of newborn screened for Congenital Hypothyroidism by 5% yearly

Strategies

Develop the clinical guidelines for Congenital Hypothyroidism newborn screening treatment and referrals.

Coordinate with the Laboratory Department to ensure that supplies are available

State Action Plan Table (Marshall Islands) - Perinatal/Infant Health - Entry 3

Priority Need

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

SPM

SPM 8 - Percent of newborn that received congenital cytomegalovirus (CMV) screening

Objectives

Increase the percentage of newborn screened for congenital cytomegalovirus (CMV) by 5% yearly

Strategies

Develop the clinical guidelines for congenital cytomegalovirus (CMV) newborn screening, treatment and referrals.

Coordinate with the Laboratory Department to ensure that test will be conducted and supplies are available.

MCH Program will work with mHIS developer to include the newborn screening in the hospital information system.

State Action Plan Table (Marshall Islands) - Perinatal/Infant Health - Entry 4

Priority Need

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

SPM

SPM 9 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Objectives

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

Strategies

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

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

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

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

Perinatal/Infant Health - Annual Report

Perinatal/Infant Health Annual Report

Having healthy infants are linked to the good health of the mothers. In 2017, MCH program with clinical advisor provided trainings in improvement of prenatal services, Maternity and Labor and Delivery wards. Standardizing the clinical guidelines to be able to improve health care given to the mother and infant.

Ensure every pregnant woman is receive with quality prenatal care

Prenatal care services are available in the 2 main hospitals and all 60 health centers. In the health centers, service is limited wherein tests that needs laboratory confirmation are not available.

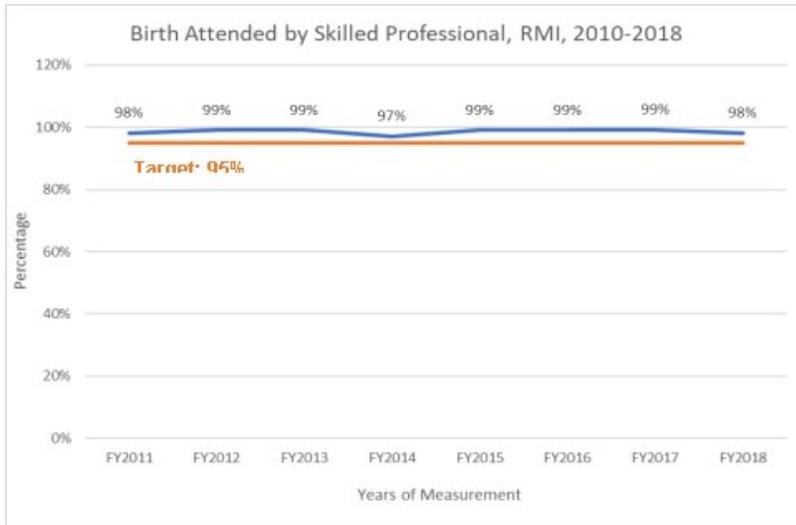
Prenatal FY2018				
	Majuro	Ebeye	Outer Islands	
Pregnant Women visited Prenatal	863	321	73	1257
1st Trimester 1st Visit	269	143	22	434
% of 1st Trimester 1st Visit	31%	45%	30%	35%
Total Number of Prenatal Visits	4352	2122	289	6763
1st Trimester Prenatal Visits (445	189	69	703
2nd Trimester Prenatal Visits	1397	578	126	2101
3rd Trimester Prenatal Visits	2500	1355	94	3949

ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits

	2017	2018
Annual Objective	90	68
Annual Indicator	66.1	66.8
Numerator	654	661
Denominator	989	989
Data Source	MCH Program	MCH Program

Ensure every woman has skilled professional at delivery

98% of births in 2018 are delivered by skilled attendants like nurse, midwife, health assistant, medical assistant and doctors. In childbearing, women need a continuum of care to ensure the best possible health outcome for them and their newborns. This includes care at the clinic before and after delivery, as well as high quality midwifery care at delivery. The risk of stillbirth and maternal deaths is reduced by about 20% with the presence of a skilled birth attendant.



Infant Health

	2016	2017	2018
Percent of low birth weight deliveries (<2,500 grams)	11.0	16.2	12.8
Percent of preterm births (<37 weeks)	7.1	9.4	10.1
Percent of early term births (37, 38 weeks)	76.1	24.7	27.2
Perinatal mortality rate per 1,000 live births plus fetal deaths	17.3	20.2	17
Infant mortality rate per 1,000 live births	23.0	18.2	9.1
Neonatal mortality rate per 1,000 live births	11.0	11.1	8.1
Post neonatal mortality rate per 1,000 live births	11.9	7.1	1
Preterm-related mortality rate per 100,000 live births	275.5	404.4	202.2

9.1 per 1,000 live births died in 2018 before they reach the age of 1 yr. old. Prematurity, aspiration, and pneumonia are the most common underlying causes of death for these infants. These are all preventable. Early and complete prenatal clinic attendance will have better management of the pregnancies and deliveries. Exclusive breastfeeding up to 6 months will boost the immune system of the infants and well nourishment.

In 2017-2018, RMI conducted survey on child health and nutrition for 0-5 yrs old. Below is the result on breastfeeding and infant feeding,

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

MCH Program is actively advocating breastfeeding inside and outside the hospitals. In the hospital, no bottle feeding is implemented but there are mothers that are not following the policy. During the MCH Workshop, the maternity nurses shared that Chinese women opted for bottle feeding than exclusive breastfeeding.

Infants that died of malnutrition are in the late stage. Pediatricians will manage the cases but still demise due to the health of the infant. One of the needs presented by the Pediatricians is to have a feeding program. MCH Program will look into this and work with the Senior Leadership for strategies and funding.

First Embrace Initiative

The Ministry of Health and Human Services continue to practice the “First Embrace” where in the newborn has immediate skin to skin with the mother followed by proper clamping and cutting of the umbilical cord with sterile instruments. Breastfeeding then initiates naturally at feeding cues, such as drooling, tonguing, rooting and biting the hand. Early initiation of breastfeeding is especially important because colostrum, or the first milk, contains essential nutrients, antibodies and immune cells.

The infants are roomed in with the mother unless the infant or the mother has medical problem

Well Baby Clinic Update

In 2016, Pacific Health Officers’ Association (PIHOA) provided consultants funded by their Zika Response Funding. 1 consultant was assigned to work on with us in MCH Clinic and Program.

From November 2016 to July 2017, consultant worked with us on the following activities:

Objectives

During a Well Child Care (WCC) visit, on a child the participant will:

- 1- know the number and intervals of WCC visits in a child's 1st 2 years of life
- 2-demonstrate understanding of what a WCC visit constitutes; "it's more than taking a weight"
- 3-demonstrate accurate skills in taking weight, Head Circumference, Chest, and length measure
- 4-record on a WHO approved graph and interpret measures accurately enough to know when to refer a child who is not developing properly
- 5-apply and interpret a simple 10 question Denver developmental based assessment tool accurately enough to know when to refer a child who is not developing properly
- 6-give at least 1 reason why WCC visits are important

Participants and dates: Over the last year, a concerted effort was made to roll out systematic training of MOHHS health care providers in an attempt to build better well child skills in hopes of identifying and referring children early to care or further evaluation. The next step is Outer Island pregnancy care.

	2016	2017	2018
NPM 4 - A) Percent of infants who are ever breastfed	100	100	100
NPM 4 B) Percent of infants breastfed exclusively through 6	50.3	40.5	42.3

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

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

Perinatal/Infant Health - Application Year

Perinatal/Infant Health

MCH Program continues to support the improvement of services in prenatal and new born screening. In May 2018, HIV/STI Program implemented SD Bioline HIV/Syphilis Duo in partnership with MCH Program. Syphilis and HIV testing at the tip of your fingers. Result will come out 15-20 minutes. Availability of Chlamydia and Gonorrhea testing through GeneXpert. For 2 years, we were not able to perform Chlamydia and Gonorrhea testing because of logistics problem.

With the recent MCH Workshop, the team identified the need to improve the newborn screening. Currently, we can only provide new born hearing screening. In 2018-2019 plan, we will introduce 2 newborn screening – Congenital Hypothyroidism and PCR-CMV Saliva test.

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

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

Objective: By 2020, increase of mothers that report exclusive breastfeeding of infant up to 6 months of age by 10%

Strategy: Continue to conduct proper breastfeeding training in hospitals, clinics and health centers

MCH Program will provide breastfeeding training to nurses at the Maternity, Labor & Delivery, Pediatric Ward, MCH Clinics, and health centers. Breastfeeding classes will continue to be offered to mothers attending post-partum clinics and visiting immunization clinics.

MCH Program will conduct at least 1 public awareness campaign during the Breastfeeding week.

Strategy: Increase community awareness on benefits of breastfeeding and proper breastfeeding

MCH Program will work with Health Promotion Unit and SSDI/Health Informatics Department to create videos and promotional materials. During Women Conference, MCH Program will participate to promote and train women on proper breastfeeding. Program will use radio, print, and social media platforms to promote breastfeeding. Continue providing health education, promotion and demonstration to mothers on exclusive breastfeeding of infants up to 6 months, complimentary food at 6 months and to continue breastfeeding up to 2-3 years of life during their prenatal and well-baby clinic visit

SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening

Objective: Increase the percentage of newborn screened for Congenital Hypothyroidism by 5% yearly

Strategy: Develop the clinical guidelines for Congenital Hypothyroidism newborn screening treatment and referrals.

Since this is a new screening, MCH Program will develop the clinical guidelines for Congenital Hypothyroidism with

the assistance from our Pediatricians. MCH Program will include newborn screening for congenital hypothyroidism through TSH testing. Our goal is to detect and start treatment within the first 1–2 weeks of life. Since we don't have endocrinologist, our pediatricians will be managing the treatment of the patients.

Strategy: Coordinate with the Laboratory Department to ensure that test will be conducted and supplies are available.

MCH Program will provide medical supplies for the newborn screening. Staff from MCH Program will ensure that the testing will be done on time

Strategy: MCH Program will work with mHIS developer to include the newborn screening in the hospital information system.

MCH Program will work with SSDI Director to create an information system for the two main hospitals.

SPM 8 Percent of newborn tested for congenital cytomegalovirus (CMV)

Objective: Increase the percentage of newborn screened for congenital cytomegalovirus (CMV) by 5% yearly

Strategy: Develop the clinical guidelines for congenital cytomegalovirus (CMV) newborn screening, treatment and referrals.

New born that shows signs of congenital CMV at birth (Petechiae/purpura, Hepatosplenomegaly, Jaundice, Seizures, Microcephaly, Retinitis , Intrauterine growth restriction) will be tested for PCR CMV laboratory test. Testing should be done within two to three weeks of birth. If testing is done more than three weeks after birth, it is not possible to distinguish between congenital CMV infection and an infection acquired after birth. MCH Program will work with Laboratory Department to be able to assist on this testing which have to be submitted to off-island diagnostic laboratory.

Once the newborn is diagnosed with CMV, MCH Program will enroll the baby to Children with Special Health Care Needs and Early Intervention Program. CSHCN Coordinator will help parents get the services their children need and understand the services a child with congenital CMV infection may need, such as regular vision and hearing screening, and speech, occupational, and physical therapy. For children with hearing loss, early interventions, such as hearing aids, can help strengthen communication and language skills. Improvements in these areas can lead to positive social interactions and educational development.

Strategy: Coordinate with the Laboratory Department to ensure that test will be conducted and supplies are available.

MCH Program will provide medical supplies for the newborn screening. Staff from MCH Program will ensure that the testing will be done on time

Strategy: MCH Program will work with mHIS developer to include the newborn screening in the hospital information system.

MCH Program will work with SSDI Director to create an information system for the two main hospitals.

SPM 9 Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

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

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

MCH Program will partner with Health Promotion Unit and SSDI/Health Informatics Department to create promotional and health education materials for distribution by radio, print and social media postings.

MCH Program will participate in the Women Conferences and Faith Based Conferences to present the benefits of prenatal visits to be able to convince the community to come to Prenatal Clinic at the earliest stage of pregnancy.

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

MCH Program will continue to partner with Immunization Program through their zone/outreach nurses to refer pregnant women that they encounter on their outreach visits to Prenatal Clinic.

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

MCH Program in partnership with HIV/STI Program recently implemented SD Bioline HIV/Syphilis Duo. Syphilis and HIV testing at the tip of your fingers. Result will come out 15-20 minutes. Availability of Chlamydia and Gonorrhea testing through GeneXpert. For 2 years, we were not able to perform Chlamydia and Gonorrhea testing because of logistics problem.

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

MCH Program will submit incentive program to the Secretary of Health and Human Services for review and approval. Once approved, program will immediately implement and include in the awareness campaign. One of the incentives suggested by the team is to waive hospital fee for pregnant women that attended the 1st trimester.

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 7.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 6

National Performance Measures

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			44
Annual Indicator	43.9	42.8	30.8
Numerator	1,668	532	500
Denominator	3,801	1,243	1,624
Data Source	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	55.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM 6.2 - Percentage of children diagnosed with ASD and ADHD

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	12.0	14.0	16.0	18.0	18.0

**NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
Indicators and Annual Objectives**

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

State Provided Data			
	2016	2017	2018
Annual Objective	625	112	110
Annual Indicator	114.4	108.7	34.6
Numerator	32	16	5
Denominator	27,965	14,716	14,457
Data Source	Hospital Database	Hospital Database	Hospital Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Provisional	Final	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	106.0	106.0	104.0	102.0	102.0	100.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Number of community campaign on awareness and promotion of child safety within the community.

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	3	3	
Annual Indicator	0	0	
Numerator	0	0	
Denominator	3	3	
Data Source	MCH Program	MCH Program	
Data Source Year	2017	2018	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	3.0	3.0	3.0	3.0	3.0

State Performance Measures

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		48	50	
Annual Indicator	46.1	46.8	61.3	
Numerator	868	795	995	
Denominator	1,881	1,697	1,624	
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	63.0	65.0	67.0	69.0	71.0	73.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Child Health - Entry 1

Priority Need

Improve child health through early childhood developmental screening and vaccinations

NPM

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

Objectives

By 2020, increase children ages 10 through 71 months who receive developmental screening and proper care by 5% yearly.

Strategies

Implement the new well baby clinic standardized developmental tool in the two main hospitals and all the health centers.

Implement data system to capture and monitor developmental screening information and referrals

Create and distribute new baby passport where monitoring of developmental tools is included.

ESMs

Status

ESM 6.1 - Implement a Comprehensive Developmental Screening tool for 10 through 71 months children Inactive

ESM 6.2 - Percentage of children diagnosed with ASD and ADHD Active

NOMs

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

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

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

Priority Need

Promote child safety in the community.

NPM

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Objectives

By 2020, MCH Program with community partners will conduct at least 3 community campaigns on awareness and promotion of child safety within the community

Strategies

Community and media awareness and health education on non-fatal injuries, first aid treatment and child safety against motor vehicle accidents, fall, burn, drowning, choking, and other injuries
 Strategy: Work with the Public School System on child safety policies and awareness education.

ESMs

Status

ESM 7.1.1 - Number of community campaign on awareness and promotion of child safety within the community.	Active
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NOMs

- NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000
- NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
- NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
- NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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

Priority Need

Improve child health through early childhood developmental screening and vaccinations

SPM

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

Objectives

To increase immunization coverage for children 19 to 35 months old by 4% yearly

Strategies

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

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

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

Child Health - Annual Report

Child Health Annual Report

Priority Need: Improve child health through early childhood developmental screening, and complete vaccinations.

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

ESM 6.1 - Implement a Comprehensive Developmental Screening tool for 10 through 71 months children

Currently, the developmental screening tool is completed by the nurses while asking the parent/s. It is easier for the health care professional and the parents to have it this way so that the health care professional explains the screening tool. In this reporting period, MCH program with PIHOA-Zika consultant updated the developmental tool. We are in the process of update our data system to accommodate the revision of the developmental tool.

ESM 6.1 is completed. Both NPM and ESM will not be applicable in the next reporting period.

Well Baby Clinic Update

In 2016, Pacific Health Officers' Association (PIHOA) provided consultants funded by their Zika Response Funding. 1 consultant was assigned to work on with us in MCH Clinic and Program.

From November 2016 to July 2017, consultant worked with us on the following activities:

During a Well Child Care (WCC) visit, on a child the participant will:

- 1- know the number and intervals of WCC visits in a child's 1st 2 years of life
- 2-demonstrate understanding of what a WCC visit constitutes; "it's more than taking a weight"
- 3-demonstrate accurate skills in taking weight, Head Circumference, Chest, and length measure
- 4-record on a WHO approved graph and interpret measures accurately enough to know when to refer a child who is not developing properly
- 5-apply and interpret a simple 10 question Denver developmental based assessment tool accurately enough to know when to refer a child who is not developing properly
- 6-give at least 1 reason why WCC visits are important

Participants and dates: Over the last year, a concerted effort was made to roll out systematic training of MOHHS health care providers in an attempt to build better well child skills in hopes of identifying and referring children early to care or further evaluation. The next step is Outer Island pregnancy care.

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

	2016	2017	2018
Annual Objective	615	112	110
Annual Indicator	114.4	108.7	34.6
Numerator	32	16	5
Denominator	27,965	14,716	14,457

2016 - Cause for hospitalization are burn, injury, suicide, MVA, and environmental accident.

2017: Cause of hospitalization: Burn, Fall, Drowning, Moving Vehicle Accident, hot liquid, injury.

2018 - Diagnosis for hospitalization are head injury, burn and MVA

Child injuries are preventable but we still continue to receive patients in the hospital. Community and families need to work together to make the environment safe for the children.

The Ministry of Public Safety continues to implement the following activities to support the promotion of child safety:

1. Seat Belt Law
2. Police man assigned to each school during arrival and dismissal of students
3. Traffic stops when school bus stopped and wait for pick up or return the students from school to their designated area

	2016	2017	2018
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	59.3	68.6	53.4

In 2017, there are 68.6 per 100,000 children ages 1 to 9 yrs old. Underlying cause of death are: 2 to drowning, 1 vehicular accident, 1 laceration of the neck (murder), 3 malnutrition, 1 dehydration, 1 probable meningitis,

In 2018, Causes of death: Severe malnutrition: 1, Drowning: 2, MVA: 1, Septicemia: 2, Meningitis: 1

It is unfortunate that young children are dying of malnutrition and dehydration. We need to strengthen family and community support group. If a child in the community is malnourished, members of the community can refer them to MCH Program to be able to refer to the health care that the child needs. We don't have WIC.

SPM 2 - Final and endorsed readiness assessment of RMI MOHHS to handle Autism Spectrum Disorder, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Program

State Provided Data

	2016 
Annual Objective	<input type="text"/>
Annual Indicator	No <input type="text"/>
Numerator	<input type="text"/>
Denominator	<input type="text"/>
Data Source	MCH program
Data Source Year	2016
Provisional or Final ?	<input type="radio"/> Provisional <input checked="" type="radio"/> Final

RMI MOHHS MCH Program needs TA in conducting the readiness assessment. This has been requested under the TA section. This will be the first time that RMI MOHHS will be assessing our capacity. Using the readiness assessment report, we can create our strategic plan to be able to address the proper management of these conditions.

In September 2017, a Psychiatrist was hired under the Bureau of Behavioral Health. He started looking into ASD and ADHD services in RMI as he has a child with ADHD. But he can't find any previous data or guidelines Referral from Well baby clinic and Children's clinic was not fully functional. A screening tool for ASD and ADHD was developed and endorsed. In 2018, Behavioral Health and MCH Program with CSHCN will implement the screening tool in all well baby and children's clinics. Strengthen referral system to be able to provide the proper diagnosis, management and treatment.

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

The National Immunization Program continue to provide vaccination services. The RMI Immunization schedule is 4DTAP, 3HepB, 1HIB, 1MMR, 3IPV for 19-35 months. Immunization program had to visit 1 island for 4 times a year to be able to reach 90% immunization rate in the Outer Islands. This is an ideal situation where in the program is having difficulty to achieve due to challenge in air and sea transportation, staff and movement of population from island to island.

RMI Immunization Coverage Rate for children 19-35months (4DTAP, 3HepB, 1HIB, 3IPV, 1MMR)

Islands	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Majuro	93%	68%	55%	60%	53%	55%	41%	40.8%	61.2%
Kwajalein	99%	99.70%	99%	99%	99%	99%	95%	89.2%	95.2%
Outer Islands	56%	55%	32%	57%	34%	46%	23%	21.8%	25.6%
RMI	84%	72%	53%	65%	55%	59%	47%	46.8%	61.3%

Below is the RMI Immunization schedule:

Recommended vaccination schedule for children 0-6 years, Republic of the Marshall Islands

Vaccine	Birth	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	4-6 years
BCG	1 st Dose						
HepB	1 st Dose	2 nd Dose		3 rd Dose			
DTaP		1 st Dose	2 nd Dose	3 rd Dose	4 th Dose		5 th Dose
Polio		1 st Dose	2 nd Dose	3 rd Dose			4 th Dose
Hib		1 st Dose	2 nd Dose		3 rd Dose		
PCV		1 st Dose	2 nd Dose	3 rd Dose	4 th Dose		
Rotavirus vaccine		1 st Dose	2 nd Dose	3 rd Dose			
MMR					1 st Dose	2 nd Dose	

We don't have cold chain equipment in the Outer Islands due to problem in supply of electricity. WHO has recommendations on solar powered cold chain equipment. But CDC didn't agree that the vaccines funded under CDC will be stored in equipment not assessed or approved by CDC.

Immunization continue to provide vaccines in Majuro, Ebeye and Outer Islands. Program has zoning and outreach mobile visits. They bring the services to the public.

Child Health

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

Priority Need: Improve child health through early childhood developmental screening and vaccinations

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

Objective: By 2020, increase the number of children ages 9 through 35 months, who received developmental screening.

Strategy: Implement the new well baby clinic standardized developmental tool in the two main hospitals and all the health centers.

In 2017, the new well baby clinic standardized developmental tool was approved and implemented to be used. 14 health centers and Majuro Hospital Well Baby Clinic were trained in using the standardized form. MCH program will continue the implementation of the tool to all remaining health centers and Ebeye Hospital Well Baby Clinic.

Strategy: Implement data system to capture and monitor developmental screening information and referrals.

SSDI/Health Informatics Director will work with the developer of mHIS (Marshall Islands Hospital Information System) to create a module that will capture and monitor developmental screening and referrals

For Outer Islands Health Center will report to the main office in Majuro through radio calls. For the health centers with DAMA System, we will create a reporting template that can be sent through email to the Majuro main office to merge to mHIS.

Strategy: Create and distribute new baby passport where monitoring of developmental tools is included.

MCH program will ensure that the parents are involved in the monitoring of growth. Program will create and distribute a baby passport where developmental growth monitoring, immunization and breastfeeding information are included.

Strategy: Strengthen referral of children with behavioral and emotional disorder to Behavioral Health

MCH Program will work closely with our Psychiatrist for referral of children with behavioral and emotional disorder for proper diagnosis and treatment.

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

Objective: Increase immunization coverage for children 19 to 35 months old by 4% yearly

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

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

WebIZ is scheduled to implement a mobile WebIZ in 2019-2020. Implementing this upgrade will be easier to search patient history and enter immunization even outside MOHHS and no internet connection. This is beneficial in the Outer Islands where we don't have island wide internet connection.

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

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

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

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

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

Priority: Promote child safety in the community.

Objective: By 2020, MCH Program with community partners will conduct at least 3 community campaigns on awareness and promotion of child safety within the community

Strategy: Community and media awareness and health education on non-fatal injuries, first aid treatment and child safety against motor vehicle accidents, fall, burn, drowning, choking, and other injuries

MCH Program will work with Health Promotion Unit to create educational materials that can be released through radio, print, videos and social media postings. Program will also partner with but not limited to Public Safety, Red Cross, WUTMI, Kijle, and other NGOs willing to assist our priority.

Strategy: Work with the Public School System on child safety policies and awareness education.

MCH program will work with PSS and Parent-Teachers' Association in training teachers and parents in First Aid and awareness on child safety in the school.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2007	24.5 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS	Data Not Available or Not Reportable	NPM 10

National Performance Measures

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	62.0	64.0	66.0	68.0	68.0	68.0

Evidence-Based or –Informed Strategy Measures

ESM 10.2 - HPV vaccine coverage of girls age 13 years

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	47	37	
Annual Indicator	34.9	36.4	
Numerator	230	245	
Denominator	659	673	
Data Source	WebIZ, Immunization Program	WebIZ, Immunization Program	
Data Source Year	2017	2018	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	39.0	41.0	43.0	45.0	47.0	49.0

State Performance Measures

SPM 5 - Increase use of Family planning services to teenagers ages 13 to 17 years old

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	10	20	
Annual Indicator	18.6	18.8	
Numerator	124	126	
Denominator	6,650	6,686	
Data Source	Family Planning Program	Family Planning Program	
Data Source Year	2017	2018	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Adolescent Health - Entry 1

Priority Need

Improve adolescent health through promotion of adolescent well-being and reducing teen pregnancy

NPM

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

Objectives

Increase HPV coverage rate for 13 years old female by 5% yearly

Strategies

Make HPV Vaccination Routine Vaccine to 11-12 yrs old.

Strengthen HPV Vaccination messages to the community in partnership with Cancer Program

Conduct meetings with Parent and Teachers Association (PTAs) to provide awareness and health education on HPV vaccines and cervical cancer

ESMs

Status

ESM 10.1 - Annual Medical visits for 12-17 years old

Inactive

ESM 10.2 - HPV vaccine coverage of girls age 13 years

Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Improve adolescent health through promotion of adolescent well-being and reducing teen pregnancy

SPM

SPM 5 - Increase use of Family planning services to teenagers ages 13 to 17 years old

Objectives

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

Strategies

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

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

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

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

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

Adolescent Health - Annual Report

Adolescent Health Annual Report

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

	2016	2017	2018
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	17.2	61.4	
Increase use of Family planning services to teenagers ages 13 to 17 years old (Rate per 1,000 Teenagers 13-17 yrs old.)		18.6	18.8
HPV vaccine coverage of girls age 13 years (%)		34.9	36.4
Adolescent mortality rate ages 10 through 19, per 100,000	76.6	51.5	103
Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	0	0	0
Adolescent suicide rate, ages 15 through 19, per 100,000	65	0	31.1
Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	37.2	21.2	40.7
Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	35.4	17	12.9
Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	28.8	13	12.9
Teen birth rate, ages 15 through 19, per 1,000 females	49	45	48.4

Preventive medical visit services include Eye check up, Stool and urine analysis, Immunization, TB Screening, Leprosy Screening and STI/HIV Screening. Due to limited and availability of complete services in the Outer Islands, preventive medical visit is only given in Majuro Hospital and Ebeye Hospital. Medical clearance is required for high school and college entry, food handlers, work clearance and immigration.

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

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

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

There are 2 suicide deaths who were both 19 yrs old male. The community supports activities like basketball games, volleyball games, drama plays, and school activities where in adolescent population are involved and given chance to excel. Behavioral Health staff are coming to the schools to provide health talks especially on stress on being a

teenager, peer pressure and bullying.

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

There are only 18.8 per 1,000 female ages 13 to 17 years old that has family planning services. We have to strengthen our activities and reach more teenagers which will eventually lower down our teen births which is 48.4 per 1,000 females ages 15-19 yrs old. Teen prevention pregnancy group continue to visit the high schools in Majuro, Ebeye and Outer Islands to provide presentations, counselling and distribution of condoms. MCH Program with partnership with HIV/STI Program created and implement the Sexual Reproductive Health curriculum to one of the private school. The trained students are able to provide SRH talk to other students. Students are more open and comfortable talking with the same age group.

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

Adolescent Health

Priority Need: Improve adolescent health through promotion of adolescent well-being and reducing teen pregnancy

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

Objective: Increase HPV coverage rate for 13 years old female by 5% yearly

Strategy: Make HPV Vaccination Routine Vaccine to 11-12 yrs old.

With assistance from the Senior Leadership of the Ministry of Health and Human Services, we will amend the RMI School Immunization Law to include HPV vaccine as a routine vaccine. HPV Task group was created in 2019 to address the activities for the HPV campaign.

HPV vaccines will be included in the vaccines that are required. By 13 years old, 2 HPV vaccines are completed including the females in the Outer Islands.

Strategy: Strengthen HPV Vaccination messages to the community in partnership with Cancer Program

HPV Task Group composed of MCH, Cancer Program, Immunization Program, and WUTMI will conduct HPV vaccination campaign. We will utilize print, radio, and social media platform to send our message. Programs will participate in women conferences and youth conferences to send out the message about HPV vaccination and link to cervical cancer.

With assistance from CDC funding, at least 1 Middle School will be engaged in HPV campaign.

Strategy: Conduct meetings with Parent and Teachers Association (PTAs) to provide awareness and health education on HPV vaccines and cervical cancer

Immunization Program will build relationship with the parents and teachers to be able to get the support and approval of the parents on getting their daughters immunized with HPV vaccines. We will include Cancer Program in presenting the link of HPV and cervical cancer.

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

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

Family Planning Program will utilize the FP IEC (Information, Education and Communication) Committee to revise old FP IEC materials and create new IEC in Marshallese, English and Chinese language. MCH Program will assist in producing the radio, print, video and social media postings. FP program will participate in the annual Women Conference, Youth to Youth Conference and Faith Based Conferences.

Strategy: Strengthen the Family Planning Services at the Youth to Youth in Health Clinic and

after dark clinic

FP services will still be available in Youth to Youth in Health and after dark clinic in Majuro. Clinic starts at 5:30 PM to 7:00 PM, Monday and Friday. The target population is the youth and patients that can't come to the FP clinic during regular clinic hours.

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

Program will ensure that FP commodities are available in all FP clinics and health centers in the Outer Islands.

Strategy: Family Planning commodities and counselling training to MCH nurses, Family Planning nurses and School Nurses

With partnership with UNFPA, MCH Program will support the Family Planning commodities and counselling training 2018-2019. The training for school nurses will build capacity to provide FP services in the schools.

Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 12

National Performance Measures

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives**

NPM 12 - Children with Special Health Care Needs

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

State Provided Data			
	2016	2017	2018
Annual Objective			8
Annual Indicator	0.1	0	0
Numerator	10	0	0
Denominator	7,978	8,045	8,119
Data Source	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	11.0	14.0	17.0	20.0	20.0	20.0

Evidence-Based or –Informed Strategy Measures

ESM 12.2 - Percent of adolescent that moved to adult health care

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	10	15	
Annual Indicator	10	16.1	
Numerator	1	10	
Denominator	10	62	
Data Source	MCH Program	MCH Program	
Data Source Year	2017	2018	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	25.0	30.0	35.0	35.0	37.0

State Performance Measures

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		48	50	
Annual Indicator	46.1	46.8	61.3	
Numerator	868	795	995	
Denominator	1,881	1,697	1,624	
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	63.0	65.0	67.0	69.0	71.0	73.0

State Action Plan Table

State Action Plan Table (Marshall Islands) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve enrollment and special care of CHSCN through developmental screening and referrals to proper care

NPM

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

Objectives

By 2020, increase number of children with special health care needs referred to proper medical management by 5% yearly

Strategies

Develop and implement the Birth Defects Registry

Develop and implement clinical management guidelines for CSHCN referrals

ESMs

Status

ESM 12.1 - Review and create a doable approach on transition to adult health care

Inactive

ESM 12.2 - Percent of adolescent that moved to adult health care

Active

NOMs

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

Children with Special Health Care Needs - Annual Report

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

	2016	2017	2018
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care	0	0	0

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

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

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

Activities implemented:

Program was able to meet with Public School system and representatives from University of Hawaii who were in Majuro to offer classes to teachers of children with special health care needs to improve quality services. After the meeting it was agreed that programs will be sharing information on database to make sure all clients are registered.

Program was also able to meet with the EHDI program and consultants and family representative to discuss on issues facing the children with special health care needs in the schools.

-Staff implementing early newborn hearing screening were able to attend the annual conference which is necessary to better serve the population.

-Program engaged in the planning and implementing process for the World Disability week.

Accomplishment:

-Collaboration with EHDI, PSS and University of Hawaii.

Challenges:

-Lack of staff to concentrate on the program and activities.

-No case find activities.

MCH Program continues to provide services to CSHCN patients.

Through MCH Block Grant, we fund the patients for their travel and 2 weeks stipend for their medical referral to Shriners' Hospital or other Hospitals that they are accepted. After 2 weeks, Medical Referral office will assume the stipend of the patients and escort.

There were 10 children with special health care needs referred to Shriners' Hospital.

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

Children with Special Health Care Needs - Application Year

Children with Special Health Care Needs Annual Plan

Priority Need: Improve enrolment and special care of CHSCN through developmental screening and referrals to proper care

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

Objective: By 2020, increase number of children with special health care needs referred to proper medical management by 5% yearly

Strategy: Develop and implement the Birth Defects Registry

MCH Program will work with SSDI Program and Birth Surveillance Program in developing and implementing birth defects and surveillance registry including standard operating procedures and referrals to proper health care.

Strategy: Develop and implement clinical management guidelines for CSHCN referrals

MCH Program with the physicians and nurses will develop and seek endorsement on the clinical management guidelines for CSHCN referrals to proper health care.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Building - Annual Report

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

Cross-Cutting/Systems Building - Application Year

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

III.F. Public Input

MCH Program has presented and discussed the MCH Block Grant Application and open for public input during the following:

- Meeting with MOHHS staff and key partners like WUTMI, KIJLE, MIEPI, UNICEF, UNFPA
- Annual Women's Conference and Youth and Adult Church Annual Conference
- MCH Bi-Annum workshop

During the MCH Workshop the MCHBG was presented and inputs and recommendations from Ebeye and Majuro MOHHS programs and other NGOs were discussed on how the MCH grant can support activities implemented under MOHHS as well as other non-governmental organizations. Each program under MOHHS and NGOs presented on their activities targeting the population. Out of these meetings and presentations, we have gathered feedbacks and use it to conduct the review and update of the needs assessment.

Feedback from last year's MCH Block Grant was reviewed including the progress of the 2018 and continued plans for 2019 and 2020. Below are the recommendations in 2018 that are still the same recommendations for 2019-2020.

- New born screening – At the moment the only newborn screening offered is Newborn hearing screening. After the MCH workshop, it is recommended that PCR CMV saliva test and Congenital Hypothyroidism Screening should be included in the newborn screening.
- Maternal and Infant/Fetal Death Review- There's a need to revitalize this committee, to have meetings on timely manners to address the issues.
- Protocol and guidelines for Maternal and Child Health- there is a need to create protocols and standards for programs to follow.
- Strengthen Children with Special Health Care Needs: enrollment and referral system
- Family Health implementation
- Address teen pregnancy
- Revision of Birth and Death Certificate: Birth: inclusion of birth defects.
- Finalize and implementation of Vitamin A and De-worming guidelines
- Strategies on patients lost to follow up
- How to increase Family Planning users: refresher training to all Health Assistants.
- Translation of health promotion materials into Marshallese language
- STI/HIV implementation of SD Duo kits
- EHDI Program: Support to EHDI outreach visits, need early intervention teacher in Ebeye, EHDI services in Outer Islands, 177 will collaborate with EHDI program
- Collaboration and referral system for Autism, ADD/ADHD
- Immunization: Pneumovax for Adult – budget, HPV to include boys, Implementation of Cold Chain System in OI: Pilot Project
- NCD Program: Add children to their program, Free medication for NCDs, Policy in banning junk food at the school
- Mapping of NGOs
- SSDI: Uniform collection forms and reporting system

III.G. Technical Assistance

The MCH Program needs technical assistance on the following areas:

1 FIMR:

The program needs assistance on developing a team to focus on this area. We currently have a perinatal committee which consists of program staff, maternity and labor staff, OBGYNs. This committee conducts biannual meetings where charts are reviewed and discussions made on how to improve services and quality patient care.

2. Assistance on creating mch related awareness through print, videos, audio and social media postings

The program needs assistance in creating materials that will bring impact to the community.

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

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [RMI ICHNS 2017 Final Report_11_06_2017_CLEAN.pdf](#)

Supporting Document #02 - [RMI Report Draft \(no CI\).pdf](#)

Supporting Document #03 - [RMI Nutrition-WASH Formative Research_March 4_Final.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [MOHHS MCH Org Chart 2019.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Marshall Islands

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 226,000	
A. Preventive and Primary Care for Children	\$ 67,800	(30%)
B. Children with Special Health Care Needs	\$ 67,800	(30%)
C. Title V Administrative Costs	\$ 22,600	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 158,200	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 200,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 200,000	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 175,745		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 426,000	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 150,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 576,000	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 150,000

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 226,608		\$ 204,914	
A. Preventive and Primary Care for Children	\$ 67,983	(30%)	\$ 61,650	(30%)
B. Children with Special Health Care Needs	\$ 67,983	(30%)	\$ 61,650	(30%)
C. Title V Administrative Costs	\$ 22,660	(10%)	\$ 20,490	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 158,626		\$ 143,790	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 200,000		\$ 200,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 200,000		\$ 200,000	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 175,745				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 426,608		\$ 404,914	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 224,374		\$ 212,229	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 650,982		\$ 617,143	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 129,000	\$ 116,855
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 95,374

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

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 33,900	\$ 36,825
2. Infants < 1 year	\$ 33,900	\$ 14,000
3. Children 1 through 21 Years	\$ 67,800	\$ 61,650
4. CSHCN	\$ 67,800	\$ 61,650
5. All Others	\$ 0	\$ 10,299
Federal Total of Individuals Served	\$ 203,400	\$ 184,424

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 65,000	\$ 65,000
2. Infants < 1 year	\$ 50,000	\$ 50,000
3. Children 1 through 21 Years	\$ 30,000	\$ 30,000
4. CSHCN	\$ 36,000	\$ 36,000
5. All Others	\$ 19,000	\$ 19,000
Non-Federal Total of Individuals Served	\$ 200,000	\$ 200,000
Federal State MCH Block Grant Partnership Total	\$ 403,400	\$ 384,424

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Marshall Islands

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 143,000	\$ 128,363
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 60,000	\$ 50,825
B. Preventive and Primary Care Services for Children	\$ 48,000	\$ 38,514
C. Services for CSHCN	\$ 35,000	\$ 39,024
2. Enabling Services	\$ 38,000	\$ 44,650
3. Public Health Services and Systems	\$ 45,000	\$ 31,901
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		\$ 15,000
Physician/Office Services		\$ 70,000
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 15,000
Dental Care (Does Not Include Orthodontic Services)		\$ 15,000
Durable Medical Equipment and Supplies		\$ 8,000
Laboratory Services		\$ 5,363
Direct Services Line 4 Expended Total		\$ 128,363
Federal Total	\$ 226,000	\$ 204,914

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 135,000	\$ 60,000
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 53,000	\$ 25,000
B. Preventive and Primary Care Services for Children	\$ 47,000	\$ 15,000
C. Services for CSHCN	\$ 35,000	\$ 20,000
2. Enabling Services	\$ 25,000	\$ 15,000
3. Public Health Services and Systems	\$ 40,000	\$ 10,000
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 15,000
Physician/Office Services		\$ 10,000
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 10,000
Dental Care (Does Not Include Orthodontic Services)		\$ 12,000
Durable Medical Equipment and Supplies		\$ 10,000
Laboratory Services		\$ 3,000
Direct Services Line 4 Expended Total		\$ 60,000
Non-Federal Total	\$ 200,000	\$ 85,000

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: 989

Data Source Year: 2018

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	890 (90.0%)	9	9	9 (100.0%)

Program Name(s)
Hearing Loss

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Consistent Audiological and ENT consultation visits. Due to lack of needed equipment, the visiting ENT doctor brings own hospital equipment. The Early Hearing Detection and Intervention (EHDI) program continue to provide monitoring and treatment. EHDI also provides counselling to family members on providing special care needed by the infant.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Total Births by Occurrence
	Fiscal Year:	2018
	Column Name:	Total Births by Occurrence Notes
	Field Note:	Majuro: 618, Ebeye: 298, Outer Islands: 73
2.	Field Name:	Data Source Year
	Fiscal Year:	2018
	Column Name:	Data Source Year Notes
	Field Note:	MOHHS Vital Statistics Office
3.	Field Name:	Core RUSP Conditions - Receiving At Least One Screen
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	New born hearing screening is only provided in Majuro and Ebeye Hospitals
4.	Field Name:	Core RUSP Conditions - Confirmed Cases
	Fiscal Year:	2018
	Column Name:	Core RUSP Conditions
	Field Note:	Conductive Hearing loss: 5 Sensory-Neural Hearing loss: 4

Data Alerts: None

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

State: Marshall Islands

Annual Report Year 2018

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

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,257	0.0	0.0	100.0	0.0	0.0
2. Infants < 1 Year of Age	989	0.0	0.0	100.0	0.0	0.0
3. Children 1 through 21 Years of Age	8,707	0.0	0.0	100.0	0.0	0.0
3a. Children with Special Health Care Needs	156	0.0	0.0	100.0	0.0	0.0
4. Others	1,984	0.0	0.0	100.0	0.0	0.0
Total	12,937					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	1,816	Yes	1,816	80	1,453	1,257
2. Infants < 1 Year of Age	1,782	Yes	1,782	85	1,515	989
3. Children 1 through 21 Years of Age	34,434	Yes	34,434	33	11,363	8,707
3a. Children with Special Health Care Needs	Not Available	Yes	Not Available	100		156
4. Others	38,323	Yes	38,323	8	3,066	1,984

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2018
	Field Note:	Pregnant women that visited Prenatal Clinic
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2018
	Field Note:	Number of births : 989
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	Number of children 1 through 21 years of age served by the MCH Block Grant and Program includes patients that come to Dental, Children with Special Health Care Needs, MCH Clinic, and Family Planning program. MCH Block grant provided training on breastfeeding, integrated children nutrition survey training, Vitamin A and Deworming training and clinic and office supplies. In dental, one staff is paid under the MCH Block Grant TB/Leprosy Mass Screening 1-21 yrs old are included in this count.
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	registered CSHCN
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	Number reflects the patients that come to the Women's Clinic with services but not limited to cervical cancer screening, OB-GYNE cases, women missions wherein MCH Block Grant supports the staff, clinic supplies, office supplies, laboratory testings and training (on-island and off-island).

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2018
	Field Note:	1,257 pregnant women were provided prenatal services in the two main hospitals and in the Outer Islands Health centers.
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2018
	Field Note:	989 infants were given services in the MCH Clinics, Labor and pediatric wards. MCH Block grant provided office and medical supplies.
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	Number of children 1 through 21 years of age served by the MCH Block Grant and Program includes patients that come to Dental, Children with Special Health Care Needs, MCH Clinic, and Family Planning program. MCH Block grant provided training on breastfeeding, integrated children nutrition survey training, Vitamin A and Deworming training and clinic and office supplies. In dental, one staff is paid under the MCH Block Grant
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	Total number of children with special health care needs that were served on 2018 including children in Early intervention.
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	Number reflects the patients that come to the Women's Clinic with services but not limited to cervical cancer screening, OB-GYNE cases, women missions wherein MCH Block Grant supports the staff, clinic supplies, office supplies, laboratory testings and training (on-island and off-island).

Data Alerts: None

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

State: Marshall Islands

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	989	0	0	0	0	6	981	2	0
Title V Served	989	0	0	0	0	6	981	2	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0
2. Total Infants in State	989	0	0	0	0	6	981	2	0
Title V Served	989	0	0	0	0	6	981	2	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Title V Served
	Fiscal Year:	2018
	Column Name:	Total

Field Note:

MCH Block Grant funded the staff and/or supplies that were provided in the prenatal clinic visits. MCH Block Grant also provided support on the training of Labor and Maternity staff on breastfeeding, first 1,000 days and First Embrace.

Total births that occurred in RMI: 989 Majuro - 618, Ebeye - 298, Outer Islands: 73

2.	Field Name:	2. Title V Served
	Fiscal Year:	2018
	Column Name:	Total

Field Note:

MCH Block Grant funded the staff and/or supplies that were provided in the prenatal clinic visits. MCH Block Grant also provided support on the training of Labor and Maternity staff on breastfeeding, first 1,000 days and First Embrace.

Total births that occurred in RMI: 989 Majuro - 618, Ebeye - 298, Outer Islands: 73

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

State: Marshall Islands

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(692) 625-7007 x2275	(692) 625-7007 x2275
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health Program	Maternal and Child Health Program
3. Name of Contact Person for State MCH "Hotline"	Caroline Johnny-Jibas	Caroline Johnny-Jibas
4. Contact Person's Telephone Number	(692) 625-7007 x2275	(692) 625-7007 x2275
5. Number of Calls Received on the State MCH "Hotline"		54

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	Ministry of Health and Human Services	692-625 3399
2. Number of Calls on Other Toll-Free "Hotlines"		13
3. State Title V Program Website Address	in progress	on going
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	https://www.facebook.com/rmimoh/	https://www.facebook.com/rmimoh/
6. Number of Hits to the State Title V Program Social Media Websites		3,866

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Marshall Islands

1. Title V Maternal and Child Health (MCH) Director	
Name	Caroline Johnny-Jibas
Title	MCH Director
Address 1	PO Box 16 Delap
Address 2	
City/State/Zip	Majuro / MH / 96960-0016
Telephone	6926257007
Extension	
Email	caroline_johnny73@yahoo.com

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Caroline Johnny-Jibas
Title	MCH Director
Address 1	PO Box 16
Address 2	
City/State/Zip	Majuro / MH / 96960
Telephone	6926257007
Extension	2275
Email	caroline_johnny73@yahoo.com

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Marshall Islands

Application Year 2020

No.	Priority Need
1.	Improve women/maternal health through cancer screening, prenatal services and family planning services
2.	Improve perinatal/infant's health through adequate and quality prenatal services and new born screening.
3.	Improve child health through early childhood developmental screening and vaccinations
4.	Improve adolescent health through promotion of adolescent well-being and reducing teen pregnancy
5.	Improve enrollment and special care of CHSCN through developmental screening and referrals to proper care
6.	Improve oral health of children and women
7.	Promote child safety in the community.

Form 9 State Priorities-Needs Assessment Year - 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 year	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:

Field Name:

Priority Need 1

Field Note:

During the MCH 1st Bi-Annum Workshop, MCH Program presented the Priority Needs. Participants composed of staff from MCH/FP Program, Immunization Program, Cancer Program, NCD Program, Health Planning Office, Hospital (Maternity, Labor and Pediatric Wards), OBGYNs, Pediatricians, Outer Islands health centers, 177 Health Care Program and partner NGOs (WUTMI, KIJLE, MIEPI) agreed that we will revise this priority. In revising the priority, the team wants it to be specific and attainable.

Field Name:

Priority Need 2

Field Note:

During the MCH 1st Bi-Annum Workshop, MCH Program presented the Priority Needs. Participants composed of staff from MCH/FP Program, Immunization Program, Cancer Program, NCD Program, Health Planning Office, Hospital (Maternity, Labor and Pediatric Wards), OBGYNs, Pediatricians, Outer Islands health centers, 177 Health Care Program and partner NGOs (WUTMI, KIJLE, MIEPI) agreed that we will keep this priority listing. The need for this priority is still there.

Field Name:

Priority Need 3

Field Note:

During the MCH 1st Bi-Annum Workshop, MCH Program presented the Priority Needs. Participants composed of staff from MCH/FP Program, Immunization Program, Cancer Program, NCD Program, Health Planning Office, Hospital (Maternity, Labor and Pediatric Wards), OBGYNs, Pediatricians, Outer Islands health centers, 177 Health Care Program and partner NGOs (WUTMI, KIJLE, MIEPI) agreed that we will keep this priority listing. The need for this priority is still there.

Field Name:

Priority Need 4

Field Note:

During the MCH 1st Bi-Annum Workshop, MCH Program presented the Priority Needs. Participants composed of staff from MCH/FP Program, Immunization Program, Cancer Program, NCD Program, Health Planning Office, Hospital (Maternity, Labor and Pediatric Wards), OBGYNs, Pediatricians, Outer Islands health centers, 177 Health Care Program and partner NGOs (WUTMI, KIJLE, MIEPI) agreed that we will keep this priority listing. The need for this priority is still there.

Field Name:

Priority Need 5

Field Note:

During the MCH 1st Bi-Annum Workshop, MCH Program presented the Priority Needs. Participants composed of staff from MCH/FP Program, Immunization Program, Cancer Program, NCD Program, Health Planning Office, Hospital (Maternity, Labor and Pediatric Wards), OBGYNs, Pediatricians, Outer Islands health centers, 177 Health Care Program and partner NGOs (WUTMI, KIJLE, MIEPI) agreed that we will keep this priority listing. The need for this priority is still there.

Field Name:

Priority Need 6

Field Note:

During the MCH 1st Bi-Annum Workshop, MCH Program presented the Priority Needs. Participants composed of staff from MCH/FP Program, Immunization Program, Cancer Program, NCD Program, Health Planning Office, Hospital (Maternity, Labor and Pediatric Wards), OBGYNs, Pediatricians, Outer Islands health centers, 177 Health Care Program and partner NGOs (WUTMI, KIJLE, MIEPI) agreed that we will keep this priority listing. The need for this priority is still there.

Field Name:

Priority Need 7

Field Note:

During the MCH 1st Bi-Annum Workshop, MCH Program presented the Priority Needs. Participants composed of staff from MCH/FP Program, Immunization Program, Cancer Program, NCD Program, Health Planning Office, Hospital (Maternity, Labor and Pediatric Wards), OBGYNs, Pediatricians, Outer Islands health centers, 177 Health Care Program and partner NGOs (WUTMI, KIJLE, MIEPI) agreed that we will keep this priority listing. The need for this priority is still there.

Form 10
National Outcome Measures (NOMs)

State: Marshall Islands

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

None

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

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

State Provided Data	
	2018
Annual Indicator	34.5
Numerator	434
Denominator	1,257
Data Source	MCH Program
Data Source Year	2018

NOM 1 - Notes:

Majuro: 269/863 = 31%

Ebeye: 143/321= 45%

Outer Islands: 22/73= 30%

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	55.8
Numerator	5
Denominator	896
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	303.3
Numerator	3
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 3 - Notes:

There are 3 maternal deaths in FY2018. 1 - Majuro, 1 - Ebeye and 1 - Outer Islands.

Majuro - 34 yrs old, Dianosis: Disseminated Intravascular Coagulation, T/C Amniotic Fluid Embolism, Intrauterine Pregnancy delivered

Ebeye - 18 yrs old, Septecimia with pulmonary congestion, hospital acquired pneumonia and eclampsia

Outer Islands - 22 yrs old - Community acquired pneumonia, post partum maternal death.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	12.8
Numerator	127
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 4 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	10.1
Numerator	100
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 5 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	27.2
Numerator	269
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 6 - Notes:

None

Data Alerts: None

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

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

NOM 7 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	17.0
Numerator	17
Denominator	998
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 8 - Notes:

Fetal Death: 9

Early Neonatal Death: 8

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	28.0		33	
2016	28.7		35	
2015	29.4		38	
2014	30.0		41	
2013	30.6		44	
2012	31.1		47	
2011	31.4		50	
2010	31.6		52	
2009	31.7		55	

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	9.1
Numerator	9
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	15.7		18	
2016	16.2		20	
2015	16.6		21	
2014	17.0		23	
2013	17.3		25	
2012	17.5		26	
2011	17.7		28	
2010	17.8		29	
2009	17.9		30	

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	8.1
Numerator	8
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 9.2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	1.0
Numerator	1
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 9.3 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	202.2
Numerator	2
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 9.4 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 9.5 - Notes:

None

Data Alerts:

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 10 - Notes:

no testing requested.

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 hospital births

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	989
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 11 - Notes:

No case to report.

Data Alerts:

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

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

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

NOM 14 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	53.4
Numerator	7
Denominator	13,116
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 15 - Notes:

Causes of death: Severe malnutrition: 1, Drowning: 2, MVA: 1, Septicemia: 2, Meningitis: 1

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	103.0
Numerator	14
Denominator	13,596
Data Source	Vital Statistics office
Data Source Year	2018

NOM 16.1 - Notes:

Cause of Death: Endometritis: 1, Malnutrition: 1, Suicide: 2, Maternal Death : 1, Cancer: 2, Pneumonia: 2, CNS infection: 1, Blood Byscrasia: 1. Bacterial Meningitis: 1, Sepsis: 1, RHD: 1, Drowning (boat coalision): 1

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	6,434
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 16.2 - Notes:

No death occurred.

Data Alerts:

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

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

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

State Provided Data	
	2018
Annual Indicator	31.1
Numerator	2
Denominator	6,434
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 16.3 - Notes:

Both male and 19 yrs old

Data Alerts: None

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

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

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	37.2
Numerator	58
Denominator	156
Data Source	MCH Program
Data Source Year	2018

NOM 17.2 - Notes:

These numbers are the patients that coordinate the visit with MCH Program. We will improve the tracking by adding fields in the information system for CSHCN visits.

Data Alerts: None

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

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

NOM 17.3 - Notes:

None

Data Alerts: None

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

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

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	100.0
Numerator	21
Denominator	21
Data Source	Behavioral Health
Data Source Year	2018

NOM 18 - Notes:

None

Data Alerts: None

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

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

NOM 19 - Notes:

Marshall Islands is not included in the National Survey of Children's Health (NSCH). Through the support from SSDI grant, RMI MCH Program is working with NORC for the Jurisdiction/Territory MCH Survey.

Data Alerts:

1.	Data has not been entered for NOM 19. This outcome measure is linked to the selected NPM 6,10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
----	---

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2007	24.5 %	1.3 %	309	1,264

Legends:

- Indicator has an unweighted denominator <100 and is not reportable
- Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

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

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

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

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

State Provided Data	
	2018
Annual Indicator	42.0
Numerator	681
Denominator	1,622
Data Source	Immunization Program
Data Source Year	2018

NOM 22.1 - Notes:

Varicella vaccine is not included in RMI's vaccine listing. For this NOM, we reported the following series 4DTAP, 3HepB, 3HIB, 1MMR, 3IPV, 4PCV

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	63.0
Numerator	18,158
Denominator	28,842
Data Source	Immunization Program/WebIZ
Data Source Year	2018

NOM 22.2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	40.7
Numerator	1,709
Denominator	4,200
Data Source	Immunization Program/WebIZ
Data Source Year	2018

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

State Provided Data	
	2018
Annual Indicator	12.9
Numerator	1,294
Denominator	10,012
Data Source	Immunization Program/WebIZ
Data Source Year	2018

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

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

State Provided Data	
	2018
Annual Indicator	12.9
Numerator	1,292
Denominator	10,012
Data Source	Immunization Program/WebIZ
Data Source Year	2018

NOM 22.5 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	48.4
Numerator	149
Denominator	3,077
Data Source	Vital Statistics Office
Data Source Year	2018

NOM 23 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.0
Numerator	0
Denominator	989
Data Source	MCH Program
Data Source Year	2018

NOM 24 - Notes:

Currently, there is no reported case. But we will improve the tracking and reporting of this NOM by revising the MCH Clinic Encounter form to include the post partum depressive symptom.

Data Alerts:

1.	A value of zero has been entered for the numerator in NOM 24. Please review your data to ensure this is correct.
----	--

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

NOM 25 - Notes:

Marshall Islands is not included in the National Survey of Children's Health (NSCH) in 2017. Through the support from SSDI grant, RMI MCH Program is working with NORC for the Jurisdiction/Territory MCH Survey. Pilot testing has been done on the survey.

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Marshall Islands

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	20	24	37
Annual Indicator	21.7	35.4	37.7
Numerator	2,150	3,605	3,733
Denominator	9,891	10,197	9,896
Data Source	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	39.0	41.0	43.0	45.0	47.0	47.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Preventive medical visit for women includes papsmear/VIA screening, breast cancer screening, family planning counselling, STI/HIV Screening, TB Screening, Leprosy Screening and Immunization service (Hep B, MCV4, Flu - for immunocompromise) in Majuro Hospital and Ebeye Hospital.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Preventive medical visit for women includes papsmear/VIA screening, breast cancer screening, family planning counselling, STI/HIV Screening, TB Screening, Leprosy Screening and Immunization service (Hep B, MCV4, Flu - for immunocompromise) in Majuro Hospital, Ebeye Hospital and Outer Islands (that reported on time)
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Preventive medical visit for women includes papsmear/VIA screening, breast cancer screening, family planning counselling, STI/HIV Screening, TB Screening, Leprosy Screening and Immunization service (Hep B, MCV4, Flu - for immunocompromise) in Majuro Hospital, Ebeye Hospital and Outer Islands (that reported on time)

NPM 4A - Percent of infants who are ever breastfed

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

State Provided Data			
	2016	2017	2018
Annual Objective	90	100	100
Annual Indicator	100	100	100
Numerator	1,089	989	989
Denominator	1,089	989	989
Data Source	MCH Program	MCH Program	RMI ICHNS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is life saving skin to skin contact immediately after birth between the baby and the mother.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is life saving skin to skin contact immediately after birth between the baby and the mother.
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Once the mothers give birth, the newborns are immediately breastfed. RMI practice First Embrace. First embrace is life saving skin to skin contact immediately after birth between the baby and the mother.

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	50	53	42
Annual Indicator	50.3	40.5	42.3
Numerator	548	401	373
Denominator	1,089	989	881
Data Source	MCH Program	MCH Program	RMI ICHNS
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.0	46.0	48.0	50.0	52.0	52.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	In the Perinatal/Infant Health, we will present the result of the latest Integrated Child and Nutrition Survey 2017.
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Data presented is from RMI Integrated Child Health and Nutrition Survey. There are 881 children under 5 yrs old from Majuro, Ebeye and Outer Islands.

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			44
Annual Indicator	43.9	42.8	30.8
Numerator	1,668	532	500
Denominator	3,801	1,243	1,624
Data Source	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	46.0	48.0	50.0	52.0	55.0	55.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Currently, the developmental screening tool is completed by the nurses and the parent/s. It is easier for the health care professional and the parents to have it this way so that the health care professional explains the screening tool. In this reporting period, MCH program with PIHOA-Zika consultant updated the developmental tool. We are in the process of update our data system to accommodate the revision of the developmental tool.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Data reported is for Majuro Only. Ebeye and Outer Islands needs more training. It was a challenge to collect and report this data because system was not update. In 2018, this measure will be collected and reported from the main hospital information system called mHIS.
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Data reported is for Majuro Only. Ebeye and Outer Islands needs more training. It was a challenge to collect and report this data because the information system needs to be updated. In 2018, the mHIS (Marshall Hospital Information System) roll out on outpatient first and plan for MCH clinic will be in 2019-2020.

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

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

State Provided Data			
	2016	2017	2018
Annual Objective	625	112	110
Annual Indicator	114.4	108.7	34.6
Numerator	32	16	5
Denominator	27,965	14,716	14,457
Data Source	Hospital Database	Hospital Database	Hospital Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Provisional	Final	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	106.0	106.0	104.0	102.0	102.0	100.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Diagnosis for hospitalization are burn, injury, suicide, MVA, and environmental accident.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Cause of hospitalization: Burn, Fall,Drowning, Moving Vehicle Accident, hot liquid, injury.
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Diagnosis for hospitalization are head injury, burn and MVA

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	62.0	64.0	66.0	68.0	68.0	68.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** 2016
Column Name: State Provided Data
Field Note:
 Preventive medical visit services include Eye check up, Stool and urine analysis, Immunization, TB Screening, Leprosy Screening and STI/HIV Screening. Due to limited and availability of complete services in the Outer Islands, preventive medical visit is only given in Majuro Hospital and Ebeye Hospital. Medical clearance is required for high school and college entry, food handlers, work clearance and immigration.
2. **Field Name:** 2017
Column Name: State Provided Data
Field Note:
 Preventive visits: 12-17 yrs old that visits Immunization program for vaccination (Tdap, MCV, HPV), HIV/STI screening test, Family Planning services, and prenatal services for teen pregnancy.
3. **Field Name:** 2018
Column Name: State Provided Data
Field Note:
 Preventive visits: 12-17 yrs old that visits Immunization program for vaccination (Tdap, MCV, HPV), HIV/STI screening test, Family Planning services, and prenatal services for teen pregnancy. In this reporting period, we included the 12-17 yrs old with TB/Leprosy Mass Screening in Majuro.

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

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

State Provided Data			
	2016	2017	2018
Annual Objective			8
Annual Indicator	0.1	0	0
Numerator	10	0	0
Denominator	7,978	8,045	8,119
Data Source	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	11.0	14.0	17.0	20.0	20.0	20.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	RMI is only reporting CSHCN data - Only 10 out of the 300 identified CSHCN moved from pediatric to adult care. For RMI, Child health care services are provided from 0-14 years old. For 15 and up, the patients are referred to adult care which are in the main outpatient and public health clinics. For this measure, we have to establish a method to measure using survey if the patients know the transition in their health care.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	This NPM will be part of the Jurisdiction Survey to be able to get better information. For 2017, no survey was done to capture this data. In 2018, we will work with Children's clinic to endorse >14 years old that needs assistance to transition to adult health care.
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	This NPM will be part of the Jurisdiction Survey to be able to get better information.

**Form 10
State Performance Measures (SPMs)**

State: Marshall Islands

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			48	50
Annual Indicator	46.1	46.8	61.3	
Numerator	868	795	995	
Denominator	1,881	1,697	1,624	
Data Source	Immunization Program, WebIZ	Immunization Program, WebIZ	Immunization Program, WebIZ	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	63.0	65.0	67.0	69.0	71.0	73.0

Field Level Notes for Form 10 SPMs:

1. **Field Name:** 2017

Column Name: State Provided Data

Field Note:

In 2016-17, RMI has several outbreaks including mumps, Hepatitis A, and conjunctivitis. Immunization nurses were also assigned to work on the Integrated Children Household Nutrition Survey which affected their work in immunization. Immunization schedule to the Outer Islands was also affected due to some administrative requirements which prolonged the processing of travel documents.

In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%.

2. **Field Name:** 2018

Column Name: State Provided Data

Field Note:

In 2017: Majuro - 40.8%, Ebeye - 89.2% and Outer Islands - 21.8% RMI - 46.8%.

In 2018: Majuro - 61.24%, Ebeye - 95.19% and Outer Islands - 25.6% RMI - 61.27%.

In this reporting period, Immunization Program was able to achieve its annual objective. Improved data monitoring and reporting was added in the program's activity in 2018. Monthly reporting of data is included in the program's meeting which strategies for improvement were derived. Although the 90% goal for immunization rate is still far, the program will continue to provide outreach services and extended clinic hours to cater to the population that are unable to come to the clinics.

SPM 4 - Percent of Women ages 25-49 yrs old screened for cervical cancer.

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	20	11	
Annual Indicator	10.3	10.9	
Numerator	828	856	
Denominator	8,009	7,849	
Data Source	MCH Program	MCH Program	
Data Source Year	2017	2018	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.0	14.0	16.0	18.0	20.0	20.0

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Increase use of Family planning services to teenagers ages 13 to 17 years old

Measure Status:		Active
State Provided Data		
	2017	2018
Annual Objective	10	20
Annual Indicator	18.6	18.8
Numerator	124	126
Denominator	6,650	6,686
Data Source	Family Planning Program	Family Planning Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old.
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Data is presented in rate. Rate per 1,000 Teenagers 13-17 yrs old.
		Number of users: Female: 126,; Male: 0
		Population: 13-17 yrs old: Female: 3,224 ; Male: \$3,461 Total: \$6,686

SPM 6 - Percent of women ages 15-44 years old that use family planning services

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	16	18	
Annual Indicator	15.5	16.8	
Numerator	1,825	1,984	
Denominator	11,773	11,790	
Data Source	Family Planning Program	Family Planning Program	
Data Source Year	2017	2018	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	22.0	24.0	26.0	28.0	30.0

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	10.0	12.0	14.0	16.0	18.0

Field Level Notes for Form 10 SPMs:

None

SPM 8 - Percent of newborn that received congenital cytomegalovirus (CMV) screening

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5.0	7.0	9.0	11.0	14.0	17.0

Field Level Notes for Form 10 SPMs:

None

SPM 9 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	37.0	39.0	41.0	43.0	45.0	47.0

Field Level Notes for Form 10 SPMs:

None

**Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Marshall Islands

ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		90	68	
Annual Indicator	88.3	66.1	66.8	
Numerator	233	654	661	
Denominator	264	989	989	
Data Source	Vital Statistics Department	MCH Program	MCH Program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	69.0	70.0	72.0	72.0	73.0	75.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

2016 calculation didn't reflect the live births of 2016. We will recalculate the annual objectives.

ESM 1.3 - Percent of women ages 18 thru 44 seen at outreach mobile visits

Measure Status:				Active		
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	5.0	7.0	9.0	11.0	12.0	14.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - Number of pregnant women with dental check up

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	53.0	56.0	59.0	61.0	63.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Percentage of pregnant women that were given comprehensive breastfeeding counselling during prenatal visit

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	70	10	
Annual Indicator	0	58.4	
Numerator	0	734	
Denominator	1,097	1,257	
Data Source	MCH Program	MCH Program	
Data Source Year	2017	2018	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	62.0	64.0	66.0	68.0	70.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Service of breastfeeding counselling is being done in the prenatal clinics. But to collect and enter it in the system is missing. In the prenatal clinical visit form, breastfeeding counselling is not included. In 2017, we included field on breastfeeding counselling. Changes will reflect in 2018 report as this is included in the Reproductive Health Information System. Revision will be implemented in Majuro, Ebeye and Outer Islands.

ESM 6.2 - Percentage of children diagnosed with ASD and ADHD

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	12.0	14.0	16.0	18.0	18.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.1 - Number of community campaign on awareness and promotion of child safety within the community.

Measure Status:		Active
State Provided Data		
	2017	2018
Annual Objective	3	3
Annual Indicator	0	0
Numerator	0	0
Denominator	3	3
Data Source	MCH Program	MCH Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	In 2017, we worked on our partnership with different stakeholders. No community awareness done in 2017. Translation of materials in to Marshallese is on-going.
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	There was no campaign done in 2018. But there is a big project on Early Childhood development which will launch in 2019.

ESM 10.2 - HPV vaccine coverage of girls age 13 years

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	47	37	
Annual Indicator	34.9	36.4	
Numerator	230	245	
Denominator	659	673	
Data Source	WebIZ, Immunization Program	WebIZ, Immunization Program	
Data Source Year	2017	2018	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	39.0	41.0	43.0	45.0	47.0	49.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.2 - Percent of adolescent that moved to adult health care

Measure Status:		Active	
State Provided Data			
	2017	2018	
Annual Objective	10	15	
Annual Indicator	10	16.1	
Numerator	1	10	
Denominator	10	62	
Data Source	MCH Program	MCH Program	
Data Source Year	2017	2018	
Provisional or Final ?	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	25.0	30.0	35.0	35.0	37.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Marshall Islands

SPM 3 - Increase percentage of fully immunized children ages 19 to 35 months
Population Domain(s) – Perinatal/Infant Health, Child Health, Children with Special Health Care Needs

Measure Status:	Active								
Goal:	To increase immunization coverage by 4% from previous year for children 19 to 35 months old.								
Definition:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of 19-35 months with complete immunization</td> </tr> <tr> <td>Denominator:</td> <td>Number of 19-35 months children</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of 19-35 months with complete immunization	Denominator:	Number of 19-35 months children	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of 19-35 months with complete immunization								
Denominator:	Number of 19-35 months children								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	IID-7 Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children								
Data Sources and Data Issues:	<p>Data Sources: RMI National Immunization Program, WebIZ (IIS Program)</p> <p>Data Issues: Basic vaccine series in RMI includes: 4 DPT, 3 Polio, 3 HepB, 1 Hib, 2 MMR. Before 2016 “complete coverage” was considered to be 4 DPT, 3 Polio, 3 HepB, 1 Hib, 1 MMR. There have been substantial delays in entering data into WebIZ in the past and there are problems with the database such as duplicate records and children not known whether out of the country.</p>								
Significance:	Reduce infant and child mortality and morbidity. Prevent vaccine related diseases.								

SPM 4 - Percent of Women ages 25-49 yrs old screened for cervical cancer.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active								
Goal:	To increase the number of women 25-49 yrs old who have cervical cancer screening. To be able to detect early any anomalies that will lead to cervical cancer.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of women, age 25-49 yrs old, who had cervical cancer screening in the calendar year</td> </tr> <tr> <td>Denominator:</td> <td>Number of women, age 25-49 yrs old</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of women, age 25-49 yrs old, who had cervical cancer screening in the calendar year	Denominator:	Number of women, age 25-49 yrs old	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of women, age 25-49 yrs old, who had cervical cancer screening in the calendar year								
Denominator:	Number of women, age 25-49 yrs old								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Related to Cancer Objective C-15 Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines								
Data Sources and Data Issues:	RMI MOH MCH Program - Cervical Cancer Screening Database								
Significance:	Cervical Cancer is the leading cause of death for Marshallese women. Cervical cancer is the most common type of cancer for female population. The Ministry of Health and Human Services address the increase of cervical cancer cases by emphasizing on the strength of prevention and early detection.								

SPM 5 - Increase use of Family planning services to teenagers ages 13 to 17 years old
Population Domain(s) – Adolescent Health

Measure Status:	Active								
Goal:	To decrease teen pregnancy.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of unduplicated female 13-17 years old family planning method users</td> </tr> <tr> <td>Denominator:</td> <td>No. of female 13 to 17 years old population</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> </table>	Numerator:	Number of unduplicated female 13-17 years old family planning method users	Denominator:	No. of female 13 to 17 years old population	Unit Type:	Rate	Unit Number:	1,000
Numerator:	Number of unduplicated female 13-17 years old family planning method users								
Denominator:	No. of female 13 to 17 years old population								
Unit Type:	Rate								
Unit Number:	1,000								
Healthy People 2020 Objective:	FP-8 Reduce pregnancies among adolescent females, FP-8.1 Reduce pregnancies among adolescent females aged 15 to 17 years								
Data Sources and Data Issues:	<p>Data Source: Family planning program database. Users are those using any of the following: female sterilization, male partner sterilized, oral contraceptive, IUD, hormonal implant, hormonal injections, male or female condoms, fertility awareness method, abstinence</p> <p>Data issues: There's a significant challenge in collecting data in the Outer Islands. The stigma and outlook of parents in family planning services for their teenage children are part of the challenges that we have to face in this measure.</p>								
Significance:	<p>Reducing adolescent pregnancies</p> <p>Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities.</p> <p>Based on RMI's Needs assessment and strategic planning, one of RMI's priorities is decreasing teen pregnancy through providing family planning services.</p>								

SPM 6 - Percent of women ages 15-44 years old that use family planning services
Population Domain(s) – Women/Maternal Health

Measure Status:	Active								
Goal:	To be able to provide full family planning services to all women 15-44 years old in Majuro, Kwajalein and Outer Islands.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of unduplicated family planning method users</td> </tr> <tr> <td>Denominator:</td> <td>Number of female population in RMI between 15-44 years old</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of unduplicated family planning method users	Denominator:	Number of female population in RMI between 15-44 years old	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of unduplicated family planning method users								
Denominator:	Number of female population in RMI between 15-44 years old								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>FP-16 Increase the percentage of women aged 15 to 44 years that adopt or continue use of the most effective or moderately effective methods of contraception</p> <p>FP-7 Increase the proportion of sexually experienced persons who received reproductive health services</p>								
Data Sources and Data Issues:	Family planning program database. Users are those using any of the following: female sterilization, male partner sterilized, oral contraceptive, IUD, hormonal implant, hormonal injections, male or female condoms, fertility awareness method, abstinence								
Significance:	Family planning services prevent unplanned pregnancies which are more likely than planned pregnancies to occur in young teens, women > 35 years of age, and to women who have had a previous baby without sufficient time to recover (i.e. <1 year between births). Babies from unplanned pregnancies are more likely to be born into poverty, premature, malnourished, and have developmental disabilities. Good coverage of women with family planning services indicates that the medical system is protecting mothers and children from preventable problems.								

SPM 7 - Percent of newborns that received Congenital Hypothyroidism newborn screening
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	Increase the percentage of newborn screened for congenital hypothyroidism.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of newborn screened for congenital hypothyroidism</td> </tr> <tr> <td>Denominator:</td> <td>Number of live births</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of newborn screened for congenital hypothyroidism	Denominator:	Number of live births	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of newborn screened for congenital hypothyroidism								
Denominator:	Number of live births								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>MICH-32.3(Developmental) Increase the proportion of children with a diagnosed condition identified through newborn screening who have an annual assessment of services needed and received</p> <p>MICH-29 Increase the proportion of young children with autism spectrum disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in special services in a timely manner</p>								
Data Sources and Data Issues:	Hospital Information System, Vital Statistics Information System								
Significance:	<p>RMI can only offer Hearing Screening for newborn which is funded under EHDI grant. During the MCH 1st Bi-Annun Workshop, the team prioritized additional newborn screening that can be done in our settings.</p> <p>Congenital hypothyroidism (CH) is a condition of thyroid hormone deficiency present at birth. Approximately 1 in 4000 newborn babies has a severe deficiency of thyroid function, while even more have mild or partial degrees. If untreated for several months after birth, severe congenital hypothyroidism can lead to growth failure and permanent intellectual disability. Treatment consists of a daily dose of thyroid hormone (thyroxine) by mouth. Because the treatment is simple, effective, and inexpensive, nearly all of the developed world practices newborn screening to detect and treat congenital hypothyroidism in the first weeks of life.</p>								

SPM 8 - Percent of newborn that received congenital cytomegalovirus (CMV) screening
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	Increase the percentage of newborn screened for congenital cytomegalovirus (CMV).								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of newborn screened for congenital cytomegalovirus (CMV)</td> </tr> <tr> <td>Denominator:</td> <td>Number of live births</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of newborn screened for congenital cytomegalovirus (CMV)	Denominator:	Number of live births	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of newborn screened for congenital cytomegalovirus (CMV)								
Denominator:	Number of live births								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Related to MICH-32.3(Developmental) Increase the proportion of children with a diagnosed condition identified through newborn screening who have an annual assessment of services needed and received								
Data Sources and Data Issues:	Hospital Information System, Vital Statistics Information System.								
Significance:	The MCH Program and Early Hearing Detection and Intervention programs advocates for the PCR- CMV Saliva test to diagnose, provide proper treatment and referrals of newborns with CMV at the right timing.								

SPM 9 - Percent of deliveries to women receiving prenatal care in the first trimester of pregnancy
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	Increase the number of women receiving prenatal care beginning in the first trimester								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of deliveries to women who received prenatal care beginning in the first trimester of pregnancy.</td> </tr> <tr> <td>Denominator:</td> <td>Number of deliveries in the hospital and health centers</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of deliveries to women who received prenatal care beginning in the first trimester of pregnancy.	Denominator:	Number of deliveries in the hospital and health centers	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of deliveries to women who received prenatal care beginning in the first trimester of pregnancy.								
Denominator:	Number of deliveries in the hospital and health centers								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>Related to Maternal, Infant, and Child Health (MICH) Objective 5: Reduce the rate of maternal mortality.</p> <p>Related to MICH Objective 8.1: Reduce low birth weight.</p> <p>Related to MICH Objective 8.2: Reduce very low birth weight.</p> <p>Related to MICH Objective 9.1: Reduce total preterm births.</p> <p>Related to MICH Objective 10.1: Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester.</p>								
Data Sources and Data Issues:	Hospital Information System, Reproductive Health Information System								
Significance:	Early and adequate prenatal care is vital to ensuring a healthy pregnancy. Receiving inadequate prenatal care increases the risk for complications and other adverse outcomes for both mother and baby. Early and adequate prenatal care provides the opportunity for early detection and management of complications which reduces the risk for pre-term labor and babies being born with low birth weight.								

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Marshall Islands

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Marshall Islands

ESM 1.2 - Percentage of pregnant women who had at least 4 prenatal visits

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

Measure Status:	Active									
Goal:	To have a healthy pregnancy, newborn and post partum condition of the pregnant women.									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of pregnant women who had at least 4 prenatal visits that delivered live birth during the reporting period.</td> </tr> <tr> <td>Denominator:</td> <td>Number of live births during the reporting period</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of pregnant women who had at least 4 prenatal visits that delivered live birth during the reporting period.	Denominator:	Number of live births during the reporting period	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of pregnant women who had at least 4 prenatal visits that delivered live birth during the reporting period.									
Denominator:	Number of live births during the reporting period									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Data Source: MCH Program - Prenatal Clinic Visits in Majuro and Ebeye, Outer Islands Health Center									
Significance:	Having a healthy pregnancy is one of the best ways to promote a healthy birth. Getting early and regular prenatal care improves the chances of a healthy pregnancy. With regular prenatal care women can: a. Reduce the risk of pregnancy complications. b.) Reduce the fetus's and infant's risk for complications. During prenatal care, the OBGYN doesn't only discuss the pregnancy but include post partum conditions which will prepare the pregnant women.									

ESM 1.3 - Percent of women ages 18 thru 44 seen at outreach mobile visits

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

Measure Status:	Active								
Goal:	Increase number of women with preventive medical visits by 5% yearly.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of 18-44 years old women that were seen during an outreach mobile visits</td> </tr> <tr> <td>Denominator:</td> <td>Number of 18-44 years old women in the population of the reporting year</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of 18-44 years old women that were seen during an outreach mobile visits	Denominator:	Number of 18-44 years old women in the population of the reporting year	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of 18-44 years old women that were seen during an outreach mobile visits								
Denominator:	Number of 18-44 years old women in the population of the reporting year								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	MCH Program - Reproductive Health Information System, EPPSO Projected Population								
Significance:	Due to geographical location, limited services and health assistants capacity, there are services that we need to send a complete outreach mobile team to the Outer Islands. Currently, Outer Islands Health Centers are limited to primary health care. To provide cancer screening, immunization, dental/oral health, TB, Leprosy, NCD, and testing of STI/HIV, RMI MOHHS need to schedule the outreach to 24 Outer Islands.								

ESM 1.4 - Number of pregnant women with dental check up

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

Measure Status:	Active								
Goal:	Increase pregnant women that received dental check up by 5% yearly								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of pregnant women with dental check up</td> </tr> <tr> <td>Denominator:</td> <td>Number of pregnant women seen at the Prenatal Clinics</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of pregnant women with dental check up	Denominator:	Number of pregnant women seen at the Prenatal Clinics	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of pregnant women with dental check up								
Denominator:	Number of pregnant women seen at the Prenatal Clinics								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	MCH - Reproductive Health Information System, Dental Clinic								
Significance:	Dental check during pregnancy is included in the clinical guidelines of Prenatal. Oral health care is an important component of a healthy pregnancy and providing pregnant women with oral health care, including educating them about dental caries is critical for both women's own oral health and for the future oral health of their children.								

ESM 4.2 - Percentage of pregnant women that where given comprehensive breastfeeding counselling during prenatal visit

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

Measure Status:	Active								
Goal:	To increase pregnant women that receive breastfeeding counselling and eventually increase infant that ever breastfed and exclusively breastfeeding up to 6 months.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>No. of pregnant women that attended the prenatal clinic given breastfeeding counselling</td> </tr> <tr> <td>Denominator:</td> <td>No of pregnant women that attended the prenatal clinic</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	No. of pregnant women that attended the prenatal clinic given breastfeeding counselling	Denominator:	No of pregnant women that attended the prenatal clinic	Unit Type:	Percentage	Unit Number:	100
Numerator:	No. of pregnant women that attended the prenatal clinic given breastfeeding counselling								
Denominator:	No of pregnant women that attended the prenatal clinic								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	MCH Program - Prenatal Clinic								
Significance:	<p>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 risk 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.</p> <p>If mothers are given proper breastfeeding counseling, they will be encouraged and will see the benefit to their children.</p>								

ESM 6.2 - Percentage of children diagnosed with ASD and ADHD

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

Measure Status:	Active								
Goal:	Strengthen referral of children with behavioral and emotional disorder to Behavioral Health for proper diagnosis and treatment								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of children diagnosed with ASD and ADHD</td> </tr> <tr> <td>Denominator:</td> <td>Number of children with behavioral and emotional disorder referred</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of children diagnosed with ASD and ADHD	Denominator:	Number of children with behavioral and emotional disorder referred	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children diagnosed with ASD and ADHD								
Denominator:	Number of children with behavioral and emotional disorder referred								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	MCH Program and Behavioral Health								
Significance:	Currently, there is no documented cases of ASD and ADHD before our new Psychiatrist came on board. We want to be able to diagnose and give proper attention and treatment as needed. As well as, preparing their families and support system on how to take care of a special child.								

ESM 7.1.1 - Number of community campaign on awareness and promotion of child safety within the community.
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active								
Goal:	To be able to reach the community on awareness and promotion of child safety within the community.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of community campaign conducted</td> </tr> <tr> <td>Denominator:</td> <td>Number of community campaign planned (3)</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of community campaign conducted	Denominator:	Number of community campaign planned (3)	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of community campaign conducted								
Denominator:	Number of community campaign planned (3)								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	MCH Program								
Significance:	Reaching community on child safety strategies will increase knowledge and lessen accident that will lead to hospitalization.								

ESM 10.2 - HPV vaccine coverage of girls age 13 years

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

Measure Status:	Active								
Goal:	By 2020, achieving greater than or equal to 90% HPV Coverage Rate for 13 years old girls.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># females age 13 years who received 2 doses of HPV vaccine (X 100)</td> </tr> <tr> <td>Denominator:</td> <td>RMI Female Population aged 13 years (projected mid-year population from 2011 census)</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# females age 13 years who received 2 doses of HPV vaccine (X 100)	Denominator:	RMI Female Population aged 13 years (projected mid-year population from 2011 census)	Unit Type:	Percentage	Unit Number:	100
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Denominator:	RMI Female Population aged 13 years (projected mid-year population from 2011 census)								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Query WebIZ for females 13 years of age on the last day of the measurement year (e.g. 3/31/16 for 2016) for the denominator, and select those who have record of 2 HPV doses received for the numerator.								
Significance:	Cervical cancer has been the leading cause of death in the RMI over the past 10 years; the incidence and death rates from cervical cancer are among the highest in the Pacific in RMI. HPV is the cause of most cases of cervical cancer. Effective delivery of HPV vaccine to girls before the onset of sexual activity can protect the next generation of RMI women from this terrible disease								

ESM 12.2 - Percent of adolescent that moved to adult health care

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active								
Goal:	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of adolescent that receive proper referral of service from adolescent to adult health care</td> </tr> <tr> <td>Denominator:</td> <td>Number of adolescent that needed transition of services</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of adolescent that receive proper referral of service from adolescent to adult health care	Denominator:	Number of adolescent that needed transition of services	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of adolescent that receive proper referral of service from adolescent to adult health care								
Denominator:	Number of adolescent that needed transition of services								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	CSHCN Program								
Significance:	To be able to tract and provide an appropriate service to CSHCN that transition to adult health care.								

Form 11
Other State Data
State: Marshall Islands

The Form 11 data are available for review via the link below.

[Form 11 Data](#)