



## State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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## 1.4 Overview of the State

The Republic of Palau is situated 814 miles southwest of Guam on the western rim of what was once known as The Caroline Islands and, more recently, The Trust Territory of the Pacific Islands. The Republic is an archipelago consisting of high volcanic islands, raised limestone islands, classic atolls and barrier reefs extending nearly 700 miles on a northeast to southwest axis. Palau has a total land mass of 188 square miles. The main island group, which lies 7 degrees above the equator, comprises 14 of the total 16 Palauan states. The grouping extends from Kayangel, the northern most atoll, to Babeldaob, Koror, and over a hundred uninhabited islands enclosed in a barrier reef, and ends with the small islands of Peleliu and Angaur to the south. The 7.1 square mile island of Koror is the Republic's administrative and economic capital, with 71% of the population residing either there or in its neighboring state, Airai, located on the island of Babeldaob. Babeldaob itself is the single largest island, second in Micronesia only to Guam. It is connected to Koror via a temporary pontoon style bridge that was opened for use almost one year after the collapse of the original bridge. The Southwest Islands comprise of two remaining states; 1. Sonsorol and its island of Fanah, Meriil, and Pulu-Anna, 2. Hatohebei and its island of Helen's Reef. They are located approximately 300 miles southwest from the main island group. They are sparsely inhabited, geographically isolated and in many ways culturally different from the rest of Palau. Map of Palau is included as Appendix A.

Traditionally, Palau was comprised of several competing chiefdoms. The society was characterized by a system of strong, ascribed hierarchical social ranking where the matrilineal descent determined social position, inheritance, kinship structure, residence, and land tenure. Since western contact, dramatic societal changes have occurred, perhaps the great contributing factor being depopulation due to the introduction of western diseases. Only a tenth of the estimated original pre-contact population of 40,000 remained by the turn of this century. Regardless, traditional society continues to play an important function in the daily lives throughout the entire strata of the contemporary Palauan society. While Palauan and English are the official languages, many persons 60 years and older still speak Japanese, having been educated during the Japanese administration of these islands from 1914 until 1945.

Given the geographic nature of the islands, several significant geographic barriers to health care access exist in Palau. Most travel in Palau is by means of boat with only Koror and parts of neighboring Airai having fully accessible paved roads. The other four states in Babeldaob are all connected to Koror by dirt roads, some of which are frequently impassable during the six month tropical rainy season. Although the Babeldaob Road Project has initially connect the upmost states to this road network, they are accessible only by four-wheel drive vehicles and dependent solely on the daily weather conditions. (Palau receives nearly 200 inches of rainfall a year.) Likewise, boat travel is dependent upon weather conditions, since traveling to several locals necessitates going outside the safety of the reef and into open water. This information emphasizes that while the 80% of the population has reasonable access to health care, the remainder must undertake lengthy and expensive boat or automobile trips to reach services. By USA standards, the entire nation of Palau is a rural area. Palau is considered a medically underserved area with a shortage of health care personnel.

## *DEMOGRAPHIC CHARACTERISTICS*

The 1995 census data shows a population of 17,225, with 10 percent or 1,762 being children age 0 to 4 years and 8.9 percent or 1,551 being children 5 to 9 years of age, (See Appendix B) Appendix B, Table 1, shows population breakdown by the five region, land mass, and population density. Table 2 shows population breakdown by sex and age group. Current census data indicates that 27 percent of total population is non Palauan (4,717/17,225). Filipinos represent the largest single group with a total of 2,858 persons. The People's Republic of China is second with 550 persons followed by 334 Americans and 218 Japanese. Tourism has also increased dramatically with a total 69,330 coming to Palau in 1996 compared to 35,030 in 1994. These visitors are predominantly from Japan, Taiwan, and the United States.

Health care services in the Republic of Palau are provided primarily through the government's Ministry of Health. The ministry provides comprehensive primary, secondary and limited tertiary services, including both preventive and curative care through a 80-bed hospital and Community Health Center/Public Health Clinic located in the most populated state. There are four Community Health Centers or in the past they were referred to as Superdispensaries. The four CHC's, the Northern, the Eastern, Western, and Southern are now fully operational and located in the outlying states of Palau. There are six additional satellite dispensaries located in states that have limited accessibility to the CHC's. The dispensaries are staffed by Health Assistants trained in primary health care. Two of the CHC's are staffed by physicians, while two others are staffed by Registered Nurses. The main Community Health Center/Public Health is located at the site of the old McDonald Memorial Hospital, and staffed by physicians, medical officers, registered nurses, graduate nurses, laboratory technicians, and health assistants.

## *ECONOMIC CHARACTERISTICS*

For the total population, the unemployment rate was measured at 7.0% during the 1995 census. Census data further indicates that the average household size is 4.86 with a mean annual household income of almost \$8,000. In comparison, the 1992 CHC user survey, revealed that 89% of the BPH/CHC user population is below poverty level and 14% are unemployed.

Insurance coverage continues to be low, with approximately 12% of CHC users reporting being insured. This number is even lower for clients under age 18, with less than 5% of these clients being insured. **Palauan citizens are not eligible for Medicare or Medicaid.** However, no one is refused medical services because of inability to pay, in accordance with Palau's constitution. See Appendix B, Table 3 for additional socio-economic information.

The geographic isolation noted earlier is compounded by the fact that the cost of transportation also affects access to services. There is no public transportation in Palau and private taxi rates are standardized at a level which is quite excessive in relation to the income level of those forced to use them.

The low socio-economic status and rural living conditions have an impact upon the health status of residents. Even though 92% of the population has access to public water, it frequently requires boiling to ensure complete safety from parasitic and bacterial contamination. The sanitation and hygienic conditions are below US standards, with only 71% of the houses having adequate sewage disposal, 81% lacking complete plumbing (32% utilize outdoor privies and 2% have not toilet facilities at all).

Nearly three fourths (73.6%) have only cold water available and 6% have no piped water. Complete kitchen facilities and refrigeration are lacking for 18% of the population. (Source: 1995 Census of population and housing).

## 1.5 The State Title V Agency

### 1.5.1 State Agency Capacity

The Republic of Palau's MCH unit is comprised of Women's Health and Prenatal Services, Postnatal and Family Planning Services, Well Child Services for infants, children, which includes immunization, and services for children with Special Health Needs. Services for adolescent is provided in collaboration with the School Health program that is part of the Primary Care Division. As part of the School Health improvement, a school based clinic was opened in 1999 within the campus of the only public High School in Palau. This clinic is within walking distance for student at the Palau Community College who makes frequent use of this facility. An additional clinic will be opening sometime in the year 2001 in one of the public elementary school.

#### 1.5.1.1 Organizational Structure

The MCH program is under the Division of primary and Preventive Services; one of the four divisions under the Bureau of Public Health. Currently, the Director of Public Health has direct oversight of the MCH program and assisted by the Chief of the Division of Primary and Preventive Services, a nurse practitioner who assumes the position of MCH Coordinator and the Preventive Services Administrator. The MCH Coordinator is responsible for the programmatic aspects of the program while the administrator is responsible for the preparation of annual grant application and annual report and other administrative functions. The division chief and the director are responsible for program policy development.

The Bureau of Public Health is one of the two bureaus under the Ministry of Health and is headed by the Minister of Health. The Minister of Health is appointed by the President of the Republic of Palau. A Table of organization is included as Appendix C.

#### 1.5.1.2 Program Capacity

A core staff consisting of two nurse practitioners, a social worker, nutritionist, and a clerk/typist provides MCH services. Additionally, teams of doctors including two OB/GYN, a Pediatrician, and other interns and health assistants assist in providing services on a rotational basis. MCH collaborates with other divisions within Public Health for services including Dental Services, Behavioral Health, specially care for children with Special Health Needs, and Health Education and Promotion.

The Division of Primary and Preventive services is in the process of integrating the basic services for pregnant women, mothers, infants, children, and children with special health needs into the four Regional CHC's. A core team consisting of the Administrators, Program Coordinators, Physicians, Nurses, Health Educators, Division Chief, and the Director meets regularly to plan for the decentralization of services as well as review, revise, and develop

protocols that to be used in these clinic sites. This group has met several times and will continue to meet to plan the needs assessment activities. Other people from within the Ministry of Health as well as other Ministries and local agencies are invited as needed to address relevant issues. The Healthy Island council will be another key group in carrying out the needs assessment.

♦ **Preventive and primary care services for pregnant women, mothers, and infants.**

The MCH program is the sole provider of prenatal services. Close to 100% of deliveries occur in the hospital. Mothers and babies are usually kept in the hospital for at least 24 hours, and sometimes for 48 hours. In May 1997, a new Health Service fee schedule went into effect. Individuals are charged on a sliding fee schedule that is based on their income level and family size. The sliding fee schedule only applies to Palauan citizens only. Most mothers are now requesting to be discharged within 24 hours the perceived high hospitalization cost. In response to early discharge, Public Health initiated a clinic for both mothers and infants at two weeks post delivery. Collaborations between public health nurses and hospital nurses are being strengthened as a way of facilitating communications and referrals of mothers and or infants who require home care before the two week visit.

Family Planning services are routinely provided as part of mothers port-partum care. Pap Smear screening for early detection of cervical cancer is also built into prenatal and postnatal care. Women are taught how to perform breast self-examination and counseled on the importance of having annual physical examinations. Pregnant women, mothers, and infants who reside in the outlying states are referred to the Health Worker in the nearest CHC for follow up of routine care.

The Ministry of Health receives funding from CDC for a Breast and Cervical Cancer Early Detection program. Two of the nurse practitioners working for this program are former MCH staff members and continue to collaborate with the MCH program.

♦ **Preventive and primary care services for children**

The MCH program conducts routine clinics for children up the age of six years. Services include physical examination and developmental assessment, immunization, and referral for appropriate specialty type of health teaching and anticipatory guidance. The nutritionist, dental assistants, and health education staffs contribute to the routine care for children and adolescent.

Within the Ministry of Education, the Health Promotion Program has been very successful in incorporating health topics into the school curriculum. MCH personnel regularly participate in health related activities in schools. The Ministry of Education conducts a Youth Risk Behavior Survey every two years (YRBS). The first YRBS was conducted in 1997 followed by a second one in 1999. The Bureau of Public Health works as well with the Belau Families, Schools, and Community Association in promoting awareness in the community on health issues especially in children. One policy issue that is being entertained is to make physical examinations required for high school entry. The Physical Examination will be performed within the school based clinic.

Further more, the MCH program assists with school activities organized by the School Health program, which is organized by the Primary Care Division of Public Health.

♦ **Services for children with special health needs**

MCH personnel collaborate closely with other agencies outside of the Ministry of Health such as Special Education, School Health program, Head Start, and other community based organizations when necessary. The Interagency Office (SSDI funded program) is housed in the Public Health building and assist MCH Program in many coordination activities. The data for tracking of children with special health needs (CSHN) is used by the MCH program. Regular Interagency meetings are ongoing,

1.5.1.3 Other Capacity

Within the office of the Minister of Health, a fiscal officer oversees the internal financial matters for MCH program. The fiscal officer works closely with the National Finance office on financial reports and other financial activities.

The Public Health Data office is responsible for data tracking and statistical reports. An epidemiologist working under contract with the Ministry of Health provides the MCH program support for these functions. The epidemiologist began working for the Palau Ministry of Health in July 1999.

The Palau Community College began an Associate Degree Nursing program in 1998, in the hopes of alleviating the staffing needs felt in many areas of nursing. The first class of thirteen students graduated in May 2000. An early childhood education program is now on going. Public Health is collaborating closely with the college in pursuit of qualified childcare workers.

On an international level, the MCH program receives assistance from other organizations such as WHO, UNICEF, UNFPA and SPC. In 1997, the SPC Secretary for the Pacific Community (formerly known as South Pacific Commission), sponsored a preliminary study on Vitamin A deficiency among children in Palau. Dr. Guy Hawley conducted this study. The report showed that Vitamin A deficiency is not a problem for children in Palau. The UNICEF has sponsored activities that allowed the Ratification of the Convention of the Right of the Child, as well as the development of the proposed National Population Policy. The WHO and UNFPA have funded numerous training for MCH staff especially in the area of contraceptive management and in particular, Norplant insertion.

Palau also receives fund for a CISS grant. The goal of this three year project was to develop a model demonstration and training facility for child care. Child Care Services are non existent in Palau, especially for infants and toddlers. Head Start and three other mission school offer kindergarten education for preschoolers. The MCH and Child Care program have conducted two focus group meetings. An overwhelming need for this type of program was voiced during both meetings. In 1999, collaborations with the Palau Community College and Head Start program were further enhanced. This is evident by the following actions; A Head Start paid staffs works full time in the Model Child Care Center. This is done so that more children could

be accepted into the program. The Palau Community College is now in the process of opening an additional Child Care site within the College Campus. Public Health and Head Start will training while students enrolled in the Early Childhood program assist. This will part of the course requirement for this program.

#### 1.5.2 State Agency Coordination

The Ministry of Health continues to collaborate with other Ministries with emphasis on the Ministry of Education, especially with Special Education Program. The Director of Public Health services is a member of the Head Start Policy Council and works closely with that program. Public Health and MCH program is represented as well in other national task force and coalitions such as; The Palau National Committee on Population and Children(CoPopChi), Tobacco Coalition, Cancer No More Task Force, the National Nutrition Council, Inter Agency Committee, and Mental Health Council. MCH program is also responsible for the initiation of several support groups, one of which is the Breast Feeding Support group.

## II. REQUIREMENTS FOR THE ANNUAL REPORT

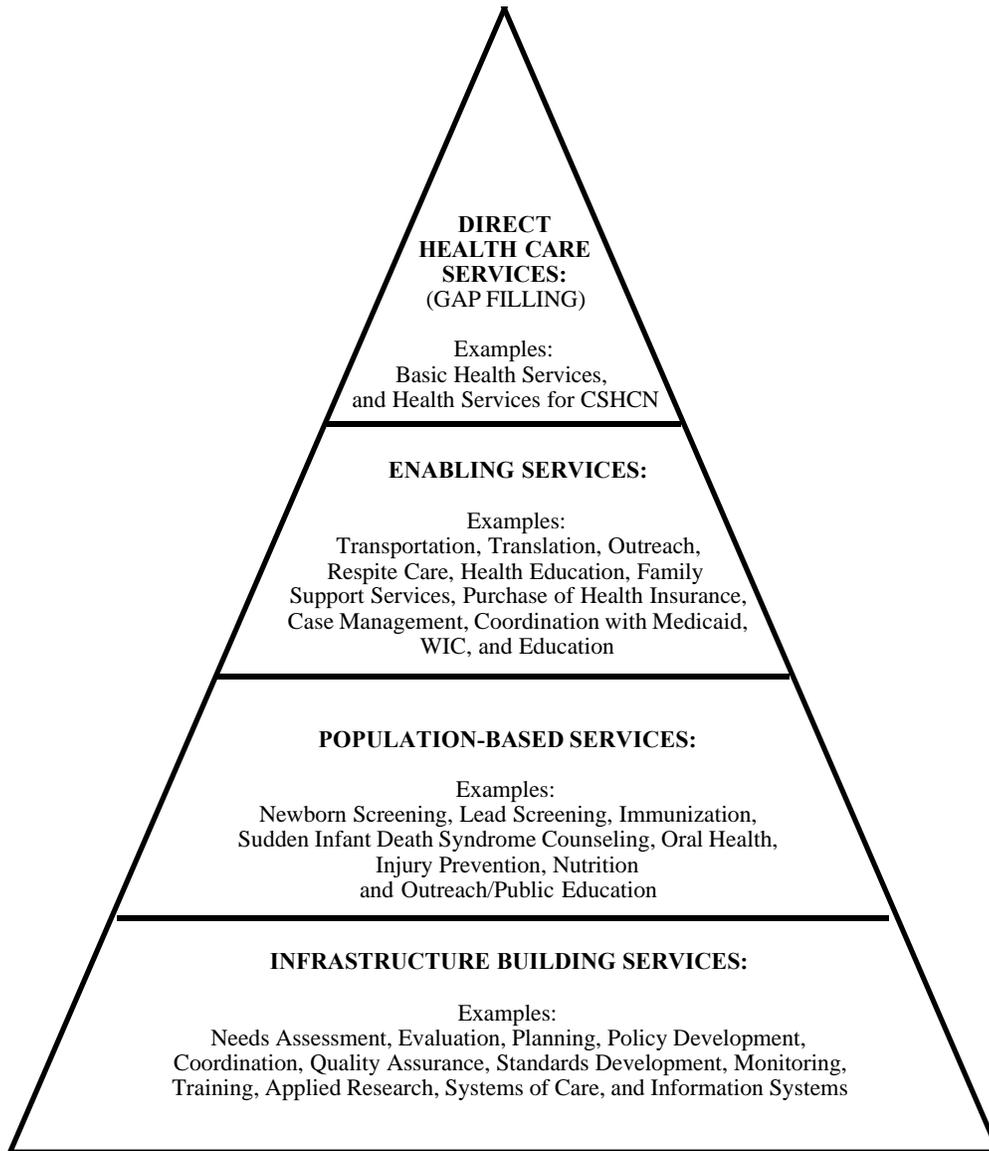
### 2.1 Annual Expenditures

For fiscal year 1999, the actual expended federal share is \$152,261 as opposed to the figures reported on Form 3. As explained in notes, the amount budgeted for this year was \$160,062, which less than what was actually awarded. The expenditure is reported the same as budgeted to avoid the warning signs.

The FY1999 budget supported salaries of key MCH staffs including 0.3 FTE of the Pediatrician. The expenditures for FY99 followed the budget plan submitted for this year.

Figure 2

## CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



## 2.2 Annual Number of Individuals Served

Details in Form 7 and Form 8.

## 2.3 State Summary Profile

Details in Form 10

## 2.4 Progress on Annual Performance Measures

The following paragraphs describes the progress made on the 18 federally mandated performance measures as well as the 10 performance measures selected by the Republic of Palau. The information about the performance measures are presented by the four levels of the pyramid; Direct Health Care, Enabling Services, Population Based Services, and Infrastructure Building Services. Within each of the levels, the information is presented by population groups; Pregnant Women, Mothers and infants, Children and Adolescent, and Children with Special Health Needs.

### *Direct Health Care Services*

Core Performance Measure #1: This is not applicable to Palau.

#### **(Children with Special Health Care Needs)**

Core Performance Measure #2: Provision of specialty services for CSHCN including the coordination of such services. Palau maintains a 100 percent compliance with this measure. The Ministry of Health sponsors various consultants at regular interval during the year for CSHCN. The specialty areas include Urology, Cardiology, EENT, Reconstructive surgery, Ophthalmology, and Orthopedics. The consultants come from Hawaii, U. S. Mainland, and Japan. CSHCN receives appropriate service free of charge. In 1999, 14 children, are 21 years and under were referred off island for treatment or corrective services. The ongoing interagency meetings provide one mechanism for coordination of services with other agencies. The Ministry of Education through its Special Education Program also supports rehabilitative consultation by providing training for staffs and parents or family members. **(Children with Special Health Needs).**

Negotiated Performance Measure #1: Exclusive breastfeeding up to age 3 months. Although the percentage of mothers who breastfeed came down in 1999, other important policy level accomplishment did take place. Nutrition in general is a big concern for Palau. This is due to significant increase in lifestyle related chronic diseases noted in the last 10 years. As a result, the task of developing a national nutrition plan was initiated. The process involved numerous opportunities for intersectoral review and comments. One section of the plan addresses Breastfeeding, in which the actions for considerations include: Ensuring that health care providers high level training on lactation management and benefits of breast feeding and that information sharing is consistent. A legislation on the implementation of the International code of marketing of breast milk substitutes is in congress. **(Pregnant women, mother, and infants)**

Negotiated Performance Measure #2: Physical Examination for children age 13 to 14 years that includes age appropriate screening and counseling. It was determined that this

information will be reported on every three year basis. The opening of the school based clinic are believed to have favorable impact on this measure. **(Children and Adolescent)**

*Enabling Services:*

The child care program have an ongoing parent support group, however, it still need a lot of guidance and support from staffs. This support group mainly involves parents of infants and young children. The Belau Family, Schools, and Community Association is a much bigger organization. MCH staffs are often requested to give presentations on various parenting issues. More is needed in terms of parents being able to assist with program and policy development. **(Pregnant women, mothers, infants, children, adolescent, and CSHCN).**

Core Performance Measure #3 addresses the need for “medical/health” home for CSHCN. By virtue of the Palau National Code, all citizens of the Republic of Palau are eligible for subsidized health care and that no one is denied of health care because of their inability to pay. All CSHCN are provided locally available services. The Belau National Health Care Plan that has gone through much scrutiny and debate was finally passed in senate early year 2000. There is hope that the House of Delegates will pass the bill. This national insurance plan will ensure that all residents of Palau will have coverage for their basic health care needs. **(CSHCN)**

*Population Based Services:*

Core Performance Measure #4: Genetic Screening for newborns; Palau does not perform any of the genetic screening, however, we report on other screenings that we do perform for infants and children as well as women including pregnant women. See Form 6 for the number of tests performed in 1999. **(Pregnant women, infants, and children)**

Core Performance Measure #5: Percent of immunization coverage for children two years old for all vaccines. Palau maintains a very high immunization coverage for two years old, the coverage of 1999 was 96 percent. Palau’s immunization requirement for two years old include four doses of DTP, two doses of MMR, three doses of OPV, 3 doses of Hepatitis B, and at least three doses of Haemophilus Influenza vaccine. We continue to run extended evening clinic hours to serve working parents and provide home visits for children who continue to miss immunization appointment. A second evening clinic will be implemented in year 2000. **(Infants and children)**

Core Performance Measure #6: The rate of birth for teenagers age 15 to 17 years. There was an increase in number of the rate of teen pregnancy, from 16.3 in 1998 to 40.7 in 1999. The YRBS data indicates that increasing number of teenagers are becoming sexually active. The 1999 YRBS shows that 45.4 students (boys and girls) have had sexual intercourse.

In 1999, the MCH continued it’s regular awareness activities and assisted the Ministry of Education’s Health program with on going school activities. Family Planning services are now provided by the school based clinic. **(Children and adolescent)**

Core Performance Measure #7: Percent of third graders who have received a protective sealant on at least one permanent molar tooth. The most current data available is for the survey that was conducted in 1997 in which the rate was measured at 81.3 percent. Results

are not yet available for the survey that was conducted during school year 1998-1999. A strategic plan for Oral Health is included as Appendix G. To further improve oral health services, for mothers and children, dental staffs are now part of prenatal and well baby clinics. Two full time dental assistants are assigned to work with parents in the well baby clinics and prenatal clinics. **(Mothers, infants, and children)**

Core performance Measure #8: The rate of deaths in children age 14 years and under caused by motor vehicle accident. There were no deaths among children 14 years and younger caused by motor vehicle accident. Overall child death rate per 100,000 for this age group is 60 in 1999. Two of the deaths were related to an air craft crash and one was related to boating accident. Injury prevention is one of the priority concern for Public Health. In 1999, a graduate student from the University of Hawaii School of Public Health spent three months in Palau conducting a needs assessment on unintentional injuries. Part of the assignment was to complete a draft plan for prevention of unintentional injuries. An intersectoral review of the draft plan took in April 2000. Some of the policy issues addressed include use of car seat belts, use of car seat for children, among others. The MCH clinic staffs also make use of the Common Household injury prevention manual that was developed by the Pacific Basin MCH Resource Center some years back. On the State Negotiated performance measure #8, there is a noted decrease in the number of common injuries that are seen in ER and Outpatient in 1999. **(Infants, children, and adolescent)**

Core Performance Measure #10: Percentage of newborns who have been screened for hearing impairment before discharge. This measure is waived for Palau, however, a state negotiated measure # 9 address hearing screening for infant by age 6 months. Palau does not have the capacity for carrying hearing right after delivery. Furthermore, there is no expertise in dealing with the problem at that age if it was found. In 1999, a Pediatric Nurse Practitioner contracted by the World Health Organization conducted a training for nurses that included growth and development assessment of infants. This includes simple assessments by use of rattle and other noise makers. **(Infants and Children)**

Negotiated Performance Measure #4: use of tobacco products by children and youth. The prevalence rate from 1998 is 36 percent, which represent a decrease from the 41 percent in 1997. The 1999 YRBS is now showing 42.5 percent. The Republic of Palau receives CDC funds for Tobacco Prevention. As a result, we now have a separate office housed outside of the Health Buildings. One of the important accomplishments has been the passage of law prohibiting sale of tobacco to minors. The tobacco office conducts vendors compliance survey with this law on an annual basis, and there is improvement in compliance. The Ministry of Education through their Comprehensive health program have ongoing programs that address tobacco, alcohol, and other substance use prevention. **(Children and adolescent)**

Negotiated Performance Measure #5: The percentage of women age 18 and older who are screened for pap smear. There is continued increase in number of women who are screened for pap smear. The MCH program works closely with the Breast and Cervical Cancer Early Detection program as well as the family Planning Clinics on this measure. Extended evening clinic hours as well as outreach visits are ways in which we reach more women. Pap smear screening services offered through the rural CHC's contributes to increase in number of women seen. **(Women)**

Negotiated Performance Measure #7: Anemia screening for infant born with low and very low birth weight infants at age 6 months. In 1999, 6 infants were born with low birth weight, while 23 were born with very low birth weight. Of the 29, 25 were screened at 6 months of age and 5 of them or 20 percent were identified to be either anemic or have borderline anemia. All 5 were treated and their condition resolved. **(Infants)**

Negotiated Performance Measure #8: The percentage of children under the age of 14 who acquire unintentional injuries requiring a visit to ER or Out patient department. As explained above, there has been a decrease in number of ER and OPD visits caused by unintentional injuries in 1999. In any case, this is still an important measure and will remain a priority for MCH. Attached as Appendix F is a Table that shows number of injuries by type and age group. This table is only showing injuries among children 0 to 19 years of age. Most common types of injury is falls and mostly occur in children 4 years and under followed by assaults that most frequently occurs among adolescents age 15 to 19 years. **(Infants, children, and adolescent)**

*Infrastructure Building Services:*

Core Performance Measure #11: Percent of Children with Special Health Care Needs with a source of payment for Primary and specialty care as explained under Core Performance measure #3, the Ministry of Health provides locally available primary and preventive as well as specialty services for CSHCN and when indicated referral to off island sites are made as part of the Medical Referral Program. **(CSHCN)**

Core Performance Measure #12: percent of children without health insurance. The explanation provided under Core performance measure #2,3 and 11 applies here. **(Infants, children, and Adolescent)**

Core Performance # 13: Medicaid eligible children who have received services paid for by Medicaid. This measure does not apply to Palau. Palau is not eligible for Medicaid program. **(Infants, children, and adolescent)**

Core Performance Measure #14: The degree to which state assures family participation in program and activities in the state CSHCN program. On the rating scale, Palau rated 11 out of 18. Even though, we continue to work toward achieving this goal, there are many barriers, some of which is the support that the parents need in order to become more involved. Currently, there is a Parent Network, but most of the activities have been mainly training and helping them to access services. We continue to work through this group. **(CSHCN)**

Core Performance Core Performance Measure #15: : Percent of Very Low Birth Weight live birth. The percent of VLBW infants in 1999 is 2.4 which is an increase from last year. Palau's goal is 1 percent. Nutrition counseling has been strengthened as a way to improve on measure. **(Infants)**

Core Performance # 16 Suicide deaths among youth 15 to 19 years of age. There was one suicide death in 1999. This is a first case in at least 10 years of no suicide for this age group. The number of unsuccessful suicide attempts is not known, however, the 1999 YRBS does show some figures on risks. The percentage of students who seriously considered attempting

suicide during the past 12 months was 27.3 percent of 468 valid responses, and 18 percent actually attempted suicide one or more times during the part 12 months. **(Adolescent)**

Core Performance Measure #17: Percent of VLBW infants delivered at facilities for high risk deliveries and neonates. This performance measure is waived for Palau. The only hospital in Palau does not have tertiary level unit for neonates. The efforts is mainly in preventing VLBW deliveries. **(mothers and infants)**

Core Performance Measure #18: Percent of infants born to pregnant women who received prenatal care beginning in the first trimester. This is one measure that Palau have struggled over for many years. We have been successful in lowering the number of pregnant women seeking prenatal care in the third trimester, but getting to come in the first trimester has not been very successful. Less than 2 percent of the pregnant women deliver without prenatal care. The average number of visits made before delivery is 8 compared to the 14 expected number of visits if one were to start in the early first trimester. **( Mothers and infants)**

Negotiated Performance Measure #9: The percentage of children who have been screened for hearing impairment at the age of 6 months. The MCH program assess compliance with this measure through medical record review. In 1999, 50 records were reviewed and all of the children were assessed. For 1999, none was detected to have hearing impairment. Other progress are explained above, under Core Performance Measure #10. **(Infants and children)**

Negotiated Performance Measure #10: The number of well child providers who are able to conduct basic nutrition assessment; dietary recall, counseling, an referral. There was some accomplishment in this area, mainly in the area of increasing the number of personnel who are able to perform the mentioned tasks. A dietician was hired in 1999 for the Non communicable disease program. The person provides services to MHC clients as needed. Mostly, he works with clients identified with gestational diabetes as well as other high risk pregnant women. **(Pregrant women, mothers, and infants)**

## 2.5 Progress on Outcome Measures

Outcome measure #1, 3, 4, 5, and 6 addresses mortality outcomes for infants and children for the Republic of Palau. There were increases in the IMR, perinatal and child death rate in 1999. As part of the Grant review recommendations from last year, we had anticipated presenting the rates by three year running averages, however, we were not successful in completing this task. Our Data and Statistics Specialist resigned in the beginning of the year, which left us with few manpower to work with. The performance objectives have been revised as needed.

For the Negotiated outcome measure, data for 1999 are not available. In 1999, we assessed weight and height information for children to 3 to 5 years old. The plan is to establish baseline BMI data for the different age cohorts. In the year 2000, we are conducting the assessment for children 6 to 8 years old. For Children 3 to 5 years, we randomly selected 50 records out of the 509 children who were enrolled in Head Start for review. Results basically shows that 80 percent of the children are well nourished, while 10 percent are on the obese or at risk for obesity, and the other 10 percent are at risk for or under nourished. The data presented in 1998

for obesity among children are 9 to 11 years showed little over 25 percent, with a similar percentage being at risk for or under nourished. This information clearly shows that the situation worsens as children grow older and not just obesity but under nourished .(Children)

### **III. REQUIREMENTS FOR THE APPLICATION [Section 505]**

#### **3.1 Needs Assessment of the Maternal and Child Health Population**

##### **3.1.1 Needs Assessment Process**

The Needs Assessment was a joint responsibility of the SSDI Coordinator, the Preventive Services Administrator, the MCH coordinator. In Early year 2000, we began a series of meetings including Directors, Division Chiefs, program manager, Epidemiologist, Data and Statistics Staffs, and other key services providers. In these meetings, several tools were introduced for use in this needs assessment. These tools were used in the past to compile statistics on health status for women, children and children with special needs in Palau. From there, 4 teams were formed and assigned specific tasks. The SSDI coordinator served as the lead person in this process and was instrumental in completing the needs assessment tables. The needs assessment data and information are referenced through out this application and some of the tables are included as appendices. Although, we set out with many things in mind, in the end, we had to limit the needs assessment to the most important things. Others will be incorporated the five plan where they will be carried out in small parts at a time.

The needs assessment involved review of existing health data, Census data, YRBS data, and other data's from medical record review. There were limited number of qualitative information derived from small scale opinion type surveys. Again this has to be limited due to staffing constraints among other things. The needs assessment process training modules that was made available by the University of Hawaii, School of Public Health was helpful in a sense that it provided a comprehensive outline to work from. Most of the resources that is needed to complete a needs assessment are available, however, the time constraint and shortness of manpower play a big role in how well this type of activity accomplished.

Following is a list of data sources where information are obtained:

- a. Birth and Death Certificate data bases
- b. Clinic and ER encounter data
- c. Hospital and Public Health Medical Records
- d. Registry for CSHCN
- e. Clinic log books
- f. Division of Environmental and Sanitation Records
- g. MCH Registry
- h. Dental Division Reports
- i. Immunization Registry
- j. Monthly reports and other relevant reports and strategic plans
- h. Data and reports from other external agencies such as; Palau Visitors Authority, Ministry of Justice, Juvenile Program, Ministry of Education, Public Safety, Office of Population and Statistics, Immigration, and Labor and Commerce.

### **3.1.2 Needs Assessment Content**

#### **3.1.2.1 Overview of the Maternal and Child Health Population's Health Status**

Details on MCH population are found on forms 7, form 8, and form 10.

#### **3.1.2.2 Direct Health Care Services**

Breast feeding is still an important initiative for Palau. There was a noted drop in exclusive BF by three months of age mostly as a result of mothers returning to work, however, more women are supplementing with formulas, so overall the number of infants who receive some breast milk is increasing. As explained in other parts of this application, BF is addressed as one section of the National Nutrition Plan. Currently, a legislation is pending in the congress on the Implementation of the International Code of Marketing for Breast Milk Substitutes. There is a plan to start prenatal classes again in which breast feeding is one of the

##### **Primary and preventive services for pregnant women, mothers, and Infants**

Nutrition in general for all MCH population groups is identified as one of the priority needs in Palau. There is a request for technical assistance for the development of a surveillance system on nutrition.

##### **Primary and preventive Services for Children and CSHCN**

Nutrition surveillance mentioned above is identified as a need for these two population groups as well.

#### **3.1.2.3 Enabling Services**

##### **Primary and Preventive Services for Pregnant women, mothers, and infants**

A short survey indicated that an additional evening clinic will improve accessibility for mothers, infants, children and CSHCN population. This is also evident from usage information for the current evening clinic. Those clients who live in the rural areas would like to see more of the basic services provided through their neighborhood CHC's and dispensaries. This issue is similar to all the other population groups; Primary and preventive services for children and CSHCN.

#### **3.1.2.4 Population-Based Services**

##### **Primary and Preventive Services for pregnant women, mothers, and infants**

A review of data and records for abortions is not very complete. This is due to many of the abortions suspected to be handled by the private clinics that are not reported. By all indications, the problem is mostly of unwanted pregnancies. Abortion is illegal in Palau which makes it a sensitive issue and difficult to assess.

##### **Primary and Preventive Services for Children and CSHCN**

Unintentional injuries is covered other parts of this application. There was a comprehensive review of injuries conducted in 1999. An injury prevention plan was then developed. A public hearing that involved key sectors of the community was carried in April 2000. The plan is now being revised to incorporate the recommendations as a result of the public review. Once that is completed then, it will be sent to the President for official transmittal to the local Congress for adoption as a national policy. The MCH program will be responsible for implementing the measures that pertains to this population.

For suicide, there was one case in 1999 of a 15 year old. As mentioned earlier, the YRBS data indicates high risk among adolescent. ER data on attempted suicide were found to be incomplete, meaning that, in most instances injuries that are sustained as a result of suicide attempt are treated just as injuries and not diagnosed a related to suicide attempt. This makes it difficult to get the true picture, and furthermore, interventions and referral to appropriate services is lacking. It is also suspected that use of alcohol and other drugs are the main contributing factor for suicide. Data collection from the Public Safety is again inadequate due to inconsistencies in documentation and reporting.

Obesity in children: This is discussed again in other sections of this application. A nation, this measure is important along with the issue of nutrition. Diabetes and other diet and life style diseases are affecting many adults and costing the nation significantly. Two thirds of the annual Health budget goes to hospital medical services that serves less than 10 percent of the population annually. Whereas, primary and preventive services serves over 80 percent of the population with only one third of the annual budget.

The YRBS data is 1999 is a significant milestone in understanding risk behaviors among adolescent. The Ministry of Education has been an important partner on this. MCH program continues to collaborate with Education in ensuring that more students from other high schools are part of the YRBS survey.

From 1995 to 1997, the Palau Lead Poisoning Prevention program, funded by the U. S. Department of the Health and Human Services estimates that the prevalence of lead poisoning, defined as a level of 10 or more micrograms per deciliter of venous blood, was 2.8 percent among children in Palau age six years and below.

The Head Start program began assessing venous blood levels for new enrollees during the 1995-96 school year and has continued until present. Head Start therefore provides an ongoing prevalence of lead poisoning among children age 3 to 5 years who are enrolled in the Head Start program. A task force of Public Health and Environmental Health and Sanitation personnel has been formed to conduct follow-up on positive cases.

To date, 690 children in Head Start program have been tested for venous lead level. The following table shows that of the new Head Start enrollees screened in 1995 to 1999, 43 (6.2 % of 690) had venous lead levels of 10 = ug/dL. The prevalence of positive cases per year ranged from 3.2 and 8.6 percent.

### **Primary and Preventive Services for Children and CSHCN**

Leading causes of Mortality among children <1 to 24 years of age: During the years 1990 to 1999, prematurity was the leading cause of infant mortality. The leading causes of deaths overall among ages one to 25 years were drowning, motor vehicle accidents, and injuries resulting from other accidents or from assault. Over the 10 year period, suicide was a leading cause of death among ages 15 to 19 years (there were five cases).

The category of other injury from assault or accident, includes deaths that resulted from the Paradise Air crash in November 17, 1999. This category also includes three deaths due to asphyxiation, strangulation, or hanging that were undetermined whether intentional or unintentional. Also included in the category are two assaults with a cutting /piercing instrument,

and two accidents involving a firearm, among others. Please see table showing the numbers and explanations on Appendix F, included as supporting document.

Included as Appendix E is another table on the Leading causes of Hospitalizations by causes among children <1 to 24 years. Respiratory illnesses and otitis media were the leading causes of hospitalization among children age <1 to 4 years.

### **3.1.2.5 Infrastructure Building Services**

#### **Primary and Preventive Services for pregnant women, mothers, and infant**

VLBW and LBW infants is a serious consideration for Palau. Much of the problem is related to premature birth as discussed above. We have not been able to pin point the root of the problem, however, there is an interest in starting folic acid supplementation for pregnant women. A nutrition assessment of pregnant women conducted in mid 1990's alluded to possible micro-nutrients deficiencies among the pregnant women who were interviewed.

Prenatal care or early prenatal care is another area of concern. It was determined that on the average, each pregnant women makes 8 visits out of the 14 expected ones through out each pregnancy. It is noted that in 1999, 73 of the 248 women who gave birth were primigravidas. Women who are pregnant for the first time tend to come early compared to women who are pregnant a second or more time. If this is the trend, then prenatal care for women pregnant for the first time need to address many skills and knowledge for subsequent pregnancies. The quality of prenatal care needs to improve.

#### **Primary and Preventive Services for Children and CSHCN**

Last year, we were not able to find the technical assistance that we requested in the area of otitis media. We were interested in a re-evaluation of the situation. Among the physicians who have provided care in Palau, the problem is still significant, however, it has improved considerably compared to 5 years and 10 years ago. This is evident by the decreasing number of children seen in the specialty clinics and the declining seriousness of the middle ear conditions. This also due to better trained providers, however, some of the key staffs with expertise in EENT services will be due for retirement in the next two years. Needless to say, the Ministry of Health is implementing cross training programs in anticipation of this situation.

## **3.2 Health Status Indicators**

Palau was able to provide most of the information required for the Health Status Indicators. In the process, we began by determining the indicators for 1999, and where possible went backwards. There were no significant barriers in accomplishing the task, other than losing the data specialist who was the key person in this process.

### **3.2.1 Priority Needs**

Priority needs for Palau are well identified on Form 14. Three changes were made on this priority listing. Implementation the activities outlined in the National Nutrition Plan pertaining to MCH population is rated of high priority. Suicide among adolescent was included as well as reduction to perinatal deaths.

### **3.3. Annual Budget and Budget Justification**

Attached as Appendix D is the Palau Fiscal Year 2001 Budget and Justification. Palau is requesting a total of \$157,320 for this program year.

#### **3.3.1 Completion of Budget Forms**

Details are in Form 2, Form 3, Form 4, and Form 5. Other informations are provided in the ERP notes.

#### **3.3.2 Other Requirements**

The MCH program complies with the requirements that: (a) at least 30 percent of funding support for primary and preventive services for children and (b) at least 30 percent support services for CSHCN.

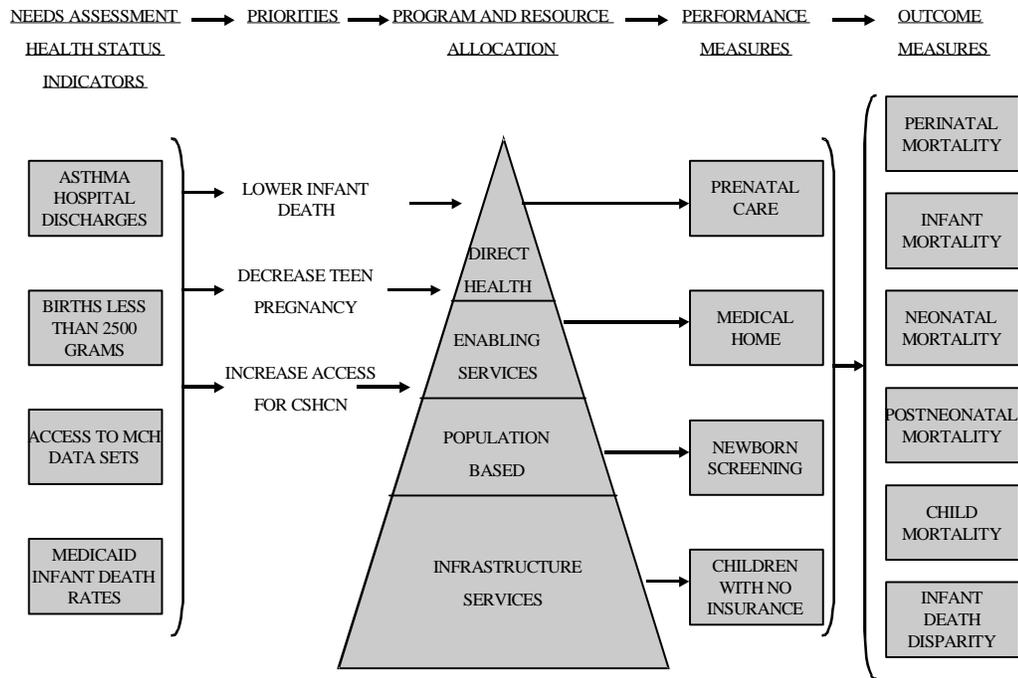
The MCH program also complies with the most current Negotiated Indirect Cost Agreement at 7.989 percent of salaries and wages, including fringe benefits. The Agreement is effective from October 1, 1999 to September 30, 2000. A copy of the Indirect Cost Agreement is attached as Appendix F.

### **3.4 Performance Measures**

#### **3.4.1 National "Core" Five Year Performance Measures**

Form 11 shows detail for each of the national core performance measures.

# Figure 3 TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



**Figure 4**  
**PERFORMANCE MEASURES SUMMARY SHEET**

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1.) The percentage of mothers who exclusively breastfeed their infants up to age 3 months.	X						X
2.) The proportion of children ages 13-14 who receive annual physical examination which includes age appropriate screening, assessment, and counseling.	X				X		
3.) To develop support systems for parents and families that address their needs for parenting skills, discipline, and other lifecycle issues.		X			X		
4.) The prevalence rate of children and youth who uses tobacco products.			X		X		
5.) The percentage of women age 18 and older who received a pap test within the preceding 1 to 3 years.			X				X
6.) The rate of birth (per 1,000) for teenagers age 12 through 18 years.			X				X
7.) Anemia screening for infants born with low and very low birth weight .			X				X
8.) The percent of infants and children under the age of 14 years who acquire unintentional injury requiring a visit to Emergency or Out Patient Department.			X				X
9.) The percentage of infants who have been screened for hearing impairment by age of 6 months.				X	X		
10.) The number of well child service providers who are able to conduct basic nutrition assessment, dietary recall, counseling, and referral.				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services  
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

### 3.4.1.1 Five Year Performance Objective

For the most part, the five year performance objectives remained the same. For those where adjustment were made, the explanations are provided in the ERP notes section.

### 3.4.2 State "Negotiated" Five Year Performance Measures

Palau chose to keep the ten negotiated performance measures that were adopted last year. Although there were changes in the priority listing, it did not warrant changing the state negotiated performance measures.

#### 3.4.2.1 Development of State Performance Measures

In the initial development of the 10 negotiated performance measures, a discussion among key stakeholders in addition to review of available data and reports was carried out. This year, the team members who worked on the needs assessment re-evaluated the measures, and the decision was to keep all 10 for the next year.

#### 3.4.2.2 Discussion of State Performance Measures

A detailed listing is provided on the negotiated performance measure table. Discussion on each of the measure is also provided in the progress report section of this application. There are no significant changes to be explained in this section.

### **3.4.2.3 Five Year Performance Objectives**

Again, performance objectives are presented on Form 11 and explanations are provided as needed in the ERP notes. A few of the performance objectives had to be revised and in this instance the explanation is provided in the notes.

### **3.4.2.4 Review of State Performance Measures**

Refer to discussion under 3.4.2.2

### **3.4.3 Outcome Measures**

Details are provided on Form 12.

## **IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]**

### **4.1 Program Activities Related to Performance Measures**

*Direct Health Care Services:*

- a. Increase to 35 percent the number of mothers who exclusively Breast feed their infants.

Types of Activities:

- continue on going one to one counseling with pregnant women and mother.
- Make available information on breast feeding, breast pump and storage of expressed breast milk
- Incorporate Breast feeding instruction in the prenatal classes
- Follow up on the legislation the Implementation of the International code of marketing for breast milk substitutes.

- b. Begin implementation of the MCH related tasks as outlined in the National Nutrition plan in FY2001.

Types of Activities:

- plan for cross training of at least two MCH staffs on nutrition counseling, dietary recall, and calculation of caloric intake.
- Continue nutrition and diet services for pregnant women, mothers and or parents.
- Pursue the TA request for development of the nutrition surveillance.
- Carry out periodic continuing education for MCH staffs on weight and height measurement for infant and children and plotting on grids.
- Purchase necessary supplies needed to carryout these activities.

- c. To increase the number of children who 13 to 14 years who receive annual PE with age appropriate screening, assessment, and counseling.

Types of Activities:

- Provide PE in the existing school based clinic.
- Provide PE through the rural CHC' s and dispensaries
- Pursue policy development to require PE as requirement for High School entry.
- Evaluate record determine success of the program.

*Enabling Services*

- a. To further develop family support systems for parents, families to address their needs for parenting and other child rearing skills.

Types of Activities:

- Initiate the prenatal class
- Encourage participation of spouses in the prenatal classes
- Continue and expand on the existing parent support class
- Collaborates with Belau Families, School, and Community Association and provide resources needed by parents as needed.

- b. To continue to provide specialty clinic services for CSHCN

Types of Activities:

- MCH/CHSCN providers to continue collaborates and ensure that all CSHCN are routed through appropriate specialty clinic.
- Provide on going training for parents and family member on skills needed for caring for their children
- Evaluate the tracking to ensure that children are not lost to supervision
- Continue on going multidisciplinary case conference on identified CSHCN
- Make special effort to empower parents and family member in the care of their children

*Population Based services and Infrastructure building services*

- a. To continue to increase the number of women who are screened for pap smear in the year 2001.

Types of activities:

- Make available pap smear screening in the rural CHC's and dispensaries.
- Increase extended evening clinic hours to include womens health care and pap smear and other screening.
- Ensure that at least 10 nurses and at least 2 medical officers attend the Annual Family Planning Conference that will be held in Palau in the year 2001. This conference usually provide training on women's health care management issues, contraceptive management, and others.
- Maintain ongoing Quality assurance activities to ensure proper management of patients with positive results.

- b. To continue current activities for injury prevention

Types of Activities:

- assist in the finalization of the national injury prevention plan
- continue to provide one on one counseling for parents and family members on common household injury prevention.
- Work with ER and Opd providers to ensure consistency in reporting
- Work with Public Safety to address reporting needs.

- c. To continue to maintain immunization coverage of over 95 percent.

Types of Activities:

- Continue with providing immunization services through extended clinic hours, rural CHC's, dispensaries, and home visitsl

- Ensure that data entry on the Immunization registry is accurate and timely.
- Ensure that vaccines and other supplies are available at all times.

d. To continue to improve oral health status of children in the year 2001.

Types of activities:

- implement the oral health plan that is included in this application as supporting document
- continue collaborations with Hawaii Health Department to utilize their services in analyzing the oral health survey done every three years.

e. To prevent child deaths caused by motor vehicle accident:

Types of Activities:

- work with appropriate staffs to implement the activities outlined in the proposed national injury prevention plan
- work with local congress to ensure passage of laws pertaining to injury prevention.

f. To ensure that over 90 percent of the children born with LBW or VLBW are screened at age six months for anemia.

Types of activities:

- involve MCH providers in the Quality Assurance activities for this measure.
- Provide incentives for staffs

g. To improve on going activities in early detection and intervention of suicide among adolescent.

Types of activities:

- Assist in arranging for staff training on this area.
- Include reporting and as part of the staff training
- Collaborate with school health nurses and counselors in identifying students at risk.
- Collaborate with key agencies on referral process
- Make use of the YRBS in public awareness programs

#### **4.2 Other Program Activities**

The Ministry of Health has adopted for its use in policy making various health initiatives, chief among which are: New Horizons in Health, the Yanuca Island Declaration on Healthy Island in the 21<sup>st</sup> century, the Rorotonga Agreement, the Noumea Declaration on Health Education and Health Promotion and most recently the Palau Action Statements adopted in February 2000. The MCH program uses these health initiatives as guidelines developing its programs. Finally, the recommendations of the IOM report are taken into consideration on future direction of the program.

#### **4.3 Public Input [Section 505(a)(5)(F)]**

For this application, the public comments were gathered in segments, and opposed to prior years where announcement is put on the radio for interested community members to make comments. For this year, key community members are invited by letters and a public

hearing is conducted for 3 to 5 days. The components that received most community input are the injury prevention and nutrition issue.

#### **4.4 Technical Assistance [Section 509 (a)(4)]**

Palau is currently applying for a CDC grant entitled, “State nutrition and physical activity programs to prevent Obesity and related chronic diseases”. If Palau were to get funded, the program year begins October 1, 2000 and will run for 3 years. In the proposal, we are asking for funds to contract our services for the development of the Nutrition surveillance system. This is listed as one TA need for Palau for the year 2001.

#### **4.5 V. SUPPORTING DOCUMENTS**

1. Appendix A—Map of Palau
2. Appendix B—Population tables and Socio-Economic indicators ( 3 pages)
3. Appendix C---Table of Organization; Ministry of Health, Palau
4. Appendix D—Budget and Justification
5. Appendix E---Summary Report on Leading Causes of hospital discharges and morbidity among children ages <1 to 24 years.
6. Appendix F—Indirect cost agreement
7. Appendix G---Oral Health Strategic Plan

## 5.1 Glossary

### GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (*Title V Sec. 501(b)(4)*)

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

## Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. **State Program Collaboration with Other State Agencies and Private Organizations.** States 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.
2. **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.
3. **Coordination of Health Components of Community-Based Systems.** A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.
4. **Coordination of Health Services with Other Services at the Community Level.** A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving 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 standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

**Outcome Measure** - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

**Performance Indicator** - The statistical or quantitative value that expresses the result of a performance objective.

**Performance Measure** - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19\_\_.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

**Performance Measurement** - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

**Performance Objectives** - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

**Population Based Services** - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

**PRAMS** - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

**Pregnant Woman** - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

**Preventive Services** - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

**Primary Care** - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State’s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

## 5.2 Assurances and Certifications

### ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-

- (1) The dangers of drug abuse in the workplace;
- (2) The grantee's policy of maintaining a drug-free workplace,
- (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
- (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight  
 Office of Management and Acquisition  
 Department of Health and Human Services  
 Room 517-D  
 200 Independence Avenue, S.W.  
 Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### 5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may

result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

### 5.3 Other Supporting Documents

**MCH BLOCK GRANT**

**Budget and Justification: FY 2001**

<b>A. Personnel:</b>		<b>\$ 111,477</b>
	1. Dr. Gregory Dever (Pediatrician) @ 0.5 FTE	\$ 35,000
	2. Johana Ngiruchelbad, Administrator @ 0.5 FTE	15,000
	3. Fermin Kebekol, Hlth. Educator @ 0.3 FTE	6,669
	4. Akilina Tewid, Social Worker @ 0.5 FTE	6,045
	5. Florence Kitalong, Hlth. Asst. @ 1.0 FTE	10,005
	6. Ucheriang Aderkeroi, Hlth. Asst. @ 1.0 FTE	10,005
	7. Merlynda Taro, Clerk @ 1.0 FTE	7,625
	8. Angeline Sakuma, Data Staff @ 1.0	8,455
	9. Nutritionist (vacant) @ 1.0 FTE	12,673
<b>B. Fringe Benefits:</b>		<b>\$ 12,262</b>
	Estimated at 11 percent of base salary: (5% for Social Security and 6 percent for Pension Plan)	
<b>C. Travel:</b>		<b>\$ 15,446</b>
	1. Participant to attend the annual AMCHP meeting held in Washington, D.C. Airfare, per diem, and ground transportation expenses for one Person -----\$ 4,046	
	2. Participant to attend the annual grants review held in Honolulu, HI Airfare, per diem, and ground transportation -----\$ 3,050	
	3. Participant to attend the annual MCH Coordinators meeting held in Honolulu, HI. Air fare, per diem, and ground transportation for one person -----\$ 3,050	
	4. On Island travel: POL @ \$150/month X 12 months----- \$1,800 Vehicle Maintenance cost -----3,500 Subtotal-----\$ 5,300	
<b>D. Equipment:</b>		<b>\$ -0-</b>
<b>E. Supplies:</b>		<b>\$ 4,781</b>
	1. Medical supplies: pregnancy test kit, gloves, speculum, cleaning solution, and others -----\$ 2,500	
	2. Office supplies: xerox papers, toner, forms, and other standard Office supplies -----\$ 2,281	

<b>F. Contractual:</b>		<b>\$ -0-</b>
<b>G. Others:</b>		<b>\$ 3,480</b>
1. Communication		
-- telephone/fax	\$ 50/month X 12 months --\$ 600	
-- E-Mail	15/month X 12 months--- 180	
-- Internet	100/month X 12 months –1,200	
	Subtotal-----\$1,980	
2. Expenses for focus groups, training, and other meetings		
	\$ 1,500	
<b>Total Direct Cost</b>		<b>\$ 147,446</b>
<b>Indirect Charges</b>		<b>\$ 9,874</b>
The current indirect Cost Agreement for the Republic of Palau is 7.98% of base salary and fringe benefits: (\$111,477 + \$12,262 = 123,739 X .0798 = \$9,874).		
<b>Total Amount Requested</b>		<b>\$ 157,320</b>

## **Oral Health Strategic Plan – MCH Component**

### **Objective 1: To reduce the incidence of Early Childhood Caries in Palau**

Activity: Continuation and strengthening of the Early Childhood Caries Program which includes the following:

1. Prenatal Activities
  - oral health education/consultation, oral examination, cleaning/prophylaxis if required for all pregnant mothers.
2. Post-natal Activities
  - 2 weeks postpartum dental visits (by automatic referral to dental clinic)
  - Oral examination/consultation and treatment of any dental pathology for mother
3. Well Baby Clinic Activities  
6 mos, 9 mos, 15 mos, 2 yrs., 3 yrs (all immunization visits)
  - Activities provided by personnel include:
    - fluoride supplementation
    - oral health consultations for parents
    - providing educational materials
    - providing tooth-brushing aids (infant brush or toothbrush)
    - providing early oral exam for children
    - providing early referral of children to dental clinics, if required
    - provide fluoride varnish application, as indicated.
4. Dental Health Education

### **Objective 2: To reduce the unmet treatment needs (untreated caries) in Palau**

Activity:

1. Continuation and strengthening of preventive dental activities (perinatal, Head Start and school programs) as outlined in activities under objective 1 & 5. Overall reduction in caries will automatically reduce percentage of children with unmet treatment needs.
2. Strengthening of referral/treatment mechanisms which are included in the preventive dental programs.
  - A. Early screening/referral of children at WBCs.
  - B. Screening and referral of all Head Start Children
  - C. Screening and treatment or referral of all elementary school children
3. Support Head Start in hiring a dental professional (dental nurse) to help reduce prevalence of untreated caries in Head Start students.

### **Objective 3: To improve manpower shortage of dental personnel**

Activities: To continue to support two individuals who are attending training to become dentists. To support 2-3 additional individuals to attend dental training (within the next 5 years) in anticipation of retiring dental nurses. To continue training a dental laboratory technician. To conduct a Dental Assistant Training Program to be held within the next 5 years.

### **Objective 4: To improve dental infrastructure**

Activities: There is no funding available at this time for improvement of infrastructure, however, the following infrastructure is required: a dental outreach vehicle, new dental units and chairs, sterilization equipment, instruments, computer, 2 x-ray machines, air compressor, nitrous oxide equipment and portable dental equipment. In addition, the CHC Dental Clinic (which provides primary dental care services) required renovation and refurbishing of equipment. The hospital dental (which primarily provides clinical services for adults) requires expansion (2-3 additional treatment rooms) to accommodate population size.

### **Objective 5: To establish/continue development of collaborative preventive dental programs with schools or other organizations to improve access to preventive measures.**

#### Activities:

#### Head Start Dental Program (services provided at no cost):

- \* Daily fluoride supplements
- \* School Brushing
- \* Dental Health Education
- \* Oral Exams/survey/referral and treatment if required

#### Elementary School Dental Program K-8 (services/supplies provided at no cost)

- \* All students provided sealants
- \* Daily fluoride supplements
- \* School brushing
- \* Fluoride gel
- \* Dental screening/exams and survey
- \* Treatment of all decayed permanent teeth/prophylaxis as indicated (private schools are treated in cooperation with local church clinic or on a referral basis)
- \* Dental Health Education (classroom presentations)
- \* Outreach to all elementary schools

State Negotiated Performance Measure: SP #3

Check List: The following four questions are rated on a scale of 0, 1, 2, 3 with 0 = not met, 1 = partially met, 2 = mostly met, and 3 = completely met.

1. The degree to which existing services for parents and families within Palau collaborate and coordinate their efforts. SCORE   2
2. A system exists within the Health Education and Promotion Unit of the Ministry of Health to provide uninterrupted services for parents and families that support parenting skills. SCORE   2
3. A system is place to periodically evaluate the effectiveness of services provided for parents and families. SCORE   2
4. The degree to which parents, families, and community members participate in developing programs and performance measures. SCORE   1

Rating for 1999: 7/12  
7/11/00

## 5.4 Core Health Status Indicator Forms

## 5.5 Core Health Status Indicator Detail Sheets

## 5.6 Developmental Health Status Indicator Forms

## 5.7 Developmental Health Status Indicator Detail Sheets

## 5.8 All Other Forms

## 5.9 National “Core” Performance Measure Detail Sheets

## 5.10 State "Negotiated" Performance Measure Detail Sheets

## 5.11 Outcome Measure Detail Sheets