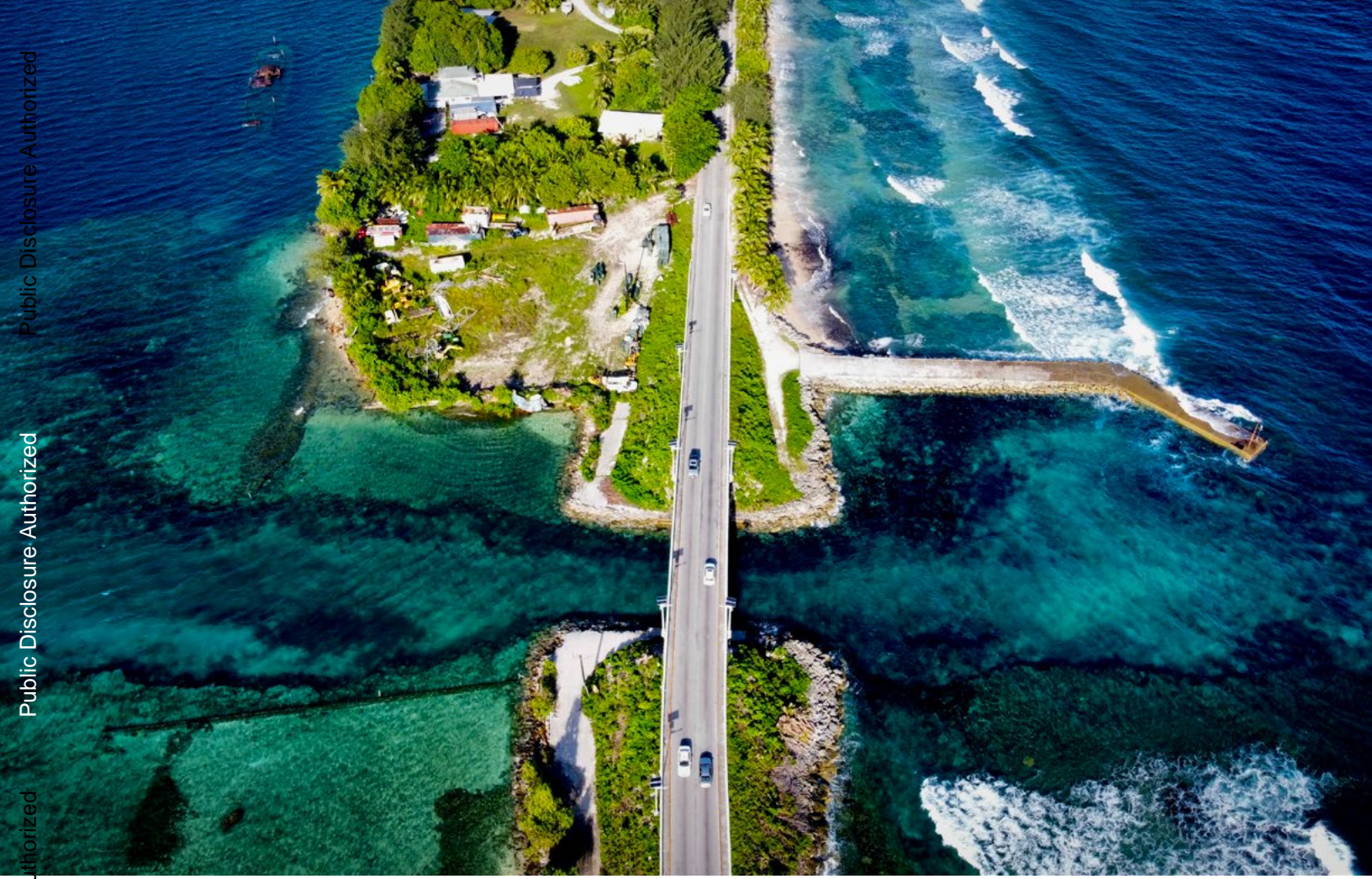


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THE PRIMARY HEALTH CARE SYSTEM OF THE REPUBLIC OF THE MARSHALL ISLANDS

A PRIMARY HEALTH CARE PERFORMANCE
INITIATIVE ASSESSMENT

MARWA RAMADAN · VALERIA CRUZ-VILLALBA · CAMERON SCOTT FEIL
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Report prepared by the World Bank in consultation with the Ministry of
Health and Human Services, Government of the Republic of the Marshall Islands



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ABBREVIATIONS

DPT	Diphtheria-pertussis-tetanus
HIES	Household Income and Expenditure Survey
MHHS	Ministry of Health and Human Services
NCD	Noncommunicable disease
PHC	Primary health care
PHCPI	Primary Health Care Performance Initiative
RMI	Republic of the Marshall Islands
RMNCH	Reproductive, maternal, newborn, and child health
UHC	Universal health care
VSP	Vital Signs Profile
WHO	World Health Organization



EXECUTIVE SUMMARY

This report presents the findings of the primary health care (PHC) system in the Republic of the Marshall Islands (RMI), an assessment that the World Bank conducted in consultation with the Ministry of Health and Human Services (MHHS) of the government of RMI. The assessment provides an opportunity to understand the performance of RMI's PHC system, highlighting important areas of strengths and opportunities to address ongoing challenges. The assessment uses the Primary Health Care Performance Initiative (PHCPI) framework, which organizes various domains and subdomains of primary care using a logic model approach that encompasses the traditional inputs and outputs of a system, emphasizing service delivery and performance.

The PHCPI uses technical tools to help countries improve the performance of their PHC systems. Its conceptual framework, which was developed to describe the critical components of a strong health care system, defines five core domains of a PHC system and serves as the foundation of the initiatives activities. The framework is operationalized into the Vital Signs Profile (VSP), which provides a snapshot of PHC systems in individual countries and states, revealing where systems are strong and where they have challenges. It is designed to help countries, states, and development partners identify priority areas for improvement and to track improvements over time.

Our assessment revealed multiple challenges in accessing reproductive, maternal, newborn and child health (RMNCH) services and communicable disease services, which can be linked to lack of availability of PHC services in most health care facilities, adding to the double burden of disease that the country is facing. Our Results show that access to health care is limited, with only 51 percent of households accessing care when needed and 32 percent facing extensive travel times to health care facilities. In terms of coverage, critical gaps are evident in communicable disease management, child and maternal health care services, and hypertension treatment. The assessment highlights a

troubling decline in immunization rates and suboptimal treatment for conditions such as HIV and tuberculosis. The quality of health care services is compromised, with notable gaps in the comprehensiveness of services, continuity of tuberculosis treatment, and adherence to patient safety standards.

Health equity is lacking in RMI, with considerable disparities in access to and coverage of PHC services. The results underscore the effect of socioeconomic status, educational background, and geographic location on access and coverage of health care services, with rural areas and people of lower socioeconomic status disproportionately affected. These findings highlight the critical need for focused policy interventions and strategic efforts to bridge the equity gap, ensuring fair and equal access to health care for all segments of the RMI population.

RMI's PHC system has strengths, as well as areas for improvement in governance, inputs, and population health and facility management. The country has built its PHC system on clear policies that acknowledge the importance of PHC, but these policies must be tailored to the specific and current needs of the population, and reliable ways to measure impact must be developed. In general, an important limitation on PHC coordination is siloed work. Because of RMI's geography and communication challenges, distribution of inputs, facility amenities, and human resources across the country is a major constraint on delivery of good-quality health care services. There is room for improvement in building an empanelment¹ system, organizing better team-based care, and boosting reporting and supportive supervision across facilities.

To overcome the challenges identified in the VSP, the following steps are recommended for RMI.

¹ The process of creating and maintaining a relationship between each patient and a primary care provider

1. Integrate PHC into health care sector governance and leadership.

To enhance care coordination, it is essential to integrate PHC into the governance and leadership of the overall health care sector. RMI could benefit from developing a consolidated PHC strategy that defines PHC's scope and roles, creating an integrated package of essential PHC services, establishing a PHC focal point within the MHHS, and forming a multisectoral action plan for noncommunicable diseases. This approach would streamline services, reduce fragmentation, and ensure that PHC is responsive to citizen and patient needs.

2. Strengthen quality management infrastructure.

Improving the infrastructure of PHC facilities is vital for safe, effective service delivery. This includes addressing facility infrastructure challenges, establishing a routine service monitoring framework, and introducing a platform for discussing and expanding PHC innovations. RMI can improve its quality management infrastructure by conducting comprehensive assessments of PHC facilities, creating national standards for infection prevention, and facilitating adoption of innovative practices. Such efforts would ensure continuous, comprehensive, accessible service delivery across RMI.

3. Enhance the capacity of the health care workforce.

To deliver equitable, high-quality services, it is crucial to evaluate density and distribution of health care workers, strengthen the licensing board for quality assurance, promote multidisciplinary team-based care, and implement routine supportive supervision. These steps will ensure equitable access to care, maintain quality assurance in health care delivery, and optimize the skills and competencies of the health care workforce. Incorporating a structured supportive supervision system will enhance service delivery and foster a culture of collaboration and shared accountability among health care workers.

4. Improve facility organization and management for efficient, responsive PHC services.

Implementing a formal empanelment system will enhance patient support and care coordination, investing in the skills of facility managers is key to effective operation and decision making, and routine performance measurement and management in PHC facilities is necessary for continuous improvement. These measures will ensure that PHC services are efficiently managed, responsive to patient needs, and aligned with national health care objectives.



INTRODUCTION

The Republic of the Marshall Islands (RMI) is one of the world's most isolated, and vulnerable nations. It consists of 29 atolls and five individual islands (24 of the 34 of which are inhabited). It covers an area of 1.9 million km (approximately the size of Mexico) but has just 181 km in land area (approximately the size of Washington, DC). The population was estimated to be 58,413 in 2018, of which approximately 28,000 (53 percent) reside in Majuro (the country's capital) and 10,000 (18 percent) in Ebeye, the two largest urban centers. Its low elevation makes the country highly vulnerable to natural and climate-related disasters, threatening the physical viability of some areas.

The prevalence of poverty in RMI is among the highest in the region and is especially severe outside of the urban centers of Majuro and Ebeye. About 51 percent of the population experiences hardship (defined as expenditures below a threshold that includes an allowance for minimum food and nonfood needs), compared with 20 percent to 30 percent in most Pacific Island countries. High transport costs and limited access to and poor quality of public goods and services exacerbate inequality between populations in the urban centers and the neighboring islands. Over the past 30 years, lack of employment opportunities on outer islands and greater reliance on the cash economy (versus a subsistence lifestyle) increased migration to the urban centers of Majuro and Ebeye, and aid dependence has undermined traditional customs and values. As a result of the crowding and lack of access to land in Ebeye and Majuro, inequality worsened within the urban centers. Informal safety nets are weakening and are not being replaced by formal safety nets or government support.

The small size and remoteness of RMI make economic activities costly and challenging to expand, limiting the competitiveness of exports and complicating provision of public services. The fishing sector is the main source of revenue, accounting for 21 percent of gross domestic product (2018), whereas infrastructure development, public administration, and fishing-related activities are the main drivers of gross domestic product

growth. Most foodstuffs (excluding local foods such as fish, coconuts, and some fruits), fuel, building materials, clothing, and manufactured products are imported, and exports are limited to fish and coconut products (raw and after some basic processing). The nation is highly exposed to fluctuations in international food and fuel prices. Economic growth was 3.5 percent in 2017 and is predicted to slow to about 1.5 percent over the medium term.

Since becoming a sovereign nation in 1986 with a Compact of Free Association with the United States, RMI's additional sources of income come from yearly financial transfers from the United States, access to a range of U.S. government services and programs, and open migration to the United States for RMI citizens in exchange for permission to retain permanent defense forces in and exclusive access to RMI's sovereign territory (among other arrangements). Transportation between the atolls and islands is by boat or air. Government-owned ships make scheduled trips between the islands, and several commercial cargo lines serve the islands. The atoll of Majuro has a commercial dock complex, and many of the atolls have good anchorages in their lagoons. The atolls of Majuro and Kwajalein have international airports, and domestic and regional flights link some of the other atolls and islands.

RMI HAS high mortality and morbidity for noncommunicable diseases (NCDs) and communicable diseases. Diabetes-related diseases and cancer are the leading causes of death. High consumption of imported canned and instant foods, lack of physical exercise, and use of tobacco products are all associated with the high prevalence of NCDs and obesity. Tuberculosis is also a leading cause of death, and the country has reported multidrug-resistant tuberculosis. The response of the Ministry of Health and Human Services (MHHS) to emergencies and disasters is ad hoc, and multisectoral approaches remain a challenge. The shortage of funds to implement programs contributes to fragmentation of health service delivery.

Increasing drought, sea level rise, and inundation affecting the health of Marshallese. Climate-induced extreme weather events and sea-level

rise are causing a range of significant health impacts, including greater risk of water-borne diseases (e.g., diarrheal diseases) and vector-borne diseases (e.g., dengue); greater food and water insecurity, leading to nutritional problems; and disruption of health systems. The MHHS and Ministry of Environment Climate Change Directorate are partnering with the multilateral organizations to tackle the health impacts of climate change and enhance preparedness for future health emergencies, including the next pandemic.

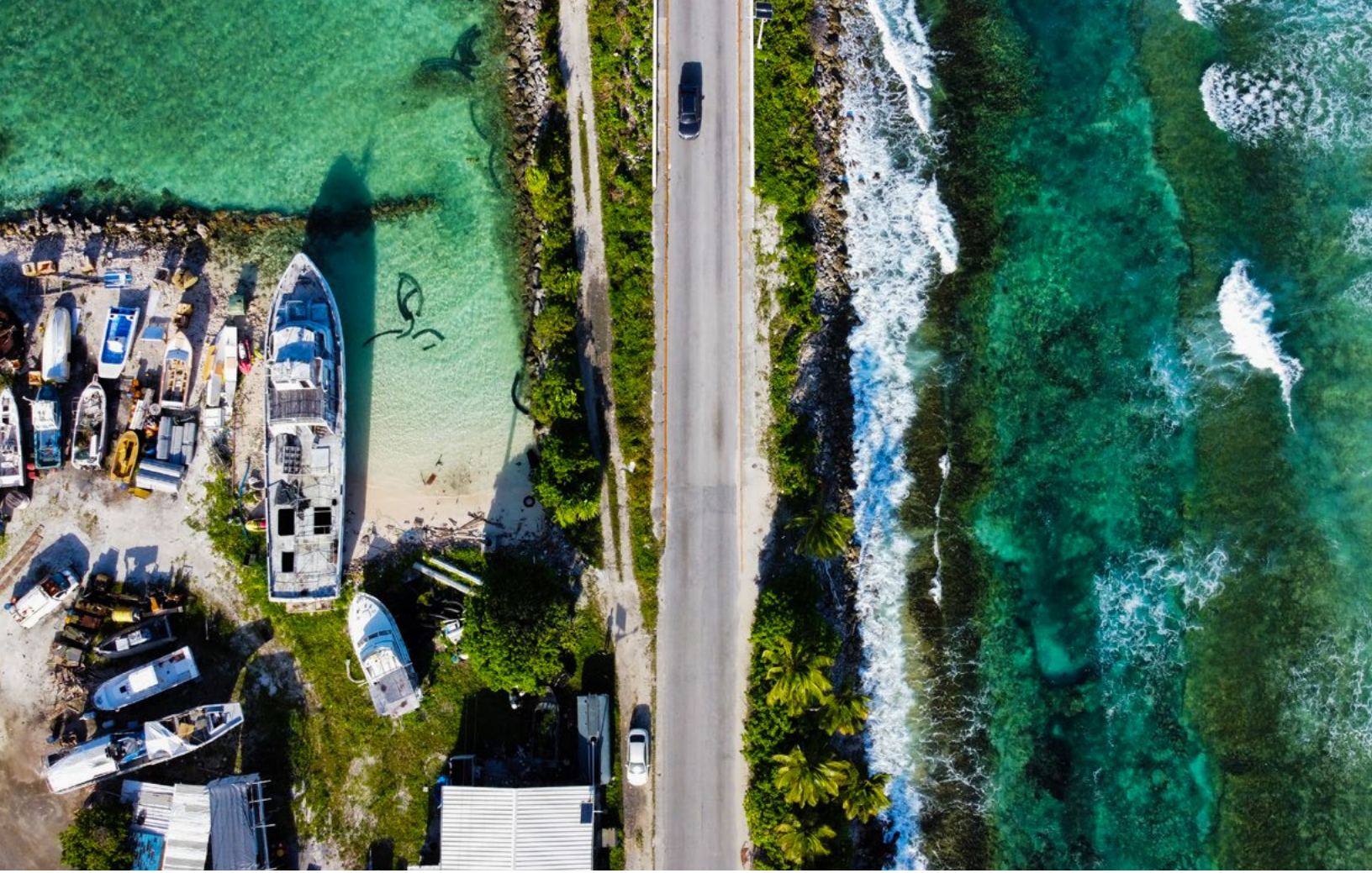
RMI faces significant challenges in building strong early foundations for childhood development, including high rates of malnutrition and stunting, which affect 35 percent of children under five, limited access to food-quality early childhood education, and the need for more support for vulnerable families with young children.

The MHHS works collaboratively with community health councils to provide health care services. The RMI health service consists of two hospitals—one in Majuro, one in Ebeye—and 56 health care centers spread across the atolls and islands. Information between health care centers is communicated to Majuro Hospital via radio. Both hospitals provide primary, secondary, and limited tertiary care. Patients who require extensive tertiary care are referred overseas. Health assistants who provide health promotion and prevention and essential clinical care services run health care centers. On the most remote atolls, only infirmaries with minimally trained attendants are available. Because of a shortage of funds, health care service delivery is inconsistent across RMI. Although the government reviews its health programs at the national level annually, public spending on the health care sector is low.

Delivery of health care services is mixed. Basic public health care is available for all residents, with a small copay (\$5) is required for all services. Supplemental insurance is also offered for residents, which offers better options for off-island care. There are private clinics available, but most of the population uses the public system. Generally, only foreigners living

in RMI have private insurance. The health care workforce is formally employed, but the system relies heavily on expatriate workers (particularly for doctors and nurses). This reliance on expatriate workers is because health care professionals emigrate, scholarship recipients are not required to fulfill their bonding agreements to serve in RMI, the local workforce is aging, continuing professional education opportunities to up-skill are limited, there is a lack of proper recruitment and retention plans, and the remuneration is inadequate system.

The MHHS has introduced the 3-Year Rolling Strategic Plan 2017–2019. The MHHS's theme is *Kumi Ejmour*, or “Health is a shared responsibility.” The health priorities of the strategic plan are to provide high-quality health care in the outer islands; achieve universal access to high-quality care for all people with communicable diseases; provide integrated NCD services along with the tools and support that people need to manage their health; increase national capacity to deliver high-quality maternal, infant, child, and adolescent health care and community-based interventions for family resource management; increase access to community-based care and supports for adults and children with mental illness or substance use disorders through a network of service providers that are committed to a person-centered and recovery-oriented system of care; increase immunization rates and reduce preventable communicable diseases; promote and educate the public on healthy lifestyle changes; and provide efficient, effective administrative and coordinated functions of preventive and public health care services.



METHODOLOGY

The assessment of the primary health care (PHC) system of RMI, presented in this report uses the Primary Health Care Performance Initiative's (PHCPI's) conceptual framework and methodologies. The PHCPI framework was developed to describe the critical components of a strong PHC system, it results in the Vital Signs Profile (VSP), which is a measurement tool that health system stakeholders can use to identify and track priority areas for improvement. The PHC assessment, using the VSP, answers some of the most critical questions about PHC systems across four core domains: financing, capacity, performance, and equity. The results include information based on a collection of quantitative and qualitative indicators for a comprehensive analysis (Figure 1). To facilitate understanding of the PHC assessment results, this report explains the assessment's methodology, describes the main findings, and proposes recommendations that can improve the PHC system in RMI.

A PHC assessment that results in a VSP is designed to collate data from several national surveys, global databases, and additional data collected in RMI, reviewing regulations, strategic plans, and key informant interviews. When available, globally comparable data sources were preferred to promote international comparability, but in some cases, such data do not exist. The PHCPI team worked with the MHHS and other partners to find alternative data sources that are consistent with the PHCPI framework and methodology. The VSP subdomains (coverage, access, quality, equity) are measured using quantitative data from available secondary sources, including surveys such as the Integrated Childhood and Nutrition Survey, and global data sources from the World Health Organization (WHO), United Nations Children's Fund, and World Bank, among others, in the last five years. The capacity domain of the VSP was assessed using the PHC Progression Model, a mixed-methods assessment tool developed to systematically assess governance capacities, availability and distribution of inputs, and PHC facility management and population outreach strategies. The progression model methodology brings together expert stakeholders with varying and complementary knowledge of PHC

from across the country to yield an objective-comparable assessment of PHC capacity.

A government official who reviewed policies, plans, strategies, reports, and surveys implemented the initial data compilation process.

A consultant conducted 18 interviews with government and multilateral agency representatives. The information collected was used to propose an initial score for the 33 Progression Model measures. These scores were validated in a national workshop in October 2023. Consolidation and validation were done in collaboration with the MHHS to address disagreements between the internal and external scores. The VSP findings have been outlined to answer the following questions:

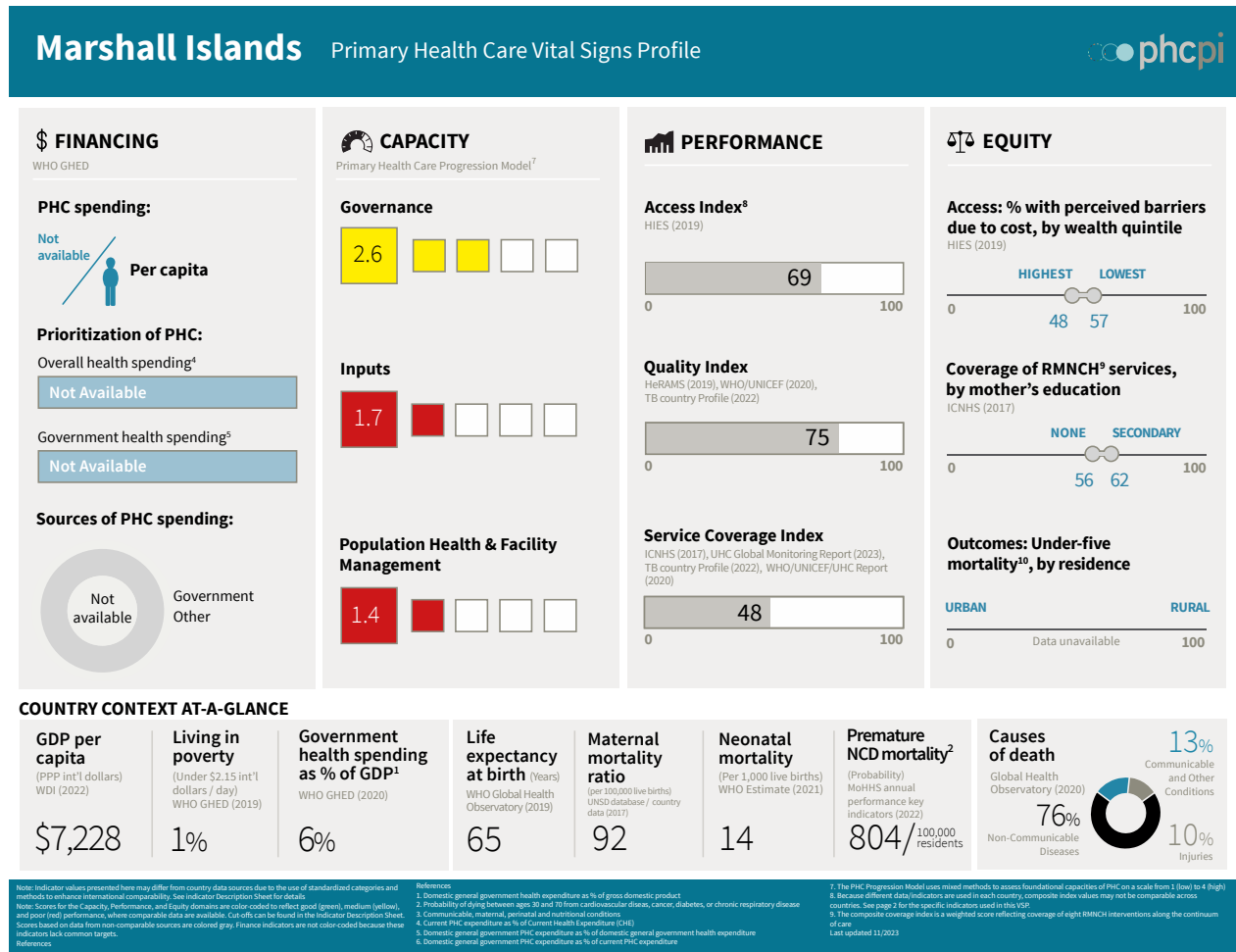
- Capacity: Have the necessary policies and governance structures, the necessary physical and human inputs, and a system for facility management and population outreach been implemented?
- Performance: Does the PHC system ensure access to high-quality services and effective coverage of the population's health care needs?
- Equity: Does the PHC system effectively serve the most marginalized and disadvantaged groups in society?

Additionally, and in support of goals to target NCDs and strengthen a gender-informed PHC approach, RMI supplemented the standard PHCPI VSP with targeted deep dives into NCD and gender across conceptual domains. The gender deep dive was a detailed investigation into the capacity and performance of the PHC system to incorporate considerations around gender into planning and to deliver gender-sensitive services, including assessing how national-level policies address the specific needs of the different genders of the population and the accessibility of high-quality, gender-sensitive services at PHC facilities. The NCD deep dive assessed the capacity of the PHC system to detect, diagnose, treat, and manage NCDs. The assessment was designed to explore the policy and planning capacities required for effective NCD management.

Questions for the gender- and NCD-targeted deep dives were answered through a desk review and as part of key informant interviews. The gender deep dive included questions on whether national health policies and plans incorporate gender-responsive considerations of PHC; who is accountable for managing gender issues; how extensively disaggregated or gender-responsive data are used in decision making; whether quality assurance mechanisms promote gender sensitivity in service delivery; how vulnerable populations, especially women and girls, provide feedback to PHC facilities; and how PHC facilities ensure a nondiscriminatory environment (Box 2, 4, and 6). The NCD deep dive included questions on whether the national strategic health plan includes components on and risk factors for NCD; whether there are clear roles and responsibilities within PHC related to NCDs; data and evidence are used to develop best practices for management of key risk factors; policies include specific funding mechanisms for NCDs in PHC; and policies and strategies include a monitoring and evaluation (M&E) framework for NCDs (Box 1, 3, and 5).

KEY FINDINGS FROM THE VSP

Figure 1. Marshall Islands Draft Primary Health Care Vital Signs Profile





RESULTS

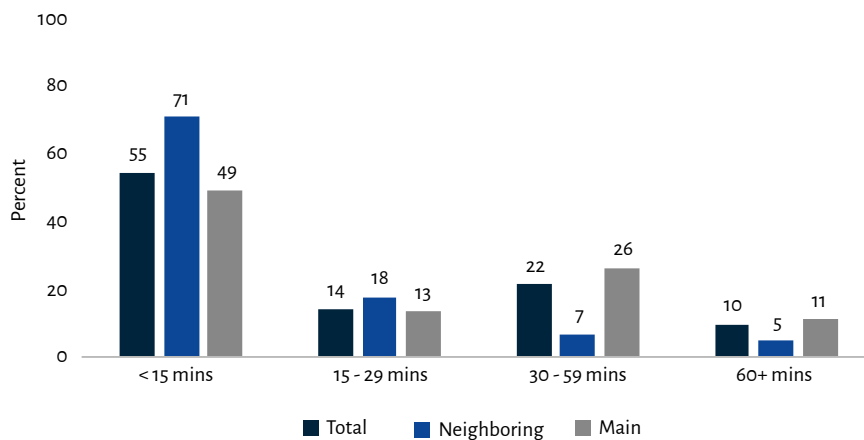
PERFORMANCE

ACCESS

The access domain measures whether services are accessible when needed and without undue barriers. Access to care is an important dimension of PHC performance, because it reveals how well health care systems address the systemic barriers that patients face when accessing high-quality PHC. RMI's VSP results on access include measurements of geographic barriers to care (reported travel time to the nearest health facility) using data from the Household Income and Expenditure Survey of 2019.

In RMI, only half of households seek care when needed, and nearly one third travel more than 30 minutes to reach the nearest health care facility. Data from the Household Income and Expenditure Survey 2019 reveal that only 51 percent of households were able to seek care when needed and that 32 percent travel longer than 30 minutes to reach the nearest health facility (Figure 2). People living on Ebeye were more likely to report longer travel times (37 percent) than those on neighboring islands (12 percent).

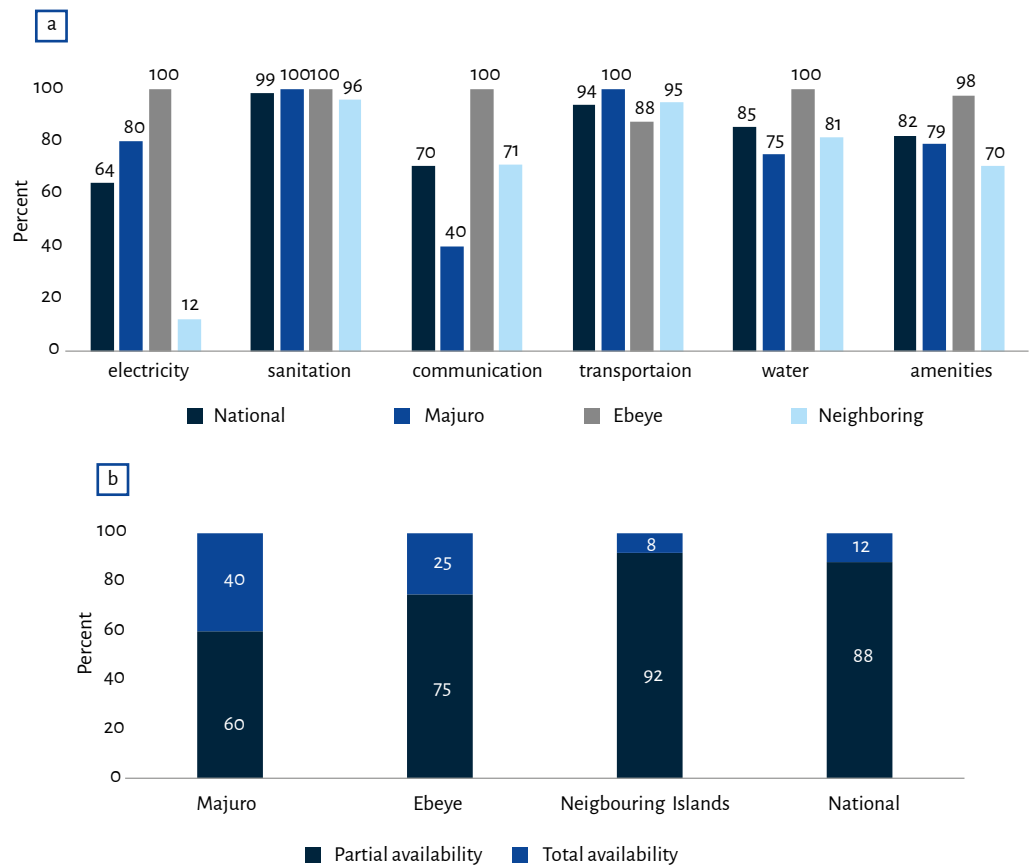
Figure 2. Travel Time to Nearest Health Care Facility on Ebeye and Neighboring Islands, 2019



Source: HIES 2019.

Access to facilities does not guarantee that services will be received; not all facilities have the operational readiness and capacity to provide services, especially those located on neighboring islands. A facility assessment through the Health Resources and Services Availability Monitoring System survey in 2019 showed that, on average, only 64 percent of health care facilities had a reliable electricity source (Figure 3a) and that only 12 percent had all the necessary essential medicines (Figure 3b). These limitations in capacity were more pronounced on neighboring islands than on Ebeye. For example, only 12 percent of health facilities on other islands had a reliable electricity source, whereas all the health care facilities on Ebeye did, and only 8 percent of health care facilities on other islands had all the necessary essential medicine, versus 25 percent on Ebeye.

Figure 3. Availability of (a) Basic Amenities and (b) Essential Medicines According to Region, 2019



Source: HeRAMS 2019.

COVERAGE

The coverage domain measures the effectiveness of service delivery for RMNCH, NCDs, and communicable diseases. VSP coverage indicators were selected through extensive literature reviews and consultations with international experts intended to measure countries' coverage of PHC services. Table 1 summarizes coverage of services for RMNCH, communicable diseases, and NCDs using data from the most recent household surveys (ICNHS 2017) and monitoring reports (UHC 2023) in RMI.

Table 1. Coverage of Services for Reproductive, Maternal, Newborn, and Child Health (RMNCH), Communicable Diseases, and Noncommunicable Diseases (NCDs) Using Data from the Most Recent Household Surveys and Monitoring Reports

Indicator	Latest coverage estimate (%)	Source
RMNCH		
Care-seeking for suspected child pneumonia	66	UHC 2023
Coverage of diphtheria-pertussis-tetanus vaccination	82	WHO/UNICEF 2021
Demand for family planning met using modern methods	72	MICS 2019-2021
Prenatal care coverage (4+ visits)	68	MICS 2019-2021
Noncommunicable diseases		
Hypertension treatment	30	UHC 2023
Communicable diseases		
Tuberculosis cases detected and treated with success	50-->51	WHO Tuberculosis Profile 2021
People living with HIV receiving antiretroviral treatment*	55	UHC 2023
Children under five with diarrhea receiving oral rehydration salts	24	ICNHS 2017

* The Western Pacific integrated HIV/TB program 2022 report suggests a coverage estimate of 100% (7 out of 7 patients with HIV in RMI received treatment)

RMI continues to face challenges, especially in coverage of preventive and curative child health care services. Coverage of child health care services is assessed using two standard universal health care (UHC) indicators: diphtheria-pertussis-tetanus (DPT) immunization coverage and

care seeking for pneumonia. In RMI, the percentage of children receiving three doses of DPT by the age of one dropped from 85 percent in 2015 to 82 percent in 2021, and data from the UHC 2023 report indicate that 34 percent of children with pneumonia did not seek care.

The latest coverage estimates for RMI's maternal health services demonstrate substantial bottlenecks that warrant further investigation.

Family planning coverage with modern methods dropped from 80 percent in 2007 (WHO data) to 72 percent in 2021 (UHC 2023), and no improvements were observed in the coverage of prenatal care, which stayed at 68 percent from 2015 (WHO data) to 2021 (UHC 2023).

The prevalence of hypertension has remained relatively stable over the past five years, although challenges persist in hypertension treatment coverage.

According to WHO Global Health Observatory data, the prevalence of high blood pressure among people aged 30 to 70 increased slightly in RMI from 31 percent in 2015 to 32 percent in 2019, although the latest UHC modeling estimates indicate that only 30 percent receive treatment, which warrants better and greater service provision to people with cardiovascular illnesses in PHC.

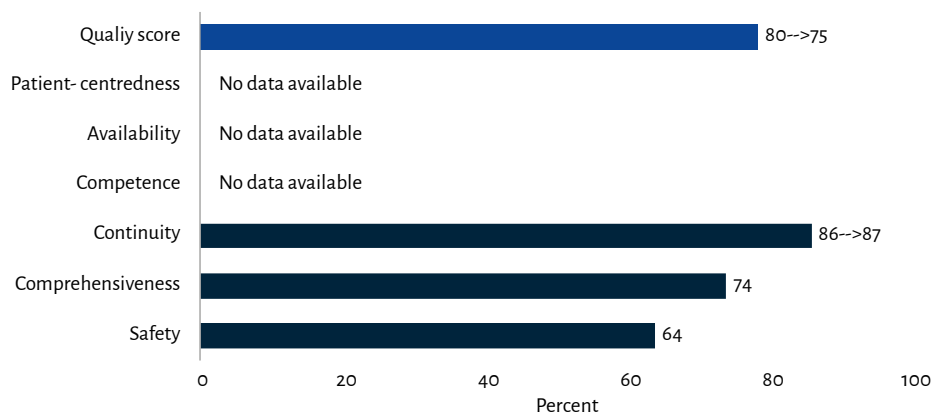
Coupled with a growing burden of NCDs, coverage of communicable diseases is significantly lagging.

Coverage of communicable diseases poses major challenges for RMI's PHC. Based on the 2023 UHC report, only 55 percent of persons with HIV received anti-retroviral treatment, and (50-->51 percent of people with tuberculosis were not successfully treated (WHO tuberculosis country profiles 2021--> 2022). Given the relatively low number of persons diagnosed with HIV in RMI, coverage estimates need to be interpreted with caution. Specifically, alternative data sources (Western Pacific integrated HIV/TB program) suggest a coverage estimate of 100% (7 out of 7 patients with HIV received treatment) in the country. Moreover, 24 percent of children with diarrhea received oral rehydration salts, according to the Integrated Childhood and Nutrition Survey 2017.

QUALITY

Analysis of the quality of PHC indicates room for improvement across all three quality subdomains for which data are available. Using PHCPI's methodology, PHC quality is measured across components of clinical quality and core principles of service provision such as comprehensiveness, continuity of communicable disease services, provider competence, person centeredness, availability, and safety. Figure 4 summarizes results on quality of PHC and indicates that there are substantial gaps in the comprehensiveness of services offered at PHC facilities, continuity of tuberculosis treatment, and patient safety at PHC facilities, presenting additional challenges to improving the quality of care. No data were found in RMI to measure person centeredness, competence, or availability of PHC providers.

Figure 4. Summary Scores for Quality Domain and Subdomains

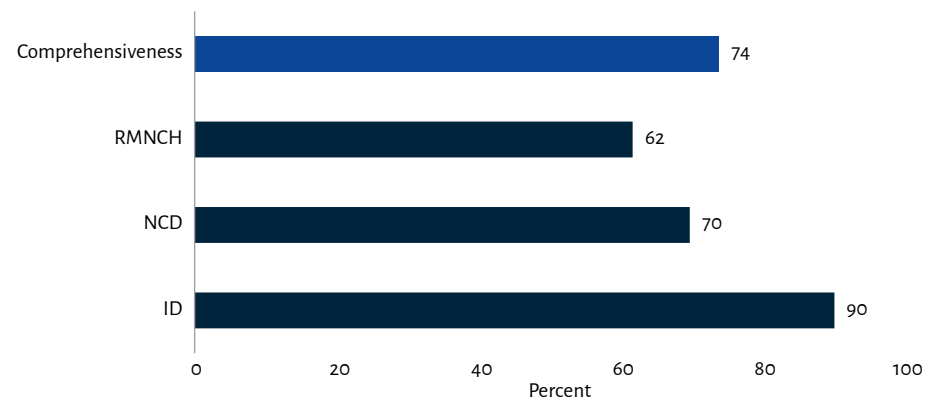


Source: [HeRAMS 2019, tuberculosis country profile 2021, UNICEF 2021]

There are substantial gaps in the comprehensiveness of RMNCH and NCD services, with an opportunity for improvement in capacity to deliver communicable disease services. A comprehensive PHC system provides integrated basic and appropriate care services between and within facilities to address a spectrum of health problems and treatment modalities for various population groups. In RMI, 70 percent of facilities offer diagnosis and management of NCD services, and 90 percent offer communicable

disease services (Figure 5), but as indicated earlier, several facilities do not have the operational capacity to provide these services at a sufficiently high level of quality because of the limited availability of medicines, diagnostic supplies, and electricity, especially outside Ebeye. There is also a substantial gap in provision of routine maternal and child health services, with only 62 percent of health facilities offering RMNCH services and 49 percent offering child health services.

Figure 5. Percent of Facilities Offering Services According to Disease Group



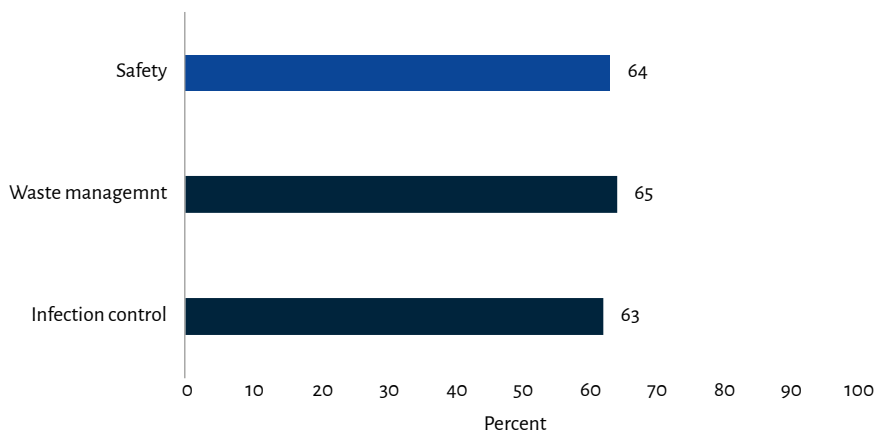
Source: HeRAMS, 2019

There are persisting challenges to ensuring continuity of care for communicable disease services. Between 2015 and 2021, slight improvements were made in DPT coverage, as demonstrated through the increase in the percentage of children who received the at least one dose of DPT vaccine from 92 percent to 95 percent, but 15 percent of children who received their first DPT vaccination did not receive a third dose. In addition, 14-->10 percent of people with tuberculosis did not complete their treatment. Incomplete vaccination or lack of treatment adherence reduces the effectiveness of prevention and complicates the course of diseases such as tuberculosis.

The most recent facility assessment (HeRAMS 2019) indicates room for improvement in patient safety practices. In this assessment, infection prevention and control and waste disposal measures are used to determine

patient safety at health care facilities. Both measures refer to availability of infection control tracer items (e.g., soap and running water, storage for sharps waste), adherence to standards for disposing of medical and hazardous waste and sharps, and availability of guidelines for waste disposal at the facility; 37 percent of facilities do not have adequate infection control measure. Similarly, adequate waste management remains a challenge in the country, with 35 percent of health care facilities not having adequate waste disposal practices in 2019 [HeRAMS data] (Figure 6).

Figure 6. Summary Scores for Safety Subdomain



Source: HeRAMS, 2019.

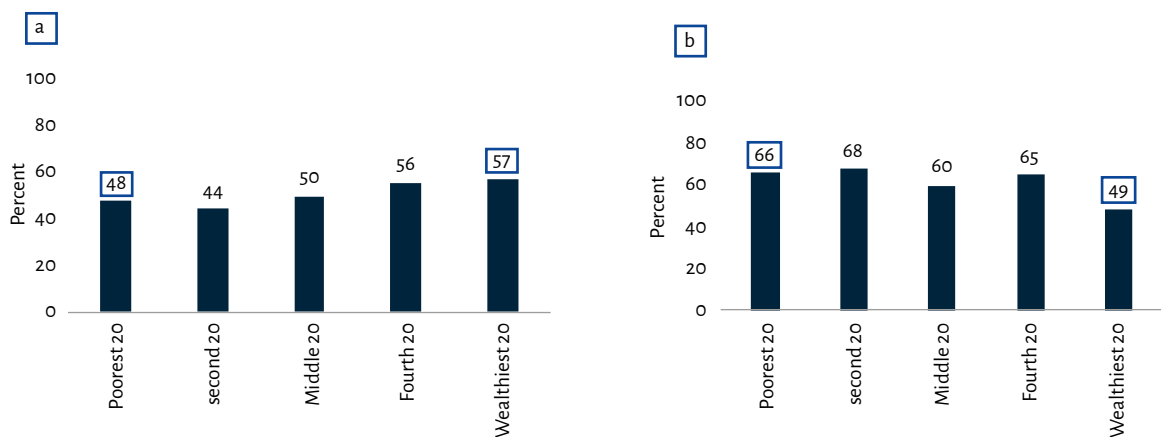
EQUITY

The equity domain in the PHCPI VSP measures access, coverage, and outcomes to determine whether the PHC system serves vulnerable and nonvulnerable populations equally. The PHCPI methodology uses indicators disaggregated according to socioeconomic status, including wealth, mother's education, and place of residence. It looks at the difference in perceived financial barriers to care, effective coverage of maternal and child health care services based on a mother's level of education, and mortality of children residing in urban and rural areas. In this assessment, no information was available to assess disparities in under-five mortality

according to residence, so disparities in coverage of key maternal health services were explored according to residence.

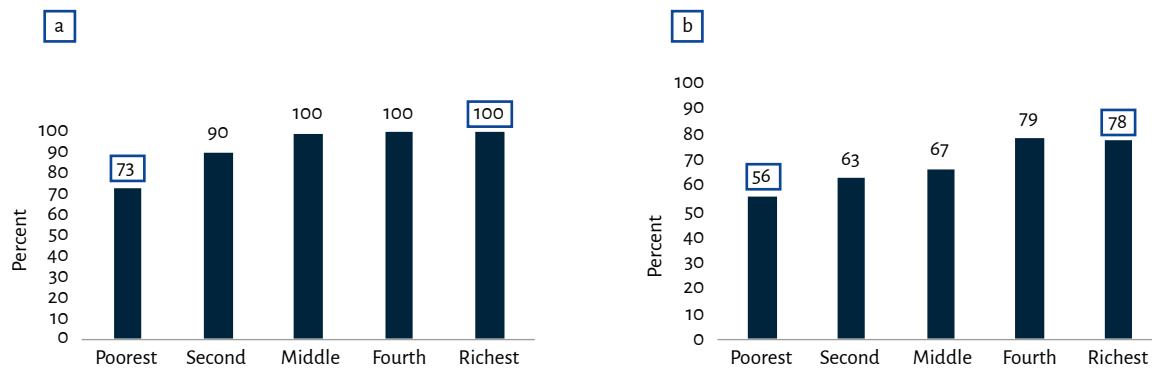
Disparity in access to and coverage of PHC services between the upper and lower wealth quintiles is notable in RMI. The latest available data (HIES 2019) show that 48 percent of households in the poorest wealth quintile seek care when needed, compared with 57 percent of households in the wealthiest economic quintile, and 6 percent of households in the poorest wealth quintile reported health care spending, compared with 49 percent in the wealthiest quintile (Figure 7). These disparities in access were reflected in coverage of some essential RMNCH services according to wealth quantile. For example, 56 percent of women in the poorest quintile had four or more prenatal visits, compared with 78 percent in the wealthiest quintile, and 73 percent of women in the poorest quintile had their babies delivered by a skilled birth attendant, versus 100 percent in the wealthiest quintile (Figure 8)

Figure 7. (a) Likelihood of Seeking Care and (b) Health Care Spending According to Wealth Quintile, 2019



Source: HIES 2019.

Figure 8. Coverage of Reproductive, Maternal, Newborn, and Child Health Services According to Wealth Quintile: (a) Deliveries by a Skilled Attendant and (b) Prenatal Care Coverage, 2019

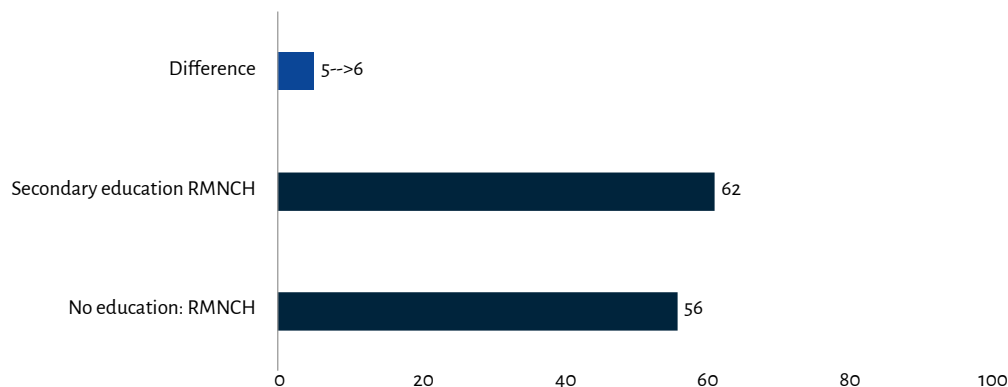


Source: ICNHS 2017.

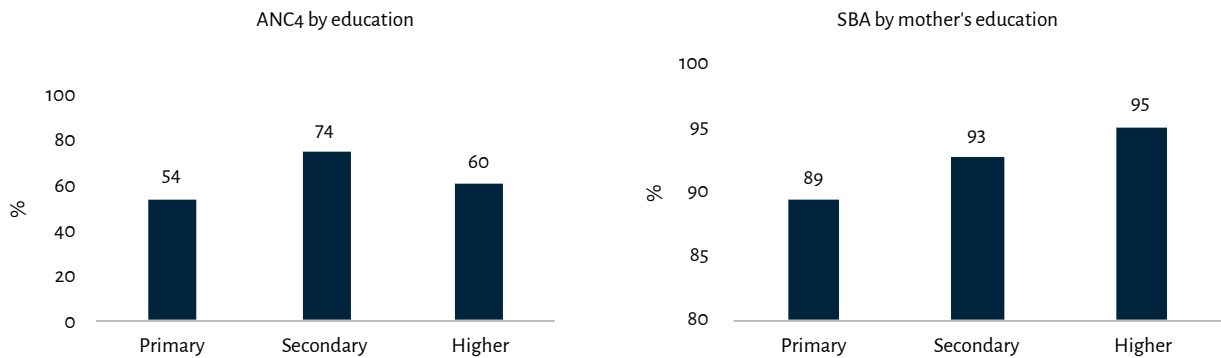
Modest disparities were also found in coverage of RMNCH services according to education, in line with disparities according to wealth.

In households in which the mother had completed secondary school or more, about 62 percent of mothers and children received key RMNCH services, compared with 56 percent in families in which the mother has not completed primary education (Figure 9)

Figure 9. Coverage of Reproductive, Maternal, Newborn, and Child Health Services According to Mother’s Educational Status



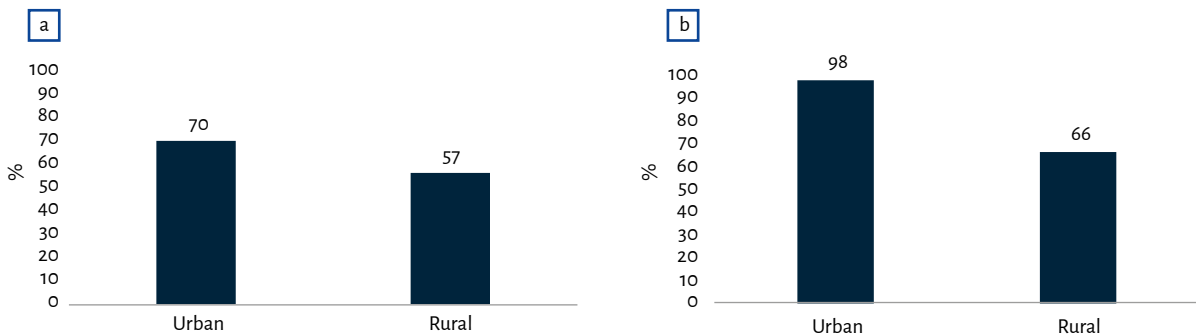
Note: This index was constructed using three indicators: attending four or more prenatal care visits, deliveries by a skilled birth attendant, and receipt of oral rehydration therapy



Source: ICNHS 2017

Notable disparities in coverage of maternal health services were reported according to residence. There is a 13–percentage point difference in coverage of prenatal care between women living in urban and rural areas (ICNHS 2017) (Figure 10) and 32–percentage point difference in frequency of deliveries by a skilled birth attendant—an indication of the challenges that the PHC system faces in rural areas.

Figure 10. Coverage of Maternal Services According to Residence: (a) Four or More Prenatal Visits and (b) Deliveries by a Skilled Birth Attendant



Source: ICNHS 2017.

CAPACITY

GOVERNANCE

RMI has important PHC policies upon which the health system is built.

There is a national strategic plan, a ministry strategic plan, and several programmatic plans for each PHC program, such as for NCDs, cancer, and immunizations. The strategic plan has seven policy objectives rooted in PHC (e.g., strengthening responses to NCDs, improving RMNCH care), emphasizing its importance and addressing disparities in primary care on the neighboring islands, but it is built from collating existing programmatic plans, rather than the other way around. Key performance indicators are included. Up until the assessment phase of this project, these were being revised as they had been last set up in 2017, but to the date of publication, these have already been reviewed and endorsed. These key performance indicators, which include indicators of the country's demographic characteristics, NCDs, RMNCH, communicable diseases, inventory, staff attendance, and availability of human and financial resources, drive budget planning and strategic reform and have been built on agreements with local and global communities. Needs assessments may inform strategic plans from some programs, such as the RMNCH one, but it is unclear whether all programs run these assessments in advance of their own planning. In the validation workshop, the importance of information from strategic plans being provided to all staff, particularly to emphasize the importance of a PHC focus, was raised. Also, the legal framework on PHC is fragmented, which makes it difficult to implement a comprehensive approach to it; national participants mentioned the possibility of creating a joint policy on PHC to improve implementation. Regarding the PHC fundamentals (having an essential package of services, a financing mechanism, and a monitoring and evaluation framework), the neighboring islands offer a limited essential package of services in their health care centers, whereas Majuro and Ebeye do not have one because of the fragmentation of services

that the various public health programs deliver. Funds are not usually earmarked for PHC, so securing funding for PHC services is challenging. The ministry strategic plan does not include the full costing required to fund all PHC services either. Monitoring and evaluation capacity is still lacking, as the system and capacity to measure PHC outcomes correctly is found to need improvement. However, important efforts in this regard are being made, as having a monitoring and evaluation framework for tracking the current strategic plan, as well as now having a designated unit to lead on it.

The deputy secretary oversees PHC but is in charge of supervising all public health programs, rather than comprising it all with a PHC focus.

Coordination and integration must be improved, as is currently being done in silos according to division and program. There is a lack of contact between coordinating authorities and clinical staff, resulting in an activity-focused system rather than a results-focused one, which incurs high expenses but is less effective.

Box 1. Overview of Key Noncommunicable Disease (NCD) policies and strategies

NCDs are a key priority for improving the health of the population, and an NCD-specific strategy is being drafted. RMI's Country Cooperation Strategy (2018-22), is a strategic framework that the World Health Organization has developed to guide its work in the country. The strategy is designed to respond to the country's health and development challenges and emphasizes NCDs, including expanding the World Health Organization package of essential NCD interventions in primary health care (PHC) settings and community health care centers, drafting legislation and developing a traffic light system for high-sodium foods, and implementing the World Health Organization framework on tobacco control. The RMI National Strategic Plan (2020-30) recognizes the strategic area of health and under policy objective 1 aims to strengthen the response to NCDs. The plan emphasizes the Healthy Island approach, which focuses on inter- and multisectoral engagement to address NCDs, although it does not include a basic monitoring framework for NCDs or specify indicators, targets, or baseline data. In addition to these key strategic documents, key

informants noted that drafting the national plan for NCDs, which focuses on national and government responses to addressing NCDs. The plan emphasizes the connection between agriculture, education, and health, although it focuses on policy and not on the role of PHC in addressing NCDs.

Ebeye is leading the way on improving the quality infrastructure, implementing satisfaction surveys, piloting projects, providing incentives for good performance, and enhancing training. Their main challenge is lack of a person whose main responsibility is monitoring quality improvement activities and of staff to provide clinical services. The ministry strategic plan commits to institutionalizing quality of care. In the neighboring islands, there are surveys and reports focused on assessing and improving quality, as well as a quality survey designed to be used on the neighboring islands but that could be adapted to be used on Majuro and Ebeye. Steps have been taken on infection prevention and control in clinical settings across the country, and checklists have been developed for safety protocols and monitoring and reporting of adverse events. Programs, divisions, and multilateral organizations assess quality and engage patients, families, and communities through various strategies, lacking consolidation and coherence between all. Moreover, results on quality are shared within the board, but there are no systems in place to share them with the community. The various public health programs and the divisions engage with the community and other stakeholders in different ways to disseminate reports, kick-off projects, and the like, but meetings with local leaders to present results are generally not systematic across programs and divisions.

There is cross-government engagement to implement actions, but roles are decided upon based on individuals, rather than organizations. Thus, roles are defined, but accountability and transparency are lacking. Moreover, policies from different ministries must be aligned.

Surveillance systems, stakeholder engagement for priority settings, and defining a specific system to expand successful innovations have

room for improvement. Although there are surveillance systems, timeliness must be improved for these systems to be efficient, particularly on the neighboring islands, where connectivity is a challenge. On a programmatic level, there is full engagement of various stakeholders to set priorities in programmatic plans, which are then taken to the ministerial level for the national plans, but at the ministerial level, only government actors engage in designing national plans, and MMHS is also moving from setting priorities based on external donors' grant requirements to setting its own national priorities, as reflected in the key performance indicators. Innovations in PHC have been implemented and expanded based on conditions from external donors' grants, which have helped set up the innovation platform. There are meetings at MMHS during which PHC innovations are discussed.

Box 2: Deep Dive into Governance and Gender

Gender-informed primary health care (PHC) governance ensures that the PHC system is responsive to the needs of all individuals, regardless of gender. It recognizes that gender influences health outcomes and that health systems must be designed to address the different needs of individuals. Gender-informed governance can help ensure that PHC services are accessible, affordable, and of high quality for all individuals through policy formulation and effective implementation strategies of specific, targeted health interventions.

The Republic of the Marshall Islands (RMI) has incorporated gender-responsive considerations into its health plan and strategic plan, primarily outlined in national policies such as the National Gender Mainstreaming Policy and the National Reproductive Health Policy and Strategy 2016-2018, which emphasize equitable access to resources and services for all genders (Anon 2016; MoH 2016). Over the last five years, the country has primarily concentrated its efforts on enhancing access to healthcare and education for adolescents and youth, with limited attention given to broader gender-responsive initiatives (MOCI, 2019). Addressing gender-based violence services is a key aspect of incorporating gender considerations into primary

healthcare policies, given the National Gender Mainstreaming Policy's emphasis on eliminating gender-based violence and providing support to survivors. RMI has reviewed legislation to ensure compliance with human rights commitments, conducted awareness programs and media campaigns, and actively involved men in the fight against gender-based violence (Anon 2016). Although there are support services, such as an online platform for victims of gender-based and domestic violence, it is unclear how effective they have been. Projects like the Weto in Mour Project involve individuals who undertake the complex and challenging task of providing support services for women and girls experiencing domestic violence in Majuro and the outer islands. These initiatives offer counseling and assistance to survivors of violence against women and girls, contributing to the advancement of gender equality (MOCIA 2019).

The Gender and Development Office of the Community Development Division in the Ministry of Culture and Internal Affairs is the coordinating authority accountable for gender and women's rights issues. While its primary emphasis is on domestic violence, it doesn't incorporate other critical gender-responsive interventions, like improving tools and care packages for healthcare providers to address the health consequences of gender inequality. The allocation of resources for gender-related matters in the country is inadequate, and there is a lack of information regarding the percentage of the national budget dedicated to gender-responsive budgeting. In particular, although the Gender Mainstreaming Policy has an implementation plan, it has not been fully costed, even though resources to address gender inequality have been increased (Anon 2016; MOCIA 2019).

Gender issues are rarely discussed in high-level government discussions, and use of sex- and gender-disaggregated data and gender analysis in policy and program development is limited. There is a potential to optimize the utilization of gender data by leveraging surveys and data collection tools incorporating gender-responsive indicators. These tools, including the national population and housing census, are utilized as necessary, providing breakdowns by sex, gender, and other characteristics. Administrative data sources are also leveraged to generate statistics on gender (MOCIA, 2019).

INPUTS

There are frequent stock-outs of essential medicines, consumables, and rapid diagnostic tests, particularly in the neighboring islands, because of the logistical challenges of distributing supplies and the supply chain structure. All facilities except those on the neighboring islands have a full supply of basic equipment.

Access to health care facilities and coverage of amenities need to be increased, and communication between Majuro and the neighboring islands and safety precautions and equipment in facilities need to be improved. PHC density and distribution throughout the country have been assessed, and the health care workforce is well aware of the results, and there is a general understanding that more facilities and greater access to them are needed, but there are no specific targets. There are critical communication challenges in the neighboring islands and a lack of all other amenities, although is work being done on implementing solar power systems and increasing access to safe water. In the neighboring islands, availability of safety precautions and equipment is limited. Medical waste is burned or buried, there is no sterilization equipment, and health assistants must often buy safety consumables (e.g., soap, gloves) themselves.

There is a high rate of registration of births and deaths, although use of health management information systems depends on the Internet. Although there is a system ready to be connected between all facilities in the country, the facilities in the neighboring islands lack the necessary access to electricity and Internet connectivity to be able to use it. RMI would benefit from having a unified identification numbering system and format throughout the different systems (Majuro, Ebeye, neighboring islands).

RMI has many health care workers, but problems with remuneration, licensing enforcement, and formal certification must be addressed. There are not enough health care workers employed in the health care workforce to cover the population's health care needs, particularly in the neighboring

islands. Although there is a Licensing Board and licenses, health care workers have been able to practice without a license, because monitoring is lacking. All departments are working toward mandatory enforcement of licenses, particularly the Nursing Department, and toward a national guideline. Foreign practitioners must comply with licensing requirements to be able to practice in the country. There are lists of competencies for the various cadres of health workers, although health assistants still lack a formal certification, even though they receive training. Competencies must be reviewed with evidence to re-shape them based on the country's health care needs. Nonetheless, these are already contextualized to the type of setting the health care worker will be practicing in. Some key functions of PHC are included in the health assistants' training, but comprehensiveness, continuity, and coordination must be enforced. Community health outreach workers are based in Majuro and sometimes go to the neighboring islands through a specific program. Health assistants, nongovernmental organizations and faith-based organizations also perform outreach activities in the neighboring islands.

A main office budget is available to all facilities, but there is not an amount specified for each facility. Having no clear budget, flow of funds, or ability to access supplies in the neighboring islands, health facilities cannot use the funds. Stability and timeliness of health care staff remuneration depends on the type of contract workers are on.

Box 3. Challenges in Funding Delivery of Noncommunicable Disease (NCD) Services

Several challenges emerged regarding effective implementation, delivery, and monitoring of NCD services. The analysis revealed that funding for NCDs is a persistent challenge, with annual shortfalls in funding of approximately \$4 million to \$5 million per year for delivery of NCD services. Funding shortfalls were linked to inefficiencies stemming from fragmented sources of funding, which consist of grants, World Health Organization support, domestic

funding, and nongovernmental organizations. Grants, which account for a large proportion of overall NCD funding, do not consider the costs of staff time and treatment, which result in deficits.

Box 4: Deep Dive into Inputs and Gender

Gender-responsiveness of primary health care (PHC) service inputs covered in this section can help ensure that health care providers are trained to provide gender-sensitive care and that quality assurance mechanisms identify and address gender-based disparities in health care access and outcomes. Gender is an important consideration in inputs such as quality assurance mechanisms and data quality. As mentioned earlier, gender-disaggregated data, while available, are not effectively utilized in planning to address disparities, impacting the quality assurance efforts aimed at optimizing their usefulness for ensuring effective PHC services.

Mechanisms to ensure that quality assurance mechanisms are applied are limited, particularly regarding gender-responsive considerations within PHC. Assessments of health care center standards do not cover gender-related performance measurements. Key informants shared that, although efforts are being made to increase gender sensitivity in health care facilities, such as ensuring that at least one female health care worker is available for each atoll, the gender sensitivity of health care services is not evaluated. Although there is training for health care workers through partnerships between the Women's Association and the College of the Marshall Islands, it is unclear whether it equips health care workers with the necessary skills and guidelines to understand and address barriers to access to health care services and the effects of gender inequality on health (CDD, MOCIA, and EPPSO; 2018). Although actions have been taken over the past five years to improve health outcomes for women and girls, including expanding sexual and reproductive health services and conducting gender-specific health promotion campaigns, there are still substantial gaps in ensuring access to health care services and providing gender-responsiveness training for health care service providers (Anon 2016; MOCIA 2019).

POPULATION HEALTH MANAGEMENT

Community involvement in priority setting is limited, but there is potential for improvement, especially in Majuro and the neighboring islands. In Majuro, involvement of kijla-women in promoting healthy lifestyles is a notable example of community engagement. In the neighboring islands, mayors play a crucial role in defining health care outreach priorities. Although there is no formal empanelment system, there is ongoing community profiling, which includes maintaining lists of patients with specific diseases such as NCDs, HIV, tuberculosis, and cancer. This community profiling, primarily at a national and aggregate level in Majuro, presents a valuable opportunity to be used at the facility level. By leveraging individual household profiles, health care facilities can achieve better follow-up and targeted care for their patients, enhancing the effectiveness of health care delivery.

Teamwork between health care workers could be improved, particularly to increase coordination, improve patient care, and build capacity. Teamwork is not strong, with most health care workers practicing in isolation. Health assistants do not have the tools to monitor patients, so they must refer them. Local midwives work with health assistants, and in Ebeye, the diabetes team works well with health assistants, but teamwork must be enhanced across divisions and programs to coordinate it throughout the health care system. When teams from the mainland go to the neighboring islands, they provide refresher courses to health assistants, but working alone in the facilities makes it difficult for them to provide training in addition to conducting their clinical work. Moreover, feedback for Health Assistants is generally lacking.

Health care facilities send basic reports via radio to the central system, but communication challenges preclude them from assessing their performance routinely. Moreover, the coronavirus pandemic has reduced the timeliness of surveillance. Only 15 percent of health care facilities are

using established performance indicators for assessing performance on PHC. Outreach teams and staff in the neighboring islands are not informed on the key performance indicators, so they are not able to report on them. Visits are uncommon, but daily calls are made with nurse practitioners. Ebeye has routine communication with staff in the neighboring islands, but in Majuro, it depends on availability of communications.

Box 5. Overview of Noncommunicable Disease (NCD) Registries and Patient Records

Some primary health care (PHC) clinics have basic registries and use charting for diabetes, cardiovascular disease, and hypertension. Registries for people with NCDs are aggregated and sent to the central level to determine disease incidence and prevalence. At the facility level, charts are used to record basic patient information on screening, medication, diagnosis, and recent measurements, which helps PHC facilities keep track of patients and refer them to higher levels of care, especially because medicines and equipment are limited in the clinics. Diabetes measures are entered into spreadsheets to evaluate and analyze patients, but there is no system in place to track patient care longitudinally and capture the quality of NCD services.

Box 6: Deep Dive into Population Health and Facility Management and Gender

Gender responsiveness of PHC is an important consideration in population health and facility management, especially in community engagement and a team-based care approach. Gender-based differences in health care outcomes and access to health care services must be recognized and addressed to ensure equitable outcomes for all individuals especially women and girls. Women are often the primary caregivers in families and communities, and their participation in health care decision making is crucial. Engaging women in health care decision making can lead to better outcomes for women and their families. It is also important to ensure that health care providers are diverse, have inclusive teams, and are trained to provide patient-centered care

that is sensitive to the needs of all patients, regardless of gender. For example, men and women may feel more comfortable discussing certain topics with providers who have the same gender identity. Gender diversity can help teams be better equipped to create safe spaces for patients to access health information and services regardless of sex and gender.

Feedback mechanisms related to quality of services, service satisfaction, and patient-provider respect and trust are primarily channeled through the Women's Association, with other partners' support. Women and girls are increasingly aware of their rights and have opportunities to provide feedback. Experts interviewed indicated that the Women's Association collaborates with the Rural Health Network, a project involving the Community College of Marshall Islands and the Ministry of Health and Human Services (MHHS) to operate a steering committee comprising Women's Association members and representatives from MHHS and the college that meets quarterly, although it is unclear whether this mechanism effectively addresses community concerns regarding health care service delivery. There was also no evidence of the impact of the Rural Health Network related to the health and well-being of women and girls. To address this gap, coordination and social accountability can be expanded through a more inclusive partnership between the government, nongovernmental organizations, civil society, and grassroots organizations to address gender issues during community engagements, including establishment of mechanisms for addressing complaints related to gender discrimination and sexual harassment at the facility level (MoH 2016).

PHC facilities in the Marshall Islands face limitations in implementing team-based care and maintaining a non-discriminatory environment based on gender. While legal frameworks like the Employment Equal Opportunity Act of 2017 ensure equality in employment benefits and protect against gender-based discrimination in retirement, the concept of team-based care is constrained. The outer and neighboring islands workforce consists of 45 to 50 health assistants, predominantly males, engaged in scattered community health work and diagnosis according to key informants. Community Health Workers (CHWs), associated with NGOs or the Ministry of Health, lack specific ties to health facilities, and though integrated into reporting systems, details

about their care approach across teams are unavailable. This reveals a need for enhanced gender-sensitive team-based care strategies and clearer roles for women in healthcare teams, aligning with legal provisions promoting equality (UN Women 2022).

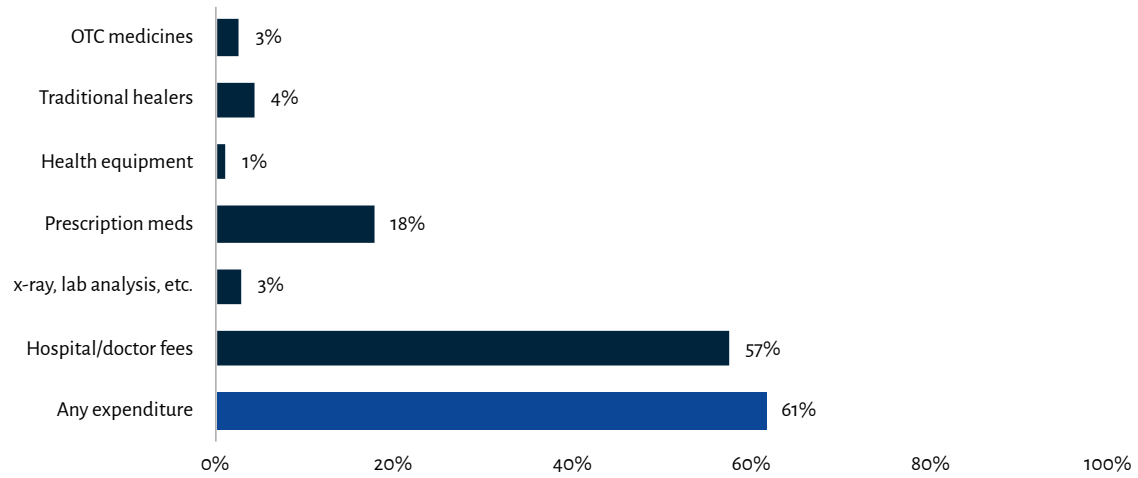
FINANCING

The financing domain assesses a country's commitment to PHC by evaluating allocation of funds to PHC and sources of expenditures.

The assessment uses five indicators to evaluate total spending on and prioritization of PHC. The first indicator, current PHC expenditure per capita, examines financial commitment to PHC by capturing the absolute amount of spending on PHC per person. The subsequent two indicators focus on prioritization of spending on PHC. The first is current PHC expenditures as a percentage of total health care expenditures. The second is domestic government expenditures on PHC as a percentage of total health care expenditures. The last set of PHC financing indicators examines sources of PHC spending, including government and other (domestic private and external) spending as a percentage of PHC expenditures. No information was available in the health care expenditure database to assess the financing of the PHC system. Therefore, only some indicators reported in the country's household and expenditure survey were available as a proxy for household health care expenditures.

Data from household and expenditure surveys reveal that the need to pay for health care makes people less likely to seek care. According to the Household Income and Expenditure Survey in 2019, only 51 percent of the population sought care when needed; 61 percent of households incur health care costs, with 57 percent reporting spending on hospital and doctor services and 18 percent on prescription medicine (Figure 11).

Figure 11. Percentage of Household Reporting Health Care Expenditures





RECOMMENDATIONS

This assessment of PHC in RMI has identified considerable strengths, along with several opportunities to strengthen the system further.

Supporting ongoing initiatives and strengthening specific areas of PHC has the potential to improve care integration, coverage, responsiveness, and ultimately the quality of PHC, reducing inequities and improving population health outcomes. This assessment recommends that RMI strengthen governance and leadership to increase care coordination and integration, strengthen quality management infrastructure to enhance accountability and effective coverage of services; increase the capacities of the health care workforce, and strengthen facility organization and management to improve operations and increase efficiency.

1. Integrate PHC into health care sector governance and leadership to increase care coordination.

Effective governance is critical for ensuring that PHC is responsive to the citizens and patients it serves. RMI has a strong policy foundation that can be built upon to increase PHC integration into the health care sector, but there are several challenges, specifically regarding lack of a single PHC policy and definition and high levels of fragmentation across PHC-adjacent programs. RMI would benefit from developing a consolidated PHC strategy that clearly outlines the definition, scope, and roles and responsibilities of stakeholders; developing an integrated package of essential services for PHC; establishing a dedicated focal point for PHC that supports the deputy secretary; and developing a multisectoral action plan to address the growing burden of NCDs.

1.1. Develop a consolidated national PHC policy and strategy that is integrated into the ministry strategic plan.

Development of a national PHC strategy, beginning with establishment of a common definition PHC, would help to establish PHC as the first point of contact in the health care system and

provide further clarity regarding the roles and responsibilities of providers and facilities in the care continuum. This process would involve bringing together stakeholders from the government, health care workers, and citizens. A common definition of PHC would guide policy objectives and actions, including integration of programmatic initiatives into PHC and the health care system. To maximize effectiveness, it is important to ensure that development of a PHC strategic plan is closely aligned with the forthcoming ministry strategic plan. For example, the PHC strategic plan can be aligned with the monitoring framework and objectives of the ministry strategic plan. Aligning objectives would identify and outline the specific responsibilities, roles, and actions of the PHC system in achieving RMI's objectives within the health care sector.

1.2. Develop an integrated package of essential services for PHC to ensure availability and equitable access.

Creation of a unified, integrated package of essential services to be delivered consistently across PHC will help ensure equitable access to PHC services. Development of an essential service package begins with gathering stakeholders, including government representatives, health care workers, and patients, to identify priorities, roles, and responsibilities. It is important that the package cover a comprehensive range of PHC services, including prevention, treatment, and management of RMNCH, communicable diseases, and NCDs, and can be adapted to various contexts across RMI. After identifying which services should be included in the package, it is necessary to prioritize them and focus on the greatest-need services and strategically plan to expand the package to include additional services. This process will identify required training for health care workers along with what supplies and medicines are available at various levels of care. Upon establishing and supporting implementation of a package of essential services for PHC, it is important that a regular schedule for

revisiting and revising priorities and adapting the essential package of health services is established. Garnering stakeholder input is important for refining the package, supporting health care workers to deliver the services, and identifying priority areas for expansion. Solomon Islands provides a compelling example of consolidated health services and programs using the role delineation policy, which defines the range of services (provided through the essential service package) to be delivered at various levels of care. This includes guidelines for staffing, infrastructure, essential registers, manuals, guidelines, and medicines. The role delineation policy and essential service package are embedded in the national health strategic plan to guide national, regional, and local resource allocation, helping to maintain integration and coordination among PHC providers and ensure consistency in delivery of health services (PHCPI n.d.a).

1.3. Establish a dedicated PHC focal point within the MHHS.

The deputy secretary of MMHS oversees all health care programs, including PHC, which provides a good opportunity to improve coordination and integration. RMI would benefit from a designated PHC focal point within the MHHS, whose role would be to deliver and coordinate the PHC agenda and program. The focal point would work closely with the deputy secretary to ensure that the roles and responsibilities of PHC are considered in health care planning and policy. One of the main roles of the focal point would be to consolidate and harmonize the various vertical programs that constitute PHC. This would involve developing a comprehensive results framework that consolidates the objectives and funding of vertical programs, which would streamline services, reducing fragmentation and promoting integrated care. In addition to consolidating vertical programs, the focal point would advise the deputy minister in strategic planning for PHC and advocate for and promote PHC within the MHHS.

1.4. Develop a multisectoral action plan to address the ongoing NCD epidemic.

RMI would benefit from establishing well-defined roles and responsibilities across various government sectors to ensure effective execution, monitoring, and assessment of multisectoral policies. Multisectoral action plans address NCDs and their risk factors, including tobacco, alcohol, diet, and physical inactivity, through a comprehensive public health approach. Developing a multisectoral action plan includes conducting a comprehensive assessments of NCDs, their determinants, and existing national responses; engaging stakeholders from a variety of sectors, including government agencies, the private sector, nongovernmental organizations, civil society organizations, and patients, to develop and establish coordination mechanisms; establishing a framework for action that includes NCD targets and priority actions; developing an implementation plan consisting of concrete actions and activities; and evaluating implementation of the plan. Developing and implementing a comprehensive multisectoral action plan would foster shared responsibility among various sectors, enhancing accountability. Implementing a results framework that clearly delineates roles, responsibilities, and funding sources and connects actions to specific targets and indicators is essential, especially in addressing the multifaceted challenges that NCDs present. Another potential avenue for developing a multisectoral action plan is to integrate the actions within the development of the role delineation policy. Connecting the multisectoral action plan to the role delineation policy would establish clear roles and responsibilities for all actors, including health care workers to external organizations, and link their roles and responsibilities to key targets and objectives. The WHO, which has launched an initiative to develop multisectoral action plans globally, with several countries demonstrating good progress, recently released a toolkit for developing these plans that can be

used to guide this process (WHO 2022). Evidence from evaluation of multisectoral action plans in four countries (Lebanon, Morocco, Sudan, Yemen) indicates that the process fosters collaboration between sectors and helps establish a common perception of health care challenges, competing priorities, responsibilities, and the meaning of success (Wickramasinghe et al. 2018).

2. Strengthen quality management infrastructure to enhance accountability and effective service delivery.

Effective quality management infrastructure is critical for planning, controlling, and improving delivery of services to ensure that populations receive high-quality care. RMI has several ongoing initiatives related to quality, including a patient satisfaction survey and incentives for provider performance, there are ongoing challenges limiting their impact. This includes challenges in facility infrastructure and amenities and continuous service monitoring and evaluation. RMI would benefit from investing in facility infrastructure to ensure safe service delivery and better monitoring of services.

2.1. Enhance the infrastructure of PHC facilities to ensure safe service delivery and routine service monitoring.

Addressing the significant challenges related to infrastructure in PHC facilities is critical for ensuring safe, continuous, comprehensive, accessible service delivery. Ensuring that facilities are properly equipped requires that they be comprehensively assessed. Understanding the status of all PHC facilities would enable the MMHS to target repairs and renovation efforts to ensure that all facilities have essential amenities, including reliable power supply; water, sanitation, and hygiene facilities; and waste disposal systems. Establishment of national standard for infection prevention and control and creation of maintenance lists for facilities must complement essential inputs. PHC facilities must have access to the Internet and

communication devices, which requires creating communication strategies for facilities to communicate maintenance challenges to higher authorities. Moreover, ensuring that facilities have access to essential amenities is essential not only for emergency situations, but also for maintaining regular communication and monitoring of patients and services. Establishing reliable mechanisms for routine data collection, even in areas with limited Internet connectivity, is vital for ongoing monitoring and evaluation of health care services. For example, Senegal has made significant efforts to monitor health care facilities using surveys, which has translated into direct action to increase availability of key inputs, amenities, and safe services. The continuous nature of the data collection allows policy and decision makers to track progress and identify gaps, enabling more effective resource allocation (PHCPI n.d.b).

2.2. Build on quality management infrastructure initiatives by establishing a routine monitoring framework and feedback system.

Ebeye has established several quality improvement initiatives, including a patient satisfaction survey, pilot projects, incentives for good performance, and training, but effective implementation of these initiatives is limited in insufficient oversight and accountability. Potential solutions to the challenges of oversight and accountability include development of a comprehensive monitoring framework for PHC that would establish clear targets related to implementation of and adherence to these initiatives, outline the responsibilities of stakeholders during implementation and establishment of budgeting needs, and identify implementation and outcome indicators related to the initiatives, effectively monitoring the implementation and impact of the programs. To collect this information, a routine auditing system can be established, which would involve routine assessment of key indicators specified in the framework. Assessment results would

be tracked over time and aggregated at the national level so that targeted support could be provided to poorer-performing facilities. Afghanistan provides an example of establishing an assessment framework to track performance and promote accountability. Upon establishing an essential package of health care services, Afghanistan developed a balanced scorecard that included a comprehensive list of indicators measuring processes and outcome indicators. The indicators were collected from facilities over a five-year period, and the tool demonstrated consistent improvement in patient and provider satisfaction, service provision, quality of services, equity, and financial management; enabled facilities to identify urgent needs for allocation of resources and innovations; and helped facilities adapt based on the findings (PHCPI n.d.c).

2.3. Formally establish a platform for discussing, monitoring, and expanding innovations in PHC.

RMI would benefit from developing a structured platform devoted to discussion, monitoring, and expansion of innovations in PHC.

The MMHS engages in discussions about primary care innovations, but this process is not systematic and is considered to be informal. This process would involve establishing a mechanism that brings together stakeholders in PHC to identify and discuss innovations at regular intervals, which would enable PHC facilities and districts to showcase, assess, and expand innovative service delivery practices. This mechanism would identify and promote novel activities within PHC facilities, facilitating their evaluation and subsequent adoption by other PHC clinics throughout RMI. These mechanisms could also bring together the latest research from academic and other research institutions to discuss how to adapt new ideas, concepts, or innovations to the RMI context. A potential starting point for facilitating research and innovation in RMI is adoption of the Institute for Healthcare Improvements Model for Improvement tool, which provides

stakeholders and teams with a methodology for understanding the essential elements of system improvement, including the cycle of innovation and ways to develop, test, and implement changes to drive improvement in a system (IHI n.d.). The tool could be adopted at the national and facility levels to identify, support, and expand innovation and learning in PHC across RMI.

3. Increase the health care workforce's capacity to deliver equitable, high-quality services.

A competent, motivated, equitably distributed PHC workforce underpins a country's ability to deliver high-quality PHC service for all. RMI has the potential to build on a strong health care workforce and quality assurance system to improve the quality of PHC. Specifically, it would benefit from evaluating health care worker density and distribution, which would help optimize the current cadre of health care workers and ensure equitable access to care; ensure the quality of PHC by ensuring that the Licensing Board includes all PHC cadres and that it is regularly enforced; optimize the workforce by promoting multidisciplinary, team-based care; and implement supportive supervision to enhance service delivery.

3.1. Evaluate health care worker density and distribution to ensure equitable access to care.

Although RMI has enough health care workers, there are substantial disparities in health care access, particularly in the neighboring Islands. RMI can begin to address the current challenges in human resources for health by conducting a systematic evaluation of health care worker density and distribution. This process would bring together stakeholders to define and evaluate the core competencies of PHC providers, after which a comprehensive evaluation would be conducted to take stock of the availability of PHC health care workers across cadres and consider their skills and competencies.

It is important that the evaluation not only assess availability, but also identify imbalances in the distribution of health care worker cadres throughout the country, allowing for optimized allocation of the existing PHC workforce. Such an assessment would also include a review of the skills and competencies of health care providers. Conducting a formal evaluation of the health care work force would help align and improve the upcoming role delineation policy and National Strategic Plan. Identifying the availability of health care workers across cadres would identify funding shortfalls necessary for the adequate remuneration of health care workers, serving as a valuable resource during budget negotiations with the Ministry of Finance. China and Ghana have used workforce assessments to identify gaps in health care worker density and distribution, which enabled researchers and policy makers to identify more nuanced inequities in the distribution of the health care workforce over time, contributing to targeted policies and actions (Appiah-Denkyira et al. 2013; Song et al 2018).

3.2. Ensure PHC quality by ensuring that the Licensing Board includes all PHC cadres and is regularly enforced.

The recent establishment of the Licensing Board provides a strong foundation for quality assurance. It is critical that the Licensing Board include all cadres of health care providers at the PHC level and that these requirements are linked to pre-service and in-service training programs. RMI can support this by working with training institutions to ensure that curriculums are aligned with Licensing Board requirements. To enable enforcement, it is critical that a register of all practicing health care providers be established and maintained at the facility and national levels. This register would include all health care workers at PHC facilities across RMI, along with those training. It is also important to consider licensing and accreditation processes for health care workers with foreign credentials. Malaysia provides

an example of how integrating and investing in quality management infrastructure can lead to improvements in PHC performance. In 1998, Malaysia institutionalized quality through regulatory and accreditation, establishing the Malaysian Society for Quality in Healthcare, which certifies providers and health care facilities. In addition, national indicators are used to compare performance of facilities. Continued commitment to quality through accreditation practices has helped establish and reinforce a culture of quality management and improvement (PHCPI n.d.d).

3.3. Optimize the health care workforce through by promoting a multidisciplinary team-based workforce.

To enhance the quality of PHC, RMI can consolidate and reorganize the health care workforce to optimize workers' skills and competencies. Establishing multidisciplinary teams comprising professionals with a diverse range of skills and expertise can streamline care delivery, foster a more holistic understanding of patients' health, and improve outcomes by leveraging the collective knowledge and skills of the team. Building on recommendation 3.1 the MHHS and PHC facilities can support strategic redistribution of work among health care workers. PHC teams can be designed to optimize skills and competencies of providers by helping PHC facilities establish defined roles and responsibilities on their teams, developing shared goals of providing good-quality patient care, establishing mutual accountability structures in which team members can hold one another accountable. It is also important to understand the size of the care team required to serve population health needs effectively, along with its composition based on the availability, skills, and expertise of different cadres of health care workers. For example, Costa Rica has established basic integrated health care teams that include a doctor, nurse, community health worker, vital registry clerk, and pharmacist. Each member has clear roles and responsibilities, enabling them to

provide comprehensive curative and preventative care, education, and surveillance activities. Teams are responsible for care coordination and referrals to higher levels of care. Data are collected from panels to ensure that the team is meeting the needs of the population it serves (PHCPI n.d.e).

3.4. Implement routine supportive supervision to improve service delivery.

RMI would benefit from establishing a structured supportive supervision system designed to increase the quality of service delivery. Supportive supervision involves providing informal training opportunities to health care workers through supervision by their peers, which increases the competency and confidence of the health care workforce while fostering a culture of shared accountability and collaboration. To implement such a program, RMI can start by identifying respected health care providers to become supervisors. Supervisors could be trained in coaching, mentoring, effective communication, and performance planning and then follow a predefined schedule for conducting supportive supervision, mentorship, and coaching. A supervision evaluation protocol and checklist would be important to support the program. This protocol would be used to assess those being supervised and the supervisor's performance against consistent, predefined criteria. It is also important that health care workers have the opportunity to provide feedback to supervisors. The supervision protocol would be most effective if aligned with the upcoming role delineation policy and co-developed with pre-service and in-service training curriculums. Developing supportive supervision criteria can be an opportunity to consolidate vertical programs by integrating their guidelines into a single protocol. The protocol must also be consistently evaluated and assessed to ensure that it contentions to reflect the most relevant clinical protocols and practices. A model to consider is the Mentorship

and Enhanced Supervision for Healthcare Quality Improvement (program, which encompasses various components including clinical mentorship, on-site education, quality improvement coaching, and data collection and has been successfully implemented in Rwanda, resulting in noticeable improvements in care delivery, operational procedures, and overall patient safety ((PHCPI n.d.f).

4. Enhance facility organization and management for more efficient and responsive PHC services

Population health and facility organization and management are critical components of effective, equitable service delivery. RMI has a strong foundation for population health management, including a basic empanelment system that can be further developed to ensure that PHC is the first point of contact in the health system. RMI's facility organization and management would benefit from further investment in the capabilities of facility managers and development of information systems for routine monitoring of targets and progress.

4.1. Implement a formal empanelment system to improve care coordination.

RMI can expand on existing community profiling efforts by establishing a structured empanelment system that identifies and supports patients throughout their care journey. Although basic empanelment through community profiling is in place to track patients with specific conditions, a more formalized approach is needed to connect patients with PHC facilities, improving care coordination and continuity. This entails assigning individuals and families to specific providers or facilities based on geography or insurance schemes and could include leveraging community health workers and conducting outreach activities through PHC facilities to identify and allocate populations to facilities, care teams, or providers responsible for proactively delivering coordinated PHC to their assigned population.

It is important to ensure that all facilities develop a patient registry that tracks patients' care records and stratifies patients based on risk. Developing an integrated registry that includes risk stratification will help facilities and providers develop targeted outreach and follow up protocols, ensuring care continuity. Turkey provides an example of establishing voluntary geographic empanelment to improve population health management. When undertaking health reforms designed to establish PHC as the focal point of care, Turkey assigned patients to health care facilities based on geography, increasing access and coverage (PHCPI n.d.g). The empanelment system also allows for provision of home care for targeted high-need patients who have trouble leaving their homes, assigning multidisciplinary teams to provide home care.

4.2. Invest in managers' skills to ensure that facilities are operated effectively.

RMI would benefit from conducting a formal evaluation of facility managers' skills, including their ability to operate the facility, deploy human resources in multidisciplinary teams, routinely collect and use information for decision making, and oversee initiatives. The first step would be to define the expected skills of PHC facility managers—as mentioned in Recommendations 1 and 3. These commonly include the ability to manage teams, set budgets, coordinate operations, set targets, and use information. A comprehensive assessment of the current skills of facilities managers could then be conducted to identify strengths and gaps in managers' abilities. This would be most efficient if conducted in alignment with a general health care workforce assessment (see Recommendation 3). Upon identifying strengths and gaps in providers' skills, the MHHS can develop or provide funding to managers to undertake in-service training programs to address their skill gaps. This can include developing training modules based on solutions to

international problems adapted to the RMI context or providing funding to providers to undertake training programs abroad. To help ensure that providers have the relevant skills and training, the MHHS could require that managers undertake a specified number of training courses annually to ensure that they continually build their competencies. It would also be beneficial to develop a management training module embedded in pre-service trainings. Ethiopia provides an example of implementing facility management reform. The government partnered with administrators from the United States to complete short courses on facility management within the Master of Public Health program. Participants who completed the course demonstrated improvement in key indicators within their facilities, increasing efficiency and effective service delivery (PHCPI n.d.h).

4.3. Implement routine performance measurement and management in PHC facilities.

RMI would benefit from instituting regular performance measurement and management in PHC facilities. This entails setting targets for service delivery and quality, monitoring performance against these targets, and implementing and adjusting improvement initiatives. It is crucial to develop standardized measures of PHC coverage and quality at the national level to facilitate comparisons between facilities. Developing a robust results framework aligned with the MHHS's objectives and goals serves a dual purpose: helping facilities identify strengths and areas for enhancement while enabling national policy makers to support underperforming facilities and learn from high-achieving facilities. RMI could strive to digitalize the monitoring system fully. As a starting point, it is important that a system of collection be established. A potential place to start would be to provide paper-based or a digital collection system (depending on the facility's capacity) and have an auditor routinely collect and aggregate information at facilities. Nepal developed the Nepal

Electronic Health Record, which combines three easy-to-use, low-cost information systems including Bahmni, an open-source facility-based information system and electronic health system; Commcare, a community-based data collection platform with offline functionality that integrates with facility records; and District Health Information Software 2, a web-based open-source management and information system with additional decision-making tools. The electronic health record system collects and aggregates patient and facility data at the community and facility level, and information is displayed on dashboards, which facilitates decision making.

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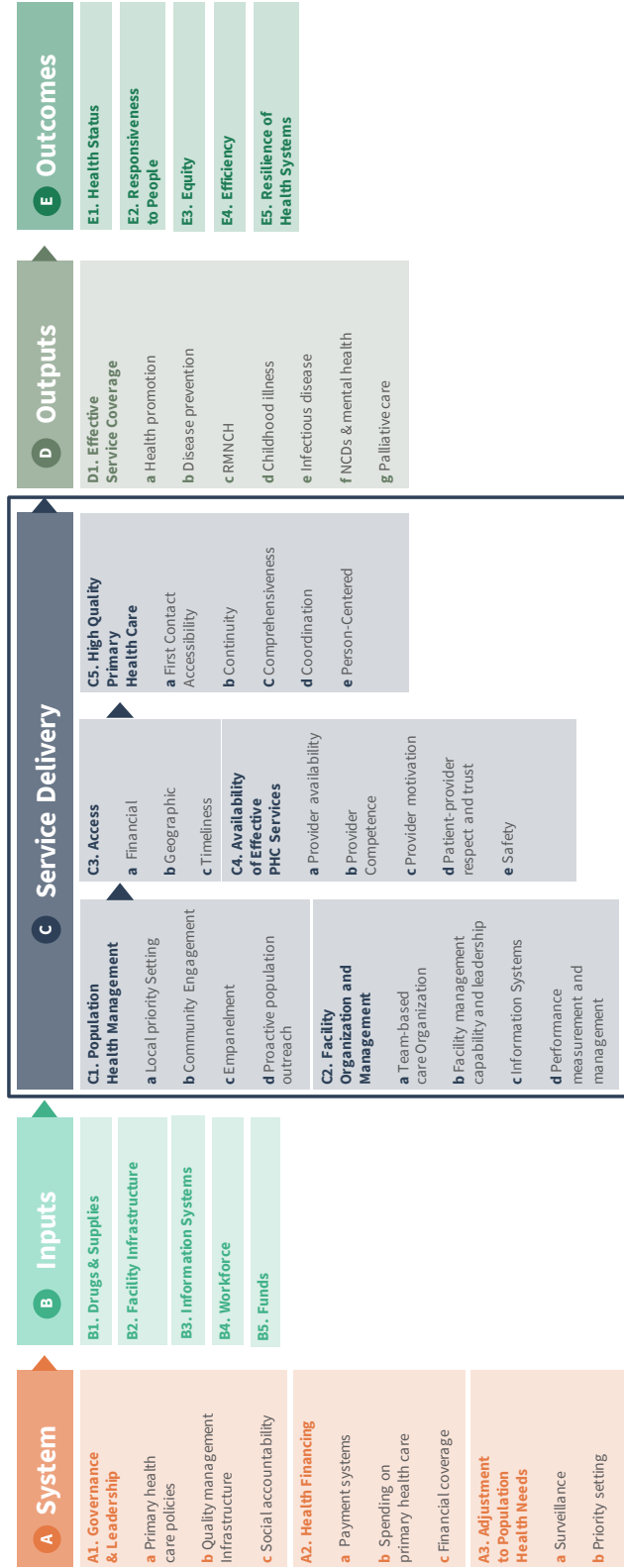
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APPENDICES

APPENDIX 1. PRIMARY HEALTH CARE PERFORMANCE INITIATIVE FRAMEWORK



Social Determinants & Context (Political, Social, Demographic, Socioeconomic)

Source: Veillard et al. 2017.

APPENDIX 2. PERFORMANCE DOMAIN



PERFORMANCE DOMAIN: DETAILED VITAL SIGNS PROFILE INDICATORS

Marshall Islands	SCORE	PERCENTAGE	SOURCE	YEAR
ACCESS	69			
Financial				
Perceived access barriers due to treatment costs*		No data available		
Geographic				
% of population who travel more than 30 minutes to reach the nearest facility*		31%	HIES	2019
QUALITY	75			
Comprehensiveness				
Avg. availability of 5 tracer RMNCH services		62%	HeRAMS	2019
Avg. availability of services for 3 tracer communicable diseases		90%	HeRAMS	2019
Avg. availability of diagnosis & management for 3 tracer NCDs		70%	HeRAMS	2019
Continuity				
DTP3 dropout rate*		85%	WHO/UNICEF	2021
Treatment success rate for new TB cases		90%	TB country Profile	2022
Person-Centeredness				
% of caregivers who were told sick child's diagnosis		No data available		
Provider competence				
Antenatal care quality score based on WHO guidelines		No data available		
Family planning quality score based on WHO guidelines		No data available		
Sick child quality score based on IMCI guidelines		No data available		
Adherence to clinical guidelines		No data available		
Diagnostic accuracy		No data available		
Provider availability				
% of family planning, ANC, and sick child visits over 10 minutes		No data available		
Provider absence rate*		No data available		
Safety				
Adequate waste disposal		65%	HeRAMS	2019
Adequate infection control		63%	HeRAMS	2019
SERVICE COVERAGE	48			
Reproductive, Maternal, Newborn and Child Health				
Demand for family planning satisfied with modern methods		72%	UHC Global Monitoring Report	2023
Antenatal care coverage (4+ visits)		68%	UHC Global Monitoring Report	2023
Coverage of DTP3 immunization		82%	UNICEF/WHO	2021
Care-seeking for suspected child pneumonia		66%	UHC Global Monitoring Report	2023
Infectious diseases				
Tuberculosis cases detected and treated with success		51%	TB country Profile	2021
People living with HIV receiving anti-retroviral treatment***		55%	UHC	2023
Children under 5 with diarrhea receiving ORS		24%	ICNHS	2017
Non-Communicable Diseases (NCDs)				
Prevalence of hypertension treatment †		30%	UHC Global Monitoring Report	2023

*Indicators where lower values are preferable were transformed before inclusion in the index. The modified indicator was defined as 100-X, where X is the original percentage shown in this table. **Country-specific (proxy) indicator, used in absence of globally comparable survey data. ***Data from Multi-Country Western Pacific Integrated HIV/TB Programme indicate that HIV treatment coverage in RMI is 100% (7/7) †UHC 2023 reported estimate based on WHO NCD Risk Group (2021 data) for prevalence of treatment (taking medicine) for hypertension among adults aged 30–79 with hypertension

APPENDIX 3. CAPACITY DOMAIN



CAPACITY DOMAIN: DETAILED VITAL SIGNS PROFILE INDICATORS

Marshall Islands	SCORE
GOVERNANCE	2.6
Governance and Leadership	2.8
Measure 1: Primary health care policies (1/2)	
Measure 2: Primary health care policies (2/2)	
Measure 3: Quality management infrastructure	
Measure 4: Social accountability (1/2)	
Measure 5: Social accountability (2/2)	
Adjustment to Population Health Needs	2.3
Measure 6: Surveillance	
Measure 7: Priority setting	
Measure 8: Innovation and learning	
INPUTS	1.7
Drugs and Supplies	1.0
Measure 9: Stock-out of essential medicines	
Measure 10: Basic equipment availability	
Measure 11: Diagnostic supplies	
Facility Infrastructure	1.3
Measure 12: Facility distribution	
Measure 13: Facility amenities	
Measure 14: Standard safety precautions and equipment	
Information Systems	2.3
Measure 15: Civil Registration and Vital Statistics	
Measure 16: Health Management Information Systems	
Measure 17: Personal care records	
Workforce	2.3
Measure 18: Workforce density and distribution	
Measure 19: Quality assurance of primary health care workforce	
Measure 20: Primary health care workforce competencies	
Measure 21: Community health workers	
Funds	1.3
Measure 22: Facility budgets	
Measure 23: Financial Management Information System	
Measure 24: Salary payment	
POPULATION HEALTH AND FACILITY MANAGEMENT	1.4
Population Health Management	1.5
Measure 25: Local priority setting	
Measure 26: Community engagement	
Measure 27: Empanelment	
Measure 28: Proactive population outreach	
Facility Organization and Management	1.2
Measure 29: Team-based care organization	
Measure 30: Facility management capability and leadership	
Measure 31: Information system use	
Measure 32: Performance measurement and management (1/2)	
Measure 33: Performance measurement and management (2/2)	

APPENDIX 4. RECOMMENDATIONS FOR IMPACT, FEASIBILITY, AND TIMELINESS

Recommendation	Resources required	Difficulty of execution	Potential impact	Time horizon from impact	Main PHC dimensions affected
1. Integrate PHC into health sector governance and leadership for enhanced care coordination.					
1.1. Develop a consolidated national PHC policy or strategy, seamlessly integrated into the ministry strategic plan.	Low	Moderate	High	Medium	Capacity, performance
1.2. Develop an integrated package of essential services for PHC.	Moderate	High	Moderate	Long	Capacity, performance
1.3. Establish a dedicated PHC focal point within the Ministry of Health and Human Services.	Moderate	Moderate	Moderate	Medium	Capacity, performance
1.4. Develop a multisectoral action plan to address the noncommunicable disease epidemic.	Moderate	High	High	Long	Capacity, performance
2. Strengthen quality management infrastructure to enhance accountability and effective service delivery.					
2.1. Enhance the infrastructure of PHC facilities to enable effective delivery and monitoring of high-quality services.	High	+	High	Medium	Performance, capacity
2.2. Build on quality management infrastructure initiatives through monitoring and evaluation.	Moderate	Moderate	Moderate	Short	Capacity, performance
2.3. Establish a platform for discussing, monitoring, and expanding innovations in PHC.	Moderate	Moderate	Moderate	Medium	Capacity, performance
3. Enhance health care workforce capacity to deliver equitable, high-quality services.					
3.1. Evaluate health care worker density and distribution to ensure equitable access to care.	Moderate	Moderate	High	Short	Performance, equity, capacity
3.2. Assure PHC quality by ensuring that the Licensing Board includes all PHC cadres and that it is regularly enforced.	High	Moderate	Moderate	Long	Capacity, quality
3.3. Promote multidisciplinary team-based care in PHC services.	High	Moderate	High	Medium	Capacity, performance
3.4. Implement routine supportive supervision for enhanced service delivery.	Moderate	Moderate	Moderate	Medium	Quality
4. Enhance facility organization and management for more efficient and responsive PHC services					
4.1. Implement a formal empanelment system to enhance patient support.	Moderate	High	Moderate	Short	Capacity, financing
4.2. Invest in managers' skills to ensure facilities are effectively operated.	Moderate	Moderate	Moderate	Medium	Capacity, financing
4.3. Implement routine performance measurement and management in PHC facilities	Moderate	Moderate	Moderate	Short	Capacity

Note: PHC = primary health care.

APPENDIX 5. STAKEHOLDER INVOLVEMENT IN IMPLEMENTATION OF RECOMMENDATIONS

Recommendation	Resources required	Difficulty of execution	Potential impact	Time horizon from impact
1. Integrate PHC into health sector governance and leadership for enhanced care coordination.				
1.1. Develop a consolidated national PHC policy or strategy, seamlessly integrated into the ministry strategic plan.	F,E,M,P	PI,D	I	I
1.2. Develop an integrated package of essential services for PHC.	F,E,M,P	PI,D	I	I
1.3. Establish a dedicated PHC focal point within the Ministry of Health and Human Services.	F,E,M,P	PI,D	I	I
1.4. Develop a multisectoral action plan to address the ongoing NCD epidemic	F,E,M,P	PI,D	I	I
2. Strengthen quality management infrastructure to enhance accountability and effective service delivery.				
2.1. Enhance the infrastructure of PHC facilities to enable effective delivery and monitoring of high-quality services.	F,E,M,P	PI,D	I	I
2.2. Build on quality management infrastructure initiatives through monitoring and evaluation.	F,E,M,P	PI,D	I	Short
2.3. Establish a platform for discussing, monitoring, and expanding innovations in PHC.	F,E,M,P	PI,D	PI	I
3. Enhance health care workforce capacity to deliver equitable, high-quality services.				
3.1. Evaluate health care worker density and distribution to ensure equitable access to care.	F,E,M,P	PI,D	PI,D	I,P
3.2. Assure PHC quality by ensuring that the Licensing Board includes all PHC cadres and that it is regularly enforced.	F,E,M,P	PI,D	I	I
3.3. Promote multidisciplinary team-based care in PHC services.	F,E,M,P	PI,D	PI,D	I,P
3.4. Implement routine supportive supervision for enhanced service delivery.	F,E,M,P	PI,D	PI,D	I,P
4. Enhance facility organization and management for more efficient and responsive PHC services.				
4.1. Implement a formal empanelment system to enhance patient support.	F,E,M,P	PI,D	PI	I,P
4.2. Invest in managers' skills to ensure facilities are effectively operated.	F,E,M,P	PI,D	PI	I,P
4.3. Implement routine performance measurement and management in PHC facilities	F,E,M,P	PI,D	I	I

Note: F = provide financing or financial incentives; E = establish strategic direction; M = manage the program; P = participate in the implementation of the program or support it; I = stay informed on the program activities; D = make informed or strategic decision; PHC: primary health care.

APPENDIX 6. PROGRESSION MODEL PARTICIPANTS

PROGRESSION MODEL KEY INFORMANTS

Interviewee	Title
Kino Kabua	RMI Chief Secretary
Francyne W. Jacklick	MOHHS Acting Secretary
Dr Durant	Health Advisor ECD Project - WB
Dr Robert Maddison	MOHHS Chief of Staff)
Dr Frank Underwood	MOHHS Public Health Director
Edlen Anzures	MOHHS Health Informatic Director
Dr Robert Maddison	MOHHS Chief of staff
Ciara Mae Reyes,	MOHHS Chief Pharmacist
Lewis Mejde Jeadrik	Ebeye Hospital [Pharmacy:
Paul Lalita	MOHHS Laboratory Manager
:Lincoln Simeon	IDS Relik Chain Coordinator
Joseph Gordon	OWS Ratak Chain Coordinator
Noatia Siofilisi	MOHHS Medical Records Manager
Michael Patrick	Supply & Procurement
Dr Rico Lareza	177 Health Program
Jerry Antolok	Majuro Supply & Procurement:
Charles Lomae	Outer Islands Health Dispensaries Actin Director
DS Mailyynn Konelios	MOHHS
Glorine Jeadrik	Ebeye Hospital
Michael Diaz	Laboratory Ebeye Hospital
Titus Bien	MOHHS
Dana Karben.	MOHHS

WORKSHOP PARTICIPANT LIST (OCT. 11-12/2023)

Steering Committee		
	Title	Name
1	Minister for Health & Human Services (MOHHS) – Chair	Honorable Otta Kisino
2	MOHHS Acting Secretary	Francine W. Jacklick
3	Acting Deputy Secretary & Primary Health Care Director	Dr Frank Underwood
4	Acting Deputy Secretary, Kwajelein/Ebeye Atoll Health Care	Dr Dustin Bantol (
5	Health Advisor – ECD Project (WB)	Dr Mark Durant
6	Director Clinical Services & Chief of Staff	Dr Robert Maddison
7	Director Informatics, Office of Health Planning, Policy, Preparedness, Personnel & Epidemiology	Edlen Anzures
Majuro Hospital		
	Title	Name & Email Address
8	Public Health Chief Nurse	Hillia Enos
9	Medical Director Human Services	Dr Holden Nena
10	MHC Program Director	Caroline Jibas
11	TB Program Manager	Risa Bukbuk
12	STI/HIV Program Manager	Adela Nakamura
13	HOD OBGYN and Chair RMHNACA	Dr Ivy Lapidez
14	Immunization Program Manager	Daisy Pedro
15	Community Profiling Nurse Officer	Tavaita Suvirara
16	MOHHS Medical Records Manager	Ms Noatia Siofilisi
17	MOHHS Supplies & Procurements	Jerry Anjolak
18	MOHHS Chief Pharmacist	Ciara Mae Reyes
19	MOHHS Laboratory Manager	Paul Lalita

Ebeye Hospital		
	Title	Participant
20	Public Health Director Ebeye Hospital	Dr Chocho Thein
21	Pharmacy Ebeye Hospital	Mr. Lewis Jeadrik
22	Laboratory Ebeye Hospital	Mr. Michael Diaz
23	Supply & Procurement Ebeye Hospital	Mr. Michael Patrick
Outer Islands Dispensary Services (OIDS)		
	Title	Participant
24	OIDS Director	Mr. Charles Lomae
25	OIDS Relik/Ratak Chain Coordinator	NP Gordon Joseph
26	OIDS Supplies & Procurements	Mr. Asden Timothy
27	OIDS Supplies & Procurements	Mr. Melvin Mellan
28	OIDS Fields Officer	Loraini Ranadi
177 Health Care Program		
	Title	Participant
31	Acting Administrator	Dr Rico
32	Epidemiologist Ebeye	Mr. Josua Ligairi
33	Epidemiologist Majuro	Ms. Jane Matanaicake
34	Monitoring & Evaluation Officer - Epidemiology Majuro	Mr. Ishael Ken

APPENDIX 7. PROGRESSION MODEL DOCUMENTS REVIEWED

Country cooperation strategy

2019 JOINT EXTERNAL EVALUATION OF INTERNATIONAL HEALTH REGULATIONS
CORE CAPACITIES of the REPUBLIC OF THE MARSHALL ISLANDS

2020 Health care readiness report

2022 Epidemic and emerging disease alerts in the Pacific

Accreditation for nursing and allied health

Accreditation standards

Accreditation standards for facility managers

CIVIL REGISTRATION AND VITAL STATISTICS IN MARSHALL ISLANDS

Community engagement organization - Island Liason

Emergency management

Health and Population Project in the Marshall Islands

Health care coalition fact sheet

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