

PRIMARY HEALTH CARE ISSUES IN THE REPUBLIC OF THE MARSHALL ISLANDS

A. Introduction

1. Primary health care (PHC) is understood in different ways. The Alma-Ata Declaration¹ (1978) defines PHC as an approach or philosophy of health care: “Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families through their full participation and at a cost that the community can afford and maintain at every stage of their development in the spirit of self reliance and self determination.”

2. A more basic definition of PHC is that it is the first level of health care—activities aimed at preventing health problems and diseases from starting. The established core practice of PHC provided by the health departments of most of the Asian Development Bank’s Pacific developing member countries (DMCs) is maternal and child health care (MCH) services (perinatal care, advocacy of birth spacing and family planning, and provision of contraceptives based on a choice of methods, vaccination of infants and children, monitoring of the growth of infants and children under 5 and interventions where needed, and provision of advice on hygiene and nutrition). It may also include other health education programs (on diabetes and STD [sexually transmitted disease]/HIV, for example), and MCH service providers may also be trained in surveillance for diseases such as tuberculosis (TB).

3. For at least the past 50 years in most Pacific DMCs, MCH has been a woman-to-woman service provided at central clinics, although in some countries such as Samoa the service is village based. Where MCH services are well established and accepted, and well organized and accessible to most women and children, the results are remarkably cost effective and account for the very good basic health indicators typical of countries such as Cook Islands, Tonga, Fiji, and Samoa.

4. Since the 1950s, and in many Pacific DMCs long before, PHC was supported by colonial administrations that enforced public health regulations to control disease vectors by removal of breeding places for mosquitoes, flies, and parasites; protect water sources or improve the supply; specify areas for burial of the dead and the location of houses in some countries; and enforce construction and use of latrines and pig pens. In many Pacific DMCs fines or even harsher penalties were used to ensure compliance. In the postindependence era, some Pacific DMCs abandoned some of the more unpopular public health regulations, but in those Pacific island countries with higher social and health indicators, many hygienic practices have become well established in the local way of life, while various public health regulations are still enforced by local authorities. In countries with the lowest social and health indicators, enforcement of public health measures is weak or has been abandoned altogether.

5. This analysis aims to explain why the objectives of the Health and Population Project in the Republic of the Marshall Islands (RMI) did not successfully achieve goals and objectives for promoting behavior change for healthy lifestyles.

¹ Alma-Ata Declaration.1978. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

B. Background

1. Historical Factors

6. The RMI is different from the other Pacific DMCs in the extent of its external dependence. The islands were administered by Germany from the late 19th century until 1914. After World War I, the islands passed to Japan, which governed under a League of Nations Mandate until 1945. The islands were a major theater in World War II, which caused devastation of a number of populated islands. After the defeat of Japan, the Marshall Islands became part of the United States (US) Trust Territory of the Pacific (under a United Nations trusteeship). In 1986, the RMI entered into a Compact of Free Association with the US, which expired in 2001. A new 20-year Compact was subsequently negotiated, effective from October 2003.

7. After 1945, the US Army rented most of Kwajalein atoll for its nuclear testing program and subsequently for its missile testing program; the military base provides an important source of private sector employment as well as substantial rents to landowners. Between 1946 and 1958, the US tested 67 nuclear weapons there. Approximately 2,000 Marshallese are currently receiving compensation benefits because they incurred diseases attributable to exposure to radiation. Also, under Article 177 of the Compact, the populations of affected atolls receive special compensatory health and social service packages from the US.

8. A further cause of high import and aid dependency, and one that contributes to health nutritional problems, is associated with the period from 1965, when most of the population of the Marshall Islands (along with other island groups in the Trust Territory) became entitled to receive a range of US federally funded programs for poverty alleviation (designed to help the US inner-city poor). They included school-based feeding programs, food stamps, and a lunch program for seniors.

9. The food programs were maintained after the RMI became independent but were eventually discontinued in the mid-1990s due to budgetary constraints. The food provided was imported and contributed to the prevailing preference for imported rather than local staple foods, as well as reducing incentives to grow and market local crops.

10. This dependency was accelerated over time as the population of the RMI became concentrated in two densely settled urban locations on Majuro and on Ebeye Island in Kwajalein Atoll. Initially, these populations grew when people were resettled from islands occupied by the US Army or affected by US Army test programs. The numbers continued to grow as outer islanders moved to urban areas to join relatives, and to seek wage employment and better services. Currently, 70% of the population live in the two crowded urban locations, and most lack land to enable self-sufficiency in food.

2. Government Primary Health Care Services

11. The Ministry of Health (MOH, formerly, the Ministry of Health and Environment) is organized into six bureaus: primary health care; referral services; administration, personnel, and finance; Majuro Hospital services; health planning and statistics; and Kwajalein Atoll health care services. Each bureau is headed by an assistant secretary reporting to the Secretary of MOH, who chairs the health services board and reports to the Minister for Health. PHC services are organized differently in the Majuro and Kwajalein population centers.

12. In Majuro, the Bureau of Primary Health Care (BPHC) is operationally and organizationally separate from the Bureau of Majuro Hospital Services. BPHC has four divisions.

13. The Division of Human Services and Health Promotion (DHSHP) has three major but overlapping programs:

- (i) The nutrition and diabetes prevention program has separate but interactive subprograms for diabetes prevention and nutrition. It has a cross-cutting role with the diabetes program in the Division of Public Health (DPH).
- (ii) The health promotion program is responsible for health education and therefore has a cross-cutting role with DHSHP programs and other divisions and programs in BPHC.
- (iii) The human services program has subprograms for mental health, social work, substance abuse prevention, and vocational rehabilitation. The program also has a cross-cutting role with other public health programs.

14. DPH has six programs:

- (i) The chronic diseases program operates clinics for diabetes and hypertension.
- (ii) The STD/HIV/AIDs program provides surveillance, treatment, and referral services.
- (iii) The immunization program operates through a well-baby clinic and a school outreach program. Its work is cross-cutting with the reproductive health services program
- (iv) The reproductive health services program provides an interrelated MCH (perinatal) care subprogram and a family planning program.
- (v) The TB and leprosy program does surveillance, treatment, and referral work and runs the TB Directly Observed Therapy subprogram.
- (vi) The clinical services program provides officially required physical examinations.

15. The Division of Dental Services has three programs: clinical service, a dentures service, and preventive services, which has subprograms for school fluoride sealant services, early childhood services, and community outreach.

16. The Division of Outer Island Health Care System (OIHCS) is responsible for the Rongrong Community Health Center and the Laura Community Health Center, which are both on Majuro Atoll, and for 51 outer island health centers (HCs) on other atolls. OIHCS coordinates the training of health assistants (HAs), who are mainly male, and provides management and clinical advice, general supervision, and supplies to the HCs.

17. Each HC is staffed by one or more HAs who have the following responsibilities overlapping with the other divisions and programs of BPHC, although the linkage is weak:

- (i) disease screening;
- (ii) management of chronic and infectious diseases;
- (iii) prenatal, diabetic and hypertension, and family planning clinics, and also attending births;
- (iv) child health surveillance;
- (v) in-patient observation;
- (vi) management and referral to hospital of acute cases;
- (vii) health education during clinics;

- (viii) health education in schools; and
- (ix) working with the community health council.

18. BPHC provides multiprogram teams of health specialists who visit the outer islands to hold clinics addressing various health problems. The program is coordinated by an officer responsible to the assistant secretary for PHC, not to OIHCS. BPHC receives a considerable portion of its operational funding from special program grants provided from US federal funds, other aid agencies, and specialized regional and international agencies. This tends to reinforce the often artificial division between programs.

19. The Bureau of Kwajalein Atoll Health Care Services provides a more effective model of service delivery from the Ebeye Hospital than Majuro, because the services are more closely integrated. It has four divisions: support services, PHC, hospital services, and information and planning. The division of PHC administers outpatient services at Ebeye Hospital, which is integrated with the hospital's medical and clinical support services. Its public health program has fairly well-integrated subprograms in health education, family planning, human services, dental services, STD and communicable diseases, MCH, well baby, immunization, hypertension, diabetes, and youth health. It also has a school health program and a community outreach program, and a small outer islands program for the dispensaries on Ebadon and Santo, which are part of Kwajalein atoll.

20. At the Ebeye Hospital, physicians, regardless of their clinical specializations, are always on duty at the outpatient clinic. Therefore, clients with several health problems can be more effectively served. Consideration is being given by MOH to adopting the Ebeye Hospital service model on Majuro when the new hospital is completed.

3. PHC Issues Identified by MOH

21. The Ministry of Health Primary Health Care Assessment² (2005) found that the PHC policy is not being practiced well in the national health system. It found that there are problems in the delivery of outer island health services at the HC level. More than 80% of HAs do not see themselves as health educators and health promoters, but as "doctors," dispensing medicine and treatments. Key PHC practices were not being done, such as weighing babies weekly to monitor growth, while few pregnant women would allow themselves to be examined or delivered by a male HA, or seek family planning advice from him, especially if he is related to them. Most HAs are members of the local community and related to many people. The HAs were not keeping records properly; 35% had no functioning radio communication with OIHCS to receive guidance and supervision, but used the local government council radio—often on another quite distant island—in emergencies. HAs cannot vaccinate children, because there is no electricity on most outer islands and no refrigeration for the vaccines; therefore, this must be attempted by visiting health teams from Majuro or in some cases from Ebeye, who face both staffing and transportation constraints, and who do not know the communities as well as the HAs.

22. The MOH assessment of PHC notes that the number of staff working in BPHC is small compared with the number employed in curative services. These staff are mainly local. They have many responsibilities both on Majuro and to provide service to the outer islands. Their coverage is inadequate in both urban and rural areas. Community involvement in primary and preventive health efforts is weak, and people still believe that MOH is responsible for health, not individuals. This makes it difficult for staff to persuade people to change their lifestyles or adopt

² MOH. 2005. *Primary Health Care Assessment*. Majuro.

healthy practices. Further, the assessment notes that few people seek preventive services such as physical or dental checkups. Finally, the assessment notes that the environment in the RMI is not conducive to healthy choices—there are few places to exercise, and stores do not stock a variety of affordable healthy foods.

C. Key Social and Environmental Issues

23. **Community Participation.** The Health and Population Project laid great emphasis on community participation as a key strategy to encourage ownership of the outer island HCs. Community health councils (CHCs) were established and trained in 51 outer islands. They were intended to inspire the communities using the HCs with a sense of ownership of the HCs so they would repair and maintain them, and also to promote the PHC philosophy.

24. In outer island communities, effective ties between people are based on kinship, which is the primary base of mutual loyalty and cooperation. Other cross-cutting affiliations are church memberships. In small communities there can also be deep rivalries and ill-feeling between groups of people, who live with these divisions by being circumspect in their dealings with one another. It is difficult for communities to manage a communal asset harmoniously unless there is effective authority exercised on the basis of accepted traditional rank and leadership rights. It is likely that the people who would feel the greatest “ownership” of the HC are those on whose land the center is built, since all the HCs were built on private land, after discussions among local leaders. It is also difficult for members of an outer island community to discuss with others, let alone instruct others, what food they should plant, what they should eat, how they should manage their water supply, or how they should maintain their health. These are regarded as sensitive, private matters.

25. The MOH Primary Health Care Assessment (footnote 2) found that CHCs were not helping maintain the HCs. A sample survey of 26 outer island CHCs by the Operations and Evaluation Department (OED) in October 2005 showed that fewer than half were still in existence after being established in 1996–1999, and of these, only five appeared to understand the roles assigned to them by the Project to promote health by encouraging the production of local food, better nutrition, and clean water. Only one understood that its role was to make repairs to the health center. The respondents did not know why the CHCs failed, other than that the members stopped meeting. Apparently in some cases the CHC leaders migrated overseas. However, the reasons for failure are likely to be more complex. Some indication of the inherent difficulty in establishing CHCs is evident from the weakness of many outer island local governments in achieving practical local development; most tend to be politicized by local rivalries between clans, which become reflected in contentious political affiliations.

26. **Culture and Health Education.** The Health and Population Project also laid great emphasis on community participation and public awareness as a key strategy to reduce the fertility rate and teen pregnancies, increase birth intervals, and encourage a healthy lifestyle and consumption of “island foods.” It gave insufficient recognition to the significant cultural and environmental obstacles to be overcome in order to successfully implement an effective program of community-based disease prevention and health promotion.

27. A Community Health Assessment³ targeting Marshallese teenage parents and teachers showed that medical services are associated in people’s minds with treating sickness,

³ Evensen, Sonja, Hilda C. Heine, and Julian Heinz. 2004. *Results of a Community Health Assessment in the Republic of the Marshall Islands*. Pacific Resources for Education and Learning (PREL).

especially very severe sickness, not with maintaining good health. There is also a continuing tendency for people to prefer “traditional medicine” over medicines and services provided at health centers and hospitals. Health workers interviewed by OED confirmed that there is a hierarchy of resorts in which a person feeling unwell decides how his or her symptoms should be dealt with. In most cases, people choose traditional remedies, self-administered or provided by a family member or someone else in the community with a reputation as a healer. An intermediate strategy before seeking medical help may be prayer, or consultation with a religious leader. Symptoms of disease are often thought to be of supernatural origin. For example, illness may be regarded as the result of a curse or witchcraft. Many chronic conditions are simply endured by Marshallese people. Only when sickness persists or causes unendurable pain or discomfort are they likely to go to a clinic for treatment. In many cases, intervention is sought when the disease is difficult or impossible to treat, reinforcing public mistrust of medical services.

28. **Contraceptive Acceptance.** The family planning and population survey demonstrated that there is a significant gap between knowledge, attitudes, and practice concerning population issues and contraceptive acceptance. Of 1,463 women and men surveyed, 37% said that they practiced family planning, a larger proportion than found in earlier surveys, but also a much higher proportion than family planning service providers currently acknowledge. While most respondents indicated that an ideal family size for themselves and for the Marshall Islands is two to four children, most women bear five to seven children.⁴ The study found a widespread fear of side effects of using contraception. Examples of such fears are that contraceptive drugs might cause cancer, or that cessation of menstruation as a result of using hormone-based contraceptives causes bad blood to be retained in the body. Condoms are thought to reduce sexual pleasure.⁵

29. Recent annual reports of MOH do not provide proportional data on contraceptive acceptance, but the latest report⁶ (2004) records a total of 908 family planning encounters, with 146 new females and 28 new male clients.

30. The latest figures for Ebeye (2004) show a coverage rate of 25%, which means that approximately 370 people of fertile age use contraception, while about 1,690 do not. The figures do not show how many continue to use contraceptives or for how long. Of those using contraceptives, fewer than 1% are male. The most popular methods are those that women can keep secret—Depo-Provera injections, Norplant, and sterilization. Other methods have minimal use rates. As the MOH assessment notes, very few women in the outer islands use contraceptives because, although they are available, women will not ask a male HA to provide them due to cultural sensitivities. Those women who use contraceptives obtain them from an HA’s wife (if she is not a relative) or public health nurses visiting with outer island health teams, who provide occasional family planning clinics, usually only one or two a year, if any.

31. **Food and Nutrition.** Most Marshallese do not understand causes of disease in scientific terms, but have cultural understandings that might be quite contrary to scientific knowledge about the cause of disease. Therefore, health education, even when well presented in the local language, may not be effective, because it contains premises that are contrary to what people believe. Further, the actions to protect or preserve health prescribed by health education

⁴ Total fertility rates vary from year to year, e.g., 5.6 in 1990, 7.1 in 1994, 5.9 in 1999, 3.9 (estimate) in 2005. ADB. 2004. *Key Indicators 2004*. Manila.

⁵ Balachandra, H.K. Report of a visit to Namu Atoll, September 2002.

⁶ MOH. 2004. *Annual Report 2004*. Majuro.

messages may be beyond the individual's control because of his or her environment or social situation.

32. The connection between diet and health is an example. Marshallese often do not believe that one food is superior to another for maintaining good health in adults or children. Food is evaluated by other criteria such as taste and price. Overweight or obesity is rarely seen as a problem, and symptoms of poor nutrition are typically considered to have other causes than an inadequate diet. Malnutrition is very common in the Marshallese population. A recent survey shows, for example, that nearly 60% of children aged 1–5 were diagnosed with Vitamin A deficiency, 25% with iron deficiency, and one third of children in the RMI have both deficiencies.⁷ One outer island survey showed that of a sample of women, 37% were obese and 34% were overweight (footnote 5). Diabetes (related to obesity, poor diet, and childhood malnutrition) was a contributing cause of disease in 75% of hospital admissions in 2004.

33. Prescriptions to eat “healthy food,” even if the message is believed, may be beyond the resources or capacity of most people. This is because most people live in large, often overcrowded households; depend on money for food; do not have enough money to make a lot of choices about food; and share food in the household with others who may not have heard the same messages about health and diet, who do not accept the messages, or who cannot afford to practice them. Food may not be a priority for spending money in the households; more money may be spent on cigarettes, alcohol, canned soda, non-nutritious snack foods, and candy than on food. In the majority of households, most individual members do not make the choices or decisions about how available money is spent.

34. On a per kilojoule/calorie basis, local food is generally more expensive than imported food and usually much scarcer, being dependent on the season and weather conditions. Table A2.1 shows the typical unit price of commonly consumed foods in the RMI. Rice is a staple food, and most people eat rice at least once a day. There is a wide variation in household incomes in urban areas; and people with low income seldom eat much meat, fish, chicken, or vegetables but eat a lot of rice flavored with soy sauce, ramen, bread, and fried pancakes.

**Table A2.1: Commonly Consumed Imported and Local Food
By Unit and Price, November 2005**

Local and Imported Foods	Typical Unit (US weight)	Price (\$)
Imported Rice	20-pound bag	7.25
Imported Flour	25-pound bag	9.95
Imported Instant Noodles	3.5-ounce pack	0.48–0.55
Imported Soy Sauce	20-fluid ounce bottle	2.89–2.49
Imported Sugar	4.4-pound pack	1.65–1.49
Local Coconut	piece	0.50
Local Fresh Breadfruit	piece	1.00
Local Cooked Breadfruit	piece	2.00
Local Pumpkin	pound	0.80

Source: OEM Survey.

⁷ Cited in World Bank. 2004. *Opportunities that Change People's Lives: Human Development Review of the Pacific Islands. Country Case Study: Republic of the Marshall Islands*. Human Development Department and Pacific Islands Country Department, East Asia and the Pacific Region, Draft. Washington DC, USA and Sydney, Australia. pp. 25–26.

35. Imported tinned meat is more expensive than local or imported fish, but is a very popular food. Canned and fresh fish are comparably priced, but fresh fish is often harder to obtain than the kind that comes in cans (Table A2.2). Canned fish is popular with big families, as it can be stretched to feed a lot of people when mixed with ramen or rice. Fresh fish is harder to serve in small portions and so is more expensive to serve to a big family than canned fish.

Table A2.2: Comparative Price per Pound of Imported and Local Meat and Fish

Meat and Fish	Price Per Pound (US weight)
Imported Corned Beef	4.11
Imported Canned Luncheon Meat	2.39–3.23
Imported Canned Mackerel	0.95–1.31
Imported Sardines	0.91–2.02
Imported Tuna	2.00
Local Fresh Wahoo, Yellowfin Tuna, Mahimahi	2.50
Local Fresh Skipjack, Marlin	1.50
Local Fresh Snapper, Grouper	2.00
Fresh Sturgeon, Parrot Fish	2.50

Source: OEM Survey.

36. On Kwajalein, where few people can produce any of their own food by fishing or growing it, the average household income is about \$14,000, while in the outer islands, where people can produce some of their own food, the average household income is about \$4,000 (footnote 7). It is estimated that about 20% of households in the RMI fall below the poverty benchmark of \$1 per day (purchasing power parity). Although the RMI is ranked 9th out of 14 Pacific DMCs on the United Nations Development Programme human development and human poverty index,⁸ reflecting health education and poverty indicators, it had the second highest per capita income of seven Pacific DMCs.⁹

37. **Masculine Roles, Mental Health, and Family Violence.** Suicide was the fifth leading causes of death in 2004. Suicide or attempted suicide is most common among young men. The MOH annual report notes that most suicides are linked to alcohol consumption, but the cause of suicide is not alcohol; it is more likely to be the lack of a meaningful male role. In Marshallese culture, a woman fulfils cultural expectations by bearing and taking care of children, whether she lives in a rural or urban environment. But many young men have no defined social role to play; traditional male activities of canoe building, sailing and navigating, fishing, and climbing coconut trees to cut toddy are now practiced only in some of the outer islands. There are few alternative roles for young men; unemployment is very high and there are few sporting and recreational facilities for positive masculine activities. Masculine roles too easily become negatively defined among young men as drinking, gang membership and lack of respect for women. Drunkenness is a factor in the prevalence of family violence in the RMI, which contributes to many physical and mental health problems among women.

⁸ ADB. 2004. *Country Strategy and Program Update (2005–2006): Marshall Islands*. Manila.

⁹ RMI. 2005. *Statistical Yearbook 2004*. Majuro.

D. Conclusion

38. This discussion is not intended to produce answers to the issues and problems described or to make recommendations about actions needed. Rather, it reflects on why the educational and social mobilization measures to promote PHC in the Project were unsuccessful. The RMI's problems are deeply embedded in its historical experience, urbanization, cultural breakdown, poverty, low levels of education, and external dependence. The problems are made worse by the limitations of an atoll environment, poor housing, the water and sanitation situation, and waste disposal. The answers to these problems lie in the arena of public policy.