# IHR (2005) State Party Self Assesment Annual Report
# National Profile 2023
# Marshall Islands


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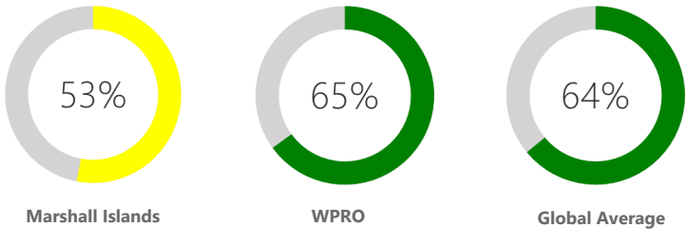
In accordance with Article 54 of The International Health Regulations (2005) and WHA resolution 61.2, all IHR States Parties and WHO are required to report to the WHA on a yearly basis on their implementation of the Regulations. This country profile provides an overview of the progress achieved as reported by this State Party in achieving selected elements of the core public health capacities required in the context of the International Health Regulations (2005), especially under Annex 1 of these Regulations.

## All Capacities Average

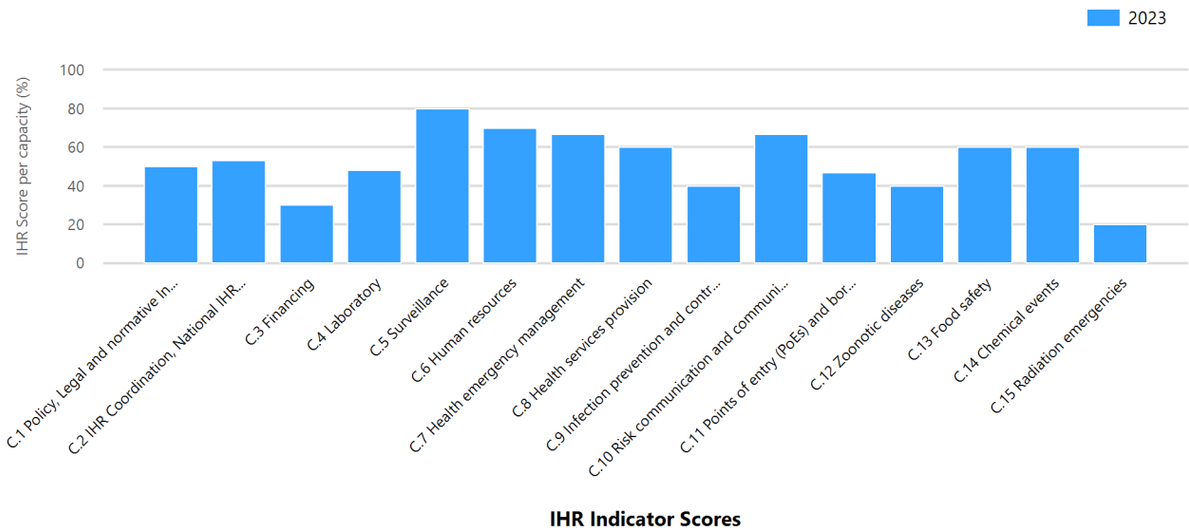



## Designated Points of Entry

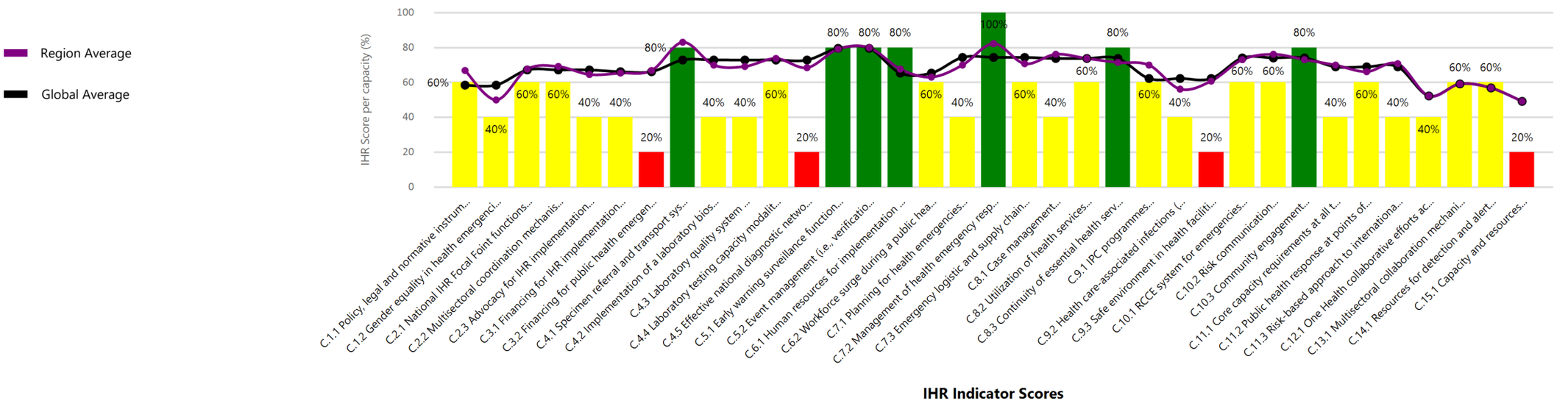
**3** Ports **2** Airports **0** Ground Crossings

**Authorized ports to issue ship sanitation certificates:** **Yes**

## IHR Capacity




## IHR Indicators



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## Achievements

| | |
|---|---|
| **C.7 Health emergency management**<br>C.7.2 Management of health emergency response | 100 |
| **C.4 Laboratory**<br>C.4.1 Specimen referral and transport system | 80 |
| **C.5 Surveillance**<br>C.5.1 Early warning surveillance function | 80 |
| **C.5 Surveillance**<br>C.5.2 Event management (i.e., verification, investigation, analysis, and dissemination of information) | 80 |
| **C.6 Human resources**<br>C.6.1 Human resources for implementation of IHR | 80 |
| **C.8 Health services provision**<br>C.8.3 Continuity of essential health services (EHS) | 80 |
| **C.10 Risk communication and community engagement (RCCE)**<br>C.10.3 Community engagement | 80 |

## Challenges

| | |
|---|---|
| **C.1 Policy, Legal and normative Instruments to implement IHR**<br>C.1.1 Policy, legal and normative instruments | 60 |
| **C.2 IHR Coordination, National IHR Focal Point functions and advocacy**<br>C.2.1 National IHR Focal Foint functions | 60 |
| **C.2 IHR Coordination, National IHR Focal Point functions and advocacy**<br>C.2.2 Multisectoral coordination mechanisms | 60 |
| **C.4 Laboratory**<br>C.4.4 Laboratory testing capacity modalities | 60 |
| **C.6 Human resources**<br>C.6.2 Workforce surge during a public health event | 60 |
| **C.7 Health emergency management**<br>C.7.3 Emergency logistic and supply chain management | 60 |
| **C.8 Health services provision**<br>C.8.2 Utilization of health services | 60 |
| **C.9 Infection prevention and control (IPC)**<br>C.9.1 IPC programmes | 60 |
| **C.10 Risk communication and community engagement (RCCE)**<br>C.10.1 RCCE system for emergencies | 60 |
| **C.10 Risk communication and community engagement (RCCE)**<br>C.10.2 Risk communication | 60 |
| **C.11 Points of entry (PoEs) and border health**<br>C.11.2 Public health response at points of entry | 60 |

## Challenges

| | |
|---|---|
| **C.13 Food safety**<br>C.13.1 Multisectoral collaboration mechanism for food safety events | 60 |
| **C.14 Chemical events**<br>C.14.1 Resources for detection and alert | 60 |
| **C.1 Policy, Legal and normative Instruments to implement IHR**<br>C.1.2 Gender equality in health emergencies | 40 |
| **C.2 IHR Coordination, National IHR Focal Point functions and advocacy**<br>C.2.3 Advocacy for IHR implementation | 40 |
| **C.3 Financing**<br>C.3.1 Financing for IHR implementation | 40 |
| **C.4 Laboratory**<br>C.4.2 Implementation of a laboratory biosafety and biosecurity regime | 40 |
| **C.4 Laboratory**<br>C.4.3 Laboratory quality system | 40 |
| **C.7 Health emergency management**<br>C.7.1 Planning for health emergencies | 40 |
| **C.8 Health services provision**<br>C.8.1 Case management | 40 |
| **C.9 Infection prevention and control (IPC)**<br>C.9.2 Health care-associated infections (HCAI) surveillance | 40 |
| **C.11 Points of entry (PoEs) and border health**<br>C.11.1 Core capacity requirements at all times for PoEs (airports, ports and ground crossings) | 40 |
| **C.11 Points of entry (PoEs) and border health**<br>C.11.3 Risk-based approach to international travel-related measures | 40 |
| **C.12 Zoonotic diseases**<br>C.12.1 One Health collaborative efforts across sectors on activities to address zoonoses | 40 |
| **C.3 Financing**<br>C.3.2 Financing for public health emergency response | 20 |
| **C.4 Laboratory**<br>C.4.5 Effective national diagnostic network | 20 |
| **C.9 Infection prevention and control (IPC)**<br>C.9.3 Safe environment in health facilities | 20 |
| **C.15 Radiation emergencies**<br>C.15.1 Capacity and resources | 20 |

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| Capacity | Average of Capacities Score (%) | Indicators | Indicator Score Details | Indicator Score ( | 2023 Comments | Status of Implementation | Areas involved |
|---|---|---|---|---|---|---|---|
| **C.1 Policy, Legal and normative Instruments to implement IHR** | **50** | C.1.1 Policy, legal and normative instruments | The country has identified and reviewed gaps in the health sector and developed and/or revised the necessary legal and normative instruments and policies for IHR implementation at the national and subnational levels, where applicable | **60** | The Republic of the Marshall Islands is committed to implementing the IHR and the MOHHS has a good understanding of its rights and obligations of the IHR. Areas that need strengthening and challenges<br>• Legislation among all sectors involved in the implementation of the IHR, e.g. animal health and the EPA, to reflect current arrangements.<br>• Having a comprehensive risk assessment that identifies threats and hazards to guide and inform legislative actions for all IHR hazards.<br>• Updating the Public Health, Safety and Welfare Act.<br>• Having a comprehensive national plan for IHR implementation. | Ongoing | 3. Coordination and Collaboration Mechanisms |
| | | C.1.2 Gender equality in health emergencies | Systematic assessment of gender gaps has been conducted in at least one IHR capacity | **40** | We are still in the same level as the previous reporting year. We have to work with Ministry of Culture and Internal Affairs and other stakeholders to develop an action plan. | Ongoing | 2. Guidelines and SOPs |
| **C.2 IHR Coordination, National IHR Focal Point functions and advocacy** | **53.3** | C.2.1 National IHR Focal Foint functions | National IHR Focal Point is a designated centre and has a clear legal and governmental mandate, with terms of reference describing the roles and responsibilities, is sufficiently organized, resourced and accessible at all times to communicate with WHO, but intersectoral collaboration and communication are inadequate to consolidate surveillance information or to obtain clearance from decision-makers in other domestic sectors | **60** | The EpiNet team is officially recognized by the President, Cabinet members and National Disaster Management Office as the NFP team. Good communication and information sharing between the NFP who is the Secretary of Health and Human Services and WHO, and other international partners including Pacific Islands Health Officer Associate (PIHOA), Pacific Community (SPC), US Centers for Disease Control and Prevention (CDC). | Planned<br>Ongoing<br>Achieved<br>Strength/best practice | 3. Coordination and Collaboration Mechanisms<br>4. Policy<br>6. Workforce<br>7. Leadership and Governance<br>10. Risk Communication |
| | | C.2.2 Multisectoral coordination mechanisms | Multisectoral coordination mechanisms for IHR implementation are in place, disseminated and are being implemented at national level | **60** | With the recent COVID-19 Pandemic, multisectoral coordination were disseminated and implemented at the national level. There were coordinated decision making and implementation of the COVID-19 pandemic plan of government, non government organizations and business sectors. | Ongoing | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>7. Leadership and Governance |
| | | C.2.3 Advocacy for IHR implementation | The advocacy mechanisms are developed but not disseminated. Advocacy activities are conducted on ad hoc basis | **40** | We need to strengthen this indicator.<br>• In the next year or two, we will conduct an evaluation of the NFP functionality, terms of reference, interoperability and training needs for NFP team. | Ongoing<br>Challenges/gaps | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>6. Workforce<br>7. Leadership and Governance<br>8. Assessments<br>10. Risk Communication<br>11. Legislation |
| **C.3 Financing** | **30** | C.3.1 Financing for IHR implementation | Financial planning is limited with a budgetary allocation or substantial external financing made for some of the relevant sectors and their respective ministries to support the IHR implementation at the national level | **40** | With the recent pandemic, most of our funds are coming from external financing. We have to conduct gap analysis and develop financial planning which will include proper monitoring. | Challenges/gaps | 1. Financing<br>2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>8. Assessments |
| | | C.3.2 Financing for public health emergency response | Public financing for responding to public health emergencies is not identified and funds are allocated and distributed in an ad hoc manner | **20** | With the recent pandemic, most of our funds are coming from external financing. We have to conduct gap analysis and develop financial planning which will include proper monitoring. | | |

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| **C.4 Laboratory** | **48** | C.4.1 Specimen referral and transport system | Referral and transport of specimens is organized systematically for diagnostics and/or confirmation of all priority diseases at all levels | **80** | Specimen referral and transport system are in place and in use. | Ongoing<br>Achieved<br>Strength/best practice | 1. Financing<br>2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics<br>6. Workforce<br>7. Leadership and Governance<br>8. Assessments<br>9. Health information systems<br>10. Risk Communication |
| | | C.4.2 Implementation of a laboratory biosafety and biosecurity regime | National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by some laboratories at the national level | **40** | Guidelines for biosafety and biosecurity are available and being practiced at the national level. | Ongoing<br>Challenges/gaps<br>Strength/best practice | 1. Financing<br>2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics<br>6. Workforce<br>8. Assessments |
| | | C.4.3 Laboratory quality system | National quality standards have been developed but not implemented | **40** | National quality standards have been developed and are practiced, however, licensing is not mandatory yet. | Planned<br>Ongoing<br>Challenges/gaps | 3. Coordination and Collaboration Mechanisms<br>4. Policy<br>6. Workforce<br>7. Leadership and Governance |
| | | C.4.4 Laboratory testing capacity modalities | Laboratory system can perform nucleic acid amplification testing, bacterial culture with antimicrobial sensitivity testing with quality assurance process in place and have access to (or has) sequencing capacity | **60** | NAT, bacterial culture with antimicrobial susceptibility testing are in place, but genetic sequencing is not available. Plans for enhancing PCR and set up advanced molecular detection are ongoing. | Planned<br>Ongoing<br>Challenges/gaps | 1. Financing<br>5. Infrastructure and logistics<br>6. Workforce<br>7. Leadership and Governance<br>8. Assessments<br>9. Health information systems |
| | | C.4.5 Effective national diagnostic network | Tier-specific diagnostic testing strategies are not available or under development. | **20** | N/A. | | |

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| **C.5 Surveillance** | **80** | C.5.1 Early warning surveillance function | National guidelines and/or SOPs for surveillance have been developed and are being implemented at the national and intermediate levels and provide immediate and weekly reporting of events and/or data | **80** | RMI does have a national standard operating procedure (SOP) for communicable diseases (CD), developed and currently being implemented at both the national level (Majuro) and the intermediate level (Ebeye) within the Ministry of Health and Human Services. This is currently undergoing revision.<br><br>Additionally, a weekly CD report covers CD and events in neighboring islands, Ebeye, and Majuro. This report is shared with other government agencies, partners, and stakeholders.<br>There is also room for the need to be inclusive of multisectoral agencies (i.e. One Health approach). As well as internal collaboration within MOHHS for the following:<br>• Health Equity Surveillance - Monitoring health outcomes and access to healthcare services among different population groups to identify and address health disparities.<br>• IHR Surveillance - Monitoring and reporting of public health events of international concern (PHEIC) in accordance with the International Health Regulations. This includes surveillance for emerging infectious diseases, such as Ebola or Zika virus, to facilitate rapid detection and response to potential global health threats.<br><br>To advance to Level 5, surveillance at the local level for community-based surveillance (CBS) or event-based surveillance through the Zoning Outreach Unit (ZOU) needs to be established. Plans are underway to establish this capability. The registry Data Unit (RDU), which is also yet to be established, will provide support for reporting to the ZOU, which will conduct the CDS/EBS. | Planned<br>Ongoing<br>Achieved<br>Challenges/gaps<br>Strength/best practice | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>6. Workforce<br>9. Health information systems |
| | | C.5.2 Event management (i.e., verification, investigation, analysis, and dissemination of information) | Process or mechanism for managing detected events has been developed and is being implemented at the national and intermediate levels | **80** | RMI MOHHS has a process for event management. When there is a threshold alert from Syndromic Surveillance (SS) or a notification from the National Notifiable Disease Surveillance (NNDSS) systems, the teams will first verify the alert and notification for confirmation. The surveillance team will accompany the public health team during disease investigations and conduct analysis and reporting to the respective stakeholders. Plans for surveillance refresher training, epidemiology, leadership, management, information systems, surveillance databses and response training to specific communicable diseases (CDs) are in place.<br><br>To advance to Level 5, two actions need to be undertaken:<br><br>• Implement community-based surveillance (CBS) or event-based surveillance at the local level through the Zoning Outreach Unit (ZOU), which is in the process of establishment. The registry Data Unit (RDU), also yet to be established, will provide support for reporting to the ZOU, which will conduct the CDS/EBS.<br>• Conduct evaluations on the event management processes in place and regularly review and update them on a regular basis. | Planned<br>Ongoing<br>Achieved<br>Challenges/gaps<br>Strength/best practice | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>6. Workforce<br>9. Health information systems |

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| **C.6 Human resources** | **70** | C.6.1 Human resources for implementation of IHR | Human resources are available as required in all relevant sectors at the national, intermediate and local levels, to detect, assess, notify, report and respond to events according to IHR provisions | **80** | Strengthening public health personnel through the development of appropriate knowledges, Skills and competencies is critical for effective implementation of the IHR. Development of human resources should enable sustainable practice of public health, surveillance and response at all levels of the health system. | Planned<br>Challenges/gaps<br>Strength/best practice | 1. Financing<br>2. Guidelines and SOPs<br>4. Policy<br>5. Infrastructure and logistics<br>7. Leadership and Governance<br>8. Assessments |
| | | C.6.2 Workforce surge during a public health event | A national multisectoral workforce surge strategic plan in emergencies is implemented to carry out the functions attributed at the national level, with procedures and limited capacity to send and receive multidisciplinary personnel within the country (shifting resources), including the government and nongovernmental partners workforce as applicable | **60** | Expanding a functional facility to treat a large number of patience after a mass casualty, is not always sufficient in disaster because the healthcare organization itself maybe to damage to operate. | Other | |
| **C.7 Health emergency management** | **66.7** | C.7.1 Planning for health emergencies | All-hazard risk informed health emergency plan is developed but not being implemented | **40** | There are emergency plans including multisectoral because of COVID-19, Drought. But we are missing chemical and radiation emergency plans. | Challenges/gaps | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics |
| | | C.7.2 Management of health emergency response | An incident management system integrated with a national levels public health emergency operations centre, or equivalent structure is in place and operational at national level and is able to support national, intermediate and local levels, and is exercised, reviewed, evaluated and updated, with improvements based on SimEx and lessons learned from real-world events, e.g. IARs or AARs | **100** | With the recent COVID-19 pandemic, our incident management system is in place and operational, table top exercises, SimEx. We are able to provide IARs and AARs. | Achieved<br>Challenges/gaps<br>Strength/best practice | 1. Financing<br>2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics<br>6. Workforce<br>7. Leadership and Governance<br>8. Assessments<br>9. Health information systems<br>10. Risk Communication<br>11. Legislation |
| | | C.7.3 Emergency logistic and supply chain management | em/mechanism is developed and is able to provide adequate support for health emergencies at national level | **60** | During the COVID-19 pandemic,we were able to develop and implement emergency logistics and supply chain management system and mechanism at the national level. We will continue to finalize our documentation. | Achieved<br>Challenges/gaps<br>Strength/best practice | 1. Financing<br>2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics<br>6. Workforce<br>7. Leadership and Governance<br>8. Assessments<br>9. Health information systems<br>10. Risk Communication<br>11. Legislation |
| **C.8 Health services provision** | **60** | C.8.1 Case management | National clinical case management guidelines for priority health events are developed but not being implemented | **40** | We have developed a Communicable Disease Response Plan that address the clinical case management guidelines but we need to develop for chemical events and radiation emergencies. | Ongoing | 1. Financing<br>2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics |
| | | C.8.2 Utilization of health services | Satisfactory levels of service utilization in tertiary health care facilities at national level (number of outpatient department visits per person per year ≥ 2.0 visit/person/year, in both urban and rural areas) | **60** | Secondary health care facilities are available at urban areas. | Ongoing | 1. Financing<br>2. Guidelines and SOPs<br>4. Policy<br>5. Infrastructure and logistics<br>6. Workforce<br>7. Leadership and Governance<br>9. Health information systems |
| | | C.8.3 Continuity of essential health services (EHS) | A package of EHS and plans/guidelines on continuity of EHS in emergencies are developed and mechanism for monitoring service continuity during emergency is in place at national and intermediate levels | **80** | | | |

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| **C.9 Infection prevention and control (IPC)** | **40** | C.9.1 IPC programmes | An active national IPC programme exists, and a national IPC operational plan according to the WHO minimum requirements is available. National guidelines/standards for IPC in health care are available and disseminated. Selected health facilities are implementing guidelines using multimodal strategies, including health workers' training and monitoring and feedback | **60** | We have not reached out to all the neighboring Islands in terms of sharing the IPC Guidelines and SOPs, and the facility assessments of all clinics and Outer Island Healthcare Service (OIHS). | Ongoing | 2. Guidelines and SOPs<br>6. Workforce<br>8. Assessments |
| | | C.9.2 Health care-associated infections (HCAI) surveillance | A national strategic plan for HCAI surveillance (including antimicrobial resistant pathogens that are antimicrobial resistant and/or prone to outbreaks) is available but not implemented | **40** | We have not reached out to all the neighboring Islands in terms of sharing the IPC Guidelines and SOPs, and the facility assessments of all clinics and Outer Island Healthcare Service (OIHS). | Challenges/gaps | 2. Guidelines and SOPs<br>9. Health information systems |
| | | C.9.3 Safe environment in health facilities | National standards and resources for safe built environment, e.g., water, sanitation and hygiene (WASH) in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and for optimization of staffing levels in health care facilities are not available or under development | **20** | We have not reached out to all the neighboring Islands in terms of sharing the IPC Guidelines and SOPs, and the facility assessments of all clinics and Outer Island Healthcare Service (OIHS). | Challenges/gaps<br>Other | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>5. Infrastructure and logistics<br>6. Workforce<br>8. Assessments |
| **C.10 Risk communication and community engagement (RCCE)** | **66.7** | C.10.1 RCCE system for emergencies | Mechanisms for coordination of RCCE functions and resources, including plans, SOPs and formal government arrangements are developed and being implemented at the national level | **60** | Risk communications (general) are channeled from government agencies/clusters through the National Disaster Management Office using outer island focal points and outer island dispensaries, relying on phone, internet and in some cases radio to reach focal points. Specific TORs for outer island focal points are under development. On Majuro and islands with internet coverage - NDMO use social media (FB/Twitter/IG) and mass SMS to reach populations. Formal feedback mechanism not established, but informal feedback mechanisms are in place. During the COVID-19 pandemic, the Ministry of Health and Human Services developed its own Health RCCE. | Ongoing | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics<br>10. Risk Communication |
| | | C.10.2 Risk communication | Mechanisms for public communication and/or media relations, including infodemics, are developed and activities are being implemented at the national level | **60** | | | |
| | | C.10.3 Community engagement | Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, have been developed, disseminated and community engagement activities are being implemented and supported at national and intermediate levels | **80** | | | |
| **C.11 Points of entry (PoEs) and border health** | **46.7** | C.11.1 Core capacity requirements at all times for PoEs (airports, ports and ground crossings) | Some designated PoE are implementing routine core capacities based on a completed associated strategic risk assessment | **40** | | | |
| | | C.11.2 Public health response at points of entry | All designated PoE have developed PoE public health emergency contingency plans for events caused by biological hazards and integrated into national emergency response plans | **60** | | | |
| | | C.11.3 Risk-based approach to international travel-related measures | National multisectoral process with mechanisms to determine the adoption of international travel-related measures, on a risk-based manner, is developed including guidelines and SOPs for their implementation | **40** | RMI Ports Authority has developed guidelines and SOPs for implementation. | Ongoing | 2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>7. Leadership and Governance |

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|---|---|---|---|---|---|---|---|
| **C.12 Zoonotic diseases** | **40** | C.12.1 One Health collaborative efforts across sectors on activities to address zoonoses | The animal, human and environment health sectors have jointly mapped existing and areas of collaboration and agreed on prioritized zoonoses for coordinated prevention and control activities | **40** | here is no formal multi-sectoral policy or national multi-sectoral coordination committee for zoonotic diseases and no exercises on responding to zoonotic diseases conducted in the past two years. The priority list of zoonotic diseases – leptospirosis, scrub typhus, African swine fever, influenza A (H1N1 or H3N1), salmonellosis,toxoplasmosis, ciguatera or scombroid and rabies – was developed through consultation with the MOHHS national epidemiologist, other Public Health staff and the lead veterinarian of the Taiwan Mission. There are control policies for swine flu, avian influenza, rabies, leptospirosis and brucellosis which focus on reducing their spread into the human populations. These control policies are implemented by the NRC and include border and pre-border inspection, inter-island surveillance, reporting and monitoring of imported animals and products. The current operational mechanism for the detection and response to outbreaks of zoonotic diseases by human, animal and wildlife sectors requires improvement. This strengthening includes human resources training ; developing infrastructure at the national laboratory to test for zoonotic diseases; developing collaboration and coordination mechanisms for surveillance activities; improving the sharing of epidemiological information between the human and animal health sectors; increasing awareness of zoonotic diseases within the human and animal sectors; and developing strong preparedness and response plans for prioritized zoonotic diseases. | Planned<br>Ongoing<br>Challenges/gaps<br>Strength/best practice | 1. Financing<br>2. Guidelines and SOPs<br>3. Coordination and Collaboration Mechanisms<br>4. Policy<br>5. Infrastructure and logistics<br>6. Workforce<br>7. Leadership and Governance<br>8. Assessments<br>10. Risk Communication |
| **C.13 Food safety** | **60** | C.13.1 Multisectoral collaboration mechanism for food safety events | A multisectoral collaboration mechanism and communication channels that includes the INFOSAN Emergency Contact Point is in place at the national, intermediate and local levels, if appropriate, to the structure and governance of the country. | **60** | The Food Regulations (2014), guidelines and procedures for food inspection, have not been endorsed. Management of food safety issues and inspections are not risk-based according to Codex guidelines. Members of the Food and Drug Safety Taskforce and those involved in outbreak response are not trained in the correct procedures for food sample collection, storage, transport and shipment for laboratory analysis. The food safety programme does not include many of the outer islands. | Planned<br>Ongoing<br>Achieved<br>Challenges/gaps<br>Strength/best practice | 3. Coordination and Collaboration Mechanisms<br>6. Workforce<br>8. Assessments<br>9. Health information systems<br>10. Risk Communication |
| **C.14 Chemical events** | **60** | C.14.1 Resources for detection and alert | A poisons information service or equivalent national service that performs surveillance for chemical exposures, and for communication of alerts is in place on a 24/7 basis | **60** | RMI needs to work on the following areas:Recommendations for priority actions<br>• Develop procedures for risk assessment, monitoring and response to chemical emergencies to complement existing all-hazard emergency preparedness and response plans.<br>• Ensure access to guidelines and protocols, and provide training opportunities for relevant personnel, for diagnosis and case management of chemical events, intoxication and poisoning.<br>• Establish a focal point for accessing and providing poison information. | | |

**Useful contacts and further information**

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **C.15 Radiation emergencies** | **20** | C.15.1 Capacity and resources | Surveillance mechanisms and resources for radiation emergencies are under development. | **20** | RMI needs to work on this capacity:<br>• Establish the national legal and regulatory framework for radiation protection and safety for all exposure situations and consider endorsing the international emergency conventions on early notification and assistance in case of nuclear or radiological emergencies.<br>• Develop capabilities for the detection, assessment, and response to radiation emergencies to complement existing all-hazard emergency preparedness and response plans.<br>• Establish a mechanism for accessing international technical assistance, information and expertise for radiation emergencies. | | |

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# National Profile 2023
# Marshall Islands


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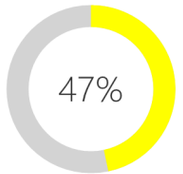
## Designated Points of Entry

| | Average number of designated PoEs | Total of all types of Points of Entry | Airports | Ports | Ground Crossings |
|---|---|---|---|---|---|
| **Marshall Islands** | | **5** | 2 | 3 | 0 |
| **WPRO** | **20** | **516** | 144 | 270 | 102 |
| **Global** | **12** | **2291** | 733 | 847 | 711 |

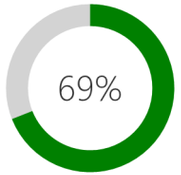
## PoEs Specific Capacities Details

| | PoEs with competent authorities identified | PoEs with Programme for vector surveillance and control | PoEs with public health emergency contingency plan | Number of States Parties reporting authorized ports to issue ship sanitation certificates (SSC) |
|---|---|---|---|---|
| **Marshall Islands** | 40% | 40% | 100% | 100% |
| | **2** | **2** | **5** | **1** |
| **WPRO** | 98% | 92% | 90% | 85% |
| | **507** | **474** | **464** | **22** |
| **Global** | 95% | 78% | 80% | 75% |
| | **2186** | **1793** | **1828** | **145** |

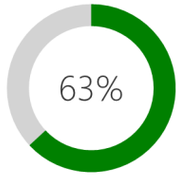
## Capacity 11 Points of Entry Score Average




Marshall Islands




WPRO




Global Average

## Score per indicator (%)

| Indicators | Marshall Islands | WPRO | Global |
|---|---|---|---|
| C.11.1 Core capacity requirements at all times for PoEs (airports, ports and ground crossings) | **40** | **70** | **63** |
| C.11.2 Public health response at points of entry | **60** | **66** | **60** |
| C.11.3 Risk-based approach to international travel-related measures | **40** | **71** | **66** |

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## PoE Details

| **Airports**<br>Name of Point of Entry | IATA Airport Code | ICAO Airport Code | United Nations Code for Trade and Transport Locations (UNLOCODE) | PoEs with competent authorities identified | PoEs with Programme for vector surveillance and control | PoEs with public health emergency contingency plan | States Parties reporting SSC authorized ports |
|---|---|---|---|---|---|---|---|
| Amata Kabua International Airport | | | MH MAJ | Yes | Yes | Yes | Yes |
| Kwajalein Airport | | | MH EBY | Yes | Yes | Yes | Yes |

| **Ports**<br>Name of Point of Entry | Code 1 | Code 2 | United Nations Code for Trade and Transport Locations (UNLOCODE) | PoEs with competent authorities identified | PoEs with Programme for vector surveillance and control | PoEs with public health emergency contingency plan | States Parties reporting SSC authorized ports |
|---|---|---|---|---|---|---|---|
| ULIGA DOCK | | | MH MAJ | No | No | Yes | Yes |
| DELAP DOCK | | | MH MAJ | No | No | Yes | Yes |
| EBEYE DOCK | | | MH QEE | No | No | Yes | Yes |

| **Ground Crossings**<br>Name of Point of Entry | Code 1 | Code 2 | United Nations Code for Trade and Transport Locations (UNLOCODE) | PoEs with competent authorities identified | PoEs with Programme for vector surveillance and control | PoEs with public health emergency contingency plan | States Parties reporting SSC authorized ports |
|---|---|---|---|---|---|---|---|

**194 out of 196 (98%) of States Parties submitted the SPAR 2023 to WHO**