

patients is rendered accessible through the registry. The recent quality assessment demonstrated the good quality of data found in the registry, making iTraumaTM a valuable and reliable method for characterizing trauma across the world.

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Ready or Not? Service Readiness of Health Facilities in High-Mortality Countries

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Background: Health systems in lower income countries face substantial challenges in meeting population health needs, including a growing burden of non-communicable disease. Existing research suggests that health facilities may be poorly equipped to provide high-quality care, yet systematic assessment of health facility readiness has been limited to date. We define and compare service readiness in nine high-mortality countries.

Methods: We used all Service Provision Assessments conducted in the past decade to provide nationally representative assessments of health systems in nine countries: Bangladesh, Haiti, Kenya, Malawi, Namibia, Rwanda, Senegal, Tanzania, and Uganda. We calculated the service readiness index (SRI) for each health facility following the 2014 World Health Organization guidelines, which define 50 readiness indicators in five domains: basic infrastructure, basic equipment, infection prevention, diagnostics, medication. We compared SRI within hospitals and non-hospitals (health centers) in each country and assessed whether readiness differed by facility ownership or location. We used linear regression to test the explanatory power of national characteristics such as total health expenditure per capita.

Findings: 7,480 facilities were surveyed, including 548 (7%) hospitals. Average service readiness was low, with hospitals scoring 76% and non-hospitals only 52%. Basic equipment was the most likely domain to be completely present and essential medications the least (25% of facilities with all equipment vs. 0.7% with all medications). Among non-hospitals, private facilities and those in urban areas scored higher on service readiness across most countries; these differences were weaker and less consistent among hospitals. Health expenditure per capita was associated with greater facility service readiness, but over 60% of variation in SRI was not explained in any model.

Interpretation: Health facilities in high-mortality settings are insufficiently equipped to address population health needs, particularly public clinics in rural areas. Hospitals are better and more uniformly equipped in most countries, though critical deficiencies persist. While higher spending on health per capita was associated with greater readiness, much of the variability in health facility readiness remains unexplained. Further research on efficient conversion of health spending into readiness and, ultimately, population health, is required to strengthen health systems for the many challenges of the Sustainable Development Goal era.

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Redefining the role of Army Medicine in Global Health: Transformation in the Indo-Asia Pacific

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Program/Project Purpose: The recent US Army medical transformation aligns medical capabilities with Regional Combatant Commands to further enhance delivery of medical services to the warfighter and beneficiary population. Regional Health Command - Pacific (RHC-P) is one of four regional Army Medicine Commands and is aligned to directly support US Army Pacific and US Pacific Commands. This area of operation includes 36 countries, 17 percent of the earth's landmass, and 60 percent of the earth's population. Based out of Honolulu, HI with nine direct reporting units (e.g. Tripler Army Medical Center, Public Health Command - Pacific, Medical Centers Japan and Korea), approximately 11,000 employees, and an operating budget over \$1.2 billion USD in support of over 229,000 beneficiaries, RHC-P developed an innovative health engagement strategy to assist partner nations in developing capability, increasing capacity, and enhancing interoperability while generating US Army military medical readiness.

Structure/Method/Design: The strategy is the first of its kind and in direct support of the US Army Medical Command 2017 Campaign Support Plan; synchronized with US Army Pacific Command, US Pacific Command, and other US Government strategies; and is informed by host nation priorities and requirements. Implementation occurs across three lines of effort and ten primary functional areas based on doctrine and includes Army Health System Support, Health Service Support, and Force Health Protection. The functional areas include casualty care (e.g. medical treatment, dental, behavioral health), combat stress control, laboratory services, medical evacuation, medical logistics, preventive medicine, and veterinary services among others.

Outcome & Evaluation: RHC-P leverages the Army medical enterprise in the Pacific across these health lines of effort through myriad military-to-military and military-to-civilian health engagements to enhance the host nation capability and capacity, achieve DoD security objectives, and increase the readiness of the military medical community to operate in all phases of operations.

Going Forward: Early successes have been achieved and are being measured by the Uniformed Services University Center for Global Health Engagement; however, changes to existing DoD medical structures and funding authorities could further empower DoD in supporting the National Security Strategy through global health engagements.

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Training Health Workers to Provide Cervical Cancer Screening: Comparison of Educational Strategies in Liberia, South Africa and Grenada

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