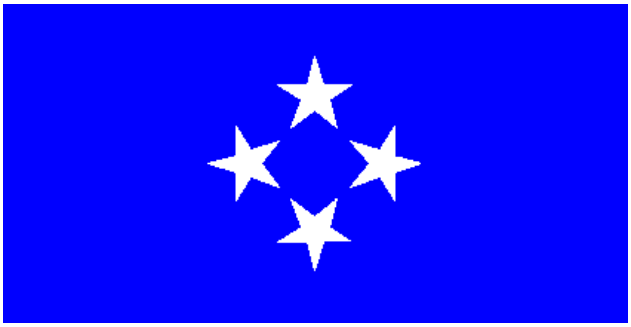
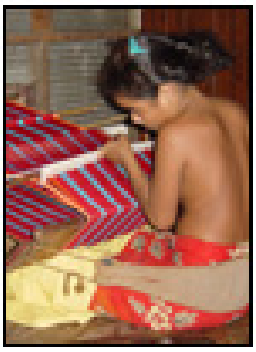
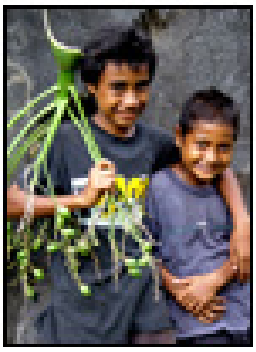
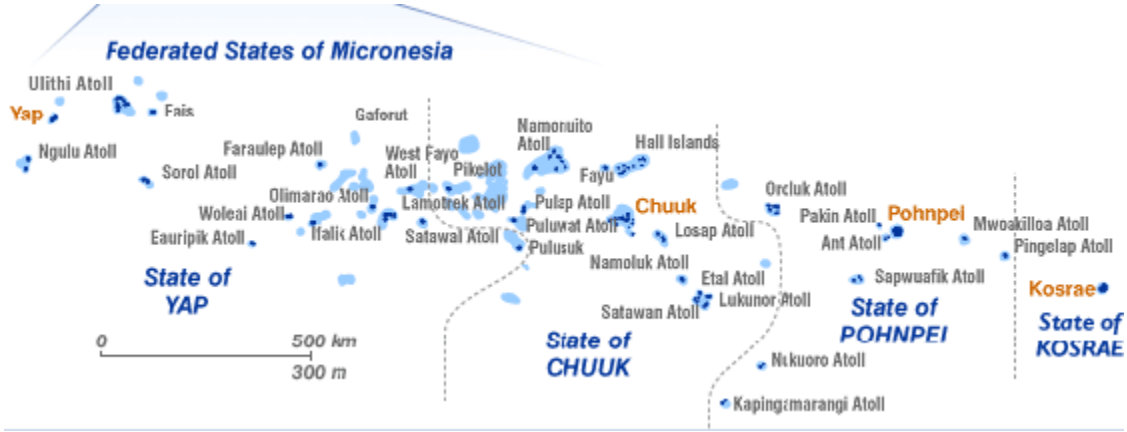






FSM

National Comprehensive Cancer Control Plan



Comprehensive Cancer Control Plan

for the

National Comprehensive Cancer Control Program, Department of Health and Social Affairs

2007-2012

TABLE OF CONTENTS

Dedication:

Dedicated to the interim National Cancer Coalition members and individuals who were volunteered their times and have make the comprehensive cancer control plan development forward. May all the challenges, pain and suffering return as skills and knowledge, so that all the people of FSM can be cancer free.

Acknowledgements:

To honor the waterways that are so important to FSM life, the proposed FSM logo shows the five stars (four FSM states and National) join together on the National CCC mission: to work collaboratively with health professionals, different areas of government and the community to improve cancer-related prevention and care for the citizens of the Federated State of Micronesia.

The National Cancer Coalition (NCC) would like to acknowledge the exemplary and the excellent guidance, support, and inspiring leadership from the University of Hawaii, John A. Burns School of Medicine, Department of Family Medicine and Community Health advisors, under the leadership of Dr. Neal Palafox, MD, Dr. Vanessa Wong MD, and most especially Dr. Lee Ellen Buenconsejo-Lum, MD, who has helped guide us through much of the development of our CCCP and Implementation Plan.

The FSM Comprehensive Cancer Control initiative would not be possible without the benevolent financial support from the US National Cancer Institute, the US National Institutes of Health, the US Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, the US National CCC Partners and other non-governmental organizations. We have experienced many challenges and have learned from them through your leadership and support. Additionally, a big thank you goes to Mr. Tom Kean and Ms. Karin Hohman of Strategic Health Concepts and Ms. Erika Strong who also came to visit our country and guided us in the early stages. This CCCP development and accomplishment is historic for the FSM and the Pacific Region, because it truly represents the first time we are collaborating and planning across so many sectors. We will keep all of you in our hearts and ensure that this CCC program and efforts remain alive and strong.

Special thanks to:

All of you who have put so many efforts and time into the National Comprehensive Cancer Control Plan (NCCC), especially an individual, who is my wife (Jane Elymore) who first represented us at the first CCCLI in March 2005 and put together a budget for the National Government to be part of the regional initiative, the planning working groups, that recently call themselves action group, the chairman and vice-chairman of the NCC whose energy, interest and dedication to the vision became the foundation for this plan.

The development of the NCCC plan was facilitated by the staff of the University of Hawaii, School of Family Medicine and Community Health under the leadership of Dr. Neal Palafox and special thanks to Dr. Vanessa Wong and Dr. Lee Ellen Buenconsejo-Lum for their excellent guidance, support and technical assistance throughout the process directly and indirectly from distance. The writer would also like to give thanks to Mr. Tom Kean, Ms. Karin Hohman, and Ms. Erika Strong for their consultation and support during the process of the planning.

We would like to acknowledge the support provided by the Center for Disease Control and Prevention (1U58DP000779-01).

Last but not least, the FSM comprehensive cancer control initiative would not be possible without the benevolent financial support from the US National Caner Institute, the US National Institute of Health, the US Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, the US National Partners and other non-governmental organizations.

EXECUTIVE SUMMARY

Cancer is the fourth leading causes of death for the people of the Federates State of Micronesia (FSM), and rank varies among the 4 FSM States (Chuuk, Kosrae, Pohnpei and Yap). 10.1% of deaths are attributable to cancer and more than 90% of all cancer cases (estimated as 500 deaths annually) are diagnosed at late stages. The most frequent cancer types are lungs, cervix and uterus, liver, breast, prostate, oropharynex (mouth), brain, and hemopoietic /leukemia. It is almost the same throughout the FSM States, except Kosrae have less lung cancers and the National Cancer Coalition agreed on their observation that this may have to due with to exposure to the risk factors (tobacco smoking, chewing, and others).

Cancer creates a physical, psychological, social and economic burden on individuals, families, and communities. This burden can be dramatically reduced as advances in prevention, early detection; diagnosis, treatment, survivorship, and palliative care are made available to the people of FSM. Recognizing this needs, the FSM have joined the UH, forward on the Regional initiative with funding support from NCI and National Partners. The assessment was completed and the planning process began thereafter to address the cancer care needs of FSM and the Pacific through a comprehensive approach.

A comprehensive approach to cancer planning was undertaken with the following guiding principles:

- **Development of goals, objectives, and strategies was data driven** (based on mortality data -death registry).

- **FOCUS:** The focus of the National Comprehensive Cancer Control plan (because of the specific role of the national government in relation to the states) is on legislation, policy, standards, protocols, training and technical assistance.

- **Overarching and Cross-cutting Strategies** are: 1) To promote and advocate community and political support in partnership with health providers to combat cancer in the FSM, and (2) To engage technical assistance at all levels that assures efficacy in the prevention, control, identification, care and treatment of cancer and cancer related disease.

- **FSM STATES:** The States (Chuuk, Kosrae, Pohnpei and Yap) are directly responsible for the provision of health services to their population, so state-specific strategies to address prevention, early detection, treatment, quality of life, disparities and improving data quality can be found in the individual State Comprehensive Cancer Control plans.

- The working groups included representatives from multisectoral of the government, non-government, private businesses, health providers, college, multilateral and bilateral agencies to coordinate and integrate supportive resources.

- The planning process was multidisciplinary with representative from administration, national bank, epidemiology, health education, program services, surveillance, clinical services, church, and cancer survivors.

The comprehensive cancer plan addresses the burden of cancer in FSM and proposed goals, objectives and strategies to help reduce the cancer burden.

The plan will be reviewed annually to determine if the goals, objectives and strategies remain relevant and updates made as needed. Work plans to implement that goals will be developed and resources identified to help move the plan forward. It will also serve a resource for community, state, national, bilateral, multilateral and regional partners and organizations who wish to focus on their own specific cancer issues with grants and other support.

The challenges faced in delivering comprehensive cancer care to FSM people are documented; vast geographic distances, subsistence lifestyles, cultural differences, transportation challenges, medical disparities, language barriers, limited resources, and a widely dispersed and variable health care delivery system, and poor infrastructures are all factors that taken into consideration in developing the National and State cancer plan.

76 % of the FSM live in the intermediate and outer islands, mostly access by boat and field trip ship.

While all cancers and all cancer care components are important, four specific areas are identified in the plan as high priorities. These are tobacco, cervix and breast, colorectal cancer screening, patient navigation, and palliative care. State and National cancer planners have agreed and lay out their roles and responsibilities.

Some cancers can be prevented. For many cancers, it is not easy to identify the cause, but when a cause can be identified, steps can be taken to prevent the disease. Avoiding tobacco, eating a healthy diet, being physically active, maintaining a healthy weight, avoiding exposure to certain chemicals and STI has been shown to prevent some cancers.

Some cancers can be detected early. Screening tests are done on people who have no signs or symptoms of cancer. Screening can detect some cancers when they have just begun to grow. Pap tests, mammograms, and colorectal exams are examples of cancer screening tests. Unfortunately, they are no proven and effective screening tests for most kinds of cancer. The earlier cancer is diagnosed, the more likely it can be treated and cured. Many cancer screenings cannot be done in the intermediate and outer islands and remote communities within the island proper. You travel 10-500 of miles to be screened for some common cancers. Cost of travel and are mainly by boats and ships on ocean and water with bad weather to receive the test and any follow up care needed may exceed the costs to conduct the test itself.

Our vision is that FSM citizen's access to comprehensive cancer services including preventative information, early detection and screening, treatment and care and that all the risk factors are identified and collaboratively address within the national, state and regional plans. Within the

National Comprehensive Cancer Control plan, see the goals, objectives and strategies to make that vision a reality.

VISION:

A CANCER FREE FSM

MISSION:

Work collaboratively with State Coalitions, health professionals, different areas of government and the community to improve cancer-related prevention and care for the citizens of the Federated States of Micronesia

FOCUS

The FSM National CCC plan focuses on legislation, policy, standards, training and technical assistance within the context of cancer prevention, early detection, treatment, quality of life and data quality. The individual FSM State CCC plans include state-specific strategies to address prevention, early detection, treatment and quality of life, disparities and improving data quality.

FORWARD

Cancer and other non-communicable diseases such as heart disease, diabetes, and lung disease related to smoking are the leading causes of death in the Federated States of Micronesia. Unlike some other diseases, we can actually control many of the risk-factors for these diseases and for certain types of cancer. In other words, we have the power to stop some cancers from happening. Certain types of cancers can be detected early and cured if caught early enough and treated correctly.

In January 2006, the Department of Health, Education and Social Affairs for the first time convened a National Health Policy Symposium. During the symposium, we learned what types of things can lead to cancer and the other leading causes of suffering in the FSM. We also learned about the many challenges facing our hospitals, public health departments and health care teams, including the lack of reliable information about how big a problem cancer is in the FSM. We also learned that cancer often presents in late stages – often too late to receive life-saving treatment – which means that people in the FSM are dying from some cancers that could have been prevented or treated if they were detected early.

In order for the people of the FSM to become free from cancer, the National and State Health Departments must work together, with other areas of the government and with the larger community and other partners to:

- educate the public about cancer;
- reduce risk-factors for developing cancer;
- develop ways to assure that certain cancers can be detected early;
- treat those cancers as best we can within our resources;
- ensure that cancer patients and their families receive information and support; and
- improve the quality of cancer-related information that will be used to guide programs and services relating to cancer.

Over the last 3-4 years, comprehensive cancer control coalitions and partnerships in each of the four States and at the National level have brought together hundreds of people from around our islands. Each State has developed their own plan to address cancer in their State. Additionally, this National CCC plan has been created to address some of the issues that affect all four States and that require us all working closely together to improve cancer-related care. This Plan contains strategies to educate the public, policy-makers and health professionals about cancer and the risk of developing cancer. Additionally, the Plan calls for actions to improve our ability to diagnose some cancers early. Improving our ability to treat certain cancers early and on-island is also a very important part of this Plan. Another major focus is on working with the States to improve health information that will allow all of us to develop more effective cancer prevention, detection and treatment programs.

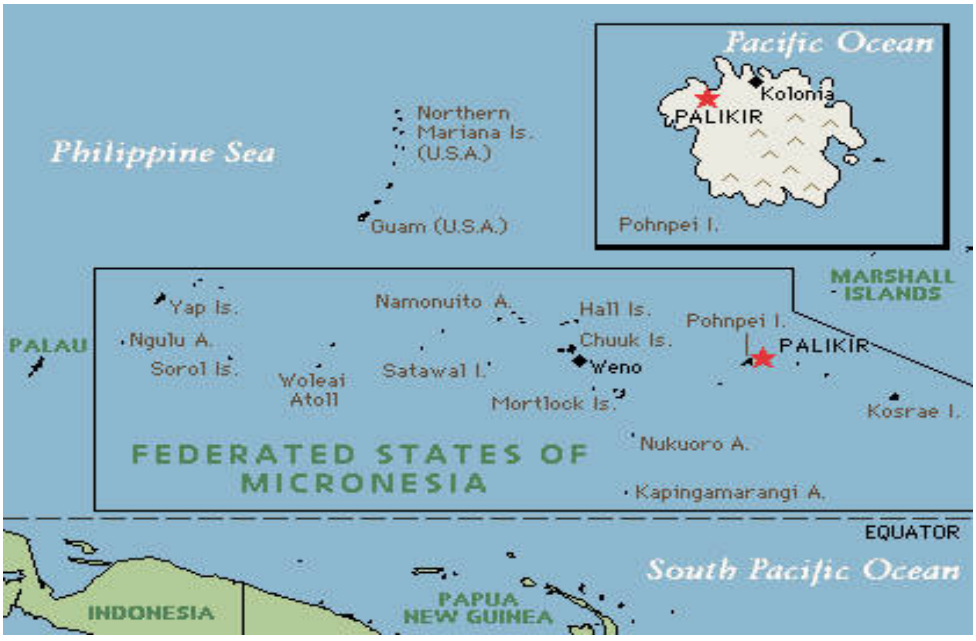
The plan is a living document, and one that will change and evolve over time. It is also a plan that honors our ability to make progress that can and should give us hope for the future. By working together, we can truly ensure a healthier FSM.

Manny Mori
President

BACKGROUND AND DESCRIPTION of the FSM

Geography and Transportation

The Federated States of Micronesia (FSM) is a democratic, constitutional federation in Free Association with the United States since 1986. From 1947-1986, the FSM was a Trust Territory of the Pacific, along with what is now the Republic of the Marshall Islands, Commonwealth of the Northern Marianas Islands. FSM consists of four States, namely, Kosrae, Pohnpei, Chuuk and Yap. 65 of 607 islands are inhabited. Kosrae is the easternmost State of the Federation with 43.2 square miles of land and no lagoons. The land area of Pohnpei State is 133.4 square miles inclusive of five outer islands. In addition to Pohnpei State's land area, it also has 297.2 square miles of lagoon area. Chuuk State consists of six (6) major island groups. The largest group is Chuuk Proper which is a complex of islands. It includes 98 islands of which 14 are mountainous islands of volcanic origin, surrounded by a coral ring forming a lagoon of over 800 square miles. Outer islands are 24 in number and are mostly low islands or coral atolls. The total Chuuk State land area is 49.2 square miles. Some of the Chuuk outer islands are over 200 miles away from Weno. Yap is the westernmost state and has a total land area of 45.9 square miles which includes 15 outer islands. In addition to the Yap State land area, there are 405.2 square miles of lagoon area. Satawal is over 600 miles away from Yap Proper. The capital of the FSM is located in Palikir, Pohnpei. The national boundaries of the FSM stretch over 1,700 miles from Yap in the east to Kosrae in the west, covering over 1 million square miles of ocean. This is nearly the size of the continental United States.



The large expanses of ocean separating the small islands and people results in isolation, infrequent communication and interaction, especially in Chuuk and Yap. Disparity varies among the FSM states, the island communities, and from village to village, due to the geographical structures of these islands. In many areas the island may be small. A health dispensary or school may be only a mile away on the map, but inaccessible by foot or road because of a mountain. In

order to reach the school or dispensary, one must travel 2-3 miles around a reef on a boat and go around a few more miles to reach these dispensaries/schools. During bad weather it is even more difficult within such islands. This is particularly problematic for health care delivery. Continental Airlines provides air services between the state centers 3-4 times a week, with round trip tickets costing over US$ 300.00. The FSM also has Caroline Island Airlines (two smaller airplanes seating 5-7 passengers) which belongs to the FSM, flying within and between Pohnpei and Chuuk. Caroline Islands Airline is servicing the outer-islands with airstrips in Chuuk and Pohnpei (3 outer islands in Chuuk, 3 outer islands in Pohnpei) while the Pacific Missionary Aviation is servicing Yap proper (also 3 outer islands in Yap which have airstrips). The flight schedules are not routine. With the rise in fuel costs, the cost of transportation also has gone up and has made it difficult for people to travel by air. Government field trips from the Trust Territory times which used to serve as transportation and cargo for the outer islands no longer work. In the past 10 years, some cargo ships have been donated to the government by foreign countries and are used to transport cargo and people between the main state centers. Lack of funding for maintenance of these ships is particularly problematic in Chuuk. There is no public transportation in any of the states. Travel from the outer or intermediate islands to the state centers (where the hospitals and main public health clinics are located) is usually by small motorboats or fishing boats over ocean. Some of the boats serve as unsafe "taxis" with 10-15 people standing in the boat. Public health and educational outreach teams have to coordinate their trips together and go on smaller supply ships. Most people cannot afford the airfare; some do not have relatives in the State center or are afraid to travel by small boat over 100+ miles of open ocean and so they do not seek secondary health care and die at home.

Demographics and Economics

The FSM has a population of 107,008, with 76% living in rural communities that require transportation by small motor boat to the state centers. Chuuk State is the most populous. Over half of the FSM population is less than 20 years old. Economic hardship, dependency on US aid, difficult access to health care and other factors contribute to an infant mortality almost five times higher than the US and a life expectancy 8 years lower. Basic health issues like sanitation and a safe water supply are not available to over 80% of the rural populations. There is no electricity or phone in many of the outer islands of Chuuk and Yap. The median household income in the FSM is ten times lower than that of the US. Minimum wage ranges from $0.80 to $1.28 per hour. Gas costs over $3.80 per gallon in all areas. Table 1 contains selected demographic, economic and health indicators among the 4 FSM States, in comparison to the US indicators. All of these factors pose significant issues for health care and comprehensive cancer control.

Table 1. Selected demographic, health and economic indicators

	Chuuk	**Kosrae**	**Pohnpei**	**Yap**	**FSM**	**U.S.**
Total Population	53,595	7,686	34,486	11,241	107,008	
Youth as % of total population					55% 0-19 yrs 33% 0-9 yrs	
Living in state centers	No public transportation				23%	
Living in intermediate islands/areas	Access to state centers by small boat or 4-wheel drive vehicle				54%	
Living in outer islands	Access to state centers by small boats because larger (safer) ships do not run consistently				22%	

	Chuuk	Kosrae	Pohnpei	Yap	FSM	U.S.
Infant mortality					29.16/1000*	6.43/1000
Life expectancy					70.05 yrs	77.85 yrs
GDP per capita	$1,246	$2,336	$2,845	$3,076	$2,032	$43,500*
Health care expenditures, per capita	$80 (1999)	$169 (2001)	$117 (2001)	$125 (2001)	$147 ^	$5,711^
Medical referral costs % of total health budget[1]	35%	9%	12%	15%	14%	
Total expenditure on health as % of GDP					7.6% ^	15.2% (2003)
Population below poverty					26.7%	12%*
1998 avg annual household income	$9,819	$15,100	$11,783	$13,075	$11,240	$46,326 (median 2005)
2000 Median wages	$3,446	$6,346	$5,521	$3,665	$4,618 (Median household income)	
% popn with access to sanitation					59.3% urban 15.6% rural	
% households with electricity - rural	9.6%	100%	33.7%	54.4%	30.4%	
% Adults >25 yrs high school graduate or higher					31.7%	84%

Data is from the FSM Census 2000, FSM Statistics Division, unless otherwise noted
^ from 2006 WHO WPRO Statistical Tables
*from the World Factbook, 2006 estimates
U.S. Data is from the CIA World Factbook, accessed 3-10-07, unless otherwise noted
https://www.cia.gov/cia/publications/factbook/geos/us.html

Ethnicity and Culture

The people of the FSM are classified as Micronesians, with their origins probably coming from Southeast Asia and Malaysia. Inhabitants of Kapingamarangi and Nukuoro in Pohnpei have a Polynesian origin. The FSM has established ethnic classifications in order to better track and identify disparate issues: Yapese (island proper only), Kosraean (all Kosreans), Chuukese (Chuuk island proper-all lagoon islands), Pohnpeian (island proper only), Ulithians (group of island closer to Yap), Oleaeian (group of islands mid-way between Yap and Chuuk), Satawalese (Satawal, Lamoterk, Elato island group), Mortlockese (all Mortlockese in Mortlocks, Chuuk, Pohnpei and anywhere) as are Mwoakillese, Pinglapese, Nukuororan, as well as Asian, Caucasians, Filipino, and other Pacific islanders. Health disparities have been identified – especially in Pinglapese and Mortlockese. Language and cultural beliefs differ among the groups. The **diversity** is typified by the existence of nine major indigenous languages or dialects - Kosraean in Kosrae; Pohnpeian, Kapingamarangi and Nukuoran in Pohnpei; Chuukese in Chuuk; and Yapese, Ulithian, Woleaian, Satowalese in Yap. English, however, is the official language of the governments and is taught in the schools. English is also spoken by most of the government leaders and is the official language which is used in entity-wide negotiations, government activities and documents. Additionally, many older people are familiar with the Japanese language due to the Japanese administration era from 1914 through World War II. The

culture of the FSM is predominantly Micronesian, but there is evidence of a Polynesian influence, particularly in some islands of the State of Pohnpei. Past contact with Europeans and Japanese is also apparent in the culture of FSM. A core feature of the culture and society in the FSM is a strong emphasis upon the extended family and clan group. Clear differences are also apparent in the culture and traditions of each of the four States which have been fostered by the large expanses of water that separates each of these. Pohnpei, where the national government is based, has emerged as the most westernized State in the FSM. Yap, on the other hand, has the most traditional culture in the FSM, which is characterized by a strong caste system. In Kosrae the Congregational Church plays a central role in everyday life while in Chuuk, clan relationship remains an important factor with extended family ties. **Religion** is predominantly Christian, with the Roman Catholic and Congregational churches (Protestant) having the largest memberships. Other Christian denominations and religious groups include the Apostolic, Latter-Day Saints, Seven-Day Adventist, Assembly of God, Jehovah's Witnesses, First Christian and the Baha'i Faith. Working collaboratively with religious organizations plays a critical role in several of the State CCC plans. **Magic** or superstition also affects health care in the FSM. Often times, when there is no clear diagnosis made on patients' illnesses, many families believe that the illness was from magic or someone putting a spell on the ill person. In Chuuk, there remains strong belief in many types of ghosts that affect every aspect of life. These beliefs often times have contributed to delays in treatment because the patient or their family requests the doctor to allow them to go home for local or **traditional medicine**. Additionally, many Micronesians accept things as they are, do not question the doctors and are not aggressive in their medical care (compared to the typical mainland US citizen). Language, culture, religion, traditional leadership and traditional medicine all factor into the various comprehensive cancer control objectives and strategies developed in the individual state CCC plans.

Communication

The FSM Telecommunication Corporation is a public corporation established on October 16, 1990. FSM Telecommunication Corporation is the sole service provider of all communication encompassing land line phone and Cellular services as well as internet access. Telephone calls cost $ 1.00 per minute within the FSM and ranges from US$2.00 to $12.00 elsewhere. Customers have connectivity options from dial-up to DSL, but the rates are more than triple what is now commonly seen in the U.S. or even in Guam. FSMTelcom is planning to provide cellular services and internet access to the outer islands in the near future, however no electricity exists in many of the outer islands.

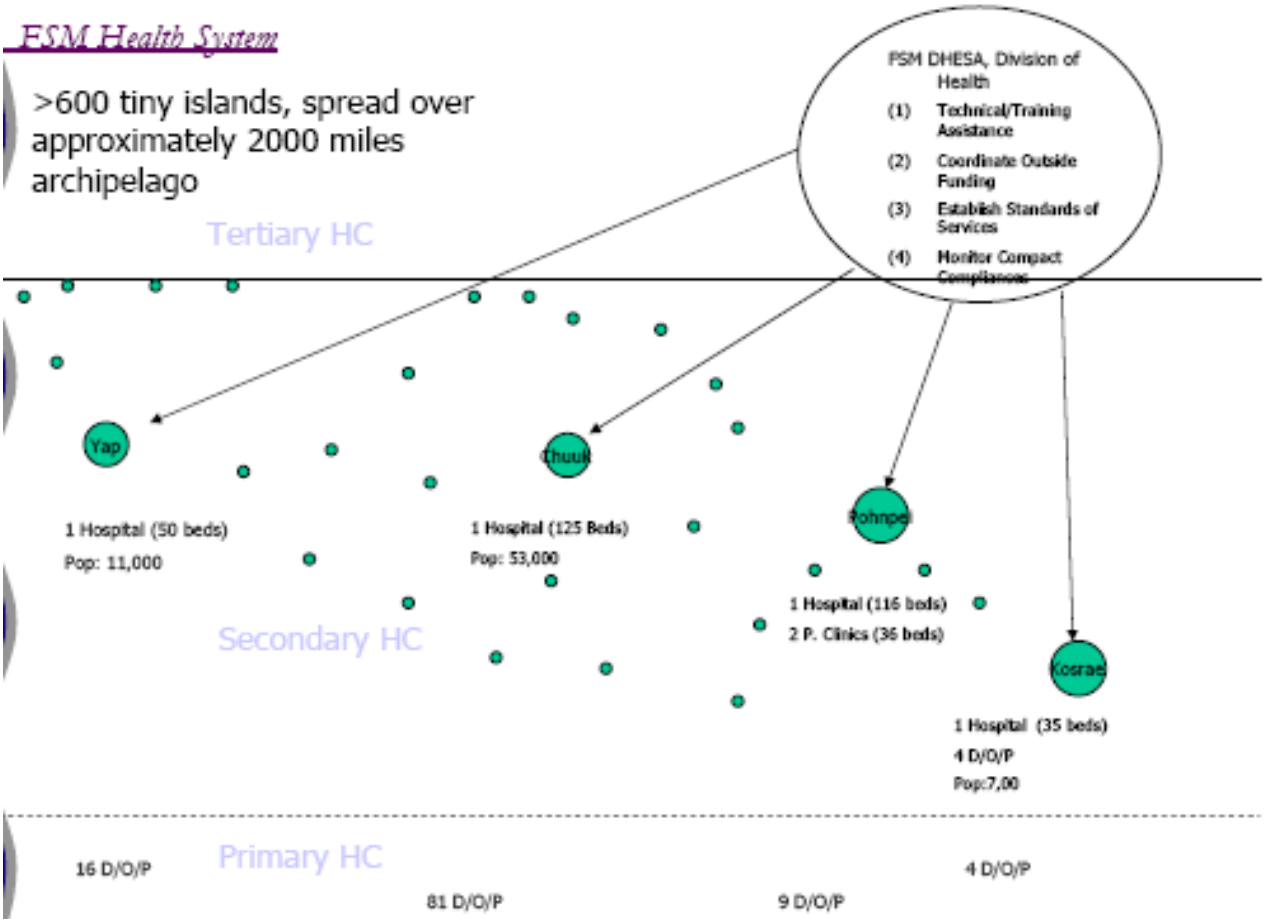
VHF and SSB radios are utilized widely within the state centers and the intermediate islands and in the outer islands. Only the SSB radios can be used to communicate to and between the outer island communities and the State centers. More recently, solar powered radio and email has been established in Yap and is now being established in Chuuk, starting in the local schools.

The four FSM hospitals currently have internet access via a DSL connection at the speed of 64 kpbs. By 2007, the Department of Health, Education and Social Affairs at the National level will be able to connect directly to each of the FSM hospitals, and be able to access information and standardized reporting from hospital inpatients, outpatients, and public health programs at the State level.

Health Care System in FSM

Health care in the FSM is divided into Primary Health Care and Secondary Health Care. The concept of primary health care was defined by the World Health Organization in 1978 as both a level of health service delivery and an approach to health care practice. Primary care should provide both the initial and the majority of health care services of a person or population. This is in contrast to secondary health care, which is consultative, short term, and disease oriented for the purpose of assisting the primary care practitioner. Tertiary care is for patients with unusual illness requiring highly specialized services. In the FSM, primary care is largely provided by health assistants, secondary care by physicians and nurse midwives. Patients must seek care outside of the country for tertiary care services.

Figure 1. FSM Health System[2]



At the national level, the Division of Health (DOH), Department of Health, Education and Social Affairs (HESA) has no direct role in the provision of health care services, but is limited to policy direction for the four states, health planning, and donor country coordination, technical and training assistance and monitoring compliance with the Compact of Free Association with the United States. In its coordination and technical assistance role, it has considerable influence on the provision of many preventive medicine and public health programs, which are funded in a

large part by the U.S. Department of Health and Human Services (DHHS) and coordinated and managed through the FSM-DOH. HESA also has an implied role in **quality assurance and health standards**. Another responsibility of the Department of HESA is to provide **technical assistance**, as may be required, to the four states in training in various fields such as nursing, medicine, sanitation, maternal and child health, mental health, program evaluation and monitoring, identifying and securing medical specialists, and disseminating information. The Department of HESA Division of Public Health Statistics receives, analyzes and disseminates **demographic and mortality data** that is collected by the States. HESA is deploying a standardized, computerized Health Information Management System (**HIMS**) that will allow real-time transfer of demographic, diagnosis and procedural data for outpatient, inpatient and public health encounters once it is fully implemented. The individual states maintain their own vital statistics and share the records with HESA.

The Secretary of HESA is a cabinet-level official with the constitutional responsibility to protect and promote the health affairs of the Nation. HESA is indirectly responsible for the administration and direction of health care services at the State level, and for reviewing, updating, and developing uniform health policies and regulations for and in conjunction with the four States of Yap, Chuuk, Pohnpei and Kosrae. The Secretary, as a Board member of the Pacific Island Health Officers Association (PIHOA), is also charged with coordinating the implementation of regional strategies that may arise. **As such, most goals of the FSM National CCC plan directly support the Regional CCC plan and efforts to attain a set of minimum standards for cancer control throughout the U.S. Associated Pacific Island Nations (USAPIN). In doing so, the FSM National Plan also supports the individual State CCC Plans.**

Secondary Health Care

The Department of Health Services (DHS) in each state is responsible for running state curative, preventive and public health services, including the main hospital, peripheral health centers, and primary health care centers, generally called dispensaries or outposts. Most DHSs have minimal capabilities for planning and programming. There is a main hospital in each state and they are directly accessible only to residents of the "urban" (state) centers. For residents who live on the outer islands, access is difficult because of the lack of public transportation between the islands described above. Each State CCC plan describes their hospital and public health services in more detail. There is no pathologist, pharmacist or radiologist in the entire country. Some of the physicians have completed post-graduate specialty training in Fiji, New Zealand or Papua New Guinea. A few expatriate physicians from the Philippines, mainly, work in the different states. There are less than 50 physicians in the entire country and less than 300 nurses in both the hospital and public health setting. The graduate nurses have 2 year degrees; most are practical nurses or nursing assistants. The main public health clinics are in the State centers. With US funding, limited pap smears are performed, in addition to screening and treatment for sexually transmitted disease, HIV, TB, and diabetes. Other public health programs include family planning, immunizations, nutrition, tobacco control and maternal-child health (prenatal care clinics). For most of the public health programs, there is one nurse running the whole program for the State.

Primary Health Care

The health dispensaries or aid-posts (referenced as D/O/P at the bottom of Figure 1), are also operated by the State Departments of Health Services in remote villages and outer islands to provide basic primary care and acute care services for residents. The dispensaries are staffed by the health assistants (who were trained for 6-12 months at the central hospital- mainly to identify and treat signs and symptoms). These dispensaries or aid-post facilities are to provide treatment for common diseases, and to provide public health, sanitation and maternal child health care and to aid mobile public health, medical and dental services teams as they come from the central Health Department to the intermediate and outer islands periodically. Patients who cannot be treated in the outer islands are transferred to the state hospitals on the main island. However, funding, logistics and personnel problems have created sub-optimal services in most areas and even led to the closing down of several dispensaries.

To illustrate the hardship and health issues faced by the outer islanders and the disparity within and between the different FSM States, Rimansi has agreed to publish her story from 2004.

RIMANSI'S STORY

Rimansi was married at age 15 after her graduation from the 8th grade on Namoluk Island atoll which 130 miles away from Weno, Chuuk State center and 400 miles from Pohnpei. RImansi visited the Chuuk hospital in Weno several times over two years for complaints of feeling ill and pain in her lower abdomen. She was referred to public health to have a pap smear performed, but they were out of supplies at the time.

Visiting the hospital is not easy, since Rimansi is a 53-year old widow with 8 children and has to travel by boat to Weno. When she goes to Weno, she must stay with her uncle, often sharing space with 30-60 other relatives besides her uncle's own family of 9. Rimansi saw several medical officers there with different findings and medical opinions. The very last visit was attended by a female medical officer who discovered something abnormal in her uterus but advised her to return to Namoluk Island to wait until the growth was bigger and required surgery.

Customarily, illness unique to female organs or body parts are not discussed among relatives, especially male relatives or even with their brothers. Rimansi's brother works in health services and was very concerned. When no one would give him any information, he assumed that she had a 'women's problem'. When her brother was finally able to speak to Rimansi, she stated that she was not feeling well and did not want to return to the outer islands. Rimansi's brother spoke to the OB-Gyn in Pohnpei who agreed to see her and he purchased a plane ticket for Rimansi to come to Pohnpei in a few days.

The OBGyn specialist in Pohnpei re-examined Rimansi, performed an ultrasound and noted a growth eroding through the top of her uterus. He and the Surgeon at Pohnpei hospital performed a total hysterectomy the next day. A clinical diagnosis of uterine cancer was made in 2004. Rimansi is still alive in 2007 without any further treatment.

There is no chemotherapy or radiation therapy available, no access to clinical trials, no CT or other tests to follow-up and no tracking of her or any other patient with cancer.

Most Micronesians do not have relatives who are knowledgeable about cancer or who have the financial means to buy a plane ticket to another island or country for self-referred care.

CANCER BURDEN

One of the greatest challenges in the FSM is the lack of capacity to describe the cancer burden accurately or even to describe the burden of risk for developing cancer. The problems are systemic and include limited understanding by health workers of the importance of good data

collection systems, inadequately trained staff, severe staffing shortages and lack of tracking systems.

As a Freely Associated State (with the U.S.), the FSM is not eligible to participate in the U.S. Behavioral Risk Factor Surveillance Survey (BRFSS). A Youth Tobacco Survey was completed in several FSM States, but had to be re-done because of methodological problems that prevented accurate statistical analysis. The FSM has embarked on a WHO STEPwise Framework for Non-Communicable Disease (NCD) which includes conducting a household survey (STEP survey) to characterize risk factors for NCD (and cancer) and presence of obesity, diabetes and hypertension, lipid disorders. The survey will also provide information on behavior (tobacco use, alcohol use, fruit and vegetable consumption. That process has just started in the country and data will not be available until late 2007 at the earliest. There is no cancer registry, no CDC Breast and Cervical Cancer Early Detection Program. Despite lack of accurate, uniform data across jurisdictions, other economic, census, CDC and HRSA program reports show very high rates of tobacco use, alcohol, obesity and diabetes, high rates of sexually transmitted diseases (Chlamydia, gonorrhoea, syphilis) across the FSM. It should be noted that the STEPwise survey will likely be the primary source of baseline data on cancer-related risk factors throughout the FSM, since there is no BRFSS and currently available data at the hospital, state or health insurance levels are not uniformly obtained, coded, or reported.

In the FSM, the issues affecting good quality health information are magnified since there is no pathologist, no radiologist, no CT scanners, no mammogram, inadequate supplies for cervical cancer screening, no supplies or equipment for colorectal cancer screening and, only recently, PSA tests in Pohnpei. Specimens are sent off-island for diagnosis *if* there is money to pay for the analysis. The incoming results and off-island consultation reports usually make their way back to the ordering physician, but there is no central log, file or tracking system to ensure those results are returned. Each State has developed their own processes for recording cancer cases, but cases are often missed or listed as "suspected" because of the limited diagnostic capability. Because of economic constraints, patients that are very ill or late stage will not be sent for formal diagnostic workup. The FSM National government is responsible for clearing, analysing and reporting morbidity and mortality information from the States, but because of limitations throughout the system, the mortality data quality is poor and often incomplete.

Because of the above mentioned reasons, cancer, if diagnosed at all, presents itself at late stages, as illustrated in Rimansi's story. The only treatment available in the FSM is surgical and that capacity varies by State. The comparative burden of cancer in the FSM can only be described using mortality data from death certificates that are often incorrectly or incompletely coded. The inability to diagnose each cancer makes accurate incidence or prevalence rates currently unachievable. In 2002-03, with support from the National Cancer Institute under the leadership of Dr. Neal Palafox, the family medicine residents and faculty from the University of Hawaii Department of Family Medicine and Community Health, and Dr. Henry Ichiho conducted a cancer infrastructure needs assessment in each of the USAPIN jurisdictions. The assessment teams met with key leaders in the curative and preventive services to compile cancer-related data from death certificates, hospital records and off-island referral databases. In addition, the teams also asked health staff to assess the gaps in existing programs and services for cancer. After appropriate verification and clearances by the Directors of Health, the assessments were

published in a special issue of the *Pacific Health Dialog* on cancer in the Pacific[3]. These assessments form the basis of each FSM State's determination of priority cancers. A summary table of the six leading causes of cancer death, by site, for varied time periods is below. The reporting time period varies from state to state because the Assessment teams used the best available data at the time (in other words, data prior to the reporting period were either unavailable, so incomplete or so flawed that it was not reportable). FSM (National) data is based on cleared death certificates for the period 1990-2003 and mortality rates were calculated using the population estimates from 1990-2003. The National data is the official reporting and is severely underreported because of challenges with diagnosis and proper completion of death certificates. Despite severe data quality issues in 1990-1998, a longer time period was chosen to calculate the country mortality rates because the overall number of cases is so small. Keep in mind that there is no capacity in the FSM to diagnose colon cancer and that diagnostic capacity is limited for all cancers in general. Much more detailed information about the cancer burden, existing programs and services, gaps, needs and priorities can be found in each State's CCC plan.

Table 2. **Leading Cancer Deaths by Site** (from 2002-03 NCI Pacific Cancer Initiative Cancer Needs Assessments[3])

	Chuuk [2000-2002] (% of cancer deaths)	**Kosrae** [1998-2002]	**Pohnpei** [1998-2002] (% of cancer deaths)	**Yap** [1998-2002] (% of cancer deaths)	**FSM** [1990-2003] (Mortality rate per 100,000 popn)
Total popn (FSM Census 2000)	53,595	7,686	34,486	11,241	107,008
# of cancer deaths in time period	51	11: 5 male, 6 female (no cancer predominant)	68	52	722
Rank 1	Lung (27.5%)	(M) Prostate, colon, sinus, parotid, skin SCC; (F) ovarian, thyroid, breast, cervical, lung, renal	Cervical (14.7%)	Liver (23.1%)	Lung (46)
Rank 2	Cervical (7.8%)		Lung (13.2%)	Lung (21.2%)	Liver (23)
Rank 3	Stomach (7.8%)		Liver (8.8%)	Oral (7.7%)	Oropharynx (20)
Rank 4	Uterus (7.8%)		Gastric (7.4%)	Breast (7.7%)	Prostate (20)
Rank 5	Prostate (7.8%)		Prostate (5.9%)	Cervical (5.8%)	Cervix (19)
Rank 6	Head/Neck (5.9%)		Nasopharyngeal (5.9%	Prostate (5.8%)	Breast (16)

Because the States are directly responsible for the provision of health services to their populations, state-specific strategies to address prevention, early detection, treatment, quality of life, disparities and improving data quality can be found in the individual State CCC plans. The States have a fair amount of autonomy and have their own health care budgets. The FSM National CCC plan and strategies tend to focus on improving coordination between the States and National efforts, promulgating policy and legislative actions, coordinating feasibility studies for resources that need to be shared among the States and working closely with the States on developing meaningful training, technical assistance, quality assurance and quality improvement programs.

EVOLUTION OF THE FSM NATIONAL CANCER PLAN:

The Pacific Cancer Initiative[4] formally started in 2002, with funding from the NCI Center to Reduce Cancer Health Disparities and the NIH National Center on Minority Health and Health Disparities, with assistance from Papa Ola Lokahi and ‘Imi Hale (who held an NCI Special Populations Network grant), under the leadership of Dr. Neal Palafox. An indigenous advisory council was formed, the Cancer Council of the Pacific Islands (CCPI). The main goals of the Pacific Cancer Initiative was to address the cancer health needs in the USAPIN by (a) Assessing and articulating the cancer health needs of the USAPIN; and (b) Developing sustainable strategies to address the cancer burden in the USAPIN under the leadership team of Pacific Islanders. Each CCPI member was nominated by his/her respective Minister, Secretary or Department of Health.

Together with the University of Hawaii, Department of Family Medicine and Community Health, under the direction of Dr. Neal Palafox, cancer need assessments were performed in 2002-03. From there, preliminary regional and jurisdiction-specific priorities were formed. Health promotion projects were developed as first steps. In 2004, the University of Hawaii (UH), on behalf of 5 of the 6 USAPIN countries, received a National Comprehensive Cancer Control (CCC) Planning grant from the US Centers for Disease Control and Prevention, Division of Cancer Prevention and Control. The Comprehensive Cancer Control programs and coalitions in each FSM State and the FSM National government are presently supported through the UH Cooperative agreement. With help of the CDC and the National Comprehensive Cancer Control Partners, a Pacific-tailored and focused comprehensive cancer control leadership institute was held in Honolulu in March 2005, which initiated much of the CCC planning in the FSM. Coalition-building has been challenging in many locations not only because it is a very Western model with some conflicts with cultural expectations, but also because of the usual “vertical” and non-integrated nature of Federal programs which have been the sustaining force for many of the public health programs in the USAPIN. The FSM States (Chuuk, Kosrae, Pohnpei and Yap) have been progressing well in the development of their planning for the improvement of cancer.

The National government joined the process during the FSM National and USAPIN Regional CCC meetings in November 2005 in Pohnpei, the capital of the FSM. The FSM States and National representatives the November 2005 meeting discussed and identified specific roles and responsibilities for the States and National governments of the FSM. A National working group was subsequently organized, comprised of appropriate staff from DHESA programs (Substance Abuse and Mental Health, Youth, Gender Development Office, Education, MCH/FH, CDC/Immunization, Environmental Health, Nutrition, Diabetes and Continue Education Program for nurses. The non-communicable disease (NCD) unit was chosen as the focal point for coordination at the FSM National level because many of the risk factors for cancer also contribute to the common NCDs like diabetes, high blood pressure, heart disease and stroke.

From February-May 2006, the working group completed the FSM CCC workbook, developed by the University of Hawaii in conjunction with the National CCC Partners and Strategic Health Concepts. The nine USAPIN jurisdictions funded under the UH CCC Cooperative Agreement

received training in the use of the CCC workbook at the end of February 2006 in Honolulu. Site visits were done to the States to enhance common understanding of existing policies and legislation, issues surrounding death certificates and data systems in general and to facilitate closer cooperation between the National government and the States. The CCC workbook greatly facilitated the step-by-step identification of existing programs, services, legislation or policies, existing data, identifying disparities in the data, identifying gaps and needs surrounding cancer control. Once the gaps and needs were identified, the individual States and the FSM National working group prioritized those needs by looking at what could be done within our present resources, what absolutely needed to be done to improve cancer control and what should be done to sustain these positive changes. Mr. Tom Kean and Ms. Karin Homan from Strategic Health Concepts visited our country in May 2006 and helped further our understanding of the CCC planning process. Ms. Erika Strong with the University of Hawaii also visited our country in June 2006 to get valuable input from cancer survivors and their families so that we could be sure to include strategies that will directly improve the quality of life for them and future cancer patients.

In April 2006, the National CCC working group began recruiting more partners outside of HESA and in August 2006, the National Cancer Coalition (NCC) was formed. The NCC presently consists of recruited champions from various FSM National government departments (Commerce and Trade, Education, Finance, Health, Justice, Foreign Affairs, State, Office of Compact Management), the College of Micronesia-National campus, private sector, individual survivors, Semi-governmental agencies, Religious groups, Authorities, Boards, and Commissions and Non-Governmental Organizations. The NCC currently comprises 23 individuals. These recruited volunteer members have contributed great amounts of their time to comprehensive cancer control through voluntary attendance and their involvement in the 14 planning meetings during the development of the FSM National Comprehensive Cancer Control Plan. Based on the prioritized needs from the FSM CCC workbook and matrices, the NCC set goals and objectives, determined strategies and continually refined these until the November 12, 2006 meeting. Dr. Buenconsejo-Lum, from the University of Hawaii, helped to facilitate the workgroup and NCC meetings in January, August, and October of 2006 and she and the rest of the UH team (Dr. Wong and Dr. Palafox) facilitated the November 2006 FSM National Coalition meeting. At the November 12-13, 2006 FSM National meeting, the entire coalition (including the representatives from the four FSM States) reviewed, suggested changes and agreed upon the goals, objectives and strategies found in this Plan. Since that time, some of the strategies have been refined to make them more manageable given our very resource limited setting.

The FSM National Comprehensive Cancer Control plan will continually evolve as new information, policies, partners and resources become available.

THE FSM NATIONAL CANCER PLAN

The individual FSM State CCC plans include state-specific strategies to address prevention, early detection, treatment and quality of life, disparities and improving data quality. The FSM National Plan is consistent with the established role, responsibility and relationship of HESA with the FSM State Departments of Health Services. Objectives and strategies presented support the State-specific efforts and will improve cancer control throughout the country. Coordinated planning and training for relevant health workers is imperative to achieving the recommended Minimum Regional Indicators for Cancer Control and to create sustainability in our resource-limited setting.

PIHOA and the CCPI agree to recommend **Minimum Regional Indicators** for cancer control. Regional collaboration, sharing of resources and capacity building will need to occur so that all USAPIN countries can meet the minimum indicators. The indicators below were discussed at the July 2006 CCPI meeting, August 2006 PIHOA meeting, further discussed, refined and approved at the (Regional) Pacific Cancer Coalition November 2006 meeting. Final approval will be sought at the April 2007 PIHOA meeting. ***It should be noted that the FSM is not presently able to meet any of the indicators below.***

Goal: To prevent cancer from occurring

- By 2012, each jurisdiction will achieve completed hepatitis B vaccination series in 90% of 2 year old children

Goal: To diagnose cancer in individuals as early as technically possible within the USAPIN region

- By 2009, jurisdictions without mammography will demonstrate a 10% increase above their baseline the number of women over 50 who are offered clinical breast exams annually
- By 2012, each jurisdiction will demonstrate a 10% increase above their baseline the number of women age 18-65 who have a cervix who are offered cervical cancer screening at least every 3 years
- By 2017, each jurisdiction will demonstrate a 10% increase above their baseline the number of women 50 and older or those at high-risk, who are offered a mammogram annually
- By 2017, each jurisdiction will demonstrate a 10% increase above their baseline the number of men and women 50 and older who are offered a CDC-recommended colorectal cancer screening test

Goal: To collect, analyze and report accurate cancer-related data across the region

- By 2010, each jurisdiction will establish a quality assurance program for tracking cancer-related data

MISSION

Work collaboratively with State Coalitions, health professionals, different areas of government and the community to improve cancer-related prevention and care for the citizens of the Federated States of Micronesia

GOALS

1. TO PROMOTE POLITICAL AWARENESS AND POLICY STRENTHENING AT THE NATONAL LEVEL IN SUPPORT OF STATE COALITION AWARENESS RAISING ACTIONS TO PROTECT THE FSM POPULATION FROM KNOWN RISKS THAT CAUSE CANCER

2. TO SUPPORT IDENTIFICATION AND DIAGNOSIS OF CANCER IN INDIVIDUALS AS EARLY AS POSSIBLE

3. ENSURE ACCESS TO APPROPRIATE CANCER TREATMENT FOR ALL FSM RESIDENTS

4. TO IMPROVE THE QUALITY OF HEALTH INFORMATION AND HEALTH SERVICES RELATED TO THE IDENTIFICATION AND TREATMENT OF CANCER

PREVENTION

Cancer is a result of combination of risk factors related to lifestyle choices, heredity, and environmental exposure. Most risk factors such as diet, alcohol and tobacco use, and sexually transmitted infections, are within an individual's control.

Currently in the FSM there is a rapidly growing epidemic of diabetes and heart disease, which share many common risk factors associated with cancer, namely physical inactivity, poor nutrition, obesity and tobacco use.

Lung cancer is the leading cause of cancer death in the FSM and oral or head and neck cancers also are in the top 5. The leading risk factor for all of these cancers (and stomach, bladder, colorectal, breast) is tobacco use. In the FSM, some communities worsen their risk by chewing betel nut, which by itself has been shown to cause cancer. Most betel nut chewers combine the betel nut with tobacco. Annually, the FSM imports an average of US$2-3 Million worth of tobacco and cigarettes for the past five years (2000-2004). From January 2005-October 2006, US$ 4.2 million worth of tobacco and cigarettes were imported. Several laws and policies are in place that address tobacco control – banning smoking in public areas, prohibiting sales to minors – but these laws are difficult to enforce. The FSM Congress has established a tax on tobacco, cigarettes and alcohol (FSM PL 9-139 § 9, modified), the tax rate is scheduled to increase in 2007, but the taxes all go to the general funds of the FSM and the states; there is no allocation specifically for health programs.

Liver cancer is the 2nd leading cancer cause of death in the country, with 70% of the liver cancer cases in men. 15-18% of the FSM population is known to be chronically infected with Hepatitis B which can lead to liver cancer. 5% of mothers screened at the prenatal clinics have hepatitis B. Although it has not been systematically studied, chronic alcohol abuse is also a growing problem through the entire nation. In the five year period of 2000-2004, US$3.2 million worth of alcohol was imported into the FSM. This is 2.7% of the total annual imports. People who have chronic hepatitis B infection AND who drink large amounts of alcohol frequently are at very high risk for developing liver cancer. There is no screening test for liver cancer and most of the time if it is found, there is not much that can be done here in the FSM.

Cervical cancer is also very common in the FSM. Risk factors include early onset of sexual activity and sex with multiple partners. In many municipalities in the FSM, cultural taboos prohibit implementation of widespread heath promotion or prevention campaigns that focus on sensitive subjects such as sex or female or male organs. This particular cultural taboo is unfortunate, because the 2001 FSM Youth Behavior Study indicated over 60% of youth 14-18 years of age were having sex with more than one sexual partner. In 2004, 50% of live births in Pohnpei were to teenagers. If these patterns of behavior continue and no changes are made to our health system, we fully expect an epidemic of cervical cancer over the next 10-20 years.

GOAL 1. TO PROMOTE POLITICAL AWARENESS AND POLICY STRENTHENING AT THE NATIONAL LEVEL IN SUPPORT OF STATE COALITION AWARENESS RSISING ACTIONS TO PROTECT THE FSM POPULATION FROM KNOWN RISKS THAT CAUSE CANCER

Objective 1.1. By 2012, introduce and pass National legislation and policies related to clean air and other known cancer risk factors

Baseline data: a) PL: banning smoking on airlines within Micronesia and in public places. Most governmental facilities have designated a non-smoking places.
b) PL: increasing of taxation on tobacco, other related tobacco substances and alcohol.
c) No sales to minors
d) Some enforcement and compliance activities supported by current Tobacco Control grant.

Sources: FSM Economics Division, FSM HESA – various program reports and studies

Strategy 1.1.1. Comprehensive Cancer Control and Tobacco Coalition members will continually educate National stakeholders and other policy-makers regarding the long-term health effects of tobacco and alcohol use

Outcome: More smoke-free establishments

Measure: Review of letters of support or testimonies; review of legislation and policies, review of educational materials and presentations

Strategy 1.1.2. Strengthen the effectiveness of tobacco legislation and policy by increasing taxation on tobacco and other tobacco substances

Outcome: Portion of sin tax being used toward prevention, health promotion and cancer screening activities,

Measure: Review annual reports on ATOD importation, number and results of compliance checks

Strategy 1.1.3. Review the impact of the banning or restricting importation of known cancer-causing agents or substances that contain cancer causing agents (foods)

Outcome: Information that may lead to new legislation and policies

Measure: Review report and assessing the programs on food safety and tobacco used

Objective 1.2. By 2009, increase public and policy-maker awareness of risk behaviors and factors that contribute to cancer

Baseline data: There is number of educational materials available, but the utilization of these materials are not fully implemented.

Strategy 1.2.1. Meet with state leaders and key health personnel to advocate for cooperation and partnership for cancer control

Outcome: MOU or MOA for specific activities to help implement the cancer plan

Measure: Reports of meeting and MOU/MOA signed and distributed

Strategy 1.2.2. Educate community leaders, health leaders and legislators to assign specific financial resources to national and state efforts to control cancer in the FSM

Outcome: Funds and policies available for program support

Measure: Amount and type of support provided by the national /state governments and other partners

Strategy 1.2.3. Formalize and adopt the FSM NCD Strategic plan

Outcome: Coordinated health promotion and prevention efforts between the National and State agencies

Measure: Minutes of meetings (state and national reps) Federal and State financial support to implement the NCD plan

Strategy 1.2.4. Ensure that health promotion activities throughout the country are congruent with and supportive of national NCD health promotion efforts in healthy eating, physical activity, tobacco control, and alcohol control

> **Outcome:** Increased public participation in health promotional activities (fun-run/walk, smoke free environments
>
> **Measure:** At least quarterly reports from cancer coalitions on amount and type of promotional activities conducted, including reporting on the numbers of participants

Objective 1.3. By the end of 2008, work with the States to improve their capacity to provide immunization against cancer-causing infection to at least 25% above baseline immunization rates.

Baseline data: No data available

Strategy 1.3.1. Work with CDC to complete a cost-benefit analysis of implementing a human papilloma virus (HPV) vaccination program in FSM

> **Outcome:** Accurate estimation of the resources that it will take to implement an HPV vaccination program per CDC guidelines
>
> **Measure:** Meeting minutes (all state and national immunization personnel); Final Report

Strategy 1.3.2. With the assistance of a CDC Public Health Advisor (or WHO Expanded Program on Immunizations advisor), develop a plan to improve hepatitis B vaccination rates in 5 year olds (Head Start) in each state by at least 25% above baseline by 2009

> **Outcome:** Increased number of pregnant women being screened for HBV, Increased number of infants receiving HBV3 by age 2, Decreased number of Head Start children with delayed immunizations
>
> **Measure:** Meeting minutes, review of reports, change in Federal and state budgets to reflect increased capacity (vaccination, staffing, outreach/travel)

Strategy 1.3.3. Develop and establish an adolescent immunization program for hepatitis B and HPV

> **Outcome:** MOA or MOU signed by Immunization Program Manager, MCH Program Manager, National Women's Health, and Cancer Program Director with approval and endorsement of Secretary, Department of Health, Education and Social Affairs.
>
> **Measure:** MOU or MOA signed document

EARLY DETECTION

It is easier to treat and cure cancer when it is found early. Some early detectable cancers include breast, colon, cervix, prostate, testicular, and skin and many of these can be found early by self-examination or physical examination by a physician. In many cases, a combination of two or more early detection approaches is the most effective strategy.

Currently, the only funded cancer screening activities in the FSM are for cervical cancer, funded through Federal cooperative agreements (Maternal-Child Health, Family Planning, STI, HIV/AIDS). Unfortunately, there is a pressing need for coordinated planning to ensure adequate supplies to match the demand. In 2005, FSM MCH/FP purchased 3700 pap smear kits for the FSM which is approximately 13 % of the child bearing age women ages between 15-49 years of age (28,937) and 10% of the total population of women ages between 15-64 years of age (34,361). Prior to 2004, FSM MCH/FP office contracted with Clinical Laboratory of Hawaii to process pap smears specimens, provided payment and coordinated all specimens sent out to Hawaii for all FSM. In 2005, it was decided to delegate those responsibilities to the States and that each State enters into their own contract with the Clinical Laboratory in Hawaii (CLH).

Significant health workforce issues face the FSM, which makes early detection even more difficult. Many of the current health workforces have inadequate foundational training and were trained on site by others in the same working position. Severe nursing shortages exist in all jurisdictions. Some outer island health assistants have not had upgrades in knowledge or skills in over 5 years. Because of this, cancer screening is almost non-existent in the outer islands. The individual State CCC plans address these direct health delivery issues, but there is need for coordinated planning for a sustainable, local health workforce that will be committed to addressing the many issues facing the people of the FSM.

GOAL 2- TO SUPPORT IDENTIFICATION AND DIAGNOSE OF CANCER IN INDIVIDUALS AS EARLY AS POSSIBLE

Objective 2.1. By 2008, improve the capacity to screen for and diagnose breast and cervical cancer across the FSM.

Baseline: Inadequate pap smear supplies and resources for processing; no pathologist or laboratory technicians skilled in cytotechnology; no mammography or radiologist; inconsistent availability of colposcopy services; no LEEP

Strategy 2.1.1. Work with the states and regional entities to develop mechanisms to ensure adequate supply of Pap smear kits and resources for shipping all specimens off-island for analysis.

> **Outcome:** Population-based distribution / allocation of resources, Contingency plan to assure specimens can always be shipped off island to an appropriate lab
>
> **Measure**: Review of agreements or contracts

Strategy 2.1.2. Work closely with the States to ensure that at least one laboratory technician from each state receives additional training at a regional training site in cytopathology so that they can do a preliminary read of the slide prior to shipping for the official analysis.

> **Outcome**: Improved ability for physicians to be able to treat suspected abnormal pap smears within 3 days of performing the test
>
> **Measure**: Review of travel completion reports and certification of accomplishment, Review of pap smear result/ QA log in the lab

Strategy 2.1.3 Work closely with States that do not currently have a colposcope and/or trained personnel to develop a plan to have an operational colposcope

> **Outcome**: Improved access to colposcopy for women with abnormal pap smears
>
> **Measure:** Hired a short term consultant; Consultant's reports; review of operational plans for colposcope.

Strategy 2.1.4. Collaborate with COM-FSM and COM-State campuses to provide training opportunities (for college credit) that will enhance the foundational knowledge and skill sets of the nursing and allied health workforce currently involved in the screening and diagnosis of breast and cervical cancer (practical nurses, laboratory technicians, health assistants)

> **Outcome**: Upgrading the basic knowledge of practical nurses and allied health (many of whom were trained on the job by others who were trained on the job and lack basic foundation coursework in health, Meaningful 'result' of the training (college credit) that may one day be tied to recruitment and retention and salary scales
>
> **Measure**: Review of existing COM Health Assistant and proposed COM nursing curricula, Review of MOA with instructors for those courses

Objective 2.2 By 2010 improve FSM capacity to process and interpret pap smears and tissue specimens in-country.
Baseline data: No pathologist or cytotechnologists or capacity to read pap smears in-country

Strategy 2.2.1. Secure stable funding for a pathologist who can meet the needs of the country

> **Outcome**: Pathologist who is able to help teach lab and staff and develop operational policies and procedures with the lab manager
>
> **Measure**: Review of justification / testimony to Congress, Successful recruitment documentation

Strategy 2.2.2. Hire a consultant to work with Pohnpei State laboratory on a strategic plan to upgrade laboratory services, including a staffing plan (expanded serology, histopathology, frozen sections/microtome, basic cytopathology)

Outcome: Evidence-based strategic business plan that can be used to also coordinate HRH development

Measure: Review of strategic business plan

Strategy 2.2.3 Chuuk, Yap and Kosrae States to determine accurate plans and projections to send patients to Pohnpei for diagnostic workup and treatment (if that service is not available in-state)

Outcome: Appropriate planning and budgeting for patients to receive diagnostic work-up or treatment in Pohnpei (if that service is not available in state), Accurate budgeting so that additional resources can be sought

Measure: Review of minutes of Directors' meetings

Objective. 2.3. By 2009, secure CDC Breast and Cervical Cancer Early Detection Program funds in order to enhance cervical cancer capacity and develop breast cancer screening capacity in the FSM

Baseline data: No mammography and inadequate pap smear supplies

Strategy 2.3.1. In 2007, begin planning process and communication with the States in preparation for submitting a competitive grant application in 2008

Outcome: Funding to support enhancement of cervical cancer screening and development of effective breast cancer screening

Measure: Review of meeting minutes (National Coalition meetings, Director's meetings)

Strategy 2.3.2 Work with National grant writer to assist with writing the CDC BCCEDP (and other health) grants

Outcome: A skilled grant writer to assist with securing additional sources of funding for the implementation plan

Measure: Review of documentation showing successful recruitment

Objective 2.4. By 2012, provide mammography services to at least 10% of the total eligible female population in the FSM

Baseline data: no mammography; approximately 30% of eligible women live near the main hospitals; difficult transportation issues for outer island women to get to the hospitals

Strategy 2.4.1. Complete a feasibility study by end of 2008 for lease, operation and maintenance of mammography machine that can be shared among all states and include short and long term personnel costs.

> **Outcome**: Evidence-based plan of action to attain a mammography unit(s) for the country with adequately trained personnel, Realistic plan to present to other potential funding sources, Plan to coordinate with FSM HRH plan
>
> **Measure:** Review of Report

Strategy 2.4.2 Work closely with States in developing plans and approximate budget for offering mammograms to women in rural areas, using three different scenarios (see also strategy 2.4.1 – feasibility study)

> **Outcome**: Coordinated plan in place prior to getting the mammography machine, so that the technology can be well-utilized
>
> **Measure:** Review of feasibility study, Review of budget projections

Strategy 2.4.3 Include mammogram technicians, biomedical technicians (for machine maintenance) and radiologists in the FSM Human Resources for Health development plan) [refer to Objective 2.6]

> **Outcome**: Coordinated long-term plan in place to develop a stable, well-trained, local health workforce
>
> **Measure:** Review of HRH plan

Objective 2.5. By 2010, procure through private-public partnership, a CT scanner that can be used by all 4 States

Baseline data: No CT scanner

Strategy 2.5.1 Work closely with Genesis hospital, the States and National leadership, MiCare and Congress to develop a coordinated plan for acquisition and operation of a CT scanner in Pohnpei, including hiring a contract radiologist and biomedical technicians for at least 5 years (see also 2.2.3)

> **Outcome**: Long-term plan to pay for the CT scanner
>
> **Measure:** Review of meeting minutes, introduced legislation at the National and State level, proposed MOA between the Genesis and the States/Federal government

Strategy 2.5.2 Introduce legislation that will lead to improved funding for diagnostic work-ups and referral to Pohnpei

Outcome: Long-term plan to pay for cancer-related diagnostic workups

Measure: Review of legislative documents

Objective 2.6. By 2009, complete a FSM Human Resources for Health (HRH) plan that takes into account the diagnostic and treatment needs for cancer patients in the FSM (health workforce development plan)

Baseline data: No HRH plan; WHO Manpower funds for capacity development and fellowships are often granted without considering the long-term needs of the country.

Strategy 2.6.1. Request the assistance of the WHO WPRO Technical Advisor on HRH to assemble a meaningful framework for HRH development

Outcome: Development of HRH plan to ensure a sustainable supply of local health workers to support cancer control efforts

Measure: Review of request/justification to WHO Manpower Development

Strategy 2.6.2 Hold a stakeholders meeting to develop the HRH plan (education, COM, HESA, State DHSs, HCA, Dental, others).

Outcome: Long-term HRH development plan that includes pipeline, bridging and maintenance programs

Measure: Review of conference proceedings, resolutions, Review of conference proceedings, resolutions; Review of HRH plan

Strategy 2.6.3. Use the HRH plan to prioritize students for government scholarships and/or WHO Manpower funds to study laboratory technology, radiation technology, biomedical equipment maintenance, supply technicians, (medical record administration, nursing, nurse practitioners, medicine – radiology, pathology, surgery, OB-gyn)

Outcome: Training opportunities are granted toward priority areas for the entire health workforce

Measure: Review request list to WHO; review end-of-training reports from funded participants

Strategy 2.6.4 Use the HRH plan to prioritize training for current health workers

Outcome: Coordinated utilization of existing resources for training and health workforce development

Measure: Review of recipient list

TREATMENT

The FSM has no capability to treat advanced malignant cancers. The only main treatment of cancer available in the FSM is surgical removal of the mass based on the location or site in the body. The surgeons that are available in the country vary in skill and availability. Since only surgical and pain management services are offered for cancer treatment in the FSM it is becomes necessary to send patients off island for necessary care. Unfortunately, healthcare in Hawaii and even the Philippines is often costly. The MiCare Health Insurance Program, a partially government-subsidized program, only covers 20% of the population and the premiums are extremely high. To maximize the impact of the insurance funds, only MiCare patients with early stage cancer are eligible for off-island referrals. It is rare for an uninsured patient to be referred off-island for care, even if they are diagnosed early, because of inadequate financial reserves in the State health budgets. Because of the relatively small size of the population and number of cancers, it will likely never be cost-effective or feasible to offer chemotherapy services in the FSM. Patients will continue to need referral to tertiary care centers in the Asia-Pacific region for induction chemotherapy. A Regional CCC goal is to develop resources within the USAPIN where maintenance chemotherapy can be accessed by FSM patients in locations closer to their home.

Medication for palliative care and healthcare personnel trained in end-of-life care are both in short supply.

GOAL 3. ENSURE ACCESS TO APPROPRIATE CANCER TREATMENT FOR ALL FSM RESIDENTS

Objective 3.1. By 2008, assist the States in providing adequate pain and palliative medications to cancer patients when they request it.

Baseline data: The National government procures the narcotics and distributes the medication based on the States' requests. Medications are often in short supply.

Strategy 3.1.1. Work closely with States to obtain an accurate estimation of need for pain and other palliative medications (anti-anxiety, sedatives, laxatives, diuretics, antipsychotics)

Outcome: Adequate supply of basic pain meds; data-driven projection of annual need

Measure: Initial report, updated annually prior to budgeting process

Strategy 3.1.2. Assist the States with training of supply and pharmacy technicians so that inventories are well-managed

Outcome: Better trained technicians; less errors; less lapses or delays in obtaining meds and supplies

Measure: Quarterly inventory report looking for # days without desired med or supply

Strategy 3.1.3. Work with state, regional and international entities to ensure a reliable and adequate supply of medications for the alleviation of discomfort from cancer

Outcome: More affordable medications; less days with no pain medication available

Measure: MOA with pharmaceutical supplier, quarterly inventory report looking for # of days without desired medication

Strategy 3.1.4 Work with regional entities to provide education for physicians, nursing and pharmacy staff regarding palliative care

Outcome: Cancer patients reporting less pain when asked using a visual or numeric pain rating scale

Measure: Review of meeting minutes discussing standing agenda item (palliative care / narcotic supply) at National CCC meetings

Objective 3.2. By 2008, strengthen existing QA programs in the States DHSs so that needed supplies and equipment are available and functional

Baseline data: Only Yap State has an integrated quality improvement program for the entire health service; Kosrae and Pohnpei only have QA programs for nursing

Strategy 3.2.1. Provide onsite, longitudinal training in QA/CQI for all dept managers and division chiefs

Outcome : Sustainable QA programs run by trained, local staff

Measure: Review of QA/CQI projects, progress, review of SDP (Compact of Free Association monitoring) progress reports for the quality improvement goal.

Objective 3.3. By 2009, work with the States to ensure compliance with established MiCare polices and procedures for off-island referral

Baseline data: Periodic occurrences of inappropriate off-island referral requests for MiCare patient

Strategy 3.3.1. With the assistance of a budget analyst and QA expert, review each States and MiCare referral cost data to determine expenditures for diagnostic work-up (referring diagnosis and final diagnosis) for suspected cancers.

Outcome: Data-driven budgeting

Measure: MRC/MiCare biannual reports

Objective 3.4. By 2012, develop a plan for a comprehensive and affordable referral system in-country and begin developing a referral system within the USAPIN.

Baseline data: Lack of services in-country; No information

Strategy 3.4.1 With outside technical assistance, conduct cost-benefit analysis of in-country referral for diagnosis and limited treatment in order to introduce and pass legislation that would enable sustainability of this system (see also objective 2.4 and 2.5)

Outcome: Data-driven health policy and legislation

Measure: Review of planning meeting minutes; review of completed plan

Strategy 3.4.2 By 2009, establish a national task force to begin discussions to establish a minimum set of basic primary, secondary and tertiary 'covered' conditions (i.e., universal health care)

Outcome: Basic universal health coverage

Measure: Review of task force meeting minutes

DATA QUALITY

Please refer to the many issues described in the "Cancer Burden" section of this Plan.
The 1994 FSM Census indicated that we registered only 50% of the total deaths There is a significant need for training on the importance of documenting properly and coding correctly. Upon close inspection of some of the death certificates, we feel that many of the "unknown" or "ill-defined" causes of death could have been cancer or that another symptom was coded as the primary cause of death, when in reality that symptom could have represented an underlying cancer.

There is no certified health information management administrator in the FSM or anyone with appropriate training in the State hospitals or health departments. Most coders are trained on the job and to do mechanical coding. Complicated cases like injuries, neoplasm, and other diseases and conditions that overlap between organs and systems are major problems of the current coders. With the support of the FSM National bioterrorism grant, major effort have been made to link data sources together and to transfer the data and information from the states to the national level regularly and electronically. The system has been designed to send alerts to National for items that require clarification. However, training is still badly needed at the primary sources of data sources (state medical records operations and procedures).

GOAL 4. TO IMPROVE THE QUALITY OF HEALTH INFORMATION AND HEALTH SERVICES RELATED TO THE IDENTIFICATION AND TREATMENT OF CANCER

The FSM is embarking on a standardized, real-time Health Information Management System, shared across the hospitals and main public health clinic in each state. This system will capture demographic data, diagnostic and procedural codes. It will also allow the public health programs to more readily share information with the FSM National government. However, fundamental training is needed to ensure that the correct type of information is entered into the HIM system. There is no cancer registry at present.

Objective 4.1. By 2011, in close collaboration with the development of the USAPIN Pacific Regional Central Cancer Registry, establish a nation-wide cancer registry.

Baseline data: No cancer registry in FSM

Strategy 4.1.1 By December 2007, pass FSM National legislation requiring reporting of cancer cases to the health departments

Outcome: FSM National Cancer Registry Act

Measure: Report on passage of act

Strategy 4.1.2. Continue to work with HIMS at state and national to enhance the standardization of the health information system to better track cancer-related risk factors and screening/ diagnostic work up

Outcome: Establish standardized procedures and FSM National standard list of cancer information for data collection

Measure: Documentation of progress reports, review of protocol and procedures

Strategy 4.1.3 By the middle of year 2, with the assistance of the regional registry staff, establish appropriate protocol and procedures to ensure an accurate and reliable screening, recording, tracking, treatment, and discharge summaries for all identified and suspect cancer patients.

Outcome: Updated policies and procedures, which staff can refer to.

Measure: Record review

Strategy 4.1.4 Set up MOA or MOU with state hospital and clinics (government and private) to report cancer to NCCPP.

Outcome: Establishment of MOA or MOU

Measure: Document of MOU or MOA signed

Strategy 4.1.5. Work cooperatively and collaboratively with the regional experts for the improvement of cancer reporting and recording within the FSM

Outcome: Appropriate coding of death certificates

Measure: Report on training/ workshop; eventual QA review of registry data

Objective 4.2: Within the first year of implementation, increase health workforce awareness on the importance of having a cancer registry

Baseline data: No cancer registry in place, lack of understanding on the importance of a cancer registry

Strategy 4.2.1: Conduct educational sessions on the importance of establishing and maintaining a cancer registry, the important role that each member of the health team plays (patients and health technicians) so that training and quality improvement activities are better accepted.

Outcome: The public and health personnel will be more aware of their role in the big picture and how their input will contribute to more effective data collections, which in turn will give rise to better planning for prevention and other areas.

Measure: # of MEMORANDUM OF AGREEMENT (MOA) or data exchange agreements with private providers; improved attendance at continuing education/training sessions

Objective 4.3: Within 2 years of implementation, with the assistance of Regional CCC, Regional Cancer Registry and other partners, begin providing relevant foundational, health information management (HIM) and registry-specific training to appropriate personnel that would be involved in the flow of information to a cancer registry.

Baseline data: Medical records staff largely trained on the job; physicians not coding appropriately

Strategy 4.3.1: Work with the local community college and/or other experts (in collaboration with Regional efforts) to conduct basic foundational training in human anatomy, physiology, medical terminology, chart review and health record coding for the medical records personnel

Outcome: Medical records technicians who are better trained to collect information for the HIM and cancer registry databases

Measure: Less errors or need for clarification when health information manager or cancer registrar does QA checks

IMPLEMENTATON PLAN:

To ensure successful implementation of the CCC plan and sustainability of the CCC program, a new organizational structure was developed and approved by the FSM National Cancer Coalition (NCC) and is under final review by the HESA. The members of the NCC are recruited based on their background of leadership and influence in the community and government. Many of them although they are working with the National government, they are also represent their states, communities and tradition.

The National CCC Program is located within the newly created Section on Non-Communicable Disease, Division of Health, Department of Health, Education and Social Affairs (HESA). The administrative assistant for the CCC Program will be working collaboratively with the Department of Finance, Budget, and fiscal officer in monitoring program funds to ensure proper expenditure. Reporting and monitoring of the program's finances shall be subject to the National Financial Management System and CDC requirements.

The National Department of Finance has established Finance Field Offices at all the State levels to also monitor national programs implementation activities and reporting.

The Steering Committee will serve as the decision-making body for the coalition, with input and final approval from the general NCC membership. Steering committee members include the Cancer Council of the Pacific Islands (CCPI) delegates from each State, National coalition officers, implementation team leaders and the program coordinators from the National and 4 State coalitions. The State coordinators and CCPI members from Chuuk, Kosrae and Yap will participate in steering committees via teleconference calls.

The FSM National CCC Program Staff will manage the CCC program, maintain communication amongst the stakeholders and coordinate and participate in implementation activities. Regular coalition meetings will be held at four times a year for the membership in order to plan, strategize and coordinate activities; this will also maintain interest in CCC and relay information. The steering committee, program staff and implementation teams will meet more frequently as a function of their role as the core implementation team. Appropriate program activities will be advertised in the local newspapers, broadcast at the Local Broadcasting radio and televised on local television. Additionally, a quarterly or semiannual newsletter will be developed and distributed to all coalition members. The plan will be formally reviewed, modified if needed based on new evidence, policies or events that affect FSM and the Region and ratified annually. The steering committee will review and propose changes and the National Cancer Program Coordinator will distribute the proposed revisions to the State Coordinators/ Coalitions 30 days in advance of the November meeting.

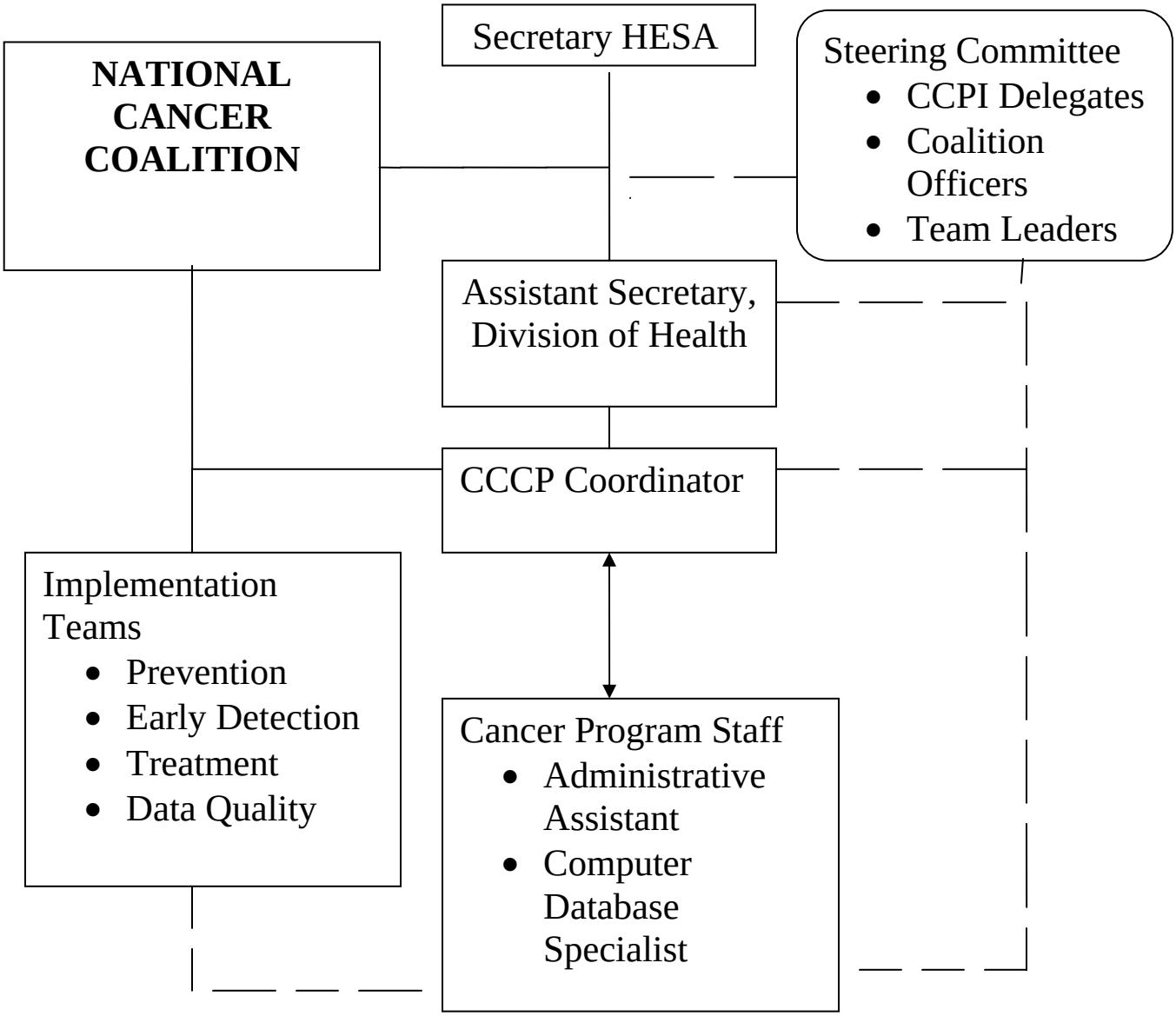
Strategies in the FSM National CCC Plan will be implemented primarily by an action team of National Cancer Coalition members participated in CCCLI and the executive officers and other active and proactive members who have interested. The NCC organization will also have subcommittees and or implementation teams representative of the major components of the CCC plan: Prevention, Early Detection, Treatment and Data Quality. Because many of the strategies align with the Regional CCC plan and because our resources are limited, the Regional CCC

program staff and all of the partners and resources they leverage will be critical to the success and sustainability of cancer control efforts in the FSM.

Such cooperative and coordinated effort must also be linked with the FSM Strategic Development Plan, the Millennium Development Goals, Compact Health Sector and Environmental Sector funding plan of the FSM. It is also vital to work with other potential and regular partners: College of Micronesia (HCOP, Land Grant college), FSM Telecom, radio, TV stations and newspapers, Pacific Mission Aviation (air transportation between outer islands) ,Caroline Island Airlines (air transportation between outer islands), Bilateral Partners (US, Japan, China, Australia),Technical advisors and/or funded programs from WHO, CDC, ADB, SPC, UN, Global Fund, HRSA / Pacific Island Health Officers Association (PIHOA), Department of Family Medicine and Community Health, John A. Burns School of Medicine, University of Hawaii, Cancer Research Center of Hawaii and Tripler Army Medical Center Pacific Islands Health Care Project.

It is with great hope and commitment that implementation of this comprehensive cancer control plan will ultimately lead to our vision of a “Cancer Free FSM.”

FSM National Cancer Coalition Organizational Chart



EVALUATION PLAN

Evaluation is a key component of any successful program. Throughout planning, various evaluation methods have been utilized to guide the process and positive changes have been made as a result. Evaluation will continue to be critical as we take the next step and begin to implement our plan.

Initially, the steering committee will function as the evaluation committee and will be responsible for developing and carrying out the evaluation plan. The committee, with the assistance of the CCC program, will determine the appropriate assessment tools and methodology, conduct the evaluation and report the results.

The evaluation plan will address three core areas for successful implementation of our comprehensive cancer control plan:

1. National CCC Coalition
2. National CCC Plan
3. Implementation Process

More specifically, the evaluation committee will regularly assess:

- Infrastructure needs and capacity
- Level of support
- Gaps in data
- Partnership composition and satisfaction
- Burden of cancer
- Progress in achieving program objectives
- National and Regional collaboration and relationship

Strategies for evaluation will reflect the measures for specific activities within each component of the plan. Results of this comprehensive evaluation will be compiled into an annual report and shared with the coalition and other local, national and regional partners. More importantly, the results will serve to improve all aspects of the CCC program, implementation process and ultimately, the burden of cancer in the whole Federated State of Micronesia.

Appendix 1. GLOSSARY AND DEFINITIONS
Glossary of Acronyms / Definition of Terms

FSM ……. Federated States of Micronesia
ICD ……. International Classification of Diseases
TTPI…….Trust Territory of the Pacific Islands
MOA…… Memorandum of Agreement
MOU……Memorandum of Understanding
U.S……... United States (of America)
CCC…… Comprehensive Cancer Control
CCC Plan……. Comprehensive Cancer Control Plan
CCCP…….. Comprehensive Cancer Control Program
CCCPC……Comprehensive Cancer Control Program Coordinator
NCCCP……National Comprehensive Cancer Control Program
NCC…….National Cancer Coalition
WHO ……...World Health Organization
WPRO……. Western Pacific Regional Office
FCTC…….. Framework Convention on Tobacco Control
EPIC…….Economic Policy Implementation Council
TB ……Tuberculoses
CD…….Communicable diseases
NCD……. Non-communicable diseases
COPD…….. Chronic obstructive pulmonary diseases
CQI…….. Continuous Quality Improvement
CT…… Computerize Tomography Scan
QA……Quality Assurance
LOS…….. Length of stay for hospital inpatients
NCI……...National Cancer Institute
NCI PDQ……..National Cancer Institute Physician Data Query
BCCEDP……...Breast and Cervical Cancer Early Detection Program
NIH…….. National Institutes of Health
CCPI…… Cancer Council of the Pacific Islands
UH……University of Hawaii
CDC…….Center for Diseases Control and Prevention
USAPIN……...United States Associated Pacific Island Nations
MCH/FH……..Maternal Child Health /Family Health
MRC…….. Medical Referral Committee
MDG…….. Millennium Development Goals
HIMS…….. Health Information Management System
HCA…… Health Care Administration
HRH…… Human Resources for Health
HRSA……. Health Resources Service Administration
HTN…….Hypertension
DM…….. Diabetes Mellitus
NHSO…….. National Health Statistics Office
ICD9……..... International Classification of Disease coding version 9

ICD10……...International Classification of Disease coding version 10
ICDO…… International Classification of Diseases Coding Oncology
SDP…….. Strategic Development Plan
DHS……. Department of Health Services
DOH……. Department of Health
SDHS…… State Department of Health Services

Definitions:

1. Intermediate islands = - refers to lagoon islands, islands within the state lagoon, on the atoll reefs that can travel to center by motor boat with 20 minutes to 3 hours of ride.

2. Outer-islands =…….- islands located outside the state center, only can be reached by small planes and ships. To travel on ship or bigger boat will take 6-24 hours.

3. Dispensary =…….- primary health care facility located in the communities and outer-islands. Operate by 1 and/or 2 health assistants (a male and a female).

4. Aid-posts =…….- primary health care facility located in the communities and outer-islands, open 1-3 times a week. Mainly to facilitate or aid outreach program visiting the communities and to provide first aids and dispensing medicines. More than one aid-post can be managed by one health assistant. It depends on the needs which varies among the states.

5. MiCare = ……..- National Health Insurance Plan: Initially for national employees and their families and relatives, it is now open to any FSM citizens who are employed by government and private businesses of the FSM within and outside of the FSM.
6. EPIC =……- It is a body made up of the President, Vice President, all the four Governors, Speakers of all the legislatures of state and national. It stands for Economic Policy Implementation Council (EPIC).
7. NCCCC and NCC……..- means the same, refer to the National Cancer Coalition

8. CCCPC and NCCCPC…- means the same, refer to the National Cancer Program Coordinator (NCPC)
9. DOH, DHS & DOHS…. –means the same, refer to the Department of Health Services

Appendix 2. PARTNERSHIPS

FSM National Congress:
Honorable Dohsis Halbert
Senator (Associate member),
FSM National Congress
Palikir, Pohnpei
FSM 96941
(691) 320-2324 or 2326

Mr. Alik Jackson
Legal Advisor,
FSM National Congress
Phone: 320-2324
Email: alik_j@yahoo.com

Ms. Lynn Narrhun
Congress Information Office
FSM National Government
Phone: 320-2324
Email: congresspio@mail.fm

Pohnpei State Legislature:
Ms. Maggie Walter (associate member)
State Senator and Businesswomen
Pohnpei State Legislature
Pohnpei State
Phone: 320-2135
Email: nihco@mail.fm

Department of Health and Social Affairs
Ms. Jane Elymore
Gender Development Officer,
FSM National Women's Health Program
FSM National Government
Palikir, Pohnpei
FSM 96941
(619) 320-2643
elymorj@mail.fm

Mr. Sepehr Sohrab
IT Consultant, Bihi Faith
Phone: 320-8300
Email:ssohrab@mail.fm

Mr. Ben Jesse
Health Planner
Division of Health, DHESA
FSM National Government
Phone: 320-2619
Email: bjesse@fsmhealth.fm

Micronesian Red Cross Society
Ms. Sizue G. Yoma
Director
NGO, Micronesia Red Cross Society
P.O. Box 2405
Kolonia, Pohnpei FM 96941
(691) 320-7077
Phone: (691) 320- 6531
Email: mrcs@mail.fm

Island Food Community of Pohnpei
Dr. Lois Englberger
Island Food Community, NGO
Phone: 320-8639
Email: nutrition@mail.fm

College of Micronesia:
Ms. Jazmin Gonzales
Director,
Health Carrier Opportunity Program
College of Micronesia-FSM
National Campus
Phone: 320-2481
Email: jazminbg@comfsm.fm

Department of Education
Mr. Whens Billen
Acting Secretary,
Department of Education Grant
FSM National Government,
Palikir, Sokehs
Phone: 320-6009
Email: aepfsm@hotmail.com

Mr. Bernis Dannis (associate member)
Manager,
Evaluation and Testing Specialist

Division of Education, DHESA
FSM National Government
Palikir, Sokehs
Phone: 320-6009
Email:bdannis@mail.fm

Girls Scout:
Ms. Eileen Mackenzie
Girls Scout, Leader
Pohnpei State
Phone: 320-2645
Email: eymackenzie@yahoo.com

Environmental Protection:
Ms. Cindy Emhes
Environmentalist
Department of Economic Affairs
FSM National Government
Phone: 320-5133
Email:climate@mail.fm

Department of Foreign Affairs
Ms. Jane Chigiyal
Assistant Secretary, Division of US Affairs
Department of Foreign Affairs
FSM National Government
Phone: 320-2613
Email: Chigiyal@mail.fm

Media and Public Information Office:
Ms. Marly Fredrick
Public Information Office
President Office
FSM National Government
Phone: 320-2548
Email: marly@mail.fm

MiCare Health Insurance Office
Mr. Yosiwo George
Director,
MiCare Insurance Office
Phone: 320-5865
Email: micare@mail.fm

Office of Statistics and Economic Management, Budget, Oversea Development Assistant and Compact Management:

Mr. Epel Ilon (associate member)
Director,
Office of Compact Management
P.O. Box
Emails: ilon_ocm@mail.fm

Mr. Olivier Wortel
Grant Writer /Assistant Director
ODA
Budget Office
FSM National Government
Palikir,Pohnpei State FM 96941
Email: olivier96@hotmail.com
Phone: 320-2823

Mr. Stoney Taulung
Administrator,
Economic Statistics/Census
FSM National Government
Phone: 320-2620
Email: stoneytng@yahoo.com

FSM Banking Board:
Mr. Wilson Waguk
Director,
Banking Board and Insurance Office
Phone: 320-2015/2065
Email: wfwbb_gov@mail.fm

Department of Finance:
Ms. Rose Nakanaga
Department of Finance, FSM
FSM National Government
Palikir, Pohnepi State FM 96941
Phone: 320-2640
Email: fsminvestment@mail.fm

Private Health Sector:
Mr. Hermie Alfonso (Associate member)
Genesis Hospital, Administrator and owner
P.O. BOX 1002
Kolonia, Pohnpei, FM 96941
320-2525
Fax: 320-3396
kit@mail.fm

NGO and Private Business:

Mr. Bermin Weilbacher
BNN, Private; Survivor
Kolonia, Pohnpei FM 96941
Bnn_fsm@yahoo.com

Ms. Josephine
Private Sector, Survivor
Pohnpei State
Phone: 320-2135
Email: jovela_pni@yahoo.com

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