'RMI NCD CRISIS RESPONSE PLAN'

NCD EMERGENCY RESPONSE TOWARDS A HEALTHY RMI

Action Plan 2013-2018

Forward by the Minister of Health

Honorable David Kabua
Minister of Health

The Republic of the Marshall Isalnds is one of the few countries with highest prevalence of NCD in the Pacific Region and in the World. However, the Marshall Islands is committed to reduce the prevalence and strong effect of NCD among Marhallese people. In furtherance, the RMI has formulated a strong mission statement as such:

"*To provide high quality, effective, affordable and efficient health services to all the people of the Marshall Islands through a primary health care program to improve the health status and build the capacity of the community and indivuduals to care for their own health and to the maximum extent possible, the Ministry of Health pursues these goals using the natinal resources of the Republic of the Marshall Islands.* "

In October 29, 2012, His Excellency Christoper Loeak, President of the Republic of the Marshall Islands declared a state of health emergency due to the epidemic of non-communicable diseases (NCD) in the Republic of the Marshall Islands.

The Ministry of Health does realizes the double burdens of NCD must be reduced to a manageable level. However, to be able to do that, a joint collaboration of all relevant government sectors and non-government organization; and full partnership are necessary to implement such plan.

Other risk factos such as negative effects of tobacco and medical complications of alcoholism must also be eliminated through changes in lifestyles and behaviors. Currently, the prevalence rate of

tobacco use amongst the youth is 25.9% and 19.8% amongst the adult population. That is quite high comparetively and that must be brought down to a lower stratum.

The Crisis Response Plan is geared to address the attributable risk factors and suggest reputale public health measures as avenues to tackle all these complication of non-communicable diseases.

There fore, the Ministry of Health is calling all relevant partners to collaborate with the Ministry of Health to change the lifestyles and behavior which are causes of all these NCD problems. After all, these are preventable by lifestyles changing and simple but robust programs of exercise. Again, the Ministry of Health appreciates the continued supports and partnership with our stakeholders.

President
REPUBLIC OF THE MARSHALL ISLANDS

PROCLAMATION

DECLARING A STATE OF (HEALTH) EMERGENCY

Declaring a state of health emergency due to the epidemic of noncommunicable diseases (NCD) in the Republic of the Marshall Islands.

WHEREAS, a political commitment has been made by our leaders at the special United Nations High Level Meeting on NCD in September 2011, the Pacific Island Forum Leaders in New Zealand in August 2011 declared NCD being a health and economic crisis,

WHEREAS, a State of Medical Emergency on Noncommunicable Diseases (NCDs) has been declared by the Pacific Island Health Officers Association (PIHOA) in May 2010 by its Board Resolution #48-01 and endorsed by the Micronesian Chief Executive, Micronesian Presidents, Association of the Pacific Island Legislatures, Micronesian Traditional Leaders Council and Micronesian Chief Justices;

WHEREAS, the Nadi Statement on the NCD crisis in Pacific Island Countries and Areas is being adopted as a pan-Pacific statement on NCDs and has been addressed at the High Level Meeting in the United Nations General Assembly;

WHEREAS, the Republic of the Marshall Islands is home to more than 53,000 people living on 70 square miles of land spanning an area of over 750,000 square miles of ocean in the Western Pacific;

WHEREAS, the leading causes of morbidity and mortality for adults in the Republic of the Marshall Islands are from noncommunicable diseases including cardiovascular disease including hypertension and stroke, cancer, obesity, diabetes, depression, and injury;

WHEREAS, the rates of noncommunicable diseases risk factors in the Republic of the Marshall Islands are high and rapidly increasing, and include high tobacco use, high alcohol consumption, unhealthy diet high in salt and lacking consumption of fruits and vegetables, and lack of physical activity;

WHEREAS, noncommunicable diseases rates of diabetes and high blood pressure are some of the highest in the pacific causing significant loss in longevity, quality of life, and loss to workforce productivity in the Republic of the Marshall Islands;

WHEREAS, the NCD burden can be expected to worsen significantly over the next generation, and will adversely affect the youth of the Republic of the Marshall Islands, shortening their lives and preventing them from achieving their full potential;

WHEREAS, NCDs are largely preventable with reduction of risk factors and early intervention;

WHEREAS, the current health care system response is insufficient to address the noncommunicable disease crisis as the health system lacks the necessary infrastructure and resources to manage noncommunicable diseases and is unable to bear the high costs of their health complications;

WHEREAS, strengthening primary health care, investing in the healthcare workforce, creating enabling environments for health, and increasing community engagement and empowerment is urgently needed at this time in order to prevent and effectively treat noncommunicable diseases to reduce their prevalence and the morbidity and mortality they cause;

WHEREAS, to mitigate the crisis there is a need not only for a whole of government but also a whole of society approach ensuring every organization is building a healthier Marshal Islands building an environment that enables and empowers individual to make healthy choices; emergency due to noncommunicable diseases;

2. The Ministry of Health to develop a noncommunicable disease strategy that builds on the current KUMIT plan detailing programmes, services, and activities that the Ministry of Health and its partners will implement to respond to the emergency and reduce the burden of noncommunicable diseases;

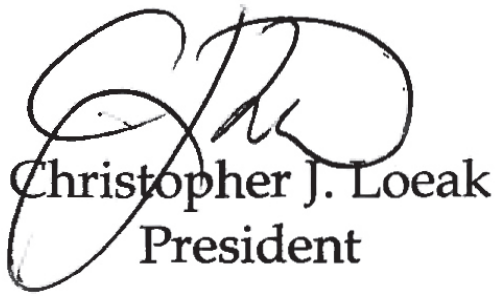
3. A NCD Task Force be established and charged with providing strategic direction and expert advice on the response of the Republic of the Marshall Islands to the noncommunicable disease crisis.

4. Sufficient investment to scale be made into combating NCDs.

5. All heads of government sectors, nongovernmental agencies,

statutory bodies and civil society proactively assist the efforts of the Ministry of Health technically and with resources to tackle the noncommunicable disease crisis;

Given under my hand this 29th day of October 2012.



Pacific Islands Health Officers Association

Board Resolution #48-01

"Declaring a Regional State of Health Emergency
Due to the Epidemic of Non-Communicable Diseases
in the United States-Affiliated Pacific Islands"

The Burden of NCDs

WHEREAS, the United States Affiliated Pacific Islands (USAPI) include American Samoa, Guam, the Commonwealth of Northern Mariana Islands, the Republic of the Marshall Islands, the Republic of Palau and the Federated States of Micronesia (Pohnpei, Chuuk, Yap and Kosrae);

WHEREAS, the USAPI are home to more than 500,000 people, who speak dozens of languages and live on hundreds of islands and atolls spanning millions of square miles of ocean and crossing five Pacific time zones, an area significantly larger than the continental United States;

WHEREAS, the leading causes of morbidity and mortality for adults in the USAPI are from non-communicable diseases (NCDs), including obesity, cancer, cardiovascular disease, stroke, diabetes, depression, injury, and arthritis and gout;[1]

WHEREAS, the rates of NCDs and their risk factors in the USAPI are among the highest in the world, are rapidly increasing, are epidemic, and include high tobacco use, high alcohol consumption, a genetic predisposition towards obesity, significant environmental and behavioral health barriers to healthy eating and healthy families, a propensity toward injury, and a high prevalence of sedentary lifestyles;[2]

WHEREAS, NCDs cause a significant loss in longevity, quality of life, and loss to workforce productivity in the USAPI;

WHEREAS, the indigenous people of the USAPI are rich in culture but comparatively small in population; are fragile, isolated and endangered in multiple ways, including economically, socially and environmentally; have endured early decimation due to communicable diseases

contracted shortly after Western contact; and now face decimation and possible extinction due to diseases and changes in climate associated with Western lifestyles; [3]

WHEREAS, the NCD burden can be expected to worsen significantly over the next generation, due to the comparatively large percentage of youth in the USAPI population and the chronic outmigration of essential skills needed for effective health care; [4]

The Economic Cost of NCDs

WHEREAS, a significant majority of the USAPI health care budgets are consumed by the management and treatment of NCDs;

WHEREAS, the burden of NCDs in the USAPI impedes economic growth and prosperity, due to a sicker workforce and the economic drain of related health care;

WHEREAS, the local, national, and international funding for NCDs is inadequate: The annual health care budgets for the USAPI are a tiny fraction of the US per capita health care expenditure and cannot sustain or manage the costs of an epidemic of NCDs. In addition, funding for health care in the three Compact Nations, including the Republic of the Marshall Islands, the Republic of Palau and the Federated States of Micronesia, is inadequate and decreasing annually. The US Federal reimbursement for health care in Guam, American Samoa, and the Commonwealth of Northern Mariana Islands is inadequate and tied to unrealistic expectations of local financial matches. Finally, even within these budgets, there is insufficient *local* USAPI financial commitment to NCDs.

WHEREAS, the USAPI medical systems—given the current and rising rates of NCDs—are unable to manage the health complications of NCDs effectively due to the high cost and infrastructure required for end stage treatment, which include dialysis, cancer surgery, cancer chemotherapy and radiation therapy, intensive cardiac care for hospitalized patient, specialty stroke units, and sub-specialty medical care;

WHEREAS, many residents of the USAPI migrate to other parts of the USAPI and to the United States for medical care that cannot be accessed locally, and this medical migration stresses already burdened health systems in Guam, CNMI and the United States and causes suffering among USAPI families and communities, due to separation and financial strain;

WHEREAS, the cost and complexity of health care in the USAPI are increased exponentially due to the geographic isolation of small islands;

Overall Inadequacy of the Current Response

WHEREAS, many NCDs are preventable and have fewer complications with early intervention;

WHEREAS, many of the risk factors for NCDs can be effectively alleviated with known strategies and models of care;

WHEREAS, the current approach to NCD prevention and control in the USAPI is inadequate and generally ineffective for a variety of reasons, including the limitations of disease-specific donor funding, poor or absent public health planning, insufficient NCD data, ineffective systems of evaluation and quality assurance, weak lab infrastructure, a largely undertrained, under-skilled, and poorly-incentivized workforce, poor coordination and communications, and a misalignment between local priorities and donor funding;

WHEREAS, external funding for health care in the USAPI from the United States and other sources is unbalanced, with significant resources and mobilization dedicated to issues such as bioterrorism and pandemic influenza but comparatively fewer resources, effort and coordination focused on NCDs, a far more urgent issue for the region;

WHEREAS, the USAPI community infrastructure necessary for effective health is not adequate for the challenge of controlling NCDs. Such infrastructure includes sidewalks, dog control, night lighting, bike paths, safe beaches, car control, as well as appropriate preventive and primary services, such as nutrition, health education, community advocacy, school-based programs, and other prerequisites to healthy communities, including those prerequisites that are dependent upon other sectors, such as agriculture, fisheries, education, and trades and industry.

WHEREAS, the current health and education workforce in the USAPI are working hard to address the challenge of NCD but overall lack the numbers, expertise, educational programs, salaries and support systems to effectively address the challenge;

WHEREAS, the United States Institute of Medicine's study on USAPI health and health care, entitled *Pacific Partnerships for Health: Charting a Course for the 21st Century*, made four significant recommendation, none of which have been adequately addressed since their publication in 1998, including:[5]

1) Adopting and supporting a viable system of community-based primary care and preventive services.
2) Improving coordination within and between the jurisdictions and the United States.
3) Increasing community involvement and investment in health care.
4) Promote the education and training of the health care workforce.

The Need for a PIHOA Regional Policy on NCDs

WHEREAS, the Board of Directors of the PIHOA is comprised of the Ministers, Secretaries, and Directors of Health of the USAPI;

WHEREAS, PIHOA's mission is to improve the health and well-being of communities in the USAPI by providing through consensus a unified credible voice on health issues of regional significance;

WHEREAS, most USAPI and NCD-related regional health association have NCD plans or strategies; however, the USAPI and their regional bodies still have not spoken with a clear, unified and cross-sectoral voice on the epidemic of NCDs in the region;

WHEREAS, a PIHOA Regional Policy on NCDs, developed in consultation with USAPI health agencies and health-related regional associations, would contribute significantly to focusing and coordinating more effectively the attention and resources of local, national and international agencies and leadership, with regards to the NCD epidemic in the USAPI;

On Declarations of Emergency and Emergency Preparedness and Response

WHEREAS, PIHOA acknowledges that Declarations of Emergency by non-governmental organizations have limited precedent and are not legally binding, though they can be ethically and morally binding;

WHEREAS, declarations of emergency commonly involve a discrete event, the activation of mutual aid, and benchmarks for ending the declaration;

WHEREAS, in the case of NCDs, the *event* is a health catastrophe that is slow moving; *the activation of aid* is a re-assessment, reorganization, and increase of resources that up until now have been fragmented, inadequate, and insufficiently effective; and *the benchmarks for ending the declaration* have yet to be clearly agreed upon and, when defined, are unlikely to be met within the timeframe commonly associated with emergency declarations and within this current generation;

WHEREAS, Emergency Preparedness and Response is often narrowly defined as a community effectively preparing for, and responding to, a discrete disaster event, such as a tsunami, landslide, earthquake or typhoon;

WHEREAS, Emergency Preparedness and Response must *also* be understood as reducing overall human susceptibility to emergencies (fostering healthy people); reducing exposure to emergencies (fostering healthy homes) and increasing resilience in the face of emergencies (fostering healthy communities);

AND WHEREAS, the epidemic of NCDs in the USAPI is both an emergency and a serious impediment to effective emergency preparedness and response in the USAPI;

NOW THEREFORE BE IT RESOLVED, that the Pacific Island Health Officers Association declares a Regional State of Health Emergency among the United States Affiliated Pacific Islands, due to the epidemic of NCDs;

BE IT FURTHER RESOLVED, that PIHOA encourages the Chief Executives in PIHOA member states to proclaim legally-binding national and territorial declarations of health emergency due to the NCD epidemic;

BE IT FURTHER RESOLVED, that PIHOA exhorts local, national, and international agencies and donors to devote the same or greater urgency and resource mobilization to the cause of and response to NCDs in the USAPI, as they have more recently devoted to pandemic influenza and bioterrorism;

BE IT FURTHER RESOLVED, that PIHOA shall develop a clear regional policy on Non-Communicable Diseases; that this policy shall respond effectively to the Declaration of a Regional State of Health Emergency of NCDs; and that this policy shall consist of a set of high level goals and recommendations that will provide voluntary and flexible guidance to PIHOA member states, donor agencies and regional partners, on addressing the epidemic of NCDs;

BE IT FURTHER RESOLVED, that the PIHOA Regional Policy on NCDs shall integrate and harmonize effectively with other regional and local NCD policies and plans;

BE IT FURTHER RESOLVED, that the PIHOA Regional Policy on NCDs shall include benchmarks for ending the Regional State of Health Emergency;

BE IT FURTHER RESOLVED, that the PIHOA Regional Policy on NCDs shall provide clear justification for its goals and recommendations, including clear, accurate and referenced data on NCDs and their impact on the USAPI;

BE IT FURTHER RESOLVED, that the PIHOA Regional Policy on NCDs shall identify whether, when, and how a Regional USAPI Plan for NCDs can and should be developed;

BE IT FURTHER RESOLVED, that this PIHOA NCD Policy shall include, but need not be limited to, recommendations to:

- Health Agencies of PIHOA Member States
- Donor and technical assistance agencies
- National and territorial legislatures
- PIHOA Affiliate Members and other USAPI-governed health-related regional associations
- USAPI Chief Executives, including the Micronesian Chief Executives Summit
- Government agencies and sectors other than health, including but not limited to education, environment, agriculture, fisheries, and parks and recreation.
- Traditional leaders, churches and faith-based organizations, and community groups.

BE IT FURTHER RESOLVED, that the PIHOA Regional Policy on NCDs shall be developed in effective consultation with PIHOA Member States and PIHOA Affiliate Members and other regional associations that are health-related and USAPI-governed, including:

- The Micronesian and American Samoan Chief Executives
- The Association of Pacific Island Legislatures
- The American Pacific Nurse Leaders Council
- The Pacific Basin Medical Association
- The Pacific Basin Dental Association
- The Pacific Substance Abuse and Mental Health Collaborating Council
- The Pacific Islands Primary Care Association
- The Pacific Chronic Disease Coalition
- The Pacific Partners for Tobacco Free Islands
- The Cancer Council of the Pacific Islands

- The Pacific Post-Secondary Education Council
- The Pacific Resources for Education and Learning
- The Secretariat of the Pacific Community
- The Northern Pacific Environmental Health Association
- The Association of USAPI Laboratories
- The Pacific Islands Jurisdictions AIDS Action Group
- The Pacific Islands Tuberculosis Controllers Association

BE IT FURTHER RESOLVED, that PIHOA Regional NCD Policy shall be developed in consultation with other associations from other sectors that are not commonly considered health-related but whose work has a significant impact on NCDs, including regional associations in agriculture, education, fisheries, business, parks and recreations, arts and culture, and other sectors;

BE IT FURTHER RESOLVED, that PIHOA shall identify and work to secure resources necessary for the development and implementation of the PIHOA Regional Policy on NCDs;

BE IT FURTHER RESOLVED, that the PIHOA Secretariat will integrate all of its priority areas into NCD control, including Human Resources for Health, Quality Assurance and Improvement, Public Health Planning, Laboratory Strengthening, Health Data Systems, and Connectivity, and will report on progress to this end at the 49th PIHOA Meeting;

BE IT FURTHER RESOLVED, that the basic framework for a PIHOA Regional Policy on NCDs shall be completed and submitted to the PIHOA Board of Directors at the 49th PIHOA Meeting, when a timeline for its completion will be identified;

BE IT FURTHER RESOLVED that this resolution will be sent to the Chief Executives of PIHOA Member States; USAPI regional associations identified above; the health committees of national and territorial legislatures in the USAPI; ministers, secretaries and directors of non-health agencies in the USAPI, such as education, agriculture and environment; traditional leaders in the USAPI; local community groups and NGOs, including women's organizations, churches and faith based organizations; international and regional donor and technical assistance agencies, including those for health, education, agriculture and other relevant sectors; appropriate USAPI media; relevant US national associations, such as the Association of State and Territorial Health Officials and the National Association of Chronic Disease Directors; and others, as necessary.

Hon. Stevenson Kuartei, MD
Republic of Palau
PIHOA President

Hon. Vita Akapito Skilling, DCHMS, DipCH
Federated States of Micronesia
PIHOA Vice President

Hon. Tuiasina Salamo Laumoli, MPH
American Samoa
PIHOA Treasurer

Hon. J. Peter Roberto, ACSW
Guam
PIHOA Secretary

Hon. Joseph Kevin Villagomez, MA
Commonwealth of Northern Mariana Islands
PIHOA Board Member

Hon. Amenta Matthew
Republic of the Marshall Islands
PIHOA Board Member

[1] The NCD mortality rates in the USAPI are indeed among the highest in the world. The prevalence of diabetes among 25-64 year-old adults was 47.3% in American Samoa, 32.1% in Federated States of Micronesia (Pohnpei) and 28.3% in Marshall Islands. The prevalence of hypertension, a kind of cardiovascular disease, was 34.2% in American Samoa, 21.2% in Federated States of Micronesia (Pohnpei) and 15.9% in Marshall Islands. The obesity rates (BMI≥30kg/m^2) were 74.6% in American Samoa, 44.8% in Marshall Islands and 42.6% in Federated States of Micronesia (Pohnpei). Sources:

- American Samoa NCD Risk Factors STEPS Report, 2007; FSM Risk Factors Steps Report, 2008; RMI NCD Risk Factors STEPS Report, 2007, www.who.int/chp/steps/reports/en/index.html
- Mortality Country Fact Sheets 2006 for Palau, RMI, FSM, World Health Organization Statistical Information System, Mortality Profiles, www.who.int/whosis/mort/profiles/en/

[2] NCD Risk Factors are also very high:

- Daily tobacco use: 29.9% in American Samoa, 25.5% in Federated States of Micronesia (Pohnpei), and 20.8% in Marshall Islands. In the Pohnpei FSM, 26.9% of the total population chew betelnut daily.
- The number of families that consume less than the recommended five combined serves of fruit and vegetables: 91.1% in Marshall Islands, 86.7% in American Samoa and 81.8% in the FSM (Pohnpei)
- High prevalence of sedentary lifestyles: 64.3% engaging in low Physical Activity in the FSM (Pohnpei), 62.2% in American Samoa and 50% in Marshall Islands
- Binge drinking (i.e., consumed 5 or more standard drinks per drinking day for men, and consumed 4 or more standard drinks per drinking day for women): 49.6% of men and 33.9% of women in American Samoa, 43.6% of men and 34.6% of women in Marshall Islands, and 35.1% for men and 22.0% for women in the FSM (Pohnpei)

Sources:

- American Samoa NCD Risk Factors STEPS Report, 2007; FSM Risk Factors Steps Report, 2008; RMI NCD Risk Factors STEPS Report, 2007, www.who.int/chp/steps/reports/en/index.html

[3] The estimated indigenous population of Pohnpei is only 29,900; of Yap, 10,200; of Kosrae, 7,300; of Chuuk, 53,300; of Palau, 14,400; of the Republic of the Marshall Islands, 49,900; of American Samoa, 50,500; of Guam, 57,300; and of the Commonwealth of Northern Mariana Islands, 17,400. 2005 Census for the Republic of Palau; 2000 Census for the Federated States of Micronesia (Pohnpei, Chuuk, Yap, Kosrae); 2000 Census for the Commonwealth of Northern Mariana Islands; 2000 Census for the American Samoa; 2000 Census for Guam; 1999 Census for the Republic of Marshall Islands. www.pacificweb.org

[4] The percentage of the population nineteen aged years or younger was percent of population of the Republic of the Marshall Islands was 55% for the RMI; 54% for the FSM; 48% for American Samoa; 31% for Palau; aged twenty years or younger was 40% for Guam and 30% for CNMI. For comparative purposes, the percentage of the population of the US aged nineteen years or younger was 28%. (2005 Census for the Republic of Palau; 2000 Census for the Federated States of Micronesia [Pohnpei, Chuuk, Yap, Kosrae]; 2000 Census for the Commonwealth of Northern Mariana Islands; 2000 Census for the American Samoa; 2000 Census for Guam; 1999 Census for the Republic of Marshall Islands. www.pacificweb.org; 2006-2008 American Community Survey 3-Year Estimates for the US Survey; www.census.gov)

[5] *Pacific Partnerships for Health: Charting a Course for the 21st Century*. 1998. Edited by J. C. Feasley and R. S. Lawrence. Institute of Medicine, Board on Health Care Services and Board on International Health. Washington, DC: National Academy Press.

SIX COMPONENTS OF ACTION

The six components of the action plan that align with the Pacific NCD and Food Security Framework are:

I Advocacy and Coordination of NCD

- Government and public sectors
- Hospital and Outer Islands

II Tobacco Free RMI

- Policy, legislation, taxation
- Strengthening Community Action in School, Workplace, Church & Villages
- Cessation initiatives

III Nutrition

- Food Safety & Salt Reduction
  - i. Strengthen Food Control System
    Policy & Legislation Enforcement
  - ii. Strengthening Community Action
    (School, Workplace, Church & Villages)

IV. Physical Activity

- Apply to AusAid for Sports and Healthy grant
- Work with government workplaces, schools, and churches to increase physical activity in these settings.

V. Primary Health Care and NCD

- Implementation of Package of Essential NCD (PEN) Services
- Community Mobilization
- Chronic Care Model (CCM)

VI. Surveillance of NCD

- NCD STEPS and Mini-STEPS
- Behavior Survey
- Global Youth Tobacco Survey
- Vital Registration (For Cause Specific Morbidity & Mortality)
- Chronic Disease Electronic Management System (CDEMS)
- Cancer Registry

1. Background

The Republic of the Marshall Islands is a collection of 1,225 low-lying coral islands grouped into 29 atolls and 5 single islands spreading across an ocean area of over 750,000 square miles. RMI is approximately 2000 miles southwest of Hawaii, 8º north of the equator and is part of the Micronesian group. The total land area is about 70 square miles (181 square kilometers). The main height of land is about 7 feet above sea level (2 meters). The total population in 2011 was 53,158 (EPPSO) with the majority residing on the two major atolls of Majuro and Ebeye. 55% of the total population comprise the working age population (15-64 years) with 42.9% under 15 years and population 65 years and older of 2% (EPSO- need to confirm). Marshallese is the official language but English is taught in the schools and is widely spoken. The total fertility rate is 4.5 (World Bank) and the annual population growth is 1.4% (World Bank). With growing populations and very limited land areas, population density continues to be a concern with 300.2 persons/km^2 (World Bank) and greatly contributes to poor living conditions.

The Government of the Marshall Islands, is politically and economically linked to the United States of America as a "freely associated state". Under the terms of the Compact of Free Association between the Republic of the Marshall Islands (RMI) and the United States, the RMI is eligible for many of the Public Health Service programs and funds from the Department of Health and Human Services. However, the RMI is not eligible for Medicaid, Medicare, WIC, EPSDT, and federal funds for education (including development disabilities). These constraints limit the referral and resource options for health care providers striving to provide comprehensive services for their clients.

The Constitution of the Marshall Islands has designated the Ministry of Health (MOH) as the "state" health agency. The health care system consists of two hospitals, in Majuro and Ebeye, and 54 community health centers in the outer atolls. The main hospital in Majuro is a 100-bed facility, and the hospital on Ebeye has 30 beds. The Bureau of Primary Health Care (PHC) within the MOH also offers a full range of preventive and primary care programs in the main hospitals and is responsible for all preventive and primary care programs throughout the country.

The MOH has six major bureaus: 1) Bureau of Primary Health Care (PHC), 2) Bureau of Majuro Hospital Services, 3) Bureau of Health Planning and Statistics (HP&S), 4) Bureau of Kwajalein Atoll

Health Care Services (KAHCS), 5) Bureau of Administration, Personnel and Finance, and 6) Bureau of Medical Referral Services. An Assistant Secretary heads each bureau and all Assistant Secretaries report directly to the Secretary of Health who is the head of the institution governed and represented politically by the Minister of Health.

2. NCD CRISIS in RMI

Like the other Micronesian countries in the pacific, RMI is facing the double burden of disease having not satisfactorily controlled communicable disease and facing rising rates of NCD or chronic diseases such as diabetes, heart disease including hypertension and stroke, cancers and respiratory disorders. In nutritional disorders there is probable coexistence of obesity and under-nutrition (micronutrient deficiency) within individuals, families and communities. Compounding this situation, RMI faces a large population increase with decreasing funds.

According to the National NCD STEPS survey in 2002, the prevalence of hypertension was 10.5% and Diabetes was 19.6% which is one of the highest in the Pacific. In recent years, diabetes has overtaken tuberculosis as the most common disease with the longest hospital stay in the Marshall Islands. Diabetic complications such as cataracts and gangrene or gangrene-related amputations have also been on the increase through the years. From 2000 to 2001, amputations increased by 28% (MOH, Planning and Statistics) Furthermore, the trend of diabetes is affecting the younger population with a gradual increase of cases in the 20-35 years of age. The increase in the number of diabetic patients and people at risk for diabetes is mainly due to the changes in the lifestyles of the Marshallese population. With the increase number of the population being screened found to be diabetic, the Ministry has placed more emphasis on screening for early detection and managing people with diabetes and hypertension, and overweight and obesity as preventive measures.

Table 1. Diabetes Prevalence Rate in the RMI

Description	FY 2007	FY 2008	FY 2009	FY2010	FY2011	FY2012
Population	52,701	53,236	54,065	54,439	53,158	53,158
Majuro	1694	1570	1369	1385	1357	1,009
Ebeye	600	600	600	623	623	785
Majuro and Ebeye	2,294	2,170	1,969	2,008	1,980	1,794
Prevalence Rate*	435	408	364	369	372	337
Increase/Decrease		6.2% ↓	10.8% ↓	1.4% ↑	0.81% ↑	
* Per 10,000 Population						

On the other hand, Cancer is the 2nd leading cause of death in RMI. It affects the female population more than the male. The death is attributed to breast cancer, cancer of the cervix, liver cancer, and of course, lung cancer.

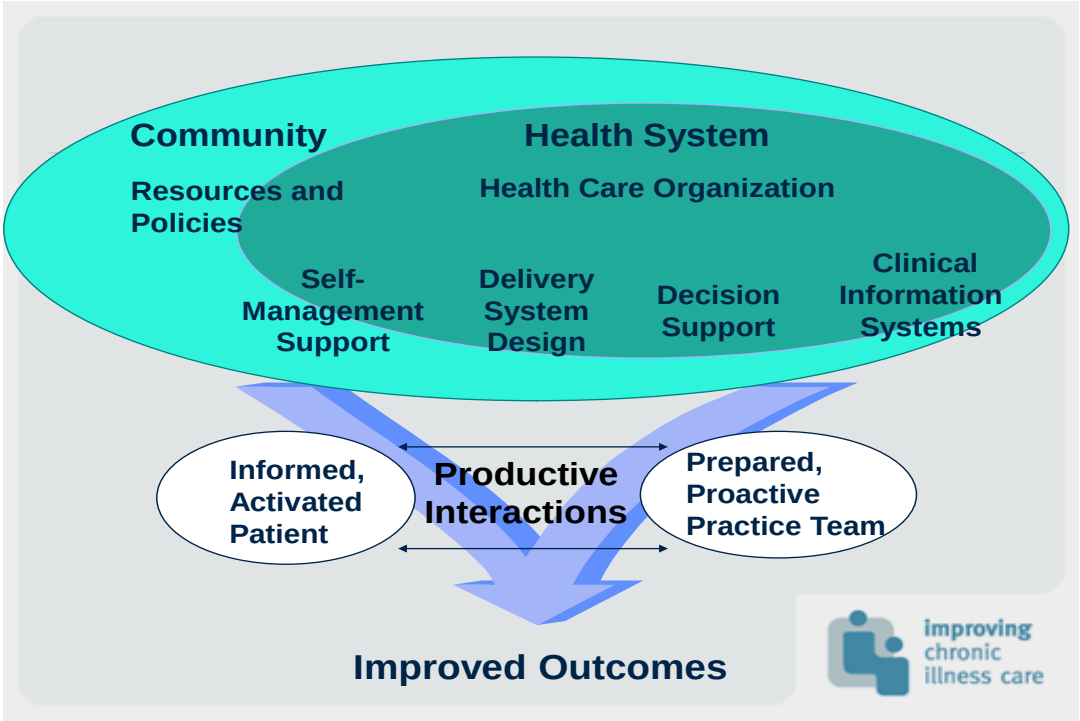
Table 2. Death due to type of Cancer,FY 2012

Cancer Site	Male	Female	Total
Cervical	0	4	4
Lung	3	1	4
Breast	1	3	4
Nasopharyngeal	3	1	4
Laryngeal	2	0	2
Ovary	0	2	2
Kidney	1	1	2
Leukemia	0	1	1
Submandibular	1	0	1
Pancreas	1	0	1
Colon	1	0	1
Neck	1	0	1
Liver	0	1	1
Stomach	1	0	1
Urinary Bladder	1	0	1
Brain Tumor	1	0	1
Lumber	1	0	1
Uterus	0	1	1
Total	**18**	**15**	**33**
Source: MOH Vital Statistics Information System (VRIS).			

There is a continuing need to look at risk factors in the general population and put in place 'primary prevention strategies' to prevent or halt progression of individuals to NCDs like Diabetes. There are four risk factors on NCDs. Among them, tobacco use and smoking is the main risk factor contributing to NCDs. According to the 2011 census, add the data here and any other data among the youth, ect.

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first international public health treaty under the auspice of the WHO. RMI ratified the WHO FCTC on 8 December 2004 and the WHO FCTC entered into force for RMI on 8 March 2005. As a Party of the Convention, RMI as a whole needs to implement effective measures to meet all its obligations. The WHO FCTC serves as an important legal instrument and tool to contribute to the prevention of non communicable diseases. The Political Declaration of the UN High Level Meeting on NCDs , 2011 calls upon countries to implement the WHO FCTC. The Government of the RMI together with the Convention Secretariat, WHO FCTC conducted a joint needs assessment on implementation of the WHO FCTC. The needs assessment report serves as a good reference document to better implement the Convention and prevent the NCDs in RMI. The 2002 STEPS results revealed startling figures which have been the thrust of the NCD/Nutrition planning. The government has realized the full implications of the figures as NCDs are not only the highest cause of morbidity and mortality now but will cause devastation in the future if nothing is done to intervene.

3. Management of the NCD Crisis



- **Comprehensive**: incorporating both policies and action on major NCDs and their risk factors together
- **Multi-sectoral:** involving the widest of consultation incorporating all sectors of society to ensure legitimacy and sustainability
- **Multidisciplinary and participatory**: consistent with principles contained in the Ottawa Charter for Health Promotion and standard guidelines for clinical management
- **Evidence Based**: targeted strategies and actions based on STEPS and other evidence. The employment of both population wide and individual based interventions termed best buys.
- **Prioritized**: consideration of strata of socioeconomic status, ethnicity and gender
- **Life Course Perspective**: beginning with maternal health and all through life in a 'womb to tomb' approach

- **Simple**: setting some strategic direction but also simple enough for any stakeholder to be able to quickly identify activities that could help drive its implementation.

The plan is intended to be a workable and realistic approach which can be achieved. As the plan will be monitored and reviewed over the next 5 years and beyond, new activities can be added based on emerging issues and also changing priorities.

With the realization that the current NCD services are quite fragmented, there is a need for coordination of the services currently in place for NCD and advocacy for awareness and commitment by government to address what has become the largest health burden in RMI.

With these considerations, and by a combination of the Pacific Framework for NCD and Food Security and the Ottawa Charter of Health Promotion, 5 components for action were prioritized under which formulation of strategies and activities for NCD and Nutrition in RMI will be carried out. These are intended to meet the targets set by RMI at the NCD Forum 2013 (see below), which are inspired by the Global and Pacific Targets for NCDs.

Area of Action	RMI TARGETS
NCD Mortality	*Reduce mortality between ages 30-70 due to Cardio Vascular Disease (CVD), diabetes, cancer or Chronic Renal Disease (CRD by 25%*
Tobacco	TOBACCO FREE RMI by 2020/2025 Tobacco reduction to 10% on current users
Physical Activity	Increase physical activity by 75% (2018)
Salt and Hypertension	50% relative reduction in salt consumption 25% relative reduction in raised blood pressure (TIMEFRAME)
Cardiovascular disease and diabetes	CVD multidrug treatment and counselling 25% relative reduction in prevalence of diabetes.(TIIMEFRAME)
Cancer	25 % of women (21-65 yrs) screened for cervical cancer 10% of women (40- up) screened for breast cancer

4.0 NCD Commitments