



Pohnpei State Comprehensive Cancer Control Plan

A collaborative effort by the Pohnpei State Department of Health Services and Pohnpei Cancer Coalition with strong technical support & consultation by Strategic Health Concepts, University of Hawaii, John A. Burns School of Medicine, Centers for Disease Control, and Papa Ola Lokahi

March 2007



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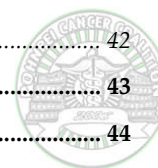
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Kaselehlie Maingkoa!



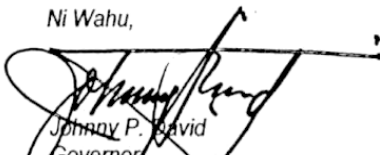
Cancer is a major disease and health burden in Pohnpei State. It is still considered as a major cause of death and remains a major source of financial health burden on the economy. The operational approaches and the current structure of our health department coexisting in our unique and proud culture do not necessarily provide a conducive setting and environment of prevention and protection against this disease. There is much energy, pain, and sacrifice, exerted from patients and family members of cancer victims and less from health services, communities, and individuals which can positively influence the outcome of the disease. As we are aware, moving forward and learning from our past experiences, we realize that tackling this

major public health issue requires a sustainable commitment, collaboration, and an integrated approach at all levels of care in order to improve the quality of life for individuals affected by cancer.

I am please to introduce the first Pohnpei State Comprehensive Cancer Control Plan. This plan aims to provide Pohnpei state with a road map and guide that can be utilized by health services, organizations, communities, and individuals towards prevention, early detection, treatment, and quality of life improvement for people affected by cancer in Pohnpei state. This plan was developed by a group of diverse individuals, experts, survivors, and healers in many sectors of government and nongovernmental organizations, and other agencies in Pohnpei state that currently formulated the Pohnpei Cancer Coalition (PCC).

I commend the PCC for their collaborative hard word during the past year to develop a practical cancer plan for the state of Pohnpei. I also like to extend our appreciation to our facilitating partners in this major health milestone. With practical innovative ideas, we are preparing ourselves to face challenges in health that cannot be controlled individually, but rather in an integrative and collaborative approach. Hence, I hereby urge the people of Pohnpei to support the content of this plan as we mobilize and prepare for implementation of the Pohnpei State Comprehensive Cancer Control Plan.

Ni Wahu,


Johnny P. David
Governor
State of Pohnpei



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BACKGROUND

Political: Blending the past and present

Pohnpei State in the Federated States of Micronesia, is the capitol of Federated States of Micronesia (FSM). What is now FSM became a part of the United States Trust Territory of the Pacific Islands from 1947 until 1986 when it became an independent nation under the Compact of Free Association between the FSM and the U.S. A brief political history is presented here to remind us of where we came from and how important it is for the two systems to work together.

Pohnpei has several periods or dynasties. Pohnpei was created and society began during the first period, *Mwein Keilahn Aio*, which translates literally as “on the other side of yesterday.” The second period is known as *Mwein Saudeleur*, or the Saudelor Dynsasty, from 500 A.D. to 1628.



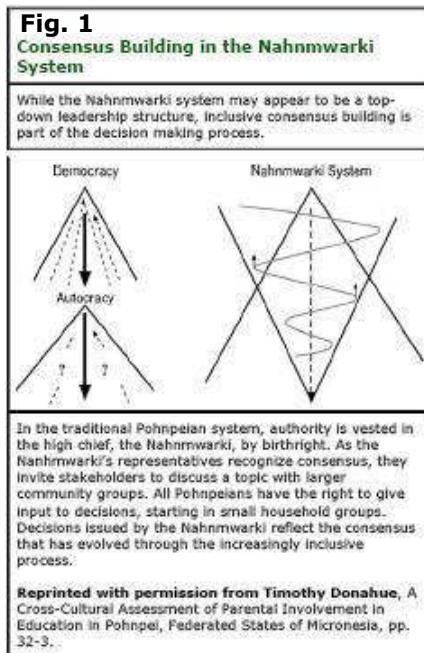
The *Nahnmwarki* system began, replacing the previous totalitarian government. This was a decentralized political system. The leaders reaffirmed the land divisions, including *Wein Madoleihmw*, *Wein Kitt*, and *Wein Sokehs*. Later on, *Wein U* and then *Wein Nett* were founded. Each subdivision was granted authority for self-governance through the *Nahnmwarki* system.

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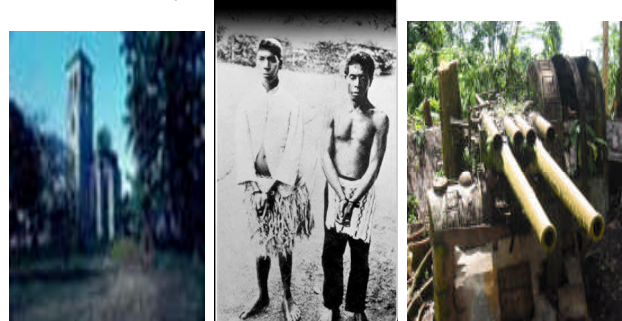
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Chiefs were authorized to lead communities, with a hierarchy of other ranked titles to support the system.



The *Nahnmwarki* system served Pohnpeians for roughly 200 years until different foreign powers – first Spain, then Germany, Japan, and America – administered



the islands starting in the 1800s. Each introduced new values, new religions, and new types of leadership. These undermined the traditional system and devalued its beliefs. The new and traditional leadership systems became vastly separated. The fourth and current period is known as *Mwein Wai*,

an era of “Sneakers,” or foreigners who sneak in. This period overlaps with the *Nahnmwarki* system and introduced the term “democracy.” The democratic system introduced new values, elected leadership, and new ways of thinking. With this system comes many expectations that problems will be solved. The new system is now turning back to the communities to find out what has gone wrong¹. The decision-making process utilized in the Nahnmwarki system is remarkably similar to the process used to develop this Comprehensive Cancer Control plan. Two paramount chiefs in each of the 5 traditional land divisions, the *Nahnmwarki* and *Nahnken* still exert considerable social and political influence. Several traditional leaders are part of our Pohnpei Cancer Coalition.

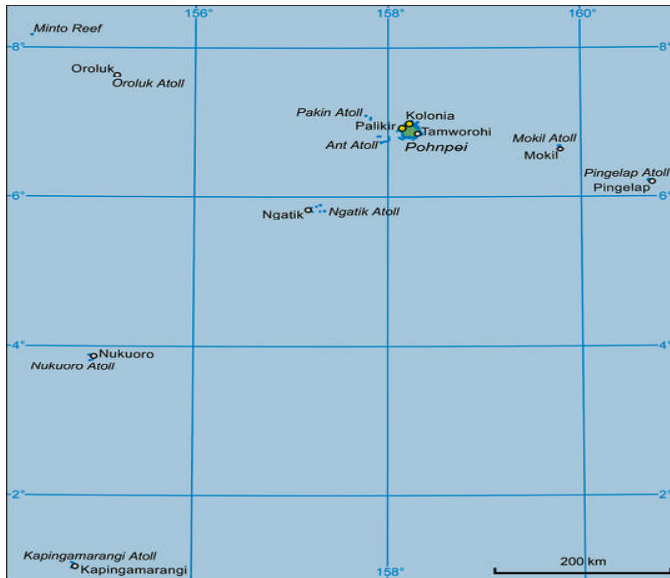


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Geography and Transportation

Fig. 2 Pohnpei State



The largest island in the Eastern Caroline group, Pohnpei state consists of a large volcanic island, Pohnpei, and six inhabited atolls, with most of its 133 square miles on Pohnpei Island. Pohnpei proper is encircled by a series of inner fringing reefs, deep lagoon waters, and an outer barrier reef with a number of islets found immediately offshore. Pohnpei State is the national capital of the FSM and the site of the College of Micronesia National campus and the FSM National Government in Pohnpei.

Travel on the island of Pohnpei proper is increasingly easier with the development and improvement of

paved roads to outlying communities from the central area. Not all roads are paved, however, and many residents of Pohnpei proper have a difficult time accessing health care. The outer islands have much less accessibility because inter-island transport is restricted to cargo ships and the “field trip ship,” which makes a monthly run through the outer islands of Pohnpei to transport mail, supplies, and health personnel. However, outer islands are building runways, making them more accessible by small plane.

Demographics and Economics

Pohnpei is the second largest state in the FSM with a total population of approximately 34,486. The median age of the population is 18.9 years, which makes this the second youngest population in the FSM. Though more Westernized than some of the other States in the FSM, Pohnpeians still face economic and health challenges in comparison to the US or other US territories.

Table 1. Selected demographic, health and economic indicators for FSM

	Chuuk	Kosrae	Pohnpei	Yap	FSM	U.S.
Total Population	53,595	7,686	34,486	11,241	107,008	
Youth as % of total population			52.8%		55% 0-19 yrs 33% 0-9 yrs	
Living in state centers	No public transportation				23%	

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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%	
Infant mortality					29.16/1000*	6.43/1000
	Chuuk	Kosrae	Pohnpei	Yap	FSM	U.S.
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 ²	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)	
% 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>

Communication

Pohnpeian is the dominant language of Pohnpei. Although there are two Polynesian languages spoken by two groups of outer islanders, it is Pohnpeian that permeates the lives of residents on the main island of Pohnpei. In public schools the language is taught in the first grade and maintained through the eighth grade. It is not taught in high school because of the assumption that students have already mastered it. Private schools teach Pohnpeian at their own discretion.

Communication across the FSM can be challenging. For example, providing the FSM with telephone service is a challenge due to the fact that FSM Telecom's service area stretches across one million square miles of the western Pacific Ocean. The FSM includes 607 islands, with some of the outer islands being among the most isolated land masses on earth. Telephone calls cost \$ 1.00 per minute within the FSM and ranges from US\$2.00 to \$12.00 elsewhere. 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. Customers have Internet 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.

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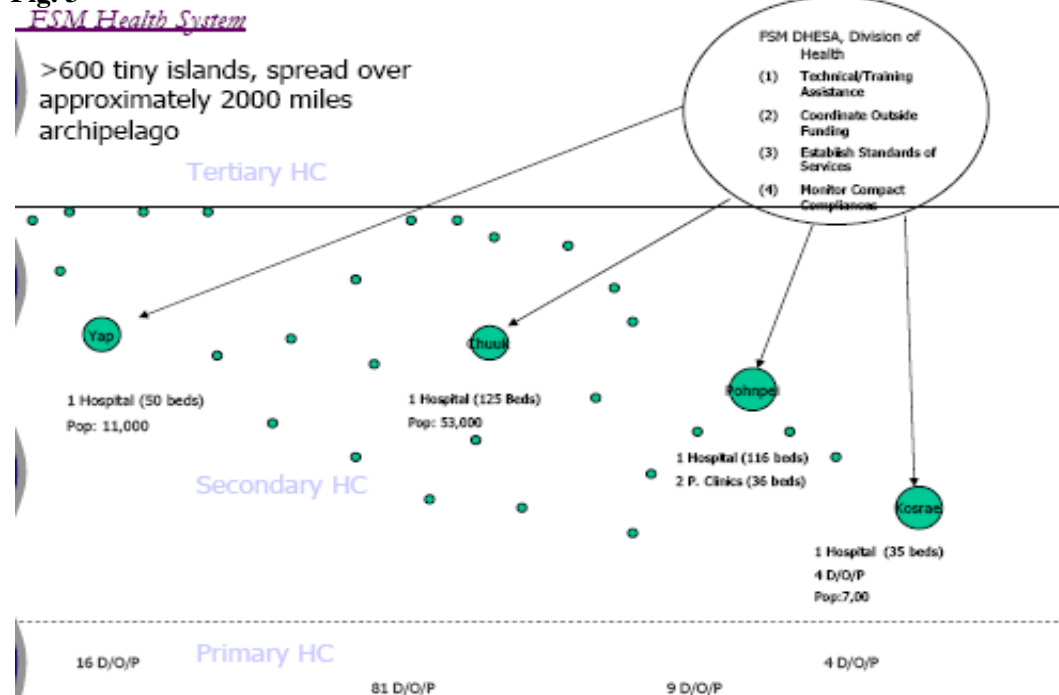
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FSM Telecommunication is planning to provide cellular services and internet access to the outer islands in the near future; however no electricity exists in many of the outer islands. The four FSM hospitals are currently have internet access via a 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

Pohnpei State Department of Health Services consists of several divisions: Hospital, Primary Health Care, Dental, and Administrative. Each State's Department of Health Services is linked to the FSM National Department of Health, Education and Social Affairs (HESA)³.

Fig. 3



The Pohnpei State Hospital provides the secondary health care with 90 acute beds and provides emergency, inpatient, surgical, labor and delivery, pediatrics, physiotherapy, lab, radiology, and hemodialysis services. Altogether, the hospital employs 80 medical and health care staff. Cases that cannot be treated in Pohnpei may be referred to Medical Referral Committee (MRC), which considers physicians' requests to transfer patients to facilities outside of Pohnpei for medical treatment. Because of limited health budgets and the fact that few patients are insured, patients with 5-year life expectancies of less than 50% are generally not referred off-island.

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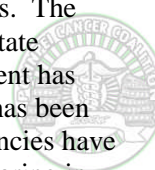
There are now four (4) private clinics operating in Kolonia (capital of Pohnpei State), with one clinic/hospital (Genesis) having 6 inpatient beds and providing surgical, OBGYN, and internal medicine services. The majority of the higher income populace attends these private clinics. Currently there is no information exchange between these private clinics and the public hospital or public health system, creating a disconnect and impacting the quality of data related to health programs.

The Division of Primary Health Care Services of the PSDHS has 36 employees. Programs include: Maternal and Child Health Program, Immunization Program, Family Planning, sexually transmitted infections, non-Communicable Disease, and nutrition. In addition to services provided at the central public health office, located in Nett, the Division is responsible for the Community Health Center (CHC), five dispensaries on Pohnpei island, and five dispensaries on the outer islands. These dispensaries are staffed by health assistants who provide primary health and preventative health care in the rural areas. The health assistants are typically high school graduates from that community, who completed an additional 6-12 months of training in the main hospital. The roles of these health assistants include but are not limited to providing basic first aid to patients, diagnosing, treating and triaging patients, performing minor procedures (i.e. incision and drainage of boils, intravenous insertion of IV catheters etc), keeping, recording and filing of medical charts, conducting quarterly inventory and maintenance of dispensary supplies and equipments, submitting medical reports, and assisting Doctors in when they visit and hold clinics. Most health assistants are male. None of them have been trained to perform any type of cancer screening.

CANCER IN POHNPEI

Being by far the most developed state in the FSM, it is not surprising to find that the capital city of Pohnpei offers the highest quality of care and facilities in the nation. There still remains a great need for development and improvement, however. Like many others in the Pacific Basin region, Pohnpeians are hesitant to seek care immediately at the hospital. Those who eventually do seek care for cases involving cancer treatment inevitably end up traveling to either Hawaii or the Philippines because of the inadequacies of the local hospital. Traditional local medicine is either often coupled with the Western medicine offered at the hospital or practiced solely for all forms of health management. There is no pathologist, no radiologist and no CT scanner. Biopsy specimens must be shipped off-island for analysis but there is occasional financial difficulty the limits or delays the diagnosis.

One of the main issues of concern for cancer prevention and treatment in Pohnpei is the large gap in development between the health care facilities and other comparative provisions. The central city of Kolonia where the majority of the government buildings and Pohnpei State Hospital are located is quickly becoming a thriving metropolis. The rate of development has increased so quickly that the capability to monitor and maintain a healthy population has been severely weakened. The consumption of fast food and other unhealthy Western tendencies have come along with this rapid rate of development and the ramifications are quickly appearing in



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the form of a higher prevalence of non-communicable diseases. Thus, the foundations in health care management are at hand in Pohnpei along with the need to modernize and maintain these programs and facilities.

There is no cancer registry in Pohnpei or in the FSM. 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 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, the assessments were published in a special issue of the *Pacific Health Dialog* on cancer in the Pacific⁴. 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 worthy of reporting). 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 for the country. 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.

Table 2. Leading Cancer Deaths by Site (from 2002-03 NCI Pacific Cancer Initiative Cancer Needs Assessments⁴)

	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;	Cervical (14.7%)	Liver (23.1%)	Lung (46)
Rank 2	Cervical (7.8%)	(F) ovarian, thyroid, breast, cervical, lung, renal	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)

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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)

*FSM data from FSM Health Statistics Office, DHESA

It is imperative that a cancer control program be formed to reduce the cancer burden in Pohnpei. Before the inception of the Pohnpei Cancer Program, cancer awareness, outreach, and prevention services were provided through the Division of Primary Health Care Services, in addition to screening for breast and cervical cancer. For cervical cancer, pap smears and education are provided by the Maternal and Child Health (MCH) and the Family Planning Programs. Statistics showed that there are 8,000 women over the age of 20 years of age who are eligible for Pap smear screening in Pohnpei. For breast cancer, physicians perform clinical breast examinations as part of the physical examination provided to women who attend the clinics. There is no mammography in the FSM. The Tobacco Prevention program is operated by the Substance Abuse and Mental Health Division. It has 12 staff of which 2 are designated as Tobacco Prevention Educators. This Division collaborates with the Pohnpei Police Department in monitoring the FSM regulation that prohibits the sale of tobacco products to minors.

With the Pohnpei Cancer Program in place, there is much anticipation that the efforts of related existing cancer control and prevention programs will be coordinated. Many of these programs (i.e. Tobacco Coalition, MCH, STI/HIV, etc.) are active partners of the Pohnpei Cancer Coalition. So far there is evidence of collaboration amongst partners. For instance, during one of the PCC meetings the Administrator for the only AM Radio on island saw the need to advertise the program activities and donated a radio spot for the program.

EVOLUTION OF THE PLAN

Since the mid 1990s, physicians from the Pacific Basin Medical Association (PBMA) began raising concern for the increasing numbers of patients dying from cancer. At the same time, the Pacific Islands Health Officers Association (PIHOA) was developing a strategic plan which included focus on chronic diseases. PIHOA is the regional health policy body for the USAPIN, an organization comprised of the chief executive health official in each of the six USAPIN, the Directors of Health of the FSM States, the CEOs of Guam Memorial Hospital and LBJ Tropical Medical Center in American Samoa. In 1999, the President's Cancer Council was presented with testimony on the cancer health disparities in the USAPIN. Dr. Freeman, the chair of the Council, encouraged development of databases to strengthen the case for true cancer disparities. In February 2001, both PBMA and PIHOA made cancer a priority and these issues were discussed in Atlanta and in many subsequent venues at the US Federal level. In 2002, the NCI Center to Reduce Cancer Health Disparities, under the direction of Dr. Harold Freeman, and the NIH



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National Center on Minority Health Disparities provided financial resources in response to Pacific advocates requests. Funding was channeled through Papa Ola Lokahi, a Native Hawaiian Health Organization with a long track record of providing advocacy and technical assistance to the Pacific. Dr. Neal Palafox, of the University of Hawaii Department of Family Medicine and Community Health serves as the Principal Investigator for this project. These combined NCI and NIH resources were used to form the Pacific Cancer Initiative⁵. The goal of the Pacific Cancer Initiative was to address the cancer health needs in the USAPIN by:

- (a) Creating a regional cancer leadership team of Pacific Islanders (the Cancer Council of the Pacific Islands (CCPI);
- (b) Assessing and articulating the cancer health needs of the USAPIN; and
- (c) Developing sustainable strategies to address the cancer burden in the USAPIN.

Family Medicine residents and faculty physicians from the University of Hawaii Department of Family Medicine and Community Health and Dr. Henry Ichiho performed the Cancer Needs Assessments in Pohnpei in January 2003. From there, preliminary regional and jurisdiction-specific priorities were formed. Findings revealed that cancer is the leading cause of death in Pohnpei, yet cancer-related awareness, prevention, detection, and treatment services were limited. A number of needs were identified, and an action plan was developed based on five priority areas: 1) increasing community awareness about cancer (especially cervix, breast, liver and lung) and related risk factors; 2) securing funding for cancer prevention and control planning and activities; 3) establishing a fully staffed cancer prevention and control office; 4) building local capacity for cancer cytology; and 5) increasing capacity to obtain and process lab specimens for high-risk patients. Health promotion projects were developed as first steps, utilizing the NCI and NIH funding.

In June 2004, the University of Hawaii, received a National Comprehensive Cancer Control Planning (NCCCP) grant on behalf for 5 of 6 USAPIN, including the FSM. These grants were funded by the U.S. Centers for Disease Control and Prevention, Division of Cancer Prevention and Control. The Pohnpei Cancer Coalition (PCC) efforts began in August 2004.

The PCC is comprised of many partners from the community, public health, religious, traditional leadership and private sector. For the first time, cancer services in Pohnpei will be addressed through a consensus of professionals in public, private, NGO, and the community to make a realistic plan that more efficiently utilizes available resources. (Please refer to the Appendix for a detailed listing of members.) The Coalition members have worked hard to develop the Pohnpei State Comprehensive Cancer Control plan. The current elected Coalition chair is the Chief of Primary Health Care Services in the Pohnpei State Department of Health Services. The Vice-Chair is a high-ranking official within the Pohnpei traditional leadership structure. Although membership of the PCC is open to any persons or organizations, the recruitment process requires that a formal invitation be given to potential parties by the Executive Committee (elected officers of the PCC) and that the party possesses the following characteristics; committed to the mission, willing to spend time and energy in to the planning and implementation process, shared the same vision of cancer control in Pohnpei, plays and important role in the community, and willing to contribute resources for cancer control whenever possible.



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Borne out of the need to combat the cancer burden in Pohnpei, the Pohnpei State Department of Health Services established a cancer prevention and control program in September 2005. The Pohnpei Cancer Program is responsible for coordinating the development and implementation of the comprehensive cancer control and prevention plan, which is designed to help alleviate the suffering amongst the Pohnpei community and its residents.

The first coalition meeting was held in 2004 and they set the initial priorities for cancer control. Through the CDC Cooperative Agreement, the University of Hawaii Department of Family Medicine and Community Health and other National Cancer Partners developed a step-by-step workbook to help the coalitions learn the CCC process while developing their plans. Since September 2005, the coalition has held 16 large meetings to develop the plan. Ad hoc workgroups were developed to refine the details of various objectives and strategies. Several technical assistance site visits and reverse site visits to Hawaii were made to further refine the plan.



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POHNPEI STATE COMPREHENSIVE CANCER CONTROL PLAN

GOALS, OBJECTIVES, STRATEGIES

VISION:

To have a cancer free Pohnpei

MISSION:

The mission is to work collaboratively with health professionals, the community, non-government organizations (NGOs), professional institutions, and other public and private sectors to coordinate cancer prevention, early detection, and treatment efforts to improve the quality of life for Pohnpeians.

PREVENTION GOAL: PREVENT CERTAIN CANCERS FROM OCCURRING

Background:

Pohnpei State Department of Health Services has been tackling the health problems of cancer in a rather ineffective multidimensional and a poorly collaborative fashion. This is largely due to its fragmented system of budgeting, resulting in many of its public health programs focusing on different elements of cancer awareness, prevention, treatment, and management. Before the establishment of Pohnpei Cancer Program, much of the existing public health programs such as Maternal & Child Health and Family Planning programs primarily focused their prevention efforts on the needs of mothers and children and cancers associated with motherhood.



The Tobacco Control Program provides awareness and prevention programs for tobacco related cancers and serves mainly as advocates to tobacco free legislations and policies. Substance Abuse & Mental Health Programs provide education and awareness of drugs and substances related to cancer. However, none of these efforts are coordinated to cover cancer issues as a whole. In addition, the public health staff is

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severely understaffed. There is no current network of programs that deals with cancer in terms of data management, prevention, planning, and treatment.

A large number of cancers in the Pohnpeian population are preventable cancers and cause significant amounts of early death. Moreover, dealing with cancer from the individual existing public health program's perspective does not improve overall cancer. Collaboratively addressing cancer prevention, early detection, and effective management is essential to provide of Cancer in Pohnpei.

Objective 1: Within the first year of implementation, develop and distribute culturally appropriate information on cancer and cancer risk-factors on the 5 most common cancers in Pohnpei.

Baseline: No cancer or cancer risk-factor education materials in 2004;
No coordination of health promotion/cancer prevention activities

Strategy 1.1: Within the first 6 months, establish a community-based multi-sector alliance to distribute cancer information into communities and refine community-based strategies as needs change.

Outcome: Solid community partnership

Measure: Attendance records of meeting

Strategy 1.2: Develop culturally appropriate materials and strategies to address cancer by partnering with traditional and spiritual leaders to address sensitive cancer-related issues

Outcome: Culturally appropriate materials

Measure: Number and type of materials

Strategy 1.3: Disseminate information educational communication (IEC) materials utilizing media, existing groups and public health programs such as Adolescent Health Peer Educators, Women's group, community groups and community theater groups who provide educational plays

Outcome: Efficient use of existing community resources

Measure: # and type of materials distributed or # of plays presented to X amount of audience

Outcome: Increased awareness and interest in cancer; increased number of relevant cancer education materials

Measure:

Survey/Data collection to determine the

of outreach activities conducted by # of community/agency partners

of adolescents presenting to PSDHS family planning clinics

of adolescent females presenting for pap smears

of people contacting the cancer office for more information



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Objective 2: Within the first year of implementation, work with State and National policymakers to strengthen existing policies/legislation and to introduce and pass legislation and policies that will lead to a reduction in cancer risk-factors

Baseline: Legislation bill # 357-94 to prevent smoking in public areas and banning sales to minors.

Strategy 2.1: Work in collaboration with the tobacco coalition to support current and proposed anti-tobacco legislation.

Outcome: Increased collaboration between cancer coalition and tobacco coalition.

Measure: # of advocacy meetings

Strategy 2.2: Support enforcement of existing smoke-free policies in the workplace and public areas

Outcome: Increased collaboration amongst cancer advocacy groups and Pohnpei State Department of Justice.

Measure: # of advocacy meetings

Strategy 2.3: Work in conjunction with the National Government to advocate for other policies and legislation relating to the FSM Non-Communicable Disease strategic plan (policies promoting healthy eating, physical activity, anti-tobacco and anti-alcohol use)

Outcome: More legislation and public policies that reduce risk factors for cancer.

Measure:

of testimonies or letters of support from the PCC

of draft legislation that is introduced; # of enacted legislation

Objective 3: Within 5 years of implementation, work with the FSM National Government and outside partners to complete a cost-benefit analysis on developing a HPV vaccination program in Pohnpei.

Baseline: 14.7% of cancer deaths were from cervical cancer [1998-2002]; no vaccination

Strategy 3.1: Provide demographic data and other information needed for the study.

Outcome: Data-driven, realistic plan to guide decision-making and resource allocation

Measure: Review of the cost-benefit analysis report



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EARLY DETECTION GOAL: TO DETECT CANCER AS EARLY AS POSSIBLE

Background:

Pohnpei State Hospital provides a number of screening programs that include Hepatitis B, TB/Hansen's Disease, HIV/STI (sexually transmitted infections), Cervical and prostate cancer screening. The amount of screening done for all types of cancers varies. There are four private clinics on the island that also provide screening for cancer. Ultrasound is available on island, but no surgeons are trained to use it, there are no radiologists nor is there equipment for ultrasound-guided transrectal biopsies or percutaneous biopsy kits. In the health dispensaries, where over 50% of the populations receive their primary care, there is no screening and no supplies.

Breast cancer screening is limited to clinical breast examination because there is no mammography in the State or country. The average age of breast cancer diagnosis is 50-60s, with most presenting at stage III.



Although cervical cancer is currently the best screened compared to all cancers, there are still significant issues. Approximately 500 pap smears per year (out of 8000 eligible women or 6%) were performed prior to increased cancer awareness efforts and the paps are performed only by the MCH program and private clinics. Supplies for paps are often inadequate and there are often problems with shipping the specimens off-island for processing and interpretation. Since comprehensive cancer control planning

started, public awareness and demand for cervical cancer screening has increased. Unfortunately, the current MCH staff and OB-gyn is overloaded with the increased case load, and the colposcopy machine is broken so there is no way to properly follow-up abnormal pap smear results.

Objective 1: Within the first year of implementation, increase by 10% above baseline the number of women between the ages of 20-40 who receive cervical cancer screening and clinical breast examinations.

Baseline: Approximately 500 pap smears performed in 2005 out of 8000 eligible women

Strategy 1.1 Increase the budget allocation for cervical cancer screening supplies (slide, brush, spatula, fixative) by 10% per year (including budget for shipping, processing)

Outcome: Adequate supply of pap smear kits to meet the demand

Measure: # of days without a pap smear kit available when a patient showed up for screening.



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Strategy 1.2: Modify personnel and clinic schedules to allow for more pap and services to improve screening efforts

Outcome: increased access to services

Measure: # of clinics compared to baseline, # of women presenting to the clinics for women's health check up and receiving services that day

Strategy 1.3: Coordinate screening efforts with private health providers so that more pap smears can be performed.

Outcome: increased access to services and improved coordination between health providers.

Measure: # of clinics compared to baseline, # of women presenting to the clinics for women's health check up and receiving services that day

Objective 2: Within 2 years of implementation, develop a cost-effective, community-based tracking system for patients with abnormal biopsies, pap smears or suspected cancer.

Baseline: No tracking system in place

Strategy 2.1: Include in patient's packet the home address and phone number of closest relative who is able to contact that person.

Strategy 2.2: Work with local (municipal) government personnel to facilitate communication with patients (if needed)

Outcome: Increase the # of women with abnormal biopsies or pap smears are brought in for follow ups.

Measure: # of women with abnormal paps without home address and phone numbers, # of patients without a follow-up appointment within 1 month after the biopsy/pap smear result is received

Strategy 2.3: Hire a registered nurse in year 1 to help develop and implement the tracking system and serve as a patient navigator (see Quality of Life, objective # 2)

Outcome: Formal policies and procedures to assure proper and timely follow-up after a screening or diagnostic procedure

Measure: Review of policy and procedure manual, review of tracking log

Objective 3: Within 5 years of implementation, provide cervical cancer screening and clinical breast exams to 90% of the eligible female population in Pohnpei.

Baseline: In 2004, less than 500 pap smears performed per year out of 8000 eligible women

Strategy 3.1: By middle of year 1, hire a part-time OB-Gyn to train the health assistants and other health personnel to perform breast and cervical cancer screening and to administer the newly developed mobile Women's Health program



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Outcome: Increased access to cervical and breast cancer screening and Women's health program facilitated.

Measure: # of trained staff, # of women presenting to a health service provider for women's health check up and receiving services that day.

Outcome: Reduction of number of woman with advanced breast cancer on initial exams

Measure: # of women getting check ups and receiving service.

Strategy 3.2: By the end of year 2, train at least 75% of health dispensary workers to conduct pap smears and clinical breast exams in rural communities

Outcome: Increased access to breast and cervical cancer screening

Measure: # of trained staff, # of women presenting to a health dispensary for women's health check up and receiving services that day

Strategy 3.3: Improve the current budgeting and ordering process to ensure adequate supply of pap smear kits

Outcome: Health Service providers have a continuous supply of pap smear kits

Measure: # of women screened on the day they show up for pap smear (as opposed to being sent away because of no supplies)

Strategy 3.4: Improve budgeting process to anticipate for increased numbers of pap smears that will need to be sent off-island.

Outcome: Improved processing of specimen; reduced the turnaround time of specimens send abroad.

Measure: Money allocated for processing specimen; # of days to send and receive specimens send abroad.

Objective 4: Starting in 2007, participate in a feasibility study for mammography services with the National government.

Baseline: No plan in place to have a mammogram

Strategy 4.1: Collaborate with FSM National Government and other states to conduct a feasibility study on mammography services in Pohnpei

Outcome 1: Realistic plan to acquire mammography services

Measure: Completed study

Objective 5: Within 5 years of implementation, increase local diagnostic capability for prostate and liver cancer.

Strategy 5.1: Train current surgical staff to perform ultrasound-guided biopsies



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Outcome: More complete diagnostic workups being performed on-island; less health care budget being spent on off-island referrals for diagnostic work-up
Measure: More surgeons trained, less patient referred off-island for this procedure

Strategy 5.2: Start budgeting process to ensure availability of appropriate equipment and supplies for ultrasound-guided biopsies

Outcome: Adequate supplies

Measure: Shorter wait times for biopsies

TREATMENT GOAL: ENSURE EFFICIENT CANCER MANAGEMENT THROUGH PROVISION OF THE BEST AVAILABLE AND PROVEN EFFECTIVE TREATMENT BY UTILIZING PRACTICAL AND AVAILABLE RESOURCES.

Background:



Cancer treatment options in Pohnpei state are limited if not non-existent. One of the main concerns in providing in any form of healthcare treatment in the state is the inadequate number of local health providers than can manage the care of patients. As well there is a lack of early-stage treatment available for cancer patients. There is no working colposcope in the State, nor are loop electrosurgical excision procedures (LEEP) able to be performed. When patients are diagnosed with cancer they have the option to be referred off-island for treatment but neither the State government nor MiCare pays for stage III or higher diagnoses or when the five year survival rate is less than 50%. For patients that are eligible for the subsidized cost off-island care the Medical Referral Committee determines whether or not the patient should be referred. The committee meets once a week and is comprised of the Director of Health Services, the Chief of Medical Services, and several physicians. The committee makes their decision on the referral and then remits their recommendation to MiCare for the final decision. The current healthcare providers are working to their maximum capabilities and what they lack in resources they make up with dedication to their patients.

Objective 1: Within 2 years of implementation, collaborate with FSM National and Regional partners to increase training opportunities for current health providers to treat stage 1 or stage 2 cancers locally.

Baseline: Inadequate numbers of health providers who are able to treat stage 1 or 2 cancers

Strategy 1.1: Work with national, regional and local institutions in providing training or making training opportunities available to local health providers.



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Outcome: Increase in the number of locally trained staff
Measure: # of local providers trained in cancer management, # of WHO scholarships to further training in surgery or cancer-related care
Outcome: Reduced number of cancer referrals
Measure: # of referred cancer cases

Strategy 1.2: Provide appropriate CPD (Continue Professional Development) activities for various health personnel

Outcome : Increase in knowledge about care of patients with cancer

Measures: Numbers/participation of CPD activities, post-test results. Should eventually be linked with QA / tracking and HIM database (i.e., correct coding);

Objective 2: Within 3 years of implementation, collaborate with the National government and the other FSM states in conducting a cost benefit analysis for a maintenance chemotherapy program.

Baseline: No maintenance chemotherapy program in place; No locally trained staff on maintenance chemotherapy

Strategy 2.1: Collaborate with the National government and the other FSM states in conducting a cost benefit analysis for a maintenance chemotherapy program.

Outcome: Increased collaboration amongst National and state governments.

Measure: Review the completed analysis

Objective 3: Within 5 years of implementation, increase by 50% above 2005 numbers, on-island treatment of stage 1 and 2 cervical cancers.

Baseline: No OB-Gyn trained in colposcopy/biopsy/cryotherapy; no pathologist; only 1 OB-gyn available to perform cold conizations or hysterectomies or LEEPs, no LEEP tip

Strategy 3.1: Acquire Lippes Loop Excision electrocautery unit to treat cervical dysplasia

Outcome: All early cervical cancer changes are treated appropriately

Measure: # of treated abnormal pap smears/cervical dysplasia

Strategy 3.2: Training of appropriate local health staff in use of LEEP

Outcome: Training and competence in staff increased

Measure: # of trained staff

Strategy 3.3: Training in the appropriate use of the existing colposcope

Outcome: Increased competence in local trained staff

Measure: # of trained staff



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Objective 4: Within 5 years of implementation, improve access to off-island referral care services for cancer.

Baseline: Off-island referral care services are very limited and the entire process is inefficient.

Strategy 4.1: By 2008, develop an effective tracking system for referred cases.

Outcome: Fewer cases lost to follow up.

Measures: Tracking system in place

Strategy 4.2: Encourage more government employees to purchase health insurance

Outcome: Most of the population informed about the benefit of purchasing health insurance

Measure: Number of promotional materials and announcement distributed

Strategy 4.3: Advocate for the Medical Referral Committee to have the authority to approve off-island referrals.

Outcome: Fewer inappropriate cases referred off-island.

Measure: Number of cases deferred for off-island referral

Strategy 4.4: Work with the National government and other states to reform the current Government employees health insurance program (MiCare) *see FSM National Plan, Objective # 3.4)

Outcome: System that can afford to pay for treatment of selected stage III or higher cancers (cancers with reasonable treatment success rates)

Measure: state-level participation in health care financing discussion

Objective 5: To advocate for a regional Cancer Resource Treatment Center.

Baseline: No Regional Cancer Resource Treatment Center in place.

Strategy 5.1: Work with the National and Regional jurisdictions to complete a cost-benefit-analysis for a Regional Cancer Resource Treatment Center.

Outcome: Evidence based decision made regarding a regional cancer resource treatment center.

Measures: Review of the cost-benefit analysis report.

Objective 6: Within 2 years of implementation, work with the FSM National Government to develop a FSM Human Resources for Health (HRH) plan that takes into account the diagnostic and treatment needs for cancer patients in the FSM

Baseline: Health workforce planning and development (or Human Resources for Health) has been a strategic priority for PIHOA since 2001, has also been important in the health sector strategic development plans for the FSM and other Compact Nations (FAS). Planning has been



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difficult and slow in many areas because of widespread economic constraints that affect all partners who should participate in planning.

Strategy 6.1: Provide the National Government with a prioritized list of needed health care workers.

Outcome: Evidenced-based, State-generated priorities for health work force.

Measure: Meeting records and HRH plan.

QUALITY OF LIFE GOAL: RESPECT AND SUPPORT PSYCHOLOGICAL, SPIRITUAL, ALTERNATIVE OR TRADITIONAL MEDICINE, AND FAMILY INVOLVEMENT IN CANCER MANAGEMENT TO IMPROVE QUALITY OF LIFE FOR CANCER PATIENTS.

Background:

Presently, only a few health providers have received any training in or are comfortable providing medications for the relief of pain from cancer. Most health providers have not been trained in the full-spectrum of palliative care. There are no resources on-island to support or educate patients or families to care for cancer-patients. When patients are fortunate enough to be referred off-island for cancer-related diagnosis or treatment, they are often left to navigate the health services in the referral country (i.e., Philippines) alone. Presently, the supply of pain medications is inconsistent.

Objective 1: Within 2 years of implementation, ensure adequate social, spiritual and psychological care for cancer patients

Baseline: No coordinate cancer management activities or programs in place

Strategy 1.1: Formulate a standardized cancer care team which includes doctors, nurses, mental health workers, traditional healers, faith Reverences, and support group.

Outcome: Functional cancer care team.

Measure: Number of meetings with minutes, and number of communications

Strategy 1.2: Encourage and support family involvement by developing hospital visitation policies, materials and other resources

Outcome: More resources for family members.

Measure: Support mechanism in place

Strategy 1.3: Train family on end-of-life issues.

Outcome: Increased family understanding of end-of-life issues.

Measure: Number of trainings given, review of family survey (evaluating the effectiveness of the training)



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Strategy 1.4: Ensure that palliative treatments (i.e. narcotics) are available if desired by the patient

Outcome: Less patient suffering from lack of appropriate narcotics for palliative care.

Measure: pharmacy stock log or similar that is developing in conjunction with a pharmacy quality improvement project; review of pain rating scales

Strategy 1.5: Modify hospital policies so that external support for cancer patients can visit anytime.

Outcome: Increase flexibility in visiting hours for cancer patient visitors.

Measures: Number of visits noted per cancer patient in the hospital, outside of the normal visiting hours.

Objective 2: Within 3 years of implementation, ensure each cancer patient is assisted by a patient navigator

Baseline: No case coordinator or manager, no support person or system is in place for cancer patients or their families.

Strategy 2.1: Hire a registered nurse to serve as a patient navigator and help develop and implement the tracking system (see Early Detection, objective # 2, Strategy 2.3)

Outcome: Patient navigator hired

Measure: Payroll records

Strategy 2.2: Develop appropriate resource list and materials for cancer patients and their families

Outcome 1: More readily available information on social and other services for cancer patients and their families

Outcome 2: Culturally relevant information for patients and families

Measure: Number of information outlets – pamphlets, posters, etc.

Objective 3: Within 3 years of implementation, establish a centralized cancer office for coordination and information resources.

Baseline: No centralized cancer office is in place.

Strategy 3.1: Collaborate with existing community-based support networks.

Outcome: Extended supports for cancer care.

Measure: Number of network groups established

Strategy 3.2: Develop a resource list of information that could be adapted to local needs.

Outcome: Resource Services established



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Measure: Number of times resources services utilized by cancer patients, their families and the general public.

DISPARITIES GOAL: IMPROVE ACCESS TO CANCER SCREENING FOR PATIENTS IN RURAL AREAS AND OUTER ISLANDS.

Background:



Accessibility of cancer screening is a major challenge in Pohnpei, especially in the remote communities and the outer islands. Although a mobile team of public health and staff travel to outer islands twice a year and to communities on Pohnpei more frequently to provide education on public health issues, cancer screening and prevention issues often times are overlooked. Records show that majority of people who lived in remote communities and outer islands usually to the Pohnpei State Hospital with advanced stage cancers. This is due in part to inaccessibility to cancer screening and awareness information and also due to low income earnings. Most of these people depend on the land and ocean resources for subsistence.

The five dispensaries on the main island of Pohnpei and the other five on each of the outer islands do not provide adequate cancer screening and awareness information and services. These dispensaries are staffed by health assistants who are supposed to provide primary public health and preventive health care in the rural areas. Most of these staff have limited resources to work with given the broad spectrum of health issues they address. Some of the health assistants have been on the job for over 5 years and only recently retrained in immunizations, commonly seen illnesses, family planning and other public health issues. Education on cancer prevention, screening and early detection have not been included in the retraining curriculum.

There are no funds earmarked to providing cancer screening and education at this time. The newly developing cancer program has limited resources such as transportation and other resources to deliver services to rural communities and outer islands. There is no electricity or phone service in all of the outer islands (6% of the population).

Objective 1: Within 3 years of implementation, increase the amount of cancer screening services provided in the remote dispensaries by 50% above baseline rates.

Baseline: No cancer screening in remote dispensaries on Pohnpei Island and in the outer island dispensaries. 39% of the total population does not have access to cancer screening.

Strategy 1.1: Develop a plan to conduct periodic outreach services to provide screening in peripheral dispensaries, community outposts, as well as outer islands by end of the year.



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Outcome: Increased access to screening and cancer awareness services in the periphery.
Measure: Number of people getting screened and number of cancer awareness fliers distributed in the peripheral.

Strategy 1.2: Provide funding for a vehicle to provide transportation support for the outreach staff and also to clients from hard to reach remote areas in order to reach service sites scheduled in the communities.

Outcome: Increased access to people in rural areas who do not have transportation
Measure: Vehicle purchased

Strategy 1.3: Train health assistants to provide clinical breast examinations and pap smear (same as Early Detection Goal, strategy 3.2)

Outcome: Increased access to breast and cervical cancer screening
Measure: # of trained staff, # of women presenting to a health dispensary for women's health check up and receiving services that day

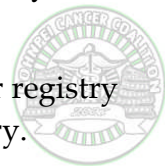
DATA QUALITY GOAL: IMPROVE CANCER-RELATED DATA COLLECTION SYSTEM

Background:

Pohnpei State does not have a centralized cancer registry. Thus, cancer data are obtained from death certificates and reports, a computerized hospital admission and discharge data system, and a computerized spreadsheet of cancer cases referred to outside hospitals. Mortality data are collected by the Medical Records Office and cleared and compiled by the National government. Based on the hospital discharge summaries in the medical records, a listing of patients with ICD-10 codes related to cancer is compiled. This data are maintained in a Microsoft Excel spreadsheet. Data from the sources mentioned above were compiled and compared to construct a complete, unduplicated list of patients diagnosed with cancer in Pohnpei State.

The Medical Records Office is headed by the Health Statistician, who is assisted by two data technicians, one Information Technician and three data clerks of whom one is assigned to handle cancer cases. A major problem identified by the Health Statistician is inconsistency among physicians in properly documenting the diagnosis and staging of cancers in medical records. Additionally, the great majority of the medical records staff do not have foundational training in health information management and there are no certified coders. This coupled with inadequate documentation by the physicians, results in difficulty assigning correct codes and in completing death certificates. This leads to great delays and extra effort to compile accurate mortality data at the FSM National level.

Objective 1: Within 3 years of implementation, establish a formal cancer registry in conjunction with the USAPIN Pacific Regional Central Cancer Registry.



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Baseline: Currently, Pohnpei Hospital does not have a cancer registry or any personnel trained to work with such a registry. Cancer cases are recorded in a spreadsheet.

Strategy 1.1: In year 1, identify the in-country data clerk/registrar who would serve as the primary point of contact for the Regional Cancer Registry

Outcome: Dedicated staff and focal person for registry-related data.

Measure: Personnel records

Strategy 1.2: 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

Objective 2: Within the first year of implementation, increase health workforce awareness on the importance of having a cancer registry

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

Strategy 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 3: Within 2 years of implementation, with the assistance of FSM National, Regional 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: Medical records staff largely trained on the job; physicians not coding appropriately

Strategy 3.1: Work with the local community college and/or other experts (in collaboration with Regional/FSM National training efforts) to conduct basic foundational



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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

Strategy 3.2: Beginning in year 1, work with FSM National Bioterrorism, PIHOA Regional lab coordinator and/or other experts to conduct quality improvement training for hospital and public health staff and to develop data flow protocols

Outcome: Staff in each department who better understand and are able to contribute to ongoing QA activities

Measure: Employee performance measure

Outcome: Improved quality of data that is produced by each department

Measure: Less missing or incorrect entries in information logs (tracking of reports)

Outcome: More standardized data flow policies across the region

Measure: Review of data flow policies, at least semi-annual reports from data clerks/registrars regarding complete information to cancer abstract

Strategy 3.3: Utilize the training modules from the CDC/ NAACCR website for medical records and physicians.

Outcome: Staff will be trained in registry basics even before 'experts' come in; reduced financial impact on health budget.

Measure: Review of test results at the end of each module

Strategy 3.4: Utilize the WebPlus abstract fields in the development and modifications of existing HIM databases.

Outcome: Some information can be gathered prior to development of the formal registry.

Measure: Review of HIM database entry form or reports

Objective 4: Within 2 years of implementation, work with the State and FSM National government to incorporate cancer-related data issues on Health Information Management System (HIMS)

Baseline: No HIMS in place

Strategy 4.1: Coordinate cancer-related data collection, where possible, with the forthcoming national Health Information Management System (HIMS).

Outcome: Cancer-related issues incorporated on HIMS

Measure: Review of records



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Implementation Plan

Since August 2004, when the Pohnpei Cancer Coalition was initially formed, members have demonstrated their commitment to comprehensive cancer control through voluntary attendance and involvement in planning meetings during the development of the Pohnpei Comprehensive Cancer Control Plan. This commitment remains steadfast as we embark on the next phase of this exciting process.

During the planning phase, the entire coalition was involved in all the meetings. To ensure successful implementation of the CCC plan and sustainability of the CCC program, a new organizational structure was developed. The coalition, with its broad-based community representation, will continue to serve as the backbone of the comprehensive cancer control program. The offices of Chair, Vice-Chair, Secretary and Treasurer will remain intact. Coalition membership will be assessed regularly to determine appropriateness, completeness and level of satisfaction.

The CCC Program is under the auspices of the Primary Health Care Services Division of the Pohnpei State Department of Health Services (PSDHS). Thus, the coalition, though community-based is considered a non-profit quasi-governmental organization. The administrative/fiscal assistant for the CCC Program will assist the PSDHS fiscal officer in monitoring program funds to ensure proper expenditure. Reporting and monitoring of the program's finances shall be subject to the PSDHS and CDC requirements.

The Steering Committee will serve as the decision-making body for the coalition, with input from the general membership and results of evaluations. Committee members include the Cancer Council of the Pacific Islands (CCPI) delegates, coalition officers, implementation team leaders and the program director.

Strategies will be implemented primarily by implementation teams representative of the major components of the CCC plan: Prevention, Early Detection, Treatment, Quality of Life, Data Quality and Disparities.

The CCC Program Staff will manage the CCC program, maintain communication amongst the stakeholders, coordinates and participates in implementation activities. Regular coalition meetings will be held twice a year for the membership at large to maintain interest 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. Program activities will be advertised in the local newspaper, the Kaselelia Press, broadcast weekly at the V6AH radio and televised on local television. Additionally, a quarterly newsletter will be developed and distributed to all coalition members. Communication to the other States, FSM, Regional and US National partners will be through the Regional CCC Program at the University of Hawaii.

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There is much to accomplish when taking a comprehensive approach to addressing the burden of cancer and the tasks can seem overwhelming. A system of prioritizing which objectives and strategies to address first will be developed. Consideration of the cancer burden, available resources and level of support, new data and emerging research and results of evaluations will be the criteria for determining priorities. 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 Pohnpei.”

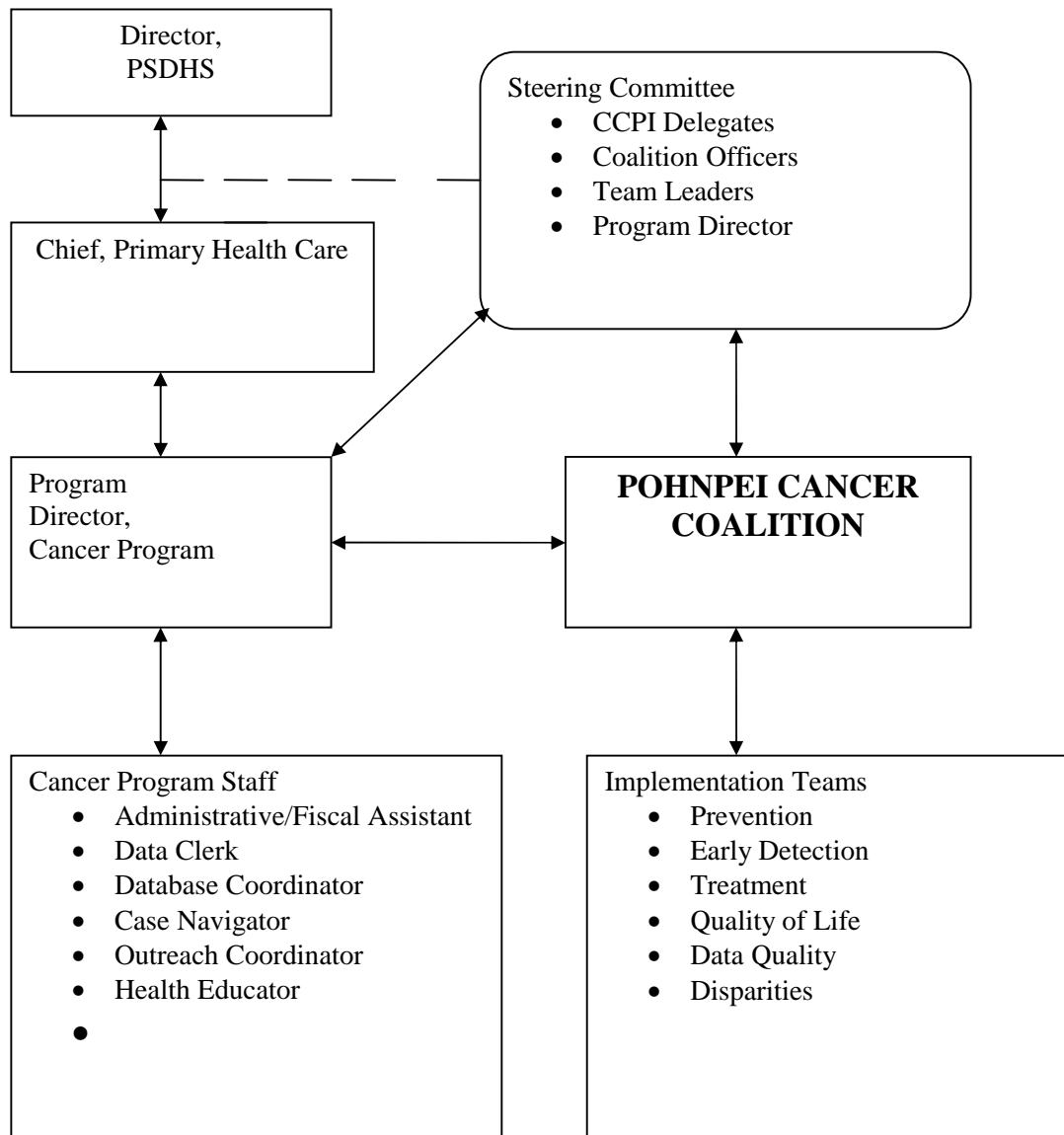


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Organizational Chart



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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. Pohnpei CCC Coalition
2. Pohnpei State 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

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 Pohnpei.



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APPENDICES

ABBREVIATIONS USED

AHD	Adolescent Health and Development Health
CCC.....	Comprehensive Cancer Control
CCCP.....	Comprehensive Cancer Control Plan
CCPI.....	Cancer Council of the Pacific Islands
CD.....	Communicable diseases
CDC.....	Center for Diseases Control or Communicable diseases control
CHC	Community Health Center
CNMI	Commonwealth of the Northern Mariana Islands
COPD.....	Chronic obstructive pulmonary diseases
CPD	Continue professional Development
EPIC.....	Economic Policy Implementation Council
FSM	Federated State of Micronesia
HIMS.....	Health Information Management System
HPV	Human Papilloma Virus
HRH	Human Resources for Health
ICD	International Classification of Diseases
ICD9.....	International Classification of disease coding version 9
ICD10.....	International classification of disease coding version 10
IDD	International Direct Dialing
MCH/FH.....	Maternal Child Health /Family Health
MRC	Medical referral Committee
LOS.....	Length of stay for hospital inpatients
MOU.....	Memorandum of Understanding
NCCCP.....	National Comprehensive Cancer Control Plan
NCD.....	Non-communicable diseases
NCI.....	National Cancer Institute
NHSO.....	National Health Statistics Office
NIH.....	National Institute of Health
PCC	Pohnpei Cancer Coalition
PCP	Pohnpei Cancer Program
PHCS	Primary Health Care Services
PIHOA	Pacific Islands Health Officers Association
PSDHS	Pohnpei State Department of Health Services
QA	Quality Assurance
RMI	Republic of the Marshall Islands
TB	Tuberculosis
TTPI.....	Trust Territory of the Pacific Islands
UH	University of Hawaii
U.S.....	United States



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USAPIN.....United States Affiliated Pacific Island Nation
WHOWorld Health Organization



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GLOSSARY OF TERMS

- 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 programs visiting the communities and to provide first aids and dispensing medicines. More than one aid-posts can be manage by one health assistant.
- CCCP**.....Comprehensive Cancer Control Plan is an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation.
- 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), usually runs 5 days a week, 8 hours a day from Monday to Friday.
- EPIC**.....Economic Policy Implementation Council. It is a body made up of the President, Vice President, all the four (governors, speakers of all the legislatures of state and national).
- Intermediate islands**.....refers to lagoon islands, islands within the state lagoon, on the atoll reefs that can be reached by motor boats and canoes with 20 minutes to 3 hours of ride.
- MiCare**..... National Health Insurance Plan: It is for national employees and their families and relatives. It is open to any FSM citizens who work or employee by government and private businesses of the FSM within and outside of the FSM.
- 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.



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For the first time, cancer services in Pohnpei will be addressed through a consensus of professionals in public, private, NGO, and the community to make a workable plan with available resources. As of October 2006, our partnership includes the following:

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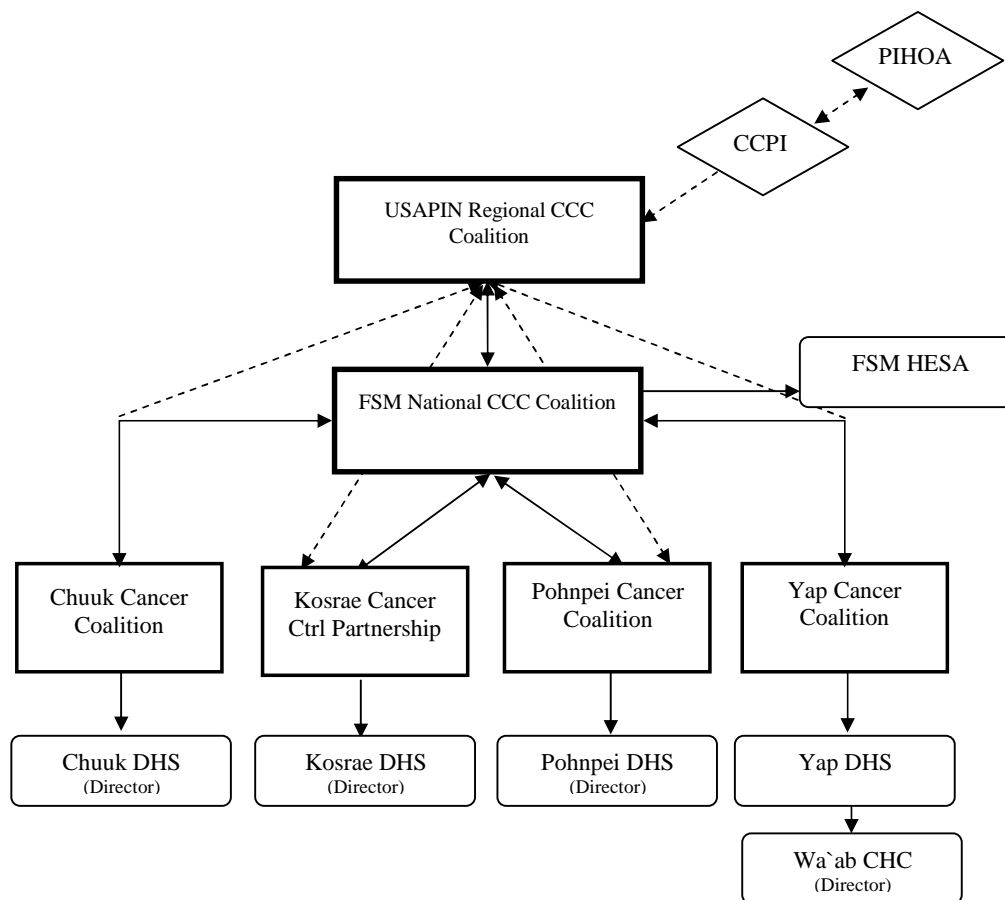


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Organizational Relationships and Communication between FSM National and States



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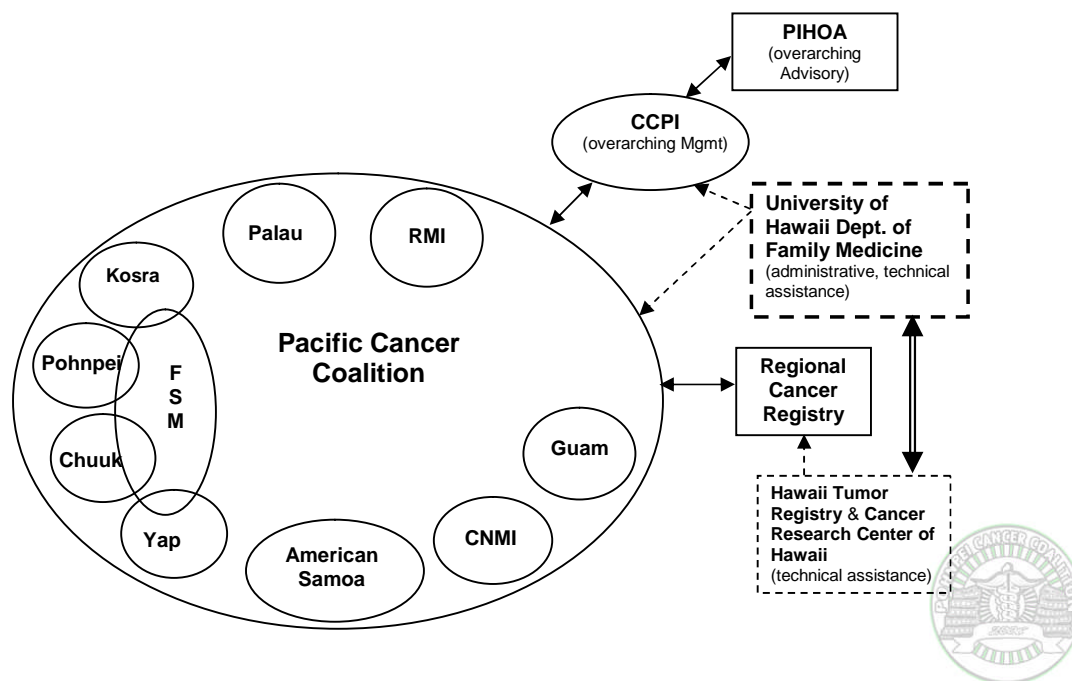
FSM National Meetings and Regional CCC Meetings

With other relevant meetings (proposed/tentative)

Jul 2007	Aug	Sept	Oct	Nov	Dec	Jan 2008	Feb	Mar	Apr	May	Jun
	NCC			NCC			NCC			NCC	
	NCD			NCD			NCD			NCD	
	DM			DM			DM			DM	
							HP				
	CDC			REG							
CCPI				CCPI					CCPI		
PIH		CCCLI			CCCLI				PIH		?CDC
PBMA				RREG						NPCR	NAACCR

NCC = National Cancer Coalition; NCD = Non-communicable disease strategic planning; DM = FSM Directors' Meeting; HP = FSM Annual Health Policy Meeting; CDC = CDC NCCCP / Cancer Conference, Aug 13-17, 2007; REG = Regional meeting; CCPI = CCPI meetings; PIH = PIHOA mtg; CCCLI = Pacific Comprehensive Cancer Control Leadership Institute; NPCR = CDC Natl Program of Cancer Registries PD mtg; RREG = Regional Registry mtg/training; NAACCR = North American Association of Central Cancer Registries annual meeting, Denver, CO.

Pacific Cancer Coalition (USAPIN Regional CCCC)



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The development of the Comprehensive Cancer Control Plan for Pohnpei State is the result of an ongoing collaboration among Pohnpei Cancer Coalition members and stakeholders. Many have dedicated their time and expertise in the development process. Without their hard work and dedication, Pohnpei would not have a sound and realistic plan to combat the cancer burden Pohnpei faces. Special thanks go out to those who help put this plan together.

PCC members (Individual names can be found in the appendix above)

Department of Health Services, Pohnpei State

Office of the Governor, Pohnpei State

Nurses Association

V6AH Radio

Bermin News Network

Kaselehlle Press

Strategic Health Concepts

University of Hawaii, John A. Burns School of Medicine

Papa Ola Lokahi

Pohnpei State Legislature

Office of the Attorney General, Pohnpei State

Center for Disease Control and Prevention, Division of Cancer Prevention and Control

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Ms. Ernel Roque

Ms. Erika Strong

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Ms. Karin Hohman

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