U.S. Affiliated Pacific Island Nations

American Samoa – CNMI – Guam – Palau – RMI - FSM

PACIFIC REGIONAL COMPREHENSIVE CANCER CONTROL PLAN 2007-2012

March 2007

FORWARD MESSAGE

Talofa, Hafa Adai, Tirow, Iakwe, Alii, Ran Annim, Len Wo, Kaselehlia, Mogethin, Hello!

On behalf of the Cancer Council of the Pacific Islands (CCPI) and the Pacific Comprehensive Cancer Control Coalition, we are pleased to present the Pacific Regional Comprehensive Cancer Control (CCC) Plan.

Cancer places a particularly heavy burden on our individual small countries and states. Our populations and absolute numbers of cancer are relatively small compared to the United States, but because of the many challenges that exist in our jurisdictions' economic and health care infrastructure, the burden is high.

Awareness and advocacy about cancer-related issues was brought to U.S. Affiliated Pacific Island Nations (USAPIN) Regional and U.S. National attention starting in the mid-1990s. After several years of advocacy by dedicated physicians and public health leaders in the USAPIN and Hawaii, the Pacific Cancer Initiative was started in 2002. With funding from the NCI Center to Reduce Cancer Health Disparities and the NIH National Center on Minority Health and Health Disparities, assistance from Papa Ola Lokahi and 'Imi Hale (who held an NCI Special Populations Network grant) and under the leadership of Dr. Neal Palafox, an indigenous advisory council was formed, The Cancer Council of the Pacific Islands (CCPI). Together with the University of Hawaii Department of Family Medicine and Community Health, also under the direction of Dr. Neal Palafox, cancer needs assessments were performed in 2002. From there, preliminary regional and jurisdiction-specific priorities were formed. In 2004, the University of Hawaii, designated as the bona fide agent for 5 of 6 USAPIN, received a National Comprehensive Cancer Control Planning (NCCCP) grant; Palau received their own NCCCP grant. These NCCCP grants were funded by the Division of Cancer Prevention and Control, CDC.

This Pacific Regional CCC Plan has been developed in conjunction with the individual CCC plans for the three Flag Territories, and the three Freely Associated States (FAS). The Flag Territories are American Samoa, Guam and the Commonwealth of the Northern Mariana Islands (CNMI). The Freely Associated States include the Republic of the Marshall Islands (RMI), and the Republic of Belau (also known as Palau) and the Federated States of Micronesia (FSM) which consists of Yap, Pohnpei, Kosrae, Chuuk States. Each of these jurisdictions has developed their own CCC plan – 9 in total – to address their specific needs.

The Pacific Regional Cancer plan speaks to maintaining a U.S. Affiliated Pacific regional format for discussing and addressing cancer. The Pacific Regional Cancer Plan is a long-term plan, designed to be coordinated in conjunction with the Pacific Islands Health Officers Association (PIHOA) efforts. The Plan aims to develop minimum standards for cancer care for the U.S. Associated Pacific largely through education and assisting with implementation of the jurisdiction-specific CCC plans, develop regional policies regarding utilization of cancer data, provide access to regional expertise in cancer care, providing regional

technical support for all parts of the comprehensive cancer plan, and developing regional Cancer advocacy at the U.S. National level. Coordinated planning will also be conducted over the next five years to determine the feasibility of developing systems to better coordinate cancer care, developing regional laboratory services for cancer diagnosis (over time) and regional cancer referral centers (over time). In addition to the jurisdiction-specific and Regional CCC projects, preliminary planning has also been done to develop a Regional Central Cancer Registry under the Centers for Disease Control and Prevention, National Program of Cancer Registries.

A Regional approach to Comprehensive Cancer Control has not previously been attempted on this scale. Communicating and coordinating across 5 time zones (Palau to Hawaii), the International Date Line and over millions of miles of Pacific Ocean has not been easy. We are thankful to the Centers for Disease Control and Prevention for supporting this effort and also thankful to the many other U.S. National Partners who have contributed resources and talent to the overall Pacific Cancer Initiative and Pacific Cancer Coalition. The largest credit goes to the people of each USAPI jurisdiction who have come together over the past three years, struggled and worked hard to create community-driven CCC plans that incorporate each location's community strengths, structure and culture. Through this CCC process, there is renewed interest in communication and collaboration among the many sectors and partners that can impact individual and population health. Through this CCC process, momentum is gaining, support is broadening and we have developed plans that serve to guide present and future leadership for our jurisdictions and the Region.

We thank you for your interest in the U.S. Affiliated Pacific Island Nations and welcome your support and collaboration in helping us work toward our vision of a cancer-free Pacific.

Dr. Kamal Gunawardane
Physician, RMI
President,
Cancer Council of the Pacific Islands

Yorah Demei
Cancer Clinical Coordinator, Palau
Vice-President,
Cancer Council of the Pacific Islands

For additional information, please contact the:
Pacific Comprehensive Cancer Control Program
Department of Family Medicine
John A. Burns School of Medicine
University of Hawaii – Manoa
95-390 Kuahelani Avenue
Mililani, HI, USA 96789

Pacificcompcancer@hotmail.com

Phone: 1.808.627.3245
Facsimile: 1.808.627.3262

The development of the USAPIN Pacific Regional CCC Plan and the CCC plans for American Samoa, CNMI, Guam, RMI, FSM National and the FSM States of Chuuk, Kosrae, Pohnpei and Yap were support by

Centers for Disease Control and Prevention
National Comprehensive Cancer Control Program
Cooperative Agreement # U55/CCU923887 awarded to the
University of Hawaii Department of Family Medicine &
Community Health, 06/30/2004 – 06/29/2007
Neal A. Palafox, MD, MPH – Principal Investigator
Vanessa S. Wong, MD – Project Director
Lee Buenconsejo-Lum, MD – Project Advisor

TABLE OF CONTENTS

Page

USAPIN Regional Vision: A cancer-free Pacific

Overview

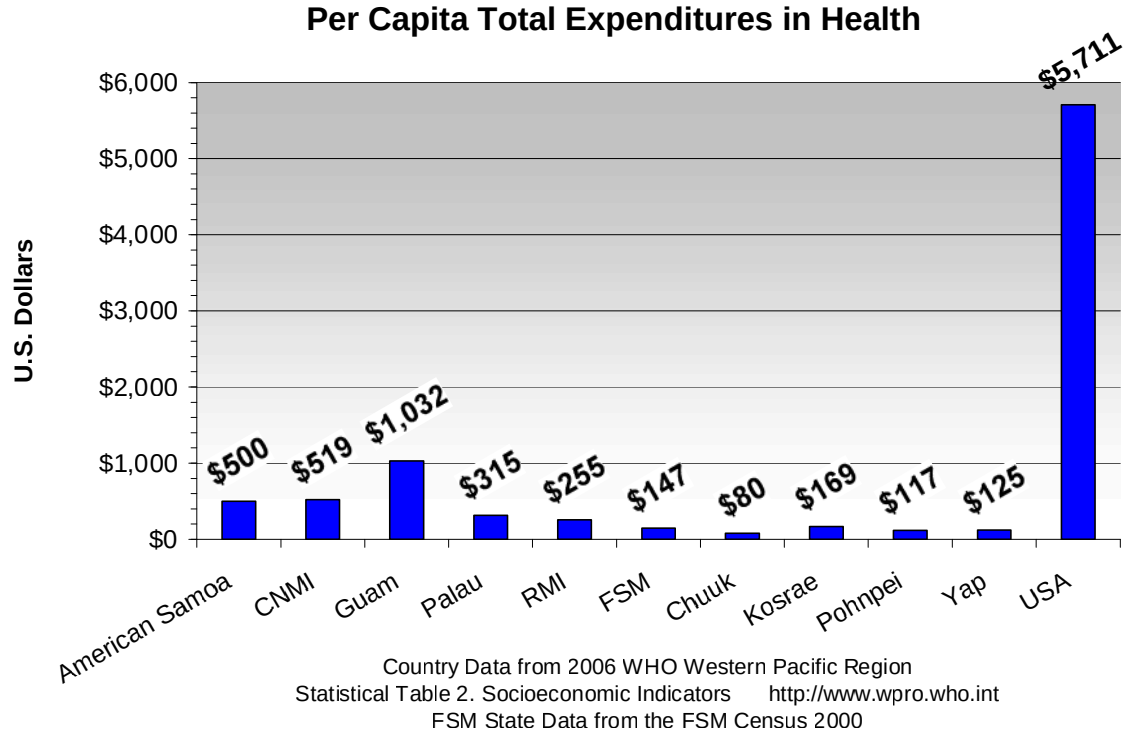
The U.S. -Affiliated Pacific Islands (USAPI) consists of three Flag Territories, and three Freely Associated States (FAS). The Flag Territories are American Samoa, Guam and the Commonwealth of the Northern Mariana Islands (CNMI). The Freely Associated States include the Federated States of Micronesia (FSM) which consists of Yap, Pohnpei, Kosrae, Chuuk; the Republic of the Marshall Islands (RMI), and the Republic of Belau (also known as Palau) (ROB). The population of the USAPI is approximately 460,000 people with 182,000 of the inhabitants living in the FAS. The expanse of the USAPIN is twice the size of the continental United States and crosses 5 time zones and the International Date Line.

American Samoa has been a territory of the United States since 1900 and Guam was annexed as possession of the United States in 1898. In 1947, under a United Nations Mandate, the United States took responsibility for the health education and welfare of the U.S. Trust Territories of the Pacific Islands (TTPI) which included what is now the RMI and FSM[1]. The FAS countries are full members of the United Nations and are sovereign except for military matters. They share a treaty with the U.S. Government under separate Compacts of Free Association that qualify them to participate in specified Federal programs including U.S. Health and Education programs.

As former colonies of the United States, the USAPI have become heavily dependent on U.S. assistance. The current political relationship of the USAPI to the U.S. Government defines the level of political, economic, and grant support from the U.S. . The citizens of the Flag Territories are classified as U.S. citizens, however they cannot vote in U.S. presidential elections. FAS citizens are classified as non-immigrants, cannot vote in U.S.

elections, but can freely immigrate to the U.S. to work without a visa. Guam and American Samoa have non-voting representatives to the U.S. Congress. The CNMI has a representative in Washington DC who is not a Congressional member. The FAS have no representatives in Washington. The citizens of the Flag Territories qualify for Medicare, Medicaid benefits, and all U.S. Federal Grants. The citizens of the FAS do not qualify for Medicare or Medicaid, and can access those U.S. Federal Grants where legislation about that grant defines their eligibility.

Each of the USAPI has unique cultures, histories and languages. The economic, health and political development of each jurisdiction of the USAPI are related but not similar. There are significant health disparities between the U.S. and the Flag territories and appalling health and education disparities between the U.S. and the FAS. The HRSA funded Institute of Medicine (IOM) report in 1998 entitled "Pacific Partnerships for Health", explained that the life expectancies among FAS countries is 9-12 years less than the U.S. , and that infant mortality rates are 4-6 times that of the U.S. . UNICEF has designated 5 countries in the Pacific which need special attention because of malnutrition[2]-- two of these countries are in the FAS. Tuberculosis and Hansen's disease are endemic in parts of the FSM and the RMI.



The ability of each jurisdiction to respond to meet the health needs of the region is dependent on the health infrastructure, financial resources, and the size and level of training of the health work force. The health care budgets expressed as a per capita

expenditure of the jurisdiction is far below that of the U.S. , ranging from $80 to $1,032[3] in comparison with $5,711 spent in the U.S. in 2003. Expensive tertiary care is purchased from Hawaii or the Philippines for advanced cases of cancer, heart or kidney disease through medical referrals. Nearly 1/4 of the already inadequate health budgets are expended on tertiary care abroad. The 1998 IOM Reports described the grossly inadequate health facilities in most of the USAPI. The amended U.S. Compact of Free Association funding is austere and does not significantly improve health care financing for the FSM and RMI, and in fact in some health areas it will be reduced[4]. The health services in the FSM and RMI already feel the impact of the decremental Compact payments[5].

The reasons for the present health status and health infrastructure in the USAPI are complex. Factors influencing policy issues, political relationships, economy, environment, culture, health system, education and human resource development all play a role. Rapid Westernization has affected the human and environmental island ecology and the traditional and cultural practices which previously maintained good health status. The epidemiologic transition, the name given to the change of morbidity and mortality patterns from infectious disease to chronic illnesses as less industrialized nations adopt Western dietary and lifestyle patterns, has brought a double burden of infectious and chronic illnesses to the Western Pacific.

One of the key indicators of the immense impact of the Western dietary and lifestyle patterns is the prevalence of lifestyle behavior related cancers in the USAPI. Cancer mortality now ranks as the second most common cause of death in nearly all USAPI jurisdictions. There are very high rates of thyroid cancers and nodules in the RMI[6,7], many attributable to the U.S. Nuclear Weapons testing program in the 1950s. Lung and oral cancer rank highly in all countries. Potentially curable cancers such as cervical and breast cancers are often found in far advanced stages. The availability of supplies or money to ship and process pap smears varies tremendously; in the FSM, less than 15% of women receive pap smears; in the outer atolls of the RMI, no screening services are available at all. There is no mammogram in one urban area of the RMI, Ebeye, and none at all in the FSM. A working colposcope for diagnosis and early treatment of cervical cancer is non-existent in several areas of the FAS. The availability of fecal occult blood testing, colonoscopy or prostate-specific antigen varies. The FSM has no pathologist or radiologist and most countries do not have an oncologist. No radiation oncology is available in the region and most areas are unable to do maintenance chemotherapy. Medications for palliation are often in short supply and health personnel require more training in this area. No support groups or patient navigators in ANY jurisdiction; the concept of hospice care is new. Traditional medicine and healing practices are used in most of the jurisdictions. Traditional leadership continues along side modern democracy in the RMI and FSM. Religion and spirituality play important roles in the lives of the people. Until the proper funds and facilities are made available for the region the strength in the fight against cancer will come by

acting as a community to provide education on prevention, early detection, and palliative care.

Table 1. Selected indicators, programs and services impacting CCC efforts in the USAPIN [2,8,9]

	American Samoa	CNMI	Guam	FSM	Palau	RMI
Political status with U.S.A.	Territory	Common-wealth	Territory	Freely Associated	Freely Associated	Freely Associated
Total Population	65,500	80,360	168,560	114,100	19,910	61,220
Land surface area (sq km)	199	477	541	702	458	181
Coastline (sq km)	116	1482	125	6112	1519	376
Public transportation	Yes	Yes	Yes	None	None	None
4-year University or College			Yes			
2-year College	Yes	Yes	Yes	Yes	Yes	Yes
Hospitals	1	1	1	5 (1 pvt)	1	1
Regularly occurring continuing education program for physicians or nurses[10]	Physicians	No	Both; hospital and PHN	Building CE programs	Both	Both
Health expenditures per capita	$500	$519	$1,032	$147	$315	$255
Cancer ranking in all-cause mortality	2nd	2nd	2nd	5th	4th	3rd
	American Samoa	**CNMI**	**Guam**	**FSM**	**Palau**	**RMI**
PROGRAM OR SERVICE						
CANCER SCREENING						
BCCEDP	Yes	Yes	Yes		Yes	
Mammography	Yes	Yes	Yes		Yes	Yes
Pap Smears	Yes	Yes	Yes	limited, none on outer islands	Yes	none on outer islands
On-island processing of pap smears						
Colorectal cancer screening (FOBT)	Yes	Yes	Yes		Yes	
Prostate cancer screening	Yes		Yes	Pohnpei only	Yes	Yes
CANCER DIAGNOSIS AND TREATMENT						
Pathologist	Yes		Yes		(in training)	Yes
On-island histopathology	Some		Yes			Yes improving
General Radiologist	Yes		Yes			
General surgeon	Yes	Yes	Yes		Yes	Yes
OB-Gyn	Yes	Yes	Yes	Yes	Yes	Yes

Surgical subspecialists	Yes	Yes	Yes			Yes
Oncologist			Yes, 1			
	American Samoa	**CNMI**	**Guam**	**FSM**	**Palau**	**RMI**
CANCER DIAGNOSIS AND TREATMENT						
On-island chemotherapy		Yes (mainten-ance)	Yes			
On-island radiation therapy						
Off-island referral to Philippines for diagnosis / treatment		Yes		Yes	Yes	Yes
Off-island referral to Hawaii for diagnosis / treatment	Yes	Yes	Yes	Yes	Yes	Yes
Off-island referral to New Zealand for diagnosis / treatment	Yes					
Off-island referral to U.S. Mainland for diagnosis / treatment	Yes	Yes				
CANCER REGISTRY OR DATABASE (refer to "Cancer Burden" for additional information)						
Cancer Registry			UOG / HTR Registry Plus		NPCR	

Individual jurisdictions cannot address their cancer burden alone. Because of the size of the population, limited health workforce, relatively small numbers of cancer cases and the economics of the region, this regional CCC plan has been developed.

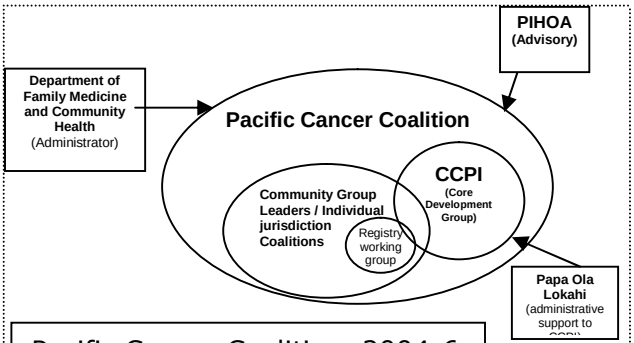
HISTORY OF CANCER CONTROL INITIATIVES IN THE U.S. AFFILIATED PACIFIC

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 many venues at the U.S. Federal level. In 2002, the NCI Center to Reduce Cancer Health Disparities, under the direction of Dr. Harold Freeman, and the NIH 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 Initiative[11]. 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;
(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 2002-03. The assessment teams met with key informants 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 key informants to assess the gaps in existing programs and services for cancer. The assessments were coordinated, reviewed and analyzed by the CCPI, presented for approval and verification of accuracy to the respective USAPIN health departments and published in a special issue of the *Pacific Health Dialog* on Cancer in the Pacific[12]. From there, preliminary regional and jurisdiction-specific priorities were formed. Health promotion projects were developed as first steps, utilizing the NCI and NIH funding. In 2004, the University of Hawaii, designated as the bona fide agent for 5 of 6 USAPIN, received a National Comprehensive Cancer Control Planning grant; Palau received their own NCCCP grant. These grants were funded by the U.S. Centers for Disease Control and Prevention, Division of Cancer Prevention and Control.



Pacific Cancer Coalition, 2004-6

EVOLUTION OF THE REGIONAL COMPREHENSIVE CANCER CONTROL PLAN

The regional planning has been led by the Cancer Council of the Pacific Islands (CCPI), the first group of its kind dedicated to developing regional collaboration, appropriate strategies and recommending minimum regional standards for cancer control. The CCPI development was funded under the Pacific Cancer Initiative in 2002. The CCPI Board Members were designated by their respective Minister, Secretary or Director of Health. The CCPI is comprised of two representatives from health services for each jurisdiction (including the individual FSM States and representatives from Ebeye in the RMI). Most of the CCPI members are physicians or nurse leaders with a few health administrators. Jurisdiction and regional priorities were initially set as a result of the 2002-03 Cancer Assessments, but the priorities were largely focused on the medical model. With the

advent of NCCCP funding to the University of Hawaii in June 2004, formal community-based coalition development started.

Each individual jurisdiction (American Samoa, Guam, CNMI, RMI, Palau, FSM National, Kosrae State, Pohnpei State, Chuuk State and Yap State) has developed a comprehensive cancer control plan to address their unique situation. NCCCP funding has provided full- or partial-salary support for a Comprehensive Cancer Control coordinator, as well as meeting logistics and travel for jurisdiction community meetings, as well as travel for the Coordinators to attend CDC Cancer-related meetings and other training. With the help of the CDC and the National CCC Partners, a Pacific-tailored and focused Comprehensive Cancer Control Leadership Institute was held in Honolulu in March 2005, which initiated much of the CCC activities. Additional technical assistance in CCC planning, writing of the plans and implementation grants has been provided by the University of Hawaii Pacific Comprehensive Cancer Control Program staff and others. Coalition-building has been challenging in many locations not only because it is a very Western model with some conflicts with cultural expectations, but also because of the usual "vertical" and non-integrated nature of Federal programs which have been the sustaining force for many of the public health programs in the USAPIN. Despite the diverse needs and infrastructure for each of the USAPIN, there remain issues and goals common to the region that make most sense to address in a coordinated fashion and in close conjunction with policy makers and partners with the region. For this reason, the Pacific Cancer Coalition developed the USAPIN Regional Comprehensive Cancer Control Plan. The Pacific Cancer Coalition is comprised of all 10 jurisdiction coalitions.

The Regional plan was developed over 3 years, with the CCPI taking the leadership and proposing goals and objectives based on the regional priorities set in August 2003. November 2005 marked the first Regional CCC meeting in Pohnpei, with 2-4 participants from each jurisdiction including the CCC Coordinator, a Coalition member and at least 1 CCPI representative. At that time, priorities were discussed. Also discussed were results of an assessment to determine the capacity for a regional central cancer registry in the USAPIN[13]. Regional goals agreed upon at the November 2005 meeting focused on sustaining a regional infrastructure for cancer control efforts, developing regional laboratory services, regional referral centers for basic cancer care and a regional cancer registry. At the July 2006 CCPI meeting, possible short- and long-term objectives and strategies were discussed and further refined. The proposed objectives were discussed with the PIHOA Board in August 2006 and some specific strategies were proposed by PIHOA to be done in close collaboration with PIHOA priorities. In November 2006 the Pacific Cancer Coalition reviewed and refined a detailed 5-year workplan, agreed on the management, implementation and evaluation plans and agreed on a set of minimum recommended Regional indicators for cancer prevention, screening and data quality.

The individual jurisdiction CCC plans contain jurisdiction-specific objectives and strategies to address cancer prevention, early detection, treatment, quality of life

(survivorship) and data quality. This regional plan focuses on objectives and strategies best coordinated at a regional level for build capacity within the region for early detection, treatment and data quality. The Regional Plan is designed to complement and help support the individual jurisdiction coalitions and CCC plans.

CANCER BURDEN IN THE U.S. AFFILIATED PACIFIC ISLAND NATIONS

Historically, the USAPIN has been challenged with developing relevant and accurate health information systems since before the Trust Territories management in the 1960s. The technology, resources and complexity have been difficult to maintain[14], especially when superimposed on inadequately trained health workers. There were no cancer registries in the USAPIN until 1997, whereas several South Pacific non-U.S. associated Pacific nations had functional cancer registries since the 1970s. The 1998 Institute of Medicine Report, a 1998-99 RMI Nuclear Claims Tribunal-funded study attempting to determine the epidemiology of cancer in Micronesia[15], and the 2002-03 Pacific Cancer Initiative needs assessments all confirmed major challenges with policy, reporting structures and no cancer surveillance system in place in the USAPIN. Additionally, limitations in tissue-diagnosis of cancer (in the FSM especially) hamper accurate recording in the medical record and on the death certificates. The numbers of cases and deaths noted in the 2002-03 assessments is generally felt to be under-reported because of challenges with diagnosis and financing to send specimens off-island for interpretation.

Heavy tobacco use in these populations, high mortality rates of cancers associated with infections (liver, cervical, stomach), cancers associated with Westernization (lung, breast, colon, prostate), high prevalence of chewing betel nut (oral cancer) and the history of the 12 years of U.S. nuclear weapons testing in the Marshall Islands requires that the USAPIN immediately develop cancer planning based on accurate cancer data systems.

In 1946 the U.S. began nuclear weapons testing in the Marshall Islands. In all, 67 thermonuclear devices were detonated between 1946 and 1958, the equivalent in tonnage to 7200 Hiroshima blasts. The vast majority of these were atmospheric explosions, accounting for almost 80 percent of the total atmospheric tonnage detonated in the history of U.S. testing.

It is difficult to quantify the direct health impact of nuclear testing in the RMI, in part because of the limited resources available for diagnosis and monitoring. A 2004 study by the U.S. National Cancer Institute estimated that U.S. nuclear testing was responsible for 530 excess cancers above the natural baseline, a 9 percent increase in the prevalence of cancer in the RMI[16]. Half of the 530 excess cancers have yet to occur because of latency periods. In particular it was estimated that thyroid cancers prevalence had increased by 200 percent above the baseline. Furthermore, the NCI

projected that undiagnosed/undeveloped stomach and colon cancers would result in future increase in prevalence of 85 and 80 percent respectively.

Although most of the radiation-attributable cancers were projected to arise in the northern atolls closest to the test sites, a number of cases were also projected in atolls outside the area previously acknowledged to be at risk by the U.S. Notably this study did not address the cancer risk of the workers from all parts of Micronesia who cleaned the test sites, people living in other parts of Micronesia such as Guam where ionizing radiation from the nuclear testing was documented, and Marshallese who ate foods contaminated with cesium for decades after the nuclear testing ended.

Detailed methodology of determining the cancer burden in each country and jurisdiction are well described in the special Pacific Health Dialog issue on Cancer in the Pacific. Data was gathered from multiple sources, even in Palau and Guam that have cancer registries. Death records, any existing registry or database and off-island referral logs were reviewed. In the FSM, much of the information was from death certificates only. In the RMI, data from the Nuclear Claims Tribunal was also included in the assessments. The Nuclear Claims Tribunal renders determination on claims based on the Pacific Nuclear Weapons Testing Program in the RMI between 1947 and 1957[17]. The assessment teams used the best available data at the time, so the reporting time period varies tremendously among jurisdictions. The FSM cancer mortality data noted in table 2 comes from the FSM Department of Health, Education and Social Affairs, whereas the remainder of information comes from the 2002-03 NCI Pacific Cancer Initiative Needs Assessments. In the FSM, the States are responsible for the direct provision of health services – prevention to treatment – and for completing their death certificates. The FSM National government however, reconciles the death certificates and is responsible for the reporting of mortality data for the country.

In the United States, many other surveys and standardized sources of information exist to determine prevalence of certain cancer risk-factors like obesity, tobacco use, poor nutrition, sedentary lifestyle and others. Only the flag territories participate in the U.S. Behavioral Risk Factor Surveillance Survey and the Youth Risk Behavior Survey. Even then, there have been challenges implementing the survey in the Territories and some have had to be re-done. The FAS are eligible for World Health Organization (WHO) programs and assistance. Several non-communicable disease (NCD) risk factor surveys are available, but have had to be redone in some countries because of sampling errors.

Table 2. Leading Cancer Deaths by Site (from 2002-03 NCI Pacific Cancer Initiative Cancer Needs Assessments[9])

Leading cancers (mortality data)	American Samoa	CNMI	Guam	FSM	Palau		RMI
Time period	1998-2001	1992-2001	1995-2001	1990-2003*	1998-2002		2000-2002
Number of cancer deaths	152	215	790	722	38	30	65
Total Population (2005)	65,500	80,360	168,560	114,100	19,910		61,220
RANK ORDER					Male	Female	
1	Lung	Lung	Lung	Lung	Lung	Cervix	Lung
2	Liver	Unknown primary	Colorectal	Liver	Gastric	Liver	Cervix
3	Prostate	Breast	Lymphoma / leukemia / multiple myeloma	Oral	Prostate	Pharynx	Liver
4	Stomach	Colorectal	Breast	Prostate	Liver	Breast	Naso/ oropharynx
5	Colon	Cervical	Head/Neck	Cervix	Pancreas	Unknown	Unknown primary
6	Breast	Head/Neck	Unknown primary	Breast	Colorectal	Larynx	Breast
7	Brain	Stomach	Prostate	*Because of tremendous issues with data, the States' ranking differs	Esophagus	Uterine	Uterine
8	Pancreas	Liver	Liver				Pancreas
9	Rectum	Lymphoma/ Leuk/Blood	Stomach				Prostate
10	Lymphoid	Central nervous system	Uterine				Gastric

Despite the challenges with obtaining accurate information, the data does reveal that many of the cancer deaths are from preventable (lung, nasopharyngeal, liver, cervix) or easily detectable and potentially curable (breast, cervix, colorectal, prostate, oral) cancers. Thus, the CCC efforts at the jurisdiction and regional levels are aimed at increasing the capacity to provide effective prevention and health promotion programs, screen for cancers using proven and cost-effective methods, develop the capacity to treat as many cancers on-island or within the region as possible, provide improved services for cancer patients and their families and improve policies, procedures and systems so that more accurate cancer-related information can be obtained for program planning and evaluation.

GOALS, OBJECTIVES AND STRATEGIES for the Regional CCC Plan

Vision: A Cancer-Free Pacific

Long term Regional goals include developing a sustainable regional collaboration to oversee cancer control efforts and set minimum recommended indicators for cancer control, developing a regional cancer registry, and developing regional cancer resource centers that will serve as a clearinghouse for practices and policies that work in the USAPI, provide regional laboratory support, become a site for training and eventually more advanced diagnostic and therapeutic services for the region. This may take 10-20 years given the present challenges and disparities faced by USAPIN countries.

The strategies outlined in this plan are comparatively short-term (2-10 years) and focus on regional efforts in training and planning to drive policy decisions affecting diagnosis, treatment and data quality especially. The unfortunate reality, given the present circumstances, is that the only appropriate treatment for some of the cancer patients is palliative, so there are some palliative care-related strategies in the treatment section of this regional plan. The jurisdiction CCC plans contain prevention and quality of life objectives and strategies that are community-based and designed to work for their particular unique situation.

PIHOA and CCPI agree to recommend **Minimum Regional Indicators** for cancer control. Regional collaboration, sharing of resources and capacity building will need to occur so that all USAPIN countries can meet the minimum indicators. The indicators are below were discussed at the July 2006 CCPI meeting, August 2006 PIHOA meeting, further discussed, refined and approved at the (Regional) Pacific Cancer Coalition November 2006 meeting. Final approval will be sought at the April 2007 PIHOA meeting.

Goal: To prevent cancer from occurring

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

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

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

- By 2017, each jurisdiction will demonstrate a 10% increase above their baseline the number of men and women 50 and older who are offered a CDC-recommended colorectal cancer screening test

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

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

---

REGIONAL GOAL 1: STRENGTHEN AND EXPAND REGIONAL COLLABORATION, PLANNING AND ADVOCACY AFFECTING ALL ASPECTS OF CANCER CONTROL

Tremendous disparities exist in many areas affecting control of cancer (refer to Table 1). The CCPI and PIHOA have been previously described. Through the NCI Pacific Cancer Initiative needs assessments and the CDC CCC process, the coalitions in each jurisdiction have confirmed and prioritized the need for improvements in infrastructure, training of existing health workers in many areas (health administration, planning, health information management and clinical care), and coordinated planning to develop and maintain indigenous health workers. Not surprisingly, this same issue of health workforce development is a top priority of PIHOA and the focus of the 2006 WHO World Health Report on Human Resources for Health (HRH). These improvements are most urgent in the countries with the least resources, but all jurisdictions face similar issues. Each country struggles with their internal issues, but unless the leaders of the countries band together to plan and advocate for improvements that affect the region, each country will continue to struggle. Poor health and education infrastructures tend to cause out-migration to neighboring jurisdictions, which further stress the health systems throughout the region[18]. Continued regional advocacy for initiatives that improve the region's and jurisdictions' ability to control cancer is needed.

Objective 1.1. Continue to advocate for coordinated planning and development of policies, legislation or educational opportunities that impact cancer control.

Baseline: Jurisdiction CCC coalitions generally remain unaware of successes in other locales; cancer-related educational opportunities for health workers are limited

Strategy 1.1.1 Monitor and inform the jurisdiction CCC coalitions of activities or policy development in the U.S. Federal Government, internationally, regionally or in other jurisdictions that could affect their CCC efforts.

Outcome: Easier access to information and strategies that could be modified to meet jurisdiction needs; more timely identification of opportunities for collaboration

Measure: Review of list-serv communication, website and/or newsletters

Strategy 1.1.2 Facilitate the coordination of cancer-related educational opportunities with each jurisdictions' continuing education coordinator/program

Outcome: Increased numbers of health providers completing educational offerings that relate to cancer

Measure: Review the number of cancer-related educational offerings, attendance records and evaluation forms

Strategy 1.1.3 Promote and support HRH plan development that includes at least one CCC coalition member at each jurisdiction level

Outcome: HRH plans that involve community member input into what is needed to assure a quality health care system that effectively addresses cancer control

Measure: Review of attendance records at jurisdiction HRH meetings to see if cancer coalition members are present to contribute to discussions

Objective 1.2 By 2008, the CCPI will work with PIHOA and member states to establish plans to meet the minimum recommended regional indicators for cancer prevention, cancer screening and data quality (refer to page 13 for indicators).

Baseline: FSM is not able to meet any of the minimum indicators at present. Populations in the outer islands or rural areas of all USAPIN face barriers to accessing cancer screening (especially mammography and cervical cancer screening). There is no baseline information on colorectal cancer screening rates in those countries with the capacity to perform fecal occult blood testing.

Strategy 1.2.1 Once implementation funding is awarded to those jurisdictions with severely limited capacity for cancer screening, determine their ability and action plan to meet the proposed minimum recommendations and provide technical assistance or advice as needed to help them achieve their cancer screening objectives

Outcome: Minimum recommended regional standards for cancer screening and data quality that are realistic and attainable by PIHOA member states

Measure: Review of technical assistance reports

Strategy 1.2.2 Once implementation funding is awarded, work with all jurisdictions to determine their ability and action plan to meet the proposed minimum recommendations for data quality (medical records, data tracking) and provide technical assistance or advice as needed to help them achieve their cancer screening objectives

Outcome: Minimum recommended regional indicators for cancer screening and data quality that are realistic and attainable by PIHOA member states

Measure: Review of technical assistance reports

Strategy 1.2.3 Share information from 1.2.1-1.2.2 with PIHOA, revise as needed and formally recommend the minimum regional standards for cancer screening and data quality

Outcome: Minimum recommended regional indicators for cancer screening and data quality that are realistic and attainable by PIHOA member states

Measure: Review of technical assistance reports

REGIONAL GOAL 2: TO DIAGNOSE CANCER IN INDIVIDUALS AS EARLY AS TECHNICALLY POSSIBLE WITHIN THE USAPIN REGION

There is differing capacity for cancer screening and diagnosis among jurisdictions. Refer to Table 1 and to each jurisdiction's CCC plan. Most allied health professionals were trained on the job by others who were trained on the job (lab, radiology, medical records) and this impacts the systems' capacity to offer screening and diagnostic services. In some areas, inventory management and planning are inadequate, resulting in supply shortages. Challenges remain with shipping specimens off-island which leads to delay in diagnosis and contributes to further delay in treatment. There is variable capacity within and among jurisdictions to conduct quality improvement activities in health services, which can worsen the limited supply of screening supplies or delay reporting in results from screening or diagnostic work-up.

On the positive side, there has been strong regional (PIHOA, CDC TB and HIV programs) commitment to help address shipping and training issues and develop shared training opportunities. PIHOA recently supported a regional public health laboratory coordinator to assist with the formation of a PIHOA public health laboratory system among the six U.S. associated Pacific Islands whereby cholera, typhoid, measles, influenza, leptospirosis, and dengue can be rapidly isolated and diagnosed[19]. The intent was to upgrade the Guam Public Health lab to serve as a level 2 lab. Though the focus was on microbiology, the regional lab coordinator has provided some general training, quality assurance, and other needed technical support to the laboratories in the jurisdictions. Unfortunately, the Guam Public Health lab has faced significant challenges in expanding and maintaining this increased capacity, so the overall project is at risk for closure. This tragedy speaks to the great need for coordinated planning and ensuring that the lab staff and managers in all of the jurisdictions have appropriate training and resources to create sustainable improvement in the system.

PIHOA also proposes to develop a HRH (human resources for health) plan at the jurisdiction and Regional levels. HRH plans include addressing issues at the primary education level so that there is a supply of students who are interested and capable of pursuing careers in the health field; additionally, there must be continuing education

and professional development for existing health workers and infrastructure should be in place to plan for attrition and minimize premature departure from the health workforce. There is also strong jurisdiction-specific commitment to improving their existing capacity within currently available resources and many potential partnerships to assist with these efforts. Given the enormous challenges facing most of the USAPI, it is critical that the community-driven cancer coalitions exert pressure on their policy-makers to tackle this difficult issue. Continuing education opportunities for the existing health workforce is one component of HRH. In the FAS especially, there is a more pressing need to provide basic foundational coursework and training, so that there is a solid base upon which to build knowledge and skills to effective address cancer screening and diagnosis.

Objective 2.1 By 2010, improve each USAPI country's capacity to process and perform preliminary interpretation of pap smears and tissue specimens in-country.

Baseline: Guam Memorial Hospital and American Samoa (LBJ Hospital) have histopathology capabilities but do not process pap smears in country. RMI is starting to develop the capacity to read tissue specimens in country. All pap smears are sent to Honolulu for processing provided that vendor contracts and funding sources are intact.

Strategy 2.1.1. Create regional opportunities to train and upgrade the knowledge and skills of laboratory personnel in cytopathology and histopathology (in those jurisdictions currently without that capability) while linking it to QA/QI projects

Outcome: At least 1 regional training event by December 2008, More lab staff will be able to successfully participate in a QI project

Measure: Review of agreements or contracts; Evaluation from participants; QA/QI plans developed as a result of the training

Objective 2.2. By 2010, increase the number of functional hospital- or public health-based continuous quality improvement (CQI) projects in the region by 10% above baseline (2007) so that needed supplies or equipment and data reporting processes are available and functional

Baseline: Yap State Department of Health Services recently implemented department-wide quality assurance (QA) programs that are tied to employee performance measures. Each jurisdiction currently has quality improvement initiatives, but those are not well-quantified and in some instances, not well understood by the health care workers.

Strategy 2.2.1 By July 2009, provide a regional training opportunity in general principles of quality assurance

Outcome: Sustainable QA programs run by trained, local staff

Measure: Review of QA/CQI projects, progress; SDP progress reports for Compact nations

Strategy 2.2.2 By July 2010, work with regional resources or outside consultants to develop longitudinal (on-site) training programs in QA/CQI for all dept managers and division chiefs in each hospital/public health dept

Outcome: A 'culture' shift toward sustaining quality by building local capacity
Measure: Written feedback from participants in the training and PIHOA members; Review of QA or CQI project reports from each jurisdiction

Strategy 2.2.3 Advocate for developing or strengthening by 2010 jurisdiction-specific policies that require travelers to provide a training / presentation (to their co-workers upon return from training) that is tied to a quality improvement activity and/or employee performance measure

Outcome: Increased sharing of knowledge/skills gained from off-island meetings; More appropriate people will be selected for off-island training; Increased accountability for grant-support
Measure: Review of policies (once policies are in place), continuing education evaluations and records; Review of QA reports from jurisdictions

Objective 2.3 Work collaboratively with regional partners so that by 2012 at least one sustainable, ongoing regional resource for training laboratory staff in cytopathology and histopathology or radiology technicians in mammography and ultrasound is operational

Baseline: Present discussions within PIHOA include development of regional "Centers of Excellence" for allied health training opportunities. PIHOA is also beginning discussions regarding future collaboration and planning with the Pacific Post-Secondary Education Council (PPEC), the organization of Presidents of the Higher Education Institutions in the USAPIN and the Chancellors of the University of Hawaii Community Colleges and University of Hawaii - Hilo.

Strategy 2.3.1 Assist potential partners in finding resources to complete a cost-benefit analysis (to them and the region) of resources needed to operate a training program that is tied to formal academic credit

Outcome: Systematic investigation into required resources, short- and long-term impact on the training institution and the region
Measure: Review of report

Strategy 2.3.2 Obtain formal agreements between appropriate/relevant USAPIN institutions

Outcome: Sustainable regional resource for training laboratory or radiology technicians is operational
Measure: Review of MOA

Objective 2.4 Promote and support human resources for health (HRH) plan development that will address cancer-related health workforce needs

Baseline: Health workforce planning and development has been a strategic priority for PIHOA since 2001, has also been important in the health sector strategic development plans for the Compact Nations (FAS). Planning has been difficult and slow in many areas because of widespread economic constraints that affect all partners who should participate in planning.

Strategy 2.4.1 Advocate to local community colleges, via the Pacific Postsecondary Education Council (PPEC), to work with appropriate hospitals to design and implement curriculum (for college credit) that will enhance the foundational knowledge and skill sets of the nursing and allied health workforce currently involved in the screening and diagnosis of breast and cervical cancer (practical nurses, laboratory technicians, health assistants)

Outcome: Upgrades in basic knowledge that will allow more confidence and skill in performing their work; Meaningful 'result' of the training (college credit) that may one day be tied to recruitment, retention and salary

Measure: # of presentations or letters of support; # of MOA between the community college(s) and local hospitals/MOH/DOH

Objective 2.5 (same process as 3.3) Work collaboratively with regional partners so that by 2012, a thorough feasibility study is completed to determine resources needed to create a sustainable regional referral lab with expanded diagnostic capability for cancer

Baseline: The Guam hospital lab has the most capacity to perform cancer-related diagnostic tests, but they do not perform pap smears and send many tests to Honolulu or the Philippines. Lab capacity is building in the RMI, but they too have challenges meeting the increased demand for services just from the RMI population. Many of the jurisdictions have significant budgetary constraints that preclude them from sending any specimens off-island even if they have a contract in place.

Strategy 2.5.1 Assist potential partners in finding resources to complete a cost-benefit analysis (to them and the region) of resources needed to operate regional referral center for basic cancer-related tests (labs, radiology)

Strategy 2.5.2 With the assistance of a budget analyst (consultant), review each jurisdictions' present and anticipated increased referral cost data to determine expenditures for diagnostic services

Strategy 2.5.3 With the assistance of consultants, review the capacity of selected hospital labs and radiology departments to develop into regional labs/radiology for basic diagnostic tests for cancer

Strategy 2.5.3 With the assistance of a consultant, determine what changes need to be made in the health care financing system to afford off-island referral within the region for diagnostic work-up

Strategy 2.5.4 PIHOA with their respective Ministries of Finance decides if it is feasible to refer to a regional center for diagnostic tests (anticipating increased numbers of patients compared to now)

Outcome (for entire objective/all strategies): Data-driven decision-making and budgeting; (for the long-term)
Measure: Review of reports

REGIONAL GOAL 3: TO IMPROVE THE CAPACITY TO TREAT CANCER EFFECTIVELY WITHIN THE USAPIN REGION

In most countries, in-country treatment is limited to surgery that is usually performed by general surgeons. With the exception of Guam, any type of chemotherapy requires off-island referral for induction. CNMI and American Samoa have capacity to perform some maintenance chemotherapy. Please refer to Table 1 for more comparisons. Medical referrals are costly and consume up to 25% of the already very small health budgets. In American Samoa, they do not have a budget for sending patients off-island, so they are developing fundraisers to help defray costs for cancer patients. In the FSM, only patients with early stage cancer are considered for referral. Challenges with diagnosis sometimes mean that there are delays in providing appropriate treatment. It is rare for an uninsured patient to be referred off-island for care, even if they are diagnosed early, because of inadequate reserves in the jurisdiction health budgets. Because of the relatively small size of the population and number of cancers, it will likely never be cost-effective or feasible to offer chemotherapy services in some countries; patients will continue to need referral to tertiary care centers in the Asia-Pacific region for induction chemotherapy. Medications for palliation are often in short supply and physicians and nurses have identified a need for more educational opportunities regarding palliative cancer care. The health workforce challenges (shortages, under-training) previously described also impact the provision of timely treatment for cancers that can be treated in-country.

Each jurisdiction in their CCC plans is committed to improving their existing capacity to provide care to cancer patients within currently available resources. Additionally, there are large numbers of currently uncoordinated medical missions from many different countries and organizations. Though not the usual medical model, efficiently using medical mission teams to provide some treatment may make sense for jurisdictions with very small populations. Kosrae State has this specifically noted in their CCC plan.

Objective 3.1. Assist the jurisdictions in providing adequate pain and palliative medications to cancer patients by 2009.

Baseline: Each jurisdiction CCC plans describe shortages in appropriate medications and/or clinicians not comfortable with providing end of life care.

Strategy 3.1.1 By July 2008, work closely with jurisdictions to obtain an accurate estimation of need for pain and other medications used at the end-of-life.
Outcome: Adequate supply of basic pain meds; data-driven projection of annual need
Measure: Initial report, updated annually prior to budgeting process

Strategy 3.1.2 By 2010, work with partners to offer with training of supply and pharmacy technicians so that inventories are well-managed (also refer to objective 2.2)
Outcome: Better trained technicians; less errors; less lapses or delays in obtaining meds and supplies
Measure: Quarterly inventory report looking for # days without desired med or supply

Strategy 3.1.3 By 2012, work with regional and international entities to ensure a reliable and adequate supply of medications for the alleviation of discomfort from cancer
Outcome: More affordable medications; less days with no pain medication available
Measure: MOA with pharmaceutical supplier, quarterly inventory report looking for # of days without desired med

Strategy 3.1.4 Starting in July 2007, work with regional entities to provide education for physicians, nursing and pharmacy staff regarding palliative care
Outcome: Cancer patients reporting less pain when asked using a visual or numeric pain rating scale
Measure: Review of CE attendance records; Review of patient pain-rating scales (during hospitalization)

Objective 3.2 Work collaboratively with regional partners so that by 2012, a thorough feasibility study is completed to determine resources needed to create a sustainable regional resource for maintenance chemotherapy

Baseline: Only Guam, CNMI and American Samoa presently offer maintenance chemotherapy to their citizens. Those services tend to be more costly than what the FAS can afford.

3.2.1 Assist potential partners in finding resources to complete a cost-benefit analysis (to them and the region) of resources needed to operate a maintenance chemotherapy program(s) for the region

3.2.2 With the assistance of consultants, review each jurisdictions present and projected referral cost data for chemotherapy to determine expenditures for treatment

3.2.3 With the assistance of a consultant, determine what changes need to be made in the health care financing system to afford for appropriate off-island referral for induction (in PI or elsewhere) and maintenance chemotherapy (in the USAPIN region)

3.2.4 PIHOA with their respective Ministries of Finance decides if it is feasible to refer to a regional maintenance chemotherapy center (anticipating increased numbers of patients compared to now)

Outcome: (for entire objective/all strategies): Data-driven decision-making and budgeting; (for the long-term)
Measure: Review of reports

REGIONAL GOAL 4: TO COLLECT, ANALYZE AND REPORT ACCURATE CANCER-RELATED DATA ACROSS THE REGION

Challenges with present health information systems and lack of cancer surveillance in the region have been described in the "Cancer Burden" section beginning on page 10. Capacity for analyzing cancer program information or for designing appropriate evaluation strategies also differs among jurisdictions. Guam has a part-time epidemiologist who primarily focuses on building the capacity of the Guam cancer registry. There are at least two other epidemiologists in the region, but their focus is on immunizations. The finance and statistics offices in some of the jurisdictions have personnel that are willing to help the fledgling CCC and cancer control programs with setting up simple systems for tracking and program evaluation.

Each jurisdiction is recording cancer cases differently and few have the capacity to track patients once they are diagnosed with cancer. In most areas, the best available data is based on death certificates, but there remain significant issues with proper completion of the death certificates by physicians and proper coding by medical records staff. Present medical records staff in all of the USAPIN have limited foundational training in anatomy, physiology, medical terminology or coding, so chart abstracting for any purpose, but especially for cancer, is difficult. Economic challenges also impact maintenance of the basic infrastructure to support quality health information in some settings (copier machines, faxes, paper to duplicate the correct encounter forms, etc.). There are no certified tumor registrars in the region but there are three registrars that are functioning well as abstractors and support the cancer registries in Guam and Palau.

Table 3. Cancer Registry-related information in the USAPIN[13]

Program or service	American Samoa	CNMI	Guam	FSM	Palau	RMI
CANCER DATA SOURCES						
Philippines hospitals		X		X	X	X
Hawaii labs and hospitals	X	X	X	X	X	X
New Zealand hospitals	X					
US Mainland labs and hospitals	X	X				
Local National (or FSM State) hospital	1	1	1	4 1 per State	1	2
Military hospital			1			
VA outpatient clinic			1			
Private hospital				1		
Private physicians and clinics	less than 5	many	many	less than 5	less than 5	less than 5
DATA						
ICD-10 coding for deaths	X	X	X sent to NCHS	X coded at FSM Natl	X	X
ICD-9 for hospital discharges	X	X	X			X
Cancer Database	Cancer mortality registry, BCCEDP	None	Abstract Plus, reports to SEER	Varies (EpiInfo, Excel, paper)	Registry Plus, EpiInfo, BCCEDP	Excel, Nuclear Claims Tribunal
REGISTRY-SPECIFIC						
Cancer Registry			UOG / HTR Registry Plus		NPCR	RMI National registry
Law authorizing reporting to CCR	X		X	Legislation Introduced 1/07	X	
Formal Policies and procedures			X		X	

Program or service	American Samoa	CNMI	Guam	FSM	Palau	RMI
Complete cancer reporting			X *		X ^	
Timeliness of case reporting			X *		X ^	
Data quality assessment			X *		X ^	
Quality Assurance procedures			X *		X ^	
Certified Tumor Registrar						
Trained Abstractor			X		X	
Certified Coder			?	1		
Registered Health Information Technician			?			
Registered Health Information Administrator						

*Guam Cancer Registry currently operates with the assistance of the Hawaii Tumor Registry as part of the NCI U56 Minority Institution/Cancer Center Partnership

^ Palau Cancer Registry is NPCR-funded (Part II, planning)

Because of these challenges, the relatively small populations and the high cost of developing a sustainable cancer registry that meets U.S. national standards, the CCPI prioritized the need to develop a regional central cancer registry. This registry would ideally be operated in the USAPIN, allow for capacity building at the jurisdiction level and allow the jurisdictions to maintain their own local files (though the central registry would be primarily responsible for ensuring that the information meets the U.S. national standards).

PIHOA has embraced the idea of a regional central cancer registry and the Centers for Disease Control are supportive of the concept. The minimum data set has already been shared with USAPIN leaders and CCPI members to help ensure their own HIM system has the same data fields. The individual jurisdictions are committed to start improving their baseline infrastructure in preparation for participation in a regional registry.

Objective 4.1 Secure funding for a developing a regional cancer registry program (planning) by 2008

Baseline: The Guam Cancer Registry is jointly operated by the University of Guam and the Guam DPHSS. The GCR capacity and functioning has improved over the last two years with the assistance of the Cancer Research Center of Hawaii partnership grant. They are not presently ready to assume the role of a regional central cancer registry, but have the most potential to do so because of the population size, economics and presence of a 4-year university on island. The Palau Cancer Registry is funded by the

CDC National Program of Cancer Registries and is willing to collaborate and share expertise as the Pacific Regional Central Cancer Registry develops.

Strategy 4.1.1 By March 2007, submit a proposal to the Centers for Disease Control National Program of Cancer Registries for a planning grant to develop a regional cancer registry in the USAPIN.

Outcome: Funded grant

Measure: Grant application

Objective 4.2 Facilitate implementation of jurisdiction-specific strategies related to improving the quality of cancer-related data

Baseline: Each jurisdiction faces challenges with health information and those are described in their CCC plans and above. Common needs that have emerged in the CCC planning process is the need for basic training so that the personnel can contribute more effectively to a cancer registry and to their own cancer control programs.

Strategy 4.2.1 Starting in July 2007, work with each jurisdiction's "data quality team" and provide or seek additional resources to support their educational needs, as needed

Outcome: Personnel better prepared to participate in a regional cancer registry

Measure: Progress reports

Strategy 4.2.2 (see also Objective 2.4) Work with PIHOA and PPEC and other partners to provide foundational coursework in medical terminology, anatomy and physiology, and health and diseases for medical record staff in the region

Outcome: Sustainable on-site credit coursework (that is transferable across institutions)

Measure: PIHOA reports, course evaluations

PARTNERSHIPS AND COLLABORATION

The individual jurisdiction CCC coalitions include representatives from the community, traditional leadership, local non-governmental organizations, churches, businesses, education and health sectors. The FSM National CCC Coalition also includes leadership from the economic and finance sectors and the Office of Compact Management. The CCC process at the jurisdiction level has fostered closer collaboration and coordination of efforts among existing public health programs in tobacco, maternal child health, sexually transmitted disease, nutrition, diabetes and breast/cervical cancer (if that exists in the jurisdiction). Those ten coalitions comprise the Pacific Cancer Coalition. Communication and coordination is primarily through each jurisdiction's CCC Coordinator and secondarily to the Cancer Council of the Pacific Islands (CCPI) members (who are part of their jurisdiction's coalition).

The Pacific Regional Comprehensive Cancer Control (CCC) Plan was developed with the assistance of many partners in addition to all of the CCC coalitions in the USAPIN, the CCPI and the Pacific Islands Health Officers Association (PIHOA). Because the Regional CCC plan is different from the typical CCC plan, feedback was obtained from U.S. National experts and partners at the UICC International Cancer Congress meeting in Washington D.C., Intercultural Cancer Council meetings, C-Change, Strategic Health Concepts and the WHO Western Pacific Region Office Human Resources for Health Technical Advisor.

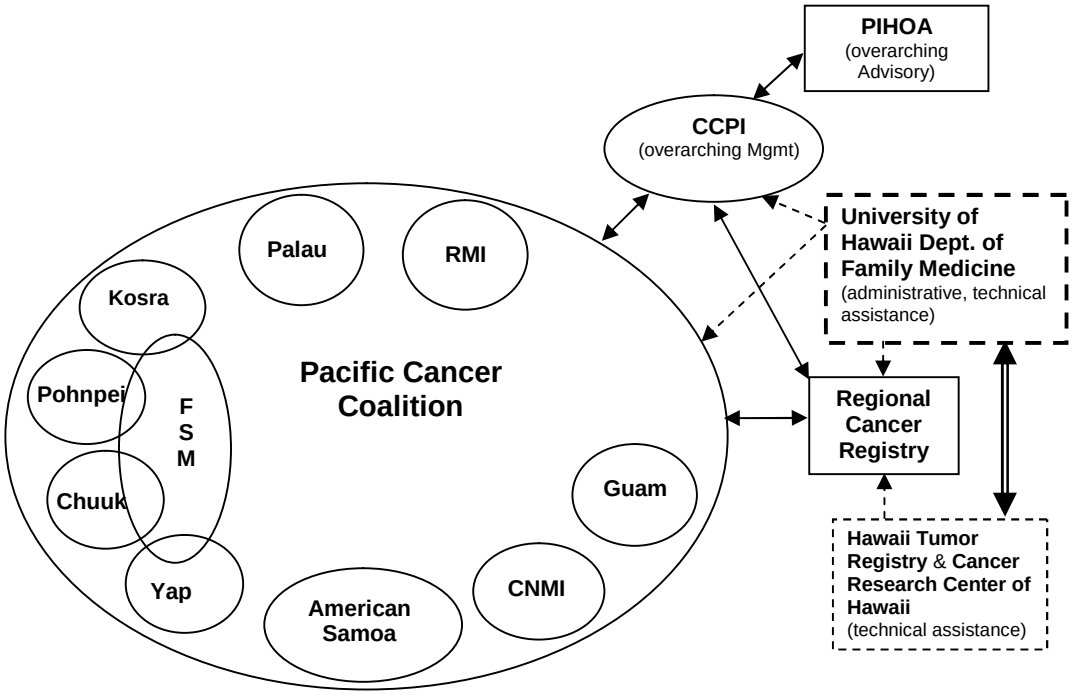
Implementation of this Regional CCC plan will require expertise and resources from U.S. National agencies and organizations, international agencies and donor countries. Implementation will also require even closer collaboration between Pacific regional organizations that deal with health, health policy, education and economics.

A partial listing of current and proposed partners follows. The CCPI, through their Secretariat, will be primarily responsible for garnering support for the strategies proposed in this Regional plan. The CCPI and PIHOA will also collaborate closely to ensure that Regional CCC efforts are congruent and coordinated with PIHOA where possible.

- Pacific Islands Primary Care Association
- American-Pacific Nurse Leaders Council
- Pacific Basin Medical Association
- Pacific Basin Dental Association (oral cancer)
- Pacific Post-Secondary Education Council
- Papa Ola Lokahi
- Cancer Research Center of Hawaii – Cancer Information Service Pacific Region
- Cancer Research Center of Hawaii – Hawaii Tumor Registry
- CDC Division of Cancer Prevention and Control

- CDC Coordinating Office for Global Health, Division of Epidemiology and Surveillance Capacity Development
- CDC – Sustainable Management Development Program
- CDC Division of Partnerships and Strategic Alliances
- U.S. Health Resources and Services Administration
- U.S. Department of the Interior
- C-Change
- Intercultural Cancer Council
- Lance Armstrong Foundation
- American Cancer Society
- National Cancer Institute – Center to Reduce Cancer Health Disparities
- National Institutes of Health – National Center on Minority Health and Health Disparities
- WHO Western Pacific Regional Office
- WHO Pacific Open Health Learning Network
- Asian Development Bank
- United Nations
- Australia AID
- New Zealand AID
- Japan International Cooperation Agency
- other international donor countries/agencies
- Fiji School of Medicine (FSMed) and FSMed Department of Public Health
- Massey University

IMPLEMENTATION OF THE PACIFIC REGIONAL CCC PLAN



The Pacific Cancer Coalition is comprised of all 10 of the Pacific Cancer Coalitions. For regional meetings and decision-making, each coalition is represented by their jurisdiction CCC Coordinator, CCPI Members, and a Coalition Representative from each of the 10 jurisdictions.

The Cancer Council of the Pacific Islands provides the overall direction for regional CCC efforts and the CCPI members from each jurisdiction are part of their jurisdiction CCC coalitions and steering committees. The Pacific Islands Health Officers Association (PIHOA) serves as overall advisory to the CCC process since the PIHOA Board and Associate Members are the Ministers/Secretaries/Directors of Health for their jurisdiction.

The Steering Committee for the Pacific Cancer Coalition is comprised of the CCPI Executive Committee (President, Vice-President, Secretary-Treasurer) and the Regional CCC Project Staff. Because the CCPI does not presently have it's own infrastructure to manage the Pacific CCC plan, they have designated the University of Hawaii Department of Family Medicine and Community Health (UH DFMCH) to serve as the Secretariat for the CCPI, to continue in its present capacity of supporting and advising the CCC process in each jurisdiction and the region, to continue to develop the Regional Cancer Registry in close coordination with jurisdiction efforts and to continue assisting with advocacy for cancer-related issues at the U.S. National, Hawaii, Regional and international levels. A long-term goal is that the CCPI will be able to be an autonomous

organization. However at this early stage of development, continuing partnerships to facilitate development of the CCPI and the Regional Cancer Coalition are critical.

Because several of each jurisdiction's objectives and strategies will be implemented in close conjunction with regional strategies, a full-time Regional CCC coordinator will be hired. Additionally, a full-time training coordinator will be hired. Drs. Neal Palafox, Vanessa Wong and Lee Buenconsejo-Lum will remain on the project as technical advisors. Each jurisdiction's implementation grant application contains a portion of the regional CCC subcontract, which will fund the Secretariat, Regional CCC Coordination, development of a web-based clearinghouse of information related to cancer control and policy issues affecting the region and a part-time epidemiologist to assist each jurisdiction with developing appropriate baseline surveys and/or designing evaluation strategies that are meaningful and appropriate to the resources of the jurisdiction.

Technical assistance provided by Hawaii-based partners will be coordinated through the Regional CCC Program office. The Cancer Information Service Pacific Region is available and interested in working closely with each jurisdiction to tailor patient and provider education materials to meet their specific needs. Additional technical assistance specifically regarding the development of the Pacific Regional Central Cancer Registry will be provided by the Hawaii Tumor Registry / Cancer Research Center of Hawaii in close collaboration with the UH Department of Family Medicine. Pacific Islands Primary Care Association members are updated regularly on cancer control efforts and most of the (Executive Directors of the Community Health Centers) are already partners with their local CCC coalitions.

Communication and coordination among the different coalitions, including the FSM State coalitions is through the CCC Coordinators. There will be one week-long Regional meeting per year, with one of the two semi-annual CCPI meetings happening one day prior to the Regional CCC meeting. The Regional CCC office will also coordinate monthly calls with cancer coordinators and CCPI members to discuss progress, scheduling of trainings, successes and challenges with implementation, distribute relevant materials and to improve coordination in general. The CCC Coordinators will disseminate information back to their respective coalitions. Additionally, the Regional CCC staff is always available by email or cell-phone. Creating a central resource portal for cancer control related information will greatly help to expedite some implementation activities. Because of telecommunication challenges, however, a list-serv will be developed and important information also sent to the jurisdictions by fax.

Communication with external partners will be accomplished by distributing the Regional and jurisdiction CCC plans to the partners listed in the previous section and participating in various meetings. A newsletter is planned for semi-annual distribution to the different potential partners. Additionally, a more succinct monograph highlighting the uniqueness of each jurisdiction and the region and a summary of the CCC plans will be developed and distributed by the Regional CCC program office. As the regional CCC

website is developed, coordinators will contribute information regarding events, opportunities and policies and external partners will also be invited to contribute information to the website.

Prioritization of the Regional CCC plan will be time- and resource-based and focused on addressing core foundational issues so that long-term sustainability can be achieved. The plan is likely to adapt based on new information, policies that affect the region, other opportunities and new partnerships. The Steering committee will review, evaluate and update the plan at least twice yearly; the entire CCPI will also discuss implementation of the Regional and jurisdiction CCC efforts semi-annually and the full Pacific Cancer Coalition will review and renew the Regional CCC plan at each annual meeting. If the Steering Committee proposes major revisions to the plan, those will be distributed at least 30 days in advance of the Regional meeting so that the jurisdiction CCC coalitions can have opportunity to reflect on the proposed changes. Decision-making will be by simple majority. Because of the health workforce shortages, it is sometimes not possible for both CCPI members to attend, so the Pacific Cancer Coalition has decided to allow for voting by proxy and/or for call-in (conference call) voting if needed.

EVALUATION OF THE PLAN AND PROCESS

Evaluation is a key component of any successful program. Throughout the regional CCC planning, various evaluation methods have been utilized to guide the process and positive changes have been made as a result.

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 Regional 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 the Pacific Regional Comprehensive Cancer Control plan:

1. Pacific CCC Coalition
2. USAPIN Pacific Regional CCC Plan
3. Implementation Process

More specifically, the evaluation committee will regularly assess:

- Infrastructure needs and capacity – via monthly progress reports and feedback from the jurisdiction CCC coordinators
- Partnership composition and satisfaction – via annual meeting evaluations and other measures
- Level of support – via partnership surveys or other methods to quantify partnership efforts
- Gaps in data – via reports from each jurisdiction's data quality working groups and the core planning teams and quality control teams of the Pacific Regional Central Cancer Registry (PRCCR)
- Burden of cancer – via reports from the PRCCR
- Progress in achieving program objectives – via reports from the Regional CCC coordinator and Regional program staff

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

ACKNOWLEDGEMENTS

The Pacific Cancer Initiative would not have come this far were it not for the tireless efforts and support of several individuals and organizations.

- National Cancer Institute Center to Reduce Cancer Health Disparities – Dr. Harold Freeman, Mr. Frank Jackson, Ms. Jane Daye, Dr. Kenneth Chu, Dr. Sanya Springfield
- National Institutes of Health National Center on Minority Health and Health Disparities – Dr. John Ruffin
- Papa Ola Lokahi – Ms. Joann Tsark, Ms. Nia Aitaoto, Dr. Kathryn Braun
- Dr. Neal Palafox and the faculty and residents of the University of Hawaii Department of Family Medicine and Community Health
- Pacific Islands Health Officers Association
- Pacific Basin Medical Association

For their efforts with facilitating the development of the USAPIN jurisdictions and Regional CCC plans, for leveraging resources and partnering with numerous National CCC Partners to help bring the plans to near completion, we are grateful to the following:

- Dr. Neal Palafox, Chair, UH JABSOM Department of Family Medicine & Community Health and Principal Investigator for the NCI-Pacific Cancer Initiative, CDC-National Comprehensive Cancer Control Program Planning grant (American Samoa, CNMI, Guam, FSM, RMI), HRSA-Pacific Association for Clinical Training (PACT) and U.S. Department of Energy-Special Medical Care Program for the Radiation Affected Populations of the Republic of the Marshall Islands
- Dr. Vanessa Wong, Project Director, Pacific Comprehensive Cancer Control Program
- Dr. Lee Buenconsejo-Lum, Project Advisor, Pacific CCC Program and Project Director, PACT
- Strategic Health Concepts – Mr. Tom Kean, Ms. Karin Homan, Ms. Leslie Given
- Ms. Erika Strong
- Ms. Mary Piliwale
- Dr. W. Thane Hancock
- Ms. Ernel Roque
- C-Change
- National CCC Partners
- Ms. Susan White, CDC DCPC/NCCCP
- Ms. Reda Wilson, CDC DCPC/NPCR

LISTING OF REGIONAL COALITION MEMBERS

The Pacific Comprehensive Cancer Control Coalition is comprised of the 10 jurisdiction coalitions, their Coordinators and CCPI members. A full list would include over 300 members. Each jurisdiction plan contains a detailed list of their coalition members and their roles in the community and in the coalition. The CCPI members, jurisdiction CCC coordinators and jurisdiction Coalition Chairs are noted below:

Cancer Council of the Pacific Islands (CCPI) Members:	**Coalition Coordinators and Chairs**
*President: Dr. Kamal Gunawardane Vice-President: Ms. Yorah Demei Sec-Treasurer: Dr. John Hedson	
American Samoa Dr. Victor Tofaeono – Acting Medical Director, LBJ Hospital Ms. Margaret Sesepasara – Public Health Women's Health Program	American Samoa Coordinator: Mr. Va'atusili Tofaeono Coalition Chair: Ms. Sherry Butler
CNMI Dr. Robin Shearer – Medical Director, CHC Ms. Lynnette Tenorio – Deputy Secretary of Public Health	CNMI Coordinator: Ms. Joanne Ogo Coalition Chair: Mr. Benjamin Seman
Guam Dr. Robert Haddock – Territorial Epidemiologist and Cancer Registrar Ms. Roselie Zabala – BPSS Administrator	Guam Coordinator: Ms. Marisha Artero Coalition Chair: Dr. Robert Haddock
Republic of the Marshall Islands Dr. Kamal Gunawardane* -- MOH Surgeon Dr. Tom Jack – DOE Program physician	Republic of the Marshall Islands Coordinator: Ms. Esther Lokboj Ebeye Coordinator: Ms. Alosiana Bejang Coalition Chair: Dr. Kamal Gunawardane
Republic of Palau Dr. Omdiderengu Francisca Yalap Soaladaob – Chief of Surgery Ms. Yorah Demei* -- Cancer Program Administrator	Republic of Palau Coordinator: Ms. Darnelle Warswick Coalition Chair: Mr. Joe Aitaro
Chuuk State, FSM Dr. Kino Ruben – Outer Islands Health Program Director Dr. Kolid Keybond – Chief of Staff	Chuuk State, FSM Coordinator: Dr. Kino Ruben Coalition Chair: Mr. Domingko Asor
Kosrae State, FSM Dr. Livinson Taulung – Chief of Staff Dr. Vita Skilling – Public Health Physician	Kosrae State, FSM Coordinator: Mr. Nena Tolenoa Coalition Chair: Senator Bob Skilling
Pohnpei State, FSM Dr. John Hedson* -- Chief of Staff Mr. Wincener David – Director of Health	Pohnpei State, FSM Coordinator: Mr. Xner Luther Coalition Chair: Dr. Rally Jim
Yap State, FSM Dr. Victor Ngaden – Physician Dr. A. Richter Yow – Chief of Staff	Yap State, FSM Coordinator: Ms. Martina Reichhardt Coalition Chair: Mr. Peter Tairuwepiy
	FSM National Government Coordinator: Mr. Amato Elymore Coalition Chair: Mr. Wison Waguk

REFERENCES

1 U.S. Congress. U.S. P.L 108-188, Article VI, Section 461 in the Amended Compacts of Free Association for the RMI and FSM, Definition of Terms. December 17, 2003.

[2] Palafox NA. Chief Editor. Marshall Islands Position Paper on Nutrition Related Illness in the Republic of the Marshall Islands for the 1992 FAO/WHO Sponsored International Nutrition Conference in Rome.

[3] World Health Organization. Western Pacific Region (WPRO) Statistical Tables. 2006. The most recent country data is presented (1999-2005 est.). FSM State data (Chuuk, Kosrae, Pohnpei, Yap) are from the FSM Census 2000, FSM Statistics Division.

[4] Palafox N. Medical Analysis: Current Inadequacies and a Future Proposal to Adequately Address Medical Needs Resulting from the U.S. Nuclear Weapons Testing Program in the Republic of the Marshall Islands; Petition Presented to the Congress of the United States of America Regarding Changed Circumstances Arising From U.S. Nuclear Testing in the Marshall Islands; September 11, 2000.

[5] GAO-07-163 Compacts of Free Association: Micronesia and Marshall Islands Face Challenges in Planning for Sustainability, Measuring Progress and Ensuring Accountability. U.S. Government Accountability Office, December 2006.

[6] Palafox NA, Katz A., Johnson D., Minami J., Briand K. Site-specific Cancer incidence in the Republic of the Marshall Islands. Cancer 83:1821-4.

[7] Palafox, NA, Minami J. Cancer in the U.S. Associated Pacific countries: Cultural Considerations. Asian American and Pacific Islander Journal of Health Vol. 6 No. 2:401-404.

[8] Tsark JU, Braun KL, Palafox NA, Finau SA, eds. Cancer in the Pacific. *Pacific Hlth Dialog* September 2004; 11(2): 17-77. Most information initially gathered from the 2002 Cancer Needs Assessments and updated during the CCC plan development.

[9] CIA World Fact Book, Country pages, accessed March 10, 2007. https://www.cia.gov/cia/publications/factbook/index.html

[10] HRSA HP01064 Pacific Association for Clinical Training (PACT): A Cooperative Agreement to Develop and Operate a Continuing Clinical Education Program in the USAPIN. Neal Palafox, MD, MPH Principal Investigator; Lee Buenconsejo-Lum, MD Project Director. Department of Family Medicine and Community Health, John A Burns School of Medicine, University of Hawaii. 9/1/03-8/31/07.

[11] Palafox NA, Tsark JU. Cancer in the U.S. Associated Pacific Islands: History and Participatory Development. *Pacific Hlth Dialog* September 22004; 11(2): 1-10.

[12] Tsark JU, Braun KL, Palafox NA, Finau SA, eds. Cancer in the Pacific. *Pacific Hlth Dialog* September 2004; 11(2): 17-77.

[13] Ou A, Buenconsejo-Lum L, Wong V, Palafox N. Regional Cancer Registries: An Option for Resource Limited Settings. Reprinted from UICC World Cancer Congress, Washington, D.C.(USA), July 8-12, 2006. Medimond International Proceedings.

[14] O'Leary MJ. Health data systems in Micronesia: Past and Future. *Pacific Hlth Dialog* 1995;2(1):126-32.

[15] Katz AR, Palafox NA, Johnson DB, Yamada S, Ou AC, Minami JS. Cancer epidemiology in the freely associated U.S. Pacific Island Jurisdictions: challenges and methodologic issues. *Pacific Hlth Dialog* 11(2): 84-87. 2004

[16] National Cancer Institute. Estimation of the Baseline Number of Cancers Among Marshallese and the Number of Cancers Attributable to Exposure to Fallout from Nuclear Weapons Testing Conducted in the Marshall Islands. A report prepared for the Senate Committee on Energy and Natural Resources. Division of Cancer Epidemiology and Genetics, National Cancer Institute, National Institutes of Health, Department of Health and Human Services: Washington D.C., September 2004.

[17] Marshall Islands Nuclear Claims Tribunal. History and Activities. Available at http://www.nuclearclaimstribunal.com/hist.htm. Accessed March 10, 2007.

[18] Pobutsky AM, Buenconsejo-Lum LE, Chow C, Palafox N, Maskarinec GM. Micronesian Migrants in Hawaii: Health Issues and Culturally Appropriate, Community-Based Solutions. Californian Journal of Health Promotion 2005. 3(4):59-72.

[19] PIHOA website, http://www.pihoa.org/projects.cfm?id=18. Accessed March 10, 2007.

Pacific Islands Health Officers Association

Board Resolution

NAHLAP

#05 08032006

"Regional Comprehensive Cancer Control Plan and Regional Registry"

WHEREAS, the PIHOA Board of Directors are concerned that cancer is amongst the leading causes of mortality and morbidity in every PIHOA jurisdiction; and

WHEREAS, PIHOA has recognized the Cancer Council of the Pacific Islands (CCPI), as the regional coordinating and oversight body for cancer control efforts in the member states and have recently granted the CCPI Affiliate Membership to PIHOA so that CCPI and PIHOA can better coordinate efforts; and

WHEREAS, the PIHOA Board of Directors supports the development of a sustainable regional cancer registry that is controlled by the individual member states and the USAPI region; and

WHEREAS, the PIHOA board has desired to develop (a) a clearinghouse of information for practices and policies that are effective, (b) regional resources for training, (c) affordable, regional diagnostic capabilities, including cancer related laboratory support, (c) regional coordination with referral networks, consultations, and sustainable cancer treatment options, and (d) efficient and sustainable health information and cancer registry systems; and

WHEREAS, the PIHOA Board of Directors recognize the previous and current work, relationships built and advocacy done by University of Hawaii Department of Family Medicine and Community Health (UH DFMCH), and understands the CCPI prefers that the UH DFMCH administer the CDC Regional CCC Plan/Implementation Grant and the CDC Regional Cancer Registry grant on behalf of the region.

NOW, THEREFORE BE IT RESOLVED; the PIHOA Board of Directors, understanding that certain regional minimum standards must be in place in order to compete successfully for the Centers for Disease Control's National Comprehensive Cancer Control Program (NCCCP) and National Program of Cancer Registries (NCPR) Cooperative agreements, will, in each member state,

- Enforce or create existing legislation and policies to mandate reporting of cancer-related information to the Ministry or Department of Health;
- Formalize Ministry or Departmental (of Health) policies and procedures by August 2007 to ensure sharing of information among programs and divisions and collaboration to better utilize existing resources, programs and services;
- Develop or expand quality assurance (QA) processes, specifically in the areas of laboratory and health information management so that cancer-related (and other) information is accurate and can serve as a strong base for future public health and health services planning;
- Continue to work collaboratively with CCPI and UH DFMCH as health information management (HIM) systems are developed so that the additional features of the regional cancer registry can be appropriately tailored to regional and individual jurisdiction needs and work in synergy with HIM systems; and

BE IT FURTHER RESOLVED that the PIHOA Board of Directors and the CCPI will work collaboratively to establish a set of recommended minimum regional standards relating to cancer control; and

BE IT FURTHER RESOLVED that PIHOA Board of Directors will begin a planning process necessary for successful implementation of regional resource centers for cancer and potentially other chronic diseases; and

BE IT FURTHER RESOLVED that copies of this resolution will be sent to the Attorney Generals of each member state, the CCPI, CDC Division of Cancer Prevention and Control, NCI National Center of Minority Health and Health Disparities and NCI Center to Reduce Cancer Health Disparities, the University of Hawaii System including the John A. Burns School of Medicine, and to the U.S. Congressional Delegation from Hawaii, Guam and American Samoa.

Hon. Nena Nena, MPH
PIHOA President

Hon. Alvin T. Jacklik
PIHOA Vice President

Hon. Utó ofili Aso Maga, MPH
PIHOA Treasurer

Hon. Joseph Kevin Villagomez, MA
PIHOA Secretary

Hon. Victor Yano, MD
PIHOA Board Member

FOR Hon. Arthur San Agustin, MHR
PIHOA Board Member

Pacific Islands Health Officers Association

NAHLAP

Board Resolution

06 08032006

"In support of the Nahlap HRH Action Plan"

WHEREAS, Human Resources for Health is one of the 10 priorities in the PIHOA's Strategic Plan;

WHEREAS, there is a chronic regional shortage of students academically prepared to enter all levels of health professions training – particularly in medicine, nursing and allied health;

WHEREAS, many of the current health workforce are under-trained in their respective disciplines, especially in allied health;

WHEREAS, all the jurisdictions recognize that there is a shortage of qualified nurses at all levels;

WHEREAS, there is a need for ongoing training for clinical, public health, oral health and psychiatric nurses;

WHEREAS, the primary and secondary school systems need strengthening in English, Study Skills, Mathematics, and Science;

WHEREAS, there are too few career ladder and bridging training programs that provide in-country health workforce training;

WHEREAS, management training for the health workforce has been identified as a priority need for Nursing, Public Health, and Health Services Administration;

WHEREAS, there is the need for appropriate planning for better HRH development among the USAPI member jurisdictions;

WHEREAS, PIHOA, within its 42nd Meeting on Nahlap Island, Pohnpei, 1-2 August 2006, conducted a 2-day workshop to address regional HRH issues;

NOW, THEREFORE BE IT RESOLVED; the PIHOA HRH Subcommittee will develop a PIHOA Strategic HRH Report – the Nahlap Action Plan, which will address HRH regional challenges and focus on critical issues including

1) Strengthening the Educational Pipeline for the new workforce,

2) Career Ladder and Bridging Training for the current workforce,
3) Management training,
4) Overall HRH planning; and
5) Partnerships with local institutions for higher learning for delivery of needed accredited curricula.

BE IT FURTHER RESOLVED for developing the new workforce, the Nahlap Action Plan will include ways to strengthen the Educational Pipeline to increase the numbers of regional students who are academically prepared to enter all levels of health care training;

BE IT FURTHER RESOLVED the Nahlap Action Plan will address training issues associated with Career Ladder and Bridging Training Programs for the current members of the health workforce;

BE IT FURTHER RESOLVED as an example of a action item, PIHOA will work with WHO to make available more Pacific Open Health Learning Network (POHLN) distance learning modules for regional Allied Health Workers (AHW) as a first step credited academic training activity which will later complement follow-up hands-on clinical training;

BE IT FURTHER RESOLVED additionally, PIHOA will work with donor and granting agencies establish clinical allied health Centers of Excellence to provide hands-on clinical training for regional AHW who have completed discipline related POHLN distance learning modules;

BE IT FURTHER RESOLVED PIHOA will advocate with local and regional health professions institutions to strengthen management training for regional nurses, public health workers, and health services administrators;

BE IT FURTHER RESOLVED the Nahlap Action Plan will provide a framework for regional gathering of HRH data with a view to appropriate HRH planning for the region; The HRH Subcommittee will develop a PIHOA Strategic HRH Report – the Nahlap Action Plan, which will address regional HRH regional;

BE IT FURTHER RESOLVED PIHOA will present the first installment of its Strategic HRH Plan at the next regular PIHOA meeting;

BE IT FURTHER RESOLVED that PIHOA extends its gratitude to the South Pacific Office of WHO for allowing Dr. Juliet Fleischl, WHO HRH Officer, Suva, Fiji; to assist it in conducting the Nahlap Island HRH Meeting;

BE IT FURTHER RESOLVED PIHOA will work with the regions scholarship boards and international donors to provide scholarships for all levels of the health workforce;

BE IT FURTHER RESOLVED that copies of this resolution will be sent to Dr. Chen Ken, WHO South Pacific Representatives, Suva, Fiji, PREL, Ministers of Education, College of Micronesia, College of the Marshall Islands, University of Guam, John A. Burns School of Medicine, Fiji School of Medicine, Fiji School of Nursing, Guam Community College, University of the South Pacific, AUSAID, JICA, NZAID, Palau Community College, U.S. Embassies of Freely Associated States, Scholarship Boards USAPI.

Hon. Nena Nena, MPH
PIHOA President

Hon. Alvin T. Jacklik
PIHOA Vice President

Hon. Uto'ofili Aso Maga, MPH
PIHOA Treasurer

Hon. Joseph Kevin Villagomez, MA
PIHOAA Secretary

Hon. Victor Yano, MD
PIHOA Board Member

Hon. Arthur U. San Agustin, MHR
PIHOA Board Member