

# MICRONESIA, FEDERATED STATES OF

## 1. CONTEXT

### 1.1 Demographics

The Federated States of Micronesia contains 607 volcanic islands and atolls scattered over 1 million square miles of the Pacific Ocean. The land area totals 704.6 square kilometres, with 7192 square kilometres of lagoon area.

Based on the preliminary results of the 2010 Census, the Federated States of Micronesia has a population of 102 624, 35.7% below 15 years old, and 3.3% 65 years and over. The average age of the population is estimated to be 21.5 years, and for every 100 females, there are about 103 males. There has been a decrease in the population due to substantial outmigration over the past decade. Approximately 49% of the population lives in Chuuk, 32% in Pohnpei, 11% in Yap and 8% in Kosrae, with almost 23% living in urban areas.

### 1.2 Political situation

The Federated States of Micronesia is a constitutional federation of four states: Chuuk, Kosrae, Pohnpei and Yap. The capital is located in Palikir, Pohnpei. The constitution provides for three separate branches of government at the national level: executive, legislative and judicial. It has a Declaration of Rights, similar to the Bill of Rights of the United States of America, specifying basic human rights standards consistent with international norms.

The Congress is unicameral and has 14 senators, one from each state, elected for a four-year term, and 10 who serve two-year terms, whose seats are apportioned by population. There are no formal political parties. The President and Vice-President are elected to four-year terms by the Congress. Elections were last held in March 2007 and May 2007. Congress elected Emmanuel Mori as president and Alik L. Alik as Vice-President.

The Division of Health is part of the Department of Health and Social Affairs. The Secretary of the Department of Health and Social Affairs is a cabinet-level position, nominated by the President and requiring congressional confirmation.

### 1.3 Socioeconomic situation

Economic activity consists primarily of subsistence farming and fishing. Primary farm products include black pepper, tropical fruits and vegetables, coconuts, cassava, betel nuts, sweet potatoes, pigs and chickens. The islands have few mineral deposits worth exploiting, except for high-grade phosphate. The potential for a tourist industry exists, but the remote location, lack of adequate facilities and limited air connections hinder development.

In November 2002, the country experienced a further reduction in future revenues from the Compact of Free Association, the agreement with the United States of America by which Micronesia received US\$ 1.3 billion in financial and technical assistance over a 15-year period until 2001. Under the new compact, the country will receive approximately US\$ 92 million a year until 2023, including contributions to a jointly managed trust fund. Additional funding from the United States totalled US\$ 57 million in 2004.

Employment declined from 16 119 in 2000 to 15 897 in 2005. Pohnpei had the highest number of employed, at 7060, and Kosrae had the lowest, at 1366. The three largest employers were the private sector, state government, and government agencies. Around 43% were in the public sector, 19.8% in wholesale trade and repair and 7% in education. The unemployment rate is 16% and the average real wage is US\$ 6037.

The country has a severe trade deficit. In 2005, total imports were valued at US\$ 117.5 million and exports were valued at only US\$ 1.3 million (exclusive of long-liner and purse seiner catches). The tourism sector is small, with only 13 415 tourists reported for 2005. Private remittances are also limited, especially compared with other Pacific island countries.

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The gross domestic product (GDP) for 2008 was estimated to be US\$ 304 million, with nominal GDP per capita estimated to be US\$ 2223.

#### **1.4 Risks, vulnerabilities and hazards**

The country's medium-term economic outlook appears fragile due, not only to the reduction in assistance from the United States of America, but also to the slow growth of the private sector. Geographical isolation and a poorly developed infrastructure remain major impediments to long-term growth.

While telecommunication costs have fallen, Internet access is still expensive and most residential Internet access is provided via dial-up accounts. This lack of affordable broadband Internet access is a significant barrier to business growth and to improving education.

## **2. HEALTH SITUATION AND TREND**

### **2.1 Communicable and noncommunicable diseases, health risk factors and transition**

The overall health situation remained unchanged between 2000 and 2009, with the population showing continuing susceptibility to both communicable and noncommunicable diseases. Noncommunicable diseases have been on the rise and have taken their toll on the population in the past 24 years. Citizens of the Federated States of Micronesia, however, continue to enjoy a level of health care that is high in comparison with the rest of the Pacific region. Micronesian doctors are taking the place of United States doctors in the health system as a result of such programmes as the, now defunct, Medical Officer Training Programme in Pohnpei.

### **2.2 Outbreaks of communicable diseases**

The number of vaccine-preventable diseases has declined considerably. However, waterborne and foodborne diseases are major causes of hospital admission. Strategies need to be developed to improve the coverage of immunization and other health programmes that address disease. The highest immunization coverage (84.1%) was in 1992 and was the result of heavy campaigning at that time due to outbreaks of measles and a hepatitis B immunization campaign. There have been sporadic outbreaks of zika virus, dengue fever and hepatitis A in recent years, and multidrug-resistant (MDR) tuberculosis has been detected. Leprosy is still highly prevalent and the country failed to reach the elimination target in 2000. There have been no major outbreaks of sexually transmitted infections, including HIV/AIDS. However, the country is fertile ground for these conditions as behaviours leading to acquiring such infections exist. Some cases of influenza A (H1N1) have been reported, but have not constituted an outbreak. No cholera outbreak has been reported for the last five years. A strategic plan is needed to continue improving health services, public health surveillance and information systems.

### **2.3 Leading causes of mortality and morbidity**

The reporting of mortality and morbidity in the Federated States of Micronesia is still problematic due mainly to late reporting and the lack of a standardized reporting system. The problem with mortality data concerns late filing of death certificates for mortality coding. This function is performed at the national level by the health information system. However, current information (2009) collected from the four states with respect to mortality and morbidity indicate that the leading causes of mortality are heart disease, diabetes mellitus, chronic obstructive pulmonary disease, cerebrovascular accidents and unknown (R99) types of death. As for morbidity, the following conditions top the list: essential (primary) hypertension, diarrhoea/gastroenteritis, diabetes mellitus, skin disorders and urinary tract infections. The 10 leading causes of both outpatient visits and inpatient care, in all four states, are listed in Table 1 below:

**Table 1. FSM 2009 morbidity – 10 leading causes (outpatient and inpatient) by body system**

<b>Outpatient visits, by system</b>	<b>Inpatient care, by system</b>
Diseases of the respiratory system	Diseases of the respiratory system
Certain infectious and parasitic diseases	Diseases of the circulatory system
Diseases of the skin and subcutaneous tissue	Endocrine, nutrition and metabolic diseases
Diseases of the musculoskeletal system and connective tissue	Certain infectious and parasitic diseases
Diseases of the circulatory system	Diseases of pregnancy, childbirth and the puerperium
Diseases of the digestive system	Diseases of the genitourinary system
Endocrine, nutrition and metabolic diseases	Diseases of the digestive system
Diseases of the genitourinary system	Diseases of the skin and subcutaneous tissue
Diseases of the ear and mastoid process	Diseases of the musculoskeletal system and connective tissue
Symptoms, signs and abnormal clinical and laboratory findings, NEC	Certain conditions originating in the perinatal period

**2.4 Maternal, child and infant diseases**

National health statistics indicate that the leading causes of death in recent years among infants and young children were prematurity, newborn sepsis, respiratory infections, undernutrition and multiple congenital anomalies, including congenital heart disease. With the addition of diarrhoeal diseases, these health problems are also the leading causes of child morbidity, measured by outpatient visits and hospitalizations. Among older children, teenagers and young adults, injuries have become the predominant cause of death. Among unintentional injuries, the number of water-associated deaths is about equal to motor-vehicle-related deaths.

Prenatal care is slowly improving in the state centres and is being expanded to remote areas. Death and illness due to diarrhoea and acute respiratory infections still account for a large proportion of infant mortality and morbidity. In 2006, the country started implementing the integrated management of childhood illness (IMCI) strategy as a way to strengthen the skills and capacity of health care workers, particularly those attending to maternal and child health, to reduce childhood illness. The maternal death rate cannot be calculated due to underreporting or missing data. However, the maternal mortality ratio is currently estimated at 0 per 100 000 live births. Child and infant diseases continue to be seen mostly in the form of respiratory diseases, diarrhoeal conditions and nutritional disorders. The estimated infant mortality rate (IMR) for 2009 was 13.5 per 1000 live births.

**2.5 Burden of disease**

Although certain infectious and parasitic diseases are prevalent, the disease burden also includes chronic and noncommunicable diseases, with diabetes and endocrine, nutritional and metabolic diseases constituting major health problems. Contributing factors are believed to be changes in diet, lack of exercise, sex, age, occupation and, in some cases, drug abuse.

Intentional (violence) injury and the high suicide rate are particularly notable and are thought to be due to the burden of cultural and economic dislocation, particularly among young adult males. Suicide rates for young adult males in the Micronesia region are among the highest in the world. Alcohol is often a contributing factor in violent incidents.

Among adults, heart disease and stroke have become the leading causes of death, with rates for adults aged 25 to 55 years double those for their counterparts in the United States of America. This suggests that a combination of lifestyle (high fat/sodium/calorie diet, lack of exercise, and tobacco and alcohol use) and genetics has created an unusual burden on the population that otherwise would follow a disease pattern similar to other developing countries.

Indeed, the fact that these high rates of noncommunicable disease exist in the Federated States of Micronesia in the face of the continued high incidence of tuberculosis, leprosy, rheumatic fever, rheumatic heart disease, etc., indicates that, in a situation similar to other Pacific island countries, the country has not completed an

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epidemiological transition, but rather, is in the unenviable position of being doubly afflicted by the disease patterns of both a developing and a developed country.

The leprosy prevalence rate of 40 per 10 000 populations is among the highest in the Pacific.

Since the first case was detected in 1989, a total of 37 HIV infections and/or AIDS cases have been reported in the country, with the number of confirmed HIV infections slowly increasing; only two cases of infection were reported between 1989 and 1997, three were confirmed in 1998 and 1999, six in 2000, three each year from 2001 to 2003, two in 2004, three in 2005, none in 2006, three in 2007, one in 2008, and one in 2009. As in many developing countries, many factors influence the reporting of HIV/AIDS and thus figures may deviate somewhat from actual counts. By the end of 2009, of the cumulative total of 37 confirmed HIV patients, 28 had died from AIDS-related illnesses and three had left the country. Thus, there were six known people living with HIV/AIDS, all adults, residing in the country. Five of these persons are on treatment, two males and three females.

One case of malaria was reported in 2009. In general, the mosquito vector is absent in the environment. However, a few nationals have been infected when travelling to malaria-endemic countries.

Like many developing countries, the Federated States of Micronesia has a high prevalence of tuberculosis (TB). In 2009, the TB incidence rate was 157 per 100 000 population and the prevalence rate was 168 per 100 000 and rising. In response to the situation, a national plan for the prevention and control/elimination of tuberculosis was developed and adapted in 1989, with revision in 1990. In 1992, full implementation commenced. In 1995, the plan was reviewed and revised, with assistance from WHO. In 2009, the plan was revisited and a revision is now being drafted.

The TB situation is similar to that in other developing countries. The disease continues to increase and remains a major cause of preventable morbidity and mortality. A shortage of skilled staff, medication and funding have resulted in generally inadequate treatment for most cases that are identified. Few people complete a full course of treatment, close contacts are evaluated in only two states, and only a few people have started on and/or finished a course of preventive therapy with isoniazid (INH). Laboratory confirmation of suspected TB cases by culture was almost impossible in the past, but that situation has changed dramatically in the past six years. Although training and human resource needs are considered critical, capacity-building of physician assistants (community health assistants) has been improving.

### **3. HEALTH SYSTEM**

#### **3.1 Ministry of Health's mission, vision and objectives**

The mission of the Department of Health and Social Affairs is to promote and protect the health status and the social welfare of citizens and residents. The vision is a healthy island nation. The Division of Health has established five health-related strategic goals with the objective of improving health services. These are:

- improvement of primary health care services;
- improvement of secondary health care services;
- prioritization of health promotion and services for major health problems;
- development of a sustainable health care financing mechanism; and
- improvement of capacity and accountability systems.

A total of 10 outcome measures were developed and used during the period from 2003 to 2005 to indicate progress in meeting these goals. In 2005, however, modifications were proposed involving the addition of four new measures. These modifications, also known as the 14 Health Indicators and endorsed by all four state Directors, the Secretary, the Assistant Secretary and programme managers, remained in effect until 2010, and will be reviewed and modified in 2011.

The proposed outcome measures involve increasing access to health services, improving immunization coverage, improving the availability of essential drugs, increasing the functionality of biomedical equipment, reducing the length of the average hospital stay, reducing infant mortality, reducing mental illness, increasing the number of individuals enrolled in health insurance plans, reducing off-island medical referral costs, increasing the number of children under seven years receiving protective tooth sealant, reducing the incidence of diarrhoeal disease,

reducing the incidence of diabetic hospitalization, and implementing a functioning quality assurance system in all states. Baseline data were collected in each of these areas and specific goals established to measure progress.

### 3.2 Organization of health services and delivery systems

Each state government maintains its own health services. Although similar in many aspects, each system is also unique autonomously. Each state maintains a centrally located hospital that provides a minimum range of primary- and secondary-level services, both preventive and curative. There are six private health clinics in the country and one private hospital. Health services are highly subsidized by the state governments, except in the private clinics.

The Division of Health of the Department of Health, Education and Social Affairs does not have a direct role in the provision of health services. The Department of Health Services in each state has primary responsibility for curative, preventive and public health services. This responsibility includes the main hospital, peripheral health centres, and dispensaries (primary health centres). Only residents of urban centres have direct access to the main hospital in each state. Transportation issues between islands often prevent residents who live on the outer islands from accessing these hospitals.

Dispensaries (similar to health clinics) are located in municipalities and outlying islands and are part of the state health departments. Their location is based on population, need and political considerations. Local mayors and the dispensary supervisors are responsible for day-to-day operations. Diagnosis and treatment of common ailments are the primary services provided, with more advanced cases being referred to central hospitals.

The Secretary of the Department of Health and Social Affairs is responsible for overseeing all health programmes and ensuring compliance with all laws and executive directives. Major mandates are coordination, monitoring, technical assistance and capacity-building. In addition, the Department:

- provides overall supervision for the Division;
- sets priorities within financial, manpower and material constraints, as approved by the Secretary;
- conducts annual programme and staff performance audits and evaluations;
- enforces department and national policies;
- improves accountability within the Division of Health;
- implements national health strategies and the Strategic Development Plan in accordance with the Secretary's directives;
- works to increase external funding to support implementation of health strategies;
- develops and implements property inventory systems; and
- coordinates financial support and assistance to the states.

**Table 2. Health facilities in the Federated States of Micronesia**

Facility Type	FSM Total	Kosrae	Pohnpei	Chuuk	Yap
<b>I. Total health facilities in country</b>	<b>122</b>	<b>6</b>	<b>19</b>	<b>71</b>	<b>26</b>
Hospitals	5	1	2	1	1
Community health centres	5	0	1	0	4
Dispensaries	92	0	9	64	19
Aid posts	6	5	0	0	1
Health clinics	6	0	3	3	0
Pharmacies	6	0	2	3	1
Dental clinics	2	0	2	0	0

Facility Type	FSM Total	Kosrae	Pohnpei	Chuuk	Yap
<b>II. Government-owned health facilities</b>	<b>107</b>	<b>6</b>	<b>11</b>	<b>65</b>	<b>25</b>
Hospitals	4	1	1	1	1
Licensed beds	326	35	116	125	50
Operating beds	312	45	92	125	42
Occupancy rate	65.5	83	62	58	59
Health centres (CHC)	5	0	1	0	4
Dispensaries	92	0	9	64	19
Aid posts	6	5	0	0	1
<b>III. Privately-owned health facilities</b>	<b>15</b>	<b>0</b>	<b>8</b>	<b>6</b>	<b>1</b>
Hospital	1	0	1	0	0
Licensed beds	36	0	36	0	0
Operating beds	36	0	36	0	0
Private health clinics	6	0	3	0	0
Private pharmacies	6	0	2	3	1
Private dental clinics	2	0	2	3	0

The state-based delivery system is an effective way of administering health. Given the geographical dispersal, remote nature and cultural diversity of the many island communities, the system has the best chance of developing more responsive and effective services to meet the needs of the community. In the environment of politically independent states, however, there are constraints on implementation of national policies.

### 3.3 Health policy, planning and regulatory framework

The Division of Health of the Department of Health and Social Affairs provides health planning, donor coordination, and technical and training assistance. It also coordinates and manages the preventative medicine and public health programmes funded by the United States Department of Health and Human Services. While the Division of Health does not have a direct role in the provision of health services, it has significant influence in the provision of health services as a result of its managerial responsibilities. Most state Departments of Health Services have very limited planning and programming capabilities. This area needs support and improvement.

### 3.4 Health care financing

Total expenditure on health goods and services and capital formation in the Federated States of Micronesia in 2008 was estimated as US\$ 32.7 million (see Table 3), representing an increase of US\$ 2.1 million over the preceding year, and equivalent to an annual growth rate of 6.7% in nominal terms and 4.6% in real terms.

**Table 3: Total health expenditure, current and constant prices (2008), and annual growth rates, 2005 to 2008**

Fiscal year	Amount (US\$ '000)		Growth rate over previous year (%)	
	Current	Constant <sup>(a)</sup>	Current	Constant
2005	30 307	33 159		
2006	29 912	31 347	-1.3	-5.5
2007	30 674	31 284	2.5	-0.2
2008	32 739	32 739	6.7	4.6
Average annual growth rate			2.6	-0.4

(a) Constant price health expenditures are expressed in terms of 2008 prices  
Source: FSM Health Accounts Database

The ratio of the country's health expenditure to gross domestic product (health to GDP ratio) provides an indication of the proportion of overall economic activity contributed by the health sector. Total health expenditure grew at an average annual rate of 2.6%, while GDP grew at a lower rate of 1.1% between 2005 and 2008 (Table 4). Consequently, the trend in the ratio of health spending to GDP increased slightly from 13.1% to 13.6% (see Table 4).

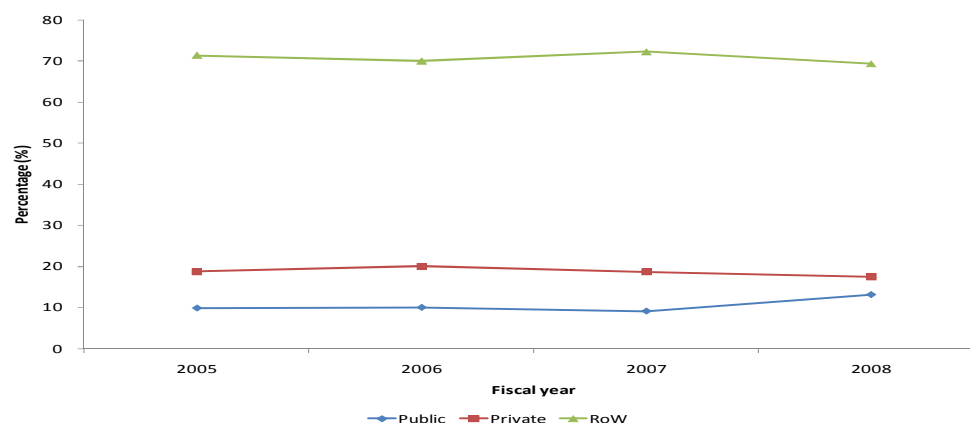
**Table 4: Total health expenditure, GDP, annual growth rates and ratio of health spending to GDP, 2005 to 2008**

Fiscal year	Total Health Expenditure		GDP		Ratio of health expenditure to GDP (%)
	Amount (US\$ '000)	Nominal growth rate (%)	Amount (US\$ '000)	Nominal growth rate (%)	
2005	30 307		232 200		13.1
2006	29 912	-1.3	236 900	2.0	12.6
2007	30 674	2.5	235 900	-0.4	13.0
2008	32 739	6.7	240 140	1.8	13.6
Average annual growth rate		2.6		1.1	

Source: FSM Health Accounts Database

In 2008, local financing of health expenditure amounted to US\$ 10.0 million, compared with US\$ 22.7 million from external funds. Of the local funds, US\$ 4.3 million were government funds, while US\$ 5.7 million came from private sources. Relative shares of public, private and external financing were largely stable during the period from 2005 to 2008 (see Figure 1). External donor funds dominated total health financing, with public and private funds accounting for about 30%.

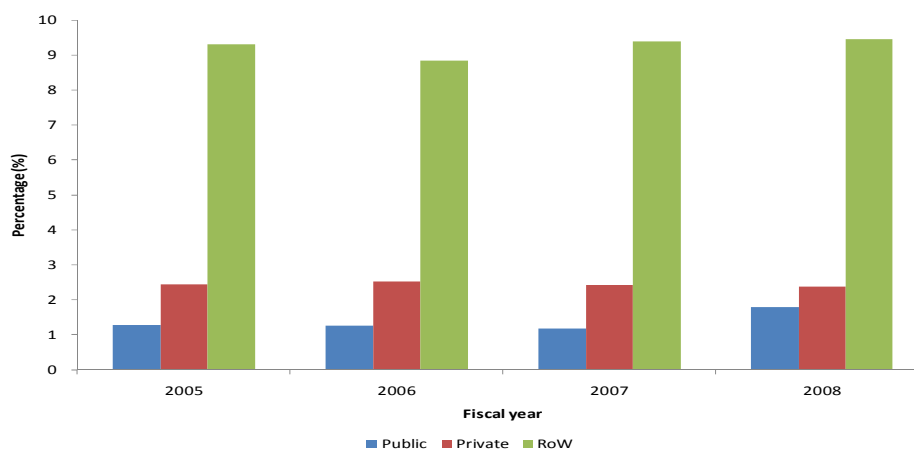
**Figure 1: Share of public, private and external funding (%), 2005 to 2008**



Source: FSM NHA

Public sector financing of health surged from 1.2%-1.3% of GDP in 2005-2007 to 1.8% by 2008, while private sector financing stayed at 2.4%-2.5% of GDP over the same period. Meanwhile, external financing ranged from 8.8% to 9.5% of GDP (see Figure 2).

**Figure 2: Public, private and external spending as a share of GDP (%)**





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### 3.5 Human resources for health

Human resources is a critical area in the health care setting nationally, as many of the current workforce will be retiring in five to 10 years and their replacement is not imminent. Development of the health workforce therefore remains a government priority. The need has been partially met through overseas fellowship training and by the several dozen graduates of the Pacific Basin Medical Officer Training Programme from 1991 to 1996, but serious constraints remain. These include the lack of a nursing school and gaps in speciality training for both nurses and physicians. However, the Government, especially the Department of Health and Social Affairs, is very concerned about the shortages of health personnel manning the state hospitals and community health facilities and, in collaboration with the College of Micronesia, has started a certificate course in public health and is planning to establish a nursing school. In addition, Yap state has established a partnership with Palau Community College for the training of nurses. At present most doctors, nurses and allied health workers pursue their education in institutions like the Fiji School of Medicine, the Republic of the Marshall Islands Nursing School and the University of Guam.

Government health services also lack specialized allied health professional workers, particularly hospital administrators, epidemiologists, medical record administrators, pharmacists, laboratory technicians, radiologists and environmentalists. However, due to limited resources, medical and nursing fellowships have been prioritized, based on the states' requests.

Four Pacific Open Learning Health Network (POLHN) Centres have been established, one in each of the four states, and are providing access to online courses and resources. A full-time coordinator is being hired to provide support for local health professionals in accessing and participating in online courses and continuing education.

### 3.6 Partnerships

Apart from the usual hospital-based health care, community participation in health promotion and disease prevention is critical to successful partnership in the Federated States of Micronesia. Local civil societies, nongovernment organizations and church groups have all played key roles in increasing public awareness on important health issues. The national Department of Health and Social Affairs is working in partnership with the four state Departments of Health Services on policy direction, coordination, monitoring and technical assistance.

External partnerships with the United States Federal Government through various health agencies (Centers for Disease Control and Prevention, Health Resources and Services Administration, Department of Interior) largely take the form of funding assistance for programme activities in public health and preventive health services. With the exception of funding through the Amended Compact, infrastructure and capacity development have been on an ad-hoc basis.

The loan funded by the Asian Development Bank (ADB), Basic Social Services, has now ended. The project was set up to assist the Government in providing capacities in health and education. Activities included training in primary health care and medical coding. Capacity-building in continuous quality initiative training is still seen as a priority for health personnel to stay abreast of new developments in health care delivery services. Partnership with the Department of Education is also essential for scholarships to prospective students in health careers.

As a Member State, the Federated States of Micronesia is also in partnerships with United Nations agencies, such as WHO, the United Nations Children's Fund (UNICEF), and the United Nations Development Programme (UNDP), as well as other regional organizations, such as the Secretariat of the Pacific Community (SPC) and the Pacific Island Health Officers Association (PIHOA). In partnerships with all these international and regional health organizations, the goal is to improve the health status of small island communities.

### 3.7 Challenges to health system strengthening

Strengthening primary health care services is among the many challenges facing the Department of Health and Social Affairs, and enhancing local health departments with specialized medical services continues to be a priority. At present, and for years to come, there are 10 key health system issues confronting the Federated States of Micronesia. These are:

- improving health status;
- setting clear priorities to ensure the most efficient use of resources;



- addressing the shortage of staff (health workers due to retirement and outmigration)
- establishing new health system funding and financial management approaches;
- building managerial capacity;
- testing innovative approaches in every aspect of the system to increase quality, including improving both access for the community and responsiveness to its needs;
- introducing cost-effective new technologies;
- focusing on functions that constitute public goods;
- establishing national policies, measurable outputs and standards to be met, including their monitoring and regulation, and developing the private health sector; and
- improving primary health care services, including community environmental health conditions in remote areas and the outer islands (accessing the Internet, using solar power to acquire health information and sharing of health data through satellite links).

#### 4. LISTING OF MAJOR INFORMATION SOURCES AND DATABASES

<i>Title 1</i>	:	National Health Statistics Office, Department of Health and Social Affairs
<i>Title 2</i>	:	Federated States of Micronesia Statistics Division, Department of Economic Affairs
<i>Web address</i>	:	<a href="http://www.spc.int/prism/">http://www.spc.int/prism/</a>
<i>Title 3</i>	:	<i>2010 FSM-Wide Census Population and Housing- Preliminary Counts.</i>
<i>Operator</i>	:	Office of Statistics, Budget and Economic Management, Overseas Development Assistance, and Compact Management. Federated States of Micronesia.
<i>Web address</i>	:	<a href="http://www.sboc.fm/index.php">http://www.sboc.fm/index.php</a>
<i>Title 4</i>	:	Secretariat of the Pacific Community (SPC)
<i>Web address</i>	:	<a href="http://www.spc.int">http://www.spc.int</a>

#### 5. ADDRESSES

##### DEPARTMENT OF HEALTH AND SOCIAL AFFAIRS

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## 6. ORGANIZATIONAL CHART: Ministry of Health

