WHO Multi-Country Cooperation Strategy for the Pacific

2013–2017

American Samoa
Cook Islands
Fiji
French Polynesia
Guam
Kiribati
Marshall Islands
Federated States of Micronesia
Nauru
New Caledonia
Niue
Palau
Commonwealth of the Northern Mariana Islands
Pitcairn Islands
Samoa
Solomon Islands
Tokelau
Tonga
Tuvalu
Vanuatu
Wallis and Futuna

World Health Organization
Western Pacific Region

WHO Multi-Country Cooperation Strategy for the Pacific

2013–2017

American Samoa
Cook Islands
Fiji
French Polynesia
Guam
Kiribati
Marshall Islands
Federated States of Micronesia
Nauru
New Caledonia
Niue
Palau
Commonwealth of the Northern Mariana Islands
Pitcairn Islands
Samoa
Solomon Islands
Tokelau
Tonga
Tuvalu
Vanuatu
Wallis and Futuna

World Health Organization
Western Pacific Region

© World Health Organization 2012

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: permissions@who.int). For WHO Western Pacific Regional Publications, request for permission to reproduce should be addressed to the Publications Office, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000, Manila, Philippines, (fax: +632 521 1036, e-mail: publications@wpro.who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Table of Contents

Foreword **2**

Executive summary **3**

Acronyms and Abbreviations **5**

Section 1 – Introduction **7**

Section 2 – Health and development challenges **9**

Background and context 10

- Geography and population 10
- Macroeconomic, social and political context 10
- Other major determinants of health 12

Health status of the population 13

- The burden of chronic and noncommunicable diseases 13
- The burden of communicable diseases 14
- Maternal, Child and Adolescent Health 16

National responses to overcoming health challenges 17

- National health policies, strategies and plans (NHPSP) 17
- Health information system 17
- Health financing 18
- Human resources 18

Section 3 – Development cooperation and partnerships **19**

The new aid environment 20

Health sector support 20

Sector coordination and aid effectiveness at country level 21

United Nations reform and CCA/UNDAF process 21

Section 4 – Review of existing WHO cooperation **22**

Review of WHO's cooperation by stakeholders 23

Section 5 – The strategic agenda for WHO cooperation **24**

Mission 25

Priorities and impact 25

Main outcomes 27

Strategic approaches 27

Section 6 – Implementing the Strategic Agenda **33**

WHO's presence and role 34

Partnership approaches 35

Using the Multi-Country Cooperation Strategy 36

Section 7 – Country-Specific Strategies **37**

Foreword

Pacific island countries and territories are confronted with a triple burden—communicable disease, noncommunicable disease and the health impact of climate change—that causes high rates of morbidity and mortality.

The number of deaths due to noncommunicable diseases is among the highest in the world, and various communicable diseases still burden the Pacific. At the same time, vulnerability to the effects of climate change has increased the threat of both communicable and noncommunicable diseases. The limited availability of skilled health personnel, infrastructure and financial resources, as well as health services that are not always responsive to the needs of society, is another major challenge for the Pacific.

The *WHO Multi-Country Cooperation Strategy for the Pacific 2013–2017* (MCCS) has been developed by the governments of the countries and territories in the Pacific and the World Health Organization (WHO) through a consultative process with the United Nations system and key development partners. The strategy identifies health and development challenges and priorities in the Pacific and establishes an overall strategic direction and approach for overcoming the challenges and achieving national goals.

The MCCS has been developed in line with national health policies and strategic plans. The strategy identifies the following five priority areas:

1. reducing maternal and child morbidity and mortality;
2. reducing morbidity and mortality from sexually transmitted infections, HIV, tuberculosis, malaria and neglected tropical diseases;
3. reducing morbidity, premature death and disabilities from noncommunicable diseases;
4. reducing mortality due to epidemics, disasters and the health impact of environmental threats and climate change; and
5. universal access to essential health services and products and sustainable health care.

The MCCS offers a vision of Healthy Islands and provides a guide for WHO cooperation with Pacific island countries and territories in addressing major health issues. Working together we hope to achieve our shared goal of better health for all people in the Pacific.

Executive Summary

The *WHO Multi-Country Cooperation Strategy for the Pacific (2013–2017)* is a key instrument to guide WHO's work in countries and territories. It represents a medium-term vision for WHO's technical cooperation with 21 countries and territories in the Pacific.[1] It is the first time that all the Pacific island countries and territories (PICTs) have a common country cooperation strategy (CCS). The CCS cycle or time frame has been adjusted to coincide with the Multi-Country *United Nations Development Assistance Framework (UNDAF)* for the Pacific Subregion 2013–2017. This *Multi-Country Cooperation Strategy* (MCCS) is the result of extensive consultations with Member States, the United Nations system and key development partners.

In recent years, PICTs have seen improvements in health indicators, with decreases in maternal and child mortality and progress in eliminating vaccine-preventable diseases. However, not all countries and territories will be able to achieve the health-related Millennium Development Goals (MDGs). Geographical challenges, resource limitations and capacity limitations are common challenges for PICTs. Each country, however, has unique needs. Prevalence of noncommunicable diseases (NCDs) is significantly higher than in other countries at the same stage of development and is associated with the four main modifiable risk factors (tobacco use, unhealthy diets, physical inactivity and the harmful use of alcohol). Communicable and emerging diseases still burden PICTs. Other challenges include gender inequality, availability of a skilled labour force, weak health systems, rapid urbanization and vulnerability to climate change.

WHO's facilitating and convening role in helping countries to achieve national health goals and outcomes is seen as essential by governments and partners. Countries increasingly are trying to see how development cooperation most effectively can support national health sector policies, strategies and plans for strengthening health systems and improving service delivery, as well as encouraging development partners to look more closely at country approaches for funding and channelling resources through national systems. WHO's comparative advantage—a strong in-country presence and an ability to provide tailored, evidence-based technical assistance—will contribute to strengthening health systems and programmes to address the triple burden of disease facing PICTs, which includes communicable diseases, NCDs and diseases resulting from the effects of climate change.

WHO aligns its support and operation modalities within the United Nations system as part of the United Nations reform. The MCCS has been developed to accommodate better alignment with a programme oriented towards a results-chain planning process and the multi-country UNDAF (2013–2017) results matrix. Five priorities have been identified as the strategic agenda for WHO's technical cooperation in the Pacific from 2013 to 2017 (Section 5) and will act as a guide for where the major work and resources of the Organization will focus. More specifically, in the Pacific, WHO aims to help make significant progress towards:

- reducing maternal and child morbidity and mortality;
- reducing morbidity and mortality from sexually transmitted infections, HIV, tuberculosis, malaria and neglected tropical diseases;
- reducing morbidity, premature deaths and disabilities from NCDs;
- reducing mortality due to epidemics, disasters and the health impact of environmental threats and climate change; and
- universal access to essential health services and products and sustainable health care.

1 American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, New Caledonia, Niue, the Commonwealth of the Northern Mariana Islands, Palau, the Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

The outcomes of the MCCS are cross-cutting and include the reduction of risk factors and vulnerabilities for communicable diseases, NCDs and environmental hazards; increasing access and coverage of high-quality health services for all; and cost-effective health services at primary, secondary and tertiary levels, together with cost-effective procurement and supply management systems.

The country-specific strategies of the 21 PICTs (Section 7) provide a snapshot of the health situation in each country and territory and a summary of national health policies, strategies and plans (NHPSP). They also include information on how WHO and each PICT will collaborate to meet the goals and objectives of its NHPSP.

By supporting PICTs in addressing these public health challenges, WHO is contributing towards improving healthy life expectancy throughout the Pacific.

Acronyms & Abbreviations

ADB	Asian Development Bank
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
AusAID	Australian Agency for International Development
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CHIPS	Country Health Information Profiles
CLO	Country Liaison Office
CROP	Council of Regional Organisations of the Pacific
CRP	Crisis Response Package
DALYs	Disability-adjusted life years
DPS	Division of Pacific Technical Support
GDP	Gross domestic product
HDI	Human Development Index
HepB	Hepatitis B
Hib	Haemophilus influenza, type B
HIS	Health information system
HIV	Human immunodeficiency virus
IDA	International Development Association
IMCI	Integrated Management of Childhood Illnesses
JICA	Japan International Cooperation Agency
MCCS	Multi-Country Cooperation Strategy
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
MTEF	Medium-Term Expenditure Framework
NCD	Noncommunicable disease
NGO	Nongovernmental organization
NHA	National health accounts
NHPSP	National Health Policies, Strategies and Plans

NHS	National health services
NTD	Neglected tropical disease
NZAID	New Zealand Aid Programme
ODA	Official Development Assistance
OOP	Out of pocket
PHRHA	Pacific Human Resources for Health Alliance
PEN	Package of Essential NCD Interventions for primary health care
PICTs	Pacific Island Countries and Territories
PIFS	Pacific Islands Forum Secretariat
PHC	Primary health care
PHIN	Pacific Health Information Network
POLHN	Pacific Open Learning Health Net
PPHSN	Pacific Public Health Surveillance Network
SPC	Secretariat of the Pacific Community
STEPS	Surveillance of Risk Factors for NCDs
STI	Sexually transmitted infection
SWAp	Sector-wide approach
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VII	Vaccine Independence Initiative
WHO	World Health Organization
WR	WHO Representative

Section 1

Introduction

The Country Cooperation Strategy (CCS) is WHO's key instrument to guide its work in countries. It represents a medium-term vision for its technical cooperation with Member States in support of their national health policies, strategies and plans, while contributing to the WHO organization-wide plans. The CCS is also the main instrument for harmonizing WHO cooperation in countries with other United Nations agencies.

The "Healthy Islands" concept was introduced at the first Meeting of Ministers of Health for the Pacific Island Countries in 1995. The Healthy Islands vision has been an overarching framework for achieving better health in the Pacific. The strategic agenda for WHO cooperation in the Pacific 2013–2017 will take inspiration from the vision of Healthy Islands.

Healthy Islands are a place where

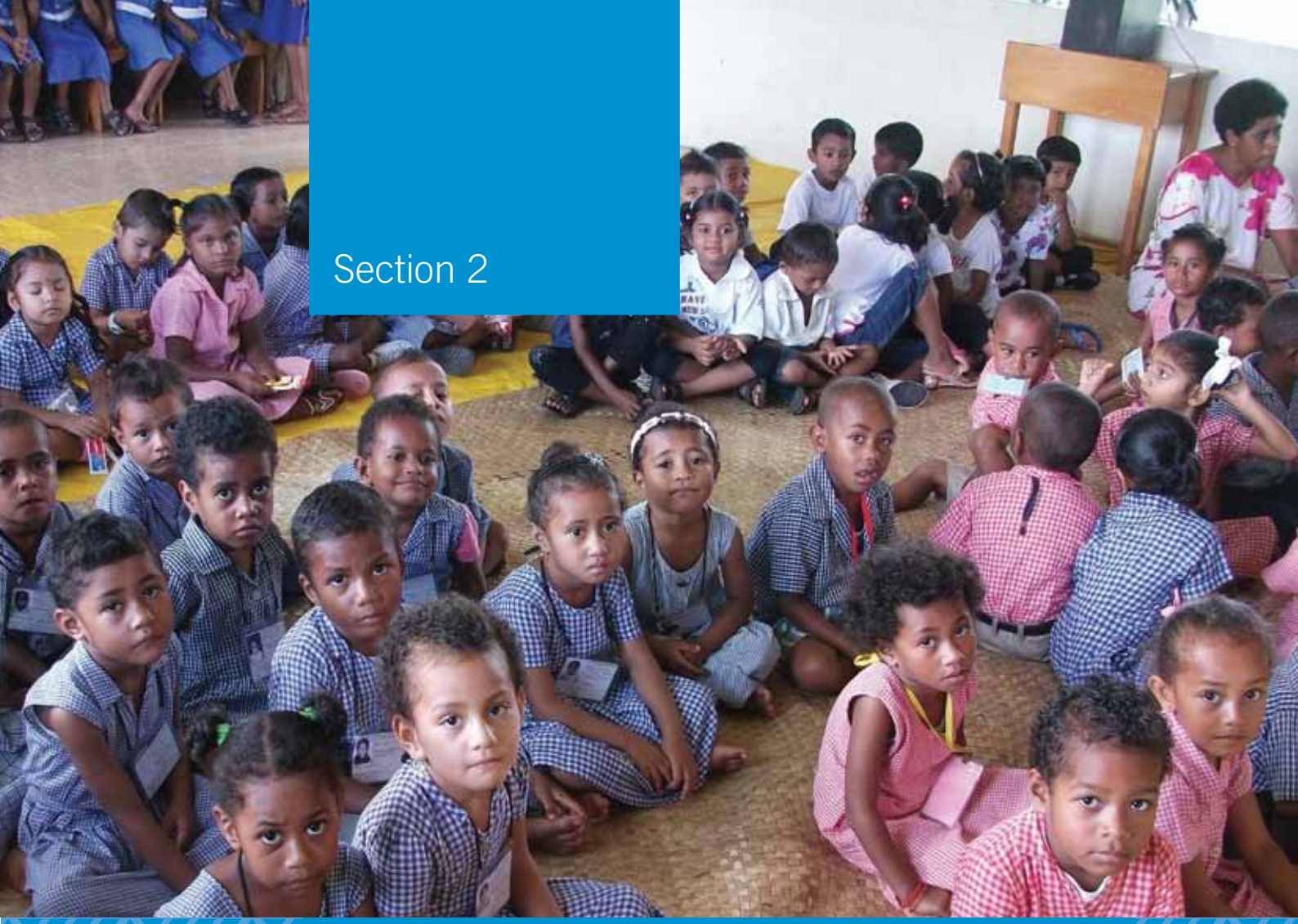
- children are nurtured in body and mind,
- environments invite learning and leisure,
- people work and age with dignity,
- ecological balance is a source of pride, and
- the oceans that sustain us are protected.

The reform initiatives of the WHO Regional Director for the Western Pacific have emphasized a greater focus on the needs of the Pacific and a commitment to improve the performance of WHO at the country level. As part of those reforms, an amplified country-needs approach will be used to better define the priority areas where WHO assistance will make the greatest contribution to achieving the health-related Millennium Development Goals (MDGs) as well as other health goals in the countries, such as tackling noncommunicable diseases (NCDs). The reforms serve as a backdrop for the development of the CCS; reinforcing the organization's commitment to support Pacific island countries and territories (PICTs).

The *WHO Multi-Country Cooperation Strategy for the Pacific* (2013–2017) covers 21 countries and territories.[2] The CCS cycle or time frame has been adjusted to coincide with the Multi-Country United Nations Development Assistance Framework (UNDAF) for the Pacific 2013–2017. This is in line with the *WHO Country Cooperation Strategies Guide 2010* that emphasizes a better fit between the CCS, the Common Country Assessment (CCA) and the UNDAF process.

This *WHO Multi-Country Cooperation Strategy* (MCCS) was prepared after reviewing the implementation of the current CCS cycle and conducting a documentary analysis, with particular reference to the draft of the multi-country UNDAF for the Pacific, the 2011 Pacific Regional MDGs Tracking Report, and the outcome and resolutions of the biennial Meetings of Ministers of Health for the Pacific Island Countries. Consultations were held with Member States, other United Nations agencies and key development partners focusing on the key health challenges in the Pacific, the strengths and weaknesses of current WHO collaboration, the comparative advantages of WHO, and modalities for potential enhanced cooperation and synergy with the work of other development partners.

2 American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, New Caledonia, Niue, the Commonwealth of the Northern Mariana Islands, Palau, the Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.



Section 2

Health and development challenges

Against a backdrop of many small island countries and territories, with relatively small populations geographically dispersed across large distances, the increasingly heavy triple burden of communicable diseases, noncommunicable diseases (NCDs) and the health impact of climate change is having a growing negative effect on the health and economies of Pacific island countries and territories (PICTs).

The incidence of NCDs in the Pacific is among the highest in the world and is a significant cause of mortality in the Pacific. Adult and child obesity, physical inactivity, poor diets, tobacco use and the harmful use of alcohol are common risk factors for most NCDs. The prevalence of NCD risk factors in adults (25–64 age group) continues to increase and is reaching critical levels in many countries. At the same time, communicable diseases remain a health threat to the population. Influenza and respiratory infections, infectious diarrhoeal diseases, dengue, typhoid fever, lymphatic filariasis and chlamydia remain major causes of serious morbidity in many countries and territories.

Background and context

Geography and population

PICTs comprise 20 000 to 30 000 islands in the Pacific Ocean. They are small countries and territories (also referred to as areas) with populations ranging from 10 000 to 850 000, with the majority having a population less than 200 000. A summary of geographic and demographic information of the 21 countries and territories included in this *Multi-Country Cooperation Strategy* (MCCS) is provided in Table 1.

PICTs are geographically and culturally grouped into Melanesia, Micronesia and Polynesia.

- Melanesia: Fiji, New Caledonia, Solomon Islands and Vanuatu.
- Micronesia: the Federated States of Micronesia, Guam, Kiribati, the Marshall Islands, Nauru, the Commonwealth of the Northern Mariana Islands and Palau.
- Polynesia: American Samoa, Cook Islands, French Polynesia, Niue, the Pitcairn Islands, Samoa, Tokelau, Tonga, Tuvalu, and Wallis and Futuna.

The islands can be classified as “high islands” and “low islands”. High islands are formed by volcanoes, often can support more people and have a more fertile soil. Low islands are reefs or atolls and are relatively small and infertile. Melanesia is the most populous group and contains mainly high islands, while most of Micronesia and Polynesia are low islands.

Macroeconomic, social and political context

The 21 countries and territories covered under the MCCS vary considerably in terms of size, culture and economic resource base, with a number of PICTs continuing to rely on overseas assistance from traditional partners such as Australia, France, New Zealand and the United States of America. A report entitled *Framework for Growth in the Pacific*, commissioned by the Government of Australia, highlights the unique problems faced by small states by showing that there is a significant “price” of smallness. This price manifests itself in the form of higher costs for transporting exports and imports, higher utility costs, and higher wages, which are largely related to market size, location and unfavourable business policies. Greater exposure to global trade is also accompanied by greater volatility in small, undiversified economies, such as those in PICTs.

Economic growth projections for most PICTs in 2011 and 2012 are expected to be weak. Governments are focused on public financial reforms, structural reforms and promoting private sector-led development to stimulate the economy and economic growth. The overall economic and development outlook for many of the PICTs remains, at best, variable and for some countries is bleak with challenges in maintaining viable and diversified economies and creating employment opportunities for young people. This will have a major impact on the ability of countries to work towards achieving the Millennium Development Goals (MDGs) and take up other health challenges such NCDs.

Small populations located on small islands often scattered over a large geographical area mean that the provision of social services and infrastructure is very costly. The high cost and the poor coverage of transport and communication infrastructure constrains the provision of low-cost and effective health,

Table 1. Country demographic information and health expenditures

Country or Territory	Population			Per Capita (GDP)		Health Expenditure			General Government Expenditure on Health as % of Total General Government Expenditure
	Year	Population (in '000s)	Urban Population (%)	Year	US$	Year	Per capita US$	As % of GDP	
Melanesia									
Fiji	2010 est	854.0	51.9	2009	2978.95	2009 p	130.40	3.60	9.30
New Caledonia	2009 p	245.6	57.4	2008	36758.00	2008	3420.76	9.5	…
Solomon Islands	2009	515.9	18.6	2008	1014.00	2009 p	71.84	5.30	16.80
Vanuatu	2009	234.0	25.6	2009 p	2685.10	2009	104.00	3.90	13.60
Micronesia									
Federated States of Micronesia	2010 p	102.6	22.7	2008	2223.00	2009 p	333.33	13.80	20.60
Guam	2010 est	180.7	93.2	2005	22661.00	…	…	…	8.71
Kiribati	2010	103.5	48.3	2010 p	1307.40	2009 p	204.8	12.20	8.70
Marshall Islands	2012	54.4	71.8	2007	2851.00	2009 p	419.35	16.50	20.10
Nauru	2010 est	10.0	100.0	2006-07	2071.00	2009 p	625.00	10.85	18.50
Northern Mariana Islands	2010 est	63.1	91.3	2005	12638.00	2007	…	…	25.40
Palau	2010 est	20.5	83.4	2007	8423.00	2009 p	1000.00	11.20	16.70
Polynesia									
American Samoa	2010 est	65.9	93.0	2005 est	9041.00	2003	500.00	…	14.00
Cook Islands	2010 est	23.3	75.3	2009 p	10298.00	2009 p	503.60	4.50	10.60
French Polynesia	2010 est	268.8	51.4	2006	16803.36	2008	3361.57	13.09	29.00
Niue	2010 est	1.5	37.5	2006	8208.20	2009 p	1866.55	16.94	15.81
Pitcairn Islands	2009	.05	n	…	…	…	…	…	…
Samoa	2010 est	184.0	20.2	2009-10	2908.02	2009 p	161.04	5.30	14.50
Tokelau	2006	1.5	0.0	2003	612.50	2001-09	3705.64	…	10.46
Tonga	2010 est	103.4	23.4	2008-09	2988.00	2009 p	161.04	5.30	14.50
Tuvalu	2010 est	11.2	50.4	2002	1139.32	2009 p	312.50	10.50	11.00
Wallis and Futuna	2010 est	13.3	0.0	2004	3800.00	2008	…	…	24.00

KEY: est=estimated; p=provisional; GDP=Gross Domestic Product
SOURCE: WHO Country Health Information Profiles (CHIPS), 2011

education and business support services and also severely constrains access to both domestic and international markets. Therefore, a major challenge for most PICTs is to develop and maintain adequate human resources for good governance and to have the technical and professional health workforce needed in the public and the private sectors.

PICTs are at different stages of human development, as ranked by the 2011 Human Development Index (HDI). Although the Marshall Islands, Nauru and Tuvalu are not included in the HDI report for 2011, Palau and Tonga (ranked 49 and 90, respectively) are part of the group of "high human development" countries. Most PICTs are in the "medium human development" category, including Samoa (99), Fiji (100), the Federated States of Micronesia (116), Kiribati (122) and Vanuatu (125). Solomon Islands, with a rank of 142, belongs in the "low human development" category.

Other major determinants of health

Gender inequality

Gender inequality is one of the obstacles for long-term development in the Pacific. All Melanesian countries, except Fiji, are not on track to achieve MDG 3 (Promote Gender Equality and Empower Women), while mixed progress was noted for the Micronesian and Polynesian countries. Gender equality in school enrolments is generally positive. However, progress on empowering women for economic participation and women's participation in political leadership is slow, with Melanesian countries behind the Micronesian and Polynesian countries. This has been attributed to patriarchal cultures in Melanesian countries, which discriminate against women, compared with the other regions.

Violence against women is common across the Pacific. The 40th Pacific Islands Forum in 2009, highlighted sexual and gender-based violence as a national and regional development issue demanding attention at the highest levels and affirmed the need to eliminate it. This political commitment to combat gender-based violence is of utmost importance. But practices in law enforcement and justice systems are not conducive to tackle violence against women, although progress is being made in some countries. Information on the handling of violence against women by the health services is limited.

Poverty

Although having access to quality verifiable data remains a challenge and because consumption from subsistence fishing and farming is difficult to assess, it has been estimated that a majority of PICTs are not on track in reducing the portion of population under the basic-needs national poverty line. The region as a whole is unlikely to achieve MDG 1 (Eradicate Extreme Poverty and Hunger) by 2015, as approximately 25% of households in the Pacific region still live under the basic-needs poverty line.

Rapid urbanization, along with the growth of informal settlements is leading to urban poverty. Settlements often have inadequate water and sanitary facilities exacerbating poor living conditions and poverty, thus increasing the health risks.

Food poverty, defined as the inability to obtain healthy affordable food, is an increasing concern in the Pacific. It is highest in Melanesia, in particular Fiji and Solomon Islands. Because of the natural conditions, PICTs have concentrated production of a limited number of food commodities. Dependency on food imports has increased in recent years due to a decline in traditional crop production and a rapid rate of urban migration. There is a link between food poverty and obesity, a major public health issue in the Pacific.

Climate change

The Pacific region is among the most vulnerable in the world to the impacts of climate change, including the detrimental effects on health. The health impacts of climate change include but are not limited to: increased burden of waterborne, foodborne and vectorborne diseases; traumatic injuries and deaths from extreme weather events; increased burden of respiratory illnesses (due to infective causes and obstructive airways diseases); increased mental health problems (from loss of land, livelihoods and population displacement, as well as the mental health impact of natural disasters); compromised food security (leading to malnutrition); and heat-related illnesses. It is important to note that these problems will be borne disproportionately by certain vulnerable sectors of the population—the very poor, young children, the elderly, people with disabilities, people with pre-existing illnesses (e.g., NCDs) and certain occupations (e.g., farmers, fishermen and outdoor workers).

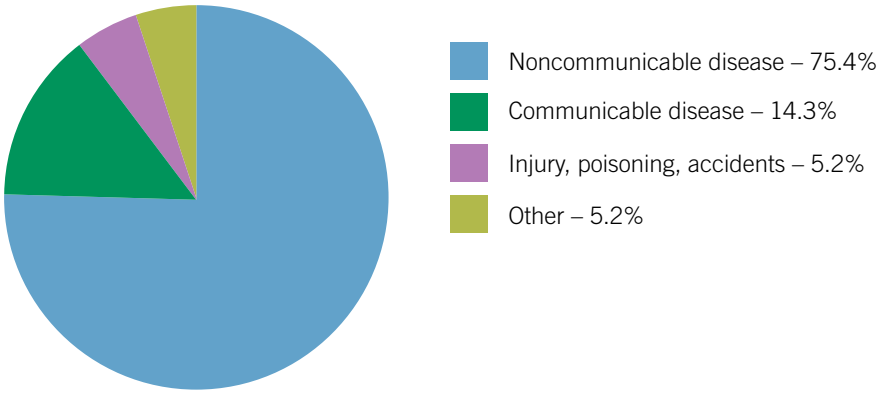
Trade

Greater exposure to global trade is also accompanied by greater volatility in small, undiversified economies, such as those in PICTs. In particular, small island states are vulnerable to fluctuations of prices for oil, food and other international commodities, as they rely heavily on imports. The impact of the variations in the global economy with the downturns in 1996–1997 and 2008–2009 also had a significant impact. The region's growth prospects are also closely linked to the performance of the Australian and New Zealand economies.

Health status of the population

PICTs are at different stages of demographic and epidemiological transition, which pose a greater challenge in addressing the triple burden of NCDs, communicable disease and the health impact of climate change. NCDs are now the leading cause of mortality in the Pacific (See Figure 1). However, communicable diseases that have been eliminated in other parts of the world are still endemic in some PICTs. Additionally, communicable diseases such as sexually transmitted infections (STIs) are a growing threat to health and well-being in the Pacific. The health impacts of climate change are significant in PICTs. Vulnerability to the effects of climate change, such as the impact on water, sanitation and agriculture, inevitably results in the vulnerability to both communicable diseases and NCDs.

Figure 1. Leading Causes of Mortality in Pacific Island Countries and Territories (PICTs)

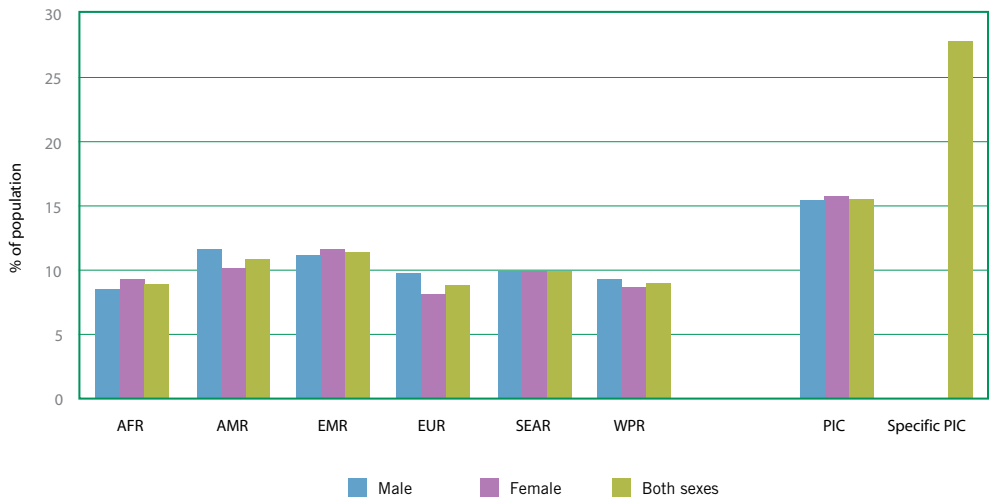


Source: WHO Country Health Information Profiles (2011)

The burden of chronic and noncommunicable diseases

NCDs and chronic diseases are the leading causes of mortality and morbidity in PICTs. The high proportion of premature death and disability caused by NCDs continues to lead to significant productivity loss for PICTs. For countries and territories in Micronesia and Polynesia, the prevalence of NCDs is significantly higher than other countries at the same stage of development. This has been associated with the frequent occurrence of obesity. Tackling NCDs has recently become a global priority, and the Pacific health ministers recognized the urgency of the problem in 2011 when they declared an NCDs crisis in the region.

Figure 2. Age-standardized prevalence of diabetes* by WHO Regions and for PICT, 2008.



**Defined as raised fasting glucose ≥ 126 mg/dl or on medication*

Key: AFR= Africa Region; AMR= Americas; EMR= Eastern Mediterranean; EUR= Europe; SEAR= South-East Asia; WPR= Western Pacific; PICTs= Pacific Island Countries and Territories

The enormous social and economic consequences of NCDs are being recognized and the need to tackle the growing crisis in the Pacific is becoming more urgent. However, the poor availability of accurate health and mortality data, which are essential for health and policy planning, and a shortage in human resources to manage the NCD crisis are major obstacles to overcome. WHO has provided country-level technical support in carrying out surveillance of the NCD burden through the WHO Stepwise Approach to Surveillance of Risk Factors for NCDs (STEPS).

STEPS has proven very useful in providing national and comparable data across the Pacific.

- The prevalence of overweight in the 25–64 age group is extremely high ranging from 60%–90% in some PICTs.
- The prevalence of diabetes in the 25–64 age group is reported to be as high as 40% in one of the PICTs.
- The prevalence of current smokers in the 25–64 age group is reported to be as high as 60% in one of the PICTs.

Although neuropsychiatric conditions have low mortality, they represent a significant portion of the disease burden, with mental illnesses such as unipolar depression, bipolar disorders, schizophrenia and alcohol use disorders as the major causes. Pacific health ministers highlighted that there had been limited progress in mental health care in the Pacific during the last decade, while trends for substance abuse, addictive behaviours, depression and suicide were increasing in many countries. A number of barriers prevented the successful implementation of mental health programmes, including stigmatization of mental illness, which is a common, well-known barrier. Additionally, accidents and injuries also contribute to the mortality and morbidity in PICTs, and a significant proportion of these fatalities and injuries are due to drinking and driving.

The burden of communicable diseases

Although progress has been made towards achieving vaccine-preventable elimination targets in many PICTs, communicable diseases still account for a high proportion of disability-adjusted life years (DALYs), specifically in Melanesian countries such as Solomon Islands. Infectious and emerging diseases continue to affect the people in the Pacific and represent a health security threat for the PICTs.

Vaccine-preventable diseases

Great progress has been made in fighting vaccine-preventable diseases. PICTs remain polio free and are currently entering an era of measles elimination. Populations in the Pacific are experiencing the public health benefits of vaccine protection. For example, only two tetanus cases have been reported in the last three years, and significant steps have been undertaken in hepatitis B prevention and control through widespread vaccine immunizations in the 1990s. However, there is concern that the measles immunization coverage, with Fiji, Solomon Islands and Tuvalu recording a decline in coverage, will fall short of achieving MDG 4 (Reduce Child Mortality).

PICTs have a strong record in regional cooperation in combating vaccine-preventable diseases. The development of a financing mechanism, known as the Vaccine Independence Initiative (VII), for which UNICEF has played a strong role, from the mid-1990s has facilitated the transition for all Pacific island governments to procure traditional vaccines. VII has also facilitated the introduction of underutilized vaccines, such as hepatitis B (HepB), and the combination DTP-HepB-Hib (pentavalent) vaccine.

Tuberculosis, leprosy and yaws

Although the burden of tuberculosis in PICTs is relatively small, in some countries and territories (e.g., Kiribati, the Marshall Islands, the Federated States of Micronesia and Solomon Islands), the case-notification rate is higher than the average notification rate of 75 per 100 000 population in the Western Pacific Region. From 2004 to 2009, a total of 45 multidrug-resistant TB (MDR-TB) cases were reported in the Pacific, the majority from the Marshall Islands and the Federated States of Micronesia. An association between diabetes mellitus and tuberculosis has been suggested and there has been renewed interest about this association in recent years due in part to the NCD crisis in the Pacific.

Most PICTs have eliminated leprosy as a public health problem. Kiribati, the Marshall Islands and the Federated States of Micronesia have not yet reached the elimination target.

Solomon Islands and Vanuatu continue to have yaws despite campaigns to combat the disease, particularly in the 1960s. Morbidity is significant particularly in children. A global goal of eradication by 2020 has been established.

Trachoma

Blinding trachoma is known to be endemic in five PICTs (Fiji, Kiribati, Nauru, Solomon Islands and Vanuatu). Mapping is being undertaken to inform the implementation of WHO's SAFE strategy for trachoma elimination (Surgery, Antibiotics, Face-washing and Environmental improvements). GET2020, a global elimination of trachoma campaign, is led by WHO and aims to reach global elimination of trachoma by 2020.

Malaria and other vectorborne diseases

A large proportion of the population in Solomon Islands and Vanuatu remains at risk for contracting malaria, especially pregnant women and children under 5 years of age. Malaria is a leading cause of morbidity and mortality in these PICTs. The two countries are aiming to eliminate malaria by 2020 and are making good progress with substantial funding from Australia and the Global Fund to Fight AIDS, Malaria and Tuberculosis, with support of WHO and other partners. Solomon Islands and Vanuatu are on track to halt and reverse the incidence of malaria (MDG 6).

Although there have been outbreaks of dengue fever in PICTs over several decades, the incidence of dengue fever in the Pacific appears to be rising due to increased urbanization, which results in more breeding sites for the main vector, *Aedes aegypti*. This may be exacerbated by increasingly mobile populations introducing the dengue virus to island communities from other islands or endemic countries. There were major outbreaks of dengue fever in the Marshall Islands and the Federated States of Micronesia in 2011 and 2012. Prevention and control of dengue are focused on integrated vector management, enhanced surveillance and improved case management.

Lymphatic filariasis is endemic in most of the PICTs. Following completion of mass drug administration campaigns over several years, it is expected that several countries and territories, including Cook Islands, the Marshall Islands, Niue, Tonga and Vanuatu will have verified elimination of lymphatic filariasis as

a public health problem by 2013–2015. Additionally, parasitic diseases, such as neglected tropical diseases (e.g., soil- transmitted helminthiasis, foodborne trematodes, etc.) are still prevalent in PICTs. Soil- transmitted helminthiases are a public health problem in at least nine PICTs, where mass deworming is required. The global goal calls for 75% deworming coverage in these PICTs.

HIV/AIDS & STI

The PICTs continue to demonstrate a very low prevalence of the HIV infection. *The Report of the Commission on AIDS in the Pacific* indicated that Fiji, French Polynesia, Guam and New Caledonia are the only countries and territories with a significant number of HIV infections. The predominant mode of reported transmission is unprotected sex. In Guam, French Polynesia and New Caledonia, a significant proportion of infections are attributed to unprotected male-to-male sex and injecting drug use. With regard to treatment for HIV/AIDS, PICTs achieved universal access to antiretroviral therapy (ART) for all those who needed it (MDG6).

Second-generation surveillance undertaken in PICTs in 2004–2005 and 2008 has shown that on average, one in four sexually active young people in the Pacific has a sexually transmitted infection (STI). The causes contributing to the high rate of STIs in many PICTs include cultural stigma related to contraceptive use, uneven access to diagnostic and curative services, and the fact that asymptomatic STIs continue to be untreated due to lack of awareness. In some PICTs up to 40% of sexually active young people have an STI. Chlamydia is the most common infection with a prevalence ranging from 10%–30% among asymptomatic antenatal women. Chlamydia infections contribute to significant morbidity, impacting on pregnancy outcome and fertility. Prevalence of syphilis and gonococcal infection, while much lower than the prevalence of chlamydia, were also at unacceptable levels in some PICTs. It is known that "among both males and females HIV transmission is facilitated by the presence of any STI"; therefore, it is imperative that prevention and treatment of such diseases be addressed in PICTs.

Emerging and re-emerging infectious diseases

Disease outbreaks continue to occur on a regular basis, including outbreaks of dengue in several countries and Chikungunya in New Caledonia in 2011. Typhoid is endemic in several of PICTs. The Pacific Public Health Surveillance Network (PPHSN), a voluntary network of countries and organizations dedicated to the promotion of public health surveillance and an appropriate response to the health challenges, jointly supported by Secretariat of the Pacific Community (SPC) and WHO, continues to monitor and provide support for investigation and response to new outbreaks. The *Asia Pacific Strategy for Emerging Diseases* has expanded its scope of activities with public health and communicable disease control during disasters and with building national public health emergency preparedness as the key priorities.

Maternal, Child and Adolescent Health

Good progress has been made in improving child and maternal health over the last two decades. A majority of PICTs are on track to reduce child mortality in line with MDG 4 by 2015. The average under-5 mortality rate is 28 per 1000 live births, including all Pacific Island Forum countries. The average infant mortality rate is also low at 20 per 1000 live births. The countries of Micronesia have a comparatively higher average under-5 mortality and infant mortality rate.

Improvement in child health has been attributed to improved coverage of cost-effective child survival measures, including immunization, exclusive breastfeeding, child nutrition, the integrated management of childhood illnesses (IMCI), clean water and sanitation, and a general improvement in socioeconomic development.

Although PICTs overall have low maternal mortality, there is mixed progress towards reducing the maternal mortality ratio and achieving universal access to reproductive health in line with MDG 5 (Improve Maternal Health). Pregnant women living in outer islands and rural communities with limited transportation and poorer access to services are at higher risk of maternal complications. The access and availability to emergency obstetrics care remain uneven. Where the numbers of midwives have increased, antenatal care and the proportion of deliveries by skilled birth attendants have improved, there is better access to emergency obstetric care, and maternal deaths are a rare event.

In the Pacific, contraceptive use has remained below the average for less developed countries, and many countries have a high level of "unmet need" for family planning. An analysis from a recent survey conducted in seven PICTs by the Division of Health Sector Development in the WHO Regional Office for the Western Pacific suggests that women may be unable to use family planning due to lack of access to a contraceptive method or be unwilling because of fear, health concerns or religious opposition. Additionally, the rate of teenage pregnancy in many PICTs is high.

National responses to overcoming health challenges

In PICTs, most health care is provided by the government free of charge or at a low cost. While private service providers are increasing, they still play a limited role in health service delivery. The out-of-pocket expenses for health are in most cases reasonable compared to other countries in the region. However, a significant proportion of the health care budget is dedicated to curative services and tertiary care services are usually outsourced to neighbouring countries.

Delivering services to a highly dispersed population, many living in isolated communities, is demanding and costly. Although in principle there is equitable access to health care for whole populations, the travel and transportation costs make people living in remote areas more vulnerable.

Demographic changes are occurring as people move from rural areas, resulting in an increased urban population with its own special health challenges to sustain a healthy environment and livelihood. The population is also ageing, and the elderly will put an extra burden of the health care system in the future.

National health policies, strategies and plans

Most countries in the Pacific have a long tradition of developing national health policies, strategies and plans (NHPSP). Because of limited national capacity in small countries, there is a tendency for dependence on external sources of expertise in developing and drafting the NHPSP, which can reduce ownership. Most Pacific countries need to build and strengthen individual and institutional capacity to lead and manage the NHPSP process.

Because the unique situation of Pacific countries with their limited systems and human resource capacities, it is essential to have modest, realistic and costed plans that are implementable, backed up by strong political commitment and linkages to overall national planning processes and documents.

The *World Health Report 2010* on health system financing suggested that a more rapid movement towards universal coverage would occur if the inefficient and inequitable use of resources were addressed effectively. At a conservative estimate, 20%–40% of health resources are being wasted. Proper NHPSPs will capture the key health priorities, consider how the government will go about addressing the priorities within its country's capacity and resources and ensure that funds are spent where they are most needed. The economic challenges for several of PICTs give more impetus to proper health sector planning to ensure that health budgets are used for achieving universal coverage of agreed essential health interventions.

Health information system

Quality, timely and complete health information generated from a country's own health information system (HIS) is the ultimate goal of all country health information systems. In the Pacific, most countries face challenges in improving their systems, but are constrained by many issues, in particular fragmentation of information that relates to function, disease or condition, and donor and global health initiatives.

In most countries, those responsible for operating the national HIS do not have the necessary resources to perform effectively and influence the allocation of health system resources. Health information systems across the region are complex, while the majority of countries still do not have reliable information regarding trends in mortality and morbidity. Although investments in HIS across the region are scarce, they are increasing. But much more advocacy at the political and leadership level is needed to make the linkages between improved HIS and policy on one hand and achieving health outcomes on the other. Stronger advocacy for reliable health information requires mobilizing effective political and health leadership, improving institutional capacity and organizing a coordinated multisectoral approach. While health information units in ministries of health need additional resources and authority, they also need

to engage with departments such as statistics, education, planning and finance, and information and communications technology experts to accelerate the use of reliable health information.

The *Pacific Health Regional Information Strategic Plan* provides excellent guidance on prioritizing improvements within country systems. HIS strengthening is not simply a technical activity, what is needed is a transformation in the culture of health information use in the region.

Health financing

An overview of health expenditures by country and territory is provided in Table 1. The two largest countries among PICTs, Fiji and Solomon Islands, spend, respectively, 3.6% and 5.3% of gross domestic product on health; percentages that have not changed dramatically over the past decade. This is in the middle to lower range of health expenditures compared to other countries in the Asia Pacific region. Government expenditures on health as a percentage of total health expenditures are at the high end compared to other countries in the region. Although the private sector and non-state providers are important for health service delivery, the public health services are the mainstay for provision of health care for the majority of the Pacific population.

Out-of-pocket (OOP) payments are at the lower end in many Pacific countries, such as Kiribati, the Federal States of Micronesia and Solomon Islands, according to a recent World Bank study. A further increase in OOP payments may be expected in the years to come as a way to finance health services with a constrained public budget. Policy-makers are concerned that with increasing health costs, current health financing will be insufficient to meet future health needs, in particular with the limited fiscal space for health and the high cost of delivering services.

Human resources

PICTs continue to face health workforce challenges relating to quantity, quality, skill-mix, distribution and retention. The most recent Meeting of Ministers of Health for the Pacific Island Countries in July 2011 reiterated that health workforce deficiencies pose threats to the successful implementation of all health programmes and to the achievement of the Healthy Islands vision and the health-related MDGs, as well as a successful battle against NCDs.

Small countries face great challenges in building an adequate workforce to deliver quality primary health services and necessary hospital and specialized services. Various strategies have been used to address health workforce shortages, such as task shifting using health staff such as mid-level practitioners and primary health-care workers for improved primary health care services. However, financial constraints also limit the options countries have.

Health workers migrating to other countries for work remains an issue. Neighbouring countries, such as Australia, rely on significant numbers of overseas trained health workers. While numbers from the Pacific are small, the impact on small Pacific countries can be disproportionately high.

Limited continuing education, training and development of health professionals are also important challenges. Various human resource programmes and initiatives in the Pacific are in place, including the Pacific Human Resources for Health Alliance (PHRHA); the Fiji National University College of Medicine, Nursing and Health Sciences[3] , the Pacific Open Learning Health Net (POLHN); and Strengthening the Specialized Clinical Services Programme.

3 Fiji National University was formerly known as the Fiji School of Medicine

Section 3

Development cooperation and partnerships

Political leaders in PICTs have expressed concern that despite continued high levels of development assistance over many years, the Pacific region is not on track to achieve the MDGs by 2015. This concern resulted in the Cairns Compact on Strengthening Development Coordination in the Pacific to ensure better aid effectiveness. Furthermore, new donor mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, have contributed to the health sector in recent years but also have provided new challenges for governments in effectively managing external partners and resources.

The new aid environment

A 2011 Tracking Report on progress in reaching the MDGs reflects the generally positive manner in which aid is managed by development partners and countries. However, given the systemic difficulties faced by many, especially smaller, PICTs, there is a need for stronger and more collaborative approaches to diagnosing the difficulties and address them through capacity-building.

There have been shifts in aid delivery modalities from project funding to a greater use of country systems or general budget support. The trend towards programme-based approaches is growing, while maintaining the focus on achieving progress on the MDGs. Experiences from Vanuatu suggest that the country is promoting the programme-based approach because it hopes to reduce the transaction costs of dealing with multiple development partners; most development partners share the same aim. However, the immediate effect of the processes involved in negotiating a programme-based approach is to increase workloads since the normal burden of project administration, basic management and adapting to political change remains.

The Pacific Aid Effectiveness Principles suggest a more country-focused approach, and WHO needs to adjust to the requirements countries are putting forward. Countries and donors are increasingly looking at systems for procurement of technical assistance that might also challenge how WHO has been selecting and managing short-term technical support. It is important that WHO and its staff ascribe to aid effectiveness principles, not only for programme planning and reporting purposes but also to be able to effectively support sector coordination at the country level.

WHO usually works with ministries of health, which are often marginal to the aid effectiveness agenda within the government structure. Usually ministries of planning, foreign affairs or finance or other central agencies are responsible for national and international discussions on sector support and aid coordination. This also means that WHO needs to follow current trends and country experiences on aid effectiveness and modalities for sector coordination. Working effectively within the United Nations system at the country and regional levels on development cooperation is therefore of utmost importance.

Health sector support

PICTs receive bilateral assistance for the health sector mainly from Australia, Japan and New Zealand. These countries also contribute substantially at the global and regional levels to organizations such as the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), WHO, the Secretariat of the Pacific Community (SPC), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Asian Development Bank (ADB) and World Bank, which are involved in the health sector in PICTs. Financial support from the United Nations system (WHO, UNICEF, UNFPA) to the health sector is limited, but these agencies remain key external in-country partners in health, together with SPC. The Global Fund has provided funds, mostly through multi-country grants managed by SPC. The GAVI Alliance is continuing to provide support for the introduction of new vaccines. ADB and the World Bank both provide grants and long-term loans while also contributing to analytical work on the economic, financing and social sectors in the Pacific. In addition, there are several other regional bodies and global initiatives that provide funding and technical assistance in health for PICTs.

A large number of regional health mechanisms are in place and put demands on government, which often have limited capacity. A review conducted in 2010 identified 52 regional health mechanisms around networking, coordination, governance and grant oversight across technical issues, geographic areas and mandates. Poor coordination, lack of joint planning, poor integration of country and regional work, and duplication, particularly around HIV and NCDs, were reported as common features. The proliferation

of health meetings has added to workloads of ministries. Some meetings have mixed mandates, which aren't helpful, and affect the continuity of staff attendance; and some meetings duplicate areas of focus with other mechanisms. Consolidation of some meetings was encouraged and it was proposed that a more focused and direct in-country support mechanism might be preferable to regional approaches.

Sector coordination and aid effectiveness at country level

Official development assistance (ODA) for the health sector remains low as a percentage of total health expenditures among PICTs. For example, external assistance accounted for 6% of total health expenditures in Fiji in 2008. Countries are increasingly concerned as to how ODA and development cooperation can support most effectively NHPSPs using a medium-term expenditure framework (MTEF) for the strengthening of health systems and improving service delivery. Some countries (Samoa and Solomon Islands) have embarked on a Sector-Wide Approach (SWAp) for better alignment of external resources to national priorities using government channels, while Kiribati and Vanuatu have also established sector coordination mechanisms along the lines of a SWAp.

A review in 2011 of the SWAp in Solomon Islands concluded that since its launch in 2008 it remains at a very early stage of implementation, with most progress observed in improving processes and systems and less evidence of improved outcomes. However, SWAps are encouraging development partners to look more closely at country approaches for funding, channelling resources through national systems and reporting their contribution against the NHPSP and MTEF. Also, development partners can actively participate in national health reviews established as part of the SWAp.

WHO is involved in sector coordination in all countries where it has a presence, but information given by donor agencies and reviews suggest that WHO could play a much more significant role in sector coordination, both at the subregional level in the Pacific and at the country level. Staff, in particular WHO Representatives and Country Liaison Officers, need to have the knowledge and interest to support health sector coordination.

United Nations reform and CCA/UNDAF process

The new UNDAF (2013–2017) for the Pacific Subregion represents an important instrument to implement United Nations reform, and is particularly significant as it spans the critical phase leading up to the 2015 MDG deadline. UNDAF covers 14 PICTs, which is slightly different than the country structure of WHO in the Pacific. A multi-country common analysis was finalized in 2011 and was informed by the five United Nations programming principles: a human rights-based approach, gender equality, environmental sustainability, results-based management, and capacity development. A UNDAF results matrix for the 14 PICTs has also been prepared.

WHO has adjusted the MCCS cycle to the UNDAF for the Pacific Subregion (2013–2017). This is in line with the *WHO Country Cooperation Strategies Guide 2010* that emphasizes a better fit between the CCS, the common country assessment (CCA) and the UNDAF process. This also indicates WHO's commitment to the United Nations reform process in the Pacific. The CCA has also been used for the preparation of this MCCS.

Section 4

Review of existing WHO cooperation

The WHO Representative Office for the South Pacific was established on 1 January 1970. WHO Country Liaison Offices are present in Kiribati, the Federated States of Micronesia (also covering the Marshall Islands and Palau), Tonga and Vanuatu. The Country Liaison Officers report to the WHO Representative Office in Fiji. Five other PICTs are covered by the WHO Representative Office in Samoa: American Samoa, Cook Islands, Niue, Samoa and Tokelau. The WHO office in Solomon Islands has been recently upgraded to a WHO Representative Office to enhance WHO support to the Government. In October 2010, a newly formed Division of Pacific Technical Support (DPS) was established, bringing together the seven Pacific-based offices and all technical staff in the region under the one umbrella. The establishment of DPS is part of an increased focus on PICTs by WHO.

Review of WHO's cooperation with stakeholders

Stakeholders have acknowledged WHO's important role in setting standards and providing technical support in health, particularly in the control of communicable diseases and NCDs. WHO, together with SPC, has documented the NCD crisis in the Pacific and brought this to the attention of the political leaders leading to a multisectoral response. The 2-1-22 Programme was a collaboration between SPC and WHO funded by the Australian Agency for International Development and the New Zealand Aid Programme aimed at addressing the NCD crisis in PICTs. The Pacific Food Summit was also seen as an important regional multisectoral event. Thus WHO's focus and strength continue to be on technical and disease- specific approaches, while less attention and capacity are seen in reproductive, maternal child health and family planning.

WHO has a strong country presence in the Pacific compared with other partners. An important part of WHO's role in setting standards is also to translate these standards in a meaningful way at the country level. This includes showing how WHO norms and standards can make a difference to health outcomes.

WHO's participation in organizing the biennial Meeting of Ministers of Health for the Pacific Island Countries has been recognized and appreciated by partners. It had been suggested that the two cosponsors, WHO and SPC, have played a too dominating role in setting the agenda. This was rectified at the most recent meeting in Honiara in 2011, where the agenda and priorities for discussion were set by the ministers, with WHO and SPC in supporting roles.

Some areas where stakeholders felt improvements could be made include:

- More focus could be given to support NHPSPs and their implementation together with other partners. PICTs, in particular smaller countries, need quality, ongoing technical and operational support for their ministries of health. Although the increased attention by WHO to the Pacific is recognized by the partners, there may be a need to adjust the modalities for how WHO can best provide country support to PICTs.
- WHO can play a more significant role in supporting health sector coordination at the country and subregional level. Countries are increasingly looking at sector coordination mechanisms such as SWAps and ways to align all partners around support for NHPSPs and national systems. The expectations are that WHO will be the lead agency to work with government, the United Nations system and other development partners to improve health outcomes through improvements in health system performance and steady progress in policy implementation.
- WHO can reduce the number of regional meetings and workshops. Because of the limited number of government staff in small countries, staff absence due to participation in international and regional meetings and workshops remains an important issue.

Section 5

The strategic agenda for WHO cooperation

WHO's strategic agenda for Pacific cooperation as outlined in the *Multi-Country Cooperation Strategy for the Pacific* (MCCS) builds on the strength, resources and commitment of the entire WHO Secretariat to determine how the Organization can contribute to universal access to quality health services and improve the health of all people in the Pacific. The focus is on providing opportunities for developing national capacities and for the long-term impact of national goals and priorities, as well as on priorities set jointly with Pacific countries. WHO's mandate and comparative advantages are reflected while recognizing and complementing the approaches and work of key partners.

The strategic agenda for WHO cooperation represents an expression of the medium-term vision for the Organization's main technical cooperation and acts as a guide for focusing the major work and resources of the Organization. The key strategic approaches were selectively included based on national health plans that reflect country need in areas where WHO could most effectively provide technical assistance.

The outcomes and impacts are a shared responsibility among governments, development partners and WHO. The specifics of the strategic approach are summarized in Figure 3 and described below.

Mission

WHO works to attain the highest level of health and well-being for all people and to maximize their contribution to sustainable development. In the Pacific, the mission is to realize the vision of the Healthy Islands approach for "improving and protecting the health of Pacific island people" through collective and collaborative efforts. The Healthy Islands approach, agreed upon by the Pacific ministers of health in 1995 and now being revitalized, provides an overarching framework for addressing health issues relevant to the Pacific.

Priorities and impact

WHO's work aims to help make significant progress towards achieving reduction of morbidity and mortality related to communicable and vaccine-preventable diseases, addressing the growing problem of NCDs and ensuring that PICTs are prepared to deal with epidemics, disasters and shared health threats in the region. More specifically, in the Pacific, WHO aims to help make significant progress towards:

1. reducing maternal and child morbidity and mortality;
2. reducing morbidity and mortality from sexually transmitted infections (STIs), HIV, tuberculosis, malaria and neglected tropical diseases;
3. reducing morbidity, premature death and disabilities from NCDs;
4. reducing mortality due to epidemics, disasters and the health impacts from environmental threats and climate change; and
5. universal access to essential health services and products and sustainable health care.

By supporting the countries in addressing these public health challenges, WHO is contributing towards making an impact on improving healthy life expectancy throughout the countries and areas in the region.

Figure 3: Outline of Framework for WHO's Multi-country Cooperation Strategy in the Pacific (2013–2017)

MISSION	Realizing the vision of Healthy Islands for Improving and protecting the health of Pacific island people				
Priorities	Maternal and child health	Communicable diseases	Non-communicable diseases (NCDs)	Emerging diseases and climate change	Health system development
Impacts	1. Reduced maternal and child morbidity and mortality	2. Reduced morbidity and mortality from HIV, STIs TB, malaria and NTDs	3. Reduced morbidity, premature deaths and disabilities from non-communicable diseases	4. Reduced mortality due to epidemics, disasters and health impacts from environmental threats, climate change	5. Universal access to essential health services and products and sustainable health care
Main Outcomes	A) Reduced risk factors and vulnerabilities		B) Increased access/coverage of high-quality health services		C) Cost-effective health services and systems
	• Reduced prevalence of known NCD risk factors • Reduced behavioural risk factors related to communicable diseases • Reduced health risks and vulnerabilities from emerging-infectious diseases, disasters, food, environmental hazards and climate change		• Improved access and coverage of essential programme interventions in the Pacific: – NCD prevention and control, including mental health – Maternal, child health services, reproductive health services and family planning – Vaccination coverage esp. against childhood diseases – Early case detection and treatment of malaria, TB, HIV and STIs – Essential elimination interventions for leprosy, LF and yaws – Dengue prevention and control • Reduced barriers to effective mental health services. • Improved access to essential medicines and health technologies.		• Health investments in the Pacific maximized through cost-effective ways of delivering services at primary, secondary, tertiary health services. • Improved cost-effectiveness of procurement and supply management systems in the Pacific. • Effective and responsive workforce to ensure efficient health service delivery. • Robust data generation and use for policy formulation as well as monitoring and evaluation.
Strategic Approaches	• Pursue "whole-of-government" and "whole-of-society" approaches for national policy and legislative interventions to address risk factors for poor health outcomes. • Build national capacity to analyse risks and vulnerabilities such as communicable diseases and climate change, and develop and implement risk management plans.		• Strengthen primary health care approach using well documented evidence based and internationally accepted interventions for maternal, neonatal, and child health including family planning and the PEN initiative as entry points.[4] • Develop innovative models of increasing access to services and health commodities in outer islands.		• Use "best-buy" evidence to define and implement a set of most cost-effective NCD interventions fit for the country context. • Define clear and practical service delivery plans and strategies to maximize access and effectiveness of health service delivery system.
	• Align human resources strengthening with overall strategic direction of improving health services delivery in the Pacific island countries and territories. • Pursue country-level health sector coordination strengthening that promotes country ownership, health sector efficiency and sustainability. • Build robust health information systems that facilitate evidence-based programming and health systems planning, advocacy and decision-making for improved policy-making and monitoring. • Use regional and country partnerships to build momentum on sustainable health financing for programmes and the health sector at the country level.				

4 Package of Essential Noncommunicable Disease Interventions (PEN) for Primary Health Care

Main outcomes

Achieving outcomes at the country level is a shared aspiration of governments, local and international partners, the private sector and communities. WHO's crucial contribution to achieving outcomes and impacts at the country level lies in its effective and appropriate performance of its core functions. More concretely at the country level, achieving these goals over the long term entails making significant progress towards achieving the following cross-cutting outcomes. While many of these outcomes cross over and are mutually reinforcing, they are discussed separately for ease of presentation.

A) Reduced risk factors and vulnerabilities

The critical public health challenges in each country will dictate which risk factors are addressed. The Sixty-fifth World Health Assembly set the first international target to "reduce premature deaths from NCDs by 25% by 2025." Vulnerabilities from behavioural risk factors such as tobacco use, unhealthy diets and physical inactivity need to be addressed, as well as emerging-infectious diseases, disasters, food, environmental hazards and climate change.

B) Increased access/coverage of high-quality services

Universal coverage is the overarching aim. Where there are significant inequities and vulnerabilities, greater efforts should be made to ensure coverage and access. There must be a focus on access by women and children, to quality health services that provide high impact interventions and public health measures needed to achieve MDGs 4 and 5. It should include improved access and coverage for vaccine-preventable diseases, tuberculosis, HIV, malaria, and NCDs, as well as reducing barriers to accessing mental health services. Improving access also means fostering the development of innovative tools and approaches to overcome barriers to universal access.

C) Cost-effective health services and systems

Improving coverage and access to services is not sufficient to achieve sustainable health impacts in a region with diverse health status and health systems capacity. In addition to coverage and access, evidence-based, high-impact and cost-effective health interventions and health services must be ensured. This includes cost-effective ways of delivering health services at primary, secondary and tertiary levels, as well as cost-effective procurement and supply management systems in the Pacific. An effective and responsive workforce and robust health information system must be in place to ensure efficient health service delivery and evidence-based policy development. In addition, adequate protection, such as access to primary health care and community-based rehabilitation, must be provided to prevent potentially devastating social consequences of illness and disabilities.

Strategic approaches

Within each outcome, a series of strategic approaches is described. This is not an exhaustive list of strategic approaches, but rather a selection of the main approaches appropriate for the Pacific context. Furthermore, many of these approaches are broader than WHO's mandate and require the collective efforts of WHO, development partners and governments. These are discussed in terms of WHO's core functions to illustrate the link to WHO's specific contribution.

WHO's core functions

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- Setting norms and standards and promoting and monitoring their implementation;
- Articulating ethical and evidence-based policy options;
- Providing technical support, catalysing change, and building sustainable institutional capacity; and
- Monitoring the health situation and assessing health trends.

Source: http://www.who.int/about/role/en/

A) Reduced risk factors and vulnerabilities

Because of the current and projected health and economic impacts of the NCD crisis, reducing risk factors and vulnerabilities related to NCDs justifiably occupies a prominent place on the health agenda of PICTs. Although it is a main focus of the strategic approach, attention to tackling NCDs cannot replace concerns for other health priorities. Main strategic approaches for reducing risk factors in the Pacific context are described below.

- Pursue "whole-of-government" and "whole-of-society" approaches for national policy and legislative interventions to address risk factors for poor health outcomes.

  There is recognition that many of the health challenges the countries in the Pacific region are facing are the result of the convergence of many different socially determined factors, which require commitment and action beyond the health sector. While treatment falls squarely on the health sector, addressing risk factors ranging from access to safe-drinking water and sanitation, to gender issues, requires involvement well beyond the health sector. The resolution of some of these issues involves the education, finance and trade sectors at the policy and implementation levels. Health promotion foundations, "blue-ribbon" campaigns, and settings such as communities, schools, workplaces and churches are critical platforms for implementation of such programmes in the Pacific. For WHO, it also requires proactive collaboration with other United Nations specialized agencies and other partners to ensure that multi-sectoral work by governments received sustained and coherent support.

  With that backdrop, this strategic approach encompasses the use of a broad range of binding instruments to address health issues systematically and on a national scale. In the specific case of PICTs, the approach catalyzes efforts to implement existing policies or legislation that address the main risk factors for poor health outcomes. For example, a key legislative instrument is the *WHO* Framework Convention on Tobacco Control (FCTC), to which 13 PICTs are parties. The FCTC calls for improved coordination among various sectors to protect public health policies on tobacco control from commercial and other vested interests as well as raising prices and taxes of tobacco in order to have a significant impact on tobacco consumption, hence reducing risks of NCDs.

  WHO contributes significantly to implementing this strategic approach as part of its core functions of providing technical support, building capacity and providing evidence-based policy options. Furthermore, WHO's extensive country presence means it is well-placed to support this strategic country-specific approach. It also requires sector-wide coordination and a whole-of-government approach, where the health ministry takes the lead with WHO support as required. For example, WHO's work with development partners such as Pacific Islands Forum Secretariat (PIFS) to address disability and rehabilitation-related work through the *PIFS Regional Strategy on Disability (2010–2015).*

- Build national capacity to analyse risks and vulnerabilities such as communicable diseases and climate change, and develop and implement risk management plans.

  National capacity must be built in order to effectively reduce risks and vulnerabilities related to communicable diseases in a sustainable way. This capacity must be focused on analysing the Pacific-specific risks to relevant communicable diseases such as:

  - HIV—focusing on populations with high-risk behaviour;
  - STIs—focusing on populations with unprotected sex;
  - TB—where risks are linked to the social determinants of health and/or diabetes; and
  - Vectorborne diseases—where risks are linked to vector ecology and distribution.

  This capacity must also be focused on:

  - risks from emerging infectious diseases and outbreak-prone diseases relevant to the Pacific, including typhoid, dengue and risks: and;
  - risks related to the health impact of climate change, including water safety, food safety and the resurgence or increase of climate-sensitive diseases, such as dengue and malaria; and

Collaboration with research institutions within and outside PICTs, including WHO Collaborating Centres, will be critical to strengthen operational research, targeting improved programme effectiveness of disease control programmes and effectively linking research and programmes.

Building capacity in countries to use the health impact assessment and other tools to identify risk factors and reduce vulnerabilities falls within WHO's core functions. Risk analysis provides information useful for prioritizing countries by risk for interventions and therefore contributes to achieving efficiency in applying health interventions.

B) Increased access/coverage of high-quality health services

Strategic approaches to achieve increased access include those directed towards coverage of major programme interventions and services, as well as reducing barriers to access to existing services. Throughout the spectrum of approaches, specific attention should be paid to ensure coverage and access specifically for women and children.

- Strengthen the primary health care approach using well-documented evidence-based and internationally accepted interventions for maternal, neonatal, and child health including family planning and the *WHO Package of Essential NCD Interventions* (PEN) initiative as entry points.

  WHO's role in assisting countries with implementation of these initiatives can be leveraged to encompass other aspects of developing and enhancing services at the primary health-care level.

- Develop innovative models of increasing access to health services and health commodities in outer islands.

  The Pacific includes a unique group of countries and territories composed of small islands states and small populations in remote locations— many with limited infrastructure and communications and transportation barriers.

  Many approaches have been tried to address access issues in outer islands, however identifying the best model for providing access to services in the outer island setting remains a challenge for many countries. While it is unlikely that a one-size-fits-all strategy would be effective across PICTs, enhancements at the primary health care level through the PEN initiative in outer islands and the development of community support mechanisms offer some possibilities. At the same time, effective referral systems for secondary care must be included.

  Through its country presence, WHO can support the development of service delivery plans and strategies for universal access to essential services, routine technical support to strengthening the quality of services, and implementation of innovative approaches such as the PEN initiative. This will be supplemented with strategic technical interventions such as assessments of service-delivery models being used, the situations for which they are appropriate and the cost-effectiveness of the models as part of its core functions of monitoring health trends and articulating policy options.

C) Cost-effective health services and systems

In addition to coverage and access, the quality of health interventions and health services must be ensured. Similarly adequate protection must be provided to prevent potentially devastating social consequences of illness and disabilities.

- Use the "best-buy" evidence to define and implement a set of the most cost-effective NCD interventions fit for the country context.

  The Pacific faces challenges in dealing with a rapid and massive health transition from communicable diseases to NCDs. Many interventions for the prevention and control of NCDs exist. However, choices have to be made about which of these interventions are prioritized for implementation due to limited resources for health. WHO and the World Economic Forum have identified a set of evidence-based best-buy interventions to combat NCDs that is not only highly cost-effective but also feasible and appropriate to tailor and implement within the constraints of the Pacific context.

Helping countries identify the most cost-effective combination of best-buys to fit their country context is useful in ensuring the investments in high impact, cost-effective interventions across Maternal, Newborn, and Child Health, family planning, tuberculosis, and malaria as well as NCDs. For NCDs, the best-buy approach has been taken one step further in the Pacific. At the Fourth Pacific NCD Forum in 2012, each country defined a Crisis Response Package (CRP) of selected best-buys for immediate implementation.

- Define clear and practical service delivery plans and strategies to maximize access and effectiveness of health service delivery systems.

  At each level of care, the package of services to be included needs to be defined, and the workforce necessary to provide it needs to be specified.

  These packages of services may vary among countries in the Pacific, and work already being done is a useful starting point. For example, current work in Solomon Islands defining service delivery delineation (types, volumes and the quality of services that should be delivered at the primary, secondary and tertiary levels in some countries) can be leveraged.

  This kind of effective service delivery planning, based on economic, social, institutional and geographical realities of individual countries, provides the foundation for well-articulated and realistically costed medium-term plans and long-term strategies, which themselves are the necessary basis for sensible operational planning and budgeting.

  Building on the strategic approach of strengthening and refocusing the primary health- care system, this work falls into WHO's core normative function. It furthermore links directly to developing models for innovative service delivery in the Pacific context. It is an outstanding need that requires further exploration.

Improving health systems performance to support health outcomes (cross-cutting)

Underpinning the strategic approaches described above is the need to improve the health system. In the context of the Pacific, two aspects of health system strengthening are paramount—human resource strengthening and development of the health information system.

- Align human resources strengthening with the overall strategic direction of improving health services delivery in PICTs.

  Ensuring the health human resources are in place and well trained is a challenge globally. Small health centres on remote islands and large distances between the islands of many Pacific countries, along with the need to address various health issues, make this a particularly pressing issue for PICTs.

  Two specific strategic approaches can be implemented in this area. The first is to ensure that available training is effective and fit for the purpose. For example, the Pacific Open Learning Health Net (POLHN), which is a joint project providing training and continuing education via open and self-directed learning modalities, could expand its scope by analysing training needs with country specificity, identifying the best courses or ways to address those needs. Additionally, the WHO Fellowship Programme provides support for undergraduate and professional training which is limited in many PICTs. This programme helps to address the issue of the frequent migration of health professionals in most PICTs.

  A second strategy involves leveraging the opportunity afforded by the increasing numbers of health professionals trained abroad, such as in Cuba and elsewhere. While this presents an opportunity to meet the workforce required for the service needs of countries including in rural areas, it also pose challenges with regards to their registration, licensing and financing by national authorities. Strategies to integrate these graduates and other health professionals recruited from abroad into health services should address these challenges and should also ensure that training and recruitment of health workers match the priority health needs and essential services of the Pacific countries.

- Pursue country-level health sector coordination strengthening that promotes country ownership, health sector efficiency and sustainability

  Another strategic approach that contributes to the achievement of all three outcomes is improved health sector coordination. With the ultimate aim of improved health systems efficiency, country-led alignment and harmonization of actions can increase efficiency of health investments, decrease the complexity of the working environment and lower transaction costs for all the partners. Coordination needs to be anchored in national policies and strategic plans, with clear definition of the roles of stakeholders.

  Where WHO has a country presence, it is well positioned to advocate the coordination processes because of its neutral and brokering role. WHO's institutional ties with ministries of health is also an asset in this situation. WHO's role at the country level needs to focus on strengthening capacity of ministries of health and its provision of stewardship. Where appropriate, mechanisms such as the Sector-wide Approach (SWAp) can be used, but other coordination mechanisms can be employed depending on the context. In all cases, the processes need to be country led and owned with development partner support, as appropriate.

  Coordinated action at the country level contributes to all of the outcomes but are most closely linked to strategic approaches related to cost-effective health services and programmes.

  Strengthening health systems also includes improving the capacity to identify operational research priorities and the needs of programmes to the specific needs of countries.

- Build robust health information systems (HIS) that facilitate evidence-based programming and health systems planning, advocacy and decision-making to improve policy-making and monitoring

  A well-functioning HIS is an integrated effort to collect, process, report and use health information and knowledge to influence policy- and decision- making, programme action, and individual and public health outcomes and research. The recent endorsement at the Meeting of Ministers of Health for the Pacific Island Countries (Honiara, 2011) regarding the importance of HIS strengthening, and in particular improvement of civil registration and vital statistics, highlights the ongoing need for evidence for decision-making.

  The Pacific Health Information Network (PHIN) articulates a strategic regional vision for improving and strengthening HIS in the Pacific. Currently several PICTs are developing country plans for HIS improvement, which include the development of health information national policy and HIS governance and leadership structures.

  WHO has identified four key areas of improvement that are necessary for strengthening overall HIS decision-making and capacity-building in PICTs:

  1. Training of and investment in the HIS workforce;
  2. Developing national health information policies and implementation plans;
  3. Improving civil registration and vital statistics and their role in decision-making; and
  4. Enhancing the reliability of health information used within and reported from PICTs.

  HIS improvements need to be aligned with the overall strategic direction in national policies and improvements in service delivery, for example, linking to ways in which HIS can support monitoring and surveillance of NCDs and in particular provide a better information platform for NCD decision-making.

- Use regional and country partnerships to build momentum on sustainable health financing for programmes and the health sector at the country level.

  In general, financing of health systems in PICTs may seem adequate and stable. The majority of PICTs fund their health system from tax revenue. Pacific countries will continue to need support to better understand health financing options as systems weaken from the growing

burden of diseases and as issues of financing sustainability become more important. Support regarding exploration of innovative financing through tobacco taxation will also be supported.

PICTs will increasingly look for ways to improve efficiencies in their current systems, and WHO together with other partners will look to support countries to understand their financing challenges better. Monitoring trends in spending, in particular disease spending, requires countries to establish national health accounts.

At the same time, many countries depend largely, if not fully, on donor funding for programmes, e.g., HIV, TB, malaria, NCDs, etc. Global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and bilateral partnerships continue to be significant sources of programme financing. However, many of these programmes are scaling back. Over the next few years, PICTs need to transition into more sustainable financing mechanisms leveraged from existing support and partnerships to maintain the current momentum in many programme areas. Part of the strategy is improving health systems efficiency in service delivery and redefining the priority health strategies and interventions that are financed.

Conclusions

This agenda is far-reaching and covers a set of strategic approaches designed to achieve three major outcomes in the Pacific context:

1. Reduced risk factors and vulnerabilities
2. Increased access/coverage of high-quality health services, and
3. Cost-effective health services and systems.

WHO's core competencies can be leveraged across this strategic agenda to contribute to the achievement of the set of outcomes. In addition, WHO's comparative advantages, such as being a neutral broker, having a strong country presence and enjoying close ties with ministries of health, can be leveraged to implement this strategic agenda in partnership with governments and other development partners. Furthermore, the newly established WHO Division of Pacific Technical Support (DPS) provides added value through the pooling of resources across DPS offices to provide PICTs with Pacific-specific technical and policy support.

This agenda also highlights the importance of whole-of-society and whole-of-government approaches to addressing today's health challenges. Against the backdrop of the global financial crisis, new ways of working across sectors for increased efficiency and effectiveness are important strategic concepts, which are needed to impact the health of the Pacific people and to help move towards the Healthy Islands vision.

Section 6

Implementing the Strategic Agenda

Implementing the strategic agenda as outlined in Section 5 of this MCCS provides an opportunity for WHO to review how it works in the Pacific context with a view to continually improving performance. It is also a chance to review how the MCCS can be more effectively used to guide ongoing activities, such as resource mobilization. Many of the enhancements have been touched on in earlier sections and are amplified here.

WHO's presence and role

The central thrust of improving WHO's performance in the Pacific is ensuring that WHO is delivering country results. To achieve this, WHO has embarked on a plan to deliver changes in its ways of working, anchored in the Division of Pacific Technical Support (DPS). DPS was established end of 2010 to pull together all of WHO's support to the Pacific, giving it one direction and a Pacific-based coordination mechanism.

DPS includes a Suva-based Division Office providing technical and managerial support to the six country offices in the Pacific. The Division Office provides the mechanism to coordinate and consolidate WHO's inputs from the different levels and to be able to identify synergies not just among offices, but also with regional and country partners. As DPS develops and adapts to the changing Pacific context, it is moving from multi-country and intercountry coordination to country-specific implementation.

Western Pacific Region Office (WPRO)	Division of Pacific Technical Support (DPS)
• Strategic direction and agenda setting	• Implement strategic direction and agenda through coordination with health partners, including SPC
• Developing norms and standards	• Adapting norms and standards to the Pacific setting
• Technical support as a back-up to DPS as needed	• Technical support to PICTs

WHO is focusing on several specific aspects of its role and function to ensure it is effective in the Pacific; the main aspects are described below.

- *Strong WHO leadership in the health sector and beyond*

  Maintaining WHO's strong leadership role in health is becoming more critical in view of the many and emerging partners and players in health and as a result of health sector reforms in the Pacific. Furthermore, the need to engage other ministries to address various health issues and the aid effectiveness agenda means DPS should engage fully with ministries of health in PICTs, as well as with other ministries. This may require WHO staff in countries to have the skill sets needed to work beyond the ministry of health to effectively support the health ministry.

- *Ensuring synergies across all DPS offices—getting the right skill mix*

  Several times each year, WHO Representatives (WRs), Country Liaison Officers (CLOs) and the Suva-based management team meet to discuss overall strategic directions and policy issues affecting the entirety of DPS, as well as key management issues. In addition, a twice-yearly meeting of the heads of country offices provides an opportunity for face-to-face meetings among the heads of the offices in DPS. There will also be an annual multi-day meeting of all DPS professional staff, including seven offices in the DPS division (three WR and four CLO offices) to mutually agree on implementation plans, to evaluate past performance and to discuss ongoing developments in the division. In addition to these DPS-wide interactions, WRs, CLOs and DPS management will have regular consultations to discuss office-specific situations, management issues and resource allocation.

- *Coordination among technical divisions in the Regional Office*

  Suva-based DPS provides technical support to PICTs for programme implementation with back up from the Manila-based technical divisions, as needed. In specific situations, either Regional Office-based divisions or DPS may take the lead on identified WHO programmes in the Pacific. This will depend on local context, the capacity of staff and funding availability so that the requirements of governments are best met and benefits to countries are maximized. Human resources may need to be realigned in DPS to reflect needs according to the disease burden in the Pacific, as seen in Figure 1, and will inform and enhance coordination of technical support to countries.

In addition, a tiered approach to country support can help effectively deploy resources where they can have the most impact. For example, clustering countries according to similarities in the type of health services delivery infrastructure, health systems capacity, health situation and the programmes that need to be delivered—and even size of the country—could be useful. This approach will be elaborated further as a potentially effective model.

WHO Comparative Advantage in the Pacific

1. Provide norms and standards to guide countries for evidence-based policy- and decision-making
2. Convening role on international health and a neutral broker to coordinate health sector with development partners
3. Significant country presence in the Pacific

Partnership approaches

The MCCS focuses on outcomes to which WHO contributes, but is not solely responsible. This underscores the need for WHO to work in collaboration with many development partners and across several sectors. As a representation of the strategic needs in the Pacific, the framework guides work with governments. This underpins the operational plans to be developed and delivered at the country level.

The framework can be used to guide the efforts of development partners in line with national priorities and policies. WHO, as a trusted broker and convenor with a strong country presence, is well placed to play a key role in coordinating efforts at the country level.

- *United Nations partners*

  The current CCS has been revised to coincide with the timing of the *United Nations Development Assistance Framework*, or UNDAF. As such, the overarching strategies, and more specifically the country strategies, feed directly into the UNDAF framework. This is one way to align WHO work within the United Nations family, as well as across the health-focused agencies, such as UNAIDS, UNFPA and UNICEF.

- *Secretariat of the Pacific Community (SPC)*

  SPC, as a Pacific-specific agency with a broad mandate that includes health, works in partnership with WHO to address country-specific needs. SPC has a clear comparative advantage in its ability to reach beyond the health sector, which is particularly useful in tackling the NCD crisis. A strong and vibrant partnership with clear and complementary roles and responsibilities provides a unique opportunity for improving the health of Pacific island people.

- *Development partners*

  Partnership approaches also extend to work with donor agencies. In order to effectively deliver support, WHO must work in partnership with its main donors, the Australian Agency for International Development (AusAID), the Japan International Cooperation Agency (JICA), the New Zealand Aid Programme and Pacific Islands Forum Secretariat. This includes holding discussions on the overarching strategic framework and country-specific implementation plans, as well as holding regular meetings and discussions to update progress and developments in achieving agreed-upon outcomes at both subregional and country levels.

- *Other Partners*

  In order to enhance country-level support, WHO in close collaboration with governments often partners with nongovernmental organizations, faith-based organizations and civil society that provide community-level support.

Using the Multi-Country Cooperation Strategy (MCCS)

The strategic agenda set out in the MCCS provides an overarching framework to guide WHO's work in the countries. The framework will help guide this work in many specific ways.

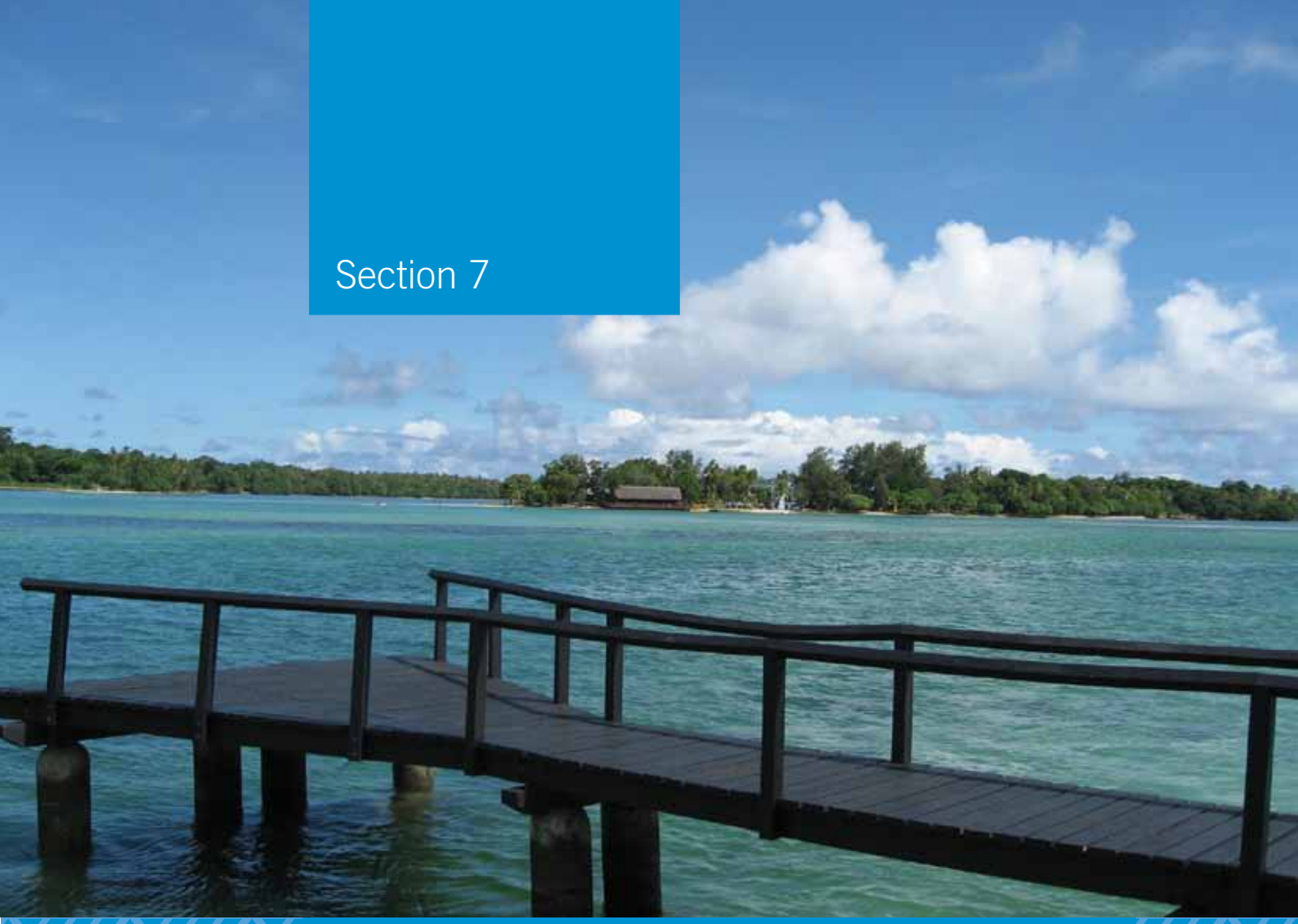
- *Strategic* Guide and Directions

  The MCCS provides overall direction for government and WHO with support from development partners, working together to achieve the Healthy Islands vision in the Pacific. The two-page country strategies identify areas of technical cooperation between WHO and the country and describe the strategic direction for WHO support to countries in achieving goals and objectives identified in their national health plans. To achieve the three major outcomes, several strategic approaches have been identified.

- *Strategic financia*l resource allocation

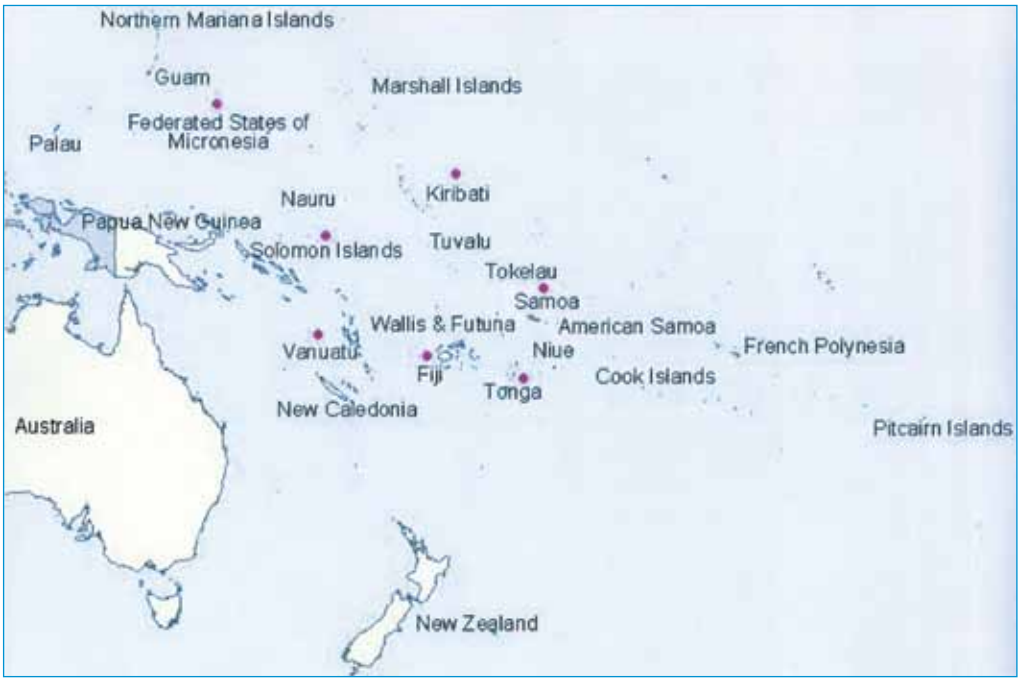
  The strategic framework provides a clear description of intended health outcomes and describes how WHO will contribute to achieving those health outcomes.

  With the goals and strategic directions for each country clearly defined through the MCCS and the country strategies, planning and monitoring discussions with all WHO Pacific offices provide an opportunity to jointly allocate resources across strategic areas. The participation of key external partners in this process will allow WHO to appropriately align and coordinate donor support for country priorities.



Section 7

Country-Specific Strategies



Pacific Island Countries and Territories	WHO offices of the Division of Pacific Technical Support
American Samoa	**Divisional Office:** Suva **Country Offices:** Kiribati Northern Micronesia Samoa Solomon Islands Tonga Vanuatu
Cook Islands	
Fiji	
French Polynesia	
Guam	
Kiribati	
The Marshall Islands	
The Federated States of Micronesia	
Nauru	
New Caledonia	
Niue	
The Commonwealth of Northern Mariana Islands	
Palau	
The Pitcairn Islands	
Samoa	
Solomon Islands	
Tokelau	
Tonga	
Tuvalu	
Vanuatu	
Wallis and Futuna	

Country and Territory Strategies

The country strategies were developed by ministries of health, in close collaboration with WHO. The country strategies consist of seven major sections. Section 1 provides an overview of economic, political, social and health status. It also includes geographical information, governance details, major economic activities and foreign affairs. Section 2 provides an overview of the health and development situation in the countries and territories and includes information such as leading causes of morbidity and mortality, survey data (where available), a brief description of health-care infrastructure and data on human resources for health. Section 3 provides demographic and health indicator data, including common global health indicators. The data included in Section 3 is primarily based on official data published in the *Western Pacific Country Health Information Profiles* (CHIPS). Section 4 identifies opportunities and challenges related to achieving health goals, while Section 5 summarizes the main objectives and/or goals of the National Health Policies, Strategies and Plans (NHPSP). Section 5 identifies the strategic approaches that ministries of health will implement to achieve national health objectives, while Section 6 identifies sector coordination and partnerships between countries and development partners. Section 7 outlines strategic priorities for collaboration between WHO and countries. The strategic priorities identified are based on country-specific needs for technical assistance in achieving the objectives outlined in their respective NHPSPs.

World Health Organization
Western Pacific Region

AMERICAN SAMOA

3. Demographic and health indicators

Estimated population (in '000s)	69.2
Population proportion under 15 (%)	35.10 (2010 est.)
Life expectancy at birth (male/female)	n
Under-5 mortality rate per 1000 live births	4.9 (2005)
Antenatal care coverage – at least one visit (%)	n
Birth attended by skilled health personnel (%)	100.0 (2002)
Measles (MCV) immunization coverage among 1-year-olds (%)	86.0 (2008)
Prevalence of elevated blood glucose (%)	41.10 (2007)
Prevalence of current tobacco use in adults (male/female) (%)	38.1/21.6 (2006)
Human Development Index Rank out of 187 (2011)	n
Per capita GDP (in US$)	9,041 (2005 est)
General government expenditure on health as % of general government expenditure	14.0 (2003)
% of population using an improved sanitation facility	99.0 (2004)
% of population using an improved drinking-water source	99.0 (2004)

est = estimated
GDP = gross domestic product
n = not available

1. Macroeconomic, political and social context

American Samoa is made up of five volcanic islands and two coral atolls covering 199 square kilometres in the South Pacific Ocean. American Samoa is an unincorporated and unorganized, territory of the United States of America. American Samoa is the farthest United States territory to the east and south of the equator and the population is Polynesian. The head of Government is a Governor who is elected by popular vote every four years. Major economic activities in American Samoa include tuna canning and handicrafts.

Projections from the 2000 census indicated that population growth rates are rising, much of it attributed to inward migration of young working people. Birth rates per 1000 people since the last census appeared to be steady between 25.0 and 26.0 per 1000. In 2010, it was estimated that over 90% of the population resided in urban areas.

2. Health and development

The most serious health issues are related to the increase in chronic and noncommunicable diseases (NCDs), with their roots in improper nutrition and physical inactivity. Significant increases have been seen in obesity, hypertension, cardiovascular diseases, cerebrovascular diseases, diabetes mellitus and its complications, arthritis and some forms of cancer. American Samoa's *STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS)* survey report showed that in 2004, in the adult population aged 25–64 years, the prevalence of obesity was 74.6%, prevalence of hypertension was 34.2%, prevalence of diabetes was 47.3% and prevalence of elevated blood cholesterol was 23.4%.

Primary health care and three new community health centres are developing slowly, but there has been considerable progress since 2000. Decentralization of services is being encouraged and will improve with the building of the new health centres. Most water is obtained from deep bores and is chlorinated. Waste disposal is still a problem but is being tackled enthusiastically and slowly improved. Interdepartmental coordination in health-related activities has been consistently and effectively supported by the Government. Also, the involvement of executive and legislative leaders is certainly encouraging. American Samoa has one acute care hospital and five primary health care centres. According to data collected in 2003, the health worker-to-population ratio was 1:1282 for doctors and 1:493 for nurses.

4. Opportunities

- Availability of technical training on island by development partners
- Potential to grow the health-care workforce over the next 5–10 years

Challenges

- Health budget is limited to carry out needed activities, therefore the Department of Health (DOH) budget needs to allocate resources to non-federally funded programme services
- Most DOH Services are run by federal grants

6. Sector Coordination and Partnerships

American Samoa is a United States territory and, therefore, is aligned with the United States health sector coordination and partnerships. American Samoa collaborates with the WHO and Secretariat of the Pacific Community (SPC) on workforce training and NCD programmes.

5. Summary of National Health Policy, Strategy or Plan

The DOH is working on developing the Territorial Health Plan, which will focus on national health priorities.

- Health manpower development with particular emphasis on the training of professionals in health education and promotion, environmental health and nutrition and its relationship to NCDs.
- Development of the health information system (HIS) for data collection, assessment and analysis as a tool to be used in health programme planning and management.
- Presently, a consultant from Pacific Island Health Officers Association (PIHOA) is conducting a Health Information System Assessment for the development of an improved centralized HIS plan in the health care system.
- Control of NCDs and the development of primary health care and outreach facilities, particularly to relatively inaccessible and underprivileged groups and communities.

7. Strategic priorities for collaboration between WHO and the Government from 2013 to 2017

WHO in coordination with development partners will provide support to the Government and people of American Samoa to:

1. Identify and provide specialized training for the health-care workforce, particularly those workers related to health promotion and disease prevention.
2. Continue affiliation with WHO to provide training, short-term courses and attachments for medical officers.

World Health Organization
Western Pacific Region

COOK ISLANDS

3. Demographic and health indicators

Total population (in '000s)	17.8 (2011)
Population proportion under 15 (%)	27.9 (2010 est)
Life expectancy at birth (male/female)	70/73 (2009 est)
Under-5 mortality rate per 1000 live births	18.4 (2006)
Antenatal care coverage-at least one visit (%)	98
Birth attended by skilled health personnel (%)	100 (2009)
Measles (MCV) immunization coverage among 1-year-olds (%)	100 (2010)
Prevalence of raised blood glucose (%)	23.6% (2004)
Estimated smoking prevalence among adults (male/female) (%)	46.6/41.1 (2004)
Human Development Index Rank out of 187	n
Per capita GDP (in US$)	10,298 (2009 p)
Total expenditure on health as % of GDP	4.5 (2009 p)
General government expenditure on health as % of general government expenditure	10.6 (2009 p)
% of population with access to improved sanitation facility	100 (2008)
% of population with access to improved drinking water source	100

est = estimated
GDP = gross domestic product
n = not available
p = provisional

1. Macroeconomic, political and social context

Cook Islands is a nation comprised of 15 islands spread over 2 million square kilometres in the Polynesian Triangle. The population is dispersed across the islands but concentrated on Rarotonga (73.6%), the centre of governance and commerce. Cook Islands has been a self-governing nation in free association with New Zealand since 1965. Cook Islands is governed by a prime minister who is the leader of the majority party/coalition in the legislature; the legislature is elected by popular vote. The major economic activities in Cook Islands are tourism, fishing, agriculture and financial services. There were economic troubles in 1996–1997 but they were resolved through a programme of reforms including public service, public asset devolvement, and economic strengthening and stimulation supported largely by New Zealand and the Asian Development Bank. Cook Islands is an economically stable democracy with strong support from New Zealand and other partners. New Zealand retains responsibility for external affairs and defence in consultation with Cook Islands. New Zealand and Australia harmonize aid to support the National Sustainable Development Plan (NSDP) through direct budget support.

2. Health and Development

The Cook Islands' health profile is largely favourable with adequate health coverage in each island, high immunization rates throughout the country and sufficient resources to meet the needs of the population. However, there are growing problems facing Cook Islands with regards to NCDs such as diabetes, cardiovascular diseases, hypertension, obesity and lifestyle-related health risk factors (e.g., smoking, excessive alcohol consumption and poor diet). NCDs are the main cause of mortality. Morbidity is also dominated by NCDs, including circulatory system diseases, respiratory system and endocrine ailments, and nutritional and metabolic diseases. Cook Islands' *STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS)* survey report showed that in 2003–2004, in the adult population aged 25–64 years, the prevalence of obesity was 61.4%, prevalence of hypertension was 33.2%, prevalence of diabetes was 23.6%, and prevalence of elevated blood cholesterol was 75.2%. Communicable diseases are few but pose a danger; sexually transmitted infections (STIs) are common in Cook Islands. Cook Islands has recorded a nil maternal mortality rate since 2001, which is a result of 100% birth attendance by a skilled health professional. Cook Islands continues to maintain a low infant mortality rate. There are still many health challenges to quickly diagnose and treat respiratory infections and other diseases to save children's lives. There is one hospital with 127 beds, nine out-patient clinics, 10 dental clinics, six health centres, 50 child welfare clinics, four private clinics, two private dental clinics and four private pharmaceutical outlets in Cooks Islands. According to data collected in 2004, the health worker-to-population ratio was 1:926 for physicians and 1:391 for nurses.

4. Opportunities

- Strategic partnership and support from donor partners
- Qualified staff
- Research opportunities for staff
- Devoted rural island staff

Challenges

- Insufficient health budget
- Need for human resource succession planning
- Inequitable access to quality health care
- Existence of some outdated legislation

6. Sector Coordination and Partnerships

The Ministry of Finance and Economic Management coordinates sector aid, development and plans. The primary partners for the health sector are New Zealand Aid Programme, WHO, the Secretariat of the Pacific Community (SPC), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA).

5. Summary of the National Health Policy, Strategy or Plan

The National Sustainable Development Plan 2011–2015 (NSDP) is a second-phase strategy towards achieving the desired 2020 development outcomes and national vision—"To enjoy the highest quality of life consistent with the aspirations of our people, and in harmony with our culture and environment." It is a comprehensive national development plan, which sets out the national priorities in line with development commitments to international and regional partners and international conventions. The NSDP has eight national goals and is aligned to sector strategies, corporate plans and the budget. The Ministry of Health recognizes health is pivotal to achieving all the NSDP goals, however Goal 4 is specific to health.

Strategic Goal 4 reads:

"Opportunity for all people who reside in Cook Islands: A Cook Islands where all people who reside in our islands can enjoy opportunities to fulfil their potential, prosper and participate in the social, economic, political and cultural life of our communities and nation."

The Ministry of Health has developed a National Health Strategy (2012–2016), which is aligned and in harmony with the NSDP and other regional and global development goals. The priority focus of the strategy includes:

- enhancing the infrastructure of the health systems and supporting ongoing health governance and organizational reforms,
- promoting partnerships for institutional capacity development,
- strengthening health sector policy, planning and regulations, and improving data collection, monitoring and evaluation,
- promoting gender-sensitive research and gender analysis,
- strengthening community capacity and capability on social determinants of health, and
- improving information, community and technology systems and strategies, to provide accessible and accurate information on health promotion and disease prevention, so that people are empowered to take ownership and responsibility for their health and their environment they live in to reduce future health risks.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the government and people of Cook Islands to:

1. Develop human resources for health for the future to ensure qualified staff for Rarotonga and the outlying islands.
2. Reduce the effects of NCDs (particularly lifestyle-related) through a variety of interventions such as those identified in the Crisis Response Package (CRP) to ensure the population makes informed choices.
3. Strengthen support for family, maternal, adolescent, child, elderly and disability-related health programmes.
4. Reduce the impact of communicable diseases with an emphasis on sexually transmitted infections (STIs), HIV, vectorborne diseases and other infections.
5. Review and develop new and update existing legislation, policies and guidelines in accordance with the International Health regulations (2005).
6. Reduce morbidity and mortality from road accidents.

World Health Organization
Western Pacific Region

FIJI

1. Macroeconomic, political and social context

Fiji is comprised of over 100 inhabited islands covering over 18 000 square kilometers in the South Pacific Ocean. Fiji is governed as a parliamentary republic by a military-appointed president, a prime minister and cabinet. Fiji's major economic activities include tourism, sugar, mining, fishing and forestry. The global economic performance of Fiji has been fairly weak, with average growth of 3.2% per year since 2007. Despite its middle ranking status on the United Nations Human Development Index (HDI), and the important role that Fiji plays as a regional centre, Fiji has not attained the levels of development that were predicted for it in the early 1980s. A series of coups over the past 20 years has produced periods of fluctuations in the levels of private investment.

2. Health and Development

In 2010, the leading causes of death in Fiji were diseases of the circulatory system (44%), endocrine, nutritional, or metabolic diseases (13%), and neoplasms (10%). The leading causes of morbidity in Fiji were diseases of the circulatory system and respiratory system and certain infectious and parasitic diseases. Fiji's *STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS)* survey report showed that in 2002 in the adult population aged 25–64 years, the prevalence of obesity was 42.6%, prevalence of hypertension was 21.2%, prevalence of diabetes was 32.1%, and prevalence of elevated blood cholesterol was 46.6%.

Approximately 38.8% of tertiary health-care costs were attributed to noncommunicable disease (NCD) treatment, while 18.5% were attributed to communicable disease treatment. The provisions of adequate and appropriate resources are vital to ensure the sustainability of the delivery of health services to the people of Fiji. Although it is making progress, Fiji faces major challenges in achieving key health-related Millennium Development Goal (MDG) targets. Some of the contributing factors to slowed progress includes: health staff shortages, high staff turnover, and the need to strengthen the health system through improving investment in technical infrastructure, such as a health information monitoring system. Health services are delivered through 900 village clinics, 124 nursing stations, three area hospitals, 76 health centres, 19 sub-divisional medical centres, three divisional hospitals, and three specialty hospitals with TB, leprosy and medical rehabilitation units at Tamavua Hospital and St. Giles Mental Hospital. There is also a private hospital located in the capital city. According to data collected in 2008, the health worker-to-population ratio was 1:2609 for doctors, 1:493 for nurses, and 1:4580 for dentists.

3. Demographic and health indicators

Total population (in '000s)	854.0 (2010 est)
Population proportion under 15 (%)	30.9 (2010 est)
Life expectancy at birth (male/female)	68.0/72.0 (2007)
Under-5 mortality rate per 1000 live births	17.7 (2010)
Antenatal care coverage-at least one visit (%)	100.0 (2005)
Birth attended by skilled health personnel (%)	99.7 (2010)
Measles (MCV) immunization coverage among 1-year-olds (%)	71.8 (2010)
Prevalence of raised blood glucose (%)	16.0 (2002)
Estimated smoking prevalence among adults (male/female) (%)	22.0/4.0 (2002)
Human Development Index Rank out of 187	100 (2011)
Per capita GDP (in US$)	2,978.65 (2009)
Total expenditure on health as % of GDP	4.8 (2009-10)
General government expenditure on health as % of general government expenditure	9.2 (2010)
% of population with access to improved sanitation facility	71 (rural)/ 94 (urban) (2010)
% of population with access to improved drinking-water source	95 (rural)/ 100 (urban) (2010)

est = estimated
GDP = gross domestic product
n = not available

4. Opportunities

- Established health education institutions for career development
- Existing collaborative partnerships with development partners
- Interest and capacity for health research

Challenges

- Need for identifying sustainable sources for health finance
- Need to improve the use of health information for better policy formulation
- Retention and effective management of the health workforce

6. Sector Coordination and Partnerships

The MOH implements support from development partners through memorandums or letters of understanding, annual work plans, or mutual agreements of biennium budgets that are based on MOH's National Strategic Plan and are prioritized in the annual corporate plan. With the idea that health is a collective responsibility, the MOH engages with other partners in delivering the best possible health-care services to the population. Many of the strategic objectives will require partnerships with and the collaboration of other organizations including nongovernmental organizations, donors and other government departments. There is a need to reiterate the focus of assistance on strategic priorities of government and health and on the attainment of the health-related MDGs. There is a need to continue to harmonize programmes and projects, which may be running concurrently by several donor agencies thereby posing a challenge to accountability and ownership.

5. Summary of the National Health Policy, Strategy or Plan

In developing its objectives and targets, the Ministry of Health (MOH) took its cue from the two principal overarching strategic goals from the government's *Roadmap for Democracy and Sustainable Socio-Economic Development*. The MOH Strategic Plan for 2011–2015 documents the policy priorities the ministry has set regarding its strategic direction for health care in Fiji over the next five years. The major public health concerns are:

- NCDs and their risk factors
- Emerging and re-emerging communicable diseases
- Maternal, adolescent and child health
- Mental health
- Environmental health issues affecting the health and well-being of the community.

The National Health Strategic Plan identifies three strategic goals set in order to impact the outcomes of the major public health concerns. The MOH aims to:

- provide adequate primary and preventive services,
- provide accessible clinical and rehabilitation services, and
- undertake health systems strengthening all levels at the MOH.

In order to strengthen the upstream efforts towards evidence-based decision-making, the MOH has recently established a new Policy, Planning and Development Unit. Also recognizing the role played by a well-functioning health information system, the MOH has recently developed a National Health Information Policy (2011), on which the Health Information Systems Strategic Plan (2012–2016) was based. There is greater emphasis on achieving targets through improved monitoring and evaluation frameworks in every programme. There is a drive towards "wellness", which is a more holistic approach to health rather than focusing merely on reduction of disease or infirmity.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the government and people of Fiji to:

1. Identify "best-buy" approaches to taking action on addressing the burden of NCDs and their risk factors such as implementing the *WHO Framework Convention on Tobacco Control* and the Crisis Response Package (CRP).
2. Develop and implement plans to prevent communicable diseases such as sexually transmitted infections (STIs), HIV and tuberculosis, as well as meet targets for vaccine-preventable communicable diseases such as Hepatitis and measles.
3. Strengthen maternal, adolescent, and child health programmes, including immunization programme support.
4. Address the health impact of climate change in Fiji, which may include reducing environmental hazards to health, providing advice on sanitation and hygiene, and advocating for access to a safe water supply for rural communities.
5. Strengthen health systems, which may include: updating health information systems, supporting health-sector capacity building with the provision of continuing education and training of health workers through Pacific Open Learning Health Net (POLHN), and expanding national health research activities.
6. Implement the *Ministry of Health Strategic Plan 2011–2015* and *National Medicines Policy of 2012*.
7. Develop health policy (e.g., *National Laboratory Legislation*) and sector coordination and National Health Accounts work; strengthen evidence-based strategic and operational planning and budgeting (including monitoring and evaluation mechanisms), and explore health financing, infrastructure and safety improvement options.

World Health Organization
Western Pacific Region

FRENCH POLYNESIA

1. Macroeconomic, political and social context

French Polynesia is comprised of five archipelagos spread out over a very extensive area in the Pacific Ocean. Its population is unevenly distributed with three-quarters concentrated on the Windward Islands. The population is becoming increasingly urbanized and ageing, with slowing growth since 2002. French Polynesia has the status of an internally self-governing overseas country while still remaining an entity within the French Republic; its head of state is a High Commissioner appointed by the French President and the head of Government is a president elected by the Assembly, comprised of representatives elected by popular vote. Major economic activities in French Polynesia include tourism, pearl farming and agricultural processing. After an economic boom during the nuclear testing years, which ended in the mid-1970s, the country began experiencing structural difficulties that have affected its economy and have been exacerbated by the global recession and political instability. Unemployment is on the rise due to job cuts and a shrinking labour market.

2. Health and Development

There is a rapid epidemiological transition under way related to the urban drift; social, economic and cultural change; evolving eating habits; developing technology and communications; and progress in medicine and education. Communicable disease morbidity and mortality rates have fallen sharply due to an improved health-care system and increased vaccinations. However, noncommunicable disease (NCD) prevalence is increasing and is second only to respiratory infection as a leading cause of morbidity. In 2007, the leading causes of mortality were neoplasm, followed by diseases of the circulatory system, and injuries or external causes. There are five public and four private hospitals in French Polynesia and over 115 primary health-care centres. According to data collected in 2009, the health worker-to-population ratio was 1:469 for doctors, 1:239 for nurses and 1:2381 for dentists.

3. Demographic and health indicators

Total population (in '000s)	268.8 (2010 est)
Population proportion under 15 (%)	24.7 (2010 est)
Life expectancy at birth (male/female)	72.8/77.83 (2010 est)
Under-5 mortality rate per 1000 live births	6.48 (2008)
Antenatal care coverage – at least one visit (%)	100.0 (2004)
Birth attended by skilled health personnel (%)	100.0 (2004)
Measles (MCV) immunization coverage among 1-year-olds (%)	99.0 (2010)
Prevalence of raised blood glucose (%)	n
Estimated smoking prevalence among adults (male/female) (%)	36.0/36.0 (1995)
Human Development Index Rank out of 187	n (2011)
Per capita GDP (in US$)	16,803.36 (2006)
Total expenditure on health as % of GDP	13.1 (2008)
General government expenditure on health as % of general government expenditure	29.0 (2008)
% of population with access to improved sanitation facility	98.0 (2008)
% of population with access to improved drinking water source	100.0 (2008)

est = estimated
GDP = gross domestic product
n = not available

4. Opportunities

- Ability of French Polynesia to define its own health policy
- A well-functioning health-care system that is active in a variety of areas from primary and specialized health care to prevention and research
- Well-developed new information and communications technology

Challenges

- A triple burden of NCDs, communicable diseases and environmental hazards
- An ageing population
- Difficulty in providing quality health care that is accessible to all
- Struggle with the relationship between health and prevention and user responsibility
- Undefined way to optimally use resources and control health expenditures

6. Sector Coordination and Partnerships

Multisectoral coordination falls under the jurisdiction and responsibility of the Minister of Health and Welfare. Sectors, departments and organizations involved in the health-care partnership include:

- Government health, welfare and education departments
- Private health-care professionals
- Hospitals
- Social welfare funds
- Health-care workers' unions;
- Patient self-help groups; women's, youth and sports associations; and religious denominations, etc.; and
- Various departments of the French Government and French Polynesian communities.

5. Summary of the National Health Policy, Strategy or Plan

The *Health Blueprint* (SOS) sets objectives for improving the quality of health care, access and efficiency with due concern for effective health expenditure controls. The SOS defined its policies for achieving optimal coverage for health needs as follows:

- improve health-care access equity by making services more readily available to the underprivileged throughout the country;
- develop disease prevention and health awareness;
- promote quality health care as a founding principle of health services;
- inform and empower health-care system users; and
- optimize available resources while duly containing health expenditures.

A reform of the general health scheme that covers nearly 100% of the population is currently under discussion, and there has been expression of the urgent need to overhaul the health system's principles and funding mechanisms and to adopt financial adjustment measures. Good governance in health needs to be strengthened; as such, the scheme will make use of tools such as the regulatory framework and health information systems.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of French Polynesia to:

1. Assist in implementation of the national Crisis Response Package to prevent and reduce NCDs with specific focus on the *WHO Package of Essential NCD Interventions (PEN)* and food-control system efforts.
2. Develop health policies, including the strategic aspects of health protection, prevention and health-service delivery.
3. Strengthen management and resources in health monitoring and build capacity with regards to implementing, monitoring and evaluating health plans.
4. Strengthen the surveillance and statistical system for producing health indicators and data.
5. Assist in using information and communications technology with a mechanism to share health information among public and private health-care bodies and facilities; and launch "telemedicine" development projects.

World Health Organization
Western Pacific Region

GUAM

1. Macroeconomic, political and social context

Guam is the largest and southernmost island in the Mariana Islands chain, located in the northwest Pacific Ocean. Guam is an unincorporated territory of the United States governed by a Governor elected by popular vote. Guam's major economic activities include military-related activities, tourism, construction, transshipment services, food processing and textiles. Guam is made up of 19 villages, with a majority of the people living in the northern part of the island. Guam is in the midst of a U.S. military build-up. Over 5000 Marines are expected to be relocated to Guam from Japan in the next few years. The Government of Guam is currently running a budget deficit.

2. Health and Development

The rate of noncommunicable diseases (NCDs) in Guam and the region continues to increase. Between 2001 and 2005, 61% of all deaths on Guam were attributed to NCDs (31% from heart disease, 16% from cancer, 8% cerebrovascular disease, 3% from diabetes, and 3% from chronic obstructive pulmonary disease). In 2006, deaths attributable to NCDs increased to 81%. Guam experienced several infectious outbreaks in 2011. According to the *2011 Annual Summary of Notifiable Diseases, Guam,* there were seven cases of pertussis, 49 cases of hand, foot and mouth disease, and three cases of dengue fever.

A new privately owned hospital is currently under construction in the northern part of the island; completion of the first of two phases is expected in 2014. Phase I will have 120 hospital beds and Phase II will have an additional 90 beds. As part of the military build-up, a new military hospital is being built in Guam. It will replace the current hospital that was built in 1954. Construction is expected to finish in 2014. The hospital will have 42 in-patient beds and six intensive care unit beds.

3. Demographic and health indicators

Total population (in '000s)	180.7 (2010 est)
Population proportion under 15 (%)	27.4 (2010 est)
Life expectancy at birth (male/female)	76.7/82.1 (2010 est)
Under-5 mortality rate per 1000 live births	10.00 (2005 est)
Antenatal care coverage – at least one visit (%)	41.3 (2011)
Birth attended by skilled health personnel (%)	100 (2011)
Measles (MCV) immunization coverage among 1-year-olds (%)	85.0 (2006)
Prevalence of raised blood glucose (%)	9 (2011)
Estimated smoking prevalence among adults (male/female) (%)	30.3/21.2 (2010)
Human Development Index Rank out of 187	n
Per capita GDP (in US$)	22,661.00 (2005)
Total expenditure on health as % of GDP	3.1% (2009)
General government expenditure on health as % of general government expenditure	27% (2012)
% of population with access to improved sanitation facility	100 (2012)
% of population with access to improved drinking water source	100 (2012)

est = estimated
GDP = gross domestic product
n = not available

4. Opportunities

- Worksite wellness programmes and healthy vending machine policies have been implemented
- The University of Guam is collaborating with the University of Hawaii to develop more programmes to address the need for more health-care providers
- The cap for United States Medicaid funding was increased for Guam
- The Governor's Office has submitted an austerity plan to address the budget deficit

Challenges

- Increasing NCD problem
- Decreasing health-care budgets
- Unreimbursed Compact Impact costs from United States Government
- Lack of health-care providers
- High number of people on public assistance (23%)
- Government of Guam budget deficit

6. Sector Coordination and Partnerships

The Department of Public Health and Social Services receives funding from various federal agencies and organizations. These include the United States Centers for Disease Control and Prevention, the Health Resources and Services Administration of the United States Department of Health and Human Services, the Food and Nutrition Service of the United States Department of Agriculture, the Secretariat of the Pacific Community (SPC) and WHO.

The NCD Consortium was formed to address the burgeoning NCD problem in Guam. Through its efforts, the first *Guam Nonommunicable Disease Strategic Plan* was developed in 2011.

5. Summary of the National Health Policy, Strategy or Plan

The *Guam Noncommunicable Disease Strategic Plan* was developed to address the growing problem of NCDs in the region. The main goals were:

- To reduce the burden of NCDs in terms of deaths, prevalence, incidence and hospitalizations;
- To reduce the prevalence of NCD risk factors by eliminating tobacco use in Guam, eliminating second- and third-hand smoke, reducing the prevalence of alcohol use and abuse and underage drinking, and reducing overweight and obesity in Guam's school-aged children through increased levels of physical activity and healthy eating; and
- To strengthen integrated NCD coordination and administration by establishing an NCD steering committee and employing an NCD coordinator.

7. Strategic priorities for collaboration between WHO and the Government from 2013 to 2017

WHO in coordination with development partners will provide support to the Ministry of Health of Guam to:

1. Develop a plan for a regional laboratory (Level 2) in Guam.
2. Increase the number of qualified healthcare personnel in the areas of medicine, dentistry, pharmacy and other allied health professions through programs such as Pacific Open Learning Health Network (POLHN).
3. Address the tuberculosis problem in Guam through surveillance and treatment programming.
4. Develop a plan to reduce salt consumption in Guam.
5. Address the sexually transmitted infections problem in Guam through the development of surveillance, awareness, screening, and treatment programming.

World Health Organization
Western Pacific Region

KIRIBATI

3. Demographic and health indicators

Total population (in '000s)	103.5 (2010)
Population proportion under 15 (%)	35.9 (2010)
Life expectancy at birth (male/female)	65.0/70.0 (2009 est)
Under-5 mortality rate per 1000 live births	61.0 (2010)
Antenatal care coverage – at least one visit (%)	n
Birth attended by skilled health personnel (%)	98.3 (2010)
Measles (MCV) immunization coverage among 1-year-olds (%)	89.0 (2010)
Prevalence of raised blood glucose (%)	24.4 (2008)
Estimated smoking prevalence among adults (male/female) (%)	56.5/32.3 (1999)
Human Development Index Rank out of 187	122 (2011)
Per capita GDP (in US$)	1307.4 (2010 est)
Total expenditure on health as % of GDP	12.2 (2009 p)
General government expenditure on health as % of general government expenditure	8.7 (2009 p)
% of population with access to improved sanitation facility	33.0 (2006)

est = estimated
GDP = gross domestic product
n = not available
p = provisional

1. Macroeconomic, political and social context

The Republic of Kiribati is comprised of 33 atolls, 22 of which are inhabited. Kiribati has a two-tier system of government at the central and local levels. The central Government consists of 42 democratically elected members of Parliament, led by the President who is elected from among the members of Parliament. The local level consists of 23 elected and appointed councils. Kiribati has enjoyed political stability since 2003. Major economic activities in Kiribati include fishing and handicrafts. The use of the Australian dollar as domestic currency, access to external assistance and sound fiscal management of the Revenues Equalizing Reserve Funds derived from previous phosphate deposits, allowed achievement of relative macroeconomic stability.

2. Health and Development

Kiribati faces a double burden of disease, with high mortality and morbidity from both communicable and noncommunicable diseases (NCDs). In 2010, the leading causes of death were diseases of the circulatory system; undefined symptoms and signs of illness; endocrine, nutritional and metabolic diseases; and infectious parasitic diseases. The leading causes of morbidity were communicable diseases, respiratory infections, diarrhoeal illness, and eye and skin infections.

High-density housing in urban areas on South Tarawa is facilitating the transmission of infectious diseases. Inadequate water supplies, variable standards of personal hygiene, and poor food handling and storage contribute to the high number of diarrhoeal, respiratory, eye and skin infections. There is a high prevalence of sexually transmitted infections (STIs), and Kiribati has had 54 known HIV cases since 1991.

Economic development and modernization has increased reliance on imported processed food and motorized transport; these changes have led to unhealthy diet and reduced physical activity. Kiribati's *STEPwise Approach to Chronic Disease Risk Factor Surveillance* (STEPS) survey report showed that in 2006, in the adult population aged 25–64 years, the prevalence of obesity was 50.6%, prevalence of hypertension was 17.3%, prevalence of diabetes was 28.1% and prevalence of elevated blood cholesterol was 27.7%.

Kiribati has a well-established, publicly funded formal health system. Comprehensive primary health-care services are offered through a network of 92 health centres and dispensaries. A referral hospital in South Tawara provides a range of secondary curative services. Other hospitals are operational in Kiritimati and North Tabiteuea Island and provide basic surgical, medical and maternity services. People requiring tertiary curative services are referred overseas.

4. Opportunities

- Renewed interest by donor partners to support the health sector
- Increased political attention to address the NCD crisis and achieve Millennium Development Goals 4 (Reduce Child Mortality), 5 (Improve Maternal Health) and 6 (Combat HIV/AIDS, Malaria and other diseases)
- Acknowledgement of unabated population growth as a hindrance to socioeconomic development
- Government commitment to progress elimination of lymphatic filariasis and leprosy

Challenges

- Geographical Isolation with widely dispersed populations poses logistical challenges with limited means of transport and communications
- Aging workforce in the health sector and insufficient output to keep up with attrition
- Unsustainable health-care financing
- Vulnerability to climate change

6. Sector Coordination and Partnerships

Recently a formal Health Sector Coordination Committee was established. The health sector is dependent on considerable development assistance. The United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) are providing support for the Expanded Programme on Immunization (EPI), child nutrition, HIV Prevention of Parent-to-Child Transmission (PTCT) sanitation, and reproductive health. The Government of Australia is showing an increased interest in upgrading of infrastructure and human resource development in Kiribati. Also, New Zealand is intensifying its support for water supply and waste management, including health-care waste, and in upgrading of the training curriculum for nurses. The Secretariat of the Pacific Community (SPC), through Global Fund to Fight AIDS, Tuberculosis and Malaria is supporting the tuberculosis programme. Kiribati as has a European Union-funded programme to address NCDs. The government of Cuba is deploying a Medical Brigade filling gaps in specialised services and is presently training 30 I-Kiribati medical students in Havana. The Japanese International Cooperation Agency is supplementing hospital staff in the referral hospital. WHO coordinates health sector cooperation to develop national health-care plans.

5. Summary of the National Health Policy, Strategy or Plan

The strategic objectives set out in the National Development Plan for the period 2012-2015 guide the formulation of the annual operational plans of the Ministry of Health and Medical Services; the strategic objectives for the MHMS for the period 2012–2015 are to:

- Increase access to and use of high quality, comprehensive family planning services, particularly for vulnerable populations including women whose health and wellbeing will be at risk if they become pregnant;
- Improve maternal, newborn and child health;
- Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks;
- Strengthen initiatives to reduce the prevalence of risk factors for NCDs, and consequently reduce morbidity, disability and mortality from NCDs;
- Address gaps in health service delivery and strengthen the pillars of the health system; and
- Improve access to high quality and appropriate health care services for victims of gender based violence, and services that specifically address the needs of youth.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Kiribati to:

1. Address the burden of NCDs and their risk factors, including the over-consumption of alcohol, food insecurity, physical inactivity and tobacco use through implementation of the national Crisis Response Package.
2. Address communicable diseases, such as STIs, HIV and tuberculosis, as well as eliminate lymphatic filariasis and leprosy.
3. Strengthen maternal, adolescent and child health programmes with focus on family planning and immunization and to continue support of the Kiribati Adolescent Girls Initiative.
4. Strengthen the health system by improving the health information and data quality system, and systems monitoring and evaluation.
5. Develop a national health plan that addresses gaps in service delivery. A health financing and national health workforce plan will be a major component and will include the education and training of health workers, as well as to facilitate integration of foreign medical graduates in the national health services.

World Health Organization
Western Pacific Region

THE MARSHALL ISLANDS

1. Macroeconomic, political and social context

The Marshall Islands covers an area of 181 square kilometers in the Pacific Ocean and is comprised of 29 atolls and five major islands. The Marshall Islands are governed by a President elected from among members of the Marshallese Congress and a legislature elected through popular vote. Major economic activities in the Marshall Islands include agriculture, copra, tuna processing and tourism. The United States Government provides direct aid to the Marshall Islands. Government assistance from the United States of America is the mainstay of the economy. Current surveys and socioeconomic indicators suggest that poverty and hardship are on the rise.

2. Health and Development

High population growth and crowded conditions in urban areas have caused the re-emergence and/or rise of certain communicable diseases, such as tuberculosis and leprosy. In addition, a sedentary lifestyle and processed foods have brought about a rise in levels of adult obesity and noncommunicable diseases (NCDs). Diabetes-related diseases and cancer are now leading causes of death. The leading causes of morbidity include child birth-related conditions, pneumonia and diabetes. Sepsis, malnutrition, pneumonia, drowning and prematurity were the major causes of infant mortality, while severe malnutrition, bacterial meningitis, gastroenteritis, and pneumonia accounted for most childhood mortality.

The vast majority of health services are provided by the Government, as there are only a small number of private providers. The United States Government supports the provision of health- care services, through the 177 Health Care Plan, to Marshallese citizens affected by the nuclear tests conducted from 1946–1958, and their descendants. The Government focuses on training native Marshallese health professionals, strengthening community health-care programmes, upgrading the quality of health-care services and improving the dissemination of health-care information to its citizens. There are two hospitals and 58 health centers in the Marshall Islands. According to estimates from 2010, the health worker-to-population ratio in the Marshall Islands was 1:1695 for doctors, 1:474 for nurses and 1:14 286 for dentists.

3. Demographic and health indicators

Total population (in '000s)	54.4 (2010est.)
Population proportion under 15 (%)	42.0 (2010)
Life expectancy at birth (male/female)	58.0/60.0 (2009)
Under-5 mortality rate per 1000 live births	28.0 (2010)
Antenatal care coverage – at least one visit (%)	2.0 (2004-2007)
Birth attended by skilled health personnel (%)	99.0 (2010)
Measles (MCV) immunization coverage among 1-year-olds (%)	90.2 (2010)
Prevalence of raised blood glucose (%)	28.7 (2008)
Estimated smoking prevalence among adults (male/female) (%)	36.0/6.0 (2002)
Human Development Index Rank out of 187	n (2011)
Per Capita GDP (in US$)	2,851 (2007)
Total expenditure on health as % of GDP	16.5 (2009 p)
General government expenditure on health as % of general government expenditure	20.1 (2009p
% of population with access to improved sanitation facility	73.0 (2008)
% of population with access to improved drinking water source	94.8 (2008)

est = estimated
GDP = gross domestic product
n = not available
p = provisional

4. Opportunities

- Increased awareness of the NCD crisis
- The ongoing burden of communicable diseases, such as leprosy and tuberculosis, has led to increased focus and funding to these areas
- New donors are showing interest in supporting health and development

Challenges

- High staff turnover and migration
- Low human resource capacity
- Quality and use of health information data
- Multiplicity of donors with parallel reporting requirements
- Geographic isolation and related logistical challenges

6. Sector Coordination and Partnerships

There are no formal mechanisms for health sector coordination in the Marshall Islands. Key inputs are coordinated by the Ministry of Health Planner. Key partners in the health sector include United States Department of the Interior; United States Department of Health and Human Services, particularly the United States Centers for Disease Control and Prevention; the United States Department of Energy, the "177" nuclear health programme sites; Taiwan, China; WHO; the United Nations Population Fund (UNFPA); the United Nations Children's Fund (UNICEF); Canvasback Missions Inc.; and several local nongovernmental organizations.

5. Summary of the National Health Policy, Strategy or Plan

The Marshall Islands *Ministry of Health National Strategic Plan (NSP)* for 2012–2014 is a three-year revolving plan (i.e., it is intended to be updated annually, always covering the following three-year period). Major goals of the NSP are to:

- Support the development of the Healthy Islands concept in promoting healthy behaviours and changing lifestyle habits;
- Address health issues related to infectious diseases and reproductive health;
- Coordinate the care of women, infants, children, adolescents and their families;
- Educate and promote health-care services to hard-to-reach communities including outer islands and atolls
- Provide a comprehensive mental health programme;
- Ensure better access to essential medicines and ensure that patients are receiving the best possible rehabilitation services; and
- Ensure effective management and administration of human and financial resources in the Ministry of Health.

In working into the future, the Ministry of Health takes into account the national goals and objectives as stated in the vision of the *2018 Strategic Development Plan Framework*.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of the Marshall Islands to:

1. Address the prevention and control of NCDs, including implementation of national tobacco regulations; mental health and legislative frameworks for food quality, safety and enforcement capacities; and improving community awareness about healthy eating and lifestyles.
2. Strengthen surveillance for vaccine-preventable diseases, delivery of immunizations and capacity-building of mid-level Expanded Programme on Immunization (EPI) managers, as well as strengthen means to prevent communicable diseases, including climate change- related issues such as improved drinking-water safety planning and rainwater harvesting, as well as household and community-based water-quality monitoring.
3. Strengthen the coordination of care for maternal and child health and reproductive health.
4. Strengthen the pharmaceutical sector through development and monitoring the national medicines policy and pharmaceutical strategic plan, with an emphasis on increasing access.
5. Scale up health workforce production, improving performance, and reduce imbalances in skill mix and distribution with a focus on reaching areas with limited access.

World Health Organization
Western Pacific Region

THE FEDERATED STATES OF MICRONESIA

1. Macroeconomic, political and social context

The Federated States of Micronesia is comprised of four main island groups with over 600 volcanic Islands and atolls scattered over 1.5 million square kilometers of the Pacific Ocean. The Federated States of Micronesia is a constitutional federation of four states: Chuuk, Pohnpei, Yap and Kosrae. 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. The Federated States of Micronesia is governed by a President who is elected by Congress from among the four senators. The Federated States of Micronesia is in free association with the United States of America. Major economic activities in The Federated States of Micronesia include tourism, construction and fish processing. There has been slow growth of the private sector, and geographical isolation and a poorly developed infrastructure remain major impediments to long-term growth.

2. Health and Development

The overall health situation remained unchanged between 2000 and 2009, with the population showing continuing susceptibility to both communicable and noncommunicable diseases (NCDs). In 2006, the leading causes of death were due to endocrine- and nutrition-related diseases, metabolic diseases (e.g., diabetes mellitus), diseases of the respiratory system (e.g., chronic obstructive pulmonary disease), and diseases of the circulatory system. The leading causes of morbidity include diseases of the respiratory system, diseases of the circulatory system, and infectious and parasitic diseases. The Federated States of Micronesia's (Pohnpei and Chuuk's) *STEPwise Approach to Chronic Disease Risk Factor Surveillance Survey* reports showed that in 2002 and 2006 respectively, in the adult population aged 25–64 years, the prevalence of obesity was 42.6% and 47.3%, prevalence of hypertension was 21.2% and 15.2%, prevalence of diabetes was 32.1% and 35.4%, and prevalence of elevated blood cholesterol was 46.6% and 19.2%, respectively. The number of vaccine-preventable diseases has declined considerably. However, waterborne and foodborne diseases are major causes of hospital admission. There have been sporadic outbreaks of zika virus, dengue fever and hepatitis A in recent years, and multidrug-resistant tuberculosis (MDR-TB) has been detected. Leprosy is still highly prevalent. Sexually transmitted infections (STIs) are hyper-endemic.

Each state government maintains its own health services with 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 state governments, except in the private clinics. According to data collected in 2005, the health worker-to-population ratio was 1:1852 for doctors, 1:498 for nurses and 1:9091 for dentists.

3. Demographic and health indicators

Total population (in '000s)	102.6 (2010 p)
Population proportion under 15 (%)	35.7 (2010 p)
Life expectancy at birth (male/female)	68.0/70.0 (2010 est)
Under-5 mortality rate per 1000 live births	39.0 (2009)
Antenatal care coverage – at least one visit (%)	80 (2009)
Birth attended by skilled health personnel (%)	100.0 (2009)
Measles (MCV) immunization coverage among 1-year-olds (%)	92.0 (2011)
Prevalence of raised blood glucose (%)	15.60 (2008)
Estimated smoking prevalence among adults (male/female) (%)	30.0/18.0 (2002)
Human Development Index Rank out of 187	116 (2011)
Per capita GDP (in US$)	2,223.00 (2008)
Total expenditure on health as % of GDP	13.8 (2009 p)
General government expenditure on health as % of general government expenditure	20.6 (2009)
% of population with access to improved sanitation facility	25.0 (2006)
% of population with access to improved drinking water source	95.00 (urban, 2008)

est = estimated
GDP = gross domestic product
n = not available
p = provisional

4. Opportunities

- Mobilization of resources from development partners to control and prevent NCDs
- Increased focus and funding to communicable diseases such as tuberculosis and leprosy
- Increased interest and commitment from government and development partners for addressing ongoing burden of diseases such as tuberculosis and leprosy

Challenges

- High staff turnover and migration
- Low human resource capacity
- Challenges with reliability of data
- Multiplicity of donors with parallel reporting requirements
- Geographic and logistical challenges

6. Sector Coordination and Partnerships

Overseas development assistance is coordinated primarily through the Federated States of Micronesia Office of Statistics, Budget and Economic Management, and the Overseas Development Assistance and Compact Management (SBOC); while specific health inputs are coordinated by the Assistant Secretary for Health. WHO chairs the Health Partners' Group, which meets regularly.

5. Summary of the National Health Policy, Strategy or Plan

The Federated States of Micronesia Strategic Development Plan 2004–2023 included the strategic aims of the Department of Health and Social Affairs. The main objectives are:

- To improve primary and secondary health care, and public and preventive health services, including national environmental health, food and water sanitation;
- To improve maternal and child health, as well as immunization and family planning coverage;
- To prevent and control diabetes, cancer and other NCDs, as well as address NCD risk factors, such as high consumption of unhealthy foods, substance abuse and tobacco use; prevent injuries and improve mental health services;
- To prevent and treat tuberculosis, leprosy, HIV/AIDS, STIs and other endemic infectious diseases, as well as improve disease surveillance and outbreak response including hospital preparedness;
- To effectively and efficiently provide leadership roles in reviewing, developing, directing and guiding policies related to national health issues; and to improve management skills in health care settings and sustain and build relationships with health partners.

7. Strategic priorities for collaboration between WHO and the Government from 2013 to 2017

WHO in coordination with development partners will provide support to the Government and people of the Federated States of Micronesia to:

1. Develop policies, strategies and action plans to address NCDs, particularly the *WHO Package of Essential NCDs Interventions (PEN)*, food security and *WHO Framework Convention on Tobacco Control*; promote mental health; reduce road traffic accidents and other injuries; and mitigate the impact of permanent disabilities.
2. Improve capacity to address vaccine-preventable diseases; prevent and control leprosy; implement and monitor tuberculosis case-finding, and enhance implementation of surveillance and monitoring of all communicable diseases of public health importance.
3. Strengthen management, planning and interagency collaboration for environmental health, water and sanitation; develop and implement multisectoral state policies, plans of action, strategies and regulations on food security, including nutrition and food safety, and on climate change.
4. Develop the health workforce by increasing the pool of prospective health workers, improve the skills and acceptance of current workforce skill mix and distribution; and increase the pool of prospective health workers through supporting the education and training of health workers, as well as in workforce management in collaboration with key stakeholders such as professional associations.

World Health Organization
Western Pacific Region

NAURU

1. Macroeconomic, political and social context

Nauru is an island nation located in the South Pacific. Nauru is governed by a President elected by the Parliament, who is both the head of state and Government. The Parliament is elected by popular vote every three years. The major economic activity in Nauru is phosphate mining, but reserves are declining. Coconut, banana and papaya are the main fruit crops and small quantities of vegetables are also grown. However, most food and water in Nauru is imported from Australia and other countries, such as China. Nauru has been without banking services since 1998.

2. Health and Development

As a result of an effective public health programme focusing on water and sanitation, there have been no recent infectious disease outbreaks. Noncommunicable diseases (NCDs), such as diabetes, hypertension and obesity have become the leading causes of morbidity and mortality in Nauru. Nauru's *STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS)* survey report showed that in 2004, in the adult population aged 25–64 years, the prevalence of obesity was 58.1%, prevalence of hypertension was 17.2%, prevalence of diabetes was 22.7%, and prevalence of elevated blood cholesterol was 20.8%.

Nauru Hospital offers a number of medical and surgical specialties including laboratory, radiological and pharmaceutical services. According to estimates from 2011, the health worker-to-population ratio in Nauru was 1:1000 for doctors, 1:162 for nurses and 1:10 000 for dentists.

3. Demographic and health indicators

Total population (in '000s)	9.7 (2011)
Population proportion under 15 (%)	35.6 (2010 est)
Life expectancy at birth (male/female)	52.5/58.2 (2010 est)
Under-5 mortality rate per 1000 live births	2.6 (2011)
Antenatal care coverage – at least one visit (%)	98.7 (2011)
Birth attended by skilled health personnel (%)	100 (2011)
Measles (MCV) immunization coverage among 1-year-olds (%)	100.0 (2010)
Prevalence of raised blood glucose (%)	12.50 (2008)
Estimated smoking prevalence among adults (male/female) (%)	47.0/54.0 (2004)
Human Development Index Rank out of 187	n (2011)
Per capita GDP (in US$)	2,071 (2006-2007)
Total expenditure on health as % of GDP	10.9 (2009 p)
General government expenditure on health as % of general government expenditure	18.5 (2009 p)
% of population with access to improved sanitation facility	50.0 (2008)
% of population with access to improved drinking water source	90.0 (2008)

est = estimated
GDP = gross domestic product
n = not available
p = provisionalt

4. Opportunities

- Clear evidence and data of disease prevalence, as the basis for developing strategies, plans and policies and further data utilization
- Government's commitment to prevent and control NCDs due to the ongoing crisis
- Substantial support from development partners and United Nations and regional agencies

Challenges

- Shortage of health professionals
- Inequity regarding social determinants, including like gender disparity
- Vulnerability due to its isolation and limited transportation of goods and services to and from the country

6. Sector Coordination and Partnerships

Under the Principles of Aid Effectiveness of the Paris Declaration, the Ministry of Health of Nauru has partnerships with WHO, the Australian Agency for International Development, the Secretariat of the Pacific Community, the United Nations Children's Fund (UNICEF), the University of the South Pacific, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, among others.

5. Summary of the National Health Policy, Strategy or Plan

The *Nauru National Sustainable Development Strategy 2005–2025* has set up a strategic framework under the goal: "A future where individual, community, business and Government partnerships contribute to a sustainable quality of life for all Nauruans." Regarding health, Nauru has committed to:

- A range of Millennium Development Goals, which were, included as high-level outcomes in the Ministry of Health's Operational Plan.
- Provision of effective prevention and control of clinical and preventive health services such as those to treat, screen for and reduce NCDs according to the *Nauru National NCD Action Plan*.
- Meet requirements of the conventions of United Nations, such as the W*HO Framework of Convention on Tobacco Control (FCTC)*, the International Convention on Population Development, the Convention on the Rights of the Child, etc.
- Improvement of the health information, health human resource development, and medicinal and equipment management systems.

7. Strategic priorities for collaboration between WHO and the Government from 2013 to 2017

WHO in coordination with development partners will provide support to the Government and people of Nauru to:

1. Prevent and control NCDs, especially overweight, obesity and diabetes through areas of focus identified in the national Crisis Response Package, such as an improved food control system; the *WHO Package of Essential NCD Interventions* (PEN), and other measures to control NCD risk factors, such as progress to meet the requirements of the FCTC.
2. Focus on progressing towards the Millennium Development Goal targets, focusing on improving maternal and child health, including measles elimination.
3. Strengthen the health information system, the laboratory services system, and develop the *National Medicines Policy* to improve the rational use of medicines.
4. Formulate a human resource policy to strengthen the health workforce, including facilitating the integration of foreign medical graduates into the national health services and enhancing education and development opportunities.

World Health Organization
Western Pacific Region

NEW CALEDONIA

1. Macroeconomic, political and social context

New Caledonia is an archipelago consisting of one main island, Grande-Terre, and several smaller islands. The population is composed of 42% Melanesians, 37% Europeans, 8% Wallisians, 4% Polynesians and 9% other nationalities. Over 57% of the population in 2010 lived in urban areas of New Caledonia.

New Caledonia is a French overseas territory. New Caledonia has a three-tiered administrative system: the French State, the Congress of New Caledonia and the Provincial Assemblies. The President of the Government of New Caledonia is elected by the members of Congress of New Caledonia. Major economic activities include nickel mining, cattle and deer, shrimp farming, fishing, forestry, agriculture and tourism. Food represents about 20% of imports.

2. Health and Development

Noncommunicable diseases (NCDs) constitute a major health burden, with cardiovascular disease, diabetes and cancers being the most common. Communicable diseases remain a public health problem in New Caledonia. Common infections include acute respiratory infections, including pneumonia, diarrhoeal diseases, sexually transmitted infections (STIs), including HIV, and rheumatic heart disease. Dengue and leptospirosis are endemic and epidemic in the country. The leading causes of mortality in 2010 were tumours, diseases of the circulatory system, and traumatic injuries and poisonings. The leading causes of morbidity were obstetric, orthopaedic and digestive conditions.

The significant improvement of the health of the population in recent years can be attributed to economic growth of New Caledonia and the quality of health-care coverage, as well as the establishment of programmes for health promotion and disease prevention. The entire population has access to health services and the social welfare system also covers the entire population. There are seven medico-social centres, 19 medical centres and four specialized medical centres based in Noumea. According to estimates from 2011, the health worker-to-population ratio in New Caledonia was 1:450 for doctors, 1:222 for nurses and 1:2041 for dentists.

3. Demographic and health indicators

Total population (in '000s)	245.6 (2009 p)
Population proportion under 15 (%)	26.4 (2009 est)
Life expectancy at birth (male/female)	71.8/80.3 (2007)
Under-5 mortality rate per 1000 live births	9.1 (2002)
Antenatal care coverage – at least one visit (%)	n
Birth attended by skilled health personnel (%)	92.0 (2005)
Measles (MCV) immunization coverage among 1-year-olds (%)	99.0 (2010)
Prevalence of raised blood glucose (%)	n
Estimated smoking prevalence among adults (male/female) (%)	28.0/34.0 (1992)
Human Development Index Rank out of 187	n (2011)
Per capita GDP (in US$)	36,758 (2008)
Total expenditure on health as % of GDP	9.5 (2008)
General government expenditure on health as % of general government expenditure	n
% of population with access to improved sanitation facility	n
% of population with access to improved drinking water source	n

est = estimated
GDP = gross domestic product
n = not available
p = provisional

4. Opportunities

- New Caledonia has autonomy to set its own public health policy
- Health system adapted to health needs of the population acting in various areas of intervention, ranging from primary care, specialty care, prevention and health research
- Development of new information technologies and communication

Challenges

- Triple burden of NCDs, communicable diseases and environmental hazards
- Ageing population
- Ensuring that the link between care, prevention and user accountability is considered in planning for health

6. Sector Coordination and Partnerships

In addition to its direct link with the French Government, the Department of Health and Social Affairs works closely with its partners. The Secretariat of the Pacific Community (SPC) and WHO are the main development partners in the health sector. New Caledonia is committed to implement various global health initiatives, such as the International Health Regulations (2005) and the Stop TB programme.

5. Summary of the National Health Policy, Strategy or Plan

The Government has endorsed the "Health for All" principle, and primary health care is one of the priorities set by health offices in all three provinces. In an effort to achieve qualitative and quantitative improvements in health care, the main elements of the health strategy are:

- prevention of communicable diseases through immunization,
- improvement of health, housing and environment through health education, and
- NCD control through programmes of prevention and screening.

7. Strategic priorities for collaboration between WHO and the Government from 2013 to 2017

WHO in coordination with development partners will provide support to the Government and people of New Caledonia to:

1. Prevent and control NCDs through policy and other intervention approaches identified in the national Crisis Response Package.
2. Strengthen surveillance and control of communicable diseases, particularly vaccine-preventable diseases, through efforts such as capacity-building of mid-level epidemiology managers.
3. Attain the regional Hepatitis B control goal, achieve the regional goal of measles through high routine immunization coverage or supplementary immunization activities (SIAs) and assist in the process of the verification for measles elimination, and continue the Stop TB programme.
4. Develop national and intercountry capacity to prevent and manage events that threaten safety, such as environmental hazards and natural disasters.

World Health Organization
Western Pacific Region

NIUE

1. Macroeconomic, political and social context

Niue is an island covering 260 square kilometres in the South Pacific. Niue is a self-governing country in free association with New Zealand. Niue's population is one of the smallest in the world and has continued to decrease over the past five decades. Niue is governed by a Premier elected by the Legislative Assembly, which is elected by popular vote. Major economic activities in Niue include handicrafts, food processing, agriculture, fishing and tourism. With around 400 employees, the Public Service remains the dominant employer on the island. Outward migration, averaging some 50 people annually since 2001, is the major reason for the state's population decline.

2. Health and Development

In Niue, common childhood illnesses and traditional communicable diseases, such as tuberculosis and leprosy, have been substantially contained. The lymphatic filariasis elimination programme is ongoing, with high coverage (88.05% among the total population at risk) through mass drug administrations. No case of HIV/AIDS has been reported and reports of sexually transmitted infections are rare. Niue has good maternal and child health care, with no maternal death recorded from 1999 to 2010. Immunization coverage is 100%.

Lifestyle-related health problems are increasing and the prevalence of risk factors for chronic diseases is high. The leading causes of death in Niue were heart disease, cancer and senility in 2009, while the leading causes of morbidity were hypertension, diabetes, skin infections and respiratory infections, according to data collected in 2001.

The Moui Olaola Project, a Healthy Islands health-promotion project, was launched in 1996, and Niue is committed to both the Healthy Islands programme and the Tobacco Free Initiative. Community outreach through village visits by public health nurses and regular village inspections by public health officers maintains good health-care coverage. According to data collected in 2008, the health worker-to-population ratio was 1:388 for doctors and 1:119 for nurses.

3. Demographic and health indicators

Total population (in '000s)	1.5 (2010 est)
Population proportion under 15 (%)	25.7 (2010 est)
Life expectancy at birth (male/female)	67.0/76.0 (2001-2006)
Under-5 mortality rate per 1000 live births	0.0 (2011)
Antenatal care coverage – at least one visit (%)	100 (2006)
Birth attended by skilled health personnel (%)	100
Measles (MCV) immunization coverage among 1-year-olds (%)	100 (2010)
Prevalence of raised blood glucose (%) (for 5 or more years)	13.7
Estimated smoking prevalence among adults (male/female) (%)	21
Human Development Index Rank out of 187	n (2011)
Per capita GDP (in US$)	8,208.20 (2006)
Total expenditure on health as % of GDP	16.9 (2009 p)
General government expenditure on health as % of general government expenditure	15.8 (2009 p)
% of population with access to improved sanitation facility	100 (2008)
% of population with access to improved drinking water source	100

est = estimated
GDP = gross domestic product
n = not available
p = provisional

4. Opportunities

- Government will and commitment to health
- Qualified, motivated health workers
- Accessible population
- Established Healthy Islands programme
- 100% immunization coverage

Challenges

- Emigration
- High incidence of noncommunicable diseases (NCDs)
- Low health worker retention
- Isolation
- Languishing effects of Cyclone Heta
- Health-care financing

6. Sector Coordination and Partnerships

Niue's principle health partners are NZ MFAT, PITIC, the Counties Manukau District Health Board, SPC, UNFPA, UNICEF and WHO. The NNSP 2011–2021 includes a proposed sector coordination process to identify priorities, promote collaboration between health partners, identify common survey instruments and encourage rationalized reporting. The work of all development partners is coordinated through an evolving mechanism under the Niue Department of Health. Regular coordination meetings will provide continual input to the NNSP implementation process and a biannual country support plan.

5. Summary of the National Health Policy, Strategy or Plan

The *Niue National Strategic Plan (NNSP)* for 2009–2013 covers all sectors as the strategic framework to develop a prosperous Niue. There are five pillars, and health is included under three: financial stability, economic development and social (development).

The *Niue Strategic Health Plan 2011–2021* was produced in close collaboration with New Zealand Ministry of Foreign Affairs and Trade (NZ MFAT), Pacific Islands Trade & Investment Commission (PITIC), Counties Manukau District Health Board, the Secretariat of the Pacific Community (SPC), the United Nations Population Fund (UNFPA) and WHO. The vision of the NNSP is for "a healthy population, well supported by quality health services". Implementation of the NNSP is focused on strategic direction and leadership, delivery of health services, the health workforce, health information, health financing and ensuring value for money. Its strategic actions are linked to the key objectives of the NNSP and based on the findings of the 2011 Niue Health Sector Needs Assessment.

A robust monitoring and evaluation framework to monitor progress towards the targets is measured against 21 core indicators. Targets for the health sector and its partners are consistent with the NNSP and will enable monitoring of progress.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Niue to:

1. Strengthen NCD prevention and control through implementation of the national Crisis Response Package, which includes improving food standards, social marketing to reduce risk factors for NCDs, and implementing the *WHO Package of Essential NCD Interventions* (PEN).
2. Strengthen the syndromic surveillance and response and its expansion to cover outer islands, focusing on Hepatitis B, measles and other communicable diseases.
3. Address climate change related health issues, including diarrhoeal and respiratory diseases, food security and safety, and traumatic injuries.
4. Improve the quality of safety of laboratory services, as well as implement and monitor the *National Medicines Policy and Pharmaceutical Strategic Plan.*
5. Strengthen the health information system, particularly with regards to policy and strategy development and improving quality of data.
6. Formulate a human resource policy to facilitate the integration of foreign-trained medical graduates into the national health services and continue the education and training of health workers, including continuing professional development.

World Health Organization
Western Pacific Region

THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

1. Macroeconomic, political and social context

The Commonwealth of the Northern Mariana Islands comprises 14 islands with a total land area of 457 square kilometres, spread out over 683 760 square kilometres in the Northern Pacific Ocean. The Northern Mariana Islands is a commonwealth in political union with the United States of America. The chief of state is the President of the United States of America, while the Northern Mariana Islands is led by a Governor who is the head of Government and is elected by popular vote every four years. The major economic activities in the Northern Mariana Islands are construction, fishing, garment manufacturing, tourism and handicrafts.

2. Health and Development

The leading causes of death in the Northern Mariana Islands are cancer, stroke, respiratory disease and heart disease. Infectious diseases such as tuberculosis, enteric food borne illnesses, vaccine-preventable diseases, and HIV and other sexually transmitted infections are still a public health concern. Improvement has been made in reducing the infant mortality rate due in part to a maternal and child health programme supported by the United States Department of Health and Human Services (DHHS); the programme provides primary and preventive health-care services for mothers and children, including children with special health-care needs.

There is one public hospital and five private hospitals in the Northern Mariana Islands, six private outpatient clinics, two district or first referral hospitals, and one primary health-care centre. However, there has been a recent privatization of health services in all of the Northern Mariana Islands. According to data collected in 2008, the health worker-to-population ratio was 1:2793 for doctors, 1:548 for nurses, and 1:43478 for dentists.

3. Demographic and health indicators

Total population (in '000s)	63.1 (2010 est)
Population proportion under 15 (%)	26.3 (2010 est)
Life expectancy at birth (male/female)	74.3/79.7 (2010 est)
Under-5 mortality rate per 1000 live births	n
Antenatal care coverage-at least one visit (%)	n
Birth attended by skilled health personnel (%)	n
Measles (MCV) immunization coverage among 1-year-olds (%)	93.0 (2010)
Prevalence of raised blood glucose (%)	n
Estimated smoking prevalence among adults (male/female) (%)	n
Human Development Index Rank out of 187	n
Per capita GDP (in US$)	12,638 (2005)
Total expenditure on health as % of GDP	n
General government expenditure on health as % of general government expenditure	25.4 (2007)
% of population with access to improved sanitation facility	98.0 (2008)
% of population with access to improved drinking water source	n

est = estimated
GDP = gross domestic product
n = not available

4. Opportunities

- Extensive range of health and development partners
- Grant and research funding available

Challenges

- Increasing cost of health care
- Retention of human resources for health
- Geographic isolation
- Limited data infrastructure

6. Sector Coordination and Partnerships

The DOPH recognizes the need for partnerships with various governmental and private agencies, non-profit organizations and other organizations (on island, regionally and internationally) to sustain and build effective health-care programmes and services. Key partners both on island and abroad include, among others: the public school system; Northern Marianas College; the Department of Community and Cultural Affairs; the Department of Commerce; the Workforce Investment Agency; the Developmental Disabilities Council; Karidat; the Ayuda Network Inc.; the Commonwealth Cancer Association; the Diabetes Coalition; NAPU Life; the Substance Abuse Prevention Coalition (SAPC); the University of Hawaii, John A. Burns School of Medicine—Area Health Education Center (AHEC) and Maternal and Child Health Certificate Program through the Health Resources and Services Administration (HRSA); Western Michigan University (Project Familia); the Secretariat of the Pacific Community (SPC); WHO; the Pacific Islands Health Officers Association (PIHOA); the United States Centers for Disease Control and Prevention (CDC); HRSA; the Pacific Substance Abuse and Mental Health Collaborating Council (PSAMHCC); the Pacific Islands Mental Health Network (PIMHnet); the National Prevention Network (NPN); the National Asian Pacific American Families Against Substance Abuse Inc. (NAPAFASA).

5. Summary of the National Health Policy, Strategy or Plan

The mission of the Department of Public Health (DOPH) is "to provide compassionate, quality health care and promote health for all people in the Northern Mariana Islands." To guide prioritization in attaining its stated mission, the DOPH plans to deliver the best possible health care by improving its financial stability.

Highest priority has been placed on goals that can be attained relatively quickly within the current resources of the DOPH, including:

- movement towards more autonomy for the Commonwealth Health Center (CHC) in the areas of operations, supply chain and finance (overarching goal);
- installation of a new hospital information system and financial management programme (VISTA—a programme through the Veteran's Administration system);
- improvement in billing and processing of collections for CHC to improve revenue and cash flow;
- reform of Medicaid to improve resources available to CHC and on-island medical providers; and
- creation of autonomy in recruitment and retention of DOPH personnel.

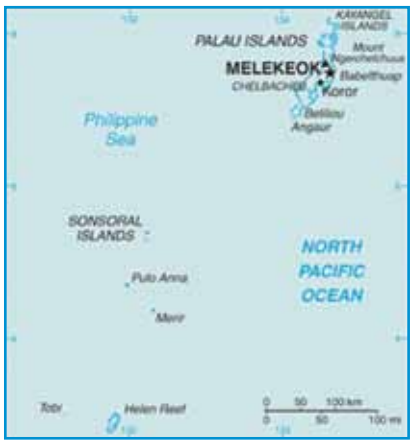
7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Commonwealth of Northern Mariana Islands to:

1. Address the threat of noncommunicable diseases (NCDs) through implementation of the Crisis Response Package (CRP).
2. Continue progress with preventing communicable diseases through maternal, adolescent and child health programmes that include provision of immunizations.
3. Strengthen health systems, which may include supporting health-sector capacity-building to retain health workers through the provision of continuing education and training through Pacific Open Learning Health Net (POLHN).
4. Strengthen health-care financing through development of optimal billing and records systems.

World Health Organization
Western Pacific Region

PALAU



3. Demographic and health indicators

Total population (in '000s)	20.5 (2010 est)
Population proportion under 15 (%)	20.5 (2010 est)
Life expectancy at birth (male/female)	61.3/68.0 (2010)
Under-5 mortality rate per 1000 live births	12.2 (2010)
Antenatal care coverage – at least one visit (%)	90.3 (2010)
Birth attended by skilled health personnel (%)	100.0 (2010)
Measles (MCV) immunization coverage among 1-year-olds (%)	39.0 (2010)
Prevalence of raised blood glucose (%)	n
Estimated smoking prevalence among adults (male/female) (%)	38.0/9.0 (1998)
Human Development Index Rank out of 187	49 (2011)
Per Capita GDP (in US$)	8423.00 (2007)
Total expenditure on health as % of GDP	11.2 (2009 p)
General government expenditure on health as % of general government expenditure	16.7 (2009 p)
% of population with access to improved sanitation facility	n
% of population with access to improved drinking water source	89.0 (2006)

est = estimated
GDP = gross domestic product
n = not available
p = provisional

1. Macroeconomic, political and social context

Palau is a democratic republic consisting of many small islands in the Western Pacific. Palau is divided into 16 states, with 79% of the population residing in the greater Koror urban area. Each state elects its own Governor and Legislature. The President and Vice-President are elected on separate tickets by popular vote. The Council of Chiefs is an advisory body to the President that contains the highest traditional chiefs from each of the 16 states. The Council is consulted on matters concerning traditional laws and customs. Palau is in free association with the United States of America. Major economic activities in Palau include tourism, handicrafts, subsistence agriculture, construction and fishing. The population in Palau is comprised of approximately 69.9% Palauan, 15.3% Filipino and 4.9% Chinese ethnic groups.

2. Health and Development

Like many developing nations, Palau has recently undergone an epidemiological shift from malnutrition and communicable diseases to an increasing burden of noncommunicable diseases (NCDs) such as diabetes, heart disease, obesity and kidney failure. In 2009, the leading causes of death included cardio/cerebrovascular disease, cancer and respiratory disease. The cost of off-island medical referrals, haemodialysis and intensive-care services is placing an inordinate burden on the already low human, material and fiscal resources. As a result, the Ministry of Health spends 55% of its annual budget on the management of NCDs. In 2009, the leading causes of morbidity were diseases of the respiratory, genito-urinary and digestive systems. In 2010, the President of Palau declared a national NCD emergency and further strengthened a multisectoral National Emergency Committee led by the Minister of Health to address the crisis.

A high percentage of health services are supported by grant funds and technical assistance from the Government of the United States of America, in addition to the provision of technical support and limited funding from a number of United Nations agencies. The Belau National Hospital is the main health facility in the country. Four community health centres, known as super dispensaries, are located strategically throughout the country. In addition, four additional satellite dispensaries serve hard-to-reach outlying localities. According to estimates in 2010, the health worker-to-population ratio in Palau was 1:714 for doctors, 1:179 for nurses, and 1:10 000 for dentists.

4. Opportunities

- Increased public and political awareness of the NCD emergency
- Strong political support to address the NCD crisis, including a multisectoral coordination mechanism
- New donors showing interest in supporting health and development in Palau
- Improved financial self-reliance based on a growing tourism sector

Challenges

- High staff turnover and migration
- Low human resource capacity
- Concern with the reliability of data
- Multiplicity of donors with parallel reporting requirements

6. Sector Coordination and Partnerships

Key inputs are coordinated by the Ministry of Health's Office for International Health. In 2011, the Palauan Government established the National Emergency Committee to coordinate the national response to the threat of NCDs. Key partners in the health sector include the United States Department of the Interior; the United States Department of Health and Human Services, particularly the United States Centers for Disease Control and Prevention; Taiwan, China; the World Health Organization; the United Nations Population Fund; the United Nations Children's Fund; and several local nongovernmental organizations.

5. Summary of the National Health Policy, Strategy or Plan

The Palau Ministry of Health produced a strategic planning framework and subsequently, the Bureau of Public Health completed its current strategic plan for 2008–2013. The objectives of the Ministry of *Health Strategic Plan* are to:

- Create an environment conducive to making positive, healthy choices,
- Assist individuals to participate in their own health promotion and maintenance,
- Develop and maintain partnerships for health, and
- Make quality care accessible to people needing restoration to health.

To achieve these objectives, the Bureau of Public Health has developed a series of eight priority thematic areas which support the Bureau's vision which include:

- Creating healthy workplaces
- Reducing Obesity
- Alcohol Abuse
- Tobacco Use
- Injury/Violence
- Depression
- Emerging and re-emerging infections
- Immunization

To address the "chronic disease emergency" caused by NCDs, the government of Palau established the National Emergency Committee to coordinate efforts to respond to the growing threat to the health and well-being of Palauans.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Palau to:

1. Address the declared NCD emergency in Palau through strategic and practical interventions addressing the NCD risk factors, including food insecurity, the harmful use of alcohol, tobacco use and physical inactivity through efforts such as enforcement of the WHO *Framework Convention on Tobacco Control.*
2. Address health burdens, such as injury and violence as well as mental health.
3. Strengthen the surveillance of vaccine-preventable diseases and capacity-building of mid-level Expanded Programme on Immunization managers to achieve the regional goals for vaccine-preventable communicable diseases.
4. Develop a health information system policy and strategy and improve quality of data, with a focus on strengthening the national hospital laboratory and the national medicines and pharmacy strategic plan.
5. Support for response to climate change and health through capacity-building in assessment of health vulnerability and strengthening health sector response to climate change.
6. Scale up health workforce production, improve performance and reduce imbalances in skill mix and distribution through the Pacific Open Learning Health Network (POLHN).

World Health Organization
Western Pacific Region

THE PITCAIRN ISLANDS

1. Macroeconomic, political and social context

The Pitcairn Islands is an overseas territory of the United Kingdom of Great Britain and Northern Ireland and comprises of a group of four islands situated in the South Pacific Ocean, about midway between Peru and New Zealand. Only one island with an area of 46 square kilometres is inhabited. The Pitcairn Islands is governed by a Mayor and Chairman of the Island Council, elected by popular vote. The chief of state is represented by a United Kingdom High Commissioner and Governor. The Governor is represented by a Commissioner who liaises between the Island Council and the Governor. Major economic activities include fishing, postage stamp production, handicrafts, beekeeping and honey production. The United Kingdom provides substantial bilateral aid to the Pitcairn Islands. Residents of the Pitcairn Islands are either self-employed or work for the local government. A scheduled supply boat stops at the inhabited island only once every three months.

2. Health and Development

The leading causes of morbidity in the Pitcairn Islands include diabetes mellitus, cardiovascular disease, allergies and asthma, and accidents. The Pitcairn Islands actively participates in the Pacific Public Health Surveillance Network (PPHSN) and closely monitors communicable diseases. Primary health care is available and accessible to all residents of the Pitcairn Islands. Health care is financed by the United Kingdom Department for International Development. A growing health-related challenge for the Pitcairn Islands is the extension of periods of drought. The health centre is equipped with a well-stocked dispensary and x-ray technology. The health worker-to-population ratio in Pitcairn is 1:52 for the only doctor and 1:52 for the only dental technician.

3. Demographic and health indicators

Population	50.0 (2009)
Population proportion under 15 (%)	n
Life expectancy at birth (male/female)	n
Under-5 mortality rate per 1000 live births	n
Antenatal care coverage – at least one visit (%)	n
Birth attended by skilled health personnel (%)	n
Measles (MCV) immunization coverage among 1-year-olds (%)	n
Prevalence of raised blood glucose (%) (for 5 or more years)	n
Estimated smoking prevalence among adults (male/female) (%)	n
Human Development Index Rank out of 187	n
Per capita GDP (in US$)	n
Total expenditure on health as % of GDP	n
General government expenditure on health as % of general government expenditure	n
% of population with access to improved sanitation facility	100 (2008)
% of population with access to improved drinking water source	100 (2008)

GDP = gross domestic product
n = not available

4. Opportunities

- Economic support from United Kingdom of Great Britain and North Ireland
- Growing tourism, communications and handicraft industries

Challenges

- Isolation
- Decreasing population
- Climate change

6. Sector Coordination and Partnerships

The United Kingdom of Great Britain and North Ireland assists the Pitcairn Government in planning efforts to address economic and societal development, as well as environmental protection. The Pitcairn Islands participates in the WHO's Pacific Syndromic Surveillance System by sending a weekly report by e-mail of the numbers of cases of outbreak-prone syndromes.

5. Summary of the National Health Policy, Strategy or Plan

A national health policy, strategy or plan was not available at time of publication.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of the Pitcairn Islands to:

1. Maintain the syndromic disease surveillance system.
2. Promote healthy living and diets for the prevention and control of noncommunicable diseases (NCDs).
3. Advocate for continued economic support to health care, particularly in the areas of dental and eye health, address climate change and health through capacity-building in the assessment of health vulnerability and strengthening the health sector response to climate change.

World Health Organization
Western Pacific Region

SAMOA

3. Demographic and health indicators

Total population (in '000s)	180.7
Population proportion under 15 (%)	39.2
Life expectancy at birth (male/female)	74.2/71.5
Under-5 mortality rate per 1000 live births	15
Antenatal care coverage – at least one visit (%)	92.7
Birth attended by skilled health personnel (%)	80.8
Measles (MCV) immunization coverage among 1-year-olds (%)	53.6
Prevalence of raised blood pressure	31.0
Prevalence of current tobacco use in adults (%)	27.2
Human Development Index Rank out of 187 (2011)	99
Total expenditure on health as % of GDP	7
General government expenditure on health as % of general government expenditure	12.8
% of population using an improved sanitation facility	94
% of population using an improved drinking-water source	97.7

GDP = gross domestic product

1. Macroeconomic, political and social context

Samoa is a Pacific island state comprised of two main islands, Savaii and Upolu, plus several smaller islands, situated half way between Hawaii and New Zealand. Samoa has a land area of about 2842 square kilometres, with a population of 180 741. Village communities and extended families continue to play a major role in Samoan society. The extended family, or aiga, is the foundation of the fa'a-samoa, or traditional way of life in Samoa. Samoa's gross domestic product (GDP) places it among lower- and middle-income countries and the Human Development Index 2011 ranks Samoa 99 out of 187 countries.

Since its independence from New Zealand in 1962, Samoa has been able to create a stable political environment. Samoa has a Westminster legal system with parliamentary democracy in which the Parliament is elected through universal suffrage every five years, and a Prime Minister and Cabinet manage day-to-day affairs.

Samoa is a small open economy, highly dependent on a narrow resource base that is limited to agriculture, tourism, small-scale manufacturing and fisheries. Its macroeconomic performance is highly dependent on external factors, like other small Pacific island countries, in the form of commodity pricing, crop disease and weather-related shocks. Many Samoans who are resident abroad continue to contribute to their social obligations by sending significant amounts of money to their extended family and church. The remittance from Samoans abroad represents 20% of GDP, which was about US$ 534 million in 2008. Per capita GDP reached US$ 2987.90 in 2008.

2. Health and Development

Noncommunicable diseases (NCDs) are among the leading causes of ill health and death, along with injuries and wounds. Over the past two decades, Samoa has witnessed almost epidemic rises in coronary heart disease, stroke, high blood pressure and mature-onset diabetes. The escalation of NCDs has been linked to changing diets, increased use of tobacco and alcohol, and limited public understanding of the associated health risks. Obesity is the single most serious threat to health in Samoa, contributing to diabetes, cardiovascular disease, hypertension, loss of mobility and premature death from one or many of these causes. Occasional outbreaks of infectious diseases—including typhoid and viral infections—have recently been reported.

The country is concerned about newly emerging diseases and its capacity to protect its population from public health emergencies, such as H1N1 pandemic influenza. The incidence of HIV/AIDS is low, with a total of 22 known cases since 1990. However, evidence indicates high- risk behaviour and poor control of sexually transmitted infections (STIs) among the young men and women. Lymphatic filariasis is endemic in Samoa. The Government is committed to eliminate lymphatic filariasis by 2015; intensive mass drug administration campaigns were carried out annually from 1999 to 2003, and again in 2006, 2008 and 2011. Samoa has nearly attained the Millennium Development Goal of reducing under-5 mortality rate, which fell to 15 per 1000 in 2009 from 42 per 1000 in 1990. However, a high neonatal mortality rate persists: half of the deaths of children under age 5 occur in the first four weeks of life. Samoa suffers from both a shortage of health professionals and a lack of capacity.

6. Sector Coordination and Partnerships

The aid environment is dominated by Australia, China and New Zealand. Aid coordination is a function of the Ministry of Finance's Aid Coordination Division. The Ministry of Finance chairs the Health Programme Steering Committee for the Sector-wide Approach (SWAp), which is comprised of the Australian Agency for International Development, the Ministry of Health, the New Zealand Aid Programme, UNICEF, WHO and the World Bank. The SWAp Health Programme Steering Committee meets every three months and is well attended by the health partners, Government and other partners with an investment in health. There are few other aid coordination forums in the health sector. Most development partners promote an environment conducive to collaboration and coordination. Samoa and America Samoa share experiences from the H1N1 pandemic.

4. Opportunities

- NCDs recognized as greatest challenge
- Reduction in under-5 mortality and reduction in infant mortality
- Free of polio and measles
- Well-functioning TB strategy: Directly observed treatment, short course (DOTS)
- Low reported HIV prevalence
- Health Sector Plan and Monitoring Evaluation Framework

Challenges

- NCDs are a critical health issue and behaviour change related to risk factors is inherently difficult.
- High incidence of chlamydia infection
- High neonatal mortality rate
- Continued outbreaks of infectious diseases
- Less than 90% coverage for childhood immunization and low measles-rubella coverage

5. Summary of the National Health Policy, Strategy or Plan

The Ministry of Health (MOH) is WHO's primary partner in the health sector, with which all health sector activities are aligned and coordinated. All planning is in coordination with the MOH to achieve the results articulated in the *Health Sector Plan 2008–2018,* which is the cornerstone for all health sector development and the reference point for policy, strategy and planning.

A Health Situational Analysis in 2006 identified four critical health challenges: rapidly increasing levels of NCDs and their impact on mortality and morbidity, the health system and the economy; ensuring reproductive and maternal and child health for the long-term health of the community; emerging and re-emerging infectious diseases; and injury as a significant cause of death and disability.

In an effort to develop a response to these challenges, the *Health Sector Plan 2008–2018* was developed in 2006, endorsed in 2008 by the Cabinet and operationalized in 2009. It presents the vision of "a Healthy Samoa", and a mission "to regulate and provide quality, accountable and sustainable health services through people working in partnership".

The six Key Strategic Goals of the *Health Sector Plan 2008–2018* are:

- Health Promotion and Primordial Prevention,
- Quality Health Service Delivery,
- Governance,
- Human Resources for Health and Health System Strengthening,
- Health Financing, and
- Partnership Commitment and Donor Participation and Harmonization.

These six Strategic Goals are reiterated in the *Strategy for the Development of Samoa 2008–2012.*

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Samoa to:

1. Contribute to strengthening health systems to improve equity, universal access, close-to-client care and comprehensive prevention services through strengthening health system development and governance, improving human resources for health, health information systems, health-care financing and quality of health care.
2. Prevention and control of noncommunicable diseases (NCDs) and conditions, including mental health and injuries, physical disabilities and their risk factors by strengthening surveillance and control and prevention of NCDs, developing an enabling environment, prevention of injury, violence and intervention of mental health.
3. Accelerating achievement of the health-related Millennium Development Goals, including control of TB and HIV/AIDS through strengthening reproductive, maternal and child health services, immunization programmes, the prevention and control of HIV/ADS and STIs, TB and other communicable diseases including typhoid fever.
4. Building capacities in responding to and mitigating public health threats and risks posed by emergencies and disasters through strengthening the capacity to respond to emerging diseases and public health events, humanitarian emergencies and health risks associated with climate change and improving food safety and the nutritional aspects of food security.

World Health Organization
Western Pacific Region

SOLOMON ISLANDS

3. Demographic and health indicators

Total population (in '000s)	515.9 (2009)
Population proportion under 15 (%)	40.6 (2009)
Life expectancy at birth (male/female)	64.9/66.7 (2009)
Under-5 mortality rate per 1000 live births	37.0 (2009)
Antenatal care coverage – at least one visit (%)	n
Birth attended by skilled health personnel (%)	86.0 (2007)
Measles (MCV) immunization coverage among 1-year-olds (%)	67.7 (2010)
Prevalence of raised blood glucose (%) (for 5 or more years)	17.7 (2008)
Estimated smoking prevalence among adults (male/female) (%)	n
Human Development Index Rank out of 187	142 (2011)
Per capita GDP (in US$)	1,014.00 (2008)
Total expenditure on health as % of GDP	5.3 (2009 p)
General government expenditure on health as % of general government expenditure	16.8 (2009 p)
% of population with access to improved sanitation facility	n
% of population with access to improved drinking water source	84.2 (2007)

est = estimated
GDP = gross domestic product
n = not available
p = provisional

1. Macroeconomic, political and social context

Solomon Islands is comprised of a group of islands located in the South Pacific. It is classified by the World Bank as a lower middle-income country. Approximately 84% of the population lives in rural areas. Major economic activities include subsistence farming, fishing, mining and timber. Solomon Islands is governed by a Prime Minister elected by the Parliament and a Governor General appointed by the British monarch. The Parliament is elected by popular vote. Since independence in 1978, it has been slow to maximize its development potential. However, economic management is slowly improving. Ethnic conflicts between 1999 and 2003 further hindered economic progress. Following these issues, the Government requested support from neighbouring countries and with collaboration from donor partners in 2003 the Regional Assistance Mission to Solomon Islands assisted in the restoration of law and order and supported modest growth.

2. Health and Development

Despite the scattered low-density population and archipelago geography of Solomon Islands, health services are accessible to most people. Ministry of Health and Medical Services facilities, church-run hospitals and traditional treatments are used. The church provides training for some health workers. Communicable and noncommunicable diseases (NCDs) are both priorities in Solomon Islands. The country is on track to meet Millennium Development Goals 4 (Reduce Child Mortality) and 5 (Improve Maternal Health), however child and maternal mortality rates are still high. The challenge has been made difficult by poor childhood nutrition, which results in the stunted growth of 30% of children under 5 years of age. The burden of NCDs is increasing, with rates of diabetes, overweight and obesity on the rise. The *STEPwise Approach to Chronic Disease Risk Factor Surveillance Survey* report for Solomon Islands showed that in 2006, in the adult population aged 25–64 years, the prevalence of obesity was 32.8%, prevalence of hypertension was 10.7%, prevalence of diabetes was 13.5% and prevalence of elevated blood cholesterol was 24.6%.

The National Malaria and Vector Borne Disease Control Programme has experienced significant success, and the number of cases has decreased considerably with the utilization of an integrated prevention and treatment strategy, including long-lasting insecticidal nets together with new drug and treatment procedures. Tuberculosis detection and cure rates have increased, and the TB programme is on track to meet its MDG targets. There are 13 known cases of HIV/AIDS, but this figure is suspected of being under-reported. Rates for sexually transmitted infections (STIs) are increasing and sexual health and family planning issues are significant. High rates of gender-based and sexual violence have been found nationally. There are 116 primary health care centres, 29 district-level referral hospitals, and 12 general hospitals in Solomon Islands.

4. Opportunities

- Strong social structures and sense of community, extended family and church systems
- Commitment by government and donor partners to the *National Health Strategic Plan*
- Stated government commitment to providing primary health care nationally

Challenges

- High levels of reliance on foreign aid and donor contributions
- Unsustainable economy
- Challenging logistics, transport, geography and political
- High youth population rate and rates of unemployment, gender inequalities, and unequal economic distribution

6. Sector Coordination and Partnerships

The Solomon Islands Sector-wide Approach (SWAp) was introduced in 2008. Major aid donors include bilateral and multilateral donors, as well as church based organizations. Since the SWAp has focused on strengthening core Ministry of Health systems, including planning and budgeting, financial management, the procurement and management of essential medicines, human resources, and the health information system. Through the SWAp process, a joint coordination and review mechanism between MHMS and donor partners has been developed. MHMS meets annually with donor partners to monitor progress at the Joint Annual Performance Review. The Australian Agency for International Development provides the most significant contributions in Solomon Islands. Other MHMS partners include WHO, the European Union; the GAVI Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Japanese International Cooperation Agency; New Zealand Agency for International Development; Taiwan, China; the Secretariat of the Pacific Community; the United Nations; and the World Bank.

5. Summary of the National Health Policy, Strategy or Plan

The Solomon Islands Ministry of Health and Medical Services (MHMS) has developed a *National Health Strategic Plan for 2011–2015*. The plan includes eight substantive and 14 organizational policies. Four policies from each category have been identified for specific focus by the MHMS in the medium term. Under the plan, the MHMS aims to transfer its focus from a medically orientated, hospital-based approach to an intersectoral approach based around primary health care principles. With this new focus it endeavours to lessen the occurrence of vertical programmes, while addressing the social determinants of health, and minimizing risk factors for disease. The plan, which endeavours to increase the efficiency of the MHMS, has a focus on the following areas:

- Improving human resources planning, management and development and improving infrastructure, including better planning and ongoing maintenance of facilities and structural services;
- Developing and supporting cost-effective interventions that address the major disease burdens, enhancing financial management with a focus on improved budgeting, accounting and financial management procedures; and
- The decentralization of decision-making processes to the provinces from the national office is planned with the aim of better engagement with the provincial governments.

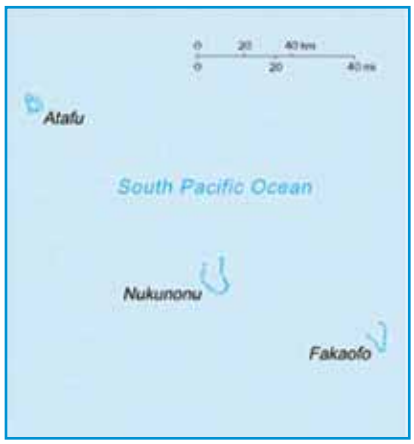
7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Solomon Islands to:

1. Address the emerging NCD burden through addressing lifestyle risk factors, strengthening screening processes, implementing tobacco control legislation, strengthening food control and other health promotion activities.
2. Improve and strengthen the health care system with particular focus on improving maternal and child health; vaccination-based disease elimination goals to eliminate communicable diseases such as measles, and the National Syndromic Surveillance programme.
3. Continue work with the National Malaria and Vectorborne Disease Control Programme.
4. Develop human resources in key areas where there is a capacity gap in Solomon Islands through efforts such as the Fellowship Programme for MHMS staff and facilitating the integration of foreign medical graduates into the national health services.
5. Continue health sector reform, which will include strengthening the National Referral Laboratory and its infrastructure, as well as develop, implement and monitor the National Medicines Policy.
6. Work on the development and implementation of National Health Accounts and identify optimal health-financing options, such as establishing tobacco tax legislation.
7. Continue work on global health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance.

World Health Organization
Western Pacific Region

TOKELAU



3. Demographic and health indicators

Total population (in '000s)	1.41 (2011)
Population proportion under 15 (%)	33.0 (2011)
Life expectancy at birth (male/female)	n
Under-5 mortality rate per 1000 live births	0 (2010)
Antenatal care coverage –at least one visit (%)	100 (2011)
Birth attended by skilled health personnel (%)	100 (2011)
Measles (MCV) immunization coverage among 1-year-olds (%)	100 (2011)
Prevalence of raised blood glucose (%)	33.6 (2005)
Estimated smoking prevalence among adults (%)	43.0 (2011)
Human Development Index Rank out of 187	n (2011)
Per Capita GDP (in US$)	n
Total expenditure on health as % of GDP	n
General government expenditure on health as % of general government expenditure	8.8 (2011–2012 fiscal year)
% of population with access to improved sanitation facility	93 (2010)
% of population with access to improved drinking-water source	97 (2010)

GDP = gross domestic product
n = not available

1. Macroeconomic, political and social context

Tokelau has been a Polynesian Trust Territory of New Zealand since 1925. In 2006 and 2007, national referendums on a Treaty of Self-Government in Free Association with New Zealand were narrowly defeated, keeping Tokelau a Trust Territory. Governance in Tokelau is a General Fono, headed by a Chairperson designated by the Taupulega (atoll) hosting the General Fono of elected representatives from each of three villages. The Council for the Ongoing Government of Tokelau, comprised of the three *Faipule* (elected head of each village) and the three *Pulenuku* (elected mayor of each village) is headed by the *Ulu*, which is rotated between each of the three *Faipule* every year.

Tokelau has a population of fewer than 1500 people (2006 population census) living on three separate atoll communities. There are more Tokelauans living in New Zealand, where most migrate for education, employment and development opportunities. Population decline is about 0.9% per year. The population total of 1466 (Atafu 524, Fakaofo 483 and Nukunonu 426, as well as 33 Tokelauan public servants working at the Tokelau Apia Liaison Office, Apia, Samoa).

Isolation from markets limits economic opportunities and presents challenges for sustainable economic growth and development. Limited natural resources are a key constraint to options for the atolls, except for a very large Exclusive Economic Zone (EEZ) for fishing—one of the best opportunities for national and household income and development.

2. Health and Development

Noncommunicable diseases (NCDs) are a health sector priority. The health services have challenges in public health, primary care, and transport given the geographical isolation and no air services. According to the 2005 *STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS)* survey which included adults age 25-64 years, and the latest figures from the Whole of Population Screening (2010) which included children from 0-15 years of age, NCD risk factors (overweight and obesity) are the biggest threat moving forward.

Immunization coverage is 100% for child immunization. The H1N1 pandemic did not affect Tokelau in part because of its strong immunization programme and good preparedness. There is zero infant and maternal mortality due to early referral.

Screening programmes are in place for early detection and treatment of important health issues. A cervical cancer screening programme was launched in April 2009, and women identified as at risk have been referred and treated. A national breast screening programme was initiated, screening 41% women age under 50 years of age and 59% of women aged 50 years or older by a visiting team of specialists from New Zealand. The team also conducted training with local medical officers and nursing staff on the conduct breast examinations. A mental health review was also carried out by a specialist from New Zealand. *A Whole of Population Screening* in 2010 covered just under 1,000 people. From the survey, a database has been created that includes NCDs and at-risk children.

Health service delivery is via locally employed staff. There is a hospital on each atoll; each with a medical officer, a mix of nursing staff, midwives and hospital aids. In 2011, two eye care technicians will have graduated from the Fred Hollows Foundations. By the end of 2012, Tokelau will have its first nurse practitioner. By the end of 2013, four graduated nurses, a public health registered nurse, and another medical officer will be added to the workforce.

Overall Development plans for the future are to recentralise health and train the Medical Officers to do simple General wraparound surgery (obstetrics, "Lumps, and Bumps," simple orthopaedic, etc.) and have every registered nurse undergo practitioner training.

6. Sector Coordination and Partnerships

The Tokelau Department of Health works closely with its development partners, including the Secretariat of the Pacific Community (SPC), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and WHO to ensure that there is a coordinated approach linking all health needs-based outcomes to the *Tokelau National Strategic Plan 2010–2015*.

4. Opportunities

- Receptive population
- Government will and support
- Strong Department of Health
- Adequate resources and technical assistance

Challenges

- Burden of NCDs and the need for NCD prevention and control
- Limited human resources for health, and training, recruitment and retention
- Isolation and a declining population

5. Summary of the National Health Policy, Strategy or Plan

The vision of the Tokelau Department of Health is "to provide quality health services for the people of Tokelau". The Health Department Draft Strategic Plan 2009–2015 focuses on four values and principles: promotion, prevention, preservation and sustainability. The Health Department plan is directly linked to the *Tokelau National Strategic Plan 2010–2015*.

Tokelau's health sector is well managed and coordinated through the Tokelau Liaison Office in Apia, Samoa and with direct communication to each Taupuleaga and health staff. The Tokelau Department of Health provides support, advice, procurement of pharmaceuticals and equipment, technical assistance, facilitation of workforce training, and development and manages the Tokelau Patient Referral System (TPRS).

The Department of Health has a holistic approach to wellness, which involves the whole person and community. This is reflective of the nature and culture of the three communities, which operate communally.

Our draft national health workforce plan will provide cohesiveness and coherence for the long term health workforce outlook. Long-term objectives of the health sector are decreasing NCDs through Wellness Model, screening activities an increasing our workforce through a whole-of-government, community, and multi-sectoral approach. Funding for more health programmes related to NCDs, climate change, and workforce development and training will remain a priority objective of the health sector.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Tokelau to:

1. Reduce the effects of NCDs through a variety of interventions such as food import control, implementing the *WHO Framework Convention on Tobacco Control (FCTC) and implementing the WHO Package of Essential NCD Interventions (PEN).*
2. Increase health sector focus on climate change, supporting the health sector in implementing health systems strengthening activities to address key climate-sensitive health risks as part of a suite of climate change adaptations in Tokelau.
3. Develop human health resources for the future to ensure qualified staff for Tokelau's three atolls.
4. Create sustainable policies for the retention and development of health workers to maintain adequate levels of staffing in the health programmes.

World Health Organization
Western Pacific Region

TONGA

1. Macroeconomic, political and social context

Tonga is comprised of 36 inhabited islands covering over 740 square kilometers in the South Pacific Ocean. Tonga is a kingdom, governed through a constitutional monarchy. The head of government is the Prime Minister, elected by the Parliament and appointed by the Monarch. Approximately 17 seats in the 26-seat Parliament are elected through popular vote and nine seats are elected from among the country's nobles. Tonga is classified by the World Bank as a lower middle-income country. Major economic activities in Tonga include tourism, agricultural products (which have a rather narrow export base), and a struggling fisheries industry. The recent global recession has negatively affected foreign remittances, tourism and export industries in significant ways. The Government has fully committed itself to addressing these challenges, using the *Tonga Strategic Development Framework* to guide its efforts. Furthermore, Tonga is committed to achieving the Millennium Development Goals (MDGs), which are utilized to monitor the progress of Government strategies in addressing priority socioeconomic and environmental issues that affect the people of Tonga.

2. Health and Development

The MDG report for Tonga in 2010 indicated overall satisfactory progress in the achievement of most of the important priority goals and objectives. However, there are important areas that need strengthening such as noncommunicable disease (NCD) prevention and control, climate change, disaster risk management, family planning and the prevention of sexually transmitted infections (STIs), and funding for health services. The leading causes of death in 2010 were diseases of the circulatory system, diseases of undefined signs or symptoms, and neoplasms. The first *STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS)* survey was conducted in 2004 and the second-round STEPS survey was under way in 2012.The *Hala Fononga Strategy to Prevent and Control NCDs (2010–2015)* was launched to promote multisectoral collaboration to address NCDs. The Health Promotion Act of 2007 established the first health promotion foundation in the South Pacific to specifically to address the growing NCD crisis in Tonga. Some NCD intervention activities are active, such as tobacco control activities, health partnerships with schools and churches, and social marketing for physical activity and healthy eating; and rheumatic heart disease screening and control. There were 11 registered tuberculosis cases on Tonga in 2010. The reported number of STIs was 498 in 2010. All Tongans receive free health care at all hospitals and community health centers. There are four hospitals, 14 health centers and 34 reproductive health clinics. According to data collected in 2012, the health worker-to-population ratio was 1:1887 for doctors, 1:306 for nurses and 1:7692 for dentists.

3. Demographic and health indicators

Total population (in '000s)	103.4 (2010 est)
Population proportion under 15 (%)	38.1 (2010 est)
Life expectancy at birth (male/female)	65.0/69.0 (2012)
Under-5 mortality rate per 1000 live births	19.7 (2010)
Antenatal care coverage – at least one visit (%)	97.7 (2010)
Birth attended by skilled health personnel (%)	100 (2010)
Measles (MCV) immunization coverage among 1-year-olds (%)	99.0 (2010)
Prevalence of diabetes among adults aged 25-64 (%)	16.4 (2004)
Smoking prevalence among adults aged 25-64 (male/female) (%)	46.2/16.3 (2004)
Human Development Index Rank out of 187	90 (2011)
Per capita GDP (in US$)	2988.00 (2008–2009)
Total expenditure on health as % of GDP	5.3 (2009 p)
General government expenditure on health as % of general government expenditure	14.5 (2008)
% of population with access to improved sanitation facility	96.0 (2008)
% of population with access to improved drinking water source	99.8 (2008)

est = estimated
GDP = gross domestic product
n = not available

6. Sector Coordination and Partnerships

There has been a commendable effort by the Ministry of Finance and National Planning in setting up the Aid and Project Management Division to better coordinate aid programmes. A donor harmonization coordinator has also been appointed.

Under the Principles of Aid Effectiveness of the Paris Declaration, the Ministry of Health of Tonga has partnerships with the governments of Australia, China, Japan, New Zealand, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Secretariat of the Pacific Community (SPC), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNPFA), and WHO, among others.

4. Opportunities

- Firm commitment by Government to MDGs
- Strong political commitment in the Tonga Strategic Development Framework (2011–2014) to address the NCD crisis and strengthen health systems, including primary health care
- National Action Plan for Climate Change Adaptation and Disaster Risk Management for Tonga (JNAP) addresses health needs
- Increased use of the health information system for policy formulation and decision-making

Challenges

- Potential negative impact of global economic crisis on government budgets
- Sustainability of current health-care financing system
- Triple burden of diseases (NCDs, communicable diseases and injuries)
- Although health issues related to climate change and disaster management have been incorporated into the JNAP, the funding source for addressing its key activities has yet to be identified.

5. Summary of the National Health Policy, Strategy or Plan

The vision of the Ministry of Health is: "By 2020, we are the healthiest nation compared with our Pacific neighbors as judged by international determinants." The six key result areas and goals for 2008–2012 are to:

- Build capacity and effectiveness in preventive health services to fight the NCD epidemic and communicable diseases;
- Improve the efficiency and effectiveness of curative health service delivery;
- Provide services in outer island districts and community health centres;
- Build staff commitment and development;
- Improve customer service; and
- Continue to improve the Ministry of Health infrastructure and information and communications technology.

The vision of the *Tonga Strategic Planning Framework (2011–2014)* is: "To develop and promote a just, equitable and progressive society in which the people of Tonga enjoy good health, harmony and prosperity in meeting their aspirations in life."

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Tonga to:

1. Fight Noncommunicable Diseases (as a major part of Tonga's MDG6), especially overweight, obesity, cardiovascular diseases, and hypercholesterolemia through efforts such as additional tobacco tax legislation, promotion of healthy eating and increasing physical activity, implementing the *Crisis Response Package*, and strengthening the national food control system with particular emphasis on food control management structures, food legislation and enforcement.
2. Strengthen the health information system, particularly with regards to policy and strategy development and improving quality of data.
3. Contribute to the advancement of the education and training of health workers, including short-term training and continuing professional development.
4. Continue leadership and ownership of health sector reform to improve health service delivery.
5. Strengthen infrastructure capacity by establishing a national regulatory framework for laboratory service with monitoring and evaluation mechanisms; a medicines regulatory system including medicines management, beginning with Viola Hospital; and a plan for assessment of health vulnerability and the strengthening of the health sector response to climate change.
6. Continue supporting overall health system strengthening initiatives.

World Health Organization
Western Pacific Region

TUVALU

1. Macroeconomic, political and social context

Tuvalu is comprised of nine atolls in the South Pacific Ocean. Tuvalu is governed as a constitutional monarchy and Commonwealth realm. The head of government is the Prime Minister who is elected by members of Parliament. The economy is dominated by the public sector and few opportunities exist for private sector development. There is no extreme poverty in Tuvalu, but according to a United Nations report, about 29% of households have incomes below the national poverty line. The Government and the population are conscious of the potential long-term negative impact of global warming on the country's landmass. New Zealand has established a migratory scheme with Tuvalu.

2. Health and development

Tuvalu has a free medical and health services, providing most of the key health services to its citizens. Serious cases are sent under a medical referral scheme, the Tuvalu Medical Treatment Scheme (TMTS), to Fiji or New Zealand. Noncommunicable diseases (NCDs) are a major cause of morbidity and mortality, and the Ministry of Health (MOH) has launched its NCD plan to focus specifically on four main areas: food and nutrition, physical health, tobacco and alcohol. The plan provides a road map for the Department of Public Health (DPH) to combat NCDs in the future. Communicable diseases are also a major cause of morbidity, with alarming numbers of acute respiratory infections, eye infections and skin infections. An increase in tuberculosis prevalence has resulted in strengthening of the TB programme with improved testing facilities and diagnostics.

For diagnosis of many diseases, specimens need to be shipped to overseas laboratories, limiting the sensitivity and timeliness of surveillance. There is a limited supply of safe water. Groundwater is brackish and is not generally considered safe for consumption. In 2009, the majority of households on Funafuti were provided with large rainwater tanks and this is expected to greatly reduce the incidence of waterborne disease. The Princess Margaret Hospital is the only hospital in Tuvalu. However, since 2008 a number of new medical centres have been built on outer islands. According to data collected in 2008, the health worker-to-population ratio was 1:971 for doctors, 1:180 for nurses and 1:4762 for dentists.

3. Demographic and health indicators

Total population (in '000s)	11.15 (2010 est)
Population proportion under 15 (%)	32.0 (2010 est)
Life expectancy at birth (male/female)	61.7/65.1 (1997-2002)
Under-5 mortality rate per 1000 live births	24.6 (2009)
Antenatal care coverage – at least one visit (%)	77.2 (2007)
Birth attended by skilled health personnel (%)	100.0 (2009)
Measles (MCV) immunization coverage among 1-year-olds (%)	84.8 (2010)
Prevalence of raised blood glucose (%) (for 5 or more years)	9.0 (2001)
Estimated smoking prevalence among adults (male/female) (%)	54.0/21.0 (2002)
Human Development Index Rank out of 187	n
Per capita GDP (in US$)	1139.3 (2002)
Total expenditure on health as % of GDP	10.5 (2009 p)
General government expenditure on health as % of general government expenditure	11.0 (2009)
% of population with access to improved sanitation facility	84.0 (2008)
% of population with access to improved drinking water source	97.0 (2008)

est = estimated
GDP = gross domestic product
n = not available
p = provisional

4. Opportunities

- Improved collaboration with regional and international donor agencies and development partners.
- Strong health promotion activities and awareness about healthy living and diet.
- Recently built Princess Margaret Hospital.

Challenges

- Limited knowledge and expertise among existing health sector staff, including clinical senior managers
- Climate change
- Limited availability and access to safe and nutritious food
- High costs of referrals and specialized clinical care
- Growing burden of NCDs and their impact on the health care system

6. Sector Coordination and Partnerships

The MOH continues to work closely with regional and international donor agencies and partners that support public health programmes and activities in the country through funding mechanisms and the provision of technical assistance at various levels. Australia and New Zealand are the main bilateral donors for development assistance in the health sector. International and regional development agencies, such as the Secretariat of the Pacific Community (SPC), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and WHO, provide technical and other assistance to aid in achieving long-term health goals and in addressing short-term priorities. *The Strategic Health Plan 2009–2019* emphasizes coordination of health-related activities between concerned ministries (i.e., Health, Education, Home Affairs and Environment). The Strategic Plan also highlights the need for optimal use of resources to avoid duplication and work overload on staff.

5. Summary of the National Health Policy, Strategy or Plan

The health reform process in Tuvalu began in 2008 with the development of a new health master plan to guide the work of the MOH over a 10-year period stretching from 2009 to 2019. The *Strategic Health Plan 2009–2019* aims at ensuring the highest attainable standard of health for all people of Tuvalu by:

- Ensuring legislative and budgetary support for efficient and effective health services for the people of Tuvalu;
- Providing high-quality and cost-effective management of health services;
- Improving the quality and cost effectiveness of curative medical services; and
- Providing the MOH with the renewed aim to focus on primary health care and disease prevention.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Tuvalu to:

1. Strengthen NCD prevention and control through implementation of the national Crisis Response Package, which includes improving food standards, social marketing for reducing risk factors for NCDs, and implementing the *WHO Package of Essential NCD Interventions (PEN).*
2. Strengthen syndromic surveillance and response and expand it to cover outer islands.
3. Achieve the regional goal of Hepatitis B control and measles elimination, to continue strengthen the tuberculosis programme to strengthen STI and other communicable disease prevention efforts.
4. Improve the quality and safety of laboratory services, as well as implement and monitor the *National Medicines Policy and Pharmaceutical Strategic Plan.*
5. Address climate change-related health issues, including diarrhoeal and respiratory diseases, as well as food security and safety, and traumatic injuries.
6. Strengthen the health information system, particularly with regards to policy and strategy development and improving the quality of data.
7. Formulate a human resource policy to facilitate the integration of foreign-trained medical graduates into the national health services and continue the education and training of health workers, including continuing professional development.

World Health Organization
Western Pacific Region

VANUATU

1. Macroeconomic, political and social context

Vanuatu is comprised of four main islands and over 80 smaller islands located in the South Pacific Ocean. Vanuatu has seen significant economic growth in the last 10 years, largely driven by construction projects, tourism, agriculture and a robust real estate sector. Major economic activities in Vanuatu include fishing, meat canning and wood processing. Improved economic and social development policies and effective financial management have facilitated this growth. Vanuatu is governed by a President elected by the Parliament and a Prime Minister selected from the majority party. While recent gains have been inspiring, more effort is required to sustain growth and ensure that economic and social gains are fairly distributed across the nation. Three-quarters of the population reside in rural areas, and providing services to a widely dispersed population is a challenge for the Government and its development partners.

2. Health and Development

Vanuatu is affected by communicable diseases, noncommunicable diseases (NCDs), and emerging and re-emerging diseases, such as yaws and dengue fever. NCDs such as diabetes, heart disease, chronic respiratory disease and cancer are the most common causes of adult morbidity and mortality. In children, respiratory infections, diarrhoeal disease and neonatal conditions continue to account for most childhood illnesses and under-5 deaths. Remarkable progress is being made towards achieving health-related Millennium Development Goals (MDGs) as under-5 mortality, infant mortality, malaria and maternal deaths have all decreased in the past five years. Despite substantial gains in health outcomes, limited access to quality health services remains a challenge. Scattered populations, geographical isolation and health systems factors contribute to this. In addition, increasing urbanization contributes to socioeconomically determined health conditions such as NCDs, sexually transmitted infections (STIs), unplanned pregnancies, childhood malnutrition and domestic violence. The health sector is in the process of undergoing significant changes through health sector reforms with considerable support from key development partners. The Government has staged a nationwide primary health care revitalization programme to improve access to essential health services and strengthen the health system. There are four major types of health facilities in Vanuatu: five hospitals, 27 health centres, 74 dispensaries and 180 aid posts.

3. Demographic and health indicators

Total population (in '000s)	234.0 (2009)
Population proportion under 15 (%)	38.9 (2009)
Life expectancy at birth (male/female)	69.0/72.0 (2009)
Under-5 mortality rate per 1000 live births	31.0 (2008)
Antenatal care coverage – at least one visit (%)	n
Birth attended by skilled health personnel (%)	80.0 (2008)
Measles (MCV) immunization coverage among 1-year-olds (%)	82.0 (2010)
Prevalence of raised blood glucose (%) (for 5 or more years)	9.4 (2008)
Estimated smoking prevalence among adults (male/female) (%)	46.5/10.1 (2007)
Human Development Index Rank out of 187	125 (2011)
Per capita GDP (in US$)	2,685.1 (2009 p)
Total expenditure on health as % of GDP	3.9 (2009)
General government expenditure on health as % of general government expenditure	13.6 (2009)
% of population with access to improved sanitation facility	52.0 (2008)
% of population with access to improved drinking water source	85.2 (2009)

est = estimated
GDP = gross domestic product
n = not available

4. Opportunities

- Sound understanding of health challenges and commitment for improvement
- Government-led health sector reform
- Substantial support from development partners
- National commitment to primary health care revitalization and health systems strengthening
- WHO country office within the Ministry of Health

Challenges

- Weak health system
- Inadequate supply of human resources
- Inadequate recurrent budget for health
- Scattered and isolated populations with weak infrastructures
- Dependence on donor agencies to finance public health programmes
- Political instability
- Prone to natural disasters such as cyclones and earthquakes

6. Sector Coordination and Partnerships

Vanuatu is moving towards a Sector-wide Approach (SWAp) for better, streamlined and coordinated health policy and management processes. Eventually, the intention is to increase coherence between policy, spending and results, while also reducing transaction costs. A health partners group was established in 2010 in the spirit of mutual partnership. The group ensures that development assistance is harmonized as defined in the Joint Partnership Agreement. Under this agreement, the partnership principles and code of conduct are not legally binding or legally enforceable; however, all signatories, in good faith and intention, subscribe to the principles and code of conduct and dedicate their efforts to its full realization in line with the Principles of Aid Effectiveness under the Paris Declaration and the Accra Agenda for Action.

5. Summary of the National Health Policy, Strategy or Plan

The Vanuatu Health Sector Strategy (2010–2016) sets out a strategic framework and establishes the context to guide national efforts to achieve improved health through better access to quality services nationwide. The Ministry of Health's vision is: "to have an integrated and decentralized health system that promotes an effective, efficient and equitable health services for the good health and general well-being of all people in Vanuatu". The key elements of the Health Sector Strategy are to:

- Gather data and aim to reach the health-related MDGs including MDG 4 (Reduce Child Mortality) and MDG 5 (Improve Maternal Health), and MDG 7 (Ensure Environmental Sustainability, including Safe Drinking-Water and Basic Sanitation)
- Improve access to health care through primary care service, supported by a functional referral system and adequate hospital staffing and services.
- Develop strategic and operational planning processes including monitoring and evaluation in order to support organizational restructuring and strengthening.
- Prevention and treatment of non-communicable diseases using the Crisis Response Package.
- Improve coordination with partners by integration of plans and strategies, as appropriate, to reduce the burden of diseases.

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Vanuatu to:

1. Use Vanuatu's 2011 *STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS)* survey findings as basis for developing multisectoral actions to reduce NCD risk factors, establish an NCD surveillance system, and reduce the burden of disease through implementation of the WHO Package of Essential NCD Interventions (PEN).
2. Step up its strategic role in combating communicable and emerging diseases by establishing a surveillance system to monitor disease patterns and to respond with appropriate interventions.
3. Improve cost-effective MDG interventions, especially MDGs 4, 5 and 6 (Combat HIV/AIDS, Malaria and Other Diseases) using an integrated continuity-of-care approach, as well as MDG 7 through multisectoral responses to clean water, sanitation and climate change.
4. Improve access to services by rolling out primary health-care interventions in all provinces and building a more responsive health system that addresses human resources, good management practices, medicines and technology, and health information.
5. Implement the Paris Declaration of joint partnerships, sector coordination and aid effectiveness through SWAp.
6. Improve human resources for health by assisting in facilitating the integration of foreign medical graduates into the national health services.

World Health Organization
Western Pacific Region

WALLIS AND FUTUNA

1. Macroeconomic, political and social context

Wallis and Futuna is a country made up of three major islands and 20 islets covering an area of 42 square kilometres located in the South Pacific Ocean. As a French overseas territory, Wallis and Futuna is led by the High Administrator, appointed by the French President, who is the chief of state for overseas territories. Wallis and Futuna is governed by the President of the Territorial Assembly. Major economic activities in Wallis and Futuna include copra production, handicrafts, fishing and lumber. Major revenues come from subsidies from the French Government, licensing of fishing rights to Japan and the Republic of Korea, import taxes and remittances from expatriate workers overseas.

2. Health and Development

Three types of diseases are found in Wallis and Futuna: noncommunicable diseases (NCDs), such as diabetes, hypertension, chronic renal failure, gout and dental and mouth conditions; communicable diseases such as streptococcal infections, leptospirosis, viral hepatitis B, brucellosis, tuberculosis, salmonellosis, shigellosis, leprosy and dengue; and conditions related to injuries. Health care in Wallis and Futuna is free. The health agency is composed of Wallis's Sia Hospital with a capacity of 51 beds, and technical and medical services at three dispensaries distributed in each district. The local hospital Kaleveleve Futuna has 21 beds. The Wallis and Futuna Health Agency (ADS) has significant medical evacuation activity both within the country and overseas. These medical evacuations are completely funded by the State. According to data collected in 2008, the health worker-to-population ratio was 1:909 for doctors, 1:337 for nurses and 1:4762 for dentists.

3. Demographic and health indicators

Total population (in '000s)	13.25 (2010 est
Population proportion under 15 (%)	28.5 (2010 est)
Life expectancy at birth (male/female)	72.7/75.9 (2005–2008)
Under-5 mortality rate per 1000 live births	n
Antenatal care coverage – at least one visit (%)	n
Birth attended by skilled health personnel (%)	94.4 (2009)
Measles (MCV) immunization coverage among 1-year-olds (%)	86.0 (2007)
Prevalence of raised blood glucose (%)	7.7 (2008)
Estimated smoking prevalence among adults (male/female) (%)	42.0/18.0 (1996)
Human Development Index Rank out of 187	n (2011)
Per capita GDP (in US$)	3,800 (2004)
Total expenditure on health as % of GDP	n
General government expenditure on health as % of general government expenditure	24.0 (2008)
% of population with access to improved sanitation facility	96.0 (2008)
% of population with access to improved drinking water source	100.0 (2008)

est = estimated
GDP = gross domestic product
n = not available

4. Opportunities

- Health care is free for all residents
- Excellent health-care system in place
- Strong financial, technical and administrative support from France:
- Availability of new information and communications technologies

Challenges

- Issues on monitoring and reduction of NCDs
- Issues controlling infectious diseases
- Alcoholism or the harmful use of alcohol, which is the cause of many road accidents
- Geographical remoteness and related logistical issues

6. Sector Coordination and Partnerships

In addition to support from metropolitan France, ADS works with the Hospital Centre of New Caledonia (CHT), the Secretariat of the Pacific Community (SPC) and WHO. CHT undertakes the implementation of the International Health Regulations (2005). In recent months, ADS has started looking for new partners to supplement the provision of care provided to date by CHT.

5. Summary of the National Health Policy, Strategy or Plan

The mission of the Wallis and Futuna's Health Agency (ADS) is to develop a programme of primary prevention, provide outpatient care, and distribute drugs and medical equipment. The ADS has administrative and financial autonomy. The policy of the ADS focuses on three areas:

1. Provide an appropriate response to medical and surgical emergencies in a care package to Wallis and Futuna;
2. Organize and strengthen cooperation with the Hospital in Noumea, New Caledonia, to cover needs not covered locally; and
3. Develop and implement a policy of prevention.

ADS is implementing a Health Project which is divided into five key areas:

- Disability and ageing
- Perinatal and early childhood
- Health risks
- NCDs
- Mental health

7. Strategic priorities for collaboration between WHO and the Government from 2013–2017

WHO in coordination with development partners will provide support to the Government and people of Wallis and Futuna to:

1. Prevent and control NCDs through the implementation of the national Crisis Response Package.
2. Strengthen and maintain the Syndromic Surveillance System and associated reporting.
3. Exchange information, best practices and guidelines on communicable disease and NCD prevention, mental health, disability and other health risks, and on health system strengthening.
4. Enable participation in regional meetings when relevant, with particular focus on the five key areas identified by the Wallis and Futuna Health Project.

For more information:

World Health Organization office
for the South Pacific/Division of Pacific
Technical Support

Level 4, Plaza 1, Downtown Boulevard
33 Ellery Street, Suva
PO Box 113, Suva, Fiji
Email: dps@wpro.who.int
Website: www.wpro.who.int/southpacific