

Family planning in the Federated States of Micronesia: past and present

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The representation at this Conference is an indication of our commonality of purpose despite our cultural and political diversities and geographical separation and isolation. Addressing this group gives me the opportunity to convey my support to your endeavors in keeping pace with the changes that are inevitable in the areas of health and medical care of this region, especially the Family Planning Program. We must keep abreast with the changes that influence our living and lifestyles which also influence the trends in which health and medical care are charted. In this connection, we should give our undivided support to the Family Planning Program in the Pacific.

In 1965 (31 years ago), the then US Secretary of Interior issued a directive mandating the establishment of Family Planning Programs throughout its territories, including the former Trust Territory of the Pacific Islands (TTPI). The states of the now Federated States of Micronesia (Chuuk, Kosrae, Pohnpei and Yap) were still part of the TTPI.

About the same time, the FSM population was increasing very rapidly, owing to a constant high birth rate of about 30-35 births for every 1,000 population, and a low death rate of 4 per 1,000 live births. The US Federal Government was very concerned over the rapid population growth in the islands, especially its ill effects on the socioeconomic progress and quality of life. The US Congress, then, appropriated additional funds under Maternal and Child Health (MCH) 314d to TTPI to initiate the Family Planning Programs in FSM, Palau and the Republic of the Marshall Islands.

**Secretary of Health, Federated States of Micronesia. This is the opening remarks at the 1996 Pacific Basin Title X Family Planning Conference, Palikir, Pohnpei, August 12, 1996*

Being the most populated island, Chuuk was the first state in FSM to be provided family planning services from 1965 through 1978 under MCH 314d. This Family Planning Program in Chuuk was coordinated by a nurse designated by the Director of Health, with direct supervision by the Chief of Public Health.

In FY 1979, TTPI became eligible for additional US federal funding under Family Planning Title X of the US Public Health Service Act. Again, Chuuk was the first island state to receive direct funding for a family planning program. In the 1982 Program year, the Family Planning Project expanded into the State of Kosrae, followed by Pohnpei, Yap and the Marshall Islands in FY 1983 (July 1, 1982).

The need for a Family Planning Program was identified by the health officials as well as by the authorities as recognized in the respective island states Comprehensive Health Plans and in the TTPI. This Five Year Comprehensive Health Plan (1980-1985) was approved by the Micronesian Health Coordinating Council and by the High Commissioner of the Trust Territory in April

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1980. (The Micronesian Health Coordinating Council was comprised of both health providers and consumers from the Marshall Islands, Kosrae, Pohnpei, Chuuk, CNMI, Yap and Belau).

At the inception of the family planning program, some of the leaders were not very receptive to the idea. The initial fear of those opposing the program was expressed by the smaller island states in that if family planning were to be practiced in full force, their population would be reduced and, thus will have a negative impact on their share of funding. With this knowledge, the TTPI, including the FSM personnel in general, were reluctant to approach family planning in an aggressive manner, which would involve seeking legislative sanctions and the employment of mass media campaigns.

The program of administering contraceptive information and supplies was entirely voluntarily as far as the patients were concerned and were not a top priority. Usually, family planning advice given was incorporated into the postnatal follow-up clinics and largely limited to those who lived in or near the government centers, and the family planning effort was limited at the very outset with regard to one's accessibility to health clinic centers. At that time, the main constraints for family planning programs in the FSM were:

- Low coverage and limited access to health services, particularly to the outer islands;
- Low utilization of existing health services, in particular, prenatal and postpartum care;
- Lack of knowledge re: family planning problems, particularly understanding the benefit of family planning among the society and among health personnel; and
- Lack of technical knowledge on family planning methods among some categories of health workers

With the lack of legislative sanction of family planning, the program was administered on a "low key, go slow" approach for two major reasons:

1. Fear of stirring up Family Planning opposition from religious and traditional leaders; and
2. The need for fertility control (population control) as perceived by TTPI and FSM health leaders, was not understood by the majority of the population.

Bearing these two factors in mind, birth control methods were not to be used entirely as a means for explicit fertility control. The focus was, and still is, to improve the quality of maternal and child health through proper child-spacing (meaning no less than 24 months between pregnancies) rather than limiting the absolute size of any family. The services were, therefore, to be available free of charge (and still are) to those who sought such services when they needed them

Then in 1979, when FSM became a separate constitutional government, it became eligible for international funding under the United Nations Population Fund, formerly the United Nations Fund for Population Activities (UNFPA). In 1982, FSM with the able assistance of a Suva-based UNFPA consultant developed a proposal entitled "Family Health/Planning Project" seeking financial assistance to supplement the on-going Family Planning Title X Program

The Family Health/Planning Project was approved and funded in 1983. In 1985, a full-time project coordinator was

hired at the FSM Department of Human Resources. Through this project, a wide range of contraceptives became available at very low cost. Family planning public awareness seminars, workshops, and conference were conducted for leaders of national and state governments, religious affiliations, traditional, communities, youth organizations, women's groups, outer islands as well as health personnel. The last 14 years have been full of family planning related activities including an FSM-wide poster contest in all the high schools.

In September 1994, an FSM-wide Census of Population and Housing was conducted. According to the 1994 Census, the annual population growth rate had decreased to 2.5% and crude birth rate was reduced from 39.2 (1979-84) to 31.4 (1989-94), indicating a decline in fertility rate from 7 in the mid-1960's to 5 in 1994. The reduction of population growth rate and the decline in fertility rate are directly attributed to the family planning program. The FSM Second Development Plan 1992-1996 stipulates strengthening of the Maternal and Child Health and Family Planning Programs to increase the contraceptive prevalence rate.

For 1995, the contraceptive prevalence rate was 49.9%. If men practicing family planning (using condoms) were counted, this contraceptive prevalence rate increases to more than 60%.

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During the First FSM Economic Summit in November 1995, the health sector identified rapid population growth as the number one health problem. To address this problem properly and adequately,

the FSM declared its intention to develop a viable national population policy by creating a National Task Force. The Office of the President was identified as the lead agency for this proposed task force as well as potential members from appropriate agencies.

The impact of the family planning programs over the last 31 years have not been wasted. Indeed, they have made a difference! It is people like you, in this room today, who should be thanked because in your own way, you have contributed to the slowing down of our population growth and the reduction in the fertility rate.

Before concluding, I wish to take this time to thank all of the participants and consultants for participating in this conference and to express our sincere appreciation to the Government of the United States, particularly the Region IX Office, for providing funds which have made it possible to hold this and the previous years' conferences.

References

Available from author on request. □