

**WHO
COUNTRY COOPERATION STRATEGY
FOR SAMOA**

February 2003



Section 1: Introduction

The WHO Country Cooperation Strategy (CCS) for Samoa sets out the strategic directions for 2003-2007 and the agenda for WHO collaboration in Independent State of Samoa for the World Health Organization as a whole.

The CCS articulates a coherent vision and selective priorities for the entirety of WHO. It is based on a systematic assessment of Samoa's development challenges and health needs, the Samoa government policies and strategies, the Health Sector Strategic Plan and health reform and the activities of other development partners.

While a clear aim is to ensure great responsiveness to country needs, this CCS also reflects WHO's mandate, roles and functions, corporate and regional strategies. An important element of the CCS is to foster strategic thinking, put more emphasis on WHO's roles as policy adviser and broker thereby moving away from routine programme support. It reconsiders WHO country priorities in light of these changes, and intends to broaden WHO partnerships at country level and collaboration with other development partners in a complementary way.

Samoa is undergoing social and economic reforms. Within the context of Strategy for the Development of Samoa, the Government is presently conducting a reform of the health sector in order to improve health services and strengthen its management capacity as well as co-ordinate the increasing international assistance more effectively. This presents a very timely opportunity for WHO to review its present programme in Samoa, assess its future priorities and based on the findings draw up an strategic medium term agenda of work.

Section 2: Government and People: Health and Development Challenge

With its land area of around 2,850 square kilometres Samoa, which consists of a small group of islands in the South Pacific Ocean, lies about half way between Hawaii and New Zealand. Upolu and Savaii are the main islands where most of the population is concentrated.

Forty years after Independence

In the forty years of Independence Samoa has been able to create a stable political environment in which through sound macroeconomic management economic growth has been stimulated. Over the past ten years it has with success sought to address the challenges of social and economic reforms.

The UNDP Global Human Development Index (HDI) ranks Samoa 96, while no ranking is available under the Human Poverty Index (HPI). Based on the HDI Samoa has one of the higher levels of social development rankings amongst the Pacific Island Countries showing higher overall education and health standards relative to the other Pacific Countries. Under current trends, Samoa, according to UNCTAD calculations, based on the World Bank's World Development Indicators 2002, has with a GDP per capita in 2000 of USD 1,431 crossed the USD 900 per capita threshold that currently forms one of the criteria for graduation from the LDC category.

Democratic Structure

Democratic traditions and a strong social system based on village communities and extended family ties continue to play a major role in the maintaining of peace in the Samoan society. The extended family, the *aiga*, is the foundation of the *fa'a-samoa* (*traditional way of life*). The Head of each *aiga* is the *matai* (customary chief), who is elected by family members. Traditionally, the family *matai* is responsible for maintaining the family's dignity and well being by administrating family affairs. More than 80% of the population lives under the *matai* system. Particularly strong in the rural areas and at village level it functions as a safety net in providing social and financial security. Many of the Samoans who are resident abroad continue to contribute to their 'social obligations' by sending significant amounts of money to their extended family and church of which there are many different denominations. The remittance income is important to many families, both in urban and rural areas including low-income groups. This explains the high component of the remittances in the GDP of Samoa. It is generally recognised that without these substantial financial contributions to the balance of payments the local economy would not thrive as much as it does presently.

The national system of Government is based on the British Westminster model. However political affiliations tend to be on the basis of family and regional allegiances rather than on defined ideological lines. The Human Rights Protection Party has been in power continuously for 18 years. The coalition forming the opposition exists of the Samoan National Development Party and 8 independent members.

The Government has since the early 1990s committed itself to the promotion of good governance. Human rights are overall respected. The, since 1996, ongoing Economic and Public Sector Reform Programme has instigated institutional reforms in the public service and in several public sector agencies, which has led to the improvement of the governance framework. Performance budgeting has encouraged a greater efficiency, accountability and transparency. Equally economic reforms are considered to be crucial for Samoa in the pursuit of the government's goals to improve the living standards and the welfare of the people.

Since 1996/97 the Government's national policy framework and development strategies are set out in the annual Statement of Economic Strategy (SES), each one building on the previous one, reviewing the outcomes in the implementation of the strategies outlined in the last SES and identifying areas requiring more attention. The current SES entitled "The Strategy for the Development of Samoa 2002 – 2004: Opportunities for All" highlights the need for every Samoan to enjoy the benefits of national development identifying the medium term vision as follows:

“For every Samoan to enjoy an improved quality of life premised on a competitive economy with sustained economic growth, improved education, enhanced health standards and strengthened cultural and traditional values”.

Economic Base

The economy of Samoa is relatively small, with an aggregate GDP in current prices of Samoan Tala 768 million (=USD 235 million) in 2000. The GDP per capita in 2000 is estimated at USD 1,431. Economic growth in that year was estimated at a satisfactory 7% with an estimated rate of inflation of 1%. Samoa's balance of payments reflects the size of the country. A trade deficit in 2000 existed due to the imports (USD 105.7 million) surpassing the exports (USD 13.7 million) substantially. The economy has a narrow export base of mainly agricultural products and remains vulnerable to external economic shocks and natural disasters over which there is little control. Increasing the export would be difficult not only due to the vast distances and related transportation costs, but also the lack of other than agricultural natural resources. The importation of certain consumer and luxury goods is largely financed through the remittances from the estimated 130:000 Samoans overseas. The balance of payments remains dominated by private and official transfers. Private transfers/remittances account for 30% of the GDP or approximately USD 70 million. Official transfers and income from tourism account for 15% of GDP. Grants from development partners in 2000/2001 added up to Tala 65,09 million (USD 23 million) equalling some 25% of the total revenue.

Social Situation

According to the 2001 census the population of Samoa is 176.848. This represents a growth of 7.4% in the last ten years. While the natural increase over the past two decades was around 2.5% per annum, the actual growth is only 0.6 % due to the high rate of overseas immigration (some 3500 p.a.): a pattern that can be expected to continue unless the Government can ensure employment opportunities and at the same time implement an effective retention policy. More than half of the population (53 %) is below 20 years with adolescence comprising 21 %, youths 18 % and women of childbearing age 22 %. The proportion of elderly people (65+) is about 4.7 % of the population¹.

Formal employment is focused on the urban Apia, the capital, which covers 32% of the population. A major challenge to the Government is to create sufficient employment opportunities to absorb a large proportion of the estimated 4000 new entrants to the labour force each year. Failure will lead to an increase in social problems. While absolute poverty is rare in Samoa and a large majority have a good standard of living some problems are emerging as people are moving from rural to urban areas. With the assistance of the ADB and UNDP the Government is developing a framework for defining poverty as well as appropriate ways for measuring and monitoring 'hardship'.

Gender issues such as the promotion and protection of women's rights, gender equity and 'women and HIV/AIDS are of high importance in the Samoan society. The Ministry of Women's Affairs was established in 1991. The rate of participation of women in the country's labour force is relatively high. Access to education and achievement in the formal educational system, is virtually equal to men. Women occupy a number of senior positions in the public. The Women's Committees in the villages play an important role in reaching the sick and needy.

In the past much attention has been given to education. The literacy rate is 98 % combined with a gross enrolment ratio of 74% (UNDP HDI 1998). The Government has

committed itself to retaining this high standard of education, which next to health is one of its prime priorities.

Health Profile

Turning to the health profile of the country it can be concluded that the health status of the Samoan population has improved significantly over the past decades and that Samoans now enjoy a relatively good health status as the following health indicators prove: Life expectancy is at 68.4 years for the total population ². The Infant Mortality Rate is 17.8 per 1000 ³, the Maternal Mortality Rate: 60 per 100 000⁴ and the Under-five Mortality Rate: 27/1000 ⁵. 96.3%⁶ of the infants are fully immunized. The whole of the Pacific region is Polio free. Over the last 4 years there have been no confirmed cases of measles in Samoa.⁷

An epidemiological transition is taking place with non-communicable diseases (NCD) replacing communicable diseases as the main causes of death.

Communicable diseases under control: more need for surveillance

Although it can be generally concluded that the communicable diseases are decreasing and under control, the main challenge in this field remains the continuing need to carry out surveillance and counter outbreaks as soon as they are identified.

Samoa has managed to eliminate leprosy⁸ and to control most communicable diseases such as TB⁹ and Filariasis. Infectious diseases such as acute respiratory infections¹⁰ and rheumatic fever¹¹ however remain a significant cause of morbidity. The recent outbreaks of dengue and typhoid¹² as well as the surprising discovery of a high prevalence of sexually transmitted diseases in pregnant women¹³ have accentuated the limitations of the existing surveillance systems. Strengthening thereof as well as a more advanced health management information system, including information collection, reporting and feed back, and an upgraded capacity of the laboratory, including blood safety, is required.

The increasing threat of sexually transmitted infections (STI) demands attention. Even though there are a very limited number of reported cases of HIV/AIDS (12), the infection could rapidly spread if the national plan is not activated very soon to address the risks.

Non Communicable Diseases: an epidemic in the making

On the other hand the non communicable diseases (NCDs) are growing to an epidemic proportion replacing communicable diseases as the main causes of death¹⁴: killer number one are cardio-vascular diseases followed by cancer. Samoans are also increasingly suffering from hypertension¹⁵ and diabetes¹⁶. The major NCDs are related to changing lifestyle and the high prevalence of risk factors such as unhealthy diets, tobacco, alcohol and lack of physical activity¹⁷. Over 53% of the population suffers from overweight or obesity¹⁸.

NCDs and more specifically, the complications of diabetes and hypertension -diabetic sepsis, blindness, stroke, disability- are becoming a burden to the health care delivery system. 5% of the operations and extensive hospitalisation are due to patients with

diabetic sepsis of the lower limb. 6% of the diabetics are hospitalised at least once a year¹⁹ often due to non-compliance to treatment regimes and to delayed presentation of complications, especially for patients living in rural areas. With the need for long term care and expensive technology based tertiary care overseas, the financial burden for the country grows enormously: overseas tertiary care expenditures rose from Tala 308,758 (USD 100,000) in 1991 to Tala 2.9 million (USD 900,000) in 1999²⁰.

The Government's focus on Primary Health Care and Health Promotion is flanked by the establishment of the National NCD Committee, the implementation of NCD awareness activities, the study of NCD risk factors, diabetes management guidelines and a diabetes registry. The recently finalized Nutrition Action Plan was drafted on the basis of the Food and Nutrition policy which was adopted 1996.

Additional effort, however, is needed to reverse the increase in NCD's. Through intensive health promotion and education programs, the population must be made aware of healthy life styles. In reaching the population- possibly by making use of mass media- the highest level of government, the health workers and civil society should work together. At the same time the supportive policies, legislation and guidelines as well as the standard of primary health care services and limited specialized secondary care require further improving.

Despite anti- and quit-smoking campaigns organized by NGOs, the MOH and other government sectors, smoking prevalence continues to increase. The review of the Tobacco legislation in line with requirements of the Framework Convention on Tobacco Control will be crucial in addressing this issue.

Injuries and deaths due to road accidents and domestic violence are increasing. Substance abuse is also a growing problem. Awareness campaigns and regulations to limit the availability of poison have not been able to stop the high prevalence of suicide²¹ in particular amongst the youth. New inter-disciplinary initiatives supported by NGOs and civil society in general could have a positive effect in persuading young persons not to take their lives.

Providing effective response to mental health is another important issue. Insufficient understanding of mental health disorders within the community can cause difficulties for the families burdened with the daily care of the patient. Although community based mental health nursing services are being delivered the services and guidance of a psychiatrist and psychologist are not available. Additionally, a review of the mental health legislation and the development of a comprehensive strategy, policy and mental health promotion framework could be beneficial in dealing with the problem effectively.

Reproductive health and child and adolescence health: more attention needed

Maternal mortality had declined significantly until in 1997-1998 a sudden rise in maternal death raised concerns about the quality and safety of services for mothers and children. The leading causes of morbidity amongst youth are related to reproductive health: some 65% of youth admissions to hospital are for complication at childbirth. Although a number of measures have been taken to improve the situation the limited access to specialised staff (obstetrician/gynaecologist) and insufficient availability of

advanced midwifery skills to provide emergency care in life threatening circumstances continue to cause difficulties.²²

A more effective reproductive health education and family planning would contribute to reducing the morbidity rates.

At the same time the observed increase in cervical and breast cancers cases, needs to be addressed.

Environmental Health and Healthy settings: maintain the natural beauty

The idyllic setting of these emerald green islands in the Pacific Ocean far away from any form of large scale industrialisation ensures that the environment is well preserved. Most of the rural and urban areas are supplied with water and sanitation²³ of which the quality can not always be guaranteed and therefore needs regular monitoring. The construction of a sewerage system and treatment plant is foreseen.

Waste management is a government priority with responsibility shared between the Ministries of Environment and Health. Legislation and policies in order to guide, monitor and control the proper management of waste in the country have been approved. Appropriate mechanisms to minimize and control the generation of solid, industrial, commercial, chemical and hospital waste need to be implemented. The MOH has appointed a focal point to draft a strategy for health care waste management.

The safety of food supply in Samoa is currently regulated by the 'Food and Drug Act (1967)'. This allows inspectors to make inspections of processing plants, restaurants and street vendors to ensure that the food is prepared in an hygienic and safe manner and condemn any food that is considered to be contaminated. However, insufficient guidelines and standards exist to deal with an expanding food and tourism industry.

Within the Pacific Regional "Healthy Islands" concept many "healthy settings" have been initiated. All need further support and strengthening to ensure their sustainability.

The need to know how to deal with natural disasters became very apparent after two consecutive cyclones in 1990-1991 caused massive destruction to the Samoan economy and infrastructure. The Prime Minister's Department is responsible for the coordination of the national management disaster programs. A National Disaster Preparedness Plan is yet to be prepared. Next to having a focal point person to deal with issues on emergencies the MOH has initiated capacity building activities. Overall a multi-sectoral approach to strengthen law enforcement and build up capacity as well as awareness through educational programmes would be beneficial in reaching all levels of the society.

Health Sector development and major issues:

Health Sector Reform

Primary Health Care, Health Promotion and the Healthy Island principles have inspired the health sector development in Samoa since 1983. Values such as equity, sustainability, quality and appropriateness of health services including the concept of culturally friendly services, are the foundations on which the health sector is based.

The economic and public sector reforms, which have been undertaken since 1996, have significantly influenced the current policies, strategies and priorities being devised by the MOH. One of the Government's public sector measures is the devolution of financial and human resource management to the line Departments within the context of strategic and corporate development focusing on key public functions.

•By introducing the *Health Sector Strategic Plan 1998-2003* the MOH set out to achieve the reform challenges and embarked on a programme across 3 priority areas. To begin with *Institutional strengthening*, with a focus on capacity building for policy development, strategic planning, human resources and financial management, service delivery and promotion of partnerships. Secondly, *Primary Health Care* and *Health Promotion* with a specific focus on Non Communicable Diseases, Child and Women health issues. Lastly, the *Improvement of Quality* in public health facilities mostly through refurbishment, rationalisation of health facilities, including establishment of a national health care waste management system.

The reform program assumes fundamental changes in the roles and relationships of the health care system actors. New and more complex functions such as the development of sustainable and fair health care financing mechanisms, monitoring and regulation of the health sector are being introduced. In order to make the changes workable and sustainable in the long run it will be essential that the internal process not only receives the commitment of those involved, but also does not reduce the attention given to the impact on health and the gains to be attained.

In providing technical and financial support partners should be aware of the complexity of the reform process undertaken and ensure the advice provided is coherent and consistent. Complementary strategic and policy advice such as on health care financing, legislation, health promotion, capacity building and human resource development could be beneficial.

National health care system

The Samoan National Health Care System is dominated by the public health sector. The Ministry of Health (MOH) provides primary, secondary, limited tertiary care and public health services through a network of facilities. In the rural areas the service is mainly provided in health care centres and very few hospitals with limited facilities. The services providing more specialized care are based in the capital Apia²⁴. Tertiary care, which basically is unavailable in country, is provided overseas generally in New Zealand.

Over the last few years the profit based private health sector has been expanding²⁵. With the exception of 2 private medical clinics one on Savaii and one in rural Upolu, these services are all located in Apia.

A large informal circle of health care providers exists including some 900 Traditional Healers and 200 plus Traditional Birth Attendants (TBAs). An extensive network of Women's Committees co-manages publicly funded rural health services. It is, however, difficult to define how many and to what extent NGO's contribute to the health services and promotion. Some are known to be focusing on home care for the elderly, cancer,

substance abuse, reproductive health, HIV/AIDS, teenage pregnancies and suicide. An umbrella organisation (SUNGO), with a few members working in the field of health, has recently been set up to try to coordinate and strengthen the capacity of their members. The fact that there are no guidelines on working in partnership with government limits the involvement of civil society and NGOs's in the health sector service delivery.

An increased involvement of this large private sector with the formal sector could strengthen the delivery of services to the population considerably. For example, TBAs play an important role in the country's birth system and conduct a significant number of the births. For nearly 20 years they have been supported by the MOH through training. However, their collaboration with the public health services and their contribution to assist in recording births have not yet been formally recognised.

These developments make it essential to introduce and enforce appropriate regulations and have monitoring mechanisms in place to ensure efficiency and quality and safety of the care provided by all health care providers, public and private.

Health care workforce²⁶

Despite relatively positive ratios of doctors and nurses per inhabitant²⁷ Samoa still encounters a major workforce problem. In addition to the need for more medical doctors and nurses²⁸ to properly cover the health services there is a lack of medical specialists and paramedical staff such as epidemiologists, nutritionists, dieticians, pharmacists, lab technicians, physiotherapists and psychiatrists. This is reflected in the high proportion of costly overseas referrals as well as the need for overseas specialists to visit the country on a regular basis. It should also be noted that the average age of the professional health workforce is rather high (50+).

A constant drain of health workers away from rural areas to work at the main hospital results in an inequitable distribution of health professionals and services concentrated in the capital. In rural areas many nurses work alone having no access to medical personnel. For example the regional referral hospital on Savaii, which covers 28 % of the population, has a limited team composed of one doctor and a few nurses. Consequently health workers in the periphery tend to feel isolated. The quality of care is affected, the primary and community health services are weakened leading to a high degree of by passing and late referrals.

Another major drain on the health sector is the migration of health workers be it doctors or nurses to countries where the remuneration is much higher and better working conditions and opportunities for their career development are offered. One of the measures taken to retain these professionals is to train all medical officers in the Fiji School of Medicine rather than in Australia or New Zealand, where the Fijian qualification is not recognised thus hampering migration to these countries. At the same time opportunity is being provided to medical officers working in the public health system to set up their own small private practice.

At present the Public Service Commission is responsible for the formulation of guidelines on the staffing of all government agencies. Although a Health Human Resources Development Plan for 1998 to 2020 exist, a review of this plan and a separate national

health workforce policy are needed to give a more precise picture of the numbers and categories of health personnel required in the future.

Over the next few years some 11 medical officers will be graduating. If the retention policy has the expected positive effect they will by joining the workforce reduce the need for training more MDs. This will create more flexibility to reorient the tertiary education efforts in the health sector from basic undergraduate to continuing education and post graduation training. Next to the off shore training at the Fiji School of Medicine tele-education and “twinning” arrangements with off shore academic and service delivery institution could be a useful means in achieving this.

With an emphasis on the necessity to provide continuing education to all categories of health care workers the donor agencies should in close consultation with the Samoan Government pool all their efforts to set up a co-ordinated off shore training programme. The appointment by the MOH of a training co-ordinator responsible for the planning, co-ordination and implementation of in-service and continuing education of health professionals is an excellent first step in that direction.

In country an education program is being developed directed at the up-grading and further expansion of the medical skills of both public and private sector medical graduates. The National University of Samoa (NUS), the largest tertiary institution, recently started offering full diploma and degree qualifications in a number of vocational and academic programmes²⁹. A three-year Bachelor of Nursing undergraduate program started in the first semester of 2002 followed in July 2002 by a one-year post graduate midwifery program. Post graduate courses in mental health, emergency and high dependency care are planned for 2003. An attempt is being made to launch a web based Medical School using distance learning techniques.

Health services development

As has already been pointed out most of the health care outside of the capital is provided by nurses. Health centres form the operational basis for community work. Although district hospitals and health centres have an inpatient capacity they are mainly used for outpatients services³⁰, which have declined by some 20% over the last 4-5 years.

Notably this decline in utilization rates is mostly due to the fact that the transport system makes it possible for patients to reach Apia within a matter of hours. As a consequence the central Hospital is overburdened with outpatient care.

A strategic redistribution of the health services could improve their efficiency. Under-utilised centres should be closed down whilst services at well located and equipped district hospitals and health centres need to be strengthened. This would ensure more equitable access to quality integrated health services in the home and at the community level for patients with NCDs and chronic illnesses, the elderly and mentally disabled.

The introduction at community level, of effective disease specific management programmes to enable early detection and intervention, treatment, monitoring and rehabilitation for example for diabetes, hypertension, breast and cervical cancers would reduce morbidity, mortality and costs to the health system and the society. To be more

effective the health facilities will also need to work more in partnership with other government sectors, community based organizations and the private sector.

With regard to secondary and tertiary care it would require further investigation to determine which services are financially and technically more viable provided locally rather than overseas . Major costs arising from overseas treatment are in particular related to renal failure and dialysis treatment, cardiac surgery and ophthalmology. It is thought however that the provision of specialized cardiac surgery and full dialysis unit would be too costly to establish and maintain, while the volume of work would probably not guarantee standards of practices.

Health financing

The first Samoan National Health Accounts (NHA) dated April 2002 is a compilation of accounts relating to the fiscal year 1998-1999. It estimated that approximately 6.6 % of the GDP and 17% of the total government expenditure was spent on the health sector, which is comparable with a middle income country. The per capita expenditure amounted to USD \$82. Government spending on health as a proportion of its total expenditure has notably increased from 10.2 % in 1991 to 17.7 % in 2001. For health care financing 62% was accounted for by public sources and 23% by private sources (out-of pocket for private sector including traditional healers). The remaining 15% was provided by international donors and other sources. It is estimated that 68% of total health expenditure occurred in the public sector, 23% in the private sector and 9% related to overseas treatment.

The Government per capita health expenditure varies significantly between the three health regions with the national hospital in Apia receiving some 60% versus the rural regions of Upolu and Savaii together some 15% of the budget.

A break down of total health expenditure by functions shows that almost 45% is spent on hospital services (of which 20.6% on salaries), 9.9% on outpatients services, 14% on supplies and pharmaceuticals, 10.8% on health administration, 10.2% on health programs and 9% on other health related functions.

These figures show that there is an imbalance between the amount spent on primary health care and health promotion services and the expenditure on hospital based care, which is not in line with the objectives of the national policy.

Health care costs are heavily subsidised by the Government. The financial burden is particularly heavy for the tertiary overseas care of patients who meet set criteria for referral, since -with the exception of travel costs- it is fully financed by the governments of Samoa and New Zealand. The recent draft study on overseas medical treatment ³¹reckons that improving eligibility criteria for these referrals thereby focusing on cases with good prognosis and clear health gains, could create substantial savings.

The epidemiological transition with the expected rising costs for NCDs, is another factor of concern for the MOH in considering a sustainable health care financing strategy to ensure the delivery of appropriate health services with reasonable quality in equitable manner to the entire population.

In response to the current situation, the government is considering options to increase further the role of the private sector in financing and delivery of health services. At the same time an increase of user fees, which have been introduced in all public health facilities, is possible although it should be noted that all households already contribute significantly to the financing of health care. The health care financing reform measures should consider these aspects and contain appropriate mechanisms for financial protection such as social health insurance.

Health legislation:

In 1995 an attempt was made to consolidate all health sector and health related legislation into one omnibus Bill titled “Health of the People’s Bill”, which ultimately was not submitted to Parliament. In collaboration with the World Bank a revision of the Health of the People’s Bill is currently being conducted to incorporate other national health policies which have been approved since 1995.

Furthermore the MOH intends to consult with its stakeholders on the review and redrafting of existing health and health related legislation. There are four areas for possible change:

- Raising the quality of services to the public. This includes strengthening professional regulation, quality assurance and licensing of facilities and certain equipment.
- Protecting the public. This includes strengthening food safety, regulation of insurance, drug regulation, public health requirements (tobacco, drink driving, advertising of infant food, quarantine law).
- Clarifying patients rights. This includes access to services, right to information, informed consent, complaint procedures, code of patients rights).
- Refining arrangements in the MOH. This includes reassignment of non core roles to other departments, access to information in the private sector for policy and planning purposes, developing capability to take on more HR and finance roles. Need to regulate private sector.

Conclusions:

In summarizing the health situation in Samoa the following conclusions can be made:

- The health status has improved significantly over the past decade
- Communicable diseases are gradually under control
- Non communicable diseases are the main causes of death
- Reproductive health and in particular the health of the child and adolescent require more attention
- The ongoing reform of the health sector is striving to ensure equity, sustainability, quality and adequate health services
- The partnership between the public and private health care providers needs to be strengthened
- A strategic redistribution of health services would improve efficiency and reduce costs

Section 3: Development Assistance: Aid Flows, instruments and coordination

Overall trends in aid

The Official Development Assistance (ODA) figures for 1990 – 1999 provided by the Treasury Department and Ministry of Foreign Affairs indicate that the amount of grants provided in that period amounts to some Tala 580 million (= USD 185 million). As a percentage of the GDP the grant component varied between 8% and 16%. In percentage of the total revenue of the Government of Samoa the ODA, in certain budget years, could account to more than 50% and of the development expenditure it maximised in 1998 to 92%. An average of 15% to 20% is allocated annually to the health sector mostly directed to the field of Non Communicable Diseases (NCD).

According to the Draft Estimates of Receipts and Payments for the financial years 2002 – 2003 (ending 30 June 2003) Foreign Capital Project Grants may add up to Tala 73,7 million (USD 24,4 million), which is marginally more than the previous budget period 2001 –2002. Foreign Soft Term Loans are expected to amount to Tala 30 million (USD 3 million). The health sector would according to the provided figures be receiving Tala 8.6 million (USD 2.8 million) in grants resulting in a decrease of some 20% in comparison to the previous financial period. From the IDA soft term loans the health sector is projected to absorb Tala 5 million (USD 1.7 million)

Momentarily Samoa receives a comparatively limited amount of assistance in the form of grants from only a very few donors. This in the years to come threatens to be reduced even further. They are Australia, New Zealand, Japan and the European Union. In addition to WHO the following the UN Agencies implement programmes/projects: UNDP, UNICEF, UNFPA, UNESCO, FAO and WMO. Both the World Bank and the Asian Development Bank are providing soft loans.

Coordination and Planning

The external assistance and all development partners activities are coordinated by the Ministry of Foreign Affairs and the Economic Policy and Planning Division of the Department of Treasury, effectively through the Project Coordinating Committee (PCC), which meets at least bi-annually. The PCC tries to ensure complementarity and avoid duplication or overlapping of donor programmes. With regard to the multilateral donors – WB, IMF, ADB, EU- roundtable coordination meetings are organised by the Government several times annually.

In the reform process the MOH also established its a joint Project Coordinating Committee (PCC), which is responsible mainly for the decision making regarding the coordination and implementation of the three key health reform projects/programmes funded by AusAid, World bank and WHO. This PCC, chaired by the DG, is an inter-ministerial committee with donor membership. A Memorandum of Understanding between the Ministry of Health, WHO, AusAID and the World Bank was concluded in April 2001, which defines the broad areas of collaboration and cooperation and provides a framework for other contributors to the health sector in the development and implementation of the projects. The PCC meetings, which are held quarterly, now also include NZaid.

The Department of Health has recently set up its own internal coordinating body: the 'Health Aid Coordinating Committee' (HACC), which is chaired by the Director of Health Planning, Information and Research. It sets strategic directions for the reform programme and monitors the development of all new programmes and projects.

Although it is too early to make a valid assessment of these relatively new co-ordination mechanisms it seems that they are functioning satisfactorily.

The United Nations Country Team (UNCT) in Samoa consists of UNDP, FAO, UNESCO, WMO and WHO. Meetings of the heads of the agencies are held regularly. A jointly published quarterly UN newsletter informs Samoans of the activities undertaken in the country as well as in the Pacific region. UN Agencies like UNFPA and UNICEF based in Fiji are implementing programmes in the country.

Within the United Nations system an effort is being made through the Common Country Assessment (CCA) and United Nations Development Assistance Framework (UNDAF) process to coordinate the assistance the various agencies are rendering. The CCA and the UNDAF for the period 2003-2007 in which WHO participated were both finalized in June 2002. In addition to a summary of the 'lessons learned' the main conclusion was that "*the contribution of the UN must be strategic, innovative and add value. Partnerships and resource mobilization efforts must reflect the unique competencies and comparative advantages of the UN system and its ability to play a catalytic role in policy development*".

The Samoan Government has not developed a "Poverty Reduction Strategy Paper (PRSP)" nor has it as yet taken the SWAps approach into account in its strategic planning.

Major Contributors to Health

All the major donors to Samoa are supportive of the ongoing reform and in one form or the other contributing to the health sector in general.

The World Bank launched a significant infrastructure-strengthening programme, providing USD 5 million over the period 2001 – 2007. In the Health Sector it is currently assisting in policy development and financing infrastructure upgrading. Negotiations are ongoing regarding the introduction of a health insurance scheme.

Parallel to the World Bank contribution *Australia's bilateral assistance* through *AusAID* is assisting the Government in adopting a more strategic approach to managing the health sector and improving the quality of training for medical personnel. The goal of the project is to strengthen the management and operational capacity of the Ministry of Health by improving the quality of the hospital clinical services, improve the quality and increase the reach of rural health services, and reduce the incidence of non-communicable diseases, particularly diabetes. *AusAID* is collaborating closely with the "WHOSTEPwise Approach" and in particular in the survey of risks factors. The clinical aspects of mental health will be a new area of investment. Since according to *AusAid's* assessment Samoa is developing satisfactorily, funding to the country, which in 1998-1999 averaged USD 7.6 million, has recently been reduced in favour of the least developed Pacific Islands.

In addition to the Visiting Medical Specialists programme which aims to treat patients in Samoa rather than in New Zealand and the Medical Treatment Scheme (USD 250,000 p.a.) through the provision within New Zealand of specialist medical treatment not available in Samoa the *New Zealand's assistance agency 'NZaid'* assistance in the Health Sector is focused on Child Health. This project (USD 200,000 p.a. until June 2004) assists in the development of a child/ adolescent health programme and improves, promote and protect the health and development of Samoan children. Within this project WHO will be linking up with the rheumatic fever component in setting up the Rheumatic Fever Register.

NZaid is considering to review the overseas treatment scheme and eventually reorient it with more emphasis on local primary prevention and treatment in addition to a larger Visiting MD program. The agency is also considering to re-orient their scholarship program towards strengthening local education, eventually with supporting visiting scholars.

The European Union recently concluded an agreement with the Government for the EU bilateral contribution to Samoa for 2001 –2007 amounting to total Euro 27.1 million (USD 27 million) under the APC-EC Partnership Agreement whereby the public health sector is mainly being targeted through a coherent programme of extended water supply and sewerage operations. The WHO Samoa office will be participating in the technical dialogue on water quality control and the community water supply.

In the framework of the South Pacific Regional Environmental Programme (SPREP) a Waste Management Improvement Programme is being formulated including the provision of technical advise and focused training in this field.

One of the five target areas of *Japan's ODA through JICA* in Samoa is health /medical services improvement. In the Health Sector Japanese Grant Aid has provided funds for the construction and upgrading of several hospitals and equipment, such as Savaii regional referral hospital (Savaii MT2). In the field of EPI equipment has been provided. A project is being implemented to improve the health education through audio/visual means. JICA also provides a technical training programme sending health persons to Japan for short term upgrading of skills.

Within the United Nations family both UNICEF and UNFPA have important health related programmes/projects. Both Funds have indicated that financial assistance is available for Samoa if it were to submit proposals in the respective areas of work.

UNICEF has provided support in the field of nutrition through the “Baby-Friendly Initiative“ (breastfeeding survey)and immunization (hepatitis B). Assistance in the implementation of Samoan national policies on HIV/AIDS to prevent new infections of young people (train the trainers) is available. Samoa could if it requested also benefit from UNICEF's Pacific Multi-country programme 2003-2007, which aims at building capacity to ensure a better outcome for the Pacific Island children. In particular the “Integrated Child Health and Development” and the “Adolescent Development” Programmes could work complementary to some of WHO's in-country programmes.

UNFPA has supported Samoa since the early 1970s, initially in the areas of population census, maternal child health and family planning, and population and family life

education in formal and non-formal education sector. Within the ongoing programme (1998-2002) it has through the DOH and in parts through the Ministry of Women's Affairs and the NGO "Samoa Family Health Association" made an effort to strengthen the "Utilisation of Quality Reproductive Health Services". Assistance was also provided through the following programmes: "Improving Adolescent Reproductive Health in the Pacific Region"; the "Reproductive Health Training Programme", which provides an 11 weeks course at the Fiji School of Medicine; a study on Violence Against Women in the Pacific and Population Advocacy and Information, Education and Communication (IEC).

Section 4: WHO current country Programme:

WHO's collaboration with the Samoa government started in 1962. Until 1980 support was provided through the WHO Fiji Office in the field of communicable diseases control. In 1980 the WHO country liaison office (CLO) was established, which was upgraded to a WHO Representative Office in 1986. Although the Samoa WHO Office is also responsible for American Samoa, Cook Islands, Niue and Tokelau, this Country Corporation Strategy only covers Samoa. The reasoning behind this is that within the Western Pacific Region in the first instance only countries which country programme budgets above USD 1 million would be considered for the development of a Country Corporation Strategy. The current country programme budget for American Samoa amounts to USD 130,000, for Tokelau USD 101,000, for Cook Island USD 426,000, for Niue USD 97,000, which excludes them for the time being.

The WHO team dedicates roughly 55 % of its time and effort to implementing programmes and providing advice for Samoa. Of the total budget provided for the 5 countries, including ECP, 62 % is allocated to Samoa.

Financial resources

For the last three consecutive biennia (1998 through 2003) the WHO country regular budget for Samoa remained stable at US\$ 1, 222, 000 excluding ECP which amounts to USD 631,960 for the five countries under the responsibility of the Country Office. Since 1998 the extra budgetary funds for Samoa also remained unchanged at US\$ 94,000 per biennium.

Additionally financial support is provided through the WHO Inter-Country Programmes (ICP). For example in 2001 Samoan representatives were able to participate in more than 20 international, regional, sub regional meetings, workshops and trainings. The ICP funds also allowed 22 WHO consultants and experts to visit the country for specific technical consultations, situation assessment, programme monitoring and follow-ups.

Human resource

To date the WHO office in Samoa comprises of six regular staff member: two professional staff i.e. the WHO Representative and the Program Manager Officer (PMO), and four regular general service staff. In addition, the Office operation is assisted by a Short Term Professional (STP) for Water and Sanitation, two technical persons through SSA and two term limited General staff. It needs to be noted that both the STP and one of the SSA will terminate in the middle 2003.

Key areas of work

The WHO *country work programme* for the biennium 2002-2003 concentrates- as it did the previous one for the greater part- on the following areas of work, classified according to the percentage of the total budget allocated

1. Human Resources Development:	49.1 %
2. Health Sector Reform:	25.61 %
3. Non Communicable Diseases:	10.27 %
4. Environment and Healthy Settings:	7.12 %
5. Child and Adolescent Health and Development:	3.68 %
6. Reproductive Health:	2.78 %
7. Sexually Transmitted Diseases:	1.06 %
8. Stop TB and Leprosy Elimination.	0.37 %
Total:	100 %

The table below shows that within the areas of work, in excluding the ECP component, the fellowship component is by far the largest activity. The staff costs for the posts of the PMO and the Administrative Clerk are included in the area of work 'Health Sector Reform' and account for 23.3% of the Samoa country budget.

**Percentage of the programme components
For the country budget Samoa for 2002-2003**

Programme components	%
Fellowships	67
Local costs	2.5
Long term posts	23.3
STCs	5.2
Supply and equipment	2
Total	100

As pointed out above *human resource development* or more specifically *activities in the field of fellowships* absorb more than half of the biennium programme budget (67%). In breaking down the numbers, it appears that in 2000-2001, of the total number of fellows, 21 out of 33 were Undergraduates i.e. 63 %. A shift can be observed in the biennium 2002-2003: the number of fellowships increased to 80 of which 24 were Undergraduates i.e. 30% . These undergraduates accounted for 72 % of the total fellowship budget. It is worth noting that no fellowships for medical undergraduate have been awarded in the biennium 2002-2003. With the financial resources remaining at the same level awarding fewer fellowships with duration of several years essentially means that more shorter training programmes (post graduate) can be provided to upgrade the skill of the health professionals.

Over the last decade the long term plan for WHO's contribution to undergraduate training has been based on the MOH draft "Health Human Resources Development Plan for 1998 to 2020". Although the WHO procedures have in the last 4 years shifted towards

including fellowships under technical programs, this will not be the case in the Pacific Region. Due to the particular circumstances in this region fellowships will remain to be part of HRD budget allocation.

The following table summarises all fellowships and training funded in the biennium 2002-2003:

Areas of work	Fellowships	Budget USD	Workshops, local training and courses	Budget USD
Human resources development	Under graduate training in medicine.	292000	Post-grad diploma for nurses in emergency and high dependency care	5000
	Post-grad training for medical doctors: paediatrics, gynaecology, internal medicine, radiology, mammography, clinical pharmacy.	80000		
	Diploma in pharmacy, Laboratory, radiography, physiotherapy.	147000		
	Clinical attachments for nurses.	14000		
Health sector reform	Laboratory management	5200		
Non Communicable diseases	Bachelors in Dental Surgery.	64000	Mental health and oral health workshops for nurses Post-grad training for nurses in mental health	165 2500
	Placements in Dentistry Clinical attachments for nurses in mental health in Australia	14000		
Healthy settings and environment	Master in Public Health	21000	Refresher courses for environmental health officers	1500
	Bachelors in Environmental health Health education	32000		
Child and adolescent health	Diploma in dietetics, Fiji	32000	Training in nutrition/dietetics for 80 health workers	988
			Training Basic and Community Nutrition at USP extension centre, 9 people	3000
Reproductive health	Clinical attachments for midwives.	28000	Workshops for nurses on maternity care. Midwifery course at national university	1835
STI/HIV/AIDS	NA		NA	
Stop TB and leprosy elimination	NA		Training workshop on TB/Leprosy.	2000
TOTAL		729200		16988

In addition to providing fellowships and local training, each area of work had its own specific activities. These can be identified as follows:

The health sector reform programme in the last biennium provided technical support in the drafting of national blood safety policy, legislation and operational guidelines and conducting training for blood bank health workers as well as devising a mass media campaign to promote community participation in securing a safe blood supply. Support was also provided in the drafting of the national policy and legislation for radiation safety; and the strengthening of capacity for emergency preparedness through training for

health workers and DOH staff, and initiating of disaster information system. As a part of this programme the Safe Motherhood project conducted a needs assessment, developed the safe motherhood protocols and a national work plan for the strengthening of the clinical competencies of the midwives and traditional birth attendants through training.

Within the Non Communicable Disease programme WHO in 2000-2001 has continued to assist in the development of a diabetes and rheumatic heart disease registries and diabetes management guidelines. The NCD risk factor STEPS survey has started to assess diseases trends and burdens. The biennium 2002-2003 sees the improvement of mental and oral health through technical support and the provision of teaching aids and books.

The Healthy setting and environment programme benefited from technical support directed at a better structuring of the current environmental health training and to increase the efficiency and effectiveness of the programme in the MOH. Water quality control and monitoring have been emphasized through providing technical consultation and conduct of national multi-sectoral workshops.

In the present as well as the previous biennium the Child and Adolescent Health programmes focused mainly on nutrition and included mass media activities to promote healthy nutrition.

Through the *Reproductive Health Programme* the 'Safe motherhood initiative' has since 2001 been addressing the surge in maternal mortality which appeared in 1997-98. This was done through workshops for nurses on maternity care and courses for midwives and providing learning material.

With regards to *Sexually Transmitted Infections including HIV/AIDS*, WHO in 2000-2001 took the lead to develop a multi-sectoral response to the UNGASS declaration on HIV/AIDS. Technical support was provided for STI control. Presently assistance is being provided in the drafting of a framework for a national plan of action.

The WHO activities within the *Communicable Diseases programme* have concentrated on the elimination of leprosy and the control of tuberculosis and filariasis as well as outbreaks of dengue and typhoid fever. In addition to technical advice drugs, DOTS treatment and equipment were provided. A national blood survey was carried out to assess the impact of the last three mass drug administrations for filariasis.

All the priority areas of work benefited from the support provided through the Inter-country Programme.

WHO is involved in the two Samoa-based UN Theme Groups on HIV/AIDS and on Food Security and Rural Development and in an advisory capacity also has input in health projects of other donors.

1. WHO's comparative strength in working in Samoa is that it is regarded as a long term partner. Over the years the WHO country office has not only established a good and stable working relationship with the Ministry of Health, but also with other governmental sectors such as Ministry of Women Affairs, Ministry of Youth, Culture and Sports, Ministry of Foreign Affairs and Attorney General's office as well as NGOs and churches

groups. Coordination is initiated and stimulated between UN agencies and other donors in the development and implementation of health projects

The WHO Country Office has with the strong back-up and technical support provided by the Inter-country team of the WHO Office for the Pacific in Fiji and the Regional Office (WPRO) in Manila and sources of information from the WHO Head Quarters in Geneva as well as its widely established networks been able to respond effectively to Samoa's requests for technical advice and updated information. In particular the timely response given to the demand for support in the areas of disaster preparedness, tobacco legislation provide good examples.

WHO's global, regional and inter-country programmes provide participants from Samoa with regular opportunities to participate in international, regional and sub-regional meetings workshops and trainings thereby enabling the sharing of information and experiences, updating of skills and knowledge, and establishing consensus to WHO technical strategies, plans of action, and joint action.

The present staffing composition and available financial resources limits the WHO country office to provide expertise and funds to areas of work other than the ones mentioned above. A shift in priorities and an increase in input will have staffing and funding consequences. Additionally, it needs to be pointed out that Samoa's remote location makes it difficult and expensive to get technical support from either the Regional Office and/or Headquarters.

Section 5: WHO Corporate Policy framework: Global and Regional Directions

WHO corporate policy framework

A WHO Country Co-operation Strategy must reflect the Organisation's corporate policy framework and regional strategies, as well as the health needs of the country and the activities of other development partners.

WHO's mission, as set out in its constitution, remains the attainment, for all people, of the highest possible level of health. A number of challenges have emerged from the significant changes in international health in the last decade, including a new understanding of the causes and consequences of ill-health; the greater complexity of health systems; increasing prominence for 'safeguarding health' as a component of humanitarian action; and a world increasingly looking to the UN system for leadership. WHO has developed a corporate policy framework to guide its response to this changing global environment and to enable WHO to make the greatest possible contribution to world health.

The policy framework continues to reflect the values and principles articulated in the global Health for All policy, which was re-affirmed by the World Health Assembly in 1998 with new emphases on:

- adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- playing a greater role in establishing wider national and international consensus on

health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
triggering more effective action to improve health and to decrease inequalities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;
creating an organisational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

WHO's goal and priorities

WHO's goals are to build healthy populations and communities and to combat ill-health. To attain these goals, the following four interrelated strategic directions have been set for WHO's areas of work:-

- reducing excess mortality, morbidity and disability, especially in poor and marginalised populations;
promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes;
developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair;
developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

These four strategic directions are inter-related and mutually supportive. They all call for the Organisation to build new and broader partnerships.

In addition to these strategic directions, WHO has also defined limited specific priorities. These are based on criteria, which include the potential for a significant reduction in the burden of diseases using existing cost-effective technologies (particularly where the health of the poor will demonstrably benefit), and the urgent need for new information, technical strategies, or products to reduce a high burden of diseases. The specific priorities are malaria, HIV/AIDS and TB; maternal health; mental health; tobacco; non-communicable diseases; food safety; safe blood; health systems; and investing in change in WHO.

Regional Emphasis

Within the WHO corporate strategy and in the light of emerging health challenges in the Region, the WHO Regional Office for the Western Pacific has tailored its own supporting framework for action around four outcome-oriented themes

- Combating communicable diseases;
- Building healthy communities and populations;
- Developing a strong health sector; and
- Reaching out (which encompasses information technology, external relations and communication).

Poverty is one of the most important determinates of health status. Large numbers of people living in poverty, the transition to market economies and globalisation can all have significant impacts on health. At the same time, rapid population growth and ageing of the population have huge implications for the health sector. Environmental factors associated with urbanisation and industrialization contribute to much of the disease burden and, although communicable diseases still impose a heavy burden, disease patterns are changing. The epidemiological transition is resulting in non-communicable disease becoming increasingly important throughout the Region. In recent years, emerging and re-emerging diseases have been a major public health issue in several countries of the Region and tuberculosis is a particularly serious problem.

Health systems in many countries of the Western Pacific Region are underdeveloped and several are still struggling to deliver a minimum level of health services to all areas. Consequently, upgrading the Region's health systems is a major challenge.

Section 6: Strategic Agenda for Samoa: the next 3 to 5 years

Overall goal

The overall goal of WHO in Samoa is to contribute to the improvement of the health status of the Samoans by building on past achievements whilst moving towards a more strategic approach in order to ensure sustainability of , and equitable access to, quality health services.

In order to achieve this goal it is important that WHO builds on the policies and strategies developed by the Samoan government and in particular the Ministry of Health to reform the health sector and recognizes the priorities which have been set i.e. institutional strengthening, strengthening of the Primary Health Care and Health Promotion and the improvement of the quality of the health facilities.

In line with the WHO Corporate Strategy and the need to take account of WHO's comparative advantages, a more selective and strategic approach will be pursued in the work of WHO in Samoa over the next five years.

WHO Strategies for 2003-2007: Three main themes of work and a shift in key roles, function and modalities of support

As set out earlier, since 1996 Samoa has been in the process of carrying out economic and public sector reforms, which inevitably is having an influence on the health sector reform presently undertaken. With this in mind, WHO will, in close collaboration with the other development partners, assist the Ministry of Health in achieving its priorities. In line with this the WHO's country co-operation strategy for the next few years (2003 through 2007) will progressively shift its focus towards the following broad areas of work

- Building Healthy Communities and Populations
- Developing a strong Health Sector

whilst at the same time continuing where necessary to support the MOH in the Combating of Communicable Diseases.

In doing so the WHO will engage in a significant shift in its roles, functions and modalities of support to:

- provide more technical advice for the development and implementation of legislation, policies, strategies and guidelines
- increase research, health sector performance monitoring, assessment and anticipation of trends
- diversify its support to training for certain categories of health workers and specialities
- intensify multi-sectoral collaboration/partnerships and regional networking
- play an increased role in co-ordination of donor assistance and mobilisation of resources

An Overview of the Main Themes of Work

I. Building Healthy Communities and Populations

The aim is to improve the health of communities and populations through integrated approaches which stress the links between development, the environment and health. This approach is characterized by strong community action and supportive public policies.

The activities will focus on *Non Communicable Diseases* including mental health and risk factors.

As has already been described the epidemiological profile of Samoa is changing drastically with the emerging epidemic of Non Communicable Diseases. The morbidity and mortality rate is seriously effected, which is having implications for the health services utilization and expenditures. Since Samoa will need assistance with the development of effective interventions not only at the community but also at the macro economic level, WHO intends to intensify its technical advisory role in an integrated approach to NCD prevention and control in:

- at national level assisting in the (re) drafting and reviewing of existing legislation, policies and strategies to be more in line with present practices in the field of NCDs in general and mental health and nutrition in particular. Internationally WHO can assist Samoa in its efforts to comply with a number of treaties/ agreements such as those dealing with the WTO and tobacco control.
- developing technical guidelines to address risk factors and to ensure the delivery of quality community based services for NCD, mental disorders and nutrition
- advocating health promotion policies dealing with risk factors and developing a mental health promotion framework, striving to achieve healthy lifestyles
- providing advice on how to strengthen integrated community based services, including out reach services and how to improve early detection, treatment, referral, rehabilitation and home based long term care for patients with NCD, chronic conditions, the elderly and mentally disabled.
- providing know-how for developing specific secondary level services for patients with NCD and the mentally disabled.

More specifically, WHO will focus on the *'health of women, child and adolescents'* by providing advice in developing a strategy for the improvement of the health of youths and adolescents and in setting up supporting services dealing with reproductive health, STI/HIV/AIDS, nutrition, mental disorders and rheumatic fever. Additionally, know-how will be provided on how to upgrade the technical guidance and review system and create an effective reproductive health education concentrating on family planning practices and the use of contraceptives. These efforts will benefit from a multi-sectoral approach with interaction between the MOH, the relevant UN Agencies and civil society.

The ongoing activities in the field of *'environment and healthy lifestyles'* will continue through :

- providing technical guidance for health care waste management,
- providing technical support to strengthen the role of the Ministry of Health on water quality and supply
- advising the programme on healthy settings on how to strengthen its input in Samoa
- advising on food safety
- encouraging the improvement of public awareness and the implementation of guidelines for disaster preparedness.

II. Developing a strong Health Sector

This theme includes issues that health policy makers face as they struggle to adapt their health systems to the changing needs of their populations and to achieve maximum impact from their investment in health i.e. health systems reform, health legislation, health care financing, supplies, human resource development, health information and evidence for policy, emergency and humanitarian action.

Within the given context WHO will be concentrating its efforts on and give guidance to the following activities of the MOH:

- Improvement of the Health Management Information System with particular attention for monitoring, evaluation, surveillance of:
 - CDs and NCDs
 - Health sector performance including the private sector
 - Reproductive health services including the quality of obstetric services and the incidence of cervical and breast cancers
 - Human Resources Development
 - Primary health care and health promotion
- Health care financing and specifically with regard to:
 - developing a social health insurance framework
 - capacity building for costing of health services and health promotion at community level related to NCDs, mental health and nutrition in order to be able to advocate a more balanced resources allocation

- Organization of Health Services from the perspective of the public- private mix and looking at the aspects of integration/coordination/collaboration, legislation/regulation and quality and safety of the care provided
- Human resources development in addition to technical guidance for policy and planning provide training for certain categories of health workers and specialities with a focus on:
 - intensifying local training
 - developing of special skills
 - networking in the region by intensifying the existing and identifying new contacts
 - shifting from providing undergraduate fellowships to more post-graduate training
 - encouraging more long distance learning by identifying the existing programmes and options

Diversifying of training for certain categories of health workers and specialties, will entail a progressive shift in resources allocations, resulting in a reduction of undergraduate fellowships to the benefit of more post graduate training in country and in the region as well as skills based training and long distance learning.

III. Combating Communicable Diseases

In implementing this theme WHO will continue to build on the work it has been doing in the past through the Inter-country programme by providing technical advice and materials to the TB and Filariasis programmes. Assistance in setting up surveillance systems to control and adequately respond to outbreaks of diseases such as dengue and typhoid deserve priority as does the strengthening of the laboratory capacity, including blood safety and diagnostic capacity for NCD and their complications. WHO will encourage that the growing threat of STI/HIV/AIDS be addressed and an action plan implemented.

Possible external constraints for the implementation of Strategic Agenda

In carrying out this WHO strategic agenda account has been taken of the problems the MOH is having with its capacity to absorb funds. A further constraint may be delays or changes in the agenda of the health sector reform process. Multiple inputs and divers interests of donor could hamper a collective approach in reaching the same goal.

Section 7: Implications for WHO: some pointers

"ONE WHO"

In accordance with the Country Co-operation Strategic Agenda, the WHO Country Office in Samoa will shift from the present 'hands on approach' towards a more 'strategic approach'. In the future it will take on a more proactive role. This entails intensification of the communication with and more effective use of services and inputs from the WHO

Headquarters, the Western Pacific Regional Office (WPRO) and the Inter-country team in the WR Fiji office.

The scope of inputs from the Inter-country team of the WHO Office in Fiji should be broadened further to include technical assistance in areas such as health financing and legislation, health sector development and health information. Their advisory role on human resources development would include more input into the identification of the options and opportunities to diversify the training of health workers in country and in the (sub)region according to the needs of the MOH. Support can also be provided in maintaining contacts with the UN agencies working out of Fiji and identifying possibilities for (sub) regional funding, partnerships and resources persons.

Building on the input required from the sub-regional level, the Regional Office and WHO Headquarters would provide more complementary technical support and back-up in all areas of work. By developing regional and global public health policies/agreement or treaties such as on tobacco, the WHO Regional Office and Headquarters can assist to strengthen member state's national policies and their implementation as well as broker support/funds from donors for Member States. In particular Headquarters could provide more support by compiling and disseminating packaged information in printed form or electronically which can be used to support the advocacy role of the country office.

On the financial side, in order to have a more flexible and responsive allocation of resources to be used at country level, a larger delegation of authority to carry out internal reallocation and the provision of not earmarked funds in order to respond appropriately to urgent country needs, would be beneficial.

The staffing capacity of the Samoa office will have to be at par with the changing priorities, the new strategic approach and its more proactive role. The staff members will need to readjust to tasks and challenges put before them. A redirection of the way of working methods is required from a hands-on approach to a more analytical and advisory input by the team is required. This will entail strengthening of the country office amongst others by the development of these skills through specific training.

In conclusion:

The implementation of this Country Corporation Strategy setting out WHO's work in Samoa for the years to come will lead to a stronger partnership with the Government of Samoa, the Ministry of Health in particular and the donor community in improving the health status of the Samoans.

¹ Demographic and vital statistics survey, analytical report. D.O. STATISTICS. Apia. 2000.

² 1999 Demographic Health Survey

³ Demographic and Vial statistics Survey, 2000. Analytical report.

⁴ In 1998. The Samoa national Health service Planning Framework, April 2002. N.B.: MMR were 6/100 000 in 1997 and 4/100 000. DOH annual report 1997-1998.

⁵ The Samoa national Health service Planning Framework, April 2002.

⁶ DOH, The Samoa National Health Service Planning Framework April 2002.

⁷ Unicef (CPP2003-2007).

⁸ Case detection rate recorded in August 2001 was 0.41/10,000. In 1997 Samoa reached the point of Leprosy Elimination according to WHO standards (prevalence below 1/10,000)

⁹ Prevalence rate 0.9/ 10 000, detection rate 26/ 100 000, cure rate 74%. DOH annual report 1999-2000. According to WHO Consultant in 2002 an accurate estimation of the tuberculosis burden in Samoa cannot be done due to lack of epidemiological information available and poor reporting. There is concern that TB control is ineffectively managed and unofficial reports believe that the incidence is rising.

¹⁰ DOH, The Samoa National Health Service Planning Framework April 2002.

¹¹ The prevalence of Rheumatic Heart Disease in school children aged 5 – 17 years diagnosed by clinical criteria was 77.8 per 1000 (95% CI 64.0 – 91.6). This is the highest in the world to date. However, echocardiography has not yet been performed on the cases diagnosed clinically. Previous studies suggest that the prevalence of RHD diagnosed by echocardiography is likely to be about 30 per 1000, which is still amongst the highest in the world.”(Steer & Adams 1998)

¹² Typhoid and Dengue are both endemic and occasionally reached epidemic levels in Samoa. The last typhoid epidemic was in 1993. In 2002 another typhoid outbreak has reached epidemic levels. The last dengue outbreak was in 2001. There is concern for inefficient and ineffective management of surveillance systems and outbreaks.

¹³ The high prevalence of STI (31% in 1999) in a moderate to low-risk population of pregnant women and its subsequent implications on the spread of HIV/AIDS highlights the need to improve STI diagnosis and treatment and strengthen surveillance of sexual behavior in the population. It is not possible to make any accurate estimation of the true burden of STIs in Samoa due to a serious lack of epidemiological information and poor reporting.

¹⁴ DOH Annual report 1999-2000, leading cause of mortality

¹⁵ McGarvey in 1995 found the prevalence of hypertension in Samoa to be 31% and 25% for men and women respectively aged 44-60 years. The 4-year incidence is also extremely high, with more than 25% of the non-hypertensive population of men and women aged 44 becoming hypertensive after only 4 years

¹⁶ Diabetes is increasing dramatically in parts of Samoa. The 1991 survey established a crude prevalence of 11.5%, almost a two-fold increase in the previous 13 years

¹⁷ The WHO NCD STEPS Surveillance Survey using a representative sample from across the country will be completed this year. This will help determine the true prevalence of NCD risk factors.

¹⁸ Between 1978 and 1991 the age – standardized prevalence of obesity (BMI \geq 30kg/m²) had risen to 44% in Poutasi (a rural village in Upolu), to 36% in Tuasivi (a rural village in Savaii), and 57% in Apia.

¹⁹ Case study, review of inpatients admissions Samoa 1999, Carol Beaver et al. WPRO

²⁰ DOH, National Health Account for the FY 1998/99, April 2002

²¹ In the late 70’s and early 80’s close to 100 people attempted suicide each year From 1983-1999, the average yearly number of attempts was 37, with a death rate of 57% or around 21 deaths. Estimated suicide rates are 11,7 deaths per 100 000 people per year in 2000. Faataua Le Ola 2002, NGO for the prevention of suicide.

²² Safe motherhood report, May 2001.

²³ Global Water Supply and Sanitation Assessment 2000 – Questionnaire 1999 – Part 1

²⁴ The Samoa National Health service Planning Framework, DOH, April 2002.

²⁵ consisting of one 21 bed private hospital, 10 private medical clinics, 3 private pharmacies, 2 private dentists, 1 private nurse practice

²⁶ Draft health workforce Human resources Plan 1998-2020. DOH, Migration study in the Pacific, WHO WPRO 2001 and Safe Motherhood Report, DOH May 2001, The Samoa National Service Planning framework, DOH, April 2002.

²⁷ Samoa has 61 medical doctors which corresponds to 1 doctor / 2754 inhabitants and 265 nurses i.e. 1 nurse per 6 33 inhabitants.

²⁸ Samoa needs at this time 16 doctors and 135 nurses. Personal communication Dr Satupaitea Vialii, June 2002.

²⁹ UN Common Country assessment Samoa, draft report May 2002.

³⁰ From 1995 to 2000, admissions to district hospitals and health centers fell by 40%.

³¹ DOH, Overseas Medical treatment for Samoans residents: status, issues and options. April 2002.