Government of Samoa

HEALTH SECTOR PLAN

2019/20 –2029/30

"A Healthy Samoa"

MINISTRY OF HEALTH

June 2019

FOREWORD FROM THE MINISTER

Hon. Faimalotoa Kolotita Stowers
MINISTER OF HEALTH

The Health Sector Plan 2019/20 to 2029/30 is timely. It signifies new directions based on evaluated experiences. It indicates our strive for self-confidence and self-respect in developing our own way of doing things. It is about devising our own home grown solutions to our problems, which are more attuned to our circumstances.

In light of the health outcome and health financing challenges facing Samoa, active management was necessary. The urgent realities confronting the health sector but not limited, to our health service delivery system being heavily hospital-centric and a corresponding weakened primary health care. Our health information management system required for disease management and patients tracking is just been developed. NCDs comprises of the largest financial burden on the health system and is the main driver of local and overseas treatment.

In that connection, the Government of Samoa has instituted structural and administrative changes for the Ministry of Health (MOH). The MOH Ammendment Act 2019 enabled the merger on February 01, 2019 and expects the revival of the country's focus on prevention, community engagement in health;the strengthening of primary health care (public health) and; reducing costs associated with duplicated organizational arrangements.

In essence, the main focus of our work through this strategic plan, is to take the service to the people rather than waiting for them to come to the hospital. That will bring value to efforts to place emphasis on 'patient-focus' or 'patient care'; it will add value to a much more collaborative thinking process in terms of strategic planning and reporting; it will serve to enhance development investments already made in the sector; it will place Human Resources for Health at an advanced planned platform with developed career paths and; it will enforce strategic systemic thinking amongst the professions to work as teams, rather than in silos.

This plan will be implemented through a whole-of-country and whole-of-government system approach. Together with our community stakeholders, partners in health and thirteen other governmnt sectors; we will strive to enhance population health by placing our communities and families at the centre of Samoa's health services.

Clearly, the emphasis contained here requires our measuring value, but not valuing measure.

Ma le fa'aaloalo lava.

Hon. Faimalotoa Kolotita Stowers
MINISTER OF HEALTH

STATEMENT FROM THE DIRECTOR GENERAL

Leausa Samau Toleafoa Dr T. Naseri
Director General of Health

The vision of "A Healthy Samoa" as in the Health Sector Plan 2008-2018 remains valid for this new strategic plan. It translates the overarching goal for health development in Samoa and entails the need for an inclusive, people-centred service with emphasis on health prevention, protection, patient-care and compliance.

It is ambitious, but can be accomplished if the sector strengthens its resolve in placing the focus back on public health, accelerate the revitalization of primary health care and commit more in fostering community engagement.

The Health Sector Plan 2019/20 – 2029/30 has been developed to assist the Government of Samoa in delivering a people-centred health service that promotes health and well-being. This strategic plan therefore reflects the sector's commitment to achieving those through the health related Sustainable Development Goals, the health commitments in the 2014 SIDS Samoa Pathway, Government's Goals in its Manifesto 2016-2021, Healthy Islands Framework indicators and the national health strategic outcomes and indicators in the Strategy for the Development of Samoa 2016/17 – 2019/20.

There is a need to re-establish the core value of services that places people and the communities as central. That requires a more holistic and people-centred approach to health, and a balanced consideration of the people's rights to health and the responsibilities and capacities of the health sector. To address these approaches, this plan proposes to:

(i) Strengthen governance, leadership and ownership through partnerships;
(ii) Improve and strengthen people-centred health services (health promotion, health protection and healthcare services);
(iii) Ensure effective and efficient human resource development of health at all levels and across all disciplines;
(iv) Strengthen health information development and management through surveillance, research and health intelligence;
(v) Improve health sector financial management and predictability;
(vi) Ensure appropriate, effective and safe health technologies; and
(vii) Continuous management of disaster and emergency preparedness and response to climate change.

Through this Sector Plan, the sector will commit to implementing our collective vision of ***"A Healthy Samoa"*** and mission of ***"Enhancing Public Health to provide people-centred health services"***. It is the responsibility of all partners and stakeholders in the sector to continue to work together in the practical translation of these inspirations,which will serve to define our realities.

Faia ma le fa'aaloalo lava.

Leausa Samau Toleafoa Dr. Take Naseri
DIRECTOR GENERAL OF HEALTH

ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
CASH	Climate Adapation Strategy for Health
CD	Communicable Diseases
DHS	Demographic Health Survey
DFAT	Department of Foreign Affairs and Trade (Australia)
EPI	Extended Programme for Immunization
FAO	Food and Agriculture Organization
FY	Financial Year
GCF	Green Climate Fund
GDP	Gross Domestic Product
GPs	General Practioners
HPAC	Health Program Advisory Committee
ICHAP	Integrated Community Health Advocacy Program
IHME	Institute for Health Metrics and Evaluation
MAF	Ministry of Agriculture and Fisheries
M & E	Monitoring and Evaluation
MESC	Ministry of Education, Sports and Culture
MFAT	Ministry of Foreign Affairs and Trade
MfR	Ministry for Revenue
MMR	Measles, Mumbs and Rubella
MNRE	Minisry of Natural Resources and Environment
MOF	Ministry of Finance
MOH	Ministry of Health
MT II	Malietoa Tanumafili II Hospital
MTEF	Medium Term Expenditure Framework
MTR	Medium Term Review
MWCSD	Ministry of Women, Community and Social Development
NCDs	Non Communicable Diseases
NGOs	Non Government Organisations
NHA	National Health Accounts
NHS	National Health Service
NKFS	National Kidney Foundation of Samoa
OVT	Overseas Treatment
PEN	Package of Essential NCD tools
PfR	Perforamnce for Results
PHC	Primary Health Care
PIC	Pacifc Island Countries
SAT	Samoan Tala
SBS	Samoa Bureau of Statistics
SDGs	Sustainable Development Goals
SDS	Strategy for the Development of Samoa
SFHA	Samoa Family Health Association
SSB	Sugar-Sweetened Beverages
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TB	Tuberculosis
TTMH	Tupua Tamasese Meaole Hospital
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
VWC	Village Womens Committee
WASH	Water Sanitaion and Hygiene
WB	World Bank
WHO	World Health Organization

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EXECUTIVE SUMMARY

Samoa has already achieved a lot in terms of health outcomes. The WHO affirms that Samoa has solid foundation for achieving the health related Sustainable Development Goals (SDGs). In terms of the HSP 2008-2018 Review, about eighty percent (80%) of the strategic indicators therein were fully or partially achieved over the course of that Plan.

Samoa continues to face an increasing burden of NCDs alongside an unfinished agenda of reducing CDs and expanding public health. NCDs account for over eighty percent (80%) of all deaths and more than half the *prematured* deaths in Samoa. Importantly, NCDs can also impose lifelong disability such as stroke or complications from diabetes that has significant health, social, financial and broader economic consequences on society.

Despite its many strengths, the current health system is not well positioned to respond to the current and future challenges as there is far too little spent on prevention in primary health care settings. Samoa has some of the highest rates and risk factors for NCDs in the world. Yet only around 3% of public health expenditure went to health promotion in 2014/15 (latest year available).

To drive change, there needs to be an increase in the share of public expenditure going to preventive care. Increasing the *share* of government expenditure going to health promotion, disease prevention, and public health is the most tangible, visible, and strategic demonstration of Government commitment to achieving its vision. In addition, there is also a need to reallocate resources *within individual* programs to achieve better efficiency and value for money from Samoa's own health expenditure. Equally important is the strategic focus on *secondary prevention*, including patients' adherence to medications so as to avert or at least postpone the progression of high burden / high cost diseases such as diabetes and hypertension.

Furthermore, the need to plan for and reallocate resources to respond to population changes over the coming decade, including ageing of the population. As noted Samoa's population is projected to increase by 19,851 people, or nearly 10%, over the life of Sector Plan (SBS, 2017). This will have implications for additional maternal, paediatric and child services, rehabilitation, dementia management, and palliative care. Similarly PEN Fa'a Samoa will be renewed, revitalised and strengthened to include prevention and treatment of CDs, public health, reproductive health services, and health security. PEN Fa'a Samoa can help drive efficiency and equity because of its focus on targeted, early, referral to primary and rural health facilities at a population level. PEN Fa'a Samoa is a key, affordable, and strategic approach to moving purposefully towardsUHC.

To finance this sector plan, five strategic areas can be used to expand public expenditure on health in Samoa without putting additional strains on available resources for health.. These include; first, continue to progressively reduce the budget for the OVT, in a phased manner every year, reallocating funds to health promotion, disease prevention and public health. Second, there needs to be further increases in the excise duty on tobacco, alcohol and other unhealthy products, and allocating that additional revenue to health promotion and disease prevention. Third, strengthen the evidence base, and manager‘s accountability for decision-making through better monitoring and evaluation, linked to budget planning. A useful and reliable M&E mechanism is an essential tool to allow managers to scale up those programs that "work" and scale down or even discontinue those that do not, as well as providing accountability for resources used. Fourth, to better align the health workforce to the current and future needs of the country. The skill set, and geographical distribution of health workers, is not well aligned to a people-centred health system envisaged by Government. Finally, the internal coherence of the Sector Plan should lead to resources being freed up over time and increased health outcomes and value for money.

For this sector plan, there are inevitably risks and uncertainties. Some of these risks are within the prerogative of the MOH to control and manage. These include the risk that the Ministry‘s financial and other resources are not allocated, or reallocated over time, to address the highest risk factors or drivers of the burden of disease in Samoa. In addition the scope and scale of the health information system, including the M&E system, is too fragmented and unreliable at this early stage of the plan to serve as the evidence base for improved planning and management.

There are also some risks that are beyond the direct span of control to manage, but which MOH can track and prepare for. One obvious risk is natural disasters including cyclones. Pandemic influenza, drug resistant TB, and relatively exotic diseases including Zika are risks to be tracked and managed. Global or regional economic downturns that reduce economic growth and government revenue are beyond the span of control of the Ministry, but focusing on improved efficiency and community based health promotion and engagement under PEN Fa'a Samoa will provide some genuine resilience to the country’s health system.

INTRODUCTION

The strategic context: progress to date but important challenges remain.

Progress to date.

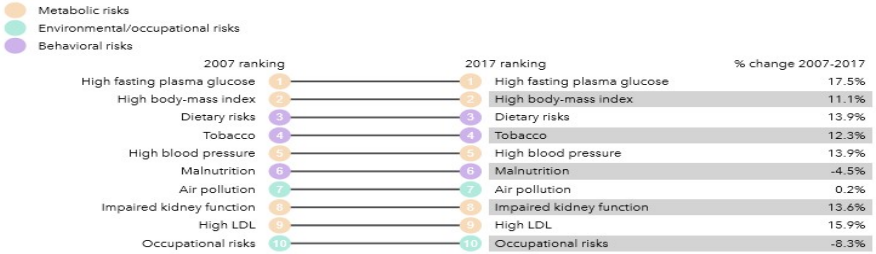
Samoa has already achieved a lot in terms of health outcomes. According to the latest WHO 2017 Tracking Report on UHC, Samoa has already scored particularly high on important SDG indicators for health coverage including 97% population coverage for sanitation, 78% coverage of care seeking behaviour for child pneumonia and 73% coverage for antenatal care visits (WHO, 2018:60). Furthermore, WHO estimates Samoa is already well on track to achieve important SDGs including those for further reducing the maternal mortality rate, as well as the under-five and neonatal mortality rate (WHO, 2018b). The Ministry of Health's assessment of the previous Health Sector Plan 2008-2018 also concluded that seventy eight persent (78%) of the 41 strategic indicators had been fully or partially achieved over the course of that Plan. The Institute for Health Metrics and Evaluation (IHME) estimates that Samoa does significantly better than comparator countries on 4 out of 10 important health outcomes, and does roughly the same as comparator countries on another 3 health outcomes.

Important challenges remain.

NCDs are a strategic challenge in Samoa. They account for over eighty perecent (80%) of all deaths and more than half the premature deaths in Samoa (WHO, 2018). Importantly, NCDs cause not only premature deaths but also cause potentially life-long disability including stroke, diabetes related blindness, and diabetic or cancer related amputations. NCD related premature deaths and disabilities then impose large but often preventable social costs on individuals and families; financial costs on the public health system; and broader costs on the economy more widely through absenteeism and lost employment. NCDs are usually complex to treat, often requiring medication and treatment for the remaining life of a patient, imposing new challenges on a health system that may have been designed to focus on addressing relatively short term maternal and child health and communicable disease challenges.

Importantly, the risk factors for that drive both death and disability in Samoa have been increasing over time. For example, as Figure 1 below shows, high fasting plasma glucose, a risk factor for acquiring diabetes estimated to have increased 17.5% between 2007 and 2017. Other risk factors for NCDs including high body mass index, dietary risk and tobacco use have all increased by more than 10% over that period (IHME, 2019).

Figure 1: What risk factors drive the most death and disability combined in Samoa?

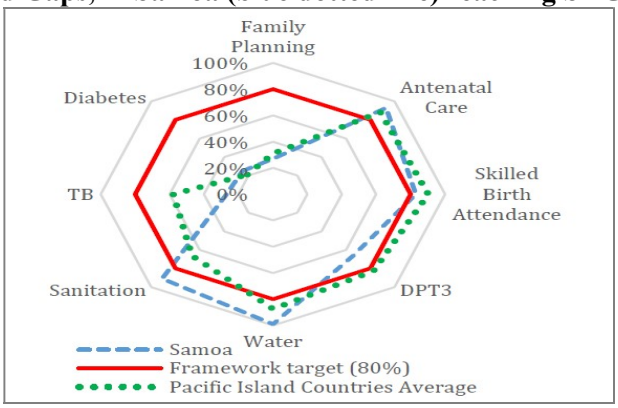


Source: Institute for Health Metrics and Evaluation.

Samoa also has an unfinished agenda of strengthening family and reproductive health and reducing communicable diseases, including TB and STIs. Despite much progress, the Government's review of the previous Sector Plan shows that several important targets have not been achieved including reducing the infant mortality rate; the maternal mortality rate; and TB incidence and death rates associated with TB

(MoH, 2018: 99 – 104). The latest WHO *Tracking of Universal Health Coverage* estimates that only 37% of family planning demand is satisfied with modern methods (WHO, 2018). This Sector Plan will increase the contraceptive prevalence rate to 80% by 2030. Figure 2 below shows Samoa (the blue dotted lines) is well below the Sustainable Development Goals target (the red lines) for immunisation (DPT3); TB; and family planning, as well as the Pacific Island countries average (the green dotted line).

Figure 2: Progress and Gaps, in Samoa (blue dotted line) reaching SDG targets (the red line)



Source: World Bank (2018) *Samoa: a review of public spending on health: improving efficiency today to ensure a sustainable and healthy future.*

Additional health challenges will be apparent by 2030. Samoa's population is projected to increase by 19,851 people, or nearly ten percent (10%), over the life of the Sector Plan. Importantly, there will be an increase of 3,192 infants(SBS, 2017) aged 0-4 years over the life of the Plan and this will have direct implications for the increased provision of maternal, paediatric and family care. At the same time, Samoa has an ageing population. There will be an additional 3,729 people aged 60 years and older between now and 2030 (SBS, 2017). This is important because spending per capita on those aged 60–80 years is, on average, three times that in those aged 30–50 years in Samoa. (World Bank, 2018, p.60). Increased public expenditure for the aged is therefore likely to be needed, especially as only 0.24% and 0.17% of Government current expenditure on health went to long term care and rehabilitative care respectively in 2014/15 (WHO, 2018). Ageing of the population also requires different services and skills including the ability to respond to rising dementia, disability and the need for palliative care. Increasing numbers of children, and the aged, can also change the dependency ratio of Samoa to relatively more young people, and elderly people, relying on workers in the formal sector to provide revenue to finance health and other social welfare needs.

Mental health issues now formally part of the SDG goals for NCDs – are now an increasingly prominent part of international health (WHO, 2018) and an emerging challenge in Samoa. An estimated 16.4% of the Samoan population have moderate to severe mental disorders (WHO, 2018). There were 210 patients consulted, admitted and treated for mental health in the TTM hospital, and 154 patients accessing mental health outreach programs in 2017/18 (GoS, 2018). Samoa has a relatively good record in terms of responding to mental health issues (Mulder R et al (2016). However, more needs to be done. That is because there has been an increase in mental health admissions to the TTM hospital of 2,014 patients since FY2014/15. There is only one specialist mental health doctor in the country, and 3 nurses with post graduate qualifications in mental health.

Two factors that are driving the need for strategic change.

First, despite its many strengths, the current health system is not well positioned to respond to the current and future challenges as there is far too little spent on prevention in PHC settings. Samoa

has some of the highest risk factors for NCDs in the world, including 84% of the adult population being overweight or obese, and 70% of those tested having hypertension but not on medication (MoH, 2018:13). The prevalence of diabetes among women has increased from 2% to 19% between 1978 and 2013 (WHO, 2018:13). This is particularly worrying given the relatively high total fertility rate of women in Samoa and the known adverse health risks for the woman and her child if she is diabetic. Yet only around 3% of public health expenditure went to health promotion in 2014/15. This amounted to an average of just SAT 14 per person per annum (MoH 2015: 24 – 27). Samoa now has a modern tertiary hospital, but this is making the health sector hospital-centric: TTM hospital absorbed 81% of the Government's total health budget in 2018/19 compared to absorbing 45% of the Government's total health budget in 2010/11. (GoS, 2018: 312).

As a result, patients bypass nearby, and lower-cost, rural health facilities to join an ever-increasing crowded hospital in Apia for often relatively minor ailments. Samoa has a relatively low health worker density (4.9 per 10,000 population) and the workers are not well-distributed geographically to improve equity and access for the majority of the population. Nor is the current health workforce now appropriately trained and skilled to respond to emerging challenges such as ageing, palliative care, mental health or disabilities. A significant number, and share, of the health workforce is made up of managers and administrators rather than front-line health workers(World Bank, 2018:8). The health information system does not provide sufficient, reliable, timely, usable, comparable, or integrated data to allow managers to scale up those programs that "work" and scale down those that do not.

Second, there are limited resources to respond. Development partners have been helpful but the core responsibility for managing and financing the government's response to the current and future health challenges will always be with government. Government's expenditure on health, at SAT 98.5 million for 2018/19, is already 18% of total Government expenditure and is the second largest item of expenditure in the national budget after MESC. The most feasible, affordable, and sustainable way to respond to the current and future challenges is therefore to improve the efficiency, effectiveness, equity, and sustainability of the resources already being used by the health sector. Samoa can do that best by (i) reallocating resources purposefully over the life of the Sector Plan away from high cost low impact programs to higher impact lower cost programs and; (ii) proactively strengthen and use evidence base to improve program management,. Importantly "resources" in this context, and throughout this Sector Plan, are not just financial resources. They also involve human resources in the form of health workers, communities and individuals.

All stakeholders, including individuals, communities, the private sector, NGOs and development partners have a role to play in transitioning the Samoa health sector to meet future needs. However, the government provides 82% of total health expenditure in Samoa. What the government does or does *not* do will therefore have a large impact on achievement of this Plan. This Sector Plan explains what, why, and how things can be strengthened over the coming decade.

Implementation issues: why this Sector Plan has good prospects of achieving strategic results by 2030.

First, and most importantly, there is clear evidence of the Government's political commitment to the health sector, and its desire for reform. Government already allocates 18% of its total health budget, the second highest allocation after education, to the health sector. Government health spending increased from 13% to 15% of GDP between 2006 and 2016, equivalent to real per capita spending increases of almost 30% over that period (World Bank, 2018). This has also resulted in relatively low levels of direct out of pocket expenditure for health and low risk of financial hardship: a good public policy outcome and an important part of UHC and the SDGs. The Government also has a clear and determined vision for "A Healthy Samoa".

Second, the past, the present and the future are key building blocks for driving change over the coming decade. Samoa has a proven, successful, tradition of effective community-based engagement in health, particularly through VWCs, going back to the 1918 global influenza pandemic. More recently, the merge of the MOH and the NHS from 1 February 2019, now offers the opportunity for more coherent policies and programs within the health sector, integration of information systems, and reduced duplication of administrative costs.

Samoa also has several supportive bilateral and multilateral development partners. This includes partners who, because they assess Samoa has an essentially sound public financial management system, are prepared to explore and consider an innovative new financing instrument that has the GoS very much in the "driver's seat" of health sector reform. If approved, the PfR funding modality would be the first such innovative financing instrument for the health sector in the Pacific.

Third, this Sector Plan is well-aligned to Samoa's circumstances. The Plan was developed after a careful review of the strengths and lessons arising from the previous Sector Plan The 7 key outcomescontained in the 2013 Mid-term Review HSP Report directly addresses the current and future strategic health challenges confronting Samoa. Furthermore, all of the proposed indicators are ambitious, but ultimately achievable, over the course of the decade. Care has also been taken to align, adapt, or link the targets in this Sector plan with Samoa's commitments to international targets as well as regional targets. Ulitmately, this Sector Plan is also consistent with and supportive of the country's *Strategy for the Development of Samoa* 2016/17 – 2019/20.

Fourth, this Sector Plan also has an overarching financing framework. The merge has enabled the production of a more unified and integrated financing plan for the duration of the Sector Plan. That financing plan is indicative at this stage as it is not possible to have detailed budget estimates of individual activities over a ten year period when the total budget envelope each year is not known. Prices of goods and services are not known; and individual priorities will need to change in the light of changing health challenges and managers' experience about what programs need to be scaled up and which ones need to be scaled down. What is possible is to have more precise estimates for expenditure in the 2019/20 year, with more indicative estimates for expenditure under the total life of the Sector Plan. Chapter 5 provides details with Table 1 below summarising the situation. The development of the budget figures for 2019/20 draw on recent detailed plans and costing work where that is available (MoH, 2018); (World Bank, 2018); (FNU, 2018).

The ten year financing plan in Table 1 has some strengths. The strengths include the fact that, for the first time in many years, this ten year financing table integrates both MoH programs and those of the former NHS, thus presenting a unified picture of the Government's expenditure in the health sector. Furthermore, the estimates include the latest, detailed, budget estimates for scaling up PEN Fa'a Samoa.

Each of the budget figures in Table 1 are assigned to one of the 7 key outcomes of the Sector Plan. That reflects organisational and divisional arrangements within MOH. However, it also means that key strategic *program* changes that lie at the heart of this Sector Plan are not visible or clear. For example, the table shows that 21.78% of the proposed financing plan over the decade will be allocated to Key Outcome 1: "Improved health systems, governance and administration". This *could* be interpreted to mean administrative overheads rather than direct service delivery. That would be a mistake for three reasons.

First, the strategic goal underneath Key Outcome 1 is "to strengthen health system governance for Universal Health Coverage (UHC)" and its theme to leave no-one behind. As part of that effort, the proposed total budget of SAT$ 266,805,535.08 includes funding for all district hospitals (which are, since the merge of MOH and NHS are now classified as "public health" rather than "clinical") to reflect the Government's intention to shift the focus of services to health promotion and disease prevention. The

proposed budget also includes all health worker salaries and services, including multi-disciplinary teams to be working in district hospitals under PEN Fa'a Samoa, and those health workers involved in providing maternal and child health services and sexual and reproductive health services.

Second, the Sector Plan involves a purposeful increase in the focus and resources being allocated to "public health services" and away from a disproportionate allocation to curative, hospital-centric services. It is relevant in this context to note that "public health services" are formally defined by the MOH as consisting of community and primary healthcare centres; district hospitals; wellness, health education and promotion; national disease surveillance and International Health Regulations, and health protection and enforcement services.

Third, the Sector Plan commits to reallocating resources from expensive efforts at curative care with a poor prognosis to broader, community based, health promotion and prevention. Under Key Outcome 1 this Sector Plan will see a 5% reduction in the OVT budget in each year over the life of the Sector Plan from 2019/20. Such a reduction will see the OVT budget reduce from SAT 5 million in 2019/20 to SAT 2.9 million by 2029/30. That planned, regular, reduction of 5% of the OVT budget each year will free up a total of SAT 2,006, 315 over the life of the Sector Plan that will then be reallocated to health promotion, disease prevention and other important public health priorities.

Moving to program based budgeting and reporting will, in future, significantly increase the clarity and transparency of how funds are allocated by program and higher level outcomes.

Table 1: Indicative financing framework for the Sector Plan

Key outcome	Indicative allocation over the life of the Health Sector Plan 2019/2020 – 2029/30 in Samoan Tala	Percentage share of the total Government financing
1. Improved health systems, governance and administration	$266,805,535.08	21.78%
2. Improved prevention, control and management of communicable and neglected tropical diseases	$259,496,398.40	21.18%
3. Improved prevention, control and management of non-communicable diseases	$564,184,009.92	46.06%
4. Improved sexual and reproductive health	$127,710,321.45	10.43%
5. Improved maternal and child health	$654,830.00	0.05%
6. Improved healthy living through health promotion and primordial prevention	$3,218,000.00	0.26%
7. Improved risk management and response to disasters, public health emergencies, and climate change.	$2,939,000.00	0.024%
Total	**SAT$1,225,008,094.85**	**100%**

An overview of the five key strategies that will drive change.

It is helpful to get an overview of the key strategies that will drive change over the life of the Sector Plan. Details of the Sector Plan, including specific activities, indicators, and indicative budgets are set out in Chapters 4 and 5. The following therefore stands back and identifies the key strategies and specific outputs and outcomes that run throughout the Plan.

First, the share of public expenditure going to preventive care will increase under this Sector Plan. The latest NHA for Samoa show that only 3% of Government health expenditure (MoH, 2016) went to preventive care. This was the equivalent of just SAT 14 per capita (MoH, 2016:27). Immunisation is one of the most cost-effective, feasible, and affordable programs within a public health system that received the lowest share of Government funding for prevention (MoH,2016:22), but with development partners contributing significantly. Curative care absorbed 71% of Government health expenditure, and over half (55%) of that went to inpatient curative care rather than lower cost outpatient, community or home based care. Hospitals absorbed more than half (52.9%) of Government health expenditure. Residential long term care, and rehabilitative care, attracted less than 0.5% and 0.17% of the Government's health budget: areas that will need to change as the number, and share, of Samoa's population aged 60 years and over increase.

Increasing the *share* of government expenditure going to health promotion, disease prevention, and public health is the most tangible, visible, and strategic demonstration of Government commitment to achieving its vision. This Sector Plan therefore intends to purposefully shift the allocation of resources going to preventive care from 3% of Government expenditure on health in 2014/15 to 10% by the MTR in 2024, and to at least 15% by 2030. This Sector Plan will also increase the average per capita Government expenditure on prevention in "real" (that is, adjusted for inflation) terms beginning in 2019/20 and then over the life of the Sector Plan.

Second, there is also a need to reallocate resources *within individual* programs to achieve better efficiency and value for money from Samoa's own health expenditure. Just as there is a need to reallocate resources to health promotion, disease prevention, and public health across the whole of the sector, there is a need to reallocate resources to more effective interventions *within* individual programs. There is significant scope to do this in all countries, including Samoa. The WHO, for example, has identified 10 major sources of inefficiency and waste in health expenditure globally, some of which are relevant to Samoa (WHO, 2010). The WHO has also identified 16 "best buy" interventions to reduce NCDs that it considers to be "cost effective, affordable, feasible and scalable in all settings costing as little as $US 1 per person per year in lower income settings between 2018 and 2025" (WHO, 2017). WHO estimates Samoa could save 200 NCD related deaths by 2025 if it scaled up all of the 16 "best buy" interventions (WHO, 2018:175).

There is scope in Samoa for making significant improvements in efficiency and achieving better value for money in its public health expenditure. As just one example, Ministry of Health reports show there were five times more screening tests for HIV than there was screening for Chlamydia (MoH, 2018:41,42). This is despite the fact that there was only 1 new case of HIV identified last year and a total of 13 patients living with HIV in Samoa, yet 24% of those tested had Chlamydia and 5.5% had Gonorrea in 2018 (MoH, 2018:41). Currently, HIV and STI tests are funded by development partners. However, the Government of Samoa should consider funding additional chlamydia testing. Similarly, the Government currently allocates the lowest share of prevention resources to immunisation as arguably one of the most cost-effective, even cost-saving, interventions available. Furthermore, there is a generally low allocation to maintenance and especially *preventive* maintenance of laboratory and diagnostic equipment and assets, reducing the technical and economic life of expensive assets and reducing value for money. Particularly given the opportunities that now arise for a more coherent and integrated approach to program activities as a result of the merger, line managers will be tasked to review expenditure programs to ensure resources are being allocated to the largest drivers of the burden of disease in Samoa.

There is scope to improve efficiency and value for money in the treatment of diabetes, including exploring alternatives to dialysis for those who have started to develop renal insufficiency. The Government's allocation to the NKFS has been increasing in both absolute amounts, and as a share, of the Government overall health budget. Eighty per cent of NKFS patients who are on dialysis either started from unmanaged diabetes or unmanaged high blood pressure. This is very important because it reconfirms the central message of this Sector Plan that early detection and proper, sustained management of diseases can avert or at least postpone subsequent health burdens, complications, and costs to the health system. There are affordable and effective interventions for patients at the pre-dialysis stage, some of which could even be an affordable alternative to dialysis, or at least defer the commencement of dialysis for up to several years.

There are other examples of how Samoa can achieve good health outcomes and achieve cost savings and value for money in the treatment of diabetes. While not a formal randomised control trial with equivalent counterfactuals, one recent study found that treatment costs of the Diabetic Foot Clinic in Apia are nearly 8 times lower when compared to the costs of admitting a client with diabetic foot sepsis into TTM Hospital. Given these and other possibilities of affordable interventions for diabetes patient, any suggestion that Samoa would fund kidney transplants with public money should be subject to the most careful scrutiny in terms of feasibility, prognosis, equity, financial cost and most importantly"opportunity cost". This Sector Plan will invest in program evaluations to identify affordable, effective, treatment options for the growing number of pre-dialysis patients, beginning in 2019/20, with the aim of reducing the cost burden on the NKFS and achieving the best quality of life for those individuals. Any proposals for kidney transplants will be subject to very careful scrutiny, cost analysis, and justification in terms of the opportunity cost.

There is also scope to improve efficiency and value for money through more strategic use of the pharmaceutical budget. Samoa, like all other PICs has little alternative other than to pay prices for pharmaceuticals that are significantly above WHO median prices (World Bank, 2018). However, what is within the span of control of the MOH is to ensure that funds spent on pharmaceuticals will achieve good outcomes. This is important because Government expenditure on pharmaceuticals was SAT$4.5million in 2018/19, or 4.4% of the current health budget.

Demand for pharmaceuticals will and should inevitably increase as PEN Fa'a Samoa scales up under this Sector Plan and more individuals are identified and prescribed drugs. Research suggests Samoa spends less on pharmaceuticals than would be considered appropriate for the country given its disease burden and level of income **(World Bank, 2018:11)**. Samoa can achieve significant efficiencies and cost savings in pharmaceutical purchases by investing resources in *secondary prevention* throughout the country and doing everything possible to ensure patients continue with their medication and do not drop out of or become lost in the public health system. Conversely, pharmaceutical costs can be unaffordable and unsustainable if secondary prevention is weak and diabetes and / or hypertension progresses in a patient. This Sector Plan will therefore update training of front-line health workers, especially community health workers, beginning in 2019/20, on the strategic importance of *secondary prevention*, including patients' adherence to medications so as to avert or at least postpone the progression of high burden / high cost diseases such as diabetes and hypertension.

The third important strategy is to plan for and reallocate resources to respond to population changes over the coming decade, including ageing of the population. As noted, Samoa's population is projected to increase by 19,851 people, or nearly 10%, over the life of Sector Plan (SBS, 2017). This includes an increase of 3,194 newborn and infants with implications for additional maternal, paediatric and child services. It also involves an additional 3,729 people (SBS, 2017) aged 60 years and older with implications for rehabilitation, dementia management, and palliative care. As with many issues in the health sector, the ageing of a population is strategically important, but not necessarily a visible or "urgent" challenge. It therefore tends to be neglected.

The fourth key strategy of this Sector Plan is that PEN Fa'a Samoa will become the renewed and revitalised centrepiece of the Sector Plan. The PEN Fa'a Samoa ("The Samoan Way") is a program designed to screen people at a community and village level for NCD related risks; place identified higher risk patients on a referral pathway to rural health facilities and, if necessary, hospital facilities; and increase health awareness. Early pilots show PEN Fa'a Samoa helps plug a major gap of over 50% of the Samoan population is at high risk of developing an NCD; yet over 70% of the population in the pilots had never had their blood pressure or blood glucose measured; and only 30–40% of those diagnosed were taking the appropriate medication.

PEN Fa'a Samoa is therefore potentially and particularly appropriate in the cultural context of Samoa given its strong community focus and engagement with local women's committees. PEN Fa'a Samoa can help drive efficiency and equity because of its focus on targeted, early, referral to primary and rural health facilities at a population level. This would be in contrast to the current situation whereby individuals self-select to go the TTM central hospital, bypassing lower level facilities, and often only when NCD complications arise. PEN Fa'a Samoa is therefore a key, affordable, and strategic approach to moving purposefully towardsUHC.

PEN Fa'a Samoa has not been given the priority and prominence required: this will change under the Sector Plan. The number of people screened for NCDs under PEN Fa'a Samoa has declined in each year since 2015 with none screened in 2018 (MoH, 2018:22). There is little tracking of how effective, and cost-effective the referral system is; the clinical quality of services received; and the extent to which patients are managing their diseases. This will change. PEN Fa'a Samoa will be the centrepiece of the Sector Plan, giving it strategic focus and coherence. More specifically, this Sector Plan will scale up PEN Fa'a Samoa to cover 50% of the targetted eligible population by the MTR in 2024 and to 100% of the targetted eligible population by 2030. To prepare for the accelerated scale up of the PEN Fa'a Samoa, there will be an intensive short-course training program of health workers on PEN Fa'a Samoa principles and approaches, and a diagnostic study of likely increased demand for pharmaceuticals as a result of the scale up, completed in 2019/20.

Fifth, PEN Fa'a Samoa will be broadened to include prevention and treatment of communicable diseases, public health, reproductive health services, and health security. PEN Fa'a Samoa focuses on NCDs. However, Samoa also faces the challenge of scaling up its response to CDs including STIs and TB as well as responding to reproductive health where there is a large unmet need for family planning and birth spacing. According to latest WHO global tracking of UHC, only around one third (37%) of the family planning demand in Samoa is satisfied with modern methods, the lowest rate in the Pacific (WHO, 2018). This Sector Plan will increase the contraceptive prevalence rate to 80% by 2030.

An expanded "PEN Fa'a Samoa" is also the best and most appropriate vehicle for making further progress on national level health security. Samoa has clearly made good progress with respect to certain aspects of national level security. The latest WHO report gives Samoa a very creditable rating of 75% when it comes to the "International Health Regulations core capacity index", the second highest rating of any country in the Pacific (WHO, 2018). But more could and should be done. There is, for example, limited capacity to test for the influenza virus. There have been recent outbreaks of lymphatic filariasis and there is the potential risk of measles. There is very little risk of exotic diseases such as Ebola emerging in Samoa (WHO, 2018) but there are tangible risks to health security in terms of "traditional" diseases. For example, the previous Sector Plan did not achieve the targets for reducing the incidence and death rates of TB (MoH, 2018:101), a particularly troublesome health security issue if drug-resistant or multi-drug resistant TB emerges in Samoa. Immunisation coverage is generally low. Given that situation, this Sector Plan will therefore focus its health security measures on the endemic rather than the exotic.

Five strategic ways to finance and resource the Sector Plan.

There are also five strategic areas that can be used to expand public expenditure on health in Samoa without putting additional strains on available resources/ on Government.. These five strategies are outlined below.

First, continue to progressively reduce the budget for the Overseas Medical Treatment (OVT) scheme, in a phased manner every year, reallocating funds to health promotion, disease prevention and public health. The OVT is an expensive program with very limited benefits. The review of the Sector Plan for Health 2008-2018 notes that OVT absorbed 10.5% of the Government's total budget for health on just 0.1% of the population. The latest available NHA shows that Government spent SAT 11.63 million on OVT during 2014/15, an average Government expenditure of SAT 37,882 per patient that year (MoH, 2016:10; MoH, 2018:24). That is 82 times more than the average SAT 463 the Government spent on all health per person per year and 2,700 times more than what the Government spent per capita on preventive care services MoH, 2016:9 & 27). The previous Sector Plan sought to reduce the number of patients referred overseas by 5% each year. This target was achieved – even exceeded (MoH, 2018: 24) – but the OVT *expenditure* still continued to rise.

There is therefore a more strategic approach which improves overall health outcomes and public expenditure but which recognises the political realities. Government has already reduced the expenditure on OVT from SAT 12 million per year recently to SAT 6 million in 2018/19, and to SAT 5 million in 2019/20. One strategic option would therefore be to reduce the OVT budget by a relatively modest but politically acceptable 5% each and every year over the life of the Sector Plan. Furthermore, it would be strategic not to increase the OVT budget due to inflation in any year of the Plan. This would have the strategic advantage of allowing all future "real" (that is, adjusted for inflation) increases in the health budget that would have gone to the OVT program to be reallocated to higher impact and more equitable health promotion, disease prevention and public health programs. It would also have the advantage of providing budgetary discipline on the OVT, increasingly encouraging greater priority being given to referrals that have a good prognosis. This Sector Plan will therefore see an annual reduction in the OVT budget by 5% ever year, and there will be no increase for inflation in any year after 2019/20 with the funds then freed up relocated to health promotion, disease prevention and public health. In 2019/20 the OVT will be SAT 5 million (i.e. no increase due to inflation over previous year) and specific plans developed for prioritising patients with a good prognosis as a result of OVT budget being reduced by 5% each year thereafter.

A second strategic way to finance the Sector Plan without putting additional strains on the Government's overall budget is to increase the excise duty on tobacco, alcohol and other unhealthy products, and allocating that additional revenue to health promotion and disease prevention. Tobacco use is one of the leading causes of NCDs, and taxing tobacco has been described as "the single best health policy in the world" (William Savedoff & Albert Alwang (2015). Raising the excise duty to the WHO recommended 70% of the retail price of cigarettes is a win-win measure for Government because it raises additional tax revenue while reducing the incidence and prevalence of tobacco use, especially among the poor. Samoa currently has a relatively low excise duty of less than half (49.5%) the retail price of cigarettes compared to the WHO recommended level of 70%, and also compared to other PICs. Niue and Cook Islands for example have excise duties of, respectively, 84.29% and 70.3% of the retail price. There is also a need to ensure complementary tobacco regulation policies are working as intended, and are being assessed for effectiveness. A new Samoa tobacco control policy is currently being developed and the new policy will provide an opportunity to strengthen the policies and implementation of tobacco control.

Raising the excise duties / taxes on other risk factors for NCDs including alcohol, sugary drinks, and unhealthy food, are also strategic responses given the particular risk factors for NCDs in Samoa. Excessive alcohol consumption directly affects the incidence of NCDs including cancers as well as injuries (domestic violence and traffic accidents). Samoa's national alcohol control policy (MoH, 2016) has several

important findings and well-targeted, strategic, recommendations for reducing the burden of alcohol consumption on health outcomes and the health system. The evaluation planned for 2021 needs to carefully assess the extent to which those findings and recommendations have been implemented in practice. Sugary drinks also significantly contribute to obesity and type 2 diabetes (Malik, V et al (2010) 1356), the key challenges in Samoa. Taxing sugary drinks and other unhealthy food is therefore another strategic investment to reduce NCDs and raise revenue for Government. Reallocating all or part of the revenue raised from those taxes would help expand PHC and UHC.

In summary, this Sector Plan will therefore increase the excise duty on tobacco to 70% of the retail price of cigarettes by the MTR in 2024. This Sector Plan also plans to increase taxes by 25 % on other unhealthy products by 2024 and evaluate the impact on consumption of unhealthy products, with a view to increasing the taxes further if they reduce their consumption. In 2019 /20 MOH will finalise the tobacco control strategy 2019-2014. It will also examine the experience of other Pacific Island countries that have raised taxes on unhealthy products, including especially SSBs and design appropriate excise duty increases in 2019/20.

The third strategic way to free up resources over the course of the Sector Plan is to strengthen the evidence base, and manager's accountability, for decision-making through better monitoring and evaluation, linked to budget planning. Samoa cannot afford to allocate scarce resources on programs that are not effective, efficient, equitable or sustainable. A useful and reliable M&E mechanism is therefore an essential tool to allow program managers to scale up those programs that "work" and scale down or even discontinue those that do not, as well as providing accountability for resources used.

Previous, and to an extent current, M&E systems do not provide sufficient accountability or drive strategic choices. The recent Health SWSAp in Samoa was rated unsatisfactory by the World Bank not because it was necessarily a bad program *but because the M&E system could not provide the evidence to show it was a good plan* (World Bank, 2016). The M&E framework was too fragmented, too complex, or simply lacked basic data on indicators. Some of those problems continue. However, the merger does provide the potential for more integrated collection and analysis of data. Weaknesses in the paper based system, including the means of tracking *quality* of services, will not be resolved simply by moving to the (long-delayed) transition to electronic data management. Nor is the M&E framework particularly good at providing early warning of emerging health risks and threats to program delivery or health outcomes. Importantly, what M&E data has been collected is not always used for purposes of real-time management decision-making; accountability, or lesson-learning. This Sector Plan will therefore have indicators to track that M&E reports are, themselves, actively being used by managers for decision making.

Moving to a system of program-based planning, budgeting and reporting will provide a better means for managers to track and reallocate resources to where they will have the greatest effect. Budgets are currently organised and tracked on the basis of individual administrative functions and activities. It is therefore difficult and time consuming to track the extent to which scarce financial and human resources are being allocated against the achievement of specific, strategic, outcomes. It is, for example, not easy to track what share of the Government's, or the whole sector's, budget is allocated to preventive services, despite the crucial role that prevention must play in reversing the NCD challenge in Samoa.

Budget planning will also be better linked to the Medium Term Expenditure Framework (MTEF). One of the advantages of a 10 year Sector Plan is that managers can shift away from budgets formulated on a one year, essentially historical funding basis, to a more medium term forward looking plan for resource allocation. To be effective, however, the transition to program-based planning budgeting and reporting needs to be better linked to the MTEF. *Refer to the Supplementary Document* for the explanations of how the financing plan and budgeting can be better linked to the MTEF, and used as a basis for identifying, and plugging, any financing gaps.

There is also a clear need to strengthen the broader evidence base to enable more informed, strategic, decision making. For example, cancer and diabetes registries, and the tracking of patient referrals, needs to be strengthened. The NHA or a similar mechanism, needs to be kept up to date so as to track the trends in the main sources and uses of all funds coming into and being used by the health sector, and to track if there is a rational allocation of resources against program priorities.

In summary, this Sector Plan will therefore strengthen the evidence base for decision making through a more useful, usable and used M&E framework by the time of the MTR in 2024. The M&E framework will include its own indicators to track the extent to which program managers are using M&E reports as part of the evidence base for better decision-making and helping the Ministry to be a learning organisation. The Sector Plan will also pilot and then move to a program budget and reporting system by 2022, better linked to the MTEF. The NHA, in a simplified version, will be produced each year by the time of the MTR in 2024 so as to track trends in the sources and uses of funds across the sector, an important basis for verifying the efficient allocation of resources against program priorities. By 2029, at least 5% of the government's public health budget will be allocated to program evaluations. By 2029 the majority of external independent evaluations will be led by Samoan nationals (as distinct from international consultants). [1] By 2021 there will be a separate Evaluation Office reporting directly to the DG, and there will be evidence that their function has contributed substantively to the performance management, and learning, of the Ministry. Key actions to be completed in the coming 2019/20 year to strengthen M&E are identified in Chapter 6.

The fourth strategic way to finance the Sector Plan without putting additional strains on the budget is to better align the health workforce to the current and future needs of the country. Samoa clearly has a major challenge in terms of risk factors, and incidence, of NCDs as well as CDs including STIs. However there are only 3nutritionists in the country; few health workers specifically trained in managing diabetes or cardiovascular disease; and in preventing and treatingSTIs. By the end of the 10 year Sector Plan there will be an estimated additional 3,729 people aged 60 years and older than they are now, but there are few health workers specialising in geriatrics, palliative care, or dementia working in Samoa at present and only 1% are currently planned for the coming 10 years. There is only one medical doctor in the country with specialist mental health training despite the likelihood of rising mental health issues with an ageing population and an increasing cohort of adolescents who are at risk of substance abuse.

The skill set, and geographical distribution of health workers, is not well aligned to a people-centred health system envisaged by the Government. The current curriculum for training nurses and health workers is not particularly well-aligned to the Government's vision or the proposed directions of the Sector. More specifically, only around 6% of the current curriculum is devoted to "public health" including health promotion and disease prevention, compared to a much heavier focus on curative care. Nor is the curriculum, or the geographical distribution of health workers well aligned to the proposed scaling up of PEN Fa'a Samoa in rural settings. Currently around 99% of doctors and 85% of nurses are located in Apia.

Furthermore this Sector Plan will increase the number health workers in rural settings to support PEN Fa'a Samoa including, the increasing of the percentage of doctors and nurses working in rural areas to 13% and 16% respectively by the time of the MTR in 2024, and to 13% and 18% by 2030. The current developing of the new *MOH Human Resources for Health Strategy 2019/20-2024/25* and *Samoa's Health Workforce Development Plan 2019/20-2024/25* is a good opportunity to make this happen.

Fifth, the internal coherence of the Sector Plan should lead to resources being freed up over time. All of the main interventions proposed in the Sector Plan have the goal of progressively reallocating resources from the existing focus on curative, hospital-centric, care towards health promotion, disease prevention and public health, delivered at primary and secondary levels of the health system via a scaled up, and broadened, PEN Fa'a Samoa. That should significantly help "reverse the trends of NCDs as well as facing challenges of emerging and reemerging communicable diseases and neglected tropical diseases." That, in turn, will also help reduce resource pressures on the health sector, allowing even more resources to be allocated to health promotion, disease prevention and public health. Early detection and treatment, particularly through a scaled up and broadened PEN Fa'a Samoa in rural areas should also reduce overcrowding at the main TTM hospital, further reducing costs and allowing the TTM hospital to concentrate on more complex and severe cases.

This Sector Plan aims to achieve an increasing number of people being screened in rural settings via PEN Fa'a Samoa; then being referred to rural clinics and district hospitals; and being on and maintaining medications and treatments in rural settings without the need to go to TTM or MTII hospitals unnecessarily, thereby increasing access and equity in the system and relieving cost and other pressures on TTM and MTII hospitals.

More specifically, this Sector Plan aims to achieve an increasing number of people being screened in rural settings via PEN Fa'a Samoa. The number of out-patients treated at rural and district hospitals will therefore increase from the baseline in 2019/20 and the number of out-patients treated at TTM and MT11 will decrease by the Mid Term Review in 2024, and again by 2030. There will be clear evidence that bypassing of rural and district hospitals to present at TTM and MT11 has decreased significantly. The share of total Government health budget allocated to hospitals will also have reduced from 75 % to 49% or lower by 2030. There will be clear evidence that TTM and MT11 hospitals are increasingly able to focus on more complex cases rather than cases that could have and should have been seen at rural clinics and district hospitals. In 2019/20 the MOH will invest in better understanding the numbers, and reasons, why patients are bypassing rural and district hospitals to present at the outpatients department of TTM and MT11. Where possible, that analysis will establish the baseline of number of patients bypassing primary and secondary facilities.

Risks and uncertainties.

There are inevitably risks and uncertainties. The World Health Organization (WHO) has recently identified 10 threats to global health that all countries face in 2019. Some of these, including especially NCDs, have special resonance in Samoa, other risks, including Ebola, less so.

Based on recent reviews (MoH, 2018; World Bank, 2016) and experiences to date this Sector Plan identifies several strategic risks that will need to be tracked and managed. Some of these risks are within the span of control of the Ministry to control, or at least manage. These include the risk that Ministry financial and other resources are not allocated, or reallocated over time, to address the highest risk factors or drivers of the burden of disease in Samoa. Another risk within the direct span of control of the Ministry is that the scope and scale of the health information system, including the M&E system, is too fragmented and unreliable to serve as the evidence base for improved planning and management or, even if it is, improved, that managers have little incentive or accountability to use that evidence base to manage programs. The recent experience of the Ministry unexpectedly being without reliable internet and email services for nearly a month highlights the dependence the Ministry has on electronic data, even while paper-based systems predominate in some areas andhaving good protocols for electronic security and backing up data will be an increasingly important risk management strategy over coming years. There are solutions and even indicatorsto address those risks which are described in Chapter 6 and 7 of this Sector Plan.

There are also risks that are beyond the direct span of control of the Ministry to manage, but which the Ministry can track and prepare for. One obvious risk is natural disasters including cyclones. Pandemic influenza, drug resistant TB, and relatively exotic diseases including Zika are risks to be tracked and managed.

Global or regional economic downturns that reduce economic growth and government revenue are beyond the span of control of the Ministry, but focusing on improved efficiency and community based health promotion and engagement under PEN Fa'a Samoa that will provide some genuine resilience to the country's health system. Funding flows and priorities of development partners is also beyond the direct control of the Ministry. However, a strong and clear Sector Plan, with a limited number of ambitious, but achievable, goals and indicators is likely to give bilateral and multilateral development partners the confidence to invest in a predictable and stable manner in the Government's vision over the coming decade. Equally importantly, the clarity and focus of the Government's vision, as set out in this Sector Plan, also gives the Ministry the "ownership" to decline external support that is not aligned to the Government's priorities and focus on reversing the hospital-centric approach.

CHAPTER 1: HEALTH SECTOR STRATEGIC AGENDA

VISION:

"A HEALTHY SAMOA"

The vision of "***A Healthy Samoa"*** focuses on the premise that with all health partners and stakeholders working effectively and cohesively will contribute to strengthening Samoa's health system's response to the health demands of the population, hence improve the population's health.

MISSION:

"Enhancing Public Health and Primary Health Care to provide people-centered health services"

CORE PRINCIPLES:

The health sector upholds the values of "Health Promotion" and "Primary Health Care" as the founding principles of its work.

In achieving the vision and mission, the sector will be guided by the following Principles:

	***Accessibility*** requires easy access to the healthcare system considering safe and friendly health facilities; quality health services are always affordable and geographically available as well as having health care providers whom the patient trusts and can communicate with.
	***Accountability*** requires improvement, transparent and accountable capacity of individuals, families, communities, the government and the country to look after and protect health and well being.
	***Efficiency*** is demonstrated by allocating resources (budgets, health workforce, equipment etc.) to where they will have the greatest result and impact.
	***Equity*** requires that all health services are fair, just and unbiased.
	***Safety*** implies that the utmost care is performed and demonstrated in the care of the public and workers at all times.
	***Quality*** is demonstrated by striving to achieve the high standards of operation of the health system.

	***Cultural Appropriateness*** is acknowledging the differences among cultural, ethnic, racial and religious groupswith tolerance and respect.

CORE VALUES:

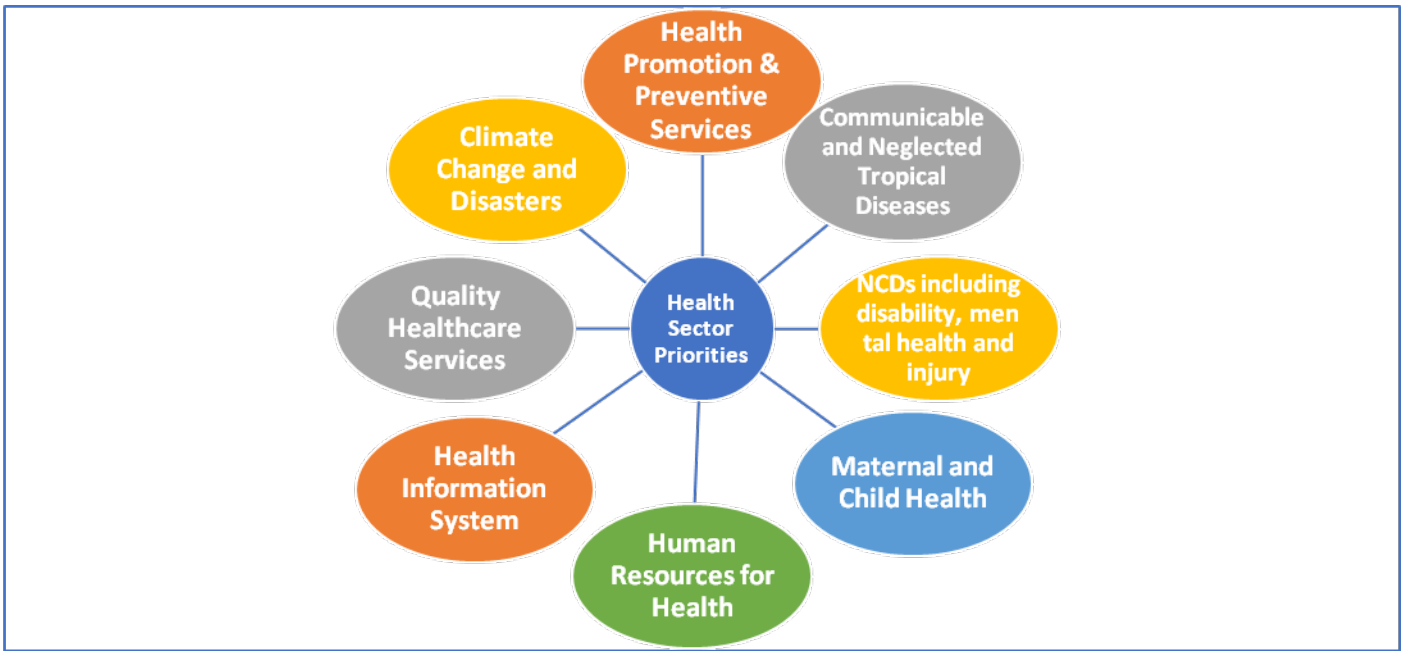
The Health Sector is committed to achieving our Mission and Vision. The adopted core values and principles are applicable today and the next ten years and are demonstrated in our health policies, procedures and protocol.

	**Genuine Partnership** Empowering patients to manage and control their own healthcare experiences, sharing decisions with patients and family members, being open and transparent, and anticipating patient needs, fostering healthcare professional partnerships with patients, encourage community partnerships, and strengthen private public partnerships.
	**Avafatafata (fa'a-Samoa) and Respect** Treat every patient equally and create an enabling environment that will allow and give the best possible care to all patients without judgement.
	**Human Rights** Everyone has the **right to** the highest attainable standard of physical and mental **health**, which includes access to all **medical** services, sanitation, adequate food, decent housing, **healthy** working conditions, and a clean environment regardless of their nation, location, language, religion, ethnic origin or any other status.
	**Quality Leadership and Stewardship** Maintaining the strategic direction of health policy development and implementation; detecting and correcting undesirable trends and distortions; articulating the case for health in national development; regulating the behaviour of a wide range of actors from health care financiers to health care providers; and establishing effective accountable mechanisms.

HEALTH SECTOR PRIORITIES:

The health sector sets its priorities for the next ten years based on the strategic outcomes indicators articulated in the Strategy for the Development of Samoa FY2016/17 – FY2019/20, Health Sector Plan 2008-2018, MTR in 2013 and full review in August 2018. These priorities include :

Figure 7: Health Sector Priorities

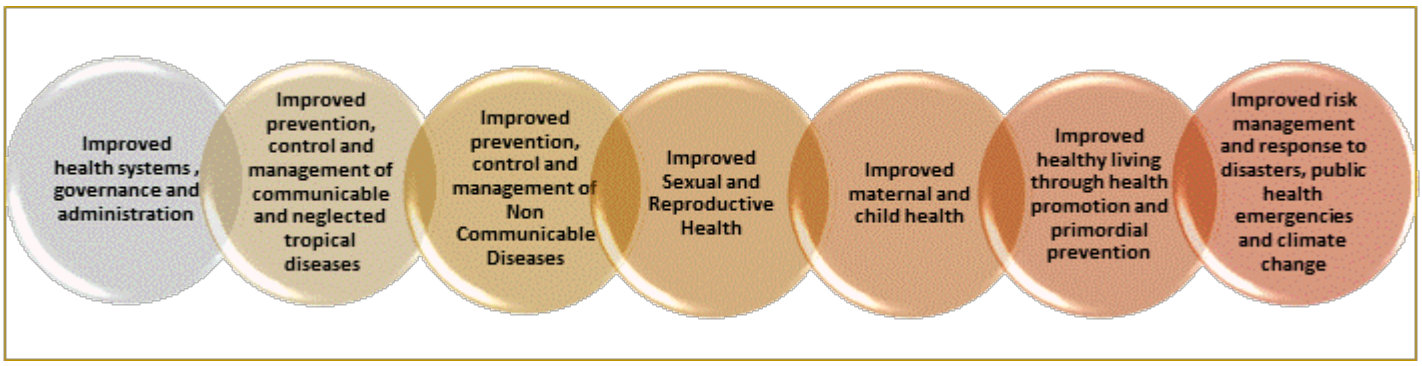


SECTOR KEY OUTCOMES:

Key Outcomes:

The sector key outcomes and targets from the Strategy for the Development of Samoa (2016/17 – 2019/20) and the Health Sector Plan 2008-2018 mid-term review remains valid for addressing this Plan's priorities.

Figure 8: Seven Key Outcomes of Samoa's Health Sector



CHAPTER 2: WHERE HAVE WE BEEN?

The Full Review report of the HSP 2008-2018 found there were notable achievements under the previous Sector Plan that provide a strong foundation for the new Sector Plan. More specifically, it found that over three quarters (78%) of all 41 indicators had been fully or partially achieved during the course of the 2008-2018 Sector Plan. Over one third (39% or 16 out of 41) of the indicators were "achieved". Every one of the 7 Key Outcomes had at least one important goal "achieved". Three out of the four strategic indicators were "achieved" in the case of Key Outcome 7: *Improved Risk Management and Response to Disasters, Emergencies and Climate Change.* The Full Review further found that the previous Sector Plan had achieved some strategically important targets including a decrease of 53.2% in the incidence of STIs; a 23% decrease in acute respiratory infections amongst children under 5 years of age; and increasing number of all categories of health professionals.

The Full Review report also found that many important goals and targets were "partially achieved" in the course of the previous Sector Plan. This included a reduction in the prevalence of smokers and increase in the prevalence of people who are physically active; a reduction in the incidence and prevalence of rheumatic heart disease; and a decrease in the under-five mortality rate.

However, the Full Review also found that some important targets and indicators were "not achieved". More specifically, 9 indicators out of 41 (22%) were "not achieved". These involved some crucial health outcomes including not being able to achieve the desired reductions in infant, or maternal, mortality rates; prevalence and incidence of diabetes, hypertension, TB, and overweight / obesity.

A summary of the overall outcomes and achievements of the previous Sector Plan 2008-2018 is in Table 2 below. The Full Review provides the evidence base on strengths to build and consolidate, and areas that clearly need additional resourcing and focus.

Table 2: Overall Health Sector Performance Against Key Health Sector Outcomes of the Health Sector Plan 2008-2018

KEY OUTCOME 1:	**Improved Healthy Living through health promotion and primordial prevention**				
Indicators	**Baseline**	**Target**	**Interim Measure**	**Progress**	**Status**
Prevalence of current alcohol drinkers	29.3% (STEP Survey 2002)	26.5% decrease	16.9% (STEP Survey 2013)	12.4% decrease	Achieved
Prevalence of current smokers	40.3% (STEP Survey 2002)	20.5% decrease	27.1% (STEP Survey 2013)	13.2% decrease	Partially achieved
Prevalence of peole who are physically active	32.6% (STEP Survey 2002)	95% increase	61.1% increase (STEP Survey 2013)	28.5% increase	Partially achieved
Proporation of population who eat at least 2 – 3 servings of fruits and vegetables	31.9% women, 33% men (STEP Survey 2002)	50% increase	6% women, 16% men consume 3+ servings per day (SDHS 2014)	Women = 25.9% decrease Men = 17.3% decrease	Not achieved
KEY OUTCOME 2:	**Improved prevention, control and management of chronic diseases (NCDs)**				
Indicators	**Baseline**	**Target**	**Interim Measure**	**Progress**	**Status**
Prevalance and incidence of diabetes	21.5% (STEP Survey 2002)	25-50% decrease	24.3% (STEP Survey 2013)	2.8% increase	Not achieved
Prevalence of hypertension	Prevalence: 21.2% (STEP Survey 2002)	40% decrease (12.7%)	Prevalence: 24.5% (STEP Survey 2013)	3.3% increase	Not achieved
Prevalence of overweight and obese	Prevalence: Overweight = 85.6% Obese = 56.0% (STEP Survey 2002)	25% decrease (69%)	Prevalence: Overweight = 89.1% Obese = 63.1%	Overweight = 3.5% increase Obese = 7.1% increase	Not achieved
Prevalence and incidence of rheumatic heart disease	No. of cases = 115 (NHS RHD 2011)	Incidence: 75% decrease	No. of new cases: 54 (NHS RHD 2016)	New cases = 61% decrease	Partially achieved
Prevalence of cancer 2 – 3 most	No. of Cancer	Not defined	No. of Cancer	Prevalence:	Partially

common types	Admissions Lung = 13 Breast = 12 Stomach = 12		Admissions: Lung = 26 Breast = 19 Stomach = 17	Lung = 13% increase Breast = 7% increase Stomach = 5% decrease	achieved
No. Of attempts and deaths associated with suicide declines	Total No. of Suicide (48) Attempts = 37 Deaths = 11 (MOHO 2011)	Reduce by 50%	Total No. of Suicide: Attempts = 26 Deaths 19 (MOH 2017)	Attempts = reduced by 4 cases Deaths = increase by 8 cases	Partially achieved
Injuries in children <15 years	290 per 1000 admissions (MOH 2012)	50% decrease (184)	141 per 1000 admissions (MOH 2015)	50% decrease	Achieved
KEY OUTCOME 3:	**Improved prevention, control and management of Communicable Diseases**				
Indicators	**Baseline**	**Target**	**Interim Measure**	**Progress**	**Status**
Prevalence and incidence of STIs	Incidence: 121.7 (any STI) per 100,000 population (MOH2012)	Reduce incidence by 50% (608) – any STI per 100,000 population	Incidence: 568 (any STI) per 100,000 population (MOH 2017)	53.2% decrease	Achieved
	Prevalence: HIV = 12 living cases Syphillis = 0 Hepatitis B = 3% Hepatitis C = 1% Gonorrhea = 5.9% Chlamydia = 205 (MOH 2012)	Not defined	Prevalence: HIV = 11 living cases/1 death Syphillis = 0.70% Hepatitis B = 2.4% Hepatitis C = 0.10% Gonorrhea = 10% Chlamydia = 23% (MOH 2018)	HIV = decrease by 1 case Syphillis = 0.60% increaes Hep. B = 0.6% decrease Hep. C = 0.905 decrease Gonorrhea = 4.1% decrease Chlamydia = 3% increase	Partially achieved
Prevalane of notifiable disease and vaccine preventable diseases – including water and food-borne diseases	Prevalence: Typhoid = 0.06% AFR = 0.04% Diarrhoea = 2.82% (NHS Lab 2008)	50% decrease Not defined Not defined	Prevalence: Typhoid = 0.05% AFR = 0.32% Diarrhoea = 4.335 (NHS Lab 2018)	Typhoid = 0.01 decrease AFR = 0.28% increase Diarrhoea = 1.51% increase	Partially achieved
TB incidence and death rates associated with TB	New cases = 19 Deaths = 2 (MOH 2015)	50% decrease	New cases = 30 Deaths = 6 (MOH 2017)	New cases increased by 11 cases Deaths increased by 4 cases	Not achieved
Acute Respiratory infections among children under 5 years	1,131 (PATIS 2011)	10% decrease	867 (MOH, 2017)	23.3% decrease	Achieved
% of drinking water suppliers compling with National Drinking Water Standards	SWA Boreholes = 33% Water Bottled Cos. = 80% SWA Treatment Plants = 90.1%	Not defined	SWA Boreholes = 40% Water Bottled Water Companies. = 92% SWA Treatment Plants = 98%	SWA Boreholes = 7% increase Bottled Water Cos. = 12% increase SWA Treatment Plants = 6.9%	Achieved
KEY OUTCOME 4:	**Improved Sexual and Reproductive Health**				
Indicators	**Baseline**	**Target**	**Interim Measure**	**Progress**	**Status**
Life Expectancy at birth	71.5 males, 74.2 females (Census 2006)	80 years	Male = 76 years Female = 79 years (Census 2016)	Male = 0.9 increase Female = 4.8% increase	Achieved
Total Fertility Rate	4.2 children per woman (Census 2006)	4	3.9 children per woman (Census 2016)	Decrease of 0.3 children per woman	Achieved
Adolescent Birth Rate per 1000 women	28.6 per 1000 women (Census 2006)	30 per 1000 women	31 per 1000 women (Census 2016)	1 per 1000 women increase	Achieved
Contraceptive prevalence rate	29% (SDHS 2009)	Increase to 75 – 80%	27% (SDHS 2014)	2% decrease	Not achieved
KEY OUTCOME 5:	**Improved maternal health**				
Indicators	**Baseline**	**Target**	**Interim Measure**	**Progress**	**Status**
Maternal mortality rate	40.2 per 1000 live births (Census 2011)	23 per 1000 live births	51 per 1000 live births (Census 2016)	10.8 per 1000 live births	Not achieved
% of births attended by skilled health personnel	81% (SDHS 2009)	95% coverage	83% (SDHS 2014)	2% increase	Partially achieved
Infant mortality rate	15.6 per 1000 live births	10	18.6 per 1000 live births	3% increase	Partially

	(Census 2011)	(505 decrease)	(Census 2016)		achieved
Under 5 mortality rate	20 per 100,000 live births (Census 2011)	12 (50% decrease)	19.25 per 100,000 live births(Census 2016)	0.75% decrease	Partially achieved
% of infants exclusively breastfed for 6 months after birth	51%(SDHS 2009)	Increase to 90%	70% (SDHS 2014)	19% increase	Partially achieved
Prevalence of cervical cancer in women aged 20 years and over	No. of patients admitted = 16 (MOH 2016)	Not defined	No. of patients admitted = 8 (MOH 2017)	Decreased no. of patients admitted by 8	Achieved
Antenatal care coverage	92.7% - (SDHS 20090	Increase to 100%	93.3% - (SDHS 2014)	0.6% increase	Partially achieved
Proportion of 1 year old children immunized against measles	MMR1 = 55.7% MMR 2 = 25% (SDHS 2009)	95% coverage	MMR1 = 76% MMR2 = 52% (SDHS 2014) MMR1 = 80% MMR 2 = 60% (NHS/EPI 2016)	MMR 1= 24.1% increase MMR 2 = 35% increase	Achieved
% of fully immunized children	25% - (SDHS 2009)	Increase to 95%	53% - (SDHS 2014)	28% increase	Partially achieved
KEY OUTCOME 6:	**Improved Health Systems, Governance and Administration**				
Indicators	**Baseline**	**Target**	**Interim Measure**	**Progress**	**Status**
Waiting time for emergencies, triaging and general outpatients	<1 hr = 15% 1-2 hrs. = 25% > 2 hrs = 57% (MOH QA Report 2012)	Emergency Unit = within 5 mins. Triaging = wait 20 – 30 mins.	<1 hr = 5.6% 1-2 hrs. = 32.4% > 2 hrs = 61.9% (MOH QA Report 2017)	<1 hr = reduced by 9.4% 1-2 hrs. = increased by 7.4% > 2 hrs = increased by 4.9%	Partially achieved
Health facilities and providers are accredited and certified	Doctors = 89 Dentists = 13 Pharmacists = 9 RN = 135	100% of all health practitioners are registered and	Doctors = 108 Dentists = 17 Pharmacists = 13 RN = 274	Doctors = increased by 9 Dentists = increased by 4	Achieved
	EN = 71 Midwives = 37 (MOH 2011)	licensed 100% of health facilities are accredited by 2018	EN = 90 Midwives = 79 (MOH 2018)	Pharmacists = increased by 4 RN = increased by 139 EN = increased by 19 Midwives = increased by 42 (MOH 2011)	
Health facilities compliance with legislations, policies, protocols and standards	NIL	100%	Average of 70% (MOH 2018)	Increased by 70%	Partially achieved
Proportion of clients satisfied with health services	30% (2009/2010)	95%	58% (MOH Clinical Audit Report 2018)	28% increase	Partially achieved
Health facilities and service utilization rate	n/a	Not defined	70% average – health facility utilization rate (MOH 2018)	70% utilization rate	Achieved
% of health personnel aged 55 years and over	5% - (Samoa HRH Profile 2011)	Not defined	No information available	No progress reported	Unknown
Ratio per 100,000 population: - **Doctors** - **Dentists** - **Nurses** - **Pharmacists** - **Midwives**	(Per 100,000 population) - Doctors = 4.74 - Dentists = 0.69 - R/Nurses = 7.47 - E/Nurses = 3.93 - Pharmacists = 0.48 - Midwives = 2.05 - (MOH 2011)	Not defined for all health professionals	(Per 100,000 population) - Doctors = 5 - Dentists = 1 - R/Nurses = 11 - E/Nurses = 4 - Pharmacists = 1 - Midwives = 4 (MOH 2018)	(Per 100,000 population) increased by: - Doctors = 0.26 - Dentists = 0.331 - R/Nurses = 3.53 - E/Nurses = 0.07 - Pharmacists = 0.52 - Midwives = 1.95 (MOH 2011)	Achieved
Total health expenditure as a percenage of GDP	5% (WHO 2006)	Not defined	8.27% (NHA FY2014/15 7% (WHO 2011)	2015 = 3.27% increase 2011 = 2% increase	Achieved
Government expenditure on	19%	Not defined	17% - (NHA FY2014/15)	2015 – 2% increase	

health	(WHO 2006)		25% - (WHO 2011)	2011 = 8%	
KEY OUTCOME 7:	**Improved Risk Management and Response to Disasters, emergencies and Climate Change**				
Indicators	**Baseline**	**Target**	**Interim Measure**	**Progress**	**Status**
% of health organizations with disaster and emergency and climate change response plans developed and reviewed in the last 5 years	1 (MOH) (MOH 2008)	Not defined	4 health organizations with Disaster and Emergency Response Plans: MOH, NHS, NKFS and Samoa Red Cross Society	67% of health organizations have disaster and emergency response plans	Achieved
% of water service providers with water safety plans developed or reviewed in the last 5 years	80% treated suppliers 33 independent water scheme untreated 37 boreholes untreated	100%	4 Water Safety plans for independent water schemes developed and implemented 4 Water Safety Plans for Samoa Water Authority being drafted.	4 water safety plans developed and implemented & 4 being drafted	Achieved
% of household in the disaster zone with good sanitation 1 year post disaster	N/a	At least 95%	-	No available information	Not achieved
% of registerd skilled health professionals with competencies to respond to emergencies and disasters	N/a	Increased by 50%	100%	Health professionals were trained during disaster and emergency disaster drills for the Tsunami in 2009 and Cyclone Evans in 2012 and disease outbreaks drills conducted by the sector for H1N1 in 2009 and Ebola in 2015.	Achieved.

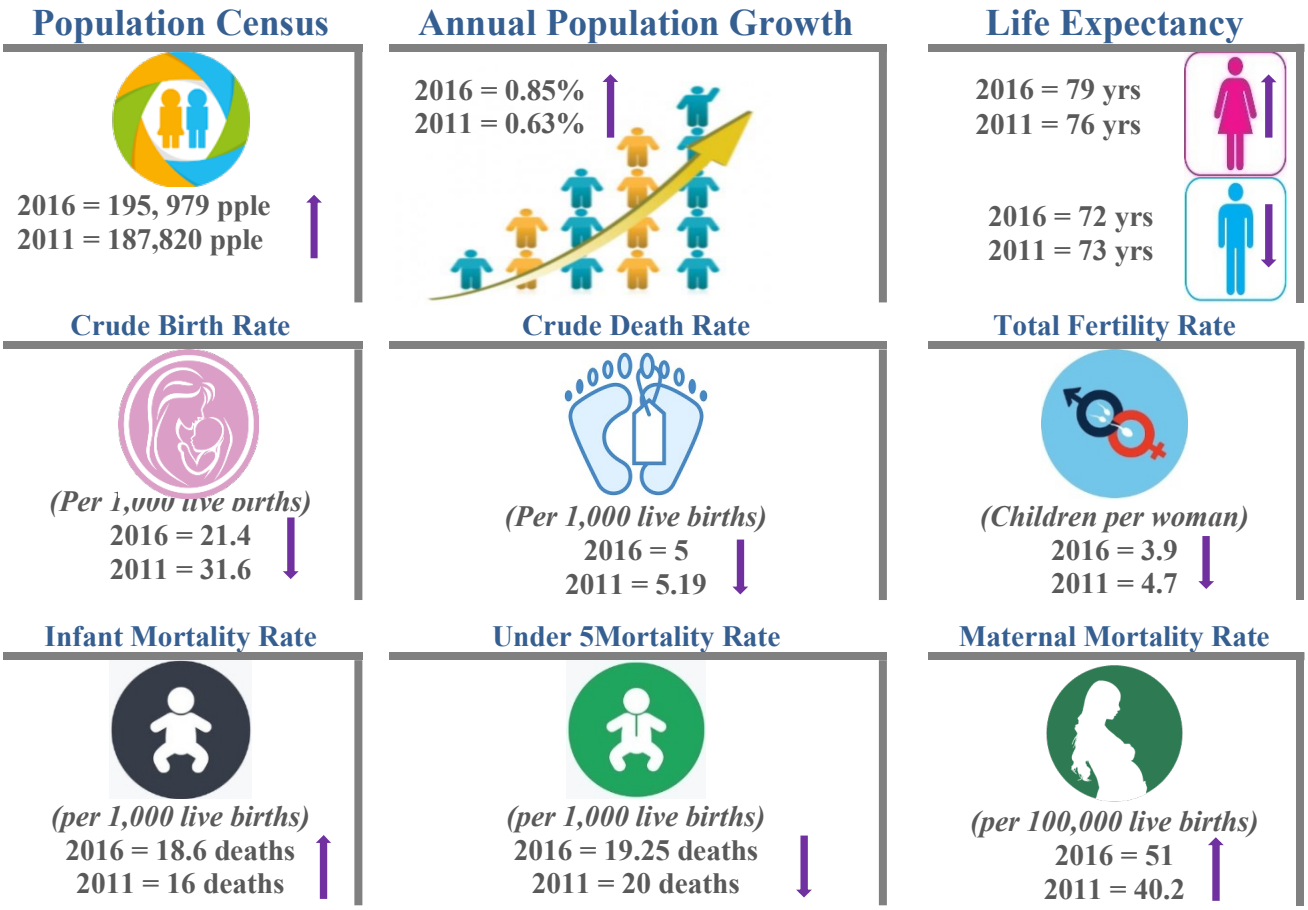
CHAPTER 3: WHERE ARE WE NOW?

HEALTH SECTOR SITUATIONAL ANALYSIS

POPULATION HEALTH:

As shown below, fertility rates dropped from 4.7 children per woman in 2011 to 3.9 children per woman in 2016. This trend indicates that although there are a lot of factors contributing to the decrease in fertility rate, it is more of an indication towards increased educational levels of the general population, greater female participation in the workforce; and increased access to knowledge of and availability of family planning methods.

FIGURE 5: SAMOA POPULATION HEALTH SNAPSHOT



Source: Population Census 2016

HEALTH SYSTEM

Samoa's health system (DHS, 2014:3) is made up of public and private health sectors. It includes private-sector practitioners, dentists, pharmacists, nurses, alternative therapists, physiotherapists, traditional healers and traditional birth attendants. NGOs, academic institutions, community-based organisations, faith-based organizations, government ministries and corporations, development and multilateral partners also play various roles in providing health services. The present health system was developed and strengthened as part of the health reforms with the objective of improving quality of life for all Samoan people to promote UHC. With this strategic national goal in mind, a nationwide network was created under the leadership of the MoH consisting of primary, secondary and tertiary health care facilities. At present, publicly funded health services dominate the Samoa health system.

HEALTH STATUS:

The Health sector has undergone major changes over the last ten (10) years. The definition of health has widened to include not just physical health but also mental and spiritual well-being. This definition of health has meant that health care services include not just the treatment of disease and illness, but also the prevention of illness and disease and promotion of healthy lifestyles.

Changes to the face of health in Samoa has included: the rapid growth of the private sector; increasing recognition of the role of community and village institutions, civil society organisations, traditional birth attendants (taulasea) and traditional healers in Samoa. That has made it vital that health be approached as an issue that is addressed by all stakeholders in health.

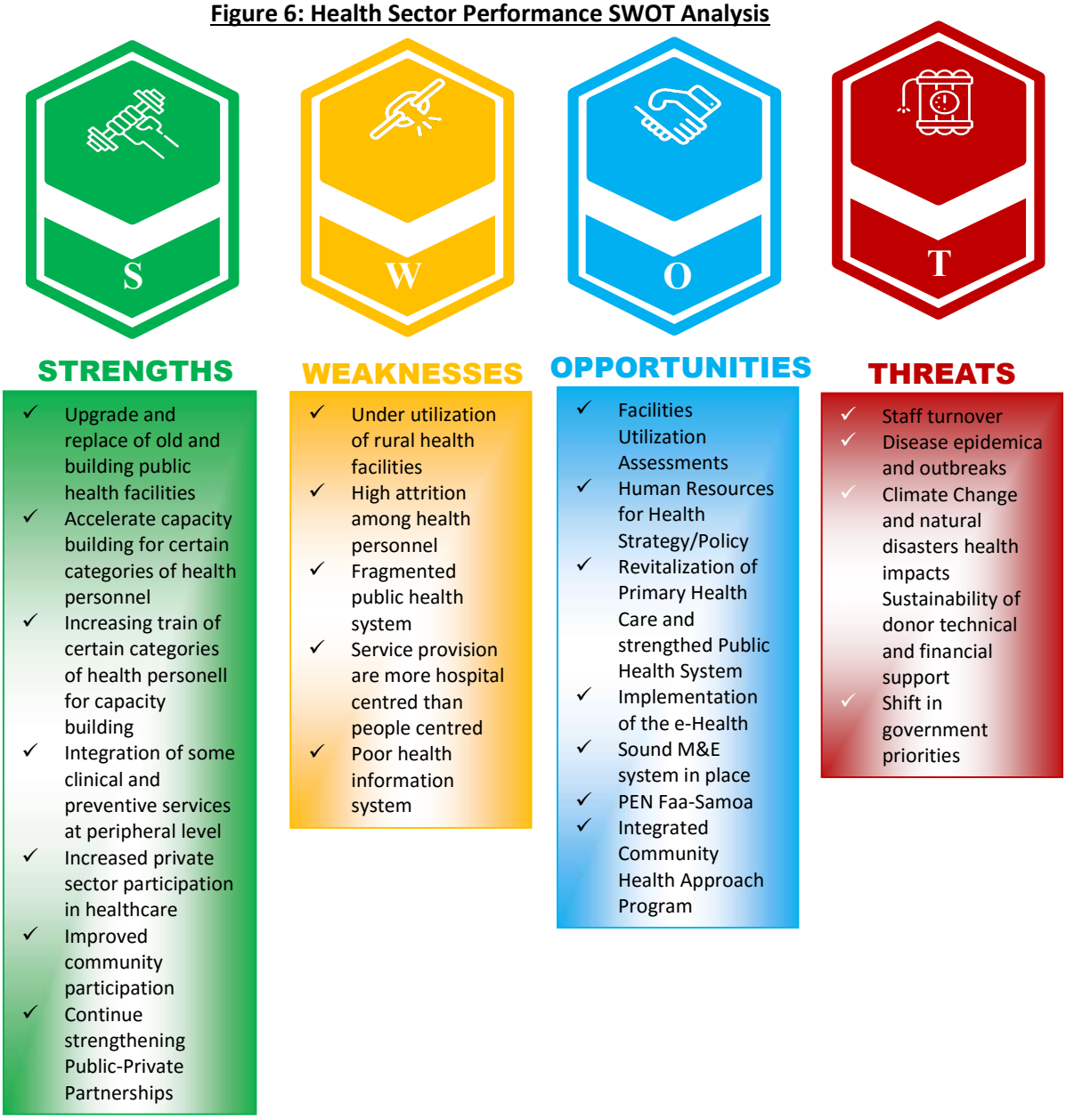
SWOT ANALYSIS OF HEALTH SECTOR PERFORMANCE

Towards the end of the Health Sector Plan 2008-2018 lifetime, the health sector was able to identify some of its strengths and weaknesses during this plan's implementation. These are detailed in the figure below with some opportunities and threats that need to be considered for the sector's preparation for this Health Sector Plan covering the sector's program and initatives for the next ten financial years.

As stated below (Figure 6), the health sector has produced many achievements as well as unpredictable challenges faced from time to time. Major achievements highlighted include:

- upgrading old and building new public health facilities
- increased training opportunities for certain categories of health personnel for capacity building
- integration of some clinical and preventive services
- increased participation of private healthcare providers in provision of healthcare services at public rural health facilities and
- slight improvement in community participation

Figure 6: Health Sector Performance SWOT Analysis



Human resources for health, public health and health information system are considered throughout the lifetime of this Sector Plan as continuous challenges for the health sector. However, the Ministry being the leading agency of the health sector in collaborative effort with development partners provides avenues for the health workforce to further advance their knowledge and skills in the vast fields of health. As a result, health service provision will continue to improve over time with the reduction of preventable errors is expected to occur.

Monitoring, regulating and evaluation of the health sector's performance require ongoing development. Although many sector partners and stakeholders had put into action these roles, there is still a need for improvement. These roles at different levels within the health sector needs to be strengthened as well as sharing information within the health sector.

LESSONS LEARNT:

1. **Public Health System Revival:**
   In the past ten years, Samoa's public health system failed to minimize the unacceptable high levels of morbidity and mortality related to CDs and NCDs and neglected tropical diseases. The existing public health interventions did not match the expected needsof the health system to deliver in an efficient and adequate manner. Placing the focus back on public health is now one of the health sector priorities for this Health Sector Plan.

2. **Strengthen Monitoring and Evaluation:**
   M&E has gained increasing significance in the health sector in the past ten years, partly due to increasing public demand for measurement and accountability in the use of health sector resources but mainly Government's planning and reporting frameworks which ensure that there is greater responsibility and transparency in the way the sector respomds and develops.

   The Ministry of Health in collaboration with the health sector has set out to strengthen the Health Sector M&E Systems within the sector through a wide range of capacity development initiatives. The Health Sector M&E Operational Manual 2011 enables all actorsof the sector to work within convergent efforts to achieve the sector's key outcomes, indicators and targets set within the Health Sector Plan 2008-2018.

   For this new Health Sector Plan (FY2019/20 – 2029/30), sound M&E Systems are built on inclusive policy dialogue and regular evidence-based assessments that inform progress and performance reviews, and that result in remedial action and mutual accountability among all stakeholders. This will form the basis for resource allocation, policy-making and effective management of programmes.

   There will be a comprehensive M&E Framework developed to address indicators selection, related data sources and analysis and synthesis practices including quality assessment, performance review, communication and use to support the implementation of this plan. This implies the existence of well-established, transparent processes at the country level involving multiple stakeholders and partners of the sector to ensure quality of data and independence.

Today, health in Samoa is no longer focused only on treatment and rehabilitation but includes the prevention of illness and disease as well as the promotion of healthy lifestyles.

CHAPTER 4: WHERE DO WE WANT TO GO?

STRATEGIC DIRECTION:

This sector plan for Samoa's health sector seeks to leverage opportunities and honor obligations presented by emerging developments at the national, regional and global levels. It provides strategic direction for stakeholders and partners in health with their expected roles and responsibilities in attaining this strategic agenda. In addition, it lays down the implementation and collaboration frameworks within which the stakeholders and partners in health contribute towards improving the health of Samoa's population.

Foreigners seeking medical treatment in Samoa will be an opportunity for potential health services. Negotiations are underway with possible international hospitals to conduct theatre audits and assist with the most common medical equipment available for surgery.

The overarching goal of this sector plan is to revitalize public health care or population health and accelerate movement towards UHC with essential health and related services needed for promotion of a people-centred healthcare system for Samoa. Thus the key objectives to be achieved include:

(i) contributing to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable quality health services;
(ii) addressing the key determinants of health through strengthening inter-sectoral collaboration and partnerships; and
(iii) enhancing health sector competitiveness in the region and globally.

To meet these objectives, the health sector will work towards strengthening the health system through:

(i) Governance, leadership and stewardship;
(ii) Disease prevention, mitigation and control;
(iii) Health education and promotion, curative services
(iv) Rehabilitation and palliative health services; and
(v) Strengthening public health surveillance
(vi) Health information management;
(vii) Human Resource development; and
(viii) Enhancing M&E mechanisms at all levels

Overall, this sector plan will focus on attaining the following results:

(i) Reorientation of health services from hospital-centred to people-centred through revitalization of primary health care;
(ii) Reduced Mortality Rate;
(iii) Reduced Morbidity Rate;
(iv) Reduced incidence of non-communicable, communicable and neglected tropical diseases;
(v) Strengthened community engagement and partnership through multi-sectoral approach; and
(vi) Strengthened public health surveillance and monitoring and evaluation systems

By doing this, the health sector will take the whole-of-system approach with more integrated service delivery and strengthened primary care ensuring Samoa's health system are placing individuals, families and communities at the centre.

CHAPTER 5: HOW ARE WE GOING TO GET THERE?

The Ministry has developed some indicative budgets that illustrate how resources will be allocated to achieve the outcomes required over the life of the Sector Plan. These indicative allocations will and should change in the light of changing health needs over the coming decade; the insights generated from an improved M&E framework; the findings of the MTR in 2024; and changing prices of goods and services in the health sector. Most importantly, these notional allocations will change as key elements of the Sector Plan, including especially the scaling up of PEN Fa'a Samoa, get traction and resources increasingly move more from curative to preventive services. The *presentation and reporting* of these notional figures will also change particularly once the Ministry completes its transition to program based budgeting and reporting.

The following summarises the overall, indicative, allocations by each Key Outcomeas noted on page 11.

Key Outcome 1 – "Improved health systems, governance, and administration" will have an indicative allocation of SAT 266,805,535.08 over the life of the Sector Plan. Key Outcome 1 has as its strategic goal "to strengthen health system governance for UHC". Unlike previous years, this Key Outcome now captures expenditure on district hospitals (which are now classified as part of "public health services" rather than curative care). Following the mergeof MOH and NHS, Key Outcome 1 also captures expenditure of front-line health workers including doctors and nurses working in district and rural areas. Key Outcome 1 includes budgets to expand health worker density (doctors and nurses per 1000 population); improve healthcare professional standards and health workforce aptitudes; strengthen the health information system including e-health; strengthen hospital performance and expand the death registry coverage.

Key Outcome 1 also currently includes the Overseas Treatment Referrals. As noted elsewhere throughout this Sector Plan, the budget for OVT will be progressively reduced by 5% every year, with the cumulative savings of just over SAT 2 million thus freed up then being reallocated within the public health budget to further expand front line health promotion and disease prevention.

Key Outcome 2 – "Improved prevention, control, and management of communicable and neglected tropical diseases" has an indicative budget of SAT 259,496,398.40. That key outcome has the strategic goal "to end the epidemic of Neglected Tropical Diseases and combat Communicable Diseases". That indicative budget allocation will help to address challenges with respect to the incidence and prevalence of HIV / AIDS; lymphatic filariasis; TB; and WASH related morbidity (including typhoid and diarrhea).

Key Outcome 3 – "Improved prevention, control, and management of Non-communicable diseases" will have an indicative allocation of SAT 564,184,009.92. The specific strategic goal under Outcome 3 is "to combat NCDs and their risk factors and minimise NCD preventable deaths". Key Outcome 3 will involve a number of individual programs including: reducing the risk of premature deaths from targeted NCDs such as cardiovascular disease and diabetes; cancer prevention and treatment; improved access to essential NCD drugs; reducing diabetic amputations; reducing obesity in adolescents and children; reduced mortality from traffic accidents; suicide prevention; and responses to mental disorders.

Key Outcome 4 – "Improved Sexual and Reproductive Health" has an indicative budget of SAT 127,710,321.45. The strategic goal is "to promote universal access to reproductive health related services". Key Outcome 4 involves four separate programs: expanding coverage of modern family planning methods so that at least 95% of women at reproductive age who currently use family planning are satisfied with those modern methods; increasing the contraceptive prevalence rate to 80% by 2030; reducing the adolescent birth rate to 10% for all age groups; and increasing the coverage of the national cervical cancer screening program. It should be noted that several important costs for achieving Key Outcome 4 including, for example, the salaries for health workers who will providing these services, are currently classified under other programs including Key Outcome 1. As a result, the actual resources allocated to Outcome 4 will be significantly larger than what is captured under the current budget allocation classification. Moving

to program budgeting and reporting by 2024 will enable a clearer and more accurate idea of what the total level of resources being allocated to this Key Outcome actually is.

Key Outcome 5 – "Improved Maternal and Child Health" has an indicative budget of SAT 654,830.00.. This Key Outcome has the strategic goal "to reduce maternal and perinatal mortality, and to reduce child morbidity and mortality". This Key Outcome in the 2019/20-2029/30 Sector Plan has been influenced and informed by the fact that the targets for the infant mortality rate, and the maternal mortality rate, were not achieved under the previous Sector Plan. Increased effort is therefore required under the new Sector Plan. This Key Outcome is also influenced and shaped by the reduction in immunisation for measles, mumps and rubella during 2018, and the need to rapidly increase and sustain MMR immunisation. Key Outcome 5 includes a very wide range of programs including reducing maternal, under-five, and neonatal mortality rates; expanding immunisation coverage for DTP3, measles and Hep B; updating the Expanded Program of Immunisation (EPI) program; expanding antenatal care coverage; training of midwives and traditional birth attendants; and reducing low birth weight and stunting.

Key Outcome 6 – "Improved Healthy Living Through Health Promotion and Primordial Prevention" has an indicative budget of SAT 3,218,000.00. The strategic goal is "to improve and strengthen people-centred health promotion and primordial prevention services". There are several programs under this Key Outcome. They include those relating to raising the excise duty on tobacco, and updating the tobacco control policy; an increased excise duty on sugar-sweetened beverages (i.e. sugary drinks that can be a particular risk factor for diabetes and obesity); measures to reduce the harmful effects of alcohol; promotion of physical activity; and school health programs. Once again, it should be noted that several important costs for achieving Key Outcome 6 including, for example, the salaries for health workers who will providing these services, are currently classified under other programs including Key Outcome 1. As a result, the actual resources allocated to Outcome 6 will be significantly larger than what is captured under the current budget allocation classification. Moving to program budgeting and reporting by 2024 will enable a clearer and more accurate idea of what the total level of resources being allocated to this Key Outcome actually is.

Raising the excise duty on tobacco to the WHO recommended level of 70% by 2024, and other tax related measures, will be explicitly explained as a *health promotion measure,* rather than a *revenue raising* measure. The evidence for that is clear as tobacco use is a leading but preventable cause of all major NCDs and therefore tobacco use imposes significant but again preventable health burdens and costs to the whole public health system. Raising the excise duty to the WHO recommended level of 70% of the retail price of cigarettes is a proven way to reduce tobacco uptake, especially among the young. The revenue raised by the increased excise duties can then be reallocated to increasing health promotion and prevention of NCDs for the nation as a whole. The excise duties can also be increased in a staged, predictable manner so that retailers and others can plan ahead and adjust prices. Raising excise duties on tobacco and other unhealthy products will be complemented by strengthened regulations about advertising and sales.

Key outcome 7 – "Improved Risk Management And Response to Disasters, Public Health Emergencies (Health Security) and Climate Change" has an indicative budget of SAT 2,939,000.00. The strategic goal is "to strengthen resilience and adaptive capacity, capacity building, and integrating climate change measures into health policies and plans, and raise awareness on climate adaptation and early warning". Key outcome 7 has four main thematic programs: compliance with International Health Regulation 13 core capacities; improved sanitation and drinking water sources; disaster risk reduction; and health facilities compliance with disaster and climate resilience plans. Strengthening health security will particularly focus on the *endemic* with existing burdens in Samoa (for example STIs and TB, as well as rapidly scaling up immunisation against measles) rather than the *exotic* (including Ebola). Once again, it should be noted that several important costs for achieving Key Outcome 7 including, for example, the salaries for health workers who will providing these services, are classified under other programs including Key Outcome 1. As a result, the actual resources allocated to Outcome 7 will be significantly larger than what is captured under the current budget allocation classification. Moving to program budgeting and

reporting by 2024 will enable a clearer and more accurate idea of what the total level of resources being allocated to this Key Outcome actually is.

CHAPTER 6: WHAT RESOURCES WILL BE REQUIRED?

This Sector Plan is intentionally ambitious as it will take additional resources. However, a central theme running throughout this Sector Plan is that, by implementing the Government's vision of a more people-centered health sector with resources increasingly allocated to health promotion and disease prevention, significant resources can be freed up from within the sector without putting unsustainable additional pressures on the Government budget. More specifically, this Sector Plan identifies five key strategies for expanding public expenditure on health in a sustainable way. Those five strategies are:

- Continue to progressively reduce the budget for the OVT scheme in a phased manner, reallocating funds to health promotion, disease prevention and public health.

- Increase the excise duties on tobacco, alcohol and other unhealthy products that are helping to drive the NCD prevalence as public health promotion measure, and then allocate the additional tax revenue to expanding health promotion and disease prevention.

- Strengthen the evidence base, and managers's accountability, for decision-making through better M&E linked to budget planning. This also involves a move to program based budgeting and reporting, updating and regularly publishing NHA so at to better ensure that the sector wide resources are being allocated to where the highest priorities.

- Better aligning the skill set, and geographical distribution, of the health workforce to the people-centred approach envisaged by the Government.

- Exploiting the internal coherence of the Sector Plan. The PEN Fa'a Samoa, has the strong potential to offer preventive and other services in rural facilities and district hospitals, thereby reducing the (expensive, inefficient, inequitable and largely unnecessary) bypassing of rural facilities by patients who then put additional pressures (and costs) on the tertiary hospitals.

Much can therefore be achieved by greater efficiency and value for money from within the health sector itself, but other additional resources will be required, especially given the growing – and ageing – population over the coming decade. It is therefore prudent to outline an indicative financing framework for the health sector over the coming decade. It should be noted this is purely indicative: there are too many variables and "unknowns" over a ten year period to be precise. However, the indicative framework below does allow a systematic discussion to be had with all key stakeholders, about the possible financing sources and financing gaps.

Table 2 provides an indicative expenditure, by key outcomes, over the life of the Sector Plan. It should be noted the figures are estimates available as of thet ime of the development of this Sector Plan.

Key Outcome	GoS	DPs	Private Sector (SCS & SFHA)	Total Annual Budget	New Initiatives (NI) - WB NCD Project	NI - expected of GoS	NI - GCF	NI - Typhoid Project & SCS	NI - ADB (e-Health and Vaccination projects)	Total NI	HSP2020-2030	% Share of Total Funding
1. Improved Health Systems, governance and administration	$ 22,087,907.28	$ 614,905.00	$ 55,000.00	$ 22,757,812.28	$ 219,600.00				$ 16,250,000.00	$ 16,469,600.00	$ 266,805,535.08	**21.78%**
2. Improved Prevention, control & management of CDs and NTDs	$ 21,948,221.72	$ 1,025,967.50	$ 319,000.00	$ 23,293,189.22		$ 2,654,000.00		$ 617,317.00		$ 3,271,317.00	$ 259,496,398.40	**21.18%**
3. Improved Prevention Control & management of NCDs	$ 49,988,513.23	$ 301,556.25	$ 25,000.00	$ 50,315,069.48	$ 10,718,245.60					$ 10,718,245.60	$ 564,184,009.92	**46.06%**
4. Improved S&RH		$ 1,671,296.00	$ 75,000.00	$ 9,905,483.77					$ 18,750,000.00	$ 18,750,000.00	$ 127,710,321.45	**10.43%**
5. Improved Maternal & Child Health	$ 8,234,187.77	$ 59,530.00	$ 75,210.00	$ 59,530.00						$ -	$ 654,830.00	**0.05%**
6. Improved Healthy Living through Health Promotion & Primordial Prevention			$ 45,000.00	$ 45,000.00	$ 2,723,000.00					$ 2,723,000.00	$ 3,218,000.00	**0.26%**
7. Improved Risk Management & Response to disasters, PH emergencies and Climate Change		$ 75,000.00	$ 65,000.00	$ 140,000.00	$ 24,000.00		$ 1,375,000.00			$ 1,399,000.00	$ 2,939,000.00	**0.24%**
Total	**$ 102,258,830.00**	**$ 3,748,254.75**	**$ 659,210.00**	**$ 106,516,084.75**	**$ 13,684,845.60**	**$ 2,654,000.00**	**$ 1,375,000.00**	**$ 617,317.00**	**$ 35,000,000.00**	**$ 53,331,162.60**	**$ 1,225,008,094.85**	**100%**

Note: DPs include only WHO, GF and UNFPA. Excludes DFAT – Aus, MFAT – NZ.

CHAPTER 7: HOW WILL WE KNOW WE ARE MAKING PROGRESS

The importance of monitoring and evaluation (M&E) as a management tool.

There is a clear business case for significantly strengthening the evidence base for decision-making over the course of this Sector Plan, beginning with some key action points in 2019/2020. One reason is that Samoa cannot afford to waste any of its resources - financial, health worker's time, drugs or expensive equipment – on services that are not effective, efficient, equitable or sustainable. The most strategic and feasible approach to expanding health services is to improve the effectiveness and efficiency of those scarce and precious public health resources. That, however, requires more reliable and timely data on changing health risks and outcomes, and how well those various scarce resources are being allocated to meet current and future needs.

Another reason for significantly strengthening the evidence base for decision-making is accountability. Government expenditure on health is currently absorbing 18% of the total Government's total budget, making it the second largest program after the Education portfolio. There is therefore a need to be accountable to Parliament, and the Samoan people more broadly, for how those resources are used. It is also important to demonstrate "results" to development partners. A recent World Bank evaluation rated an important health program in Samoa as "unsatisfactory" not because it was a bad program per se, but because the M&E system could not provide the evidence to show it was a good program.

A third reason is that weaknesses and gaps in generating and then using evidence for better decision-making and resource allocation have been known for some time. Part of the development of the 2019/20-2029/30 Sector Plan involved a careful assessment of lessons to be learned from previous Sector Plans. The MoH review noted, among other things, the absence of key baselines for certain programs which made tracking progress difficult or impossible. This will change under the new Sector Plan as baselines will be included for all programs. Other reviews noted that even when useful data was generated it was not regularly or systematically used to better inform and justify decision-making (World Bank, 2016:9).

Strategic strengths on which to build.

Samoa has several advantages and foundations on which to build a more useful, and usable, evidence base for improved decision-making. To begin with, the scale and geography of the country means data can, in principle, be collected relatively easily and cheaply, at least compared to countries with large, diverse, and remote populations. Second, the sector indicators in place are developed to track national progress are then demonstrably linked to international, and regional, goals targets and indicators. This has the advantage of reducing a proliferation of different overlapping or potentially competing indicators. Third, existing sector programs such ICHAP and PEN Fa'a Samoa, as well as outreach visits by the SFHA and other organisations, have the potential to generate valid, representative, regular, timely and gender-disaggregated data at a community level across the country. Fourth, the merger of MoH and NHS in February 2019 provides a strategic opportunity to unify and streamline data sources and have a more coherent, less fragmented, insight into the trends and management of the health sector. Finally, most development partners are committed to the *Paris Declaration on Aid Effectiveness* and the *Accra Agenda for Action* both of which emphasise the importance of using host country M&E systems where they are robust and reliable, and avoiding the use of parallel systems where possible.

Existing weaknesses and how these will be addressed over the course of the Sector Plan.

There are however important weaknesses in the current generation and use of evidence as a tool in decision making and resource allocation. Responding to some of these, including through a

movement to program-based budgeting and reporting, will take time to develop and institutionalise, although a genuine start can be made in 2019/20. Others can be implemented more quickly, including training of front-line health workers on the importance, use, and "ownership" of health data.

Improving data for policy requires strengthening health information and vital statistics.

The foundation of improving M&E nationally is strengthening the health data and data systems within the country.The health sector is at the 'initial stage' of actioning its E-Health Agenda with the complete overhaul of the HIS and ICT given developments at the national level. The fragmentation and lack of coordination is recognised, which entails the prevalence of manual systems and lack of automation, and where automation exists there is lack of interoperability connectivity between the different systems. Thus the National E-Health Policy and Strategy 2017 to 2022 sets out the sector's E-Health Agenda. This national strategic planning document is underpinned with the principles of1) **Accountable Governance in Health,** 2) **Sharing and Accessibility of Health Data and Information, and 3) Appropriateness (confidentiality and integrity),** all of which are rationale for the development of an M&E System.

As priority, the E-Health Strategy expects a greater focus on strengthening HIS and civil registration and vital statistics, which directly expands the efficacy of M&E systems and evidence-based management. The emphasis will therefore be on highighting the importance of reliable and timely health data as well as the importance of stong HIS and CRVS Systems in monitoring health outcomes, such as the impact of NCDs and understanding the health status of the population. Harnessing e-health for improved health service delivery also creates a strong health information infrastructure to achieve total UHC with quality and accountability. We are ensuring our eHealth delivery Programme is clinically led, but not IT commanded.

This means that M&E developments must be made at the point of service, i.e. providers must be part of improving health data as well as public health. Ehealth will serve as the mechanism to change data collection at the point of service, thus providing the foundation for broader M&E processes.

Finally, M&E is a sector-wide effort that all departments and disciplines must take ownership over and take action. M&E staff ideally should be stationed at all service points, units, and levels of the health sector. To properly coordinate and govern this network of staff for M&E functions, a taskforce or technical mechanism will need be established so that data flows throughout the sector and are properly managed and reported.

CHAPTER 8: RISK AND RISK MANAGEMENT

Based on recent reviews (MoH, 2018) (World Bank,2016) and experiences to date, this Sector Plan identifies several strategic risks that will need to be tracked and managed. Some of these risks are within the span of control and manage. These include the risk that Ministry's financial and other resources are not allocated, or reallocated over time, to address the highest risk factors or drivers of the burden of disease in Samoa. **There are also some risks that are beyond the direct span of control of the Ministry to manage, but which the Ministry can track and prepare for.** One obvious risk is natural disasters including cyclones. Pandemic influenza, drug resistant TB, and relatively exotic diseases including Zika are risks to be tracked and managed.

Table 4: Risk Management Table

RISK	LIKELIHOOD OF RISKS OCCURING	RESPONSE
Risks within the span of control of MoH to manage		
Ministry's financial and other resources are not allocated, or reallocated over time, to address the highest risk factors or drivers of the burden of disease in Samoa.	Medium	The existing strong political vision and commitment to a more people-centric, preventive, primary health care system should be used to drive the changes required. The mergeing of MOH and NHS significantly reduces the earlier fragmentation and "silo" approach to financial, health workforce, and other resources in the sector. A movement to program based budgeting and planning will make the extent to which financial and human resources are – or are not - being reallocated in line with this Sector Plan more transparent and actionable. That in turn will help to make managers more responsible and accountable for implementing the changes required by Government. Making PEN Fa'a Samoa the centrepiece of the Sector Plan draws resources into a primary health care approach to public health. Reforms to the OVT will allow it to continue for broader social and political reasons, but not allow OVT to draw resources away from health promotion and broader public health in a disproportionate way.
Health workers are trained in important and valuable skills but permanently migrate out of the Samoan health system	High	The Sector Plan provides new and additional pathways for public health specialisation and career development in response to the changing population of Samoa over the coming decade. For example, there will be a need for additional health workers in paediatrics, mental health, palliative care, disease surveillance and epidemiology, health evaluation and impact assessment. PEN Fa'a Samoa also provides employment opportunities in rural areas close to families. If there is still a large and systematic emigration of health workers Government could consider requiring those leaving to refund the cost of government provided training if they emigrate before a certain time after graduating. Risks of health staff emigrating soon after graduating will be specifically addressed in the *MOH Human Resources for Health Strategy 2019/20-2024/25* and *Samoa's Health Workforce Development Plan 2019/20-2024/25*
The scope and scale of the health information system, including the M&E System	High	Finalising the e-health system and health information system, and testing it to ensure it is working as intended, will be a first-order priority for MOH. Incentivising people to *use* an improved health information and M&E as management and decision-making tool will take time. Short term training, including for front line health workers, on how to use M&E to achieve better health outcomes is a first step. Allocating 5% of the Government health budget to implement evaluation and impact evaluation should generate a critical mass of useful and usable studies that will help to enhance the culture of MOH into a "learning organisation". Tracking the evidence that managers have actually used M&E reports, updated NHA, and similar reports as part of their decision-making and resource allocation should also incentivise managers to use those sources of information more actively.
Development partners provide assistance in areas or in ways that is not aligned to	Medium	The Sector Plan specifies what the Government strategic priorities are, and where development partners can align their assistance and best harmonise given their comparative advantages. Updating the NHA, including with better data

RISK	LIKELIHOOD OF RISKS OCCURING	RESPONSE
the Sector Plan		on development partner contributions, and using the NHA as a strategic management tool can be helpful in ensuring there is accountability and management of development partners' support.
Risks that are outside of the direct span of control of MoH to manage		
Behavioural risk factors for NCDs (eg diet and / or physical inactivity) and for STIs do not change sufficiently to slow, let alone reverse, incidence of NCDs and STIs	Medium.	Raising the excise duty on tobacco to 70% of the retail price, accompanied by other supportive measures, is a proven means of reducing uptake and use of tobacco – a leading cause of NCDs – especially among the young and the poor. Significantly raising the excise duty on sugar-sweetened beverages does reduce consumption of those drinks, but it would be prudent to evaluate the impact on health outcomes including changes in the risk factor for diabetes.
Health security. This includes natural disasters such as cyclones as well as diseases such as pandemic influenza, drug resistant TB, and relatively exotic diseases including Zika.	Medium	Samoa is experienced in responding to natural disasters such as cyclones. Strengthening the e-health and broader HIS is an essential prerequisite to tracking and managing disease outbreaks. Having diagnostic equipment to test for high burden / high probability diseases (influenza strains, drug resistant TB etc) and sufficient health worker staff to use the equipment is essential.
Economic downturns and budget cuts	Medium to high	Samoa's economy is relatively small, and highly exposed to economic shocks including natural disasters or major global economic downturns and shifts in overseas remittances / tourism receipts. The health budget is the second largest program in the national budget so would not be immune from budget cuts in a major downturn. A shift to program budgeting and reporting will give a more informed evidence base on how to respond to any budget cuts.

REFERENCES:

Anderson, I & Irava, W. 2017.*The implications of aging on the health systems of the Pacific Islands: challenges and opportunities.* Health Systems & Reform, 3:3, 191-202.

Anderson I et al. 2013. *The costs and affordability of drug treatment for diabetes and hypertension in Vanuatu* Pacific Health Dialog Vol 19:2

Beaglehole, R et al. 2008. *Improving the prevention and management of chronic disease in low-income and middle-income countries: a priority for primary health care.* The Lancet Vol 372 No 9642.

Food and Agriculture Organisation. 2011. *Samoa's Food Country Profile.* Apia

Food and Agriculture Organization. 2009. *The Evolution of Samoa's Food Supply Situation: Trends over the past 40 years based on Analysis of Food Balance Sheets.* National Food Summit. Apia

Government of Samoa. 2006. *Ministry of Health Act 2006.* Apia

Government of Samoa. 2006. *National Health Service Act 2006.* Apia

Imamura, F et al. 2015. *Consumption of sugar sweetened beverages, artificially sweetened beverages, and fruit juice and incidence of type 2diabetes: systematic review, meta-analysis, and estimation of population attributable fraction.* British Medical Journal.

Institute of Health Metrics and Evaluation. 2019. Samoa. http://www.healthdata.org/samoa

Institute for Health Policy, Colombo, Sri Lanka and the Centre for Health Information Policy and Systems Research, Fiji National University, Suva, Fiji. 2018.*Samoa National NCD Cost Analysis Study.*

Jha, P et al. 2012. *Tobacco taxes: A win-win measure for fiscal space and health.* Asian Development Bank. Manila.

Lee R and Mason A. 2006. *What is the demographic dividend?* Finance and Development Vol 43:3;

Mackerras, D. 1999. *Samoa National Nutrition Survey.*

Malik, V et al. 2010. *Sugar-Sweetened Beverages, Obesity, Type 2 Diabetes*

Mellitus, and Cardiovascular Disease Risk. In *Circulation* Volume 121 pp 1356-1364.

McGarvey, S.T. et al. 2007. *Nutrition and health in modernizing Samoans: temporal trends and adaptive perspectives.* Cambridge University Press, Cambridge

McGrath K. 2016.*Cutting costs while improving care: Samoa's Diabetic Foot Clinic.* Available at http://www.devpolicy.org/cutting-costs-improving-care-samoas-diabetic-foot-clinic-20161013/

Mulder R et al. 2016.*Building on the strengths of Pacific mental health: Experience from Samoa.* Australian and New Zealand Journal of Psychiatry.

Ministry of Finance.2017 *Strategy for the Development of Samoa FY2016/17 – FY2019/20.* Government of Samoa, Apia,

Ministry of Finance. 2012. *Strategy for the Development of Samoa 2012-2016.* Apia

Ministry of Health. 2017. *National Health Sector Disaster Risk Management Strategy 2017*. Apia

Ministry of Health.2016 & 2017.*National Health Sector Career Talk Program 2016 & 2017.*Apia

Ministry of Health. 2014. *Ministry of Health Services Standards 2014.* Apia

Ministry of Health. 2013. *National Alcohol Control Policy 2013-2018.* Apia

Ministry of Health and World Health Organization. 2013. *Samoa STEPS Non-communicable Disease (NCD) Risk Factors Survey Report 2013.* Apia

Ministry of Health. 2013. *Health Sector Plan 2008-2018 Mid-Term Review Report.* Apia

Ministry of Health.2008 – 2017.*Annual Health Sector Forum Reports (2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017).*Apia

Ministry of Health. 2011, 2013, 2015.*Samoa & American Samoa Bilateral Health Summit Reports*. Apia
Ministry of Health.2008 – 2013.*Annual Reports for Financial Years (2008-09, 2009-10, 2010-11, 2011-12, 2012-13)*. Apia

Ministry of Health 2005 Samoa National Non-Communicable Disease (NCD) Control Policy 2018-2023: For the Primary Prevention of Non-Communicable Diseases, (November) Government of Samoa: Apia

Ministry of Health. 2015. *The Samoa National Health Accounts FY 2014-2015*, Government of Samoa, Apia

Ministry of Health. 2015. *MOH Annual Report for Financial Year 2015 – 2016.* Apia

Ministry of Health. 2014. *MOH Annual Report for Financial Year 2013 – 2014.* Apia

Ministry of Health. 2013. *MOH Annual Report for Financial Year 2012-2013.* Apia

Ministry of Health. 2012. *MOH Annual Report for Financial Year 2011-2012.* Apia

Ministry of Health. 2011. *MOH Annual Report for Financial Year 2010 – 2011.* Apia

Ministry of Health. 2010. *MOH Annual Report for Financial Year 2009 – 2010.* Apia

Ministry of Health. 2009. *MOH Annual Report for Financial Year 2008-2009.* Apia

Ministry of Health. 2008. *Health Sector Plan 2008-2018.* Apia

Ministry of Health. 2008. *MOH Annual Report for Financial Year 2007/2008.* Apia

Ministry of Health & WHO. 2013. *NCD Risk Factor Stepwise Report 2013.* Apia

Ministry of Health & WHO. 2002. *NCD Risk Factor Stepwise Report 2002.* Apia

Ministry of Natural Resources and Environment. 2012. *Water and Sanitation Sector Plan 2012-2016*. Apia

MOH Realignment Review Committee. 2011. *Review of the Ministry of Health Realignment.* Apia

National Health Service. 2017. *NHS Corporate Plan 2017 – 2020.* Apia

National Health Service. 2017. *Overseas Medical Treatment Report for FY2014-15 and FY2015-16.* Apia

National Health Service. 2016. *NHS Annual Report for Financial Year 2015-16*

National Health Service. 2015. *NHS Corporate Plan 2014 – 2015.* Apia
National Health Service. 2014. *NHS Annual Report for Financial Year 2013-2014.* Apia

National Health Service. 2014. *NHS Workforce Plan 2014.* Apia

National Health Service. 2013. *NHS Annual Report for Financial Year 2012-2013.* Apia

National Health Service. 2012. *NHS Annual Report for Financial Year 2011 – 2012.* Apia

National Health Service. 2011. *NHS Annual Report for Financial Year 2010 – 2011.* Apia

National Health Service. 2010. *NHS Annual Report for Financial Year 2009 – 2010.* Apia

National Health Service. 2011. *NHS Corporate Plan 2011 – 2015.* Apia

Samoa Bureau of Statistics. 2017. *Samoa Population Census 2016 Report: Preliminary Results.* Apia

Samoa Bureau of Statistics. 2014. *Samoa Demographic and Health Survey Report 2014.* Apia

Samoa Bureau of Statistics. 2009. *Samoa Demographic and Health Survey Report 2009.* Apia

Samoa Ministry of Health & JTA International, 2006, *Samoa Health Sector Situational Analysis.* Apia

Savedoff, W and Alwang, A. 2015 *The single best health policy in the world: taxing tobacco.* Center for Global Development. Washington DC.

UNFPA. 2014.*State of the world population 2014: the power of 1.8 billion adolescent youth and the transformation of the future.* New York.

World Bank. 2018.*Samoa: a review of public spending on health: improving efficiency today to ensure a sustainable and healthy future.* Washington DC.

World Bank. 2016.*Global Monitoring Report 2015/16: Development goals in an era of demographic change.* Washington DC.

World Bank 2016. *Sin tax reform in the Philippines: transforming public finance.* Washington DC.

World Bank. 2016.*Samoa health sector management support project: implementation status and results report.*Washington DC.
World Bank. 2014. *Pacific NCD Roadmap Report: circulated June 2014 for consideration by the Joint Forum Economic and Pacific Health Ministers' Meeting held in July 2014.*

World Bank. 2014. *Economics of tobacco: myths and facts.* Available at http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTETC/0,,contentMDK:20365226~menuPK:478891~pagePK:148956~piPK:216618~theSitePK:376601,00.html

World Bank Public Expenditure Review 2018: *Samoa a review of public spending on health: improving efficiency today to ensure a sustainable and healthy future*

World Health Organization. 2018. *Tracking Universal Health Coverage: 2017 Global Monitoring Report.* Geneva.

World Health Organization. 2018.*Noncommunicable Disease Country Profiles 2018.*Geneva.

World Health Organization. 2017. *Tackling NCDs: "Best buys" and other recommended interventions for the prevention and control of noncommunicable diseases.* Geneva.

World Health Organization. 2016. *Universal Health Coverage: Moving Towards Better Health Action Framework for the Western Pacific Region.* Geneva.

World Health Organization. 2010. *WHO Technical Manual on Tobacco Tax Administration.* Geneva.

World Health Organization. 2010. *World Health Report 2010*. Geneva.