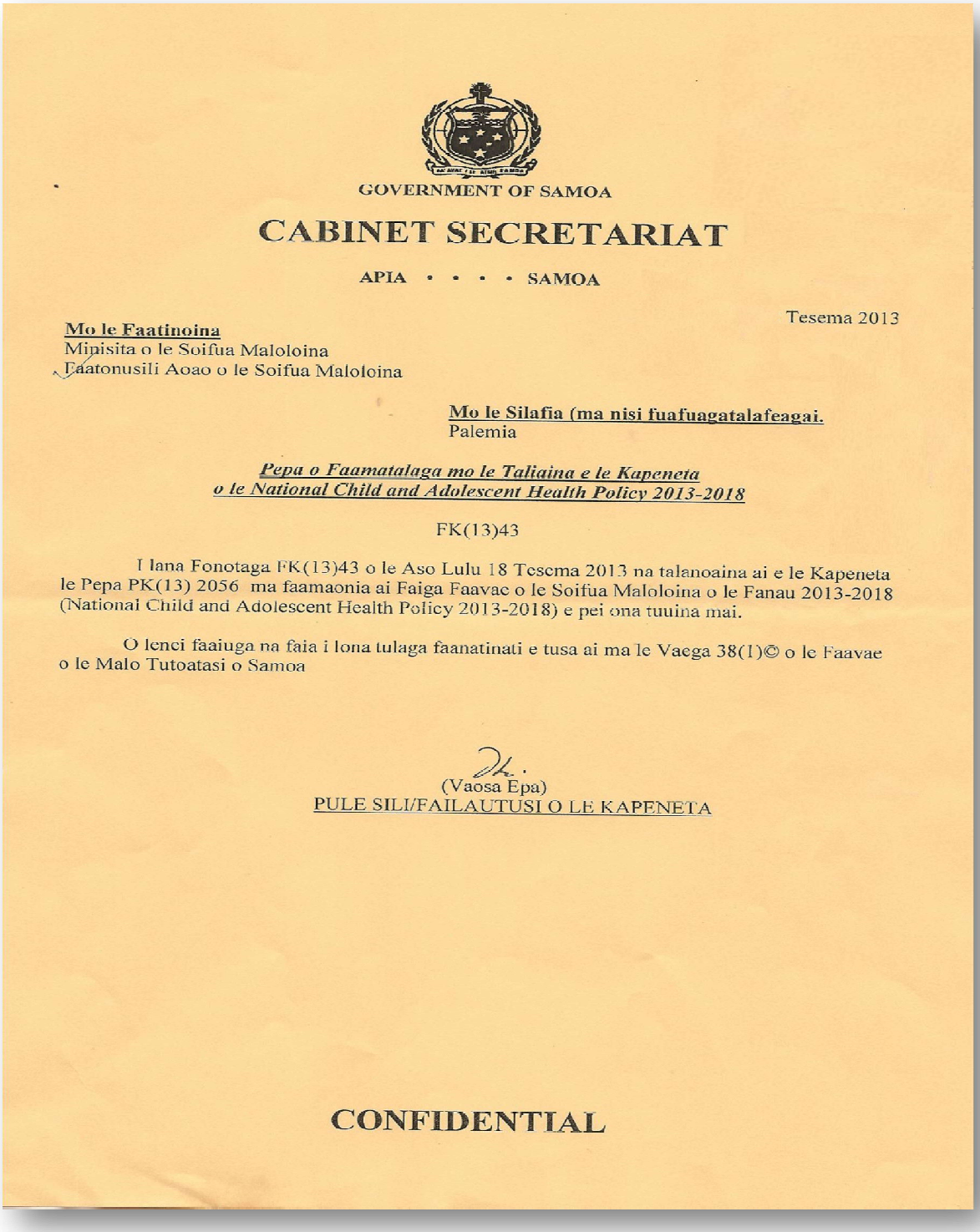
CHILD and ADOLESCENT HEALTH POLICY 2013

Ministry of Health

FAAIUGA A LE KAPENETA MO LE FAIGA FAAVAE O LE SOIFUA MALOLOINA O LE FANAU



GOVERNMENT OF SAMOA

CABINET SECRETARIAT

APIA • • • • SAMOA

Tesema 2013

Mo le Faatinoina
Minisita o le Soifua Maloloina
Faatonusili Aoao o le Soifua Maloloina

Mo le Silafia (ma nisi fuafuagatalafeagai.
Palemia

Pepa o Faamatalaga mo le Taliaina e le Kapeneta o le National Child and Adolescent Health Policy 2013-2018

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O lenei faaiuga na faia i lona tulaga faanatinati e tusa ai ma le Vaega 38(1)© o le Faavae o le Malo Tutoatasi o Samoa

(Vaosa Epa)
PULE SILI/FAILAUTUSI O LE KAPENETA

CONFIDENTIAL

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ACRONYMS

AIDS	Acquired Immuno-deficiency Virus
ARF	Acute Rheumatic Fever
ARI	Acute Respiratory Infection
CEDAW	Convention on the Elimination of Discrimination Against Women
CRC	Convention on the Rights of a Child
DHS	Demographic & Health Survey
EPI	Expanded Program on Immunization
GDP	Gross Domestic Product
HDI	Health Development Index
HIV	Human Immuno-deficiency Virus
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
MAF	Ministry of Agriculture & Fisheries
MCIL	Ministry of Commerce Industry & Labour
MDG	Millennium Development Goals
MESC	Ministry of Education Sports and Culture
MNRE	Ministry of Natural Resources & Environment
MOH	Ministry of Health
MPP	Ministry of Police and Prisons
MTII	Malietoa Tanumafili II Hospital
MWCSD	Ministry of Women Community & social Development
NCD	Non Communicable Disease
NGO	Non Governmental Organization
NHS	National Health Services
PATIS	Patient Information System
RHD	Rheumatic Heart Disease
SPAGHL	Samoa Parliamentary Advocacy Group for Healthy Living
STIs	Sexually Transmitted Infections
SRH	Sexual and Reproductive Health
SVSG	Samoa Victim Support Group
TTM	Tupua Tamasese Meaole Hospital
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WinLA	Women in Leadership Advocacy

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May we continue to work in sincere partnership to ensure the achievement of our Health Sector's vision of a "Healthy Samoa".

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    a. Mental Health Unit
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7. Public Service Commission
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11. Samoa Nursing Association
12. Samoa Family Health Association
13. Samoa General Practitioners Association
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15. Samoa Red Cross
16. National Council of Churches
17. Loto Taumafai Society
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INTRODUCTION

The Government of Samoa is committed to ensuring the health of all children and adolescents, regardless of ethnicity, status, disability or gender, in keeping with its vision of a 'Healthy Samoa for All', both now and in the future. Our young people hold our greatest potential – their health and safety must be protected and they must be encouraged to thrive through effective policies and programs, community participation, and family care and support.

Not only is the health of Samoa's children and adolescents of highest priority, but the Government of Samoa also takes a life course view of health that recognizes the cumulative impact of changes in health status over an individual's lifetime. Establishing and maintaining early health leads to better adult health outcomes. Conversely, children beginning life at a health disadvantage will likely experience poorer adult health outcomes and accompanying socioeconomic impacts. Ensuring healthy development of our nation's children ensures a healthy future for our population.

As a signatory to the Convention of the Rights of the Child[1], Article 24 specifically on child's rights to health, Samoa has committed to protecting children's rights, including the right to survival, to develop to the fullest, to protection from harmful influences, abuse and exploitation, and to participate fully in the family, cultural, and social life. Samoa is also a signatory under CEDAW[2], which supports the realization of children's health rights through their mothers and the girl child. Ensuring child survival and health is a fulfilment of Samoa's commitments under both Conventions. The health articles of both Conventions are annexed to this policy document.

The Government of Samoa is also committed to achieving the Millennium Development Goals in order to improve human development and secure a positive future for Samoa. Several of these goals have particular relevance to child health, specifically MDG4: Reducing Child Mortality, MDG5: Improving Maternal Health, and MDG6: Combat HIV/AIDS. Other Millennium Development Goals, such as MDG1: End Poverty and Hunger and MDG2: Universal Primary Education, also have a direct or indirect impact on child and adolescent health and must be considered as part of our commitment to achieving greater health and wellbeing for our youth.

Additionally, Samoa recognizes the importance of Health Promotion and participatory Primary Health Care approach as the philosophies and models of service delivery that will promote health and wellbeing across the life course, from childhood through adulthood, and ensure the healthiest future for all people. The National Child and Adolescent Health Policy will emphasize a Health Promotion and Primary Health Care approach to providing services for child health.

Child health is at a critical juncture in Samoa. While there have been significant reductions in child morbidity and mortality in recent years, there are also signs of increased health vulnerabilities among our children. Immunization rates have been falling in recent years, malnutrition appears to be on the rise, there is a severe public health anaemia problem, and increasing rates of child obesity, dental cavities and preventable accidents and injuries threaten children's health and wellbeing. Samoa has an opportunity to build on recent improvements and to address these emerging and persistent challenges in order to continue maximizing child health.

[1] Convention on the Rights of the Child, ratified by Samoa in 1994.
[2] Convention on the Elimination of Discrimination Against Women, ratified by Samoa in 1992.

National Child & Adolescent Health Policy 2013-2018

This National Child and Adolescent Health Policy will cover children and adolescents ranging from 0-18 years of age. This definition of childhood is taken from the Convention on the Rights of the Child. Within this age range, particular health activities and policy directions will be geared towards the age groups of under five (0-5 years), 6-9 years and the adolescent age group of 10-18 years. This document will provide the framework for the planning, management, delivery, monitoring, and evaluation of services targeted at improving and maintaining child and adolescent health for all these specific age groups in Samoa.

VISION

Healthy Samoan Children & Adolescents

MISSION

For all children & adolescents of Samoa to live & enjoy a healthy lifestyle & general wellbeing

GOALS & OBJECTIVES

- To ensure the protection of children and adolescents through healthy living and healthy eating
- To ensure all children and adolescents of Samoa access high quality and comprehensive health care through a primary health care approach
- To improve child and adolescent health with effective health information systems by collecting data to inform planning and policy decisions
- To improve on early detection, intervention and prevention of disability for all children of Samoa

SITUATIONAL ANALYSIS

The population of Samoa is approximately 187,820 persons which comprised of 96,990 males and 90,830 females[3]. The population growth rate is determined by fluctuations in outmigration in addition to birth and death rates and other population dynamics. The majority of the population resides on Upolu, with most people living along the coastal fringe. Approximately 19 percent of the population resides in the Apia Urban Area, 33 percent in Northwest Upolu, 24 percent in the rest of Upolu, and 24 percent in Savaii[4]. The Northwest Upolu and Apia Urban Area regions have the highest population density, and Northwest Upolu has doubled its growing rate from 1.3 percent to 2.2 percent per annum. The two important factors that lead to this increase is the availability of freehold land for sale in Northwest Upolu (particularly Vaitele) and is where the industrial zone is located, hence many people from other regions move to seek for employment opportunities[5].

The main sources of income are remittances from Samoans living and working overseas and tourism. Agriculture, fishing, and development aid also play major roles in the economy of Samoa, and tourism is an expanding sector[6]. At the end of March 2010, GDP per capita was US$2881.81. The Human Development Index places Samoa at 94th out of 182 countries[7]. Among the Pacific nations, Samoa has one of the higher development indices, with greater educational and health outcomes than several other Pacific Island nations.

Over the past two decades, the health status of most Samoans has seen significant improvement. Life expectancy is at 74.2 years for the total population, an increase from 73.2 years in 2006[8]. However, non-communicable diseases are on the rise, due to social and economic dynamics leading to unhealthy diet, low physical activity, smoking, and alcohol use. These factors are both the result of individual lifestyle decisions and the result of environmental forces such as food, tobacco, and alcohol pricing and availability and increased urbanization. Communicable diseases are also very evident with typhoid and dengue fever existing as a constant threat. In order to stem the tide of communicable and non-communicable diseases in the population of Samoa, the health sector must work inter- and multi-sectorally to address the factors leading to these diseases. Prevention of morbidity and mortality also means beginning prevention efforts early in the life course, recognizing the cumulative effect of lifetime health experiences, and ensuring the best start for children to promote their development as healthy adults.

Samoa has a young population. Thirty-nine percent of the population is between the ages of 0-14 and the median age is 20.7. Samoa has a sex ratio of more males than females in all age groups younger than 60 years old, with an average sex ratio of 107 males per 100 females. The infant mortality rate is 15.6/1000 live births, a 4.8 percent decline from the infant mortality rate of 20.4/1000 in the 2006 Census. While Samoa's infant mortality rate is lower than in other Pacific countries, Samoa still has a long way to go in sustaining decreases in infant mortality[9].

[3] Samoa Bureau of Statistics, Population and Housing Census Analytical Report 2011, Apia, Samoa.
[4] Ibid.
[5] Ibid.
[6] WHO Western Pacific Region (2010). *Country Health Information Profiles: Samoa.* WHO. Geneva, Switzerland.
[7] Ibid.
[8] Samoa Bureau of Statistics, Population and Housing Census Analytical Report 2011, Apia, Samoa.
[9] Samoa Bureau of Statistics, Population and Housing Census Analytical Report 2011, Apia, Samoa.

Overall, the health status of children has been improving, but there are key areas that still require attention. In particular, immunization rates have been dropping in recent years, malnutrition appears to be increasing, anaemia is widespread, and obesity and injuries pose a significant burden of ill health on the child population. According to the 2009 Samoa Demographic and Health Survey, the under-five mortality was 15/1000 live births, and the infant mortality was 9/1000, in the most recent five-year period preceding the survey, meaning that 1/66 children born during the period died before reaching their fifth birthday. Since the 2006 Report of the Population and Housing Census found an under-five mortality rate of 20/1000 live births, the 2009 DHS estimate is likely an underestimate[10] as the Census Survey has a broader sample size, capturing a wider scale of the population.

Major areas of concern in the 0-18 age group include perinatal and neonatal health, infant and young child feeding, major childhood illnesses (including infection, malnutrition, anaemia, diarrhoea, vector born disease, acute respiratory infection, and rheumatic fever), nutrition, injury, maternal transmission of HIV/AIDS and STIs, dental health, adolescent health, and mental health. In addition, there is paramount concern regarding areas such as physical inactivity and child obesity as such trend is remarkably high, as well as smoking, which is also seen as another prominent risk factor, with the increase in the number of youth smoking over the years in Samoa. These areas are discussed in detail as Thematic Areas in the following section.

Since the health sector reforms in 2006, access to health care services has improved. Health care services are provided through a network of village health centres, district hospitals, national hospitals, and private health care providers. There are six district hospitals in Samoa which are manned by qualified multi-skilled nursing staff who provide a range of health care services to the community, inclusive of services pertaining to child health; such as immunization, treatment of common illnesses and injury and prenatal care. Referral services are provided at the national hospitals, Tupua Tamasese Meaole (TTM) Hospital in Upolu and Malietoa Tanumafili II (MTII) Hospital in Savaii. Some members of the public utilize the services of private practitioners and NGO providers. The combination of national referral and district hospitals, village health centres, school-based services, and private practitioners provide a holistic network of health services to the people of Samoa. The health sector also provides outreach programs in schools and community as well as mass media campaigns mainly to maximize community awareness and gage their participation for their good health and wellbeing of their family members.

Despite these improved programs and services, a shortage of providers, gaps in training, and low service utilization present persistent barriers to improved child and adolescent health. Data and documentation also continue to be a challenge to monitoring improvements in child and adolescent health status. The population is mobile in its use of health services, creating difficulties in ensuring effective documentation of individuals' health history. Although the PATIS health information system allows for effective tracking of aggregate data from the national and district hospitals, there are persistent issues with collecting comprehensive data from the district hospitals and village health centres. There is also a particular gap in data about the health of children and adolescents over the age of 5. This gap is due in part to different classifications for youth used in different surveys. For instance, the 2009 Demographic and Health Survey, which has provided a wealth of data about the health of the population of Samoa, asked questions primarily about early childhood (0-5 years), and grouped adolescents (15-18 years old) with adults in the data analysis. In order to gather a full picture of the status of child health, and to

[10] Ministry of Health, Samoa, Samoa Bureau of Statistics, ICF Macro (2009). *Demographic and Health Survey 2009.* Apia, Samoa.

engage in subsequent planning that addresses the highest priority health needs of the population, these data and documentation challenges must be addressed.

THEMATIC AREAS[11]

There is increasing recognition of the interrelated social, economic, and environmental factors underlying many health conditions. There is also an accompanying recognition that integrated primary health services are more effective, provide greater cost-benefit, and are more empowering and inclusive of communities and individuals. Although this drive toward integration represents necessary progress, it is still instructive to discuss the status of our young people's health in relation to key thematic areas that drive the prioritization of health needs among the target population.

1.1 Perinatal and Neonatal Health

According to data from the PATIS health information system, the neonatal[12] death rate has remained steady over the period 2006 to 2010, at around 8.0/1000 live births[13]. However, the perinatal[14] death rate has been on the rise.

High-quality, comprehensive antenatal care is essential for preventing neonatal morbidity and mortality. Elements of effective antenatal care include at least four visits to a health care provider, iron and folate supplements, birth spacing and family planning, tetanus immunization, birth planning and preparation, early identification of complications, HIV/AIDS management, antenatal education and birth in a well-equipped health facility under the care of a skilled attendant/provider. Additionally, good maternal nutrition and effective management of maternal health contribute to improved neonatal health.

According to the 2009 DHS, a high percentage of women received some antenatal care during their most recent pregnancy (in the five years preceding the survey), but a much lower percentage received the full four recommended antenatal visits over the course of their pregnancy. Only 58 percent of women in Samoa had all four antenatal visits for a pregnancy during the five years preceding the survey. Twenty-eight percent had 2-3 visits, and 6 percent had only one visit. Fortunately, only 4 percent of women received no antenatal care during their pregnancy. There is some association between higher level of education or higher wealth and increased likelihood of receiving antenatal care. Early antenatal care is especially important – it is recommended that the first visit occur during the first trimester. Women in Samoa generally receive antenatal care late in pregnancy. Only 13 percent of mothers received antenatal care during the first trimester. The majority (72 percent) had their first visit between the fourth and

[11] Unless otherwise noted, all data on thematic areas of child health is derived from the 2009 Demographic and Health Survey.
[12] Number of deaths during the first 28 completed days of life per 1,000 live births in a given year or period.
[13] Percival, T (2010). *For Every Child.* Presented at Samoa Child Health Symposium. 11 February, 2011. Apia, Samoa.
[14] Number of stillbirths and deaths in the first week of life per 1,000 live births.

seventh months and 9 percent had their first visit during the eighth month or later. Overall, antenatal care coverage does not differ by region, although women in urban areas tend to seek care earlier.

More than half (58 percent) of women received iron supplements during their most recent pregnancy, but among them, 44% reported taking supplements for than 60 days. Only 5 percent received treatment for intestinal parasites, with the percentage of women taking these treatments increasing with age and birth order. Only 31 percent of births were protected against neonatal tetanus, with only 25 percent of mothers receiving the recommended two or more immunization injections (given if the mother is not already immunized). There is little variation by age at birth, rural-urban residence, or wealth, though there is some variation by region and a decrease in immunization at the highest education levels. Almost all women underwent basic tests during pregnancy, but only 27 percent were informed of the signs of complications during pregnancy.

Most births in Samoa take place in a health facility (81 percent), with the vast majority of births occurring in a public health facility (79 percent), as opposed to at a private facility or overseas. The percentage of deliveries at a health facility is significantly higher among urban mothers, among mothers with higher levels of education, and with increasing wealth. 97 percent of births are delivered with the assistance of a trained health professional, with 81 percent delivered by a health care provider and 16 percent assisted by a traditional birth attendant. Out of recognition of the important role of traditional birth attendants, the Ministry of Health provides training and monitors their services to ensure safer deliveries.

Another essential service following delivery is high quality essential newborn care. This includes improving thermal care by drying the baby thoroughly, ensuring skin-to-skin contact for at least one hour, early initiation of breastfeeding, hygienic cord care, and looking for danger signs. The Tupua Tamasese Meaole and Malietoa Tanumafili II Hospitals have also committed themselves to implementing the Baby Friendly Hospital Initiative which takes this newborn care a step further.

Postnatal care is very important for averting health problems in mothers and newborn children and in promoting healthy parenting practices. Postnatal coverage is relatively low in Samoa, with just 66 percent of mothers receiving a postnatal check-up within the recommended 48 hours after delivery.

In order to reduce neonatal and perinatal mortality, efforts must be made to ensure maternal antenatal care usage, access to a skilled birth attendant, quality essential newborn care and postnatal care and to improve maternal health generally.

1.2 Infant and Young Child Feeding (ICYF)

Early initiation of breastfeeding is beneficial to health in a number of ways, including establishing immunity, providing a full complement of necessary nutrients, protecting against obesity and avoiding infectious diseases, such as diarrhoea.

At the time of the 2009 DHS, 92 percent of children born in the last five years had been breastfed at some point. 88 percent of last-born children who were breastfed started within one hour of birth and 97 percent started within 24 hours of birth. Children in urban areas are less

likely to receive breast milk within the first hour after birth, and children attended by a health care provider were slightly less likely to receive early breastfeeding compared to births attended by a traditional birth attendant.

Generally, breastfeeding duration tends to be long in Samoa (the median duration of breastfeeding is 22 months). However, exclusive breastfeeding[15] is recommended because it provides the best health outcomes for children, is short (median 2 months). Only about half of children under six months are exclusively breastfed. Children in rural areas are more likely to be breastfed than children in urban areas. One quarter of children under six months are fed using a bottle, which presents child health concerns over hygiene early cessation of exclusive breastfeeding.

It is recommended that complementary feeding begin at 6 months with the introduction of nutrient-rich solids and semi-solid foods. When assessing the percentage of children ages 16-23 months whose dietary intake met minimum standards for infant and young child feeding (focusing primarily on food diversity, feeding frequency, and consumption of breast milk, milk, or other milk products) – approximately 48 percent of breastfed children were fed in accordance with all three IYCF practices. Only 15 percent of non-breastfed children were fed in accordance with all three IYCF practices. Overall, only 40 percent of children were fed in accordance will all IYCF practices, with inadequate number of feedings as the most frequent problem with feeding practices.

The Ministry of Health has adopted the WHO/UNICEF Global Strategy for Infant and Young Child Feeding as a guide to national efforts to improve the nutritional health of infants and young children. The Ministry promotes the practice of breastfeeding through the Baby-Friendly Hospital Initiative and provides continuing education and training for health care providers as part of ongoing efforts to improve infant and young child feeding practices in Samoa. In addition, the Nutrition Section of the Ministry is also taking the lead in drafting the regulations on marketing of infant and young child foods and products as part of the regulations for the Food Bill (currently under final review and being prepared for cabinet submission) and promoting appropriate IYCF (Infant and Young Child Feeding). The Ministry of Health also advocates for breastfeeding support in the workplace by promoting improved working conditions for all employed women so they have adequate maternity leave, the ability to bring their infants to work, to take breaks to breastfeed and to have a comfortable and private space for nursing.

In 2011, the Public Service Commission and the Ministry of Health, and its partners under the WinLA (Women In Leadership Advocacy Group) initiative, was successful in pushing through cabinet the approval of a policy on Nurseries in the Public Service. This paper was submitted to Cabinet by the Public Service Commission with the technical support of the Ministry of Health and all WinLA[16] members on the 7th August 2011. The policy does not serve to enforce but to encourage and promote nurseries in all public ministries as well as within the private sector to ensure that working mothers are able to breastfeed their children within working places and ensuring that all mothers are able to exclusively breastfeed their children for the first six months. Cabinet approval for this policy was received in November 2011.

[15] Exclusive breastfeeding means feeding baby with just breast milk and nothing else.
[16] WinLA members include all Women CEOs and General Managers of all public service organizations.

1.3 Major Childhood Illnesses

Six of the nine priority health issues for the children of Samoa identified by the Pasifika Paediatric Society and Pacific CHIP 2010[17] are preventable childhood illnesses, including malnutrition, acute respiratory infection, acute gastroenteritis (diarrheal diseases), vector-borne diseases, rheumatic fever, and injury. The other three priority health issues (congenital abnormalities, neonatal morbidity, and neonatal mortality) have complex causes and are not as readily prevented. Anaemia is also a serious health concern among the children of Samoa and overweight/obesity is an increasing problem.

Factors that contribute to the prevalence of these major childhood illnesses include:

- Decreasing rates of immunization
- Poor diet and inadequate physical activity
- Poor sanitation and water quality
- Inadequate parental education and community education
- Inadequate utilization of health services

In keeping with a Primary Health Care approach that recognizes the enhanced effectiveness and user-friendliness of integrated health services, the health sector shall strive to integrate services for the prevention and management of major childhood illnesses to the greatest extent possible. One such approach that protects a child's complete wellbeing is the Integrated Management of Childhood Illness (IMCI).[18] Through a child-centred, integrated approach, Samoa aims to reduce the incidence of preventable illness in children and to increase their wellbeing.

1.3.1 Malnutrition and Micronutrient Deficiency

Malnutrition and micronutrient deficiencies impede cognitive and physical development in children. The causes of malnutrition include insufficient or non-nutritious food, infection and chronic illnesses, and acute gastroenteritis. A recent audit of the 2260 total cases admitted to the paediatric ward between 2006 and 2010 showed that malnutrition cases only made up 2% of admissions. Despite the relatively low number of malnutrition hospital admissions, malnutrition appears to be an increasing problem in Samoa, with malnutrition admissions to TTMH increasing in recent years. In 2010, the malnutrition rate for admissions was 18.33 (17.69 for individuals), compared to 8.85 for admissions and a comparable number for individuals in 2006[19]. Among malnutrition cases between 2006 and 2010, 51 percent were also found to have anaemia. Many malnutrition cases also presented with co-morbidities: acute gastroenteritis 40%, pneumonia 29%, and skin problems 22%. Only 11% presented with malnutrition alone[20]. Another study conducted under the Pacific Child Health Indicator Project noted that of all malnutrition cases presented to TTMH from 2005-2006, 56% were from the Apia district, clearly showing a positive relationship between the urban drift, poor living conditions, and the multiple factorial impact of low socio-economic status on child health and nutrition.

[17] Percival, T. *For Every Child.* Presented at the Samoa Child Health Symposium. 17 February 2011. Apia, Samoa.
[18] Developed by WHO and UNICEF.
[19] Developed by WHO and UNICEF.
[20] Ibid.

There is also concern about micronutrient (vitamin and mineral) deficiencies in Samoa. Iron deficiency is a common and serious micronutrient deficiency and vitamin A and iron deficiencies are also suspected.

Vitamin A deficiency can lead to blindness and increases susceptibility to illness by weakening one's immune response. Vitamin A is found in breast milk and in a range of foods. Periodic dosing (every 6 months) with vitamin A supplements is one method of ensuring that at-risk children do not develop vitamin A deficiency. There is a pressing need for more baseline data on Vitamin A deficiency to provide the evidence needed to determine whether we need a routine vitamin A supplementation program for children in Samoa. Currently, there is not routine vitamin A supplementation of children.

Iron is essential for cognitive development. Iron deficiency anaemia can be caused by low iron intake, poor absorption of iron due to other micronutrient deficiencies, disease or infection, or chronic diarrhoea. Iron deficiency anaemia has physiologic, psychomotor, affective, and intellectual consequences for children. A 1999 study found that 61% of children 0-2 years old, 23% of children 2-4 years old, and 20% of teenagers had anaemia[21]. It is assumed that most of this anaemia is caused by iron deficiency. Intestinal worms can also contribute to vitamin A deficiency and iron deficiency anaemia. Reducing other diseases and infections, and reducing chronic diarrhoea are two important means of reducing iron-deficiency anaemia.

Iodine deficiency is the single most common cause of preventable mental retardation and brain damage in the world. The effects of iodine deficiency disease (IDD) include reduced physical and mental development, lower IQ, goitre (swelling on the neck), stillbirth and in adults apathy and reduced mental functioning. While the severe forms of iodine deficiency (i.e. with no obvious clinical signs) where there is a small degree of brain damage and reduced cognitive ability in the entire population of those affected. This affects the overall intellectual and socio-economic development potential of affected communities and this has potentially huge economic consequences. There is ad hoc evidence that iodine deficiency exists in Samoa. Research is needed to determine the extent of the problem. The provision of iodised salt will help combat iodine deficiency.

While recent surveys have provided information about breastfeeding and complementary feeding practice, micronutrient intake among children under 3 years old, and food and micronutrient intake among adults, there is a gap in information about overall dietary intake among children 3-15 years old. Additionally, the DHS report groups adolescents 15-18 with adults. In order to undertake effective planning, more evidence is needed as to the prevalence and causes of micronutrient deficiency among the children of Samoa.

In addition to efforts to improve infant and young child feeding, key strategies for reducing malnutrition include: policies to require food fortification, micronutrient supplementation, health education and promotion on healthy eating.

1.3.2 Immunization and Vector Borne Diseases

[21] Samoa National Nutrition Survey, 1999. Part 1, Anaemia survey, Technical Report by Dorothy Mackerras-PhD & Deidre M. Kieman-MPH.

The immunization rate in Samoa has dropped dramatically over the last decade. Overall, only 25 percent of children 18-29 months in Samoa are fully immunized with all basic vaccinations. A high percentage of children have received the first dose of multi-dose vaccines, but coverage declines significantly with subsequent doses. Despite the low vaccination rate, only 15 percent of children received no vaccinations.

Samoa uses the Expanded Program for Immunization (EPI)[22], primarily administered by the nurses of the National Health Service, to immunise children. Low immunization rates are partly a result of inadequate parental education and low utilization of health services, and are also a reflection of actual or perceived barriers to the utilization of health services. Formerly, immunizations were provided on a community schedule, with nurses visiting each community and immunizing all children simultaneously. Both as an effort to adhere to proper immunization schedules for individuals and in response to a shortage of staff in relation to the size of the child population, responsibility for immunization has shifted more to parents who must bring their child to a district hospital or community health centre according to the correct immunization schedule for their individual child. This change in practice may be partly responsible for reduced rates of full immunization.

The drop in immunization rates highlights the importance of increased health promotion efforts to educate parents about immunization. Recent mass media campaigns have been undertaken to educate parents about the importance of childhood immunization, and about all of the locations where immunization is offered. Continued health promotion, including education and relationship building with parents during antenatal visits, in addition to mass media outreach, is necessary to strengthen health sector efforts to improve immunization rates. A health card which contains the immunization schedule for all children was used in the past and is now being replaced by the 'Baby Book' which serves the same function, that is, to keep track of each child's health and immunization records. This Baby Book (i.e., a complete record of immunizations) is recommended as a requirement for enrolment in school to ensure that all children receive the full schedule of immunizations.

There exists a National EPI Coordinating Committee, but the group has not been active recently. Revitalization of the National EPI Coordinating Committee and assessment of what factors may have led to a drop in immunization coverage would allow for improved planning to increase immunization rates.

1.3.3 Acute Respiratory Infection

Acute respiratory infection is among the leading causes of childhood morbidity and mortality globally and in Samoa. Viruses are the exclusive causes of the common cold syndrome; they also play a prominent role in the production of pharyngitis (or sore throat) and of the upper and lower respiratory tract illnesses[23]. In 2009, mothers reported that 2% of children had experienced the symptoms of ARI in the two weeks preceding the DHS survey. About nine in ten children with symptoms were taken to a health facility or health care provider for treatment. Just over half of children received antibiotics to treat the symptoms of ARI. Pneumonia and

[22] This program provides immunization vaccination for children against the infectious childhood diseases that affect children's health.
[23] Abraham M. Rudolph et al: *Pediatrics,* 17th ed, 1982, Prentice-Hall Inc, U.S.A. (p. 592)

bronchitis admissions to TTM hospital have been increasing since 2006, with 910 pneumonia and 301 bronchitis admissions in 2009[24].

1.3.4 Gastroenteritis

According to the 2009 DHS, 5% of children under five years old in Samoa had diarrhoea in the two weeks preceding the survey. The highest prevalence was between 12-23 months (8%), which may coincide with weaning from breastfeeding and the introduction of other liquids and complementary foods. There were few differences due to background characteristics or source of drinking water; however, children from households with a non-improved toilet facility were slightly more likely to experience diarrhoea than those from households with an improved toilet facility. More than two-thirds (68%) of children were taken to a health care provider. More than nine in ten children with diarrhoea were treated with some form of oral rehydration therapy or increased fluids.

Mothers exhibited relatively low levels of knowledge about oral rehydration salts (or *vai masima*, also known as Recommended Home Fluid), and low knowledge of the proper way to administer fluids and food during an episode of diarrhoea. These findings, along with relatively high rates of improper stool disposal indicate the need for increased parental education about diarrhoea in children.

Currently, there are high rates of improved water sources in households in Samoa, as well as relatively high rates of improved toilet facilities. The Ministry of Health is working with the community to further improve toilet facilities and water sources in households. The Ministry of Health is also working with schools to introduce and maintain sanitary toilet facilities. These ongoing efforts should contribute to a reduction in gastroenteritis among children.

1.3.5 Rheumatic Fever[25]

Acute rheumatic fever and rheumatic heart disease (RHD) have serious health consequences for the people of Samoa, and both adults and children are affected. Repeat incidences of acute rheumatic fever (ARF) can lead to heart disease, commonly seen as heart failure. It is essential to reduce rates of acute rheumatic fever starting early, in order to prevent the morbidity and mortality that can follow from repeated episodes. Fortunately, the incidence of ARF in Samoa has been declining in recent years. It has steadily reduced from 35 per 100,000 in 2000, to 30 per 100,000 in 2005, 12.8 per 100,000 in 2007, 7.3 per 100,000 in 2008 and 9.5 per 100,000 in 2009.

Due to the fact that people in Samoa generally do not present to health services with ARF symptoms, but rather at more advanced stages of disease, there have been school screening programs and other efforts to identify RHD cases for early intervention and treatment to prevent the progression of RHD and prevent the recurrence of ARF.

[24] Percival, T. *For Every Child.* Presented at Samoa Child Health Symposium. 17 February 2011. Apia. Samoa.
[25] Viali, S., Saena, P., Futi, V. (2011). *Rheumatic Fever Programme in Samoa.* Journal of the New Zealand Medical Association: 124(1329). http://journal.nzma.org.nz/journal/124-1329/4529/

A paper was recently published regarding a current echocardiogram screening program for RHD in primary schools in Samoa. The screenings were for children ages 5–13 years old (year 1 to year 8) and 3200 children were screened from both public and private schools in the urban region of Upolu. The results showed more cases of RHD in the public schools compared to private schools, and many children with RHD were living in the urban areas of Upolu.

1.4 Nutrition, Physical Activity and Obesity[26]

Modern diets, particularly urban diets, show an increased consumption of imported refined food products, packaged snack foods and fatty foods and a low consumption of fruit and vegetables. Increasing obesity in Samoa has largely coincided with a change in the Samoan dietary pattern from locally cultivated, low fat foods to "modern" diets[27] which corresponds to the rise in Non Communicable Diseases (NCDs). There is evidence that NCDs may start in very early childhood if infants and young children do not receive the appropriate diet. Inappropriate diet may also cause diarrhoea and pneumonia, which are significant health problems among infants and young children in Samoa[28]. Breastfeeding protects against these infections. It has also been reported that bottle-fed infants are heavier, but not necessarily more obese, than breastfed infants of the same sex and age[29].

Notably, a rise in obesity levels has also been associated with increasing physical inactivity amongst adults and children in Samoa. Many studies showed that lack of physical activity is a major cause of death, disease and disability. Physical inactivity as a risk factor has contributed to the 10 leading causes of death and disability in the world. Professional sedentary jobs in Samoa have increased in number as society has modernized. These require much lower levels of energy expenditure than traditional subsistence activities[30]. People in remote village communities are more physically active compared to those living in the urban area.

Obesity is strongly associated with diseases such as diabetes, coronary heart disease, stroke and high blood pressure. These non-communicable diseases have largely replaced infectious diseases as the main health problems among adults in Samoa[31]. As among farm-working adults, children who grow up having worked on a farm have greater access to locally grown fruits and vegetables, and may consume them more frequently. Thus participation in this traditional activity may help children to maintain healthier body weights and eat diets richer in traditional foods.

Recently, a distinct rise in childhood and adolescent obesity has been seen in Samoa, which will lead to earlier onset of NCD in the future.[32] Given the evidence of the rising level of obesity

[26] Information in this section derived from: Samoa Fanau Manuia Programme (2009). *Draft: Samoa Child Health: Needs Analysis.*
[27] Hodge et al. 1993; McGarvey 1995.
[28] Plan of Action for Infant and Young Child Feeding 2006-2010; Ministry of Health, Apia. Samoa.
[29] Abraham M. Rudolph et al: *Pediatrics,* 17th ed, 1982, Prentice-Hall Inc, U.S.A. (p. 172)
[30] Keighley, E., McGarvey, S., Quested, C., McCuddin, C., Viali, S., Maga, U. (2007). *Nutrition and health in modernizing Samoans: temporal trends and adaptive perspectives.* Health Change in the Asia-Pacific Region: Biocultural and Epidemiological Approaches. Cambridge University Press.
[31] Adams, Sio 1998.
[32] Keighley, E., McGarvey, S., Quested, C., McCuddin, C., Viali, S., Maga, U. (2007). *Nutrition and health in modernizing Samoans: temporal trends and adaptive perspectives.* Health Change in the Asia-Pacific Region: Biocultural and Epidemiological Approaches. Cambridge University Press.

among Samoa's youth, there is cause for concern. Keighley et al. predicts that "if present trends continue, it is easy to project that obesity-related NCDs will become important pediatric health problems in Samoans, as well as worrisome antecedents to the health of future Samoan adults."

To reduce rates of obesity and overweight among the youth of Samoa, this policy aims to encourage consumption of more local, low fat foods, including fruits and vegetables, especially through better school nutrition and the promotion of home vegetable gardens. This policy will also promote children's and adolescent's levels of physical activity, both through sports at school and extracurricular activities. These aims also closely relate to those outlined in the draft National Food and Nutrition Policy and National NCD Policy 2010-2015.

1.5 Dental Health[33]

Dental health is closely intertwined with overall health, especially through its influence on nutrition. Not only does poor nutrition contribute to tooth decay, children and adolescents with cavities are also less likely to eat nutritious food, such as fruits and vegetables, if they have pain or prematurely missing teeth from cavities. Children with poor dental health may also have difficulty speaking and less confidence as they grow older. For these reasons, it is important that this policy address issues of nutrition and access to dental care to improve the oral health of children and adolescents in Samoa.

Research shows that children and adolescents are especially prone to dental decay[34]. Dental health data for children presenting to public health facilities is not readily available as it is currently not being entered into the Patient Information System and this is an area that needs to be addressed under this policy. Despite the lack of age-specific data for children, the rise in diets of refined foods presents a challenge to dental health and anecdotally, an increase in dental caries has been seen. To combat these rising numbers of children presenting with tooth cavities at the public hospitals, three static dental clinics have been built into three primary schools (St Mary's Savalalo, Marist Brothers Mulivai and Apia Primary Schools) through the Sector Wide Approach Program. These primary schools were selected on the basis of being the most populated and having the most children presenting with tooth cavities.

Dental health is not only a problem for primary school age children, however. Even babies, (especially those that are being fed with bottles or eating solid food) need to have their teeth cleaned by their parents and to have regular check-ups for cavities. Finally, the bacteria that cause cavities can be passed between people by kissing or the sharing of utensils, so it is also important for parents and other family members to have good oral health. For all of these reasons, this policy should also address appropriate infant and young child feeding and dental health promotion for all ages.

1.6 Maternal Transmission of HIV/AIDS and STIs

[33] All information for "Dental Health" section derived from: Government of Samoa, UNICEF (2006). *Samoa. A Situation Analysis of Children, Women, and Youth.* UNICEF Pacific Office, Fiji.
[34] Wilkins, E. M. (1999). Clinical Practice of the Dental Hygienist: Eighth Edition. Lippincott Williams & Wilkins

Samoa is classified as a low prevalence country for HIV and AIDS, based on the number of known cases that have been identified to date. As of June 2009, there were 20 known cases of HIV in Samoa. There have been three recorded cases of mother to child transmission of HIV. The high rate of STIs among antenatal mothers is cause for concern, however, due both to the neonatal burden of disease from congenital chlamydia and syphilis, and the link between STIs and HIV/AIDS that might permit HIV/AIDS to spread rapidly in the future. HIV/AIDS and STI control activities are lead by the National Advisory Committee on HIV/AIDS, with the assistance of the Technical Advisory Committee on HIV/AIDS/STIs. Particular attention is paid to plans for the prevention of congenital chlamydia and syphilis and the prevention of mother-to-child transmission of HIV/AIDS. Effective antenatal care is paramount in the prevention of child illness due to HIV/AIDS/STIs. Antenatal care is integrate testing and treatment for HIV/AIDS/STIs. Prevention and treatment activities are guided by the National HIV/AIDS Policy 2011-2015.

1.7 Injury

A needs analysis, conducted in 1999 on behalf of the Samoa Child Health Project, found injury and poisonings were the leading causes of death in children and youth aged 1-14 years and the second leading cause of hospitalization for 5–14 year-olds.[35] A situational analysis of injuries to children was completed in 2001.[36] Data collected for the analysis from TTM Hospital and the village health centres showed children were over-represented, with more than half the total number of injuries occurring in young people aged 0-19 years. Males sustained three times more injuries than females.

The study also found the most common injuries to children were caused by:

- Sharp objects (mainly knives)
- Falls
- Dog bites, and
- Road related injuries.

Other frequent causes of injuries included poisoning, burns and fights. The analysis also indicated that the head, followed by the foot were the most frequently injured body parts. The survey found that most of these injuries to children occurred around the home, and on the road. Factors influencing injuries are many and varied. The relationship between these influences is similarly complex, involving socio-economic factors, lifestyle, and social, cultural, occupational and community influences.

Fast-forward more than ten years and the trend in child and adolescent injury has barely changed. Injury still remains a leading cause of hospital morbidity for children, representing nine percent of total child admissions to TTM Hospital alone.

International experience suggests that injury prevention activities will be most effective when:

[35] McClellan VE, Eastwood J. 1999. *Samoa Child Health Needs Analysis: An information paper*. Department of Health/NZODA Fanau ma Aiga Manuia/Child Health Project. (Unpublished).
[36] Irving LM. 2002. *The Children of Samoa: An analysis of Injuries*. Ministry of Health/NZAID Fanau ma Aiga Manuia / Child Health Project. (Unpublished)

- the multiple factors contributing to injury are addressed
- behavioural and environmental changes are encouraged
- activities are spread across a variety of sectors (e.g. health, police, churches)
- programmes are maintained and reinforced over time

1.8 Adolescent Health

Adolescence is an important phase of life where patterns of adult health are established.[37] Improving adolescent health requires improving young people's daily life with families and peers and in schools, addressing risk and protective factors in the social environment at a population level and focusing on factors that are protective across various health outcomes.[38] Therefore, it is important to consider all of the factors that influence adolescents' daily life in order to improve their current and future health outcomes. The following sections are important factors in adolescent health:

1. Educational Attainment
2. Working Youth
3. Tobacco, Alcohol and Drug Use
4. Sexual and Reproductive Health
5. Smoking
6. Teenage Pregnancy
7. Suicide

1.9 Mental Health

Mental health services for children and adolescents need immediate development. Recent data from TTM Hospital shows that, out of the total number of deaths reported and certified for the age group of 0-18 years, 27 percent were caused by injury, poisoning and certain consequences of external causes. From this 27 percent, 50 percent are deaths through intentional self harm by hanging and poisoning by paraquat chemicals. This is typically within the age group of 14-18 years[39].

Suicide is obviously a concern here and is a problem that needs addressing under the mental health umbrella of the health sector. Currently, this area is generic towards the Samoan population with an all inclusive approach towards children's mental health. However, the rising statistics have demonstrated that it is an area that needs to be prioritized by the health sector and its partners to be acted upon instantly.

This policy also makes reference to the reviewed Mental Health Policy 2012, which will, in conjunction with this policy, drive all issues on mental health for children in Samoa.

[37] Sawyer SM, Afifi RA, Bearinger LH, Blakemore SJ, Dick B, Ezeh AC, Patton GC. *Adolescence: a foundation for future health.* The Lancet. 379(9826):1630-1640 (2012).
[38] Viner RM, Ozer EM, Denny S, Marmot M, Resnick M, Fatusi A, Currie C. *Adolescence and the social determinants of health.* The Lancet. 379(9826):1641-1652 (2012).
[39] PATIS, Ministry of Health, Information Unit, SDPD

KEY STRATEGIC AREAS

This policy will be structured in alignment with the following key strategic areas. As essential elements of an effective health system, these key strategic areas are designed to ensure that multi-sectoral work in the provision of child health services are consistent, aligned with relevant legislation and mandates, and lead to comprehensive policies and services related to child health.

KSA 1: Governance and Leadership

Improving and maintaining the health of the children and adolescents of Samoa will require the coordinated efforts of all sectors, not just the health sector. It will also require the coordinated work of public, private, and non-government entities with regional and international partners. In keeping with the mandate established in the Ministry of Health Act 2006, the Ministry of Health will be the lead organization for establishing policies, legislation, and regulations to ensure child and adolescent health. The Ministry of Health will work with key stakeholders in all sectors, including:

- National Health Service (NHS)
- Ministry of Women, Community and Social Development (MWCSD)
- Ministry of Education, Sports and Culture (MESC)
- Ministry of Natural Resources and Environment (MNRE)
- Ministry of Commerce, Industry and Labour (MCIL)
- Ministry of Agriculture and Fisheries (MAF)
- Samoa Parliamentary Advocacy Group for Healthy Living (SPAGHL)
- Private Health Care Providers
- Relevant Non-Governmental Organizations
- Relevant Community-Based Organizations

The partnerships and collaboration with the above organizations require effective leadership from the lead agency (Ministry of Health) in joint planning, cooperative implementation and transparent reporting to safeguard the health and well-being of children and adolescents. It is also required under this policy that there be the right workforce with the appropriate skills and capacity to deliver health outcomes and this is encouraged under the platform of leadership and governance.

One of the partnerships that need to be strengthened by the health sector is that with the MNRE. This relationship is important, considering the effects of climate change and environmental factors on the disease and illness patterns affecting youth nowadays. This is highly evident from both the situational analysis presented above, as well as the most recent data received from the PATIS Information System on child health (Annex A).

Research conducted by the Surveillance and IHR Division of the Ministry of Health have highlighted that over the last six years, 53 percent of those affected by diarrhoea are below the age of 5. Evidence also shows that the numbers of diarrhoeal cases tend to increase during the wet season in Samoa and therefore children below the age of 5 will be most vulnerable.

This policy aims to strengthen the collaboration with environmental partners to improve preventive efforts for safeguarding children's and adolescent's health rights. Review and revision of this policy will be the sole responsibility of the Ministry of Health, as per its mandate. In keeping with Ministry of Health procedures, this policy will be reviewed at least once every five years. If there is a significant change to the situation related to children, in terms of health status, service delivery, or any other relevant reason, this policy may be reviewed in advance of the five-year review period.

Guiding Legal Frameworks

The National Child and Adolescent Health Policy is guided by the legal framework established by the Government of Samoa through policies, legislation, and strategic plans, including:

- Ministry of Health Act 2006
- National Health Service Act 2006
- National Policy for the Children of Samoa 2010-2015
- National Non-Communicable Disease Policy 2010-2015
- National Health Promotion Policy 2010-2015
- National Tobacco Control Policy 2010-2015
- Draft Food and Nutrition Policy 2012-2017
- Draft Policy for Disability
- Family Safety Bill
- Health Sector Plan 2008-2018
- Strategy for the Development of Samoa 2008-2012
- Health for All Samoans in the 21st Century
- Alma Ata Declaration
- Ottawa Charter
- Physical Activity Guidelines
- Samoa School Nutrition Standards
- School Sanitation Guidelines
- Dietary Guidelines
- Protocols/Guidelines for Standard Management in Pregnancy and Childbirth, 2012

In particular, the National Policy for the Children of Samoa 2010-2015 includes child health among its priority areas to ensure comprehensive wellbeing of the children of Samoa. Through the National Child Health and Adolescent Policy, the health sector will work to advance the health of Samoa's young people, in collaboration with other sectors dedicated to ensuring children's and adolescent's wellbeing.

Additionally, Samoa is party to the International Convention on the Rights of the Child and the Convention on the Elimination of Discrimination Against Women and is working toward the achievement of the United Nations Millennium Development Goals. These international commitments affirm the importance of the National Child Health Policy, not just to Samoa alone, but in recognition of Samoa's participation as part of the international community.

KSA 2: Health Service Delivery

2.1 Child and Adolescent Health Services

The National Health Service will play a lead role in the provision of improved and stronger child and adolescent health services, both in the national and district hospitals, and in the community. The Ministry of Health and the National Health Service will work in collaboration to establish service standards, monitor health service performance, administer programs to the community, and identify emerging child and adolescent health needs and the appropriate response.

One way that service delivery for the under-five age group can be improved is through the use of the WHO's Integrated Management of Childhood Illness (IMCI). By improving the case management skills of health-care staff, improving the overall health system and improving family and community health practices, children's total wellbeing can be maximized. For this reason, the policy aims to achieve better integration of service delivery.

Private health care providers and non-governmental organizations play a key role in the provision of child and adolescent health services and will be fully involved in coordinated planning efforts. The perspective of private and NGO service providers is invaluable, and providing the highest-quality youth health services will necessitate full participation and coordination by all parties in the health sector, including the collaboration of the Ministry of Health, National Health Services, private health care providers, and non-governmental organizations that provide health and social services to families and young people. These key players in the health system need to align the delivery system around the health and well-being of children and adolescents to ensure that their needs are met. In addition to the delivery of health services the health sector in particular NHS, private GPs, NGOs and the Ministry of Police and Prisons will need to strengthen existing referrals systems on child victims of abuse, violence or attempted suicide presenting to the hospitals and clinics, police station or NGOs such as SVSG and Faataua le Ola.

2.2 Pre-school and School Health

The pre-schools and schools provide an enormous opportunity to improve and maintain child and adolescent health, both because they provide venues to provide health services to young people and because they are environments where they spend a significant portion of their time. The health and education sectors must continue to be aligned in their child and adolescent health activities and, as a result, there are ongoing collaborative activities to improve child and adolescent health through the schools.

There are currently school programs related to preventing tobacco-use among youth (and smoking cessation for teachers), improving nutrition in schools and pre-schools, and improving sanitation and water quality. In addition, the Ministry of Health administers the Health Promoting Schools program which is a collaborative effort between a number of stakeholders to improve health in schools. Community nurses make annual child health monitoring visits to provide health services to children directly at the schools and dentists provide dental health education as well as examination and treatment. The Samoa Parliamentary Advocacy Group for Healthy Living (SPAGHL) also regularly visits and inspects schools, which highlights and promotes awareness of sanitation issues as well as helps to enforce the School Nutrition

Standards and School Sanitation Guidelines. This involvement of political leaders takes the advocacy level of school health programs to a higher level and helps to gain their support as well. The Ministry of Health is also utilizing the Manu Samoa Champions of the World Sevens Series 2009 to promote physical activity in schools. These linkages between the education sector and the health sector must continue to grow and strengthen to fully capitalize on the effectiveness of schools to improve and safeguard child and adolescent health.

2.3 Community Child and Adolescent Health

Community-based organizations and village women's committees in particular, play a key role in health service delivery. The Ministry of Health, National Health Service, NGOs and private providers will continue coordinating with the community to maintain, and enhance, health services provided to the community. Village leadership and the village women's committees are important partners in working toward improved child and adolescent health. Under Primary Health Care principles, community participation and self-determination are critical to providing effective, integrated services that meet communities' needs. To this end, health service providers should strive to be responsive not only to the needs, but also to the strengths and capabilities, of the communities they serve.

KSA 3: Health Financing

Currently, health services for children and adolescents are relatively well-financed; however, there is a great need to allocate available resources appropriately to address emerging and persistent needs. These needs relate particularly to training and human resourcing. Efforts to increase funding for training opportunities and to increase nursing, allied health and medical human resources will contribute greatly to strengthening child and adolescent health services.

KSA 4: Health Information, Education, and Awareness

4.1 Health Education and Awareness

Improving child and adolescent health requires the full participation of communities and in particular, the awareness and participation of families. In order to educate families about important considerations for the health of their children, the Ministry of Health and National Health Service currently collaborate in the production of mass media campaigns and other forms of public awareness related to immunization and other child health issues. Continuing efforts should be made to identify key issues that require the full awareness and participation of children's caregivers, and that would be effectively addressed through mass media campaigns, for future public education campaigns.

In particular, the Health Protection and Enforcement Division of the Ministry of Health is well-positioned to continue its lead role in identifying, coordinating, and disseminating public health information, in collaboration with the MWCSD through the Aiga ma Nu'u Manuia Program, the Education Sector and other members of the health sector. The MWCSD also include in their peer education programs the education of youth through their peer educators on sexual and

reproductive health and nutrition issues with the technical help and assistance of the Ministry of Health.

NGOs can also make a significant contribution in this area, for instance, NGOs such as the Samoa Cancer Society, provides outreach programmes that emphasize the importance of good lifestyle choices, and promote awareness of cancer risks and early symptoms among children, adolescents and their families.

This policy therefore serves to further support, encourage and build on the work of the Health Sector in collaboration with the MWCSD, MESC and NGOs on improving awareness and strengthening health education in homes, schools and communities.

4.2 Health Information Systems

In order to meet the needs of the child and adolescent populations of Samoa, timely and comprehensive data and patient information are essential. The effective use of data from sources such as the PATIS information system, vital registration records, community nursing records, demographic and health surveys, census, surveys to evaluate interventions, and additional relevant surveys shed light on the child and adolescent health situation and commission the delivery of youth health services in Samoa.

Despite the existence of these data sources, there are at least two persistent challenges to compiling comprehensive and timely health information: linking data sources and ensuring full, accurate, and consistent completion of patient information forms by all members of the medical staff. The population is mobile in its use of health services and seeks services at the village health centres, district hospitals, and national hospitals. Recent efforts aimed at improving the coordination of patient information and provider knowledge of patient history, most notably the introduction of the “Baby Book”, should be accompanied by extensive provider training and parent/caregiver education to encourage their effective use. The Baby Book will encourage caregivers and health professionals to keep track of each child’s health and immunizations. Promotion and trainings on the Baby Book for all providers and parents should be included under this policy.

The need for the current information system to be upgraded is significant considering the longstanding problem of data inefficiency within the public system itself. Areas that need improvement include the availability of data on mental health and dental health for children, data on children and adolescents with disabilities as well as data on all areas of health from private and public facilities other than TTM Hospital. The current information system does not readily capture this information and the need for this to be addressed immediately under this policy is paramount.

KSA 5: Health Medical Technology and Products

The health sector, through its partnership with all sector partners, needs to ensure the availability of enabling devices for all, including the disabled children and adolescents with mental health issues. This means that comprehensive rehabilitation and clinical care should be accessible to all through the availability of proper rehabilitation and clinical equipment.

Furthermore, this policy calls for the health sector to ensure the availability of safe and high quality medicine for all children and adolescents.

The procurement of all medicine and medical equipment are to strictly follow the current procurement procedures of the Samoan government. In any case where the same are donated to the health sector by any donor organization the Ministry of Health in its regulatory and monitoring role shall ensure the safety of all children and adolescents by inspection of such donations. This policy also calls for the strict adherence to the National Medicines Policy 2008 to ensure the full protection of young people from unsafe and/or counterfeit drugs and the avoidance of drug resistance in children and adolescents.

KSA 6: Health Human Resources and Capacity Building

Ensuring sufficient and skilled human resources for health is critical to guaranteeing that the health sector provides child and adolescent health services that meet the needs of these populations. Nurses provide the majority of youth health services to the community, through the district hospitals, village health centres, and school health visits. Efforts are being made to increase the size of the nursing workforce by increasing the number of nursing students matriculating at the national nursing program.

Physician care is a vital aspect of child and adolescent health services. The current system of referral physician staff at the national hospitals combined with physician presence 2-3 days a week at the district hospitals leverages the mix of physician and nursing staff to provide maximum coverage to communities at the existing workforce level. Efforts to further improve coordination between nurses and physicians will further improve the provision of child and adolescent health services in Samoa.

Allied health workers including physiotherapists, occupational therapists, nutritionists and dieticians, health promotion officers, environmental health officers, etc. all play a vital role in improving child and adolescent health and therefore require continuous capacity building in their areas of technical expertise. Furthermore, with the increasing number of children with disabilities it is recognized here that there is a chronic shortage of specialists in Samoa who are able to diagnose children with intellectual disability, autism, hearing and vision impairment to name a few. In saying this efforts should spearhead towards the encouragement of Samoan students to undertake tertiary studies in speech therapy, physiotherapy, occupational therapy, counselling and other related allied health professions.

Continuing education and training are essential in providing the highest-quality health services to the population. There are currently ongoing efforts to ensure continuing education and service enhancement among providers; however, there are still unrealized opportunities to enhance services through targeted training. For instance, the Baby Book presents an opportunity to greatly improve patient information and subsequent care, and the books have been produced, but providers have not yet been trained in their use.

Improved coordination of the health sector in support of child and adolescent health issues would aid in the optimization of service provision, and hopefully in turn, lead to improved child and adolescent health status. In the past, coordinating committees have played an important planning role, but have not always met with the consistency or longevity that would enhance

their work. Efforts should be made to explore the potential expanded use of coordinating committees to increase the impact of child and adolescent health programs and services.

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OUTCOME	GOVERNANCE AND LEADERSHIP	RESPONSIBLE	COSTING	SOURCE OF FUNDS
1. Improved partnership commitments amongst health sector partners, NGOs, and public community.	**Activities:** 1. Promote sector partnership and improve on governance and leadership to the effect of improving child and adolescent health. 2. Health Promoting School Networking to Monitor and Oversee the implementation of the Child and Adolescent Health Policy. 3. SPAGHL to lead the monitoring and inspections of Sanitation and Nutrition Standards in schools. 4. Develop and promote healthy public policies: a. Provide adequate maternity leave and breastfeeding work breaks for working women. b. Provide working women with an allocated space/area for breastfeeding in their workplaces. c. Control marketing of infant feeding products and marketing of	***Lead:*** MOH ***Support:*** MWCSD, SPAGHL, NGOs, MESC, NHS, WinLA, Chamber of Commerce, Samoa Council of Churches	$5,000 per year (over 5 years policy timeframe)	-Local Budget -WHO Biennium Budget

	unhealthy foods to children. d. Update the Safe Motherhood Policy. e. Monitor compliance of other related health policies such as Tobacco control, health promotion, noncommunicable diseases. 5. Monitor the provision of child and adolescent health services to ensure they are accessible, affordable and of high quality. 6. Continue Health Promoting Schools Committee meetings every two months to provide feedback and discuss the implementation of health promoting school activities. 7. Regularly review the Child and Adolescent Health Policy, and other policies affecting the health of Samoa's youth.			

OUTCOME	HEALTH SERVICE DELIVERY	RESPONSIBLE	COSTING	SOURCE OF FUNDS
1. Increased access to quality basic health care **2.** Improved health care delivery to all children and adolescents in the community through a primary health care approach. **3.** Improved access of children and adolescents with mental health illnesses to high quality comprehensive mental health services and related rehabilitation services. **4.** Increased access of children and adolescents with disabilities to quality, comprehensive healthcare services and related rehabilitation	**Activities:** 1. Hospital and community health services; a. Implement the Baby Friendly Hospital Initiative and the Baby Friendly Community Initiative. b. Implement the Obstetrics and Gynaecology Protocols 2012. 2. Pre-school & School Health a. Create supportive, enabling and injury free environments in pre-schools and schools. b. Ensure the availability of first aid resources within all schools. c. Build the capacity of teachers with first aid skills. d. Ensure the adherence of all schools to School Nutrition Standards. e. Ensure the adherence of all schools to Sanitation Guidelines. f. Ensure the development of Sexual and Reproductive Health school curriculum. g. Continue to develop IEC Materials	***Lead:*** MOH & NHS ***Support:*** MESC, MWCSD, NGOs, MAF, Private GPs, SPAGHL, MPP.	$5,000 per year (over 5 years policy timeframe)	-Local Budget -WHO Biennium Budget

services.	displaying healthy messages to be distributed to all schools. h. Tobacco Control Programmes strengthened and continuous. i. Implement and sustain physical activity programmes. 3. Community Child and Adolescent Health a. Strengthen community action to promote healthy eating and physical activity. b. Encourage the involvement of children in physical activity programs in the community. c. Provide technical and financial support to villages and communities in fruits and vegetable gardening. d. Ensure universal immunization coverage for all children of Samoa. e. Ensure the availability and accessibility of Sexual and Reproductive health commodities to youth. f. Ensure the provision of free medical care and drugs for all children of Samoa <5yrs at the TTM and MTII hospitals.			

	g. Strengthen referral system between health providers (particularly NHS and private GPs), MPP and relevant NGOs on child victims of abuse presenting to hospitals and clinics. 4. Mental Health and Disability Services a. Ensure the provision of a special ward for children with mental illnesses. b. Ensure the provision of medical care and drugs to children with disabilities and adolescents >5yrs and ≤18yrs c. Strengthen rehabilitation services for children and adolescents with injury related disabilities.			

OUTCOME	HEALTH FINANCING	RESPONSIBLE	COSTINGS	SOURCES OF FUNDS
1. Strengthened financing mechanisms for child and adolescent health activities	**Activities:** 1. Establish and/or strengthen existing financing mechanisms for child and adolescent health a. Increase funding towards assistive devices for children and adolescents with disabilities. b. Sustain and/or Increase funding for SRH commodities and SRH education and awareness programs for youth. c. Mental Health d. Allocate/Prioritize funding towards training and scholarship programs for tertiary studies in allied health professions i.e. speech therapists, psychosocial, counselling, physiotherapists, occupational therapists etc.	***Lead:*** MOH ***Support:*** MWCSD, NHS, NGOs.	$5,000 per year (over 5 years policy timeframe)	-Local Budget -WHO Biennium Budget

OUTCOME	HEALTH INFORMATION, COMMUNICATION AND AWARENESS.	RESPONSIBLE	COSTING	SOURCE OF FUNDS
1. Increased awareness amongst parents, guardians and caregivers on existing and emerging child and adolescent health issues. 2. Improved access to and availability of child and adolescent health data. 3. All child and adolescent health data fully captured from the health sector and its sector partners.	**Activities:** Health Education and Awareness a. Increase awareness on child injury within homes and local community focusing on the leading causes of injuries reported by the TTM and MTII Hospitals. b. Coordinate and facilitate smoke and alcohol free programs in schools. c. Ensure the adherence of all schools to the Tobacco Control Program and enforce smoke free policies within schools through. d. Monitoring Site Visits. e. Raise awareness on proper infant and young feeding measures through Media and community based programs. f. Further promote the Rheumatic Fever heart diseases through Media campaign and community based programs. g. Ensure all public, private and	***Lead:*** MOH ***Support:*** MWCSD, MESC, NHS, Private GPs, NGOs, Council of Churches.	$5,000 per year (over 5 years policy timeframe)	-Local Budget -WHO Biennium Budget

	missionary primary schools are included with the distribution of fruit trees to promote healthy dietary in schools. h. Educate community, parents and guardians on injury prevention within their home environments. i. Further promote the Safe Homes campaign currently spearheaded by the Ministry of Health. j. Educate parents, guardians, caregivers and youth (14-18yrs) on sexual and reproductive health issues. k. Increase awareness of parents, caregivers and/or guardians on the signs and symptoms of different kinds of disability. l. Increase awareness of parents in the prevention of disabilities and the importance of early detection. Health Information Systems a. Establish a health information system that fully captures and			

	protects health data on all children and youth for policy and planning purposes. b. Ensure the Child Health Book (containing medical and immunization history) is a requirement for school entry.			
OUTCOME	**HEALTH MEDICAL PRODUCTS AND TECHNOLOGIES**	**RESPONSIBLE**	**COSTING**	**SOURCE OF FUNDS**
1. Improved access of children and adolescents to safe and quality medicine. 2. Increased access of all children and adolescents with disabilities to assistive devices	**Activities** 1. Medicine a. Ensure access of children and adolescents to safe quality medicine. 2. Medical Technology a. Ensure the provision of assistive devices to children and adolescents with disabilities.	***Lead:*** NHS & MOH.	$5,000 per year (over 5 years policy timeframe)	-Local Budget -WHO Biennium Budget

OUTCOME	HUMAN RESOURCES/CAPACITY BUILDING	RESPONSIBLE	COSTING	SOURCE OF FUNDS
1. Enhanced capability of service providers particularly involved with child and adolescent health services. 2. Increased number of nursing students matriculating at the nursing program. 3. Enhanced capacity of allied health professionals in their areas of technical expertise.	**Activities:** 1. Promotion of careers in nursing and other allied health disciplines. 2. Conduct training plans for programme staff providing child and adolescent health services. 3. Training for all health professionals of 'how to use the Baby Book'	***Lead:*** MOH & NHS	$5,000 per year (over 5 years policy timeframe)	-Local Budget -WHO Biennium Budget

ANNEXES

HEALTH ARTICLES

Convention on the Elimination of Discrimination Against Women

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Convention on the Rights of the Child

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.