SAMOA

NATIONAL FOOD AND NUTRITION POLICY 2013-2018

REVIEW

Ministry of Health

November 2020

Executive summary

1. Introduction

This report presents the findings of the Review of the Samoa National Food and Nutrition Policy (NFNP) 2013-2018. In 2013 the Government of Samoa (GoS) endorsed the NFNP 2013-2018 to 'facilitate and support action through the entire food and nutrition system to achieve better nutrition and health outcomes for Samoans'. The NFNP is aligned to the Health Sector Plan's vision of '*A Healthy Samoa'*, and global and regional policy frameworks, such as the 2015 Global Sustainable Development Goals (Goal 3: ensure promote well-being for all at all ages), United Nations Decade of Action on Nutrition (2016–2025), and 2015 Pacific leaders' Yanua Island Declaration on health in Pacific island countries and territories.

The NFNP's (2013-2018) vision is 'nutritional health for Samoa'. Its mission is 'access to safe, affordable, nutritious and sustainable food'. A total of 19 goals and 75 strategies were identified in the NFNP 2013-2018 action plan for implementation within its five-year timeframe. The seven key result areas (KRAs) were: collaboration among sector partners; capacity building for implementation; food system understanding; community mobilisation; advocacy for societal change; behavioural change through messaging; and evidence-based research.

2. Methodology

With the conclusion of the NFNP 2013-2018, a review of the Policy and its Action Plan is required to establish progress made and lessons learnt, and to inform the formulation of the next NFNP 2021-2026 (see Annex A for the Review Terms of Reference). The methodology used for the Review involved inception meetings with key counterparts; desktop and literature review; and consultations with MoH staff, other key implementing agencies, and stakeholders within the health sector (see Annex C).

3. Findings

3.1. Implementation status and achievements

The overall assessment of the NFNP 2013-2018 is rated 2.6 (out of 5) (see Annex B) – indicating a moderately successful achievement. Progressive achievements are noted in the following areas where an assessment rate of 2.5 (out of 5) is being made:

- Finalisation of the Food (Marketing of Products for Infants and Young Children) Regulations 2020 which were submitted to Cabinet in late 2020 for endorsement.
- Undertaking of targeted research on food and nutrition issues in Samoa, with a particular focus on maternal and child health.
- Strengthened partnership with the Ministry of Education, Sport and Culture (MESC) on improving consolidated focus on health promoting schools and school nutrition.
- Ongoing awareness and health promotion on food and nutrition issues/matters – such as breastfeeding, infant and child feeding, and healthy lifestyles.
- Ongoing collaboration with health partners to strengthen food and nutrition knowledge through curriculum and course development and delivery, capacity building and other in-service training.
- The conducting of the 2015 'study on options for controlling nutrition related health problems in Samoa' which analysed and recommended options for Samoa to consider.
- Completion of an adjustment of import duties and excise tax in 2018 and 2019 on healthy and unhealthy foods in order to support healthy choices and encourage healthy eating/lifestyles.
- Enactment of the Waste (Plastic Bag) Management Regulation 2018 which prohibit the import, manufacture, export, sale and distribution of plastic shopping bags, packing bags and straws.
- Strengthening of the focus on NCDs reduction through the PEN *Fa'aSamoa* initiative.

- Ongoing collaboration on issues relating to food trade through the National Codex Committee in which key implementing agencies of the NFNP 2013-2018 attend as members.
- Ongoing efforts and advocacy initiatives on food waste management.
- Continuous efforts to promote locally produced food (e.g. organic products).
- Ongoing efforts to promote sustainable food and food security through local food production through the agriculture sector and the role of the Ministry of Agriculture and Fisheries (MAF).
- Implementation of the salt project which aimed at reducing salt intake in Samoa.
- Enactment of the Food Safety Act 2015 and Food (Safety and Quality) Regulations 2017, with the MoH Health Promotion and Enforcement Division taking the lead in enforcing these legislation.
- Continuous health promotional messaging on national media about good hygiene and food preparation practices; which is part of the whole health movement to revitalise public health.
- Regular testing of the safety and quality of bottle water in collaboration with Scientific Research Organisation of Samoa (SROS), with results publicised on national media.
- Testing for food contamination when needed in collaboration with SROS.
- Promotion of safe water drinking, especially during disasters and disease outbreaks.
- Ongoing awareness programs and activities for food industry to build understanding of the Food Safety Act and Regulations, with regular monitoring of food safety in the food industry.
- The issuing of health card (a form of licensing for restaurants and other food processors) as a mechanism to enable monitoring compliance with food safety requirements.

Limited implementation are noted in the following areas where an assessment rate of 2.0 or below is being made (see Annex B):

- Strengthening of dental health including the contribution of food and nutrition to dental health.
- Development of food and nutrition guidelines during disaster and emergency responses.
- Strategies to implement and monitor trans fatty acids in food supply.
- Capacity building for food importers, distributors and processors on ways to reduce fat, trans fatty acids, salt and sugar in food products.
- Promotion of healthy lifestyle improvement projects amongst private and public sectors.
- Strategies to control the marketing of foods and non-alcoholic beverages to children.
- Community-based approaches and projects for reducing obesity.
- Strengthening promotion of dietary guidelines including operationalisation at the local community and family levels.
- Promotion of environmental health models that integrate food and nutrients for built, natural, social and economic areas.
- Promotion of education and awareness about food waste and its impact on the environment;
- Advocating for research that informs health sector partners about sustainable food.
- Advocating for community awareness programs for food system responsibility.
- Driving national and Pacific regional policy development for continuous improvement for the reduction of greenhouse gas emissions and management of land fill.
- Limited reporting against and through the NFNP framework on measures undertaken to reduce fish/seafood contamination through protection of marine areas.
- Limited information on actions undertaken for monitoring of pesticide levels in food, including knowledge made available for the information and awareness of the public.
- Lack of evidence about awareness levels across the community about unsafe pesticide use and which pesticide that are safe and not safe, including information about dangers/risks.

3.2. Assessment against the review criteria

- ***Relevance and appropriateness*** – The Review reaffirmed the relevance of the NFNP and its Action Plan 2013-2018 to Samoa's health challenges and health development priority needs. It provided the

overall strategic framework and a coordinated national focus and response on interventions and actions to address food and nutritional health challenges and issues in Samoa. Most of the NFNP 2013-2018 strategies remains valid for continuous implementation. However, gaps concerning the design of the policy were identified through this Review (which affected effective and efficient implementation) are summarised in section 3.2.3 should be considered as learnings to inform the design/formulation of the next NFNP.

- ***Effectiveness*** – ***13% of the NFNP Action Plan 2013-2018 strategies were assessed as achieved, 64% as partially achieved, and 23% not achieved***. Most strategies are ongoing normal work of the MoH and its implementing partners, and as such, they should not be strictly assessed as completed as in the case of a project or program activities, but should be assessed mostly in terms of their impact on improvements made and achieved, such as the social change that is being made, and at which level that such a change has taken place.

- ***Efficiency*** – It is difficult to assess the implementation efficiency level of the NFNP Action Plan 2013-2018 given the absence of specific timelines for implementation of the different 75 strategies outlined in the Action Plan. Nevertheless, the overall efficiency level of the NFNP 2013-2018 can be judged from its overall assessment in achievements. With only 13% of strategies achieved, it suggests a slow implementation modality and progress of the NFNP and its action plan (i.e. most of the strategies) during its 5-year lifespan.

- ***Impact*** – the Review assessed that the impacts of the implementation of the NFNP 2013-2018 were shown in these results: increased recognition across sector partners of nutritional health challenges; improved evidence-based knowledge about nutritional health; and more recognition of the nutritional value of foods and their contributions to diseases, including ongoing efforts to address accessibility of local foods for consumption. The legislative framework for food safety is being strengthened, with plans to improve food standards, and to adjust fiscal policy to address nutritional and unhealthy lifestyle challenges. There is improved emphasis to integrate a nutritional focus in public health and primary care initiatives aiming at reducing NCDs, including ongoing efforts to collaborate on issues when needed through existing mechanisms. Measuring impact at the outcome level is difficult given limited evaluative data to establish a clear connection between the implementation of the NFNP and existing national nutritional indicators.

- ***Sustainability*** – The moderate implementation of the NFNP 2013-2018 posed a question about the sustainability of the implementation of food and nutrition strategies, given limited attention given to issues concerning implementation requirements - capacities, resourcing, commitments and collaboration among key implementing agencies/partners. Addressing food and nutritional health challenges and issues, and improving 'access to safe, affordable, nutritious and sustainable food' is a never-ending process for Samoa. However, proper monitoring and evaluation is needed to show progress made and areas needing more sustainable interventions, efforts and commitment.

3.3. Lessons learnt

The Review identifies the following key lessons learnt from the implementation of the NFNP and its Action Plan 2013-2018:

- ***Shared understanding of the policy and its implementation*** – the lack of having a shared awareness and understanding of the NFNP and its action plan 2013-2018 was identified as one of the most important issues impacting on effective and efficient implementation. About 80% of key implementing agencies (when consulted) did not know that this national policy existed. Having a shared understanding is about having collective ownership of the strategies and actions, and implementing agencies knowing about what is needed to be implemented, to contribute to the progressive achievement of the national vision, mission and goals outlined in this national Policy. This limited

awareness and understanding about the NFNP impacted on the lack of collaborative efforts and commitments that are needed to progress implementation.

- ***Multi-sectoral leadership and governance for effective and efficient implementation*** – there has been limited active mechanisms for building the needed multi-sectoral leadership and governance for the implementation of NFNP. The NFNP 2013-2018 identified strong association and collaboration between MoH and its partners for the implementation of the Policy. However, collaboration on the implementation of the Policy has been one of the key issues. The Food and Nutrition Policy Committee (FNPC) established under the Food Safety Act 2017 has not been activated, which should provide the needed multi-sectoral leadership and governance for food and nutrition policy development, implementation, and monitoring. It is crucial that this Committee is initiated as a matter of priority to provide the overall strategic leadership, governance mechanism and ongoing monitoring for the next NFNP 2021-2026.

- ***Policy design/formulation*** – Gaps identified with policy design and implementation arrangements must be considered in future policy development. These include having specific activities with a costed work plan and specific timelines for implementation; and a Monitoring and Evaluation (M&E) framework with SMART (Specific, Measurable, Attainment, Relevant and Time-Bound) indicators. There is a need for a clear identification of a NFNP focal point (whose primary role is to facilitate progressive implementation of the NFNP) and the lead implementing agency for each strategy/action. As well, implementation arrangements for the operationalisation of the Policy should be well articulated and continuously communicated to all key implementing agencies of the Policy.

- ***Implementation and capacity building*** – The adoption of a programmatic approach to the NFNP is needed in order to facilitate the availability of financial and technical support (or development assistances) for the implementation and operationalisation of the NFNP action plan across the sector. Identification of required implementation capacities, clarification of roles and responsibilities for the NFNP implementation, and addressing existing overlaps and duplications in the performance of policy and regulation roles are needed, for improved utilisation of existing capacities and resources. The M&E of the implementation of the NFNP was lacking, an area that need serious attention for improvement.

4. Recommendations on areas for improvement

Based on the findings of this Review, recommended areas for improvement are identified as follows:

4.1. Multi-sectoral leadership and governance

- As a matter of priority, establish and activate the Food and Nutrition Policy Committee (FNPC) to provide multi-sectoral governance and public policy leadership for food and nutrition health development efforts for Samoa.
- Develop a Terms of Reference for the FNPC to be endorsed by the Director General of Health and approved by the FNPC once it is activated.
- Through the FNPC, build collaboration amongst sector partners to address food and nutrition issues and to consider appropriate policy interventions that are needed to address those issues.
- MoH to strengthen its leading and facilitating role in driving the implementation of the NFNP across the health sector.
- FNPC to adopt the NFNP and its action plan as its national or sectoral action plan or work plan, with the Committee providing strategic oversight, multi-sectoral governance mechanism, and leadership guidance for the implementation, and M&E of the NFNP.
- MoH's Health Promotion and Enforcement Division (HPED) to provide effective and efficient secretariat role to the FNPC, with regular M&E reports provided to the FNPC meetings on progress made on the implementation of food and nutrition interventions in Samoa.

- Use the FNPC as a national and sectoral mechanism to build the need policy discourse on food and nutrition, including the right messaging for building civic education and awareness.

4.2. Shared policy ownership and understanding

- Build shared ownership and understanding of the NFNP through inception briefings, quarterly meetings of the FNPC, robust M&E reporting, and using the NFNP as a strategic guide for the implementation of food and nutrition programs and projects across the sector.
- Carry out regular updates with key implementing staff across the different implementing agencies on the implementation of the NFNP - to discuss progress made, issues encountered, collaboration requirements, and needed changes in activity implementation modalities.
- Strengthen communication of progress made on the implementation NFNP, highlighting results, achievements, and ongoing challenges.
- MoH to consider the establishment of an internal policy committee, with memberships comprising of all focal points of all policy areas, to be used as a key M&E committee for all health policies.

4.3. Policy design/formulation

- Ensure alignment of the NFNP to all national sectoral plans and policies to avoid and address duplications, overlaps and contractions.
- Policy formulation to ensure the identification of activities/actions to be implemented within specific timelines and with a specific leading implementing agency.
- Policy design to ensure the inclusion of an M&E framework with SMART (Specific, Measurable, Attainment, Relevant and Time-Bound) performance indicators corresponding to the action plan.
- Policy design to clearly designate a focal point in the MoH with the primary role of ensuring that the implementation of the NFNP does take place, and this includes facilitating the needed processes and mechanisms to initiate, progress and continue the implementation stage.
- MoH to ensure operationalisation of the NFNP through detailed work plans, including the use of concept notes, briefing papers, terms of references, and other formats – to further unpack and clarify what is needed to progress the implementation of a specific strategy, activity or action.
- Policy design to clearly outline implementation arrangements for the NFNP, which should be inclusive of the required governance structure, partnerships and collaboration, resourcing/financial commitments, M&E and reporting, and others.
- The NFNP to be treated as a living document that is to be continuously reviewed and updated to ensure relevance and to adapt to changing priorities and other changes in the policy environment.
- NFNP design to identify manpower and capacity gaps and needs including technical support for the effective and efficient implementation of the NFNP.

4.4. Implementation and capacity building

- The design of the NFNP to include a full costed implementation plan, inclusive of a budget, staffing requirements, technical inputs, and operational costs.
- Use the FNPC and other existing governance mechanisms (e.g. National Code Committee, Pesticide Committee, Agriculture Sector Coordinating Committee, and others) to promote the implementation of the NFNP.
- MoH's Strategic Policy, Planning and Research Division (SPPRD) to ensure that M&E of the NFNP is carried out in accordance with the required policies and procedures of the MoH and other implementing partners in the sector.
- MoH's NFNP focal point to drive and lead the implementation of the NFNP through communication, and facilitation (of what needed to be done), as well as through M&E.
- Continuously revisit the NFNP action plan (and to report on revisions made) to identify what can be realistically implemented and achieved within existing capacities and resources.
- Monitor the alignment of the NFNP to all national sectoral plans and policies to address duplications, overlaps, contractions and areas for parallel support and collaboration.

- Conduct a job analysis and organisational review of the MoH to identify unnecessary duplications of functions, roles, work, and areas where manpower and resources could be better utilised.
- Consider the impact on core service and roles of the ad hoc pulling of core staff towards project-based works and routine matters of urgency.
- MoH to strengthen M&E reporting on the NFNP implementation progress.
- Adopt a programmatic approach among health sector partners for the NFNP to facilitate the availability of development assistances for the implementation and operationalisation of the NFNP action plan across the sector.
- FNPC to discuss sharing and pool of resources for the implementation of strategies and actions that cut across the sector and which require collaborative efforts of key implementing agencies.
- Strengthen the linkages between policies and national budgets of the MoH and other health sector key implementing agencies. This involves revisiting annual work plans and budget performance measures to ensure linkages to sector and agency performance indicators as outlined in sector plans and policies.

4.5. Areas needing prioritised focus

All strategies outlined in the NFNP Action Plan 2013-2018 remain relevant for ongoing and further improvements in implementation. The Review however highlighted a number of areas for priority consideration in the next NFNP 2021-2026:

- Follow-up on the take-up and effective implementation of the recommendations of the 'study on options for controlling nutrition related health problems in Samoa'.
- Strengthen the fiscal policy responses on food and nutrition with strong push for increased taxation and price controls on food, to improve accessibility and affordability to healthy choices, and to discourage the consumption of unhealthy food.
- A strong focus on childhood obesity as a matter of priority. This includes more work on strengthening monitoring and responses to improve infant and young child feeding.
- More health promotion and education to raise community awareness and understanding about food and nutritional health.
- More research to build research and awareness about nutritious food and the health implications of what people are eating as their normal daily dietary intakes.
- Promotion of eating healthy local food including working with Ministry of Agriculture and Fisheries (MAF) and Ministry of Commerce, Industry and Labour (MCIL) and other key actors on improving food availability and accessibility.
- Enforcement of food legislation across the food industry, including the need to develop more food standards, and capacity building for the food industry.
- Adopt and implement deliberate measures to address the impact of the influx of unhealthy food from overseas.
- Work with communities on addressing their food and nutrition issues.
- More work on the health promoting schools through strengthening partnerships with MESC.

Acknowledgement

We wish to acknowledge the support and assistances provided by many people who contributed to the completion of this Review of the Samoa National Food and Nutrition Policy (NFNP) 2013-2018.

We are grateful to all stakeholders of the health sector; representatives of the public sector, private sector, civil society, and development partners who were able to provide their inputs to this Review. Your invaluable insights have contributed to the credibility of the Review findings and recommendations which inform the next Samoa NFNP and Plan of Action 2021-2026.

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The Review was undertaken by Muliagatele Dr Potoae Roberts-Aiafi of the Oceania SMART Consulting as Technical Assistant, including the write-up of this Review Report as well as the Samoa National Food and Nutrition Policy and Plan of Action 2021-2026.

Faafetai tele lava. Ia faamanuia tele le Alii.

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Abbreviations

ACEO	Assistant Chief Executive Officer
AG	Attorney General
APTC	Australia-Pacific Technical College
AUSaid	Australian Aid
BFHI	Breastfeeding Friendly Hospital Initiative
CEO	Chief Executive Officer
FNPC	Food and Nutrition Policy Committee
MFAT	Ministry of Foreign Affairs and Trade
DMO	Disaster Management Office
FAO	Food and Agriculture Organisation of the United Nations
GoS	Government of Samoa
ILO	International Labour Organisation
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MAF	Ministry of Agriculture and Fisheries
MCIL	Ministry of Commerce, Industry and Labour
MESC	Ministry of Education, Sports and Culture
MNRE	Ministry of Natural Resources and Environment
MoF	Ministry of Finance
MoH	Ministry of Health
MfR	Ministry for Revenue
MWTI	Ministry of Works, Transport and Infrastructure
MWCSD	Ministry of Women, Community and Social Development
NCECE	National Council for Early Childhood Education
NEOC	National Emergency Operation Centre
NFNP	National Food and Nutrition Policy
NGO	Non-governmental organisations
NHS	National Health Service
NUS	National University of Samoa
NZAid	New Zealand Aid
OUM	Oceania University of Medicine
PSC	Public Service Commission
SAME	Samoa Association of Manufacturers and Exporters
SBEC	Samoa Business Enterprises Corporation
SACEP	Samoa Agriculture Competitiveness Enhancement Project
SCCI	Samoa Chamber of Commerce and Industry
SDG	Sustainable Development Goal
SDS	Strategy for the Development of Samoa
SFHA	Samoa Family Health Association
SPAGHL	Samoa Parliamentary Advocacy Group for Healthy Living
SPC	Secretariat of the Pacific Community
SROS	Scientific Research Organisation of Samoa
UNICEF	United Nations Children Fund
USP	University of the South Pacific
WHO	World Health Organisation
WIBDI	Women in Business Development Incorporated

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1. BACKGROUND

1.1. Introduction

This Report presents the review of the Samoa National Food and Nutrition Policy (NFNP) 2013-2018 (MoH, 2013). The NFNP, endorsed by Cabinet in November 2013, provided the strategic policy framework for developing food and nutrition in Samoa. The Policy outlined the key strategic areas, strategies and an action plan to address issues and challenges concerning food and nutrition in Samoa.

This Review is prepared to assess the NFNP 2013-2018 and its implementation status at the completion of its five-year lifespan. The findings of the Review, which are documented in this Report, aims to inform the development of the next NFNP for Samoa, for the period of 2021-2026.

1.2. Context

1.2.1. Health challenges

The vision of *'An Improved Quality of Life'* (Strategy for the Development of Samoa (SDS) (2016-2020) denotes the Government of Samoa's commitment to improve the economic and social well-being of its people. The health sector's vision of '*A Healthy Samoa'* further emphasises this commitment; that a healthy population is a productive society able to contribute to everyone's welfare and well-being. Such a commitment is also promoted and supported through global and regional policy measures – such as the 2015 Global Sustainable Development Goals (SDGs) (*Goal 3: Ensure promote well-being for all at all ages*), 2016–2025 *United Nations Decade of Action on Nutrition,* as well as the 2015 Pacific regional leaders' *Yanua Island Declaration on health in Pacific island countries and territories*.

The focus towards 'a healthy Samoa' requires a contextual understanding of population health demographics and trends. Being a small island economy naturally presents itself with challenges, such as a narrow economic base, limited financial resources, and a small pool of qualified people across various service areas and specialities. Samoa's growing young population, increasing vulnerability to climate and environmental changes (leading to increased diseases and illnesses), globalisation, urbanisation, trade and migration continue to put demands and pressures on the health system. These population health demographics, dynamics, and trends, together with the health sector absorbing the largest portion of the national budget, signify a need to rethink the way in which the health system operates for improved effectiveness and efficiency in services, and to remain focus on the priorities that needs to be addressed, which is a challenge given competing development and service delivery priorities.

Notable achievements were made in overall health outcomes, such as increased life expectancy and infant mortality rates, as well as reduced prevalence of sexually transmitted diseases. However, Samoa continues to face a number of critical health challenges, such as increasing burden of non-communicable diseases (NCDs)[i] alongside an unfinished agenda of reducing communicable diseases. Health areas where Samoa has not able to make much improvements include reducing maternal mortality rates, diabetes, hypertension, TB, and overweight/obesity prevalence and incidence (MoH, 2019). The 2019 measles epidemic further confirms declining immunisation rates, which has been partly contributed to a weakening focus on primary health care over the past years. Pressures on Samoa's small health administration is further exacerbated by the ongoing priority responses to the COV-19 pandemic.

[i] NCDs account for over 80% of all death and more than half of premature deaths in Samoa (WHO, 2018). NCDs are associated with significant personal, social and economic costs. They amounted to SAT40.3million in total health spending (36.4%) during the 2014-2015 financial year.

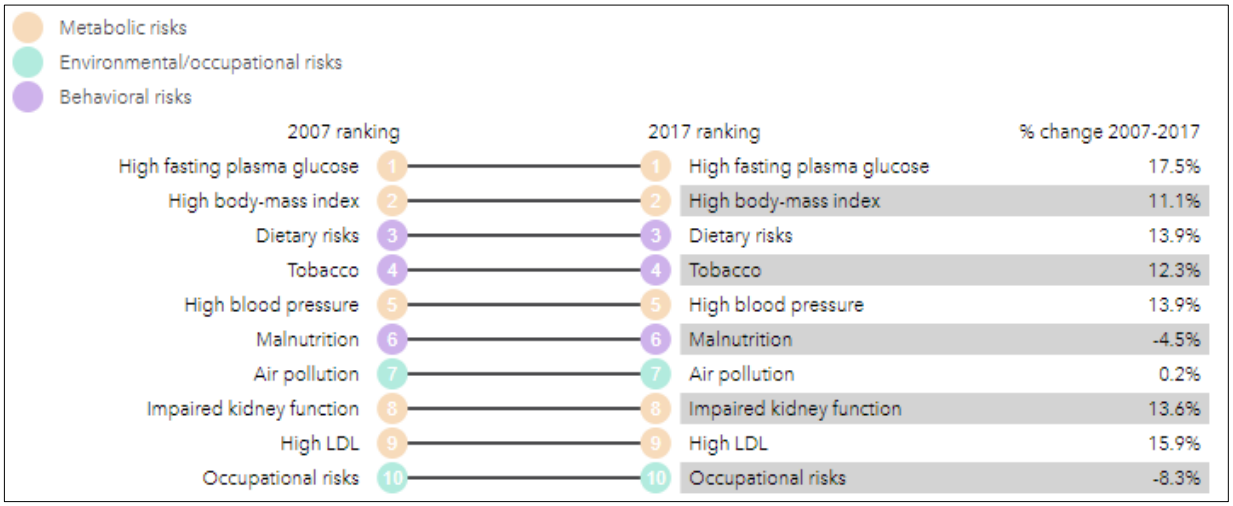
NCDs prevalence is an alarming problem in Samoa (see Table 1). According to the 2014 NCD Risk Factors STEPS Report 2014, 50.1% of Samoan adults (aged 18-64) were identified as at risk of developing an NCD, with 84.7% identified as overweight and 55.8% as obese. Those who had impaired fasting glucose were 25.8% while 45.8% had raised blood glucose. A total of 24.5% were, while 70.6% were not, on medication, for raised blood pressure. Of the adolescent aged group (13-17), 59.2% were identified as overweight, and 26.2% as obese, in accordance with the 2017 Global School Health Survey. Higher levels of NCD-risk factors were found among Samoans living in urban areas compared to those living rurally.

Table 1: Prevalence of non-communicable disease risk factors in Samoa
Source: MoH (2014; 2017)

Disease prevalence and risk factors		Total (%)	Males (%)	Females (%)
18-64 aged group (NCD Risk Factors STEPS Report, 2014)				
Mental health	Moderate to severe mental disorder	16.4	10.4	20.2
Obesity	Overweight	84.7	79.8	90.4
	Obese	55.8	44.8	68.6
Diabetes	Impaired fasting glucose	25.8	28.2	23.3
	Raised blood glucose	45.8	48.4	43.1
Hypertension	On medication for raised blood pressure	24.5	23.1	18.8
	Not on medication for raised blood pressure	70.6		
	Risk of developing an NCD	50.1		
13-17 aged group (Global School Health Survey 2017)				
Obesity	Overweight	59.2	53.7	64.3
	Obese	26.2	24.6	27.6

Existing evidence shows not only high but also soaring prevalence rates of NCDs and associated risk factors (smoking, dietary risks diet, and alcohol use) when compared to global averages.[ii] Figure 1 shows that the prevalence rates of all NCDs risk factors (except malnutrition and occupational risks) that drive the most death and disability in Samoa have increased by over 10% over the 10-year period of 2007 to 2017. Dietary risks increased by 13.9%, with high fasting plasma glucose (diabetes) and high LDL (low-density lipoproteins) increased by 17.5% and 15.9% respectively. High body-mass index and high blood pressures had also increased by 11.1% and 13.9% respectively.

Figure 1: What risk factors drive the most death and disability combined in Samoa?
Source: Institute for Health Metrics and Evaluation, 2017



[ii] Samoa's proportionality mortality due to **diabetes** is **9% (**global average is ***4%***); **22% for other NCDs (**global average is ***15%);*** and the risk of **premature death** is **21% (**global average is ***19%***). Samoa is the top **4th** country (out of the 21 countries) in the Western Pacific Region with the highest proportional mortality due to **diabetes** and is the top **5th** country (out of the 21 countries) in the Western Pacific Region with the highest proportional mortality due to **cardiovascular diseases** and **other NCDs** (WHO, Noncommunicable diseases country profiles 2018, 2018).

The NCDs crisis in Samoa is notable with significant increases in Type 2 Diabetes Mellitus (DM) and obesity prevalence over the last 30 years. Type 2 DM from 1.2% (males) and 2.2% (females) in 1979 to 19.6% (males) and 19.5% (females) in 2013. During this 35-year period (1979-2013), obesity prevalence also increased from 27.7% to 53.1% for males, and from 44.4% to 76.7% for females. These are substantial increases in Type 2 DM of 1,533% (for males) and 786% (for females) while obesity prevalence increased by 92% (for males) and 73% (for females). With these trends, Type 2 DM rates were expected to reach 26% (both males and females), while 59% (for males) and 81% (for females) for obesity prevalence, by 2020 (MoH, 2018). The 2019 Samoa Demographic and Health Survey-Multiple Indicator Cluster Survey (DHS-MICS) preliminary results identified 85.2% of women (aged 15-49) as obese/overweight (SBS, 2019).

Table 2 further gives an overview of Samoa's nutrition status (malnutrition and NCDs risk factors) across different aged groups (from infants to adults), and as benchmarked against global averages. For under-five years old, Samoa is doing relatively well, when compared to the global levels for wasting, stunting, and 6-month exclusive breastfeeding of babies. However, under-five stunting and overweight increased by 49% and 64% respectively from 2013 to 2019. Samoa is now above the global average of 5.9% for under-five overweight. Under-fiver anaemia levels also increased from 2013 to 2015 by 47% while exclusive breastfeeding (for the first six months since birth) also decreased by 26%. Similarly, for childhood and adolescent aged group (5-19), while Samoa is still below the global average for underweight, childhood and adolescent overweight and obesity have increased significantly between 2000 and 2014 and are exceeding the global averages. Overweight amongst increased by 87% (for males) and 55% (for females), while obesity increased by 165% (for males) and 211% (for females).

Anaemia amongst women of reproductive ages and pregnant women have increased, by 42% and 25% from 2000 to 2014, with anaemia amongst pregnant women slightly higher than the global average (by 6%). Diabetes, overweight and obesity amongst adults are increasing, from 2000 to 2014/2016. Diabetes increased significantly by 46% (for males) and 42% (for females), and this is the same for obesity which increased by 41% (for males) and 21% (for females). Overweight increased by 13% (males) and 10% (females), while raised blood pressure increased by 6% and 8% for males and females respectively. Diabetes and obesity in Samoa are over 50% higher, while overweight is 50% higher, than the global averages. Raised blood pressures is 9% higher (males) and 4% higher (females), than the global averages. Samoa has a rapid uprising in obesity and diabetes and are at a critical level when benchmarked globally.

Table 2: Nutrition status in Samoa

Source: Choy, et al. (2017); WHO (2019); SBS (2019); Development Initiatives Poverty Research Ltd (2020)

Nutrition indicators	N	M	F	N	M	F	Global average	Global Targets
Infant & maternal (%)	**1999-2013***			**2019++**			**2014-2018**	**2025**
Under-five wasting	3.9 [2013]	3.0	4.9	3.1 [2019]			7.3	5.0%
Under-five stunting	4.9 [2013]	5.6	4.1	7.3 [2019]			21.9	40% reduction
Under-five overweight	5.3 [2013]	6.2	4.3	8.7 [2019]			5.9	5.5%
Under-five with anaemia	23.2 [1999]			34.1 [2015]+	32.5	35.8		
6 months exclusive breastfeeding	70.3 [2013]			51.7 [2019]			42.2	At least 50%
Low birth rate							14.6	10.5%
Childhood/adolescent (%)	**2000***			**2014***			**2015-2018**	**2025**
5-19 aged underweight		2.2	1.6		1.4	0.9	31.6 (M); 25.9 (F)	
5-19 aged overweight		25.4	37.1		47.5	57.6	19.2 (M); 17.5 (F)	
5-19 aged obesity		8.8	6.4		23.3	19.9	7.8 (M); 5.6 (F)	
Maternal (%)	**2000***			**2016***			**2015-2018**	**2025**
Reproductive women with anaemia			22.1			31.3	32.5	15.0%
Pregnant women have anaemia			34.1			42.5	40.1	
Adults (% and grams)	**2000-2017***			**2014-2016***			**2014-2017**	**2025**
Adult diabetes		15.5	18.7		22.7	26.6	9.0 (M); 7.9 (F)	9.0% (M); 7.9% (F)
Adult overweight		65.3	74.5		73.6	82	38.5 (M); 39.2 (F)	
Adult obesity		28.3	45.5		39.9	55	11.1 (M); 15.1 (F)	10.4% (M); 14.4% (F)
Adult raised blood pressure		25.2	19.4		26.6	21	24.1 (M); 20.1 (F)	18.2% (M); 15.2% (F)
Sodium intake (grams per day)	2.2 [2017]						5.6 [2017]	3.95g per day

*N – National. F – Female. M – Male. * Source: WHO (2019). Samoa Country Overview – Malnutrition Burden; + Source: Choy, et al. (2017); Global averages and targets were obtained from 2020 Global Nutrition Report. ++ SBS (2019). Blank means data not available.*

Countries worldwide, including Samoa face the double burden of malnutrition; the co-existing of the impacts of undernutrition (e.g. childhood stunting, micro-nutrient deficiencies, and anaemia among women of reproductive age) – and direct-related NCDs (overweight/obesity and diabetes). However, the statistics presented in the previous section situate Samoa in a critical level when compared to other countries on the global level. NCDs risk factors (i.e. smoking, nutrition/unhealthy diet, harmful consumption of alcohol and physical inactivity (SNAP)) are being identified as the underlying causes of NCDs and are acquired behavioural factors (and lifestyle changes) that are preventable. Dietary factors are directly linked to NCDs as everyone consumed food. And it is what and how much people consume as their normal diets across their life course (from infant to adolescent, and to adult, life cycle) that are the underlying contributory factors to the high prevalence of diseases in Samoa and other countries.

1.2.2. Food and nutrition challenges

a) Dietary patterns

Nutrition is a key determinant for health, diseases and disabilities. The rising burden of NCDs is associated with significant nutritional shifts (and lifestyle changes) in Samoa over the years. With urbanisation, monetisation and globalisation, dietary patterns have changed from traditional foods to increased dependence on imported foods, which resulted in increased consumption of canned foods, sugar-sweetened beverages (SSB), and micronutrient-poor processed foods. This increasing consumption of 'modern diet' (energy-dense and micronutrient-poor highly processed foods), together with shifts towards a more sedentary way of life, adversely affects health across the life course.

Children are particularly vulnerable to malnutrition as this nutrition transition progresses. Malnutrition in young children are proven to be closely linked with increased mortality and impaired cognitive, physical and metabolic development which will continue affect their health from young ages into adults (Choy, et al., 2018; Choy, et al., 2017; Choy, et al., 2020). These changes in dietary structures are contributing to the high levels of obesity and other associated metabolic disorders among the Samoan population.

Existing dietary patterns of most Samoan children and adults are not nutritionally balanced, and are inadequate for appropriate development and healthy growth, contributing to a higher risk of malnutrition (under- and over-nutrition), and which can result in long-term risk of diseases and premature NCDs mortality (Thow & Reeve, 2015; FAO, 2017; Choy, et al., 2017). For instance, the FAO (2017) study identified that the average Samoan consumes excessive amounts of sodium,[iii] protein and iron, but fall far short of the required vitamins. Other similar research (Choy, et al., 2018; Choy, et al., 2017; Choy, et al., 2020) which focused mainly on examining Samoan children's diets have identified that most young children in Samoa exceed recommended levels for carbohydrate, fat and protein (macronutrients) and sodium intake. However, more than half of the children studied have inadequate dietary micronutrients (calcium, potassium and vitamin A and E) intake.

Further household expenditure on the consumption of fruits and leafy vegetables has been identified as relatively low. The latest 2019 Samoa DHS-MIC identified that only 1*.7% of Samoan women* and *0.5% of men* (aged 15-49) consumed at *least 20 servings of fruits per week*, and only *1.5% of women* and *0.7% of men* (aged 15-49) consumed at *least 20 servings of vegetables per week* (SBS, 2019). This is a reduction from 9% (women) and 18% (men) consumed at *least 20 servings of fruits per week*, and 4% (women) and 17% (men) consuming at *least 20 servings of vegetables per week* in 2014 (SBS, 2014; 2019).

[iii] Sodium intake is around 50% higher than intake recommended, while average energy (calories) per adult male equivalent is 50% higher than recommended for average active male, and 100% higher than recommended for average sedentary male (Thow & Reeve, 2015, p. 46).

The above evidence shows that the Samoan diet is not appropriate for healthy developments, especially amongst the young (future) generations, and this is contributing to the high and increasing levels of NCDs in Samoa. The diet and nutritional intakes must change in order to attain and maintain a healthy Samoa.

b) Key factors influencing food and diets in Samoa

Price, availability, preference, convenience, and culture are factors determining population food intake. The 2017 FAO study identified that the availability of lower cost, nutritionally superior diet has been identified as critical to improving food security, and health. However, the minimum cost of a diet which meets the food and nutrition needs of households (recommended calorie, protein, fat, sodium, vitamin A, and iron intake, including recommended intake of total dietary fibre, vitamin C and E, and share of food energy from carbohydrates) is more expensive than the food poverty line established for Samoa in 2015. The study further shows that only 37% of the top 30 food items (by share of expenditure) are locally produced, an indication that imported (processed) food items have become a far more important share of food expenditure in Samoa households.

Price appears to have a significant influence on consumption in Samoa. Perceived cost of food was more strongly associated with dietary intake than either healthfulness or social status, with decreasing consumption with increasing food cost. Studies have shown that the consumption of modern food in spite of references for traditional foods (e.g. fish and vegetables) is likely to be due to lower costs and convenient availability of modern foods (e.g. cereal, instant noodles and bread). As well, the increased movement of people into waged labour has reduced time available for traditional food preparation leading to increased use of faster-cooking foods (e.g. white rice and instant noodles) and other convenient foods (e.g. simple to cook and food takeaways).

With its strong communal society, eating and feasting is a cultural norm for Samoan communities (churches, villages, districts, organisations, groups etc.) and families to socialise and maintain connections and customs. The influence of culture on food intake (and hence obesity) is of particular importance in Samoa. This is seen in the bulk preparation and sharing of foods during *faalavelave* (events such as funerals, weddings, title ceremonies, birthdays, etc.) and family *toonai* (Sunday feast) given social obligations to feed and consume large portion of foods for large social gatherings.

Having more (perceived) 'prestige' foods (e.g. meat and canned food which are associated with modern diet) to eat and share is a reflection of social status, with the regular replacement of traditional foods (e.g. drinking coconuts and local Samoa chicken) with modern foods (e.g. canned soft drinks and corned beef) - and this is often observed during traditional gift exchanges (*sua*) during rituals and festivities. Traditional beliefs (e.g. *e sau le aso ma lona ai; ole fuata ma lona lou*) further partly contribute to the practice of consuming all, or larger amount of, food, such as eating all food by the end of the day, resulting in people eating more than what they actually need.

The above contributing factors are to be addressed in food and nutrition policy responses and strategies.

1.3. National food and nutrition policy 2013-2018

The Samoa National Food and Nutrition Policy (NFNP) 2013-2018 was developed to be in line with other national policy frameworks (the Samoa National Plan of Action for Nutrition 2002-2007, and Samoa National Plan of Action for Infant and Young Child Feeding 2006-2010), as well as regional and global policy frameworks (e.g. WHO Global Strategy for Infant and Young Child Feeding, Global Strategy on Diet, Physical Activity and Health, and relevant UN Millennium Development Goals (now replaced by the Sustainable Development Goals or SDGs)). The NFNP built on review findings of the Samoa National Food and Nutrition Policy 1995 and stakeholder consultations that were conducted at the time.

1.3.1. Overview of the policy

The introduction of the NFNP 2013-2018 stated that it intended 'to facilitate and support action through the entire food and nutrition system (food production, processing, distribution, nutrition knowledge and food consumption, sanitation, as well as preventive health actions) to achieve better nutrition and health outcomes for Samoans'. The NFNP highlighted the following four policy areas:

- ***Food, nutrition and health as a priority*** for Samoa - in reducing NCDs and malnutrition, and in response to emerging issues such as the impact of climate change on safe water, sanitation, drought, food security and people's health.

- The need to look at the whole ***food system*** (covering all aspects of good – from field to table and back again) in addressing nutrition and health, as it affects the what, where, when, why and how of eating/consumption. This includes farming and agricultural practices through to the manufacturing, packaging, transportation, distribution, and sale of food, as well as the waste that is being generated.

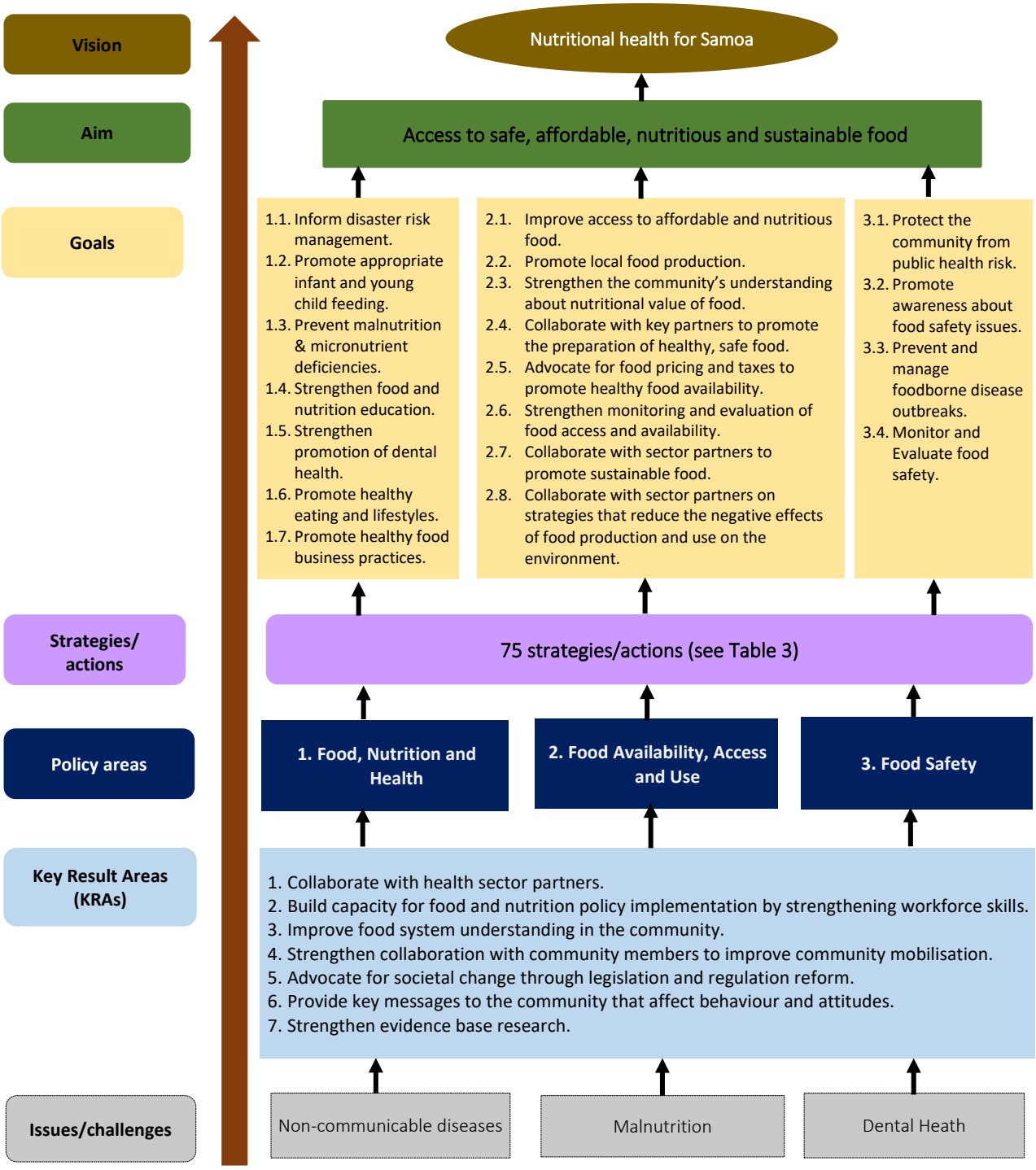
- The need to address ***food security*** in Samoa – where all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food, to meet dietary needs and food preferences for an active and healthy life.

- The importance of ***health promotion*** in encouraging individuals and communities to adopt healthier behaviours, and to make healthier choices, through community mobilization, and facilitating appropriate supportive environment for people and community to make those choices.

1.3.2. Theory of change

Figure 2 reiterates the vision, aim/objective, goals (food, nutrition and health; food availability, access and use; and food safety) and seven key strategic areas (KRAs) of the NFNP 2013-2018 – visualising the theory of change envisioned under the NFNP 2013-2018 as a National Policy addressing food and nutritional related issues in Samoa:

Figure 2: National Food and Nutrition Policy 2013-2018 strategic direction and theory of change



1.3.3. Action plan

Table 3 reiterates the Action Plan of the NFNP 2013-2018 (also see Annex B for the detailed version) to achieve the vision, aim and key result areas of the Policy and intended theory of change outlined in Figure 2. A total of **19 goals** and *75 strategies* were outlined in the NFNP 2013-2018 Action Plan for implementation, together with identified responsible agencies and indicators.

Table 3: National Food and Nutrition Policy Action Plan2013-2018

Goal	Strategy
1. Food, Nutrition and Health Action Plan	
1.1. Inform disaster risk management.	1.1.1. Collaborate with Disaster Advisory Committee on developing operational guidelines for nutrition and infant and young child feeding during emergencies in readiness for first response (during initial rapid assessments). 1.1.2. Contribute technical and expert advice during national disaster relief efforts and monitor food and nutrition related issues for the Disaster Plan procedures.
1.2. Promote appropriate infant and young child feeding (IYCF).	1.2.1. Promote national and community support for and awareness about infant and young child feeding issues. 1.2.2. Collaborate with sector partners to ensure IYCF capacity building and continued education for health staff and other relevant stakeholders. 1.2.3. Build capacity for and monitor Baby Friendly Hospital Initiative and breastfeeding initiatives in other settings e.g. health centres, workplaces, community settings. 1.2.4. Finalise, implement and enforce the draft Food (Marketing of Products for Infants and Young Children) Regulations. 1.2.5. Strengthen protection of breastfeeding rights of working women. 1.2.6. Encourage research and monitoring of issues related to IYCF.
1.3. Prevent malnutrition and micronutrient deficiencies.	1.3.1. Implement research that establishes rates of malnutrition and micronutrient deficiencies and develops evidence for responding to the deficiencies. 1.3.2. Establish routine data collection and reporting for on anaemia in pregnant women and young children. 1.3.3. Promote community awareness about the causes of and solutions for malnutrition and micronutrient deficiencies. 1.3.4. Finalise, implement and enforce the Food Safety and Quality Regulations specific to the fortification of flour, rice and iodisation of salt. 1.3.5. Advocate adequate iron supplements for deficient groups based on evidence.
1.4. Strengthen food and nutrition education.	1.4.1. Collaborate with education sector on policy strengthening activities for food and nutrition. 1.4.2. Develop personal food and nutrition knowledge and skills for pre-school and school age children and families. 1.4.3. Build capacity for education sector to respond to health promoting school model. 1.4.4. Promote local food education. 1.4.5. Advocate for continued strengthening for the existing school curricula on nutrition in food and textiles, health, agriculture, environmental science and physical education. 1.4.6. Promote food and nutrition policy to be embedded with national education strategies. 1.4.7. Advocate for tertiary scholarships to increase the nutrition skills in the workforce. 1.4.8. Collaborate with academic institutions to promote food system understandings. 1.4.9. Implement and monitor obesity reduction projects in pre-schools and schools.
1.5. Strengthen promotion of dental health.	1.5.1. Promote dental health information. 1.5.2. Improve maternal dental health information distribution. 1.5.3. Advocate price control on dental products. 1.5.4. Identify dental research priorities.

1.6. Promote healthy eating and lifestyles.	1.6.1. Advocate for and conduct research about people's attitudes to food and food consumption. 1.6.2. Promote increased uptake of fruit and vegetables in the community. 1.6.3. Promote regular physical activity for improved physical fitness. 1.6.4. Promote reduced smoking and alcohol consumption in the community. 1.6.5. Strengthen nutrition curriculum focus for health and allied health workforce training courses 1.6.6. Provide food and nutrition information to the community about the management NCD with a focus on diabetes. 1.6.7. Provide information to the community about the prevention of obesity in children. 1.6.8. Implement and monitor salt reduction project strategy (ref. Best Buy). 1.6.9. Implement and monitor strategy to control trans-fatty acids in food supply. 1.6.10. Collaborate with sector partners for strengthening community-based approaches for reducing obesity. 1.6.11. Develop and promote strategies to control the marketing of foods and non-alcoholic beverages to children.
1.7. Promote healthy food business practices.	1.7.1. Promote healthy lifestyle improvement projects amongst private and public sectors e.g. healthy workplaces. 1.7.2. Promote the business sector understanding of issues related to the food system. 1.7.3. Collaborate with food safety partners to build food industry capacity to improve food safety. 1.7.4. Promote the use of locally produced foods by all food industry partners e.g. supermarkets, hotels, restaurants, small shops, government catering, institutions (hospitals, boarding schools). 1.7.5. Strengthen capacity building for food importers, distributors and processors on ways to reduce fat, trans fatty acids, salt and sugar in food products.
2. Food Availability, Access and Use Action Plan	
2.1. Improve access to affordable and nutritious food.	2.1.1. Strengthen promotion of dietary guidelines. 2.1.2. Collaborate with primary health care services sector to strengthen actions that reduce obesity. 2.1.3. Strengthen capacity building actions for health workers on issues related to food trade and trade agreements e.g. WTO, PICTA. 2.1.4. Conduct a feasibility study to analyse the options for Samoa to consider in addressing nutrition related health problems and advise on policy direction to control diet related health problems. 2.1.5. Promote transport systems improvement to link locally produced food to market and to promote economic gain.
2.2. Promote local food production.	2.2.1. Collaborate with sector partners on key messages they could utilize to promote locally produced food. 2.2.2. Advocate for more locally grown food.
2.3. Strengthen the community's understanding about nutritional value of food.	2.3.1. Promote research and development of under-utilized indigenous nutritious crops and dissemination of findings.
2.4. Collaborate with key partners to promote the preparation of healthy, safe food.	2.4.1. Promote food preparation messages to the community focusing on lower fat, salt and sugar and safe food preparation. 2.4.2. Advocate for new technology/ recipe modification to improve the nutritional quality of locally produced processed foods
2.5. Advocate for food pricing and taxes to promote healthy food availability.	2.5.1. Review and adjust import duties, price controls and taxes to increase availability of healthy foods and products that support healthy lifestyles.

2.6. Strengthen monitoring and evaluation of food access and availability.	2.6.1. Advocate for research on access to and availability of food.
2.7. Collaborate with sector partners to promote sustainable food.	2.7.1. Collaborate with sector partners on strategic directions for food sustainable systems approach. 2.7.2. Collaborate with health sector partners to build capacity for continued sustainable food strategy implementation sector wide. 2.7.3. Promote environmental health models that integrate food and nutrients for built, natural, social and economic areas.
2.8. Collaborate with sector partners on strategies that reduce the negative effects of food production and use on the environment.	2.8.1. Promote education and awareness about food waste and its impact on the environment. 2.8.2. Advocate for research that informs health sector partners about sustainable food. 2.8.3. Advocate for community awareness programs for food system responsibility. 2.8.4. Advocate for regulations to prevent use of injurious packing material for packaging food and water and non-recyclable packaging. 2.8.5. Advocate for recycling facilities which include food waste management. 2.8.6. Drive national and Pacific regional policy development for continuous improvement for the reduction of greenhouse gas emissions and management of land fill.
3. Food Safety Action Plan	
3.1. Protect the community from public health risk.	3.1.1. Finalise and implement Food Bill and regulations. 3.1.2. Promote key messages on good hygiene and food preparation practices to reduce food borne related incidence in the community.
3.2. Promote awareness about food safety issues.	3.2.1. Promote awareness about the dangers of unsafe pesticide use. 3.2.2. Promote water quality awareness in the community.
3.3. Prevent and manage foodborne disease outbreaks.	3.3.1. Contribute technical and expert advice during national disaster relief efforts. 3.3.2. Build capacity of food businesses on issues related to food safety.
3.4. Monitor and Evaluate food safety.	3.4.1. Regular and planned testing for food contamination. 3.4.2. Monthly data collation of reports of food borne illness. 3.4.3. Strengthen services for testing food contamination. 3.4.4. Drive measures to reduce fish/seafood contamination through protection of marine areas. 3.4.5. Monitor pesticides levels in food. 3.4.6. Promote safe water.

1.4. Review of the national food and nutrition policy 2013-2018

The full Terms of Reference for the Review of the Samoa NFNP 2013-2018 is attached as Annex A. With the conclusion of the Policy and it Action Plan in 2018, a review is required to establish progress made so far in the achievement of the Policy targets within its timeframe.

1.4.1. Purpose and objective of the Review

The Review needs to draw on the successes and challenges involved in the implementation of the Food and Nutrition Policy 2013-2018 through programming, policies and practices. The completion of this Review of the NFNP 2013-2018 is being highlighted by the Ministry of Health (MoH) as a significant milestone achieved by the Ministry and its partners. The Review will identify the risks and challenges involved in implementation which may have resulted in unmet goals and objectives of the policy.

The Review is intended to inform the development of the next NFNP and Plan of Action 2021-2026, which will provide a framework guiding the efforts of all stakeholders involved for better health outcomes through the strengthening the focus on improving food and nutrition in Samoa.

The development of the third NFNP and Action Plan 2021–2026 will build on the findings of this Review of the NFNP 2013-2018, as well as the review of the Health Sector Plan 2008-2018, in consultation with health sector partners.

The formulation process of the NFNP and its Action Plan 2021–2026 was undertaking together with this Review process – in terms of the processes undertaken for the stakeholder consultation, desktop review, data collection and analysis as well as report writing.

1.4.2. Methodology - review of the national food and nutrition policy

Overall, the methodology used for the Review involved the use of the following methods, approaches, tools and processes.

a) Inception meetings with key counterparts

Two inception meetings were held with key counterparts (Strategic Planning Policy and Research Division (SPPRD) and Nutrition Section) of the MoH in September 2020 to establish mutual understanding about the Review and its purpose/objective and methodological processes, and to confirm key counterparts who will be working with the Technical Assistant (TA) (i.e. the Reviewer) in the undertaking of the Review.

Requests were made during these inception meetings for making available to the TA all key relevant documents as soon as possible for the desktop review and for finalising the data collection methods and tools, including the stakeholder consultative process.

b) Desktop and literature review

All relevant documentation relating to the initiation, formulation, implementation, monitoring and evaluation (M&E) of the NFNP 2013-2018 were requested from the MoH, with other relevant literature were requested from the Secretariat of the Pacific Community (SPC) and other key implementing agencies (see Annex B) of the NFNP.

An online literature review was further undertaken to identify relevant research and studies relating to food and nutrition (in Samoa, Pacific island countries and small island developing states), including the grey literature relating to global and regional policy measures, standards and practices as well as development and implementation efforts undertaken for improving food and nutrition.

c) Stakeholder consultation

Consultation (one-on-one and group interviews) were held with representatives of organisations identified as 'responsible agents' (see Annex B) in the NFNP Action Plan 2013-2018. They were the agencies/partners responsible for implementing the different strategies outlined under the NFNP and its Action Plan 2013-2018, and hence their views and feedback on the implementation of the NFNP were important to the Review.

Annex C gives the list of people who were consulted and contacted for information on the Review. Some of them (key counterparts in the MoH) were consulted more than one time in order to collect more information and/or to verify or validate information/data that have been provided.

The key questions guiding and directing the interviews with stakeholders as well as the purpose and intentions of the Review are outlined in Table 4. The questions aimed to assess the NFNP and its Action Plan's (2013-2018) relevance, effectiveness, efficiency, impact and sustainability, which are criteria often used for evaluation/review purposes.

Table 4: Guiding questions for the stakeholder consultation/discussion

	Questions
Review of the Previous Policy 2013-2018	1. *What is your understanding of the Policy? What was it intended to achieve?* 2. *What are your views on the areas and strategies included in the Policy? How relevant are these strategies to Samoa's needs?* 3. *Who was supposed to make them happen? Who was responsible for implementation, monitoring and evaluation (M&E)?* 4. *How was the multi-sectoral approach working for this policy?* 5. *What is the status of implementation of each of the activities?* 6. *What are the issues and challenges with implementation? What could have done better?* 7. *What are the lessons learnt, to consider in the next Policy?*
Formulation of the Next Policy (NFNP 2021-2026)	1. *What should be the focus of the next policy? What are the priority areas to cover in this next Policy and why?* 2. *What are the key strategies and activities to be included in this next Policy?* 3. *Who should take the lead in driving the implementation of the new Policy?* 4. *Who is responsible for implementation?* 5. *How do we ensure that the Policy will be implemented?* 6. *Who will ensure the effective and efficient monitoring and evaluation of the Policy?*

It is intended that a validation workshop will be held in end November/December 2020 to present the draft Review Report (its key findings) and the draft NFNP 2021-2026 once the write-up is completed. This Review Report will be revised following further inputs from this workshop.

d) Review – assessment template

To direct the Review process towards the NFNP 2013-2018, an assessment template (see Annex B) based on the NFNP Action Plan 2013-2018 was prepared and provided to those who were consulted prior to the actual meetings/interviews.

Based on the information provided in the above template (Annex B) and the interviewing questions in Table 4 above, informants were asked to assess the implementation status of the different strategies (those that are applicable and relevant to themselves and their organisations) as outlined under the NFNP Action Plan 2013-2018. This includes providing evidence to support assessments (or claims) made.

As shown on the template, specific questions relating to the assessment of each strategy are provided to guide informants with making their assessments and in providing the necessary information on their activity implementation relating to the NFNP and its Action Plan 2013-2018.

e) Analysis

Information/data collected from the desktop and literature review and stakeholder consultation were analysed by the reviewer to arrive at the findings documented in this Report.

Comparative analysis of information/data from the different informants/stakeholders show commonalities or contentions within and between different stakeholder groups and hence ensured rigorous evidence, validity and credibility of review findings (as presented in Section 2 of this Report), to inform the formulation of the next NFNP 2021-2026.

It is intended that this Review Report, its key findings will be presented to all key stakeholders for further inputs during a validation workshop, planned for November/December 2020.

The findings presented in this draft Report will be revised following further inputs from this workshop and MoH's management as well as any technical inputs from the SPC and other relevant agencies and experts.

1.4.3. Limitations

Limitations pertaining to the Review relate mainly to information and data availability limitations. A period of two weeks was allocated for data collection, on the assumption that informants will be forthcoming with providing the needed documentation for the Review within this two weeks' timeframe. Unfortunately, it took time for counterparts to try and locate key information/data that relate directly to the implementation of the different strategies and activities relating to food and nutrition – as they are the evidence for the actions undertaken and on 'where things are' with the NFNP 2013-2018 implementation. Several follow-ups were made with key informants/stakeholders, but some needed information were not made available up the time of completing this Review.

Given such limitations, the findings presented in this Report are as good as the information/data made available to assist with providing a robust and fair assessment and review of the NFNP 2013-2018.

2. REVIEW FINDINGS

2.1. Introduction

This Report presents the Review of the Samoa National Food and Nutrition Policy (NFNP) 2013-2018. The previous Section 1 provides a background on the Policy as well as the Terms of Reference and Methodology adopted and used for the Review. This Section 2 presents the findings of the Review.

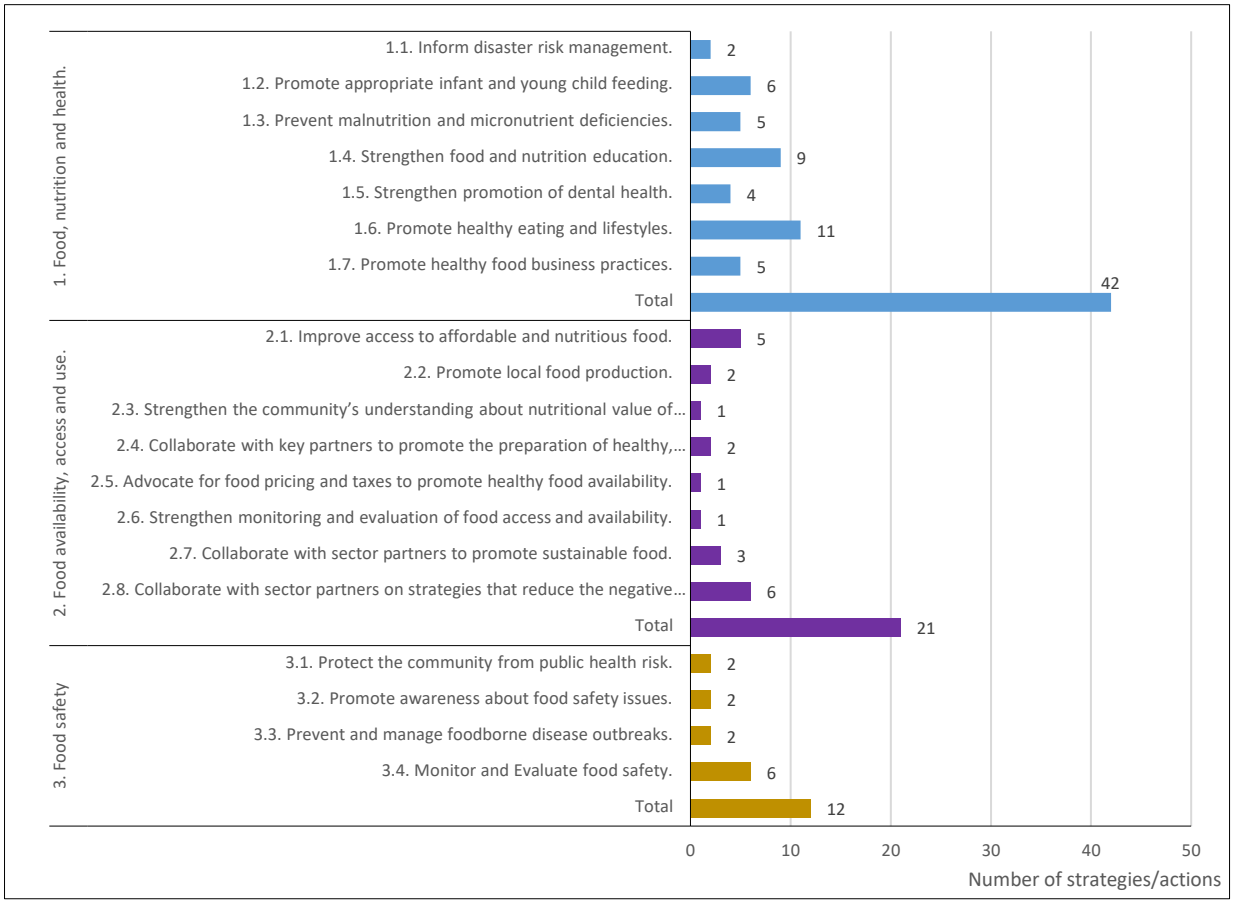
This Review is prepared to assess the NFNP 2013-2018 and its implementation at the completion of its lifespan. The Review findings aimed to inform the formulation of the next NFNP 2021-2026 for Samoa.

2.2. Implementation status and achievements

2.2.1. Overview

A detailed assessment of the implementation status of the NFNP Action Plan 2013-2018 is provided in Annex B. As reiterated in section 1.3 above, the NFNP 2013-2018 addressed three broad interrelated areas: food, nutrition and health; food availability, access and use; and food safety. These areas concern the whole food system – from farm to table (and back again); food trade; and the food environment. As such, and given the national focus of the policy, the adoption and implementation of the 75 strategies identified in the NFNP Action Plan 2013-2018 (corresponding to its 19 goals) are beyond the mandate, roles, capacities and resources of the Ministry of Health (MoH), as the lead government agency of this national policy. A multi-sector approach was required for effective implementation of the 75 strategies. The majority of strategies (42 in total) were directed at addressing food, nutrition and health, while 21 strategies focused on addressing food availability, access and use; and 12 aimed at improving food safety (see Figure 3).

Figure 3: Strategies to achieve the 19 goals of the National Food and Nutrition Policy 2013-2018



The NFNP and its Action Plan 2013-2018 did not outline any specific activities or actions that are needed to be implemented to achieve the 75 strategies, and thereby contributing to the achievement of the 19 goals. As such, and given the high level formulation of the strategies, it is difficult to unpack and identify clearly what are the activities that were intended to be implemented versus what was actually implemented across the different 75 strategies. This is further complicated by the fact that there was no documented monitoring and evaluation (M&E) framework of the NFNP 2013-2018, including no M&E reporting on the implementation of the NFNP and Action Plan 2013-2018.

Given such limitations, the assessment provided in Annex B, are based mainly on the desktop review and consultations held with key responsible agencies (as identified in the NFNP and Action Plan 2013-2018) undertaken during October 2020 to inform this Review. The desktop review is further subject to the information made available, as well as the quality of that information, in order to provide a more robust and fair assessment of the implementation status of the NFNP and its Action Plan 2013-2018.

Based on this assessment, the overall implementation of the NFNP 2013-2018 is rated 2.6 (out of 5) (see Annex B) – indicating a moderately successful achievement level. Areas where achievements have been made and those with limited implementation are discussed below, in accordance with the three focal areas of the NFNP and Action Plan 2013-2018.

a) Food, Nutrition and Health – Action Plan

The Food, Nutrition and Health Action Plan outlined 42 strategies aimed at improving the management and monitoring of food and nutrition issues during disaster and emergency responses; promoting of appropriate infant and young child feeding (IYCF); preventing malnutrition and micronutrient deficiencies; strengthening food and nutrition education; promotion of dental health and healthy eating and lifestyles; as well as improving healthy food business practices.

The overall implementation status of this first component of the NFNP Action Plan 2013-2018 is 2.5 (out of 5), as per detailed assessment provided in Annex B. Key achievements are noted in the following areas Food, Nutrition and Health Action Plan, where an assessment rate of 2.5 or above is being made:

- Finalisation of the Food (Marketing of Products for Infants and Young Children) Regulations 2020 which were submitted to Cabinet in late 2020 for approval;
- Undertaking of targeted research (particularly with the establishment of the OLAGA (Obesity, Lifestyle and Genetic Adaptation) research arm within the MoH)) on food and nutrition issues in Samoa, with a particular focus on maternal and child health;
- Strengthened partnership with Ministry of Education, Sport and Culture (MESC) to improve the focus on health promoting schools and school nutrition;
- Ongoing awareness and health promotion programs and activities on food and nutrition issues/matters – such as breastfeeding, infant and child feeding, healthy lifestyles, etc.; and
- Ongoing collaboration with health partners to strengthen food and nutrition knowledge and skills through curriculum and course development and delivery, capacity building and other in-service training.

It is obviously from the assessment that more work is needed to continue and further develop the above areas, as ongoing developmental areas that will strengthen nutritional health in Samoa. However, the assessment highlighted a number of key areas where shortfalls in implementation are noted, as indicated by a rate of 2.0 or below in the assessment provided in Annex B:

- Strengthening of dental health and including the contribution of food and nutrition to oral and dental health;
- Development of food and nutrition guidelines during disaster and emergency responses;

- Strategies to implement and monitor trans fatty acids in food supply;
- Capacity building for food importers, distributors and processors on ways to reduce fat, trans fatty acids, salt and sugar in food products;
- Promotion of healthy lifestyle improvement projects amongst private and public sectors;
- Strategies to control the marketing of foods and non-alcoholic beverages to children; and
- Community-based approaches and projects for reducing obesity.

b) Food Availability, Access and Use – Action Plan

The Food, Nutrition and Health Action Plan outlined 21 strategies aimed at improving access to affordable and nutritious food (including monitoring and evaluation of access and affordability of nutritious food); food pricing and taxation to promote healthy food availability; promotion of local food production and sustainable food; strengthening community's understanding about the nutritional value of food; promoting the preparation of healthy and safe food practices; and reducing negative effects of food production and use on the environment.

The overall implementation status of this second component of the NFNP Action Plan 2013-2018 is 2.7 (out of 5) as per assessment in Annex B. Key achievements are noted in the following areas of the Food, Nutrition and Health Action Plan, where an assessment rate of 2.5 or above is being made:

- The conducting of the 2015 'study on options for controlling nutrition related health problems in Samoa' which analysed and recommended options for Samoa to consider;
- Completion of a review and adjustment of import duties and excise tax in 2018 and 2019 on healthy and unhealthy foods in order to support healthy choices and encourage healthy eating/lifestyles[iv];
- Enactment of the Waste (Plastic Bag) Management Regulation 2018 which prohibit the import, manufacture, export, sale and distribution of plastic shopping bags, packing bags and straws effective from 30 January 2019;
- Strengthening of the focus on NCDs reduction through the PEN *Fa'aSamoa* initiative (World Bank funded);
- Ongoing collaboration on issues relating to food trade through the Samoa National Codex Committee in which key implementing agencies of the NFNP 2013-2018 attend as core members;
- Ongoing efforts and advocacy initiatives on food waste management;
- Continuous efforts to promote locally produced food (e.g. organic products) including indigenous nutritious crops, including fruits and vegetables;
- Ongoing efforts to promote sustainable food and food security through local food production through the agriculture sector and the role of the Ministry of Agriculture and Fisheries (MAF); and
- Implementation of the salt project which aimed at reducing salt intake in Samoa.

Key strategies where implementation have been limited are outlined below – those with an assessment rate of 2.0 or below in Annex B:

- More work is needed to strengthen promotion of dietary guidelines including their operationalisation at the local community and family levels;
- Promotion of environmental health models that integrate food and nutrients for built, natural, social and economic areas - it is not clear what are these models and there is limited evidence to show whether those models have been developed, promoted and implemented;
- Promotion of education and awareness about food waste and its impact on the environment - the Ministry of Natural Resources and Environment (MNRE) is the lead government agency on environment protection and waste management matters. However, it is not clear given limited

[iv] The adjustment was approved by Government but has been put on hold to become effective after the March 2021 general elections.

reported evidence on what are the initiatives that have been undertaken through the NFNP and Action Plan 2013-2018 to promote education and awareness about food waste and its impact on the environment;
- Advocating for research that informs health sector partners about sustainable food - there is a need for research but the conducting of needed research on sustainable food has been limited;
- Advocating for community awareness programs for food system responsibility - it is unclear what has been undertaken to increase community awareness on food system responsibilities; and
- Driving national and Pacific regional policy development for continuous improvement for the reduction of greenhouse gas emissions and management of land fill - MNRE takes the lead on this area, but there is a lack of reported evidence (against the NFNP framework) on any existing initiatives contributing to this strategy.

c) Food Safety – Action Plan

The Food Safety Action Plan outlined 12 strategies aimed at protecting the community from public health risks; promoting awareness about food safety issues; preventing and managing food borne disease outbreaks; and monitoring and evaluation of food safety.

The overall implementation status of this third component of the NFNP Action Plan 2013-2018 is 3 (out of 5) as per assessment in Annex B. Key achievements are noted in the following areas, where an assessment rate of 2.5 or above is being made:

- Enactment of the Food Safety Act 2015 and Food (Safety and Quality) Regulations 2017, with the MoH Health Promotion and Enforcement Division (HPED) taking on the lead role of promoting and enforcing these legislation;
- Continuous health promotional messaging on national media about good hygiene and food preparation practices, which is also part of the whole health movement to revitalise public health and primary health care;
- Regular testing of the quality of bottle water undertaken by the MoH National Disease Surveillance and International Health Regulations Division (NDSIHRD) in collaboration with Scientific Research Organisation of Samoa (SROS), with results publicised on national media;
- Testing for food contamination when needed in collaboration with SROS;
- Promotion of safe water drinking, especially during disasters and disease outbreaks;
- Ad hoc programs/activities undertaken by MoH for food industry to become aware of the Food Safety Act and Regulations. Regular monitoring of food safety in the food industry are conducted by MoH HPED; and
- The issuing of health card (a form of licensing for food processors) as a mechanism introduced by MoH to enable monitoring compliance with food safety requirements.

Limited implementation are noted in the following strategies of the Food Safety Action Plan – those with an assessment rate of 2.0 or below in Annex B:

- Limited reporting against and through the NFNP framework on measures undertaken to reduce fish/seafood contamination through protection of marine areas;
- Limited information on actions undertaken for monitoring of pesticide levels in food, including knowledge made available for the information and awareness of the public; and
- Lack of evidence to show awareness levels across the community about the dangers of unsafe pesticide use and which pesticide that are safe and those that are not safe including information about the dangers/risks.

2.2.2. Relevance and appropriateness

The consultation and document review as well as the background information in Section 1 above reaffirmed the relevance of the NFNP and its Action Plan 2013-2018 to Samoa's health challenges and health development priority needs. The Policy goals and strategies are closely aligned with the Strategy for the Development of Samoa (SDS) (2016-2020). A '20% increase in volume of local food production' is being stipulated in the SDS 2016-2020 as a key strategic outcome for increased food security and improved nutrition options in Samoa. The SDS also highlights the significance of food safety through improved health promotion, protection and compliance and strengthening of health service standards. The NFNP 2013-2018 further contributes to the achievement of the Health Sector Plan's (HSP) (2019-2030) vision of 'A Healthy Samoa'.

The HSP highlights 'improved food safety and compliance with food legislations and standards'; 'exclusively breast feeding'; and 'promotion of healthy food choices in schools', as key performance outcome areas of the Samoa health sector.

The NFNP 2013-2018 provided the overall strategic framework for the development and strengthening of a coordinated national focus and response on addressing food and nutritional health challenges and issues in Samoa. However, gaps concerning the design of the policy were identified through this Review, which affected the effective and efficient implementation of the NFNP and Action Plan 2013-2018. These gaps are summarised as follows:

- The absence of specific activities/actions corresponding to the implementation and progressive achievement of the 75 strategies and 19 goals has made it difficult to map what was intended to be implemented and what was actually implemented to contribute to the strategies and goals;

- The absence of specific timelines for the implementation of the different strategies has made it difficult to provide time-bound measurements for mapping timely progress, delays, time lapses and inefficiencies in implementation against performance indicators;

- Too many 'responsible agents' listed for each strategy led to agency confusion about who is the agent that should take the lead and be held responsible and accountable for the implementation of a particular strategy;

- Development partners should not have been listed as responsible agents as they do not have implementing roles, although their important supportive role in providing technical and financial assistances is to be stipulated and acknowledged;

- The absence of implementation arrangements for the NFNP and its Action Plan led to confusion about implementing and monitoring roles, including having a key focal point for the monitoring and facilitating the implementation process;

- With the absence of an M&E framework there were established and well-articulated mechanisms for ongoing monitoring and regular evaluation against progress and achievements of indicators for each of the 75 strategies outlined in the NFNP Action Plan; and

- Duplication of some of the NFNP strategies with those in policies and plans of other sectors (e.g. Agriculture sector plan). The main concern here is the contradictions in development approaches and outcomes, which is not the best utilisation of resources, and can result in unintended results. An example of this is the food security strategies outlined in the NFNP which duplicate those

outlined in the Agriculture sector plan. Approaches for implementation of these strategies can differ from the health side as opposed to the agriculture side due to conflicting interests.[v]

2.2.3. *Effectiveness*

Through the implementation of the 75 strategies outlined in its action plan, the NFNP 2013-2018 intended to contribute to seven key result areas (KRAs) of:

- collaboration with health sector partners;
- capacity building for food and nutrition policy implementation by strengthening workforce skills;
- improvement in the food system understanding in the community;
- strengthening of collaboration with community members to improve community mobilisation;
- advocacy for societal change through legislation and regulation reform;
- provisions of key messages to the community to affect behaviour and attitudes; and
- strengthening of evidence base research.

The Review (as per assessment documented in Annex B) confirmed that there were initiatives (programs and activities) carried out by the MoH and health sector partners that contributed to the progressive achievement of the above seven KRAs. However, given limited M&E of the NFNP 2013-2018, it is difficult to provide a robust assessment about the extent of the contribution of the NFNP and the implementation of its Action Plan to the above seven KRAs – in terms of any improvements in areas such as policy change, collaboration, capacity building, knowledge and understanding, community mobilisation, societal change, behavioural change, and evidence. The measurement of these types of adaptive or social changes at different levels (individual, organisation, sector, community, and society) required proper research (surveys, studies, reviews, assessments, etc.), evidence-based analysis and robust evaluation, which should have been built within the NFNP M&E framework.

Nevertheless, the assessment in Annex B which focused at examining the effectiveness of the implementation status of the NFNP 2013-2018 Action Plan (based on the desktop review and feedback from key responsible agencies of the NFNP Action Plan) gives the overall achievement level of the in Figure 4.

A total of 10 (or 13% of) strategies were assessment as 'achieved'; 48 (or 64% of) strategies were assessed as 'partially achieved'; while 17 (or 23%) were assessed as 'not achieved'.

Table 5 below outlined the strategies that were assessed as 'achieved', 'partially achieved' and 'not achieved'.

Figure 4: National Food and Nutrition Food 2013-2018 achievement levels

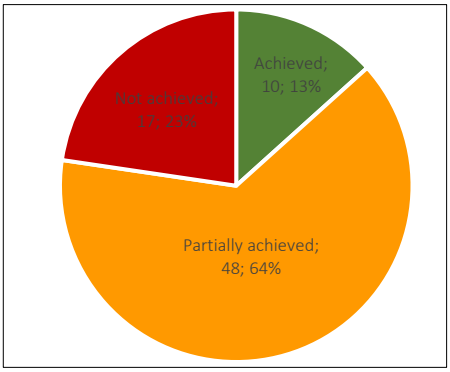


Table 5: National Food and Nutrition Action Plan 2013-2018 – strategies' achievement levels

Strategy	Indicators
Achieved	
1.2.4 Finalise, implement and enforce the draft Food (Marketing of Products for Infants and Young Children (IYFC) Regulations.	Regulations on Marketing of Food Products for Infants and Young Children finalised, implemented and enforced.
1.3.1 Implement research that establishes rates of malnutrition and micronutrient deficiencies and develops evidence for responding to the deficiencies.	Rates of malnutrition and micronutrient deficiencies established. Evidence based strategies available to inform programs for improving maternal and child health and wellbeing.

[v] For instance, MAF is looking at revitalising the tobacco planting in Samoa for economic reasons, while MoH has been pushing for more tobacco controls including limiting local tobacco growing. Similarly, MCIL is promoting free market economics (e.g. removing price controls for all foods because of free trade and other economic reasons) while MoH is pushing for more price controls on unhealthy foods.

1.3.4 Finalise, implement and enforce the Food Safety and Quality Regulations specific to the fortification of flour, rice and iodisation of salt.	Fortified flour and rice and iodized salt only products available.
1.4.3 Build capacity for education sector to respond to health promoting school model.	Evidence of food and nutrition education and promotion being delivered by teachers in schools. Teachers attend accredited workshops offered overseas or locally to build capacity to deliver nutrition education.
2.1.4 Conduct a feasibility study to analyse the options for Samoa to consider in addressing nutrition related health problems and advise on policy direction to control diet related health problems.	Increased implementation of policy options to control diet related health problems.
2.5.1 Review and adjust import duties, price controls and taxes to increase availability of healthy foods and products that support healthy lifestyles.	Evidence of pricing that Supports healthy eating and lifestyles.
2.8.4 Advocate for regulations to prevent use of injurious packing material for packaging food and water and non-recyclable packaging.	Food System education available to the community.
3.1.1 Finalise and implement Food Bill and regulations.	Food Bill and Regulations adopted and implemented Reduced incidence of food borne disease reports.
3.1.2 Promote key messages on good hygiene and food preparation practices to reduce food borne related incidence in the community.	Improved food safety information and knowledge in the community.
3.3.1 Contribute technical and expert advice during national disaster relief efforts.	Reduced risk for food borne disease outbreaks during disasters.
Partially achieved	
1.1.2 Contribute technical and expert advice during national disaster relief efforts and monitor food and nutrition related issues for the Disaster Plan procedures.	Evidence of efforts to protect the community from public health risk during and following disasters.
1.2.1 Promote national and community support for and awareness about infant and young child feeding issues.	Evidence of increased national and community support for and awareness about IYCF as evidenced through community-led initiatives. A National approach to coordinating IYCF.
1.2.2 Collaborate with sector partners to ensure IYCF capacity building and continued education for health staff and other relevant stakeholders.	Increased IYCF content in pre-service and in-service education for health sector.
1.2.3 Build capacity for and monitor Baby Friendly Hospital Initiative (BFHI) and breastfeeding initiatives in other settings e.g. health centres, workplaces, community settings.	Baby Friendly and Breastfeeding Initiatives established in hospitals and other settings.
1.2.5 Strengthen protection of breastfeeding rights of working women.	Evidence of improved protection of breastfeeding rights for working women through national or settings-based policies.
1.2.6 Encourage research and monitoring of issues related to IYCF.	Increase in information related to IYCF to inform policy and Planning.
1.3.2 Establish routine data collection and reporting for on anaemia in pregnant women and young children.	Data on anaemia in pregnant women and young children routinely collected and reported.
1.3.3 Promote community awareness about the causes of and solutions for malnutrition and micronutrient deficiencies.	Evidence of strategies and activities implemented to increase community awareness about malnutrition and micronutrient deficiencies.
1.3.5 Advocate adequate iron supplements for deficient groups based on evidence.	Targeted interventions delivered for iron deficient groups in the community e.g. young children and pregnant women.
1.4.1 Collaborate with education sector on policy strengthening activities for food and nutrition.	Increased teacher capacity for cross curricula –nutrition strategy. Increased participation rates in agriculture learning.
1.4.2 Develop personal food and nutrition knowledge and skills for pre-school and school age children and families.	Food and nutrition knowledge and skills evident in pre-school and school children.
1.4.4 Promote local food education.	Increased child, youth and adult awareness of culturally specific foods and nutritional benefits.
1.4.5 Advocate for continued strengthening for the existing school curricula on nutrition in food and textiles, health, agriculture, environmental science and physical education.	Increased cross curricula on food and nutrition.
1.4.6 Promote food and nutrition policy to be embedded with national education strategies.	Compulsory School Nutrition Standards implemented across all preschools and schools in the education sector.
1.4.7 Advocate for tertiary scholarships to increase the nutrition skills in the workforce.	Increased number of students studying food and nutrition.

1.4.8 Collaborate with academic institutions to promote food system understandings.	Strengthened nutrition education streams within academic curriculum. Local food and nutrition courses available.
1.6.1 Advocate for and conduct research about people's attitudes to food and food consumption.	Increased data available about factors affecting food consumption and why people consume the food they do
1.6.2 Promote increased uptake of fruit and vegetables in the community.	Increased data available about factors affecting food consumption and why people consume the food they do.
1.6.3 Promote regular physical activity for improved physical fitness.	Increased percentage of population consuming at least 5 servings of fruit and vegetables per day.
1.6.4 Promote reduced smoking and alcohol consumption in the community.	Increased percentage of the population physically active.
1.6.6 Strengthen nutrition curriculum focus for health and allied health workforce training courses.	Decreased percentage of the population smoking and binge drinking.
1.6.7 Provide food and nutrition information to the community about the management NCD with a focus on diabetes.	Food and nutrition information with a focus on NCD distributed to the community.
1.6.8 Provide information to the community about the prevention of obesity in children.	Information about childhood obesity distributed to the community.
1.6.9 Implement and monitor salt reduction project strategy (ref. Best Buy).	Reduced salt intake.
1.6.11 Collaborate with sector partners for strengthening community-based approaches for reducing obesity.	Proactive community-based activities that promote the reduction of obesity.
1.7.2 Promote the business sector understanding of issues related to the food system.	Healthy lifestyle projects implemented by private and public sectors.
1.7.3 Collaborate with food safety partners to build food industry capacity to improve food safety.	Evidence of activities to promote understanding of the food system throughout the business sector.
1.7.4 Promote the use of locally produced foods by all food industry partners e.g. supermarkets, hotels, restaurants, small shops, government catering, institutions (hospitals, boarding schools).	Positive industry practice for food safety
2.1.1 Strengthen promotion of dietary guidelines.	Increased knowledge about dietary guidelines for promoting healthy food and healthy lifestyles
2.1.2 Collaborate with primary health care services sector to strengthen actions that reduce obesity.	Sector partners actively engaged in a coordinated response to reducing obesity in the community.
2.1.3 Strengthen capacity building actions for health workers on issues related to food trade and trade agreements e.g. WTO, PICTA.	Increased health worker. Knowledge about food trade, trade agreements and how they affect health
2.1.5 Promote transport systems improvement to link locally produced food to market and to promote economic gain.	Improved transport systems and greater access to local foods.
2.2.1 Advocate for more locally grown food.	Key messages promoted in the community that affect attitudes to food.
2.2.2 Collaborate with sector partners on key messages they could utilize to promote locally produced food.	Increased local food production.
2.3.1 Promote research and development of under-utilized indigenous nutritious crops and dissemination of findings.	Increased utilisation of Indigenous crops
2.4.1 Promote food preparation messages to the community focusing on lower fat, salt and sugar and safe food preparation.	Households using improved. Food preparations techniques
2.4.2 Advocate for new technology/ recipe modification to improve the nutritional quality of locally produced processed foods.	Improved variety of local food-based products and dishes which are healthy.
2.6.1 Advocate for research on access to and availability of food.	Information available for Promoting improved access to and availability of healthy local food and other healthy food options. Improved food quality and affordability.
2.7.1 Collaborate with sector partners on strategic directions for food sustainable systems approach.	Food system information will be available to the community and industry.
2.7.2 Collaborate with health sector partners to build capacity for continued sustainable food strategy implementation sector wide.	Food production according to nutritional needs of the population. Increased community awareness about the food system. Decrease reports of food wastage. Improved food system awareness in the community and business sector.
2.8.5 Advocate for recycling facilities which include food waste management.	Improved recycle packaging. Less use of injurious packaging.
3.2.2 Promote water quality awareness in the community.	Collaborative water management in the community.

3.3.2 Build capacity of food businesses on issues related to food safety.	High incidence of food safety compliance for food businesses.
3.4.1 Regular and planned testing for food contamination.	Reduced incidence of reports of food borne disease.
3.4.2 Monthly data collation of reports of food borne illness.	Monthly reports
3.4.3 Strengthen services for testing food contamination.	Improved capacity for food testing evident
3.4.4 Drive measures to reduce fish/seafood contamination through protection of marine areas.	Reduced incidence of food borne illness due to seafood consumption, especially consumption of crustaceans.
3.4.6 Promote safe water.	Improved water quality
Not achieved	
1.1.1 Collaborate with Disaster Advisory Committee on developing operational guidelines for nutrition and infant and young child feeding during emergencies in readiness for first response.	Operational guidelines developed to support a sector wide approach to managing disaster planning nationally.
1.4.9 Implement and monitor obesity reduction projects in pre-schools and schools.	Schools implementing projects which include strong evaluation project.
1.5.1 Promote dental health information.	Evidence of campaigns on dental health. Evaluation demonstrates increased dental health awareness in the community.
1.5.2 Improve maternal dental health information distribution.	Nursing workforce delivers antenatal education about dental health and relevant interventions for maternal health.
1.5.3 Advocate price control on dental products.	Price control implemented.
1.5.4 Identify dental research priorities.	Dental research plan developed.
1.6.10 Implement and monitor strategy to control trans-fatty acids in food supply.	Evidence of reduced trans-fat utilization across the food industry e.g. fast-food outlets. Evidence of reduced trans fats in imported foods.
1.6.12 Develop and promote strategies to control the marketing of foods and non-alcoholic beverages to children.	Reduced “junk” food promotion to children in various settings, e.g. Prime TV time, schools, sports.
1.7.1 Promote healthy lifestyle improvement projects amongst private and public sectors e.g. healthy workplaces.	Healthy lifestyle projects implemented by private and public sectors.
1.7.5 Strengthen capacity building for food importers, distributors and processors on ways to reduce fat, trans fatty acids, salt and sugar in food products.	Reduced levels of fat, trans fatty acids, salt and sugar in food products
2.7.3 Promote environmental health models that integrate food and nutrients for built, natural, social and economic areas.	Sustainable food system awareness
2.8.1 Promote education and awareness about food waste and its impact on the environment.	Increased community awareness about sustainable food.
2.8.2 Advocate for research that informs health sector partners about sustainable food.	Improved land use. Reduce impacts measurable on the environment.
2.8.3 Advocate for community awareness programs for food system responsibility.	Food system education available to the community.
2.8.6 Drive national and Pacific regional policy development for continuous improvement for the reduction of greenhouse gas emissions and management of land fill.	Collaborative solutions for the management of environmental challenges relating to the food system will be developed.
3.2.1 Promote awareness about the dangers of unsafe pesticide use.	Increased awareness about the dangers of unsafe pesticide use in the community.
3.4.5 Monitor pesticides levels in food.	Reduced levels of pesticides in foods.

These findings should be interpreted with cautious given that most strategies outlined in the NFNP Action Plan 2013-2018 are ongoing work of the MoH and its implementing partners - as part of their normal and routine responsibilities, such as work undertaken for health promotion, awareness and advocacy; health regulatory control, enforcement and monitoring; capacity building; and service delivery. Hence strategies should not be strictly assessed as ‘completed’ (as in the case of a project activity completion), but should be assessed in terms of their indicative impact on any improvements achieved in relation to the change being made, and at which level that such a change takes place and is being institutionalised – individual, organisation, sector, community and national levels.

2.2.4. Efficiency

There are no timelines for the implementation of the different 75 strategies of the Action Plan of the NFNP 2013-2018, except for the timeframe of the Policy which is 2013 to 2018. The discussions during the consultation indicated that there has been limited efforts to try and address this gap – to operationalise the NFNP Action Plan, by identifying concrete actions that are needed, realistic timelines, as well as estimated costs for implementation of the NFNP Action plan. The NFNP Action Plan as a whole was left in its entire original design/format, without much attention given to adapt and revise it, to what can be implemented within existing capacities and resources, and within given timelines.

Further, the link of the NFNP and its Action Plan to the MoH and implementing partners' national budgets (during the 2013-2018 years) is weak. In matching the NFNP 2013-2018 and the approved budget estimates for the MoH and MAF during this 5-year period, 'improving food and nutritional security (through agriculture)' and 'compliance with school nutritional standards' were the only two performance measures (relating to the NFNP) adopted and mentioned in the national budgets of all the five years of the NFNP 2013-2018.

In spite of these limitations, the overall assessment of the NFNP 2013-2018 provided in section 2.2.3 above, is indicative of the efficiency level of the NFNP 2013-2018. With only 10 (or 13% of) strategies achieved, 64% partially achieved, and 23% not achieved, these findings demonstrate a slow progress with the implementation of the majority of the strategies identified under the NFNP Action Plan 2013-2018.

2.2.5. Impact

The NFNP's (2013-2018) vision is 'nutritional health for Samoa'. The mission is 'access to safe, affordable, nutritious and sustainable food'. It has 19 goals altogether (see Figure 2). The fact that there is no M&E Framework of the Policy and Action Plan, including the absence of governance mechanisms and implementation arrangements for the M&E of progress and achievements, and for addressing issues encountered during the implementation process, it is difficult to identify (based on documented evidence) any impact made as a result of the implementation of the NFNP and its Action Plan.

Nevertheless, this Review has identified based on the consultation and desktop review, some positive impact (at the output levels) that has been made to strengthen the focus and movement towards improving food and nutrition in Samoa. These include:

- Improved recognition across the sector (partners) of the health burdens that Samoa faces and the contributing nutritional issues and challenges.

- Strengthened evidence-based analyses, with more research and studies undertaken to inform policy options and strategies that Samoa needs to adopt to combat health, food and nutrition issues and challenges.

- Increased recognition of the nutritional value and security of local food, with ongoing efforts to look at improving the accessibility of value added (local) food products for consumption.

- Strengthened legislative framework for food safety, with plans to adopt and develop more food standards for Samoa.

- Increased emphasis to integrate a nutritional component in programs aiming at reducing NCDs prevalence (e.g. PEN *Fa'aSamoa*) through the focus on revitalisation of primary health care and public health.

- More recognition of the need to work as a sector in addressing food and nutrition issues in Samoa. There are some ongoing efforts to collaborate when needed on issues through existing governance and policy mechanisms such as the Samoa National Codex Committee and National Working Committee on Trade Arrangements (NWCTA).

- Ongoing movements to maneuver and adjust Samoa's fiscal policy (e.g. through taxation) as national policy efforts to address Samoa population's nutritional and unhealthy lifestyle challenges.

If the NFNP 2013-2018 is assessed at the outcome level, and is assessed strictly against Samoa's nutrition indicators revisited under previous section 1.2.2, then it can be said that Samoa has not made any progress in improving these indicators. In fact, the situation for nutritional health in Samoa has deteriorated given increases in NCDs risk factors. In this regard, one can argue that the NFNP has not contributed to the vision of improved 'nutritional health for Samoa' and mission of improved 'access to safe, affordable, nutritious and sustainable food'. However, establishing a strong connection between the implementation of the NFNP 2013-2018 and current nutrition indicators (outlined under section 1.2.2) is difficult to make given the limitations with M&E - to properly provide a fair assessment of the NFNP's progressive contribution to Samoa's existing and future nutritional health situation.

2.2.6. Sustainability

The sustainability of the implementation of some of the key strategies (e.g. enforcement of food legislation, developing and implementing further food standards, and improving access to affordable nutritious food) is questionable, given limited current capacity (number and expertise). This signifies the need to re-assess and improve existing and needed policy, regulatory, monitoring and collaborative capacities of key implementing agencies across the sector so that they have the capability to develop and implement food and nutrition policy options and programs.

Addressing food and nutritional health challenges and issues, and improving 'access to safe, affordable, nutritious and sustainable food' is a never ending process for Samoa. This ongoing developmental process is to be adopted and promoted in the formulation and implementation of appropriate policy responses, including the design of performance outcome and output level indicators for the measurement of progress and achievements made in addressing nutritional challenges and issues. Progressive achievement of the NFNP 2013-2018 vision, mission and key result areas including effective implementation of all the strategies outlined in the action plan require long-term sustained collaborative efforts amongst key health sector partners. Efforts need normalisation and institutionalisation into policy and implementation processes of key implementing agencies, with leading authorities (such as MoH, MAF, Ministry of Commerce, Industry and Labour (MCIL), and others) driving, facilitating and monitoring those processes.

2.3. Key issues, challenges and lessons learnt

The consultation and desktop review highlighted several key issues, challenges and lessons learnt with the adoption and implementation of the NFNP 2013-2018, which should be taken into account in the development of the next NFNP for 2021-2026. These are discussed in the following sections.

2.3.1. Shared understanding of the policy and its implementation

The NFNP 2013-2018 Key Result Area 1 is 'collaborate with health sector partners' – 'build a strong association and collaboration between MoH and its partners where there is an exchange of information about programs and research that can benefit common goals across portfolios.' This collaboration is essential given the national and multi-sectoral focus of the NFNP and its action plan – where the required

shared understanding and ownership of the strategies and the collaborative efforts of responsible agencies are built and fostered for the implementation of those strategies.

However, the consultation with responsible agencies of the NFNP Action Plan 2013-2018 revealed that the majority (approximately 80%) of those agencies did not know that this Policy was in existence – that such a Policy was in place to guide developmental work in food and nutrition for Samoa. Given this lack of awareness about the NFNP, they were poorly informed about the NFNP strategies that were earmarked for implementation by their respective agencies:

> *I am not aware of this Policy. This is the first time I saw it, when you sent it yesterday. Having gone through it now, I can see that our connection is breastfeeding and maternal health* [MoH clinical staff]

Having a shared and consistent understanding of the Policy is essential for building ownership of the strategies; what is expected to be implemented by different implementing agencies. Given that each agency/ministry often operates within own territorial institutional settings and within specific mandates, portfolio set-ups and work plans, it is important that once a policy is launched and initiated, a process of vibrant dialogue/communication (and through regular monitoring) is undertaken, to ensure that all key implementers are kept well-informed and be reminded of their responsibilities and obligations as expected and agreed to under the endorsed policy.

2.3.2. Multi-sectoral leadership and governance for effective and efficient implementation

This lack of awareness and understanding of the NFNP signify the limitations with having the needed multi-sectoral leadership and governance for the Policy – to facilitate the multi-sectoral approach that is required for the implementation of the Policy, through collaborative efforts among key implementation agencies of the (health) sector. Implementing agencies expected MoH to take on the leadership role to initiate and facilitate the necessary collaboration and required governance mechanisms for the Policy and its implementation. However, the collaboration which was expected to be driven from MoH as the lead agency of the NFNP was lacking, and was identified as the fundamental issue impacting on the effective and implementation of the NFNP 2013-2018 and its action plan:

> *I have been here for 10 years and we have not seen this policy. We can see that this policy is relevant to us. For this policy to work, we need the collaboration, and that is for MoH to initiate. We need to have a policy that forces us to collaborate on this. There is a lot of discussions but there is not enough collaboration. We can see a lot of research mentioned in the Policy. But there is no collaboration and no funding. For example, with trans-fat there has never been an analysis done on that. We are conducting research on the nutritional value of fermented coconut cream. And we have a lot of other similar research proposals but there is no funding to implement.* [Health sector implementing agency]

With the enactment of the Food Act in 2015, it establishes (under section 18) a Food and Nutrition Policy Committee (FNPC) that provides advice to the Director General (of Health) on any matter dealing with the Food Act as referred to it under a term of reference issued by the Director General. The other function of the FNPC specified under the Food (Safety and Quality) Regulations 2017 is determining any food or class of food to be listed in a high risk food list and/or a food list of regulatory interest. The FNPC consists of the MoH (chairperson), MAF, MNRE, Samoa Tourism Authority, MCIL, Ministry of Revenue (now called the Ministry of Customs and Revenue (MCR)), MESC, a body responsible for national food standards, and a private-sector body responsible for food consumers. The FNPC must meet once every three months.

The consultation and desktop review confirm that the intention of establishing the FNPC under the Food Act 2015 is to provide for the needed multi-sectoral governance and leadership for food and nutrition in Samoa, given the multi-sectoral coordination and collaboration that are required to address the complex challenges and issues that Samoa faces with food and nutritional health. However, the FNPC has not yet been establishment – and there appeared have been limited movement to have this national multi-

sectoral governance mechanism for food and nutrition activated and utilised for the above purpose. This body/committee could have provided the much needed multi-sector governance and leadership for the implementation of the NFNP and its Action Plan 2013-2018.

Given that the challenges and issues concerning food and nutritional health in Samoa go beyond the mandate and capacity of the MoH, and that a multi-sectoral approach is required, the FNPC must be established as a matter of urgency. The FNPC can provide the governance and collaborative mechanism where the mandates, capacities, strengths, and resources of different key actors are pooled together to address the key issues and to provide coordinated responses. The needed comprehensive dialogues on issues, consensus building on appropriate policy responses, clarification of implementing roles and expectations, and mapping progressive efforts are areas that should be considered and discussed widely through this FNPC multi-sectoral governance mechanism.

It is crucial that this gap/issue is addressed in the adoption and implementation of the NFNP 2021-2026 if MoH and its partners are serious about improving the effective and efficient implementation of food and nutrition targeted strategies, and to address the burden of NCDs and unexpected emerging and re-emerging of communicable diseases.

2.3.3. Policy design and implementation

The gaps identified under section 2.2.2 above with the formulation/design of the NFNP and its action plan 2013-2018 must be considered and addressed in the formulation/design of the next NFNP 2021/2026. The Action Plan must identify activities, indicators and targets that are SMART (Specific, Measurable, Attainment, Relevant and Time-Bound). At the same time, the NFNP document should be treated as a living document where ongoing revisions are made and ongoing thinking about what will work and not work are clarified through detailed operational work plans and other supporting documents such as concept notes, briefs, terms of references and others.

> *We have a contribution to that policy. But the overall implementation of the policy through work plans has been ineffective. As implementing agencies that is leading this, MoH needs to drive it. Second, these actions should be reviewed. Because some overlap and some are unrealistic. It's being there for a while.* [Health sector implementing agency]

Further, a specific focal point, as the lead implementing agency/partner for each strategy/activity should be clearly identified. This will address the issue of having too many identified 'responsible agents' (under the NFNP 2013-2018) which has caused confusion about implementing roles of the NFNP 2013-2018. A focal point (a section and person(s) within the MoH being the lead authority of the NFNP) should be identified, whose role is to take primary responsibility in facilitating the implementation of the Policy and its Action Plan, through the multi-sectoral wide approach. The consultation shows that there was not consensus among MoH staff about who has direct responsibility for this role – to take charge with facilitating and monitoring the implementation of the NFNP. Some pointed to the Strategic Policy, Planning and Research Division (SPPRD) while others stated that the Nutrition Section (of the HPED) has that implementation facilitating role.

Moreover, implementation arrangements for the Policy and Action Plan should be well articulated and communicated to all key implementing partners so that there is a consistent and shared understanding about what is needed to progress the implementation process. Those arrangements address the 'how' question of implementation - what needs to be in place (governance and leadership, collaboration, financial and physical resources, capacities, etc.) to enable implementation. Many of the people consulted indicated that the NFNP 2013-2018 provided the appropriate strategies for addressing food and nutrition in Samoa, however given lack of attention to implementation arrangements as well as

limited awareness and understanding about is to be implemented by the specific agencies and across the sector, the policy had existed mainly as a paper document.

2.3.4. Monitoring and evaluation - evidence-based reporting and learning

Continuous improvements in policy and implementation efforts require a robust M&E process to provide evidence-based learnings, gaps identification, and the way forward. There were no M&E reports made available during the time of this Review which highlighted the absence of having an M&E process for the NFNP and its Action Pan since its inception and during its five-year lifespan. There are no specific guidelines for M&E in the NFNP 2013-2018 document, which is being identified as a weakness in the design of the policy. Lack of ownership of the NFNP, competing priorities, and limited M&E capacity were identified as contributing factors to these gaps.

The effective and efficient implementation of the next NFNP will depend on the leadership of the MoH and its key implementing partners ensuring that an M&E framework is developed and implemented as an integral and integrated component of the NFNP and its Action Plan. The development and implementation of the next NFNP must address the above factors which has contributed to the lack of having a robust M&E process for the Policy. The FNPC, when activated as the multi-sectoral governance for the NFNP; providing the overall required strategic leadership for the implementation and operationalisation of the Policy, should be tasked with the role of providing strategic M&E oversight of the NFNP implementation. The performance of the M&E role at the operational and reporting levels is the responsibility of the MoH HPED and SPPRD.

2.3.5. Capacity building

Implementation is deemed to fail if there is not enough attention given to the required capacity on the ground to implement. One of the key issues emerging from the consultation that impacted on the effective and efficient implementation of the NFNP and will continue to affect the implementation of the next NFNP is insufficient capacities. The NFNP outlined many developmental areas, with some assessed as fairly new initiatives or undertakings[vi] in Samoa, and these are expected to be developed and implemented within existing capacities of the MOH and its implementing partners.

For instance, the Food Safety Act 2015 and Food (Safety and Quality) Regulations 2017 have been expected to be enforced by only three existing staff within the HPED, on top of other regulatory responsibilities such as tobacco control, port health, school health, and other public health and environmental health areas in general. The same staff are also responsible for policy monitoring and reporting, as well as health promotion, awareness, and education at the community levels. As well, the nutrition section has only three qualified nutritionists servicing the whole country. With the HPED being the MoH focal point for national public health response, the performance of the HPED's core policy and regulatory functions have been on hold for months since the COV-19 started. Staff capacity limitation is an issue that needs serious attention in order to address effective and efficient implementation of food and nutrition policies and strategies in Samoa:

> *I understand the lack of staff. They need to have at least 10 (health) inspectors in my views – there are doing so many things. But there is only Edward and a few others. This issue needs a stronger recommendation for consideration.* [Health sector implementing agency]

There appeared to be a duplication of functions and duties undertaken by staff working in different divisions (e.g. between HPED and 'National Disease Surveillance and International Health Regulations

[vi] E.g. development and monitoring of food standards, regulating and capacity building for the food industry, and research into food with more nutritional value.

Division' (NDSIHRD), and Quality Assurance & Infection Control) of the MoH, which appeared to contribute to the unnecessary overlaps in work, ineffective division of labour, and poor utilisation of existing manpower, skills and resources. There are also issues concerning the ad hoc pulling of staff from performing their core roles to perform project implementation roles (in order to meet project funding requirements and deadlines), leading to neglected performance of core line responsibilities and services.

For instance, while existing school nursing staff existed with the community nursing section, one staff of the Quality Assurance section was tasked with the implementation of a school nursing project, she no longer performed school nursing responsibilities once the project completed. Similarly, the NDSIHR undertakes water quality and food borne disease monitoring/testing, while the HPED undertake food safety monitoring/testing in general which includes food and water. Given the lack of qualified public health staff in the MoH, it is important that there is a proper examination of the structures, functions and operations of these divisions/sections as to identify better ways of allocating and utilising limited resources and staff on the ground doing the implementation work.

> *This issue of pulling people to do work that do not strictly fall under their mandated functions is an ongoing issue here – because it runs through every divisions – to multitask.* [MoH staff]

> *It's a matter of delegation, organisational structuring, and management of work. That is why they are fatigue. Like [name omitted], she's doing work that should be done by another person. With our work on the NEOC (COVID-19), we can see the issues MoH faces, it's all over the place. They must look at the structure to clarify functions and roles of each individual staff.* [Health sector implementing agency]

There was no costing plan or budget for the NFNP, which is a serious problem given expectation for effective and efficient implementation and to see results. If there is limited funding commitment for the Policy, then there is limited resourcing for implementation. As mentioned by one of the informants in their comments quoted under section 3.2.2 above, there is a lot of needed research, but there is no funding for implementation. It is obvious (from the desktop review and consultation) that most projects and activities, especially recently developed initiatives (e.g. food taxation, research, health promotional activities, salt project, school gardening, and PEN Fa'aSamoa, etc.)[vii] that were implemented were those that received additional financial support from development partners. However, while these types of funding support have assisted to a large extent to the implementation of needed health programs and projects, they do have the downsides of being ad hoc, unpredictable, and short term in focus.

> *The strategies under the Policy are valid, but implementation and reporting are problematic. The Ministry of Finance will not give us a budget allocation, unless we provide clear performance measures, like how much is our dental health service coverage in Samoa. We do not have those and we do not have funding to implement those strategies. WHO used to give us funding for community outreach but it got discontinued. Our current dental outreach coverage across the whole of Samoa is only 20%.* [MoH staff]

Given ongoing resourcing constraints, key agencies of the health sector recommended strengthening collaborative efforts amongst key sector health partners as a way forward for the Policy. This collaboration will facilitate discussions on ways in which functions and services could be better shared amongst partners of the sector, thereby sharing the workload and minimising unnecessary duplications of work. For instance, the collection of water samples is undertaken by three different government ministries – MNRE, MoH and Samoa Water Authority (SWA) – and are provided to SROS for quality testings. Questions were raised about the responsibility of allocating the collecting of water samples for water safety and quality testing to SROS, provided that a clear partnership is formed between agencies/ministries to clarify roles, responsibilities, and standards:

[vii] PEN *Fa'aSamoa* has been implemented with financial support from the World Bank. The Salt Project was implemented with funding support from the Australia's National Health and Medical Research Council. School gardening (called school feeding) program was implemented with financial support from the SACEP - Samoa Agriculture Competitiveness Enhancement Project (World Bank funded). Some of the health promotion activities are also funded with assistances from FAO and WHO.

Given their short staff, only three people for food safety, we are wondering whether MoH maintains the policy role but gives us water sample collection and testing to do on their behalf, and they get the reports. [Health sector implementing agency]

2.3.6. Modality for implementation

There was consensus support from all stakeholders consulted for the NFNP to continue to provide strategic guide on policy responses addressing food and nutrition related health problems in Samoa. All the strategies outlined in the NFNP 2013-2018 remain valid for continuation - but they are complex efforts requiring sustained multi-sectoral leadership and resourcing commitments over the long term for effective implementation and for any impact to materialise.

Given limited resources within national budgetary provisions, key implementing agencies must be proactive (especially the MoH as the lead agency) in seeking program funding support from development partners, as another modality to foster the implementation of the NFNP and its action plan. This programmatic approach (translating key strategic policy priorities into programming initiatives) of the NFNP needs to become a vibrant process, where partnerships and collaboration (among health sector partners and development partners and agencies) are facilitated and formed, for the localisation and operationalisation of the high level strategies in the NFNP, which in turn provided additional resources (funding, technical assistance and staff, and operational resources) to enable and support implementation on the ground. The discussions however highlighted that more work is needed to strengthen the adoption of such a programmatic approach for the NFNP:

Ministries are still not proactive to tap into the expertise we have. We can be here forever, but if they do not come to utilise it, then we can only do so much. Food and nutrition cover not only MoH and MAFF, but a lot of other agencies, MCIL, MoF, SROS and others. So the opportunity is here but it is not utilised properly. They need to be more proactive in order to implement that Policy. Most of the projects that we have with them are those we initiate through our own interventions, because we could not wait for them. We need the food and nutrition strategies to be programmatic. [Health sector development partner]

If there are projects activated from MoH that is where we build our collaboration... to build the implementation focus. We are not in a position to be proactive to do food testing and all that, unless the client requests them, and unless we do it as a part of a project, to do research for instance, such as the salt project. [Health sector implementing partner]

2.4. Summary

Based on the overall findings of this Review, Table 6 below gives the overall assessment ratings of the NFNP 2013-2018, which show an overall achievement rating of 2.6 for the NFNP implementation:

Table 6: Assessment rating of the National Food and Nutrition Policy 2013-2018 implementation

Criteria	Assessment/rating (out of 5)
Relevance and appropriateness	4.0
Effectiveness	2.5
Efficiency	2.0
Impact and sustainability	2.0
Total	**2.6**

The MoH and its partners must continue the progress made under the NFNP 2013-2018, and this includes taking into account the key learnings from the implementation of the NFNP 2013-2018.

3. CONCLUSION - RECOMMENDATIONS & WAY FORWARD

3.1. Introduction

Taking into account the findings of the Review of the Samoa National Food and Nutrition Policy (NFNP) 2013-2018 as presented in the previous Section 2, this section provides recommendations on areas to consider in the development of the next NFNP for 2021-2026.

3.2. Recommended areas for improvement

The next NFNP 2021-2016 should continue to support the implementation of food and nutrition development initiatives in line with the government policies and plans such as the Strategy for the Development of Samoa 2016-2020 and Health Sector Plan 2019-2030. It should align, complement and support relevant development priorities of other sectors (particularly the Agriculture; Trade, Commerce and Manufacturing; Education; Community Development; Water; Environment; and Tourism) as outlined in their strategic plans and policies.

Key areas needing improvement in the health sector's policy efforts aimed at strengthening food and nutritional health in Samoa are identified in the following sections:

3.2.1. Multi-sectoral leadership and governance

a) As a matter of priority, establish and activate the Food and Nutrition Policy Committee (FNPC) as required under the Food Safety Act 2015, to provide needed multi-sectoral governance and overall public policy leadership for food and nutrition in Samoa.

b) As part of recommendation a), develop a Terms of Reference for the FNPC to be endorsed by the Director General of Health and approved by the FNPC once it is activated.

c) Through the FNPC, build collaboration amongst the sector partners about food and nutrition issues and challenges as well as appropriate policy responses/interventions that are needed to address those issues and challenges.

d) MoH to strengthen its leading and facilitating role in driving the implementation of the NFNP across the health sector.

e) FNPC to adopt the NFNP and its action plan as its national or sectoral action plan or work plan, with the Committee providing strategic oversight, multi-sectoral governance mechanism, and leadership guidance for the implementation, monitoring and evaluation of the NFNP.

f) Health Promotion and Enforcement Division (HPED) to provide effective and efficient secretariat role to the FNPC, with regular monitoring and evaluation (M&E) reports to be provided to the FNPC meetings on progress made with the implementation of food and nutrition interventions in Samoa.

g) Use the FNPC as a national and sectoral mechanism to build the need policy discourse on food and nutrition including the right messaging for building civic education and awareness.

3.2.2. Shared policy ownership and understanding

a) Build shared ownership and understanding of the NFNP through inception briefings, quarterly meetings of the FNPC, undertaking of a robust monitoring process (M&E), and using the NFNP as

a strategic framework to guide implementation of programs and projects aimed at addressing food and nutrition issues across the sector.

b) Carry out regular updates with key implementing staff across the different agencies on the implementation of the NFNP, to discuss progress made, issues encountered, collaboration required and needed changes in activity implementation modalities.

c) Strengthen communication of progress made on the implementation NFNP, highlighting results, achievements, and ongoing challenges.

d) MoH to consider the establishment of an internal policy committee, with membership comprising of all focal points of all policy areas, to be used as the M&E committee for all policies.

3.2.3. Policy design/formulation

a) Ensure alignment of the NFNP to all national sectoral plans and policies to avoid and address duplications, overlaps and contractions.

b) Policy formulation to ensure the identification of activities/actions to be implemented within specific timelines and with a specific leading implementing agency.

c) Policy design to ensure the inclusion of an M&E framework with SMART (Specific, Measurable, Attainment, Relevant and Time-Bound) performance indicators corresponding to the action plan.

d) Policy design to clearly designate a focal point in the MoH with the primary role of ensuring that the implementation of the NFNP does take place, and this includes facilitating the needed processes and mechanisms to initiate, progress and continue the implementation stage.

e) MoH (focal point) to ensure operationalisation of the NFNP through detailed work plans including the use of concept notes, briefing papers, terms of references, and other simple formats – to further unpack what is needed to progress implementation of a specific strategy, activity or action.

f) Policy design to clearly outline implementation arrangements for the NFNP which should be inclusive of governance structure, partnerships, and collaboration, resourcing/financial, people capacity, other resources, M&E and reporting, and others.

g) The NFNP to be promoted and treated as a living document that is to be continuously reviewed and updated to ensure relevance, and to adapt to changing priorities and other changes in the policy environment.

h) NFNP design to identify manpower and capacity gaps and requirements, including technical support for the effective and efficient implementation of the NFNP.

3.2.4. Implementation and capacity building

a) The design of the NFNP to include a full costed implementation plan inclusive of the needed budget, staffing requirements, technical inputs, and operational costs.

b) Use the FNPC and other existing governance mechanisms (e.g. National Code Committee, Pesticide Committee, Agriculture Sector Coordinating Committee, and others) to promote the implementation of the NFNP.

c) MoH Strategic Policy, Planning and Research Division (SPPRD) to ensure that M&E of the NFNP is carried out in accordance with the required policies and procedures of the Ministry and other implementing partners in the sector.

d) MoH NFNP focal point to drive and lead the implementation of the NFNP through communication, facilitation of what needed to be done, and M&E.

e) Continuously revisit the NFNP action plan (and report on revisions made) in order to identify what can be realistically implemented and achieved within existing capacities and resources.

f) Monitoring of the alignment of the NFNP to all national sectoral plans and policies in order to address duplications, overlaps and contractions.

g) Conduct a job analysis and organisational structure review of the MoH to identify unnecessary overlaps and duplications of functions, roles, and work and to identify areas where manpower and resources could be better utilised.

h) Consider the impact on core service and roles of the ad hoc pulling of core staff towards project-based works and matters of urgency.

i) MoH to strengthen M&E reporting on the NFNP implementation progress.

j) Adopt a programmatic approach among the health sector for the NFNP in order to facilitate the availability of financial support/development assistances for the implementation and operationalisation of the NFNP action plan across the sector.

k) FNPC to discuss the sharing and pooling of resources amongst key implementing agencies for the implementation of strategies and actions that cut across the sector and which require collaborative efforts of more than one implementing agency/ministry in the sector.

l) Strengthen the linkages between policies and the national budgets of the MoH and other key implementing agencies of the health sector. This involves revisiting annual work plans and budget performance measures/indicators to ensure linkages to sector and agency performance indicators outlined in sector plans and policies.

3.2.5. Areas needing prioritised focus

All strategies outlined in the NFNP Action Plan 2013-2018 remain relevant. The Review however highlighted the following areas for priority consideration in the next NFNP 2021-2026:

a) Follow-up on the take-up and implementation of the recommendations of the 'study on options for controlling nutrition related health problems in Samoa'.

b) Strengthen the fiscal policy responses on food and nutrition, with strong push for increased taxation and price controls on food, in order to improve accessibility and affordability to healthy choices, and to discourage the consumption of unhealthy food.

c) A strong focus on childhood obesity as a matter of priority. This includes more work to strengthening nutritional approaches/responses on infant and young child feeding.

d) More health promotion and education to raise community awareness and understanding about food and nutritional health.

e) More research to build research and awareness about nutritious food and the health implications of what people are eating as their normal daily dietary intakes.

f) Promotion of eating healthy local food including working with MAF, MCIL, and other key actors on improving food availability and accessibility.

g) Enforcement of food legislation across the food industry, including the need to develop more food standards, and capacity building for the food industry.

h) Deliberate measures to address the impact of the influx of unhealthy food from overseas markets.

i) Work with communities on addressing their food and nutrition issues.

j) More work on the health promoting schools through strengthening partnerships with MESC.

3.3. Conclusion

This Review assessed the overall implementation the NFNP 2013-2018 as moderately successful (with an assessment rating of 2.6 (out of 5). Only 13% of the strategies of the NFNP Action Plan 2013-2018 were assessed as achieved, 64% were partially achieved, and 23% were not achieved.

Impacts made include increased recognition across sector partners of Samoa's nutritional health challenges; improved evidence-based knowledge about nutritional health given increased research focus; and increased recognition of the nutritional value of local food, including ongoing efforts to address accessibility of local foods for consumption. The legislative framework for food safety is being strengthened, with plans to improve food standards and to adjust fiscal policy to address nutritional and unhealthy lifestyle challenges. Integrating a nutritional focus in public health initiatives aiming at reducing NCDs is being emphasised. There are ongoing efforts to collaborate when needed through existing mechanisms (e.g. National Codex Committee and National Working Committee on Trade Arrangements).

Implementing agencies and stakeholders of the NFNP and health sector regarded the NFNP and action plan as highly relevant to Samoa's food and nutritional health development needs. Most of the strategies identified under the NFNP 2013-2018 still remain valid for continuous implementation. Addressing food and nutritional health challenges and implement initiatives to improve 'access to safe, affordable, nutritious and sustainable food' is a never ending process. Improving and sustaining implementation efforts requires a serious consideration of the key issues, challenges and lessons learnt identified through this Review of the NFNP and Action Plan 2013-2018. They include the need to build shared understanding and ownership of the policy and its implementation requirements, and building multi-sectoral leadership and governance for strengthening collaborative efforts on food and nutrition. It is important that gaps identified in this Review with policy design are considered and addressed. They include having clear activities for implementation, a proper M&E framework, and clarifying implementation arrangements and resourcing requirements. Attention to capacities and modalities for implementation is needed.

It is important that the MoH and its partners consider the review findings and recommended areas for improvements identified in this Review Report, for the ongoing improvement of food and nutritional health public policy efforts for a *Healthy Samoa*.

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Annexes

A: Terms of reference

Review of the National Food and Nutrition Policy 2013-2018 & Development of the National Food and Nutrition Policy and Plan of Action 2021-2026

SAMOA
HEALTH SECTOR PROGRAM

STRATEGIC LONG-TERM OUTCOME: 1
Improved Health Systems, Governance and Administration

A. Background

Non-communicable diseases (NCDs) continue to be the priority area of concern for the Health Sector in Samoa given its high prevalence in the population, contributing to premature deaths, morbidities, disabilities and loss of productivity. The WHO STEPS Survey 2014 revealed that 63% of adults (25-64 years) are obese, 24% suffer from high blood pressure, 49% have type 2 diabetes, 14% of adults have high risk level of cholesterol and 16% have moderate to severe mental disorder.[viii] Although there have been improvement in the health and life expectancy of people in Samoa, food and nutrition-related diseases continue to threaten long-term health and wellbeing. People's health and life expectancies are suffering due to poor nourishment and lack of food, or obesity caused by overeating and lack of awareness on healthy eating. What we eat and our nutritional status can also contribute to the development of cardiovascular diseases, some types of cancer and diabetes. Further to this, food choice is influenced by environmental and societal factors, hence the adoption of healthful behaviours of individuals may be made difficult due to the environments they live in.[ix]

The National Food and Nutrition Policy 2013 – 2018 was developed to facilitate and support action through the food and nutrition system so to achieve improved nutrition and health standards and outcomes for Samoa. The primary goal was to improve food systems across sectors with the goals to achieve a food system that is nutritious, affordable and accessible. This policy has now expired, hence requiring a *review* of the progress made so far in terms of the targets achieved within the policy timeframe. The *Full Review Report* will draw on the successes and challenges involved in the implementation of the Food and Nutrition Policy 2013 through programming, policies and practices. In addition, the *Full Review Report of the National Food and Nutrition Policy 2013-2018* will inform and provide the basis for the development of the *National Food and Nutrition Policy and Plan of Action 2021,* which will result in a framework that will guide the efforts of all stakeholders involved for better health outcomes in terms of food and nutrition in Samoa.

Conducting the Full Review Report of the National Food and Nutrition Policy 2013-2018 is significant in realizing the milestones achieved by the Ministry of Health (MoH) and our Health Partners as well as the risks and challenges involved in implementation which may have resulted in unmet goals and objectives of the policy. The development of the 3rd National Food and Nutrition Policy and Plan of Action 2021 – 2026 builds on the findings of the Review of the FNP 2013-2018 and the Full Review of the Health Sector Plan 2008-2018, in consultation with relevant health sector partners.

[viii] World Health Organization. (2014). *Samoa STEPwise Approach to NCD risk factor surveillance report.* Manila.
[ix] Booth SL, Sallies JF, Ritenbaugh C, Hill JO, Birch LL, Frank LD, Glanz K, Himmelgreen DA, Mudd M, Popkin BM, Rickard KA. *Environmental and societal factors affect food choice and physical activity: Rationale, influences and leverage points.* Nutrition reviews. 2001 Mar 1; 59 (3): S21-36.

In this respect, the MOH and the Secretariat of the Pacific Community (SPC) is seeking a Technical Assistant/Consultant to conduct the Review and Develop the new Food and Nutrition Policy for Samoa.

B. Objectives for the consultancy

To provide strategic advice and technical assistance to the Ministry of Health to conduct the Full Review of the National Food and Nutrition Policy 2013-2018 and develop the National Food and Nutrition Policy and Plan of Action 2021-2026

C. Scope of Services

The TA/Consultant will have the following specific tasks:

(i) Conduct the Review the National Food and Nutrition Policy 2013-2018, providing a comprehensive analysis of the achievements, challenges and gaps of the policy;
(ii) Consult with responsible agencies in gauging feedback on progress of the programs, activities and practices implemented in relation to the National Food and Nutrition Policy 2013-2018.
(iii) Conduct key informant interviews with relevant stakeholders during data collection process and report on findings after report is compiled.
(iv) Develop the National Food and Nutrition Policy and Plan of Action 2021-2026 collaboratively with the MOH, SPC and key stakeholders in Samoa, ensuring that the policy is aligned to national, regional and international strategies.
(v) Formulate an M&E Framework to track progress of policy implementation.
(vi) Assist the MOH in the public consultative process through technical input where necessary.
(vii) Incorporate comments from consultations to improve both the Review Report and new Policy.
(viii) Conduct overview of key findings for the information of the MOH Executive Management.
(ix) Build the capacity of the MOH HPE, HSCRM and SPPR Divisions in expediting the new policy.
(x) Raise the awareness of the responsible agencies regarding the new National Food and Nutrition Policy and Plan of Action 2021-2026, to strengthen collaborative and multidisciplinary approach to food and nutrition.

D. Key Deliverables

The expected outputs are:

1. Full Review Report of the National Food and Nutrition Policy 2013-2018.
2. National Food and Nutrition Policy and Plan of Action 2021-2026.

E. Duration of the assignment

The duration of this assignment is 4 months commencing from August to November 2020.

F. Institutional Arrangements & Reporting Relationships

The TA/Consultant will work closely with the MOH through the Director General of Health and SPC. Online (zoom) meetings will be hosted by the MOH and will be conducted preferably every two weeks or as needed, to update on progress of work, for the information of key stakeholders and SPC.

The Assistant Chief Executive Officers (ACEOs) of the 1) Health Protection and Enforcement Division (HPED) and 2) Strategic Planning Policy and Research Division (SPPRD) will be the counterparts.

B: Assessment – Implementation of national food and nutrition policy action plan 2013-2018

2013-2018 National Food and Nutrition Policy Action Plan				Assessment of the implementation of the 2013-2018 National Food and Nutrition Policy Action Plan			
Goal	**Strategy**	**Responsible Agents**	**Indicator**	**Questions**	**Implementation status [0 – 5 rating][x]**	**What has been implemented under the strategy to meet the goal? Evidence?**	**Comments / Issues affecting implementation and assessment**
Food, Nutrition and Health Action Plan							
1.1. Inform disaster risk management	1.1.1 Collaborate with Disaster Advisory Committee on developing operational guidelines for nutrition and infant and young child feeding (IYCF) during emergencies in readiness for first response (during initial rapid assessments).	MoH, MNRE/DMO, WHO, FAO, MAF, NHS, MWCSD, Samoa Red Cross	Operational guidelines developed to support a sector wide approach to managing disaster planning nationally.	Are these guidelines in place?	0	A nutrition guideline is in place. However, 'operational guidelines for nutrition and IYCF during emergencies are not yet in place.	Lack of effective coordinated mechanism on the NFNP and its Action Plan implementation.
	1.1.2 Contribute technical and expert advice during national disaster relief efforts and monitor food and nutrition related issues for the Disaster Plan procedures.	MoH, MNRE/DMO, WHO, FAO, MAF, NHS, MWCSD, Samoa Red Cross	Evidence of efforts to protect the community from public health risk during and following disasters.	How are these efforts and issues being monitored by these agencies?	3	These efforts are part of the ongoing responses coordinated through the disaster management committee (e.g. COV-19 National Emergency Operation C)	
1.2. Promote appropriate infant and young child feeding (IYCF)	1.2.1 Promote national and community support for and awareness about infant and young child feeding issues.	MoH, NHS, SFHA, Universities, WHO, SPAGHL, UNICEF, AUSaid, NZAid, MWCSD	Evidence of increased national and community support for and awareness about IYCF as evidenced through community-led initiatives. A National approach to coordinating IYCF.	How is this Strategy being implemented? Programs? Any studies about these issues and how they are being addressed. What is the evidence in place of increased national and community support for IYCF?	3	There has been a number of promotional activities (e.g. mass campaign on breastfeeding every year, collaboration with MWCSD on complementary feeding) for breastfeeding - with evidence provided by MoH nutrition section on these activities. However, it is difficult to establish the status of national and community support for and awareness about IYCF issues.	Lack of evidence about whether national and community support for and awareness about IYCF issues has increased.
	1.2.2 Collaborate with sector partners to ensure IYCF capacity building and continued education for health staff and other relevant stakeholders.	MoH, NHS, WHO, UNICEF, AUSaid, NZAid, MWCSD, SFHA, MESC, NUS, OUM	Increased IYCF content in pre-service and in-service education for health sector.	Is IYCF included in content of health education? How and to what extent?	3	According to the NUS calendar, Healthy Lifestyles; Physical Education and Health; Understanding Nutrition; Eating for Health, Food Technology, Nutrient Requirements throughout the Lifespan, Food and Nutrition Security, Soil Properties and Plant Nutrition & Metabolic, Nutrition, Body Systems Regulation are some of the courses offered. It is not clear how IYCF is addressed in these pre-service course	Difficult to address given lack of evidence about pre-service and in-service education on IYCF.

[x] *5 – Achieved (70-100%); 3 – partially achieved (50-69%); and 0 – not achieved (0-49%).* Rate between 0-5 (0, 1, 2, 3, 4, and 5) can be selected to indicate a fair assessment of the level of achievement for each strategy.

						programmes. In-service programmes are provided by the Nutrition Section of the MoH and the extent of the coverage and effectiveness of previous and existing in-service programmes is difficult to assess given lack of data/information.	
	1.2.3 Build capacity for and monitor Baby Friendly Hospital Initiative (BFHI) and breastfeeding initiatives in other settings e.g. health centres, workplaces, community settings.	MoH, NHS, WHO, UNICEF, SFHA, AUSaid, NZAid, MCIL, PSC	Baby Friendly and Breastfeeding Initiatives established in hospitals and other settings.	Evidence on the establishment of breastfeeding initiatives?	3	MoH reports show increased compliance with breastfeeding in the two main public hospitals since 2008, with 72% and 66% compliance (with the BFHI 10 steps to successful breastfeeding) in the MTII and TTM hospitals in 2014/2015. MOH staff interviews further validated this compliance level and indicated that hospitals and other health setting, workplaces and community settings in Samoa are not yet 100% baby friendly. Samoa's health indicators (see Table 2) show that 51.7% (2019) of babies are exclusively breastfed in Samoa, a decrease from 70.3% in 2013. The global average is 42.2%.	Due to limited information, it is difficult to assess BFHI and breastfeeding in other health settings (e.g. district hospitals and health centres) and including workplaces and community settings. Reports for years after 2014/2015 were not made available. The 26% drop in the exclusive breastfeeding in Samoa from 2013 to 2019 reflects that Baby Friendly and Breastfeeding Initiatives are not sufficient or mothers not fully realising the importance of breastfeeding.
	1.2.4 Finalise, implement and enforce the draft Food (Marketing of Products for Infants and Young Children) Regulations.	MoH, NHS, SFHA, GPs Association, MWCSD, MCIL, AG, MFAT, SCCI, media, WHO, UNICEF	Regulations on Marketing of Food Products for Infants and Young Children finalised, implemented and enforced.	Are these regulations in place?	4	Regulations have been drafted and are being translated into Samoan, ready to be submitted to Cabinet for approval.	Regulations were being translated into Samoan during this Review in October 2020.
	1.2.5 Strengthen protection of breastfeeding rights of working women.	MoH, NHS, WHO, UNICEF, PSC, AUSaid, NZAid, MWCSD, MCIL, SCCI	Evidence of improved protection of breastfeeding rights for working women through national or settings-based policies.	Evidence in place? And what are they? How do we know there is improvement?	2.5	Maternity leave and workplace breastfeeding policy provide for the protection of breastfeeding rights for working women. In Samoa paid maternity leave is 4 weeks in the private sector and 12 weeks in the public sector. The ILO Convention C183 stipulates a minimum paid maternity leave of 14 weeks. Samoa has not yet ratified ILO Conventions C183 and C103 on maternity protection. Interviews and observations show the absence of workplace breastfeeding policy and supportive practices to promote and encourage breastfeeding for working women and in workplaces.	Need for better documented evidence on the status of breastfeeding for working women.
	1.2.6 Encourage research and monitoring of issues related to IYCF.	MoH, WHO, UNICEF, MWCSD, NUS, OUM	Increase in information related to IYCF to inform policy and Planning.	Evidence of research and monitoring undertaken	3	There has been an increased in research relating to IYCF since the establishment of the OLAGA research centre with the	Limited documented evidence on how the monitoring of issues relating to IYCF is being

						MOH, in partnership with the Yale University. A number of publications from those research are cited in this Review Report.	undertaken, including key findings and recommendations from monitoring.
1.3. Prevent malnutrition and micronutrient deficiencies	1.3.1 Implement research that establishes rates of malnutrition and micronutrient deficiencies and develops evidence for responding to the deficiencies.	MoH, NHS, MoF, MWCSD, MESC, MNRE-soil, FAO, WHO, UNICEF, ICCIDD, AUSaid, NZAid, SROS, Universities, Red Cross.	Rates of malnutrition and micronutrient deficiencies established. Evidence based strategies available to inform programs for improving maternal and child health and wellbeing.	What are the rates? Are these established? Are these strategies in place? How well are being implemented?	3.5	OLAGA research, DHS-MIC (2019) and other studies (e.g. FAO/WHO) have established rates of malnutrition and micronutrient deficiencies in Samoa.	It is difficult to ascertain how these research (evidence) are being used to inform strategies and programs for improving maternal and child health and wellbeing.
	1.3.2 Establish routine data collection and reporting for on anaemia in pregnant women and young children.	MoH, NHS, MoF, WHO, UNICEF, AUSaid, NZAid, Samoa Red Cross	Data on anaemia in pregnant women and young children routinely collected and reported.	Are data available? What is the progress on this activity?	2.5	Data are mostly captured through national surveys (e.g. DHS) and research (e.g. OLAGA research).	There is limited routine data collection and reporting on anaemia in pregnant women and children.
	1.3.3 Promote community awareness about the causes of and solutions for malnutrition and micronutrient deficiencies.	MoH, NHS, o, MNRE-soil, FAO, WHO, UNICEF, AUSaid, NZAid, USP, NUS, OUM, Samoa Red Cross	Evidence of strategies and activities implemented to increase community awareness about malnutrition and micronutrient deficiencies.	What are the promotion that have been undertaken?	3	A number of health promotion activities/programs[xi] were carried out. However, it is not clear whether there is increased community awareness about malnutrition and micronutrient deficiencies based on those activities/programs.	Limited evidence made available to enable an assessment of strategies and activities implemented to increase community awareness about malnutrition and micronutrient deficiencies.
	1.3.4 Finalise, implement and enforce the Food Safety and Quality Regulations specific to the fortification of flour, rice and iodisation of salt.	MoH, AG, MCIL, FAO, WHO, UNICEF, AUSaid, NZAID, MOR, SCCI, SROS.	Fortified flour and rice and iodized salt only products available.	Are these regulations on fortification of flour, rice and iodisation of salt in place?	4	Food Safety Act 2015 and Food (Safety and Quality) Regulations 2017 are being enacted which incorporated provisions on fortification of flour, rice and iodisation of salt.	There is no evidence to indicate or show whether only fortified flour and rice and iodized salt only products are available in Samoa.
	1.3.5 Advocate adequate iron supplements for deficient groups based on evidence.	MoH, NHS, MCIL, FAO, WHO, UNICEF, AUSaid, NZAID, MESC, MWCSD, MNRE – soil SPAGHL, SCCI.	Targeted interventions delivered for iron deficient groups in the community e.g. young children and pregnant women.	What are the advocacies/ targeted interventions that have been undertaken on adequate iron supplements for deficient groups? Evidence?	2.5		Difficult to assess any targeted interventions undertaken on iron supplements for deficient groups (e.g. young women and children).
1.4. Strengthen food and nutrition education	1.4.1 Collaborate with education sector on policy strengthening activities for food and nutrition.	MoH, NHS, MESC, NCECE, Universities, Media, MOF, SPGHL, MAF, MCIL, MWCSD, FAO, WHO, UNICEF.	Increased teacher capacity for cross curricula –nutrition strategy. Increased participation rates in agriculture learning.	Evidence on Increased teacher capacity for cross curricula – nutrition strategy? Evidence Increased participation rates in agriculture learning?	2.5	As per comment under 1.2.2 above, course programs are being taught at NUS on food and nutrition. Efforts to increase teachers participating in health training overseas and locally and including outreach programs from the MOH staff.	Limited evidence available to assess whether there is an increased capacity for cross curricular-nutrition and increased participation rates in agriculture.

[xi] TV talk programs (e.g. *ete silafia* program on healthy eating), booths (e.g. PSC day, USP/NUS open day), health messages on TV (e.g. eat the rainbow), newspaper articles, radio spots, cooking shows (e.g. *kuka manaia*), nobesity school program, nutritional promotion materials (e.g. posters, pamphlets, and calendars), and celebration of special days – e.g. salt awareness week, world health day and world breastfeeding week).

						A partnership was formed with the SACEP (Samoa Agriculture Competitiveness Enhancement Program – World Bank funded) where fruit tree and vegetable seedlings were supplied to schools for planting – a pilot initiative in 2015/2017 to support agriculture learning and to promote local nutritious foods in schools.	
	1.4.2 Develop personal food and nutrition knowledge and skills for pre-school and school age children and families.	MoH, MAF, NGOs, MESC, Universities, Private and Religious Schools, NCECE, MCIL, MWCSD, FAO, WHO, UNICEF.	Food and nutrition knowledge and skills evident in pre-school and school children.	How is this being implemented? Evidence?	2.5	Example of activities undertaken to improve food and nutrition knowledge and skills in schools include the nobesity program, partnership with SACEP on healthy eating promotional activities and nutrition gardens in schools; physical activity and nutrition exhibitions; distribution of health and nutrition promotion materials, etc.	Difficult to assess the extent of food and nutrition knowledge and skills evident in pre-school and school children.
	1.4.3 Build capacity for education sector to respond to health promoting school model.	MoH, MAF, NUS, MESC, NCECE, Private and Religious Schools, MOH, WHO, FAO, NGOs.	Evidence of food and nutrition education and promotion being delivered by teachers in schools. Teachers attend accredited workshops offered overseas or locally to build capacity to deliver nutrition education.	What is the health promotion school model? Is this in place? And how is it being implemented? Evidence in place? Any teachers attending?	3.5	In addition to comment under 1.2.2 above on food and nutrition courses that being offered at the NUS, a Health Promotion School Networking (Guideline) is being developed. The School Nutrition Standards were developed in 2007, pilot tests from 2008-2010, endorsed by MOH and MESC in 2011 with ongoing regular revisions. MESC's School Management and Organisation Manual 2018 include minimum service standards for health and safety provisions for schools. Monitoring reports from MOH HPED show ongoing regular monitoring of schools for compliance with approved School Nutrition Standards.	
	1.4.4 Promote local food education.	FAO, WHO, UNICEF, AUSaid, NZAid, MESC, Private and Religious Schools, NCECE, MWCSD, MNRE, NGOs, WIBDI, SPAGHL, media.	Increased child, youth and adult awareness of culturally specific foods and nutritional benefits.	How? What is the evidence of the increased awareness?	2.5	Same comment as in 1.3.3. However increased awareness of 'culturally specific foods and nutritional benefits' is difficult to assess. There is a need to define what are 'culturally specific food and their nutritional benefits' and then conduct a survey/research to establish if there is an increased understanding of those food.	

	1.4.5 Advocate for continued strengthening for the existing school curricula on nutrition in food and textiles, health, agriculture, environmental science and physical education.	MESC, MoH, NUS	Increased cross curricula on food and nutrition.	How? What is the evidence of the increase?	2.5	Same comment as in 1.2.2 above. Food and textiles, health, agriculture, environmental science and physical education.	Difficult to assess whether there is increased cross curricula on food and nutrition – including the extent of their coverage/scope in teaching across all schools as well as student participation levels.
	1.4.6 Promote food and nutrition policy to be embedded with national education strategies.	MESC, Private and Religious Schools, NECEC, Academic Institutions, MoH, WHO, FAO	Compulsory School Nutrition Standards implemented across all preschools and schools in the education sector.	Are these standards in place? How are they being implemented? Reports? M&E?	3	The School Nutrition Standards (Booklet) 2012 states that 'it is compulsory for all government schools… to implement the standards. It is strongly recommended that all private schools and pre-schools implement the standards.	The standards do not have a regulatory enforcement basis; hence they can be regarded as voluntary. Monitoring reports show voluntary compliance of those standards across schools.
	1.4.7 Advocate for tertiary scholarships to increase the nutrition skills in the workforce.	MoH, NHS, MESC, MWCSD, MoF, MCIL, MAF, MFAT, Academic Institutions.	Increased number of students studying food and nutrition.	Any increase? Evidence?	3	The number of qualified nutritionists increased from 1 in 2013 to 3 in 2019. Nutrition assistants are being recruited and trained to assist with the shortage of qualified nutritionists.	Some qualified nutritionists are not recruited in the right areas of work due to lack of available established positions in the MoH to absorb returning graduates in nutrition.
	1.4.8 Collaborate with academic institutions to promote food system understandings.	MOH, MESC, SROS, Academic Institutions,	Strengthened nutrition education streams within academic curriculum. Local food and nutrition courses available.	Is nutrition education stream in academic curriculum? Any courses available locally?	2.5	As stated in 1.2.2 above, food and nutrition courses are available at NUS and in the school curriculum.	Lack evidence to substantiate the level of promotion and strengthening of the nutrition education streams in Samoa.
	1.4.9 Implement and monitor obesity reduction projects in pre-schools and schools.	MoH, MESC, Private and Religious Schools, NCECE, MWCSD, SPAGHL, Academic Institutions.	Schools implementing projects which include strong evaluation project.	What are these projects? What is the status?	2	The Nobesity program and PEN *Fa'asamoa* (district-based) are examples of projects aimed at monitoring obesity and NCD risk factors and which incorporated a nutrition focus. Based on the information provided, there are no specific projects/programs targeting obesity reduction in pre-schools and schools.	Due to limited evident it is difficult to assess the extent of any previous/existing projects aimed at monitoring obesity in schools. There is no M&E documentation on the nobesity program. The inclusion of the nutrition focus in the PEN *fa'aSamoa* is in early stages of its phase 2, hence it is too early to assess impact.
1.5. Strengthen promotion of dental health	1.5.1 Promote dental health information.	MoH, NHS, Dental Practitioners, MESC, NCECE, SCCI, Private and Religious Schools.	Evidence of campaigns on dental health. Evaluation demonstrates increased dental health awareness in the community.	What are the campaigns? Evidence of increased dental health awareness in community?	2	Discussions with MOH dental staff indicated the lack of focus on dental health awareness in the community over the recent years.	
	1.5.2 Improve maternal dental health information distribution.	MoH, NHS, Dental Practitioners, SFHA	Nursing workforce delivers antenatal education about dental health and relevant interventions for maternal health.	How? Evidence?	2	Difficult to assess due to limited information. But discussions with MOH staff indicated a lack of focus on dental health over recent years.	
	1.5.3 Advocate price control on dental products	MCIL, AG, MoH, NHS, Dental Practitioners.	Price control implemented.	Are these controls in place?	0	Has not been actioned based on discussions with MOH staff.	Lack of understanding about this strategy and what is needed to be implemented.

	1.5.4 Identify dental research priorities.	MoH, NHS, MESC, MWCSD, NGOs, Dental Practitioners	Dental research plan developed.	Research plan in place?	0	Has not been actioned based on discussions with MOH staff.	Lack of understanding about this strategy and what is needed to be implemented.
1.6. Promote healthy eating and lifestyles	1.6.1 Advocate for and conduct research about people's attitudes to food and food consumption.	MoH, NHS, MoF, MWCSD, Tourism, SPAGHL, WHO, FAO, Academic Institutions, NGOs	Increased data available about factors affecting food consumption and why people consume the food they do.	What are the advocacy and research that have been undertaken? Data in place?	3	Some research undertaken through the OLAGA research unit which has a major focus on maternal and children health.	More research is needed.
	1.6.2 Promote increased uptake of fruit and vegetables in the community.	MoH, NHS, MAF, MWCSD, MoF, MFAT, Tourism, NGOs, Media, SCCI, SPAGHL, Religious Organisations, Academic Institutions, WHO, FAO	Increased percentage of population consuming at least 5 servings of fruit and vegetables per day.	Any increase? Evidence?	2.5	Eat the rainbow, school nutritional gardens, cooking shows are some of the health promotion initiatives undertaken by MOH to promote increased uptake of fruits and vegetables. However, the DHS 2014 and DHS-MICS 2019 show declining intake of fruits and vegetables in the community, by both men and women.	
	1.6.3 Promote regular physical activity for improved physical fitness.	MoH, NHS, MOF, MWCSD, Tourism, SPAGHL, Sports Organisations, Religious Organisations.	Increased percentage of the population physically active.	Any increase? Evidence?	2.5	MOH has been implementing programs (e.g. Nobesity, Zumba and health challenge) to promote physical activity in Samoa.	However, limited documented evidence makes it difficult to identify or assess any increased percentage of population physically active.
	1.6.4 Promote reduced smoking and alcohol consumption in the community.	MoH, NHS, MoF, MWCSD, MESC, Tourism, SPAGHL, Religious Organisations, Sports Organisations	Decreased percentage of the population smoking and binge drinking.	Why is smoking and alcohol mentioned in here?	2.5	Research, studies and assessments have shown decreasing percentage of population smoking but increasing percentage of population with alcohol consumption.	
	1.6.6 Strengthen nutrition curriculum focus for health and allied health workforce training courses.	NHS, MOH, NUS, OUM	Highly skilled health workforce able to deliver food and nutrition education in the community / primary health care.	Are these education/training courses delivered? Evidence	2.5	As per comment in 1.2.2, courses are offered at NUS and OUM on food and nutrition. Ad hoc training is also provided by the nutrition section to health workers.	It is however difficult to assess how the training is being put into practice in community/ primary health care by the health workforce.
	1.6.7 Provide food and nutrition information to the community about the management NCD with a focus on diabetes.	NHS, MOH, National Diabetes Centre	Food and nutrition information with a focus on NCD distributed to the community.	How are these information being provided? Evidence?	2.5	Provided through the PEN Samoa and health promotional and awareness programs of the MOH, including the METI health seminars.	Need for more evidence to assess the extent of information provision to the community on food and nutrition and their relationship to NCD management.
	1.6.8 Provide information to the community about the prevention of obesity in children.	NHS, MoH, MWCSD, MESC, NCECE, Private	Information about childhood obesity distributed to the community.	How are these information being provided? Evidence?	2.5	Examples of programs where childhood obesity information were provided included information provided via the health promoting school committee	

		and Religious Schools				program, nutrition education sessions for schools, collaboration with sporting bodies and recreational groups to incorporate nutritional promotion in their programs for children, physical activity and nutrition exhibitions during health week, and health promotional messages through media campaigns.	
	1.6.9 Implement and monitor salt reduction project strategy (ref. Best Buy).	MoH, NHS, MoF, MWCSD, SCCI, Tourism, SPAGHL, WHO, George Institute, SROS	Reduced salt intake.	What are these strategies? How are they being implemented? Evidence?	2.5	A salt reduction project was implemented around 2014/2015. Salt reduction messages incorporated into health promotional programs/activities (e.g. Slash the salt message included in the PSC Public Service Official Circular).	The effectiveness of this project in salt reduction is not yet being identified.
	1.6.10 Implement and monitor strategy to control trans-fatty acids in food supply.	MoH, NHS, MoF, MWCSD, SROS, Tourism, Chamber of Commerce, SPAGHL, WHO	Evidence of reduced trans-fat utilization across the food industry e.g. fast-food outlets. Evidence of reduced trans fats in imported foods.	What are these strategies? How are they being implemented? Evidence?	2.5	Limited focus on the implementation of this strategy.	
	1.6.11 Collaborate with sector partners for strengthening community-based approaches for reducing obesity.	MoH, NHS, WHO, AUSaid, NZAid, MWCSD, MNRE, Samoa Red Cross, SPAGHL, NGOs.	Proactive community-based activities that promote the reduction of obesity.	Who is being collaborate? How are these collaboration being undertaken? Evidence?	2.5	Same comments as in 1.6.8	Difficult to assess the extent and effectiveness of previous/existing community-based activities promoting obesity reduction.
	1.6.12 Develop and promote strategies to control the marketing of foods and non-alcoholic beverages to children.	MoH, AG, SCCI, MESC, Private and Religious Schools, SPAGHL, media, WHO, Sports organizations	Reduced "junk" food promotion to children in various settings, e.g. Prime TV time, schools, sports.	What are these strategies? How are they being implemented? Evidence?	2	Promoted through the Health Promotion School Programs.	Limited media and other programs aimed at reducing junk food promotion.
1.7. Promote healthy food business practices	1.7.1 Promote healthy lifestyle improvement projects amongst private and public sectors e.g. healthy workplaces.	SCCI, Tourism, MCIL, MAF, AG, SBEC, SAME	Healthy lifestyle projects implemented by private and public sectors.	What are these projects? How are they being implemented – outcomes?	2	The nobesity is an example of a program aimed at promoting healthy lifestyle improvement. There are also programs undertaken by workplaces to promote healthy lifestyle. The MOH also prepared and distributed a catering guideline which is being used by Government ministries/agencies	
	1.7.2 Promote the business sector understanding of issues related to the food system.	MoH, MCIL, SCCI, SROS, Tourism, MAF, MFAT, SBEC, SAME, FAO, WHO, WIBD	Evidence of activities to promote understanding of the food system throughout the business sector.	What are these strategies? How are they being implemented? Evidence?	2.5	Business sector involved through sector wide coordination mechanisms such as the trade, commerce and manufacturing sector and agriculture sector in which MOH is a member.	
	1.7.3 Collaborate with food safety partners to build food	MoH, SCCI, SROS, Tourism, MCIL, MAF, AG, SBEC,	Positive industry practice for food safety	What are these practices?	2.5	Ad hoc programs/activities undertaken by HPED for food industry to become aware of the Food Safety Act and	Limited capacity of the HPED to fully implement food safety strategies and standards.

	industry capacity to improve food safety.	Food Industry, FAO, WHO				Regulations. Regular monitoring of food safety in the food industry conducted by HPED. The use of health card (a form of licensing for food processors) is a mechanism introduced to monitor compliance with food safety requirements.	
	1.7.4 Promote the use of locally produced foods by all food industry partners e.g. supermarkets, hotels, restaurants, small shops, government catering, institutions (hospitals, boarding schools).	MoH, NHS, MCIL, SCCI, SROS, Tourism, MWCSD, MESC, MNRE, MAF, MFAT, SBEC, SAME, FAO, WHO, NGOs	Increased utilisation of locally produced foods in business	Evidence of increased utilization?	2.5	A monitoring of fruits and vegetable availability in 140 supermarkets and shops undertaken by MOH in 2019 quarter 1 identified that: • 57% sells local fruits & vegetables. • 89% sells overseas fruits & vegetables. • 14% sells local 5+ fruits & vegetables. • 29% sells overseas 5+ fruits & vegetables.	Lack of available baseline to benchmark whether there is an increase utilisation of locally produced foods over the years. Observations indicated that with the impact of COV-19 there has been an increased availability of local vegetables. But there is a need for proper data to confirm observations on increased consumption of local produce.
	1.7.5 Strengthen capacity building for food importers, distributors and processors on ways to reduce fat, trans fatty acids, salt and sugar in food products.	MoH, MCIL, AG, MAF, MOF, MNRE, Samoa Red Cross, NGOs, SCCI, Food Industry, FAO, MFAT	Reduced levels of fat, trans fatty acids, salt and sugar in food products.	Evidence of reduction?	2	HPED has been undertaken capacity building and awareness programs with food industry (e.g. bakery businesses on how salt that should be in breads). These programs were also conducted for the industry in preparation for the South Pacific Games in 2017.	There is a need to expand the scope of these programs and to assess their effectiveness.
Food Availability, Access and Use Action Plan							
2.1. Improve access to affordable and nutritious food	2.1.1 Strengthen promotion of dietary guidelines.	MoH, NHS, MAF, MCIL, MOR, MoF, MFAT, WHO, UNICEF, AUSaid, NZAid, MWCSD, MSEC, academic Institutions, Private and Religious Schools	Increased knowledge about dietary guidelines for promoting healthy food and healthy lifestyles	Evidence of increased knowledge?	2.5	Dietary guidelines promoted through health promotional programs/activities of the MoH – through schools, media, booth and other avenues – as identified under 1.3.3 above.	Difficult to measure any increase in knowledge about dietary guidelines due to lack of M&E.
	2.1.2 Collaborate with primary health care services sector to strengthen actions that reduce obesity.	MOH-NHS, WHO, AUSaid, NZAid, MWCSD, NGOs	Sector partners actively engaged in a coordinated response to reducing obesity in the community.	How are these engagements? What are they? Evidence?	3	Same comment as in 1.6.7, 1.6.8 and 1.6.11. The PEN *Fa'aSamoa* program is being used to foster collaboration with primary health care services to monitor and reduce NCD prevalence.	
	2.1.3 Strengthen capacity building actions for health workers on issues related to food trade and trade agreements e.g. WTO, PICTA.	MoH, NHS, MFAT, MAF, MCIL, AG, MOR, MOF, WHO, UNDP, SPC, C-POND	Increased health worker Knowledge about food trade, trade agreements and how they affect health	Evidence of increased knowledge? What has been done to increase knowledge?	3	Capacity building is strengthened through the participation of MoH in the Samoa National Codex Committee as a member. There is ongoing collaboration between MoH and other agencies (through this committee) to discuss	Food trade and trade agreement information to be disseminated to other staff of the MoH but not able to participate in the Codex Committee or involved in

						issues relating to food trade and trade agreements. The Samoa National codex Strategic Plan 2017-2021 guides the Committee and members with the promotion and coordination of the development, implementation and monitoring of food standards.	discussions of food trade related matters.
	2.1.4 Conduct a feasibility study to analyse the options for Samoa to consider in addressing nutrition related health problems and advise on policy direction to control diet related health problems.	MoH, MFAT, MAF, MfR, MCIL, MAF	Increased implementation of policy options to control diet related health problems.	Feasibility study undertaken?	4	Study undertaken in 2015 which analyse options for Samoa.	Need for follow-up assessments on the implementation of options adopted and to identify areas for improvements.
	2.1.5 Promote transport systems improvement to link locally produced food to market and to promote economic gain.	MoH, MWTI, MAF	Improved transport systems and greater access to local foods.	Evidence of improved transport systems?	3	Improving agricultural access roads has been a priority of the Government. Roadside food stalls also provided options for people to sell food (rather than transporting foods to the market) as well as easier accessible links for consumers.	Need to establish a clear link between the current status of transport systems and current availability and accessibility of locally produced foods for improved local consumption.
2.2. Promote local food production	2.2.1 Collaborate with sector partners on key messages they could utilize to promote locally produced food.	MoH, MAF, MCIL, MESC, MoF, SCCI, FAO, WIBD, NGOs	Key messages promoted in the community that affect attitudes to food.	What are these messages? How are they being disseminated? Any evidence on effectiveness?	2.5	Promotion through cooking shows, TV health messages, health promoting school programs and other programs. Notable increase in local food production during COV-19.	Need for proper documented evidence to show changes in attitudes to food as a result of health messages.
	2.2.2 Advocate for more locally grown food.	MoH, NHS, MoF, MNRE-soil, FAO, WHO, AUSaid, NZAid, USP, Red Cross, NGOs, MAF, MCIL, MOR, SCCI, MESC, Private and Religious Schools, WIBD, SPAGHL	Increased local food production.	Evidence of increase? What were the advocacy initiatives undertaken?	2.5	A number of initiatives have been undertaken by MAF to try and increase local food production – e.g. revival of coconut and cocoa industry, subsidised distribution of fruit and vegetable seedlings to schools and communities, school local nutrition gardens, and others.	Need for proper documented evidence to show increases in local food production.
2.3. Strengthen the community's understanding about the nutritional value of food	2.3.1 Promote research and development of under-utilized indigenous nutritious crops and dissemination of findings.	MoH, MAF, MNRE, MWCSD, MESC, SROS, WIBD, Academic Institutions	Increased utilisation of Indigenous crops	Evidence of increase utilization? Research undertaken?	2.5	There is limited research undertaken on under-utilised indigenous nutritional crops. SROS has undertaken testing of some selected Indigenous plants, crops (e.g. *tumutumu tamaligi*) and foods (e.g. *miti mafu*) to establish their nutritional and medicinal values and are looking at how to turn those foods into value added products for public access.	

2.4. Collaborate with key partners to promote the preparation of healthy, safe food	2.4.1 Promote food preparation messages to the community focusing on lower fat, salt and sugar and safe food preparation.	MoH, MWCSD, MESC, NCECE, APTC, NUS, Media, NHS	Households using improved Food preparations techniques	Evidence of improvement in good preparation techniques?	2.5	Same comment as in 1.7.3 and 1.7.5 above.	
	2.4.2 Advocate for new technology/ recipe modification to improve the nutritional quality of locally produced processed foods.	MOH, SROS, SCCI, MCIL, SAME, MAF, FAO, Tourism, WHO, USP, FAO	Improved variety of local food-based products and dishes which are healthy	Evidence of improvement?	2.5	Same comment as in 2.3.1 above.	
2.5. Advocate for food pricing and taxes to promote healthy food availability.	2.5.1 Review and adjust import duties, price controls and taxes to increase availability of healthy foods and products that support healthy lifestyles.	MoH, MCIL, FAO, WHO AUSaid, NZAID, MOF, MfR, MESC, MWCSD, MNRE, SPAGHL, SCCI, tourism	Evidence of pricing that Supports healthy eating and lifestyles.	Evidence?	4	Cabinet approved a review of unhealthy and healthy food duties and taxes in 2018/2019 but deferred decision to 2021 following the completion of the March 2021 general elections.	
2.6. Strengthen monitoring and evaluation of food access and availability.	2.6.1 Advocate for research on access to and availability of food.	MAF, MoH, SROS, SCCI, MCIL, MfR, MoF, FAO, Tourism, WHO, USP	Information available for Promoting improved access to and availability of healthy local food and other healthy food options. Improved food quality and affordability.	Research undertaken? Evidence on food quality and affordability?	2.5	Some research were undertaken by FAO, and OLAGA Study Group.	Most of these research examine dietary patterns and not so much nutritional food availability and accessibility in Samoa, which need to be undertaken in close collaboration with the food industry including MAF, SROS, and other key authorities.
2.7. Collaborate with sector partners to promote sustainable food.	2.7.1 Collaborate with sector partners on strategic directions for food sustainable systems approach.	MoH, MCIL, MoF, FAO, WHO AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL, WIBDI	Food system information will be available to the community and industry.	Update on this – what is the food system information – how are they being made avail to the community and industry?	2.5	Collaboration fosters through the sector-wide approach (e.g. through the health sector committee, agriculture sector, trade, commerce and manufacturing, codex committee, National Working Committee on Trade Arrangements and others). It is assumed that information is feed through these multi-sector mechanisms where representatives of the food industry (public, private, civil society and community) participate.	It is difficult to establish how food system information are being made available to the community and industry.
	2.7.2 Collaborate with health sector partners to build capacity for continued sustainable food strategy implementation sector wide.	MoH, MCIL, MoF, MAF, FAO, WHO, AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL, SCCI, WIBDI	Food production according to nutritional needs of the population. Increased community awareness about the food system. Decrease reports of food wastage. Improved food system awareness in the community and business sector.	Update on this activity?	2.5	Same comment as in 2.7.1 above.	Difficult to assess increased (community and business sector) awareness about the food system and decrease reports of food wastage given limited information on what has been undertaken to improve awareness about sustainable food system.

	2.7.3 Promote environmental health models that integrate food and nutrients for built, natural, social and economic areas.	MoH, MCIL, MoF, FAO, WHO AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL, SCCI, IBD	Sustainable food system awareness.	Awareness? Evidence?	2.0	Same comment as in 2.7.1 above	Same comment as in 2.7.2 above
2.8. Collaborate with sector partners on strategies that reduce the negative effects of food production and use on the environment	2.8.1 Promote education and awareness about food waste and its impact on the environment.	MoH, MCIL, MoF, FAO, WHO, AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL,	Increased community awareness about sustainable food.	Awareness? Evidence	2	Same comment as in 2.7.1 above	Difficult to assess given the lack of M&E on what has been undertaken to increase community awareness about sustainable food and food waste.
	2.8.2 Advocate for research that informs health sector partners about sustainable food.	MoH, MCIL, MoF, FAO, WHO, AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL	Improved land use. Reduce impacts measurable on the environment.	Research undertaken?	2	Same comment as in 2.7.1 above	Same comment as in 2.8.1 above.
	2.8.3 Advocate for community awareness programs for food system responsibility.	MoH, MCIL, MoF, FAO, WHO AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL	Food System education available to the community.	Awareness? Education undertaken? Evidence?	2	Same comment as in 2.7.1 above	Same comment as in 2.8.1 above.
	2.8.4 Advocate for regulations to prevent use of injurious packing material for packaging food and water and non-recyclable packaging.	MoH, MCIL, MoF, FAO, WHO, AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL	Improved recycle packaging Less use of injurious packaging.	Regulations in place?	4	Legislation are in place to ban the use of plastics in Samoa. Notable increased use of recycle packaging since the ban of plastic bags in Samoa.	Need for proper studies/ assessments to establish good evidence on improved recycle packaging and less use of injurious packaging.
	2.8.5 Advocate for recycling facilities which include food waste management.	MoH, MCIL, MoF, FAO, WHO, AUSaid, NZAid, MESC, MWCSD, MNRE, SPAGHL	Available food Waste management Systems including recycling.	Food Waste management Systems including recycling in place?	3	Same comment as in 2.8.3 above.	Same comment as in 2.8.3 above. Difficult to assess given the lack of a multi-sector approach to the adoption and implementation of this NFNP and Action Plan.
	2.8.6 Drive national and Pacific regional policy development for continuous improvement for the reduction of greenhouse gas emissions and management of land fill.	MoH, NGO partners, Pacific region partners, MNRE, MoF, MFAT, UN/FAO	Collaborative solutions for the management of environmental challenges relating to the food system will be developed.	What are these solutions? How are they being implemented?	2	Environmental issues are handled through the role of the MNRE. But it is difficult to direct solutions/efforts made towards this NFNP and Action Plan.	Difficult to assess given the lack of a multi-sector approach to the adoption and implementation of this NFNP and Action Plan.
Food Safety Action Plan							
3.1. Protect the community from public health risk.	3.1.1 Finalise and implement Food Bill and regulations.	MoH, AG, MAF, MFAT, MWCSD, MCIL	Food Bill and Regulations adopted and implemented Reduced incidence of food borne disease reports.	Issues with implementation of the Act and Regulations?	5	Food Safety Act 2015 and Food (Safety and Food (Safety and Quality) Regulations 2017 enacted.	
	3.1.2 Promote key messages on good hygiene and food preparation practices to reduce	MESC, MoH, SROS, Media, SCCI, MESC, NCECE, MWCSD	Improved food safety information and knowledge in the community.	How is this strategy being implemented – outcomes, issues, evidence, etc.?	4	Regular health promotional messages on national TV and on radios.	Need for assessments/research to establish increases in food safety information and knowledge in the community.

	food borne related incidence in the community.						
3.2. Promote awareness about food safety issues.	3.2.1 Promote awareness about the dangers of unsafe pesticide use.	MoH, MNRE, MAF, FAO, MoF	Increased awareness about the dangers of unsafe pesticide use in the community.	Status of these awareness? Outcomes? Evidence?	1	Awareness programs on the dangers of unsafe pesticide use in the community is limited. There is a pesticide committee (multi-sector), MoH is a member of this committee.	There is a need to first establish the pesticide that are unsafe including their dangers to the food system and health.
	3.2.2 Promote water quality awareness in the community.	MoH, NHS, Samoa Water Board	Collaborative water management in the community.	How? What are the outcomes? Issues?	3	Testing of water safety and water is being regularly carried out and results are regularly publicised in the media for the public information.	Testing and publicising of water testing results are limited to bottled water companies, and do not include tap water (under the Samoa Water Authority/SWA) used by most households.
3.3. Prevent and manage food borne disease outbreaks.	3.3.1 Contribute technical and expert advice during national disaster relief efforts.	MoH, NHS, Disaster Advisory Committee, SWA, MOH, Red Cross	Reduced risk for food borne disease outbreaks during disasters.	How? What are the outcomes? Issues?	4	This is undertaken through the disaster management committee in which MoH is a member, as well as through the role of the MoH Surveillance Division.	
	3.3.2 Build capacity of food businesses on issues related to food safety.	MoH, NHS, MoF, MWCSD, MNRE, FAO, WHO, USP, AUSaid, NZAid, Red Cross, SROS.	High incidence of food safety compliance for food businesses.	How? What are the outcomes? Issues?	2.5	Same comment as in 1.7.3 above.	Need for proper monitoring reports on food safety compliance. Reports not made available for this Review.
3.4. Monitor and evaluate food safety.	3.4.1 Regular and planned testing for food contamination.	NHS, MoF, SROS, MWCSD, MNRE-soil, FAO, WHO, AUSaid, NZAid, USP, Red Cross	Reduced incidence of reports of food borne disease.	How? What are the outcomes? Issues?	3	Testing for food contamination are the roles carried out by the MoH HPED and Surveillance Divisions and with the assistance from SROS (when requested).	Lack of information (reporting) on any increasing or decreasing status of food borne diseases in Samoa.
	3.4.2 Monthly data collation of reports of food borne illness.	MoH, NHS, Food Industry partners	Monthly reports.	How? What are the outcomes? Issues?	3	Monitoring of food borne illnesses are undertaken by the MoH.	Recent reports are on hold due to COV-19 responses.
	3.4.3 Strengthen services for testing food contamination.	MoH, NHS, SROS	Improved capacity for food testing evident.	How? What are the outcomes? Issues?	3	Testing services and capacity available at SROS – but this depends on requests from MoH on needed tests.	
	3.4.4 Drive measures to reduce fish/seafood contamination through protection of marine areas.	MoH, MAF, MNRE, NHS	Reduced incidence of food borne illness due to seafood consumption, especially consumption of crustaceans.	How? What are the outcomes? Issues?	2.0	Measures undertaken through collaboration between MAF, MNRE and FAO.	Limited reporting through the framework of the NFNP on measures undertaken including effectiveness of those measures.
	3.4.5 Monitor pesticides levels in food.	MoH, NHS, AG, MNRE, MCIL, MAF	Reduced levels of pesticides in foods.	How? What are the outcomes? Issues?	2.0	Difficult to establish what has been undertaken to monitor pesticide levels in food. There is a Pesticide Committee where pesticide issues/concerns should be raised and discussed.	Reporting through the NFNP framework is limited.
	3.4.6 Promote safe water.	MoH, Samoa Water Board, Community	Improved water quality.	How? What are the outcomes? Issues?	3.0	Same comment as in 3.2.2 above. Awareness programs via media on ensuring water is safe before drinking.	
				Average	**2.6**		

C: List of people and organisations consulted

One-on-one interviews		
Name	Designation	Organisation
Maee Ualesi	Assistant CEO, HPED	MoH
Christina Soti-Ulberg	Principal Nutritionist	MoH
Siufaga Simi	Principal Health Educator	MoH
Edward Asi Brown	Principal Environmental Officer	MoH
Faaifoaso Moala	Senior Health Promotion Officer	MoH
Analosa Manuele	Nutrition Officer	MoH
Mele Tanielu	Acting ACEO, National Disease Surveillance, International Health Regulations	MoH
Fata Paulo Pemita	Principal Sanitation Officer	MoH
Tupou Chan Tung	Principal Lab Technician (Surveillance)	MoH
Miriama Asoiva	Senior Disease Surveillance Officer	MoH
Rosalei Tenari	Senior Disease Surveillance Officer	MoH
Julieth Gafa	Disease Surveillance Officer	MoH
Hionona Tapu	Senior Water Quality Office	MoH
Jun Ho Kim Gregory	Project Coordinator	MoH
Poutasi Seuseu	Principal Regulatory & Monitoring Officer	MoH
Lokeni Tiatia	Principal Quality Assurance Officer	MoH
Faloai Soolefai	Principal Quality Assurance Officer	MoH
Mitzi Ah Kuoi	Senior Regulatory & Monitoring Officer - Dental	MoH
Sally Mcfall	Infection Control Officer	MoH
Acquin Fiu	School Health Nurse/ Quality Assurance Officer	MoH
Dr. Tito Kamu	Head of Unit, Paediatrics	MoH
Robin Roache	Senior Nurse Specialist Obstetrics and Gynaecology	MoH
Avaia Tuilaepa	Nurse Manager, Community nursing	MoH
Quandolita Reid-Enari	Assistant CEO, SPPRD	MoH
Christian Atoa	Senior Policy Officer	MoH
Chrioni Posini	Policy Officer	MoH
Delphina Kerslake	Legal Consultant	MoH
Suafai Salima	Principal Dietician	MoH
Kima Savusa	OLAGA Research	MoH
Dr Sale Fau	Manager, Dental and Oral Services	MoH
Dr. Sina Ioapo	Dentist	MoH
Roy Andrews	Dental Officer	MoH
[Name missing] *	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
[Name missing]	Dental and Oral Services	MoH
Pulotu Lyndon Chu Ling	CEO	MCIL
Philip Tuivavalagi	Assistant FAO Representative	FAO
Ms Molly Nielsen	Principal Disaster Management Officer	MNRE

Tilafono David Hunter	CEO	MAFF
Taimalietane Matatumua	Assistant CEO, Policy, Planning and Communication	MAFF
Kolisi Lomialagi T VIKI	National Professional Officer, NCDs	WHO
Dr Dyxon Hansell	Technical Officer, Health Systems Strengthening	WHO
Nella Tavita-Levy	Assistant CEO Trade	MFAT
Seuseu Dr Joseph E Tauati	CEO	SROS
Tuimaveve Kuinimeri Finau	Manager, Plant & Food Technology	SROS
Pousui Dr. Fiame Leo	Manager, Technical Services Division	SROS
Nimera Taofia	Principal School Improvement Officer	MESC
[Name missing]	Senior School Improvement Officer	MESC
[Name missing]	Curriculum Officer	MESC
[Name missing]	Curriculum Officer	MESC
Talaitupu Lia		MCR
** Records of the list of names of people attended was lost. But the number of people attended could be identified.*		
Stakeholder workshop (two workshops – internal for MoH and external stakeholders)		
Name	Designation	Organisation
Day 1 – Internal (MoH) Stakeholder Consultation Workshop		
Tommy Leia	Principal IT Officer	MoH
Leota Vaitoelau	Nurse Manager	MoH
Dr Emosi Ah Ching	Principal Dental Officer Savaii	MoH
Talalelei Laepa Tapuai	Registered Nurse	MoH
Lokeni Tiatia	Principal Officer Quality Assurance	MoH
Poutasi Seuseu	Principal Office Regulatory	MoH
Malienafau Tupai	Health Environmental Officer	MoH
Siatua Loau	Principal Office Professional Development	MoH
Fuatai Maiava	ACEO, Nursing	MoH
Tinei Tuilagi	Senior Nurse Specialist Medical TTM Hospital	MoH
Perenise Tupeli	Food Safety Officer	MoH
Funefeai Tuiala Tiotio	Manager, Medical Imaging and Radiology	MoH
Sina Ioapo	Dental Consultant	MoH
Laulu Tamati Fau	ACEO, Quality Assurance	MoH
Moeli Meatoga	Principal Monitoring and Evaluation Officer	MoH
Faalagilagi Polataivao	Principal Officer Professional Development	MoH
Siaeauli Siau	Professional Development Officer	MoH
Sisavaii Papalii	Principal Officer Health Information Services	MoH
Avaia Tuilagi	Nurse Manager Public Health	MoH
Edward Brown	Principal Food Safety Officer	MoH
Delphina Kerslake	ACEO, Legal	MoH
Aharoni Viliamu	ACEO, Pharmaceutical Services	MoH
Sam Fruean	Health Information Services	MoH
Sinei Sinei	FCTC	MoH
Dr Robert Thompsen	Deputy Director General Public Health	MoH
Lesa Vili	Dietitian	MoH
Elisapeta Anitelea	Dietitian	MoH
Josephine Afuamua	Health Information System	MoH
Lagaau Uili	Principal Quality Assurance Officer	MoH
Kalala Voe	Registered Nurse	MoH
Timothy Betham	Warehouse Pharmaceutical Services	MoH
Logomai F Lualua	Senior Nurse Specialist	MoH
Fauatea Henry Taylor	Principal Nurse Officer Savaii	MoH
Jin Ho Grey Kin	NCD	MoH
Rosalei Tenari	Principal Officer Disease Surveillance	MoH
Mareta Tautogi	Physician Public Health	MoH
Wesley Tuioti	Public Health	MoH
Tupou Chan Tung	Lab Technician	MoH

Victoria Ieremia Faasili	Principal Officer Climate Change	MoH
Sisiliafupou Eteuati	Health Planner	MoH
Chrioni Posini	Health Policy Analyst	MoH
Talale Joe Sofaea	Senior Health Planner	MoH
Sina Faaiuga	ACEO, SPPRD	MoH
Anaroa Manueli	Senior Nutritionist	MoH
Meeltina Atimalala	Nutritionist Part Time	MoH
Christian Atoa	Senior Policy Analyst	MoH
Muliagatele Dr Potoae Roberts Aiafi	Consultant	Oceania SMART Consulting
Day 2 – External Stakeholder Consultation Workshop		
Dorothy Ah Ching Meredith	Principal SFO	MFAT
Queenie Mikaele	FSO	MFAT
Panioa Lesatele	Senior Policy Officer	PSC
Maselino Enoka	Senior FSO	MFAT
Alesana Malo	Principal Officer	SROS
Siope Pele	Principal Officer	SROS
Max Lee Lo	Principal Officer	MCIL
Lotomau Talosaga	Senior Officer	MNRE
Frita Kruse	Policy Officer	MAF
Keyonce Lee Hang	Principal Officer	MAF
Alice Seuseu	Senior Policy Officer	MAF
Dr Agape P Tavita	Program Director	ADRA
Cassandra Teo	HR Manager	ADRA
Patricia Palamo Pulega	Operations Manager	APTC
Leapaga Moni	Program Officer	SFHA
Dr Viali Lameko	Vice Chancellor	OUM
Melania SEtu	Olaga	MoH
Faasosola Masa	Olaga	MoH
Solialofi Papalii	President	Samoa Nurse Association
Fana Lee Zumba	Zumba	Fana Lee Zumba
Salausa John Ah Ching	Associate Minister Health	Parliament of Samoa
Rosa Mataeliga	Administration Officer	Carita Samoa
Tofilau Raymond Voigt	Executive Member	SAME/BAS
Asiata Gerard Anapu	Senior FSO	MFAT
Angela M Ula	Principal FSO	MFAT
Christabelle Gabriel	Program Manager	DFAT Australia
Luaiufi Aiono	Office Manager	Samoa Farmers Association
Dr Water Vermeulen	Executive Director	METI
Dr Rasul Baghirov	WHO Representative	WHO
Kolisi Viki	NPO NCD	WHO
Shelley Burich	President	SWAG
Ronicera Fuimaono	Program Coordinator, Development	NZ High Commission
Ulisesio Faaleaga	Book Manager	SROS
Sua V Ryan	CEO	Samoa Cancer Association
Naomi Eshraghi	CEO	Coshen
Taugofie Aleki	Health Educator	MoH
Sisiliatupou Eteuati	Health Planner	MoH
Chrioni Posini	Health Policy Analyst	MoH
Talale Joe Sofaea	Senior Health Planner	MoH
Sina Faauiga	ACEO, SPPRD	MoH
Anarosa Manuelu	Senior Nutritionist	MoH
Meeltina Atimalala	Nutritionist Part Time	MoH
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