GOVERNMENT OF SAMOA

SAMOA HEALTH WORKFORCE DEVELOPMENT PLAN

FINANCIAL YEARS 2020/21 – 2025/26

MINISTRY OF HEALTH

KEY MESSAGE

It is a great pleasure to present this "Samoa Health Workforce Development Plan" (SHWDP) for 2020-2026. The Plan identifies the workforce development needs of the Ministry of Health (MoH) over the next 5 years, based on a forecast of current and future health workers that Samoa needs to service the health needs of its increasing population.

The government is committed to work together with its key partners to develop our health workforce. We know we cannot develop our health workforce without the support of our key health sector partners as well as the commitments of all our managers and staff within the Ministry.

We recognise the complex challenges and issues that we face with our health system. The burden of rising non-communicable and communicable diseases, the ongoing effects of climate change on our population health, and accommodating increasing population growth, are some of the key challenges that we will continue to face and need to address, especially for our small island economy. The lack of trained and experienced health workers to deal with these ongoing challenges and issues will remain a challenge for us.

Dealing with these challenges/issues requires looking at the ongoing development of our health workforce. The fact remains that there is no health without a workforce. It is the workers who maintain, improve and shape the health services. We cannot improve health services without improving the numbers and quality of our health workforce; the workers who are providing and maintaining these services.

This Plan articulates a shared commitment between the government and its health sector partners to work together to contribute to its vision for this SHWDP of *"A trained and professional workforce that meet the needs of the population A trained and professional workforce that meet the needs of the population".*

We ask for your commitment to work with us to implement this 2020-2026 SHWDP and to improve on our efforts in going forward.

Faafetai.

Hon. Faimalotoa Kolotita Stowers
MINISTER OF HEALTH

FOREWORD

We recognise that health workforce development is essential for the realisation of "*A healthy Samoa*"; the vision of the Samoa Health Sector Plan, 2019/20-2029/30.

Health workforce development, a key component of developing Human Resources for Health (HRH) in Samoa, is one of our health sector priorities for the next 10 years, 2019-2030. It is inevitable that we develop a capable and committed health workforce to address the health needs of our population, now and into the future.

The development of this 2020-2026 Samoa Health Workforce Development Plan" (SHWDP) therefore signifies our commitment to ensure the ongoing development of our health workforce, as a key strategic priority for the Ministry of Health.

This 2020-2026 SHWDP identifies three strategic objectives that will contribute to its vision of *"A trained and professional workforce that meet the needs of the population":*

- Availability and preparedness of health workers in response to population health needs improved.
- Work performances and professional development of the health workforce enhanced.
- A conducive working environment for a productive and committed health workforce is strengthened.

This SHWDP further outlines the actions that we are committed to implement to improve the availability and enhance the quality of a health workforce for our Ministry.

We seek you support and collaboration in the implementation of this Plan and we thank in your advance for your support and commitment.

Faafetai.

Leausa Samau T. Dr. Take Naseri
DIRECTOR GENERAL OF HEALTH

ACKNOWLEDGEMENT

This Samoa Health Workforce Plan (SHWDP) 2020–2026 is informed by the 2020 'Situational Analysis' which was conducted from September 2019 to January 2020 to provide the evidence-based analysis needed for the development of this SHWDP. The Situational Analysis Report documents the data collection and analysis undertaken to inform this SHWDP, to ensure that the SHWDP is grounded in the key issues and challenges of the health sector that are needed to be addressed. The groundwork undertaken for the completion of the Situational Analysis and this SHWDP would have impossible without the technical and funding assistances provided by the World Bank. We acknowledge with appreciation your continuous support towards the development of our health system and its human resources for health.

Faafetai tele lava to everyone, especially the representatives of the health sector organisations, groups and individuals, as well as the Ministry of Health (MoH) management and staff, who were able to make their time available to provide the necessary inputs for the formulation of the SHWDP. Thank you for providing the needed information for the completion of this Situational Analysis and for the formulation of the SHWDP 2020–2026.

Special thanks to the managers and staff of the MoH's Strategic Planning, Policy and Research, Human Resources and Administration for the administrative and logistic assistances provided which enable the completion of this initiative. We further acknowledge the technical assistances provided by Muliagatele Dr Potoae Roberts Aiafi in the undertaking of this workforce development exercise for the Ministry of Health.

Faafetai tele ma ia faamanuia tele le Atua.

SUMMARY: SAMOA HEALTH WORKFORCE DEVELOPMENT PLAN (SHWDP) 2020 – 2026

Vision

A trained and professional workforce that meet the needs of the population.

Mission

Visible improvements in health workforce numbers and performances.

Overall goal

To improve the numbers, quality and performances of the health workforce.

Principles

- Universal health coverage
- Partnerships, alliances and collaboration
- Multi-sectoral approach
- Fit for purpose – fit for practice
- Transparency and accountability
- Shared responsibility
- Professionalism and integrity
- Effectiveness and efficiency
- Sustainability
- Equality and human rights
- Innovation and best practices
- Samoanisation

Strategic objectives

1. Availability and preparedness of health workers in response to population health needs improved.
2. Work performances and professional development of the health workforce enhanced.
3. A conducive working environment for a productive and committed health workforce is strengthened.

Targets (by 2030)

- 50% increase in health worker density by 2030.
- Equal health worker density across all health facilities/services by 2030.
- 50% increase in professional worker density including clinical specialists by 2030.

TABLE OF CONTENTS

ACRONYMS

ADB	Asian Development Bank
AHS	Allied Health Service
CBO	Community-based Organisation
CS	Corporate Services
CSO	Civil Society Organisation
DFAT	Department of Foreign Affairs and Trae (Australia)
DH	District Hospital
DHS	Demographic and Health Survey
GoS	Government of Samoa
HC	Health Centre
HPAC	Health Program Advisory Committee
HPES	Health Promotion, Enforcement and Surveillance
HR	Human Resource
HRH	Human Resources for health
HRHFP	Human Resources for Health Focal Point
HRHMC	Human Resources for Health Multi-sectoral Committee
HRHWG	Human Resources for Health Working Group
HRM	Human Resource Management
HSP	Health Sector Plan
M&E	Monitoring and Evaluation
MESC	Ministry of Education, Sports and Culture
MFAT	Ministry of Foreign Affairs and Trade
MIR	Medical Imaging and Radiology
MOF	Ministry of Finance
MOH	Ministry of Health
MTII	Malietoa Tanumafili II
MWCSD	Ministry of Women, Community and Social Development
NCD	Non-Communicable Diseases
NGO	Non-governmental organisation
NHS	National Health Services
OAHS	Other Allied Health Services
OHS	Occupational Health and Safety
OUM	Oceania University of Medicine
PIFS	Pacific Islands Forum Secretariat
PSC	Public Service Commission
SBS	Samoa Bureau of Statistics
SDG	Sustainable Development Goal
SDS	Strategy for the Development of Samoa
SHRHS	Samoa Human Resources for Health Strategy
SHWDP	Samoa Health Workforce Development Plan
SPC	Secretariat of the Pacific Community
SQA	Samoa Qualification Authority
TTM	Tupua Tamasese Meaole
TVET	Technical and Vocational Education Training
UN	United Nations
WHO	World Health Organisation

LIST OF TABLES AND FIGURES

1. THE NEED FOR A SAMOA HEALTH WORKFORCE DEVELOPMENT PLAN

1.1. Introduction

This document is the 'Samoa Health Workforce Development Plan' (SHWDP) 2020-2026; the Ministry of Health's (MoH) workforce development plan for 2020-2026. It identifies the Ministry's workforce needs and development priorities for the next 5 years, from July 2020 to June 2026. The SHWDP was developed in close alignment with the "Samoa Human Resources for Health Strategy" (SHRHS) 2020-2026. As such, the two policies and their action plans are mutually interlinked and reinforcing and must be consulted together, and closely monitored and evaluated during their joint implementation.

This SHWDP together with the SHRHS 2020-2026 are being developed in response to the health strategic directions set out in the Samoa *Health Sector Plan* (HSP) for 2019-2030. Improving *Human Resources for Health* (HRH), which also involves health workforce development, is one of the key priority development outcome areas of the health sector as identified under the HSP 2019-2030. Improving HRH and workforce development is essential for the implementation and achievement of the HSP priorities of: improving health promotion & preventive services, maternal and child health, quality healthcare services, and health information management systems; reducing communicable, neglected tropical, and non-communicable diseases; and responding to the effects of climate change and disasters.

The fact remains that there is "no health without a workforce" (WHO, 2014). The HSP 2019-2030 vision of *A Healthy Samoa* cannot be achieved without a capable and competent workforce that delivers, maintains and improves health services. Without improving the workforce capacity for health, there will be limited realisation of the HSP vision and outcomes. This realisation about the significance of HRH meant that Samoa needs to critically re-examine its workforce development needs over the next 5 years, in alignment with the 2019-2030 HSP's strategic directions. The development of this SHWDP together with the SHRHS 2020-2026 signifies the ongoing commitment of the MoH and its partners and stakeholders to address Samoa's HRH and health workforce development needs.

1.2. Situational analysis

A comprehensive situational analysis about the status of HRH and health workforce development in Samoa is provided in a separate report (MoH, 2020). This Situational Analysis report is to be closely consulted with this plan; the SHWDP 2020–2026. The Situational Analysis details the methodology undertaken to provide the evidence-based analyses and assessments of the current health workforce and existing HRH systems and practices. The methodology used included a desk and literature review, participant observations, consultations held with key stakeholders and MoH's management and staff, as well as a staff survey. All of this ground work were carried out from September 2019 to January 2020, in order to provide solid evidences and grounding for the preparation of the SHRH and SHWDP 2020-2026. The evidences presented in the Situational Analysis report inform the development of this SHWDP 2020-2026 and are grounded in the realities and core issues of the health system and the MoH, being the national focal point and lead agency for health public policy, regulation and service delivery in Samoa.

The following sections summarised Samoa's health demographics, dynamics and trends, workforce characteristics, and efforts undertaken on workforce development strategies and actions – these are detailed in the Situational Analysis report (MoH, 2020).

1.2.1. Samoa health demographics, dynamics and trends

As per Situational Analysis (MoH, 2020), HRH and health workforce development are (or should be) shaped by the following health demographics, dynamics and trends in Samoa:

- *Samoa is a small island country*, this in itself presents natural challenges such as the lack of economic and financial resources, and limited pools of qualified people with the required technical experiences and expertise in various service areas and specialities of health.

- *Climate change* – Samoa, a small island state, is highly vulnerable to climate change which is impacting on health globally. Pollution and extreme weather conditions expose people to all sorts of health problem and risk as well as excess mortality. An expected increase in diseases and illnesses will continue to put pressure and demands on the health system and its workforce to respond and address health problems, risks and disease outbreaks, including implementing disaster and outbreak risk reduction and preparedness measures.

- *Samoa's health within a complex global system* – challenges such as new and re-emerging global diseases and factors/dynamics such as trade, migration and brain drain are beyond the control of the government and partners, but they will continue to impact on the health system and its human resources capacity. The health workforce needs to respond according to these ongoing challenges and dynamics including workforce preparedness for usual and unusual emergencies and events in order to mitigate impacts on public health and clinical health in Samoa.

- *Samoa's population is increasing, by approximately 1,632 people or 1% per year*, and this population increase remains higher among females compared to males (SBS, 2018). The human resources for health will need to increase to accommodate the ongoing growth in Samoa's population, including the special health needs of the female population in terms of maternal and child health, sexual reproductive health, and other services. Increased number of patients as well as the complexities of illnesses and conditions of patients (e.g. NCDs and communicable diseases) require the upgrade of knowledge and skills of health workers in different areas and specialisations of health.

- *Samoa's dependent and aging population* (aged below 21 years & 55 years and over) (which amounts to 61%) is increasing. Life expectancy is increasing, and remains higher among women than men. These evolving population demographic trends continue to demand more and better health and social services to care for the increased dependent population. Implications for additional and better maternal, paediatric and child care, mental, disability and palliative care services are self-evident.

- *NCDs account for over 80% of all deaths* and more than half of premature deaths in Samoa. Reducing communicable diseases and maternal mortality rates are unfinished businesses for Samoa (HSP, 2019-2030, p. 3). The human resources and workforce for

health need to address and respond to the burden of rising non-communicable diseases (NCDs) as well as the uprising of communicable diseases on the health system, public expenditure and economy.

- *The health has the highest allocation of the government total budget* (SAT$112,081,674 for the 2019/2020 financial year). Completing demands to address priorities in other sectors may mean that there is a need for consolidated efforts to address deficiencies that exist and improve operational efficiency in the health system, within existing resources and capacities.

- *The 2019 measles epidemic* and implications confirm declining immunisation rates; partly contributed to a lack of public trust in the health system, and a weakening focus on primary health care over the past recent years. It attests to the ability of the health system to respond effectively and efficiently to disease outbreaks. Samoa is recovering from the impact of this epidemic, and it needs to use the lessons from this set-back experience to improve the health system.

  The experiences with the 2019 measles outbreak as well as with the coronavirus (COV-19) global epidemic further show that given its limited local manpower capacity for health, Samoa cannot on its own deal with major health issues such regular disease outbreaks – it needs the support and response of other health actors both in Samoa and from other countries – working together in partnerships.

1.2.2. Samoa health workforce characteristics

The full analysis on the Samoa's health workforce characteristics, dynamics and trends is provided in the Situational Report – their implications for the Samoa health workforce development are reiterated as follows (MoH, 2020):

- *Imbalanced occupational/professional distribution* – 45% of the total MoH workforce are in nursing and only 6% are medical physicians/doctors. A total of 4% are in dental services, 2% in pharmaceutical services, and 10% in allied health services (AHS).[i] A total of 23% are in hospital support services (HSS), 9% in corporate support areas,[ii] and 1% in management.

  These percentages show an imbalanced distribution of the workforce in relation to different professional/occupational groups in health. Health workers in key clinical areas such as medical (e.g. physicians) and allied health services (e.g. physiotherapists) are relatively lower in numbers compared to health workers in the HSS for instance.

- *Imbalanced locational distribution of health workers* – 78% of workers are located in

[i] Allied health services (AHS) include all health technicians, scientists and other technical professionals (except medical doctors) in the laboratory, medical imaging and radiology (MIR), health promotion, enforcement and surveillance (HPES), and other allied health services (OAHS). OAHS include physiotherapy, prosthetic and orthotics, mobility services, social services, and biomedical services.

[ii] Hospital support services (HSS) include domestic assistants/cleaners, security, kitchen, porters, medical records, and transport). Corporate support area includes strategic policy and planning, research, legal, information management, finance, auditing, HR, procurement, sector coordination, administration, registrar, quality assurance and professional development – all work areas concerning policy, governance, regulatory, administration and corporate support of health.

the Upolu's main TTM hospital and MoH main office (health worker density is 8.43 per 1,000 population). Only 10% are located in the Savaii's main MTII hospital including its Tuasivi administration office (health worker density is 3.35 per 1,000 population). Only 12% are located in the district hospitals (DHs) and (rural) health centres (HCs) with a health worker density of 1 to 2 health worker per 1,000 population.

- *Imbalanced gender distribution* – the male to female ratio is 40% to 60%, with males dominating the medical doctor/physician profession, pharmaceutical services, medical imaging and radiology (MIR), other allied health services (OAHS) and HSS. Females outnumbered the males in the nursing, laboratory services, dental services, health promotion, enforcement and surveillance (HPES), corporate support (CS) areas, and management.

- *Young workforce* in terms of ages and experiences – 43% of the MoH workforce are below the age of 31 years (with 19% below the age of 25) - the majority are nurses (57%) and physicians/doctors (58%) followed by staff in the laboratory, HPES, pharmaceutical and OAHS. A total of 72% of the total MoH workforce have less than 5 years' experience - with 54% having 1 or less than 1 year of working experience – the majority are nurses.

- *Higher retirement* (within the next 6 to 10 years) in certain professional/occupational groups such as dental (38% will retired in the next 6-10 years) and nursing (most are senior midwives and dental therapists) will leave critical gaps in these service areas. A total of 9% of the workforce are retirees while 26% will retire in the next 5-10 years. A total of 2 senior doctors are retirees and 14% will retire within the next 6-10 years. A total of 10% of nurses are retirees and 16% will retire within the next 5-10 years.

- *Higher educational achievements* – 16% (of the MoH workforce) hold an undergraduate certificate or diploma, 46% hold a bachelor degree, 4% hold a postgraduate certificate/diploma, and 3% hold a master degree - as the highest qualification attained. A total of 31% are school leavers.

- *Professional/occupational health worker density per 1,000 population* – Samoa's national health worker density is 4.66. The nursing has the highest worker density of 3.15, followed by HSS (1.58) and corporate support (0.62). The national medical physician/medical doctor density is 0.58. The medical specialist density is 0.01 to 0.06 per 1,000 population – but it's worth noting that medical specialists may not necessarily work or practise in their specialised areas of medicine. Most of those in the private sector are working as general practitioners. The national midwife density is 0.42. All other health professions have a worker density of below 0.3. The TTM hospital has the highest density of all health professionals compared to the MTII Hospital and DHs/HCs.

- *Turnover rate* – around 8% of health workers leave the MoH every years – 4 to 5 (or 8%) of doctors and 5% of nurses leave the service every year.

1.2.3. Previous workforce development policy/strategy/plan

This SHWDP 2020-2026 builds on progress made and lessons learnt with the implementation of the previous policy/strategy and plan – the 'MoH HRH Policy & Plan of Action 2007-2015' and 'National Health Service (NHS) Workforce Development Plan 2014'. **Annex 3** and **Section 4.2** of the Situational Analysis Report (MoH, 2020) summarised the 2016 Review of the MoH HRH Policy & Plan of Action 2007-2015 and provided a review of the NHS Workforce Development Plan 2013-2018, based on the document review and consultations held with MoH staff in September 2019 to January 2020.

These reviews, based on the document review and consultations conducted on the development of the SHRHS and SHWDP 2020-2026, highlighted the following status and lessons learnt about health workforce development in the MoH:

- There was limited implementation of key workforce development activities[iii] identified under the HRH Policy & Plan of Action 2007-2015 and NHS Workforce Development Plan 2013-2018.

- A number of workforce developmental areas[iv] identified under the HRH Policy & Plan of Action 2007-2015 and NHS Workforce Development Plan 2013-2018 remain relevant to date, and to this SHWDP 2020-2026. Addressing these developmental areas requires the implementation of long-term strategies and actions aimed at addressing health workforce development – which will continue to build upon previous, existing and ongoing efforts aimed at improving and sustaining HRH and health workforce development.

- Monitoring and evaluation (M&E) of the implementation of the HRH Policy & Plan of Action 2007-2015 and NHS Workforce Development Plan 2013-2018 were limited. Proper documentation on the status of implementation was lacking.

- It is not clear who was responsible for the implementation and M&E of the various activities under the HRH Policy & Plan of Action 2007-2015 and NHS Workforce Development Plan 2013-2018, including reporting on progress made on the implementation progress of these policies and their action plans.

- Given limited M&E, an identification of a way forward and lessons learnt on health workforce development based on any proper assessment of the implementation status of existing policies and action plans was lacking.

Most actions identified under the NHS Workforce Development Plan 2013-2018 and MoH

[iii] Such as developing postgraduate programs in local universities, implementation of a 'hard to recruit' strategy for priority medical specialists, temporary employment of overseas nurses to fill vacancies, provisions of various specialised training and credentialing programs for all clinical and allied health areas, establishment of positions in allied health profession areas to give confidence to school leavers to undertake studies in allied health disciplines, establishment of a Workforce Development Committee, and others.

[iv] Such as strengthening human resource information management, partnership development, pre-service and in-service trainings, professional development, performance management, OHS, workforce planning, resource availability for staff (especially those in rural areas) to deliver and improve health services, salary model for doctors, promotion of staff policy, development of sub-specialisation interests, forecasting of required health workers, and others.

HRH Policy & Plan of Action 2007-2015 were not properly followed through in terms of implementation. As such, the consultations indicated that most staff, particularly those in the clinical services, were sceptical about the effective and efficient implementation of a further health workforce development plan, if issues and aspects of implementation are not given serious and proper consideration in this next follow-up health workforce development plan.

1.3. Key health workforce development issues and challenges

The Situational Analysis Report (MoH, 2020) further provides a full analysis of key health workforce development issues and challenges, that the MoH and its partners and stakeholders need to consider and address in health policy, strategies, planning and programming initiatives. A summary of these key issues and challenges is provided as follows:

1.3.1. Shortage of health workers, imbalance workforce distribution and inadequate resourcing of health facilities especially those in rural areas

The evidence summarised under section 1.2.2 confirms the critical shortage of health workers across all service areas of health. The national health worker density is 0.58 per 1,000 population for medical doctors/physicians, below 0.3 per 1,000 population for the allied health workers, and 0.42 per 1,000 population for midwives. The medical specialist density is 0.01 to 0.06 per 1,000 population. As well, an imbalanced distribution of health services and workforce across health facilities and health population in Samoa exits. The health worker per 1,000 population for the Upolu TTM hospital is 8.43, while it is 3.35 for the MTII hospital in Savaii, and 1 to 2 for the rural DHs/HCs.

Health facilities especially those in rural areas are not properly resourced which partly contributed to existing deficiencies in service delivery and staff performances. Given the lack of health services and amenities (e.g. laboratory, medical imaging and radiological, pharmaceutical and allied health services) in rural areas, most residents living in rural areas still prefer to travel to the main TTM hospital for health services even for basic outpatient consultation services.

1.3.2. Health partnerships for better utilisation of workforce available in country

The analysis presented in section 2.3 of the Situational analysis Report (MoH, 2020) further shows a total of 115 local medical doctors in Samoa - 20 house surgeons and 95 fully registered medical doctors. Of these 95 fully registered medical doctors, 61% (or 58) are working in the MoH while 39% (or 37) are working in the private sector. Table 1 and Figure 1 below show the areas of specialisations of these 95 medical doctors – 13 doctors have specialisation in obstetrics & gynaecology, 12 specialists in general surgery, 8 in internal medicine, 6 in anaesthesia, 5 in public health, and so on. The key question to consider here from a health workforce planning and development perspective is '*are the available health human resources available in country best utilised at the moment for health service delivery*?'

Experiences with health systems in other countries show that the government and its public health system cannot on its own deliver better health services. It needs to utilise the resources and services already available in the private sector (and in other countries) to

assist with the shortage of staff in hospitals and health clinics. It is the role of government (and this includes MoH) to ensure that the available capacity and resources in-country are best utilised so that the people receive the best care possible.

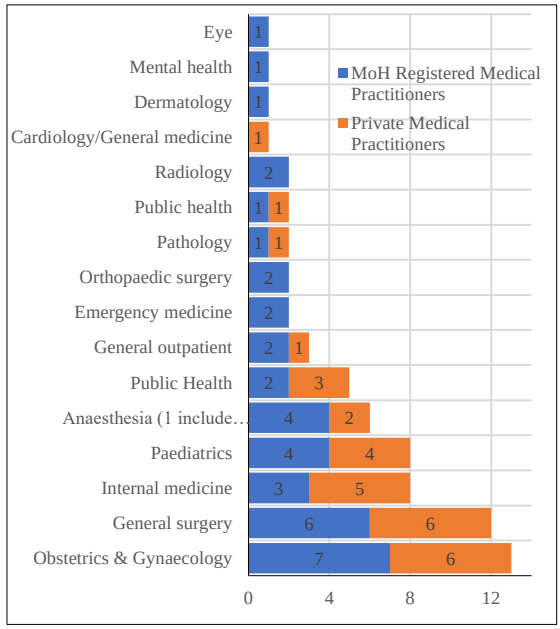
The extent of the utilisation levels of available health workers in country needs proper assessment and research. The Situational Analysis Report assessed that while the significance of 'partnership in health' has been emphasised in many health plans and policies over the years, it is difficult to clearly see well-articulated working partnerships (including outsourcing policies and arrangements) that promote and operationalize the better utilisation of available health services and professionals in the private sector. The intention of 'partnerships in health' is not yet fully materialised in Samoa, with most of the health services still controlled and delivered by the public sector.

The workload in the public health system which is mainly shouldered by the MoH's workforce can be minimised through better utilisation of available health workers in the private sector, most of them are doctors/physicians – sharing the burden of delivering health services across different health areas, such as in general outpatients, paediatrics, primary health care, preventive health, mental health, and other health service areas.

Table 1: Medical practitioners in Samoa, Sept 2019
Source: MoH Registrar records (MoH, 2020)

Specialty	MoH	Private	House Surgeons	Total	% MoH + Private
Obstetrics & Gynaecology	7	6		13	14%
General surgery	6	6		12	13%
Internal medicine	3	5		8	8%
Paediatrics	4	4		8	8%
Anaesthesia (1with Intensive Care)	4	2		6	6%
Public Health	2	3		5	5%
General outpatient	2	1		3	3%
Emergency medicine	2			2	2%
Orthopaedic surgery	2			2	2%
Pathology	1	1		2	2%
Public health	1	1		2	2%
Radiology	2			2	2%
Cardiology / General medicine		1		1	1%
Dermatology	1			1	1%
Mental health	1			1	1%
Eye	1			1	1%
No speciality	19	7	20	46	
Total	58	37	20	115	
	95		20		

Figure 1: Medical practitioners in Samoa, Sept 2019



1.3.3. HRH and health workforce development systems, processes and practices

The Situational Analysis Report (MoH, 2020) highlighted that 88% of the required HRM and workforce development areas in the MoH are '*not done too well, needs a fair bit of effort'* and 13% are '*done but needs improvement*' (see **Annex 8** in MoH, 2020). This reflects an under-appreciation of the significance of HRH, and that there is a great need to strengthen the functions of HRH including workforce planning, at the strategic and operational levels.

A number of HRH systems (policy, planning, processes, structures, and procedures) need further development and strengthening. A good HRH system for health should be able to

provide sound policy analysis and advice that support and guide decision-making about the management of people and staffing matters, as well as facilitating the development of a quality and productive health workforce. Existing policies, procedures and ethos that are constraining (and not enabling) the positive development of a required health workforce for Samoa and not servicing the national interests for a *healthy Samoa* need to change. Some of these policies and procedures are as follows:

- Scholarship schemes need to be properly aligned to the critical priority HR needs of health rather than basing mainly on the interests of individuals at the expense of organisational needs and interests.

- Study leave policy, scholarship bond and staffing policy encourage qualified people to go on study leave and not to return to work in critical areas of health. Samoa is training people to go away which means there is a limited return in the investments made on human resource development if people on study leave do not return to the areas of their trainings - those areas that Samoa needs the most in terms of qualified people.

- The removal of the 'direct graduate placement' policy and practice meant that sponsored students do not return to serve in critical areas and that there is no guarantee that students will return to work in areas that are mostly needed, and especially given the non-enforcement of the scholarship bond.

- Opportunities are made available but not fully utilised (e.g. OUM scholarships) – existing policies do not allow support staff to work as medical students during their third and final years. There is a need to have a local supportive system to encourage students to utilise existing study opportunities.

- Compulsory retirement policy is affecting the manpower needs in critical areas (e.g. doctors and midwiferies) and where there is an ongoing shortage of staff. The retirement policy should be reviewed to allow staff who are retired but still fit to work. There must be an emphasis on knowledge transfer and succession planning for areas where retirement will leave big workforce gaps in the near future.

- The direct promotion and reclassification of positions policy do not allow for the progression (and hence retention) of staff in specialised areas (where there is a lack of market competition) Direct promotion in this case should be allowed provided that staff recommended for promotion have demonstrated exceptional work performance and with years of specialised experiences that are mostly needed by the health services.

- Operational control from the PSC of decisions on operational staffing matters is contributing to unnecessary delays and red tapes with the implementation of health HR policies and processing of staff requests and other staffing and HR matters.

1.3.4. Developing a positive health workforce culture

Building a positive working culture across all sections of the MoH and health partners is needed - so that there is a strategic understanding and collective ownership of the key issues in the health system and the prioritisation of resource allocation towards addressing

those issues. The consultations (see Situational Report in MoH, 2020) reaffirm the ongoing issue of a silo/territorial and blaming culture existing among units and professional groupings of the Ministry. This issue is to be considered and addressed, so that a positive collaborative working culture is built across all sections, and that there is a better utilisation of existing resources to improve and extend health services.

The workforce is supportive of the vision and reforms of the MoH and the health sector. The consultation and staff perception survey findings (see **Annex 7** of the Situational Analysis Report in MoH, 2020) highlighted that staff especially those at the middle management level want to be part of the development process of the reforms including the planned changes in health. This is crucial so that staff are able to contribute to the effective and efficient implementation of the changes that are required at different levels of the workforce and organisation for the implementation of the health vision at those different levels. Thus communication from the top level of leadership/management to the middle management and operational level staff is being identified as an area needing further improvement.

1.3.5. Attraction and retention of critical health workers

The quality of health services is a reflection of the quality of the health workforce. The health workforce characteristics and realities presented in the Situation Analysis (MoH, 2020) and summarised in section 1.2.2 above show that issues concerning the attraction and retention of skilled and experienced people in key clinical and allied health service areas need serious consideration. There is a need to retain a minimum number of doctors to maintain a good health service at the hospitals and health centres. Retention strategies are to be considered in order to maintain that minimum number of medical doctors/physicians at the hospitals and health centres including the most critical specialised clinical areas.

The highest turnover rate is noted in the medical profession (in all clinical areas) and then in the allied health areas (e.g. physiotherapy and laboratory scientists/technicians). Around 5 doctors (most are senior medical specialists) leave the service every year. With around 72% of the workforce having less than 5 years of working experience (which is a reflection of the maturity levels of the workforce), the health system does not have sufficient qualified and senior experienced people to deal with the ongoing complexities of health and its developmental issues and challenges.

Doctors/physicians, nurses and allied health workers deal with sick people on a daily basis - to ensure that quality care services are provided on time. They are also the health workers (especially doctors) with the most complaints about long hours of work (overwork and fatigue) and other HR issues (e.g. cut in overtime payment and lack of salary adjustments in recognition of qualification achievements). Their needs as key people of the organisation delivering frontline services must be properly taken care off. The consultation and staff satisfaction survey findings (see **Annex 7** of the Situational Analysis Report, MoH, 2020) show that most medical doctors leave not only because of remuneration levels, but because of their frustrations with the system. Most doctors do not feel like coming to work and being at work. They feel that their issues are not being considered and addressed – which is about providing that supportive environment for the workers. All doctors who participated in the survey stated that they are overworked. The discussions further indicated that this issue need further serious consideration, otherwise most senior doctors will leave the service. The survey findings further show that ‘a positive working environment’ and ‘job

satisfaction' are the factors that motivate people the most to come and being at work. Most of staff who responded that 'they are considering leaving the MoH within the next 2 to 12 months' are doctors, nurses and some in the allied health service areas.

1.3.6. Health workers' working conditions and entitlements

The lack of attention given towards addressing staff concerns about their working conditions, entitlements and other employment matters (remuneration, entitlements, occupational health and safety, hours of work, etc.), including the provisions of administrative support is the cause of the many frustrations, unhealthy communications and relationships between and among staff, as well as low staff morale in the workplace. The MoH management and HR unit need to address a number of these issues (most of them are outstanding) that were consistently raised during the consultation with staff (see sections 3.3 and 4.3 of the Situational Analysis Report (MoH, 2020)). Apart from those already identified under other sectors above and below, the following are examples of these burning staffing issues:

- Cut in overtime hours and payment without proper explanation for the cut.
- Staff (especially nurses) not working in areas where they are properly trained or working in areas where they have not had proper training.
- Inconsistencies in remuneration levels of doctors and nurses commensurable with qualifications and years of experiences.
- Lack of staff professional development across most clinical areas of health.
- Need to provide proper counselling service for workers especially front line staff (e.g. doctors and nurses) given their everyday exposure to patient issues, traumatising experiences, workload and burnout.
- The on-call system of doctors needs to be reviewed to ensure timely responses from doctors to attend to patients when required.
- Need for better succession planning across all units of the MoH.
- Staff benefits and entitlements are not given proper consideration – e.g. slow response from HR unit of the MoH on salary adjustments of staff in light of their qualification achievements and inconsistent application of benefits and entitlements among staff.
- Need for better administrative support to the DHs/HCs so that nurses are supported in the performance of their primary care and clinical roles and are relieved from undertaking

1.3.7. Health workforce and professional development, succession planning and career pathways

Health care involved technical and specialised skills - and staff need to be continuously trained in the different areas of health care including the use of medical equipment, tools and applying methods. Improvements in staff performances and health services are

expected. However, customised capacity development, professional development, and succession planning is lacking (or is provided but limited to a large extent) across all health professionals. Developing and implementing an appropriate professional development framework (encompassing the required professional development standards and criteria and staff capacity developmental strategies, policies and procedures, across all health professionals) is needed.

There is not enough training and professional development provided for staff especially front line health workers and particularly the needed trainings in specialised areas of work and services. There are some local trainings provided but are provided to a few staff and are often ad hoc in their provisions. The availability of training opportunities depend on the ability of the responsible manager to look for opportunities and to lobby for sponsorships and funding through their networks. For the doctors and nurses, their only local professional development activity is the CME (continuing medical education). There are no other formalised professional development programs (e.g. fellowships) for the different health professions. There is potential to develop programs (e.g. fellowships and teaching careers for senior and near retired workers) for the different health professions provided that the appropriate incentives and structures are established to enable a professional development culture. This includes developing the local institutions (e.g. medical schools and medical profession) and individuals so that they have the capacity to provide professional development programs.

A review of career pathways and structures of all health professionals is needed to facilitate and support professional development, succession planning, attraction and retention of health workers. The medical doctor profession is the only profession that had its career salary and structure recently reviewed and approved by the NHS Board, Remuneration Tribunal and Cabinet in 2015. However that approved career and salary structure has not been implemented effectively, citing differences in interpretations as the issue. With the localisation of the medical schools and plans to develop these schools further to accommodate provisions for postgraduate courses, the career structures of health professions should be revised to encourage health workers to take up courses and other professional development initiatives. The career structures must also provide incentives for the professional development and career development of health workers.

1.4. Samoa health workforce development plan - purpose and objectives

This Samoa Health Workforce Development Plan (SHWDP) 2020-2026 is a policy attempt by the MoH in response to the health workforce issues and challenges identified in the previous sections. The SHWDP focuses specifically on the ‘workforce development’ function and role of HRH, hence it complements, reinforces and operationalizes the implementation of the broader human resources for health (HRH) strategies and actions identified under the Samoa Human Resources for Health Strategy (SHRHS) 2020-2026.

The purpose of this SHWDP 2020-2026 is to identify the Samoa MoH workforce needs and workforce development priorities for the next 5 years. The SHWDP, if implemented, is expected to contribute to the achievement of the Samoa health sector development outcomes and priorities identified under the HSP 2019-2030.

The SHWDP 2020-2026 signifies the significance of workforce development as a critical component of HRH – that without addressing critical health workforce needs and priorities,

there will be limited realisation of the HSP's vision of *A Health Samoa* and its outcomes, which are all aimed at improving the health systems and health service delivery in Samoa.

The SHWDP 2020-2026 aims at providing the MoH with policy responses and options, possible strategies and actions to respond to the key health sector challenges and health workforce development issues and gaps identified in the previous section. The objectives of this SHWDP 2020-2026 are therefore:

- To define the quantity, composition, skill mix, training credential of the health workforce;
- To facilitate a balanced distribution/deployment of the workforce among referral hospitals and primary care facilities;
- To provide a 10-year health workforce projection;
- To define critical health workforce needs to address as priorities; and
- To provide possible strategies and actions to address gaps in health workforce needs and workforce development requirements.

2. CURRENT & FUTURE HEALTH WORKFORCE NEEDS

2.1. Health workforce demands

2.1.1. Defining the health workforce

Health workers refer to "all people engaged in actions whose primary intent is to enhance health", and are normally disaggregated according to three subgroups: "*physicians*", "*nurses/midwives*", and "*other cadres*". Other cadres refers to "*dentistry personnel; pharmaceutical personnel; laboratory health workers; environment and public health workers*; and *community and traditional health workers, health management and support health workers, and other health workers"*. Other health workers include "*medical assistants, dieticians, nutritionists, occupational therapists, medical imaging and therapeutic equipment technicians, optometrists, ophthalmic opticians, physiotherapists, personal care workers, speech pathologists and medical trainees*" (WHO, 2016c, p. 5 & 9).

In Samoa, health workers are defined as "*healthcare professional*" under the 'Healthcare Professions Registration and Standards Act 2007' and are persons registered or entitled to be registered under that Act or any of the Professional Acts as a *medical practitioner; dental practitioner; nurse or midwife; pharmacist; and allied healthcare professional*. The above act and the Allied Health Professions Act 2014 further define the different allied health professionals.[v] These definitions do not necessarily mean that all these different health workers or health professionals exist in Samoa.

Maintaining a reasonable balance in terms of numbers, diversity and competencies of the health workforce in response to the driving forces and challenges that shape health, including the education systems and labour markets requires the development of a health workforce that is inclusive of all healthcare professionals under the above six cadres. Defining and determining the health workforce needs must address the following areas, as discussed under the previous section 1.2:

- Samoa's health population trends and dynamics;
- Current and emerging health challenges at the global, regional and local levels;
- Gaps in health services, across different areas of health;
- Existing, ongoing and future shortages in human resources for health;
- Best practices in human resources for health considering the global shortage of health workers which is a universal challenge for every country and health system; and
- Development priorities of the health sector and the Ministry of Health including the strategic outcomes set out in the health sector plans, policies and directives.

The Situational Analysis (MoH, 2020) provides the detailed background information and analysis for this 'Samoa Health Workforce Development Plan' (SHWDP) 2020-2026.

[v] Include *audiologists, chiropractors, dieticians, nutritionists, physiotherapists, occupational therapists, speech therapists, acupuncturists, massage therapists as health practice for healthcare, chiropractors, podiatrists, environmental health officers, health promotion officers, qualified first aid officers, counsellors, psychologists, social workers, radiographers, medical laboratory scientists, medical laboratory technicians, pharmacologists, qualified pharmacology applied profession analysts, biomedical engineers, biomedical technicians, optometrists, optometrist technicians, orthotists, prosthetists, naturopaths, traditional birth attendants and traditional healers*.

2.1.2. Current demands by health facilities or service areas

Determining current and future health workforce needs to take into account population health demographics, dynamics and trends, health workforce characteristics and profiles, key workforce development issues/challenges, as well as health development issues and priorities (as discussed under section 1 of this SHWDP).

Tables 2 and 3 show the MoH's current workforce demands, based on the consultations held with MoH staff from September to November 2019. Staff were asked to provide existing and proposed (comfortable and not ideal) numbers of workers that their facilities, units or departments required - considering factors such as:

- current population health demographics (e.g. number of people in the service area, types of illnesses and diagnoses/treatments required);
- needed services (that are and are not being provided due to staff shortage – e.g. cervical cancer screening, and heating testing for children);
- demands (number of patients, follow-ups required, visitations, etc.);
- staff workloads (e.g. amount of hours worked, staff burnouts, staff absence (e.g. 1 to 2 staff on leave, on training or attending a meeting or another commitment); and
- duties performed and not performed (e.g. management, supervision, research, training, or professional development not undertaken properly due to overwork with clinical work) (see (MoH, 2020)

a) Medical doctors and nurses

Table 2 gives the current shortfalls of medical doctors/physicians, nurses and midwives across the different health facilities (TTM hospital, MTII hospital, District hospital, and Health Centres) and clinical areas of the two main national referral hospitals). The current MoH staff is short of 100 medical doctors/physicians and 226 registered nurses (inclusive of midwives) across the different health facilities and areas of clinical services.

Table 2: Current demands for medical doctors and nurses by health facilities/service areas
Source: MoH (2020)

Department/ Unit/ Section	Current physicians required							Current nurses required						Required specialisation
	HoD	CS	SR	R	Total	Gap		NM	SNS	RN	EN	Total	Shortfall	
TTM Hospital (Upolu)														
General Outpatient	1	1	2	5	9	4		1	1	12	6	20	8	
Accident and Emergency	1	1	3	6	11	5		1	1	24	8	34	3	
Paediatrics	1	2	2	5	10	6		1	1	20	6	28	5	
Obstetrics & Gynaecology	1	2	2	4	9	4		1	1	52	6	60	9	Midwives
Surgical Unit (Acute 7)	1	2	3	6	12	5		1	1	18	6	26	8	
Medical Unit (Acute 8)	1	2	3	3	9	5		1	1	18	6	26	6	
ICU	1	1	2	2	6	6		1	1	32	6	40	15	
Anaesthesia/OT	1	2	2	2	7	1		1	1	20	6	28	5	
Mental Health	1	1	1	1	4	3		1	1	10	6	18	8	
Eye/Ophthalmology	1	1	1	1	4	3		1	1	5	6	13	8	Eye
ENT	1	2	1	2	6	5		1	1	5	6	13	11	ENT
Public Health	1	2	2	2	7	6		1	1	20	12	34	4	Public Health
Laboratory Services	1	1	1	1	4									
MIR Services	1	1	1	1	4									
Oral and Dental Services	1	2	8	8	19									
Total	**15**	**23**	**34**	**49**	**121**	**53**		**12**	**12**	**236**	**80**	**340**	**90**	
MTII Hospital (Savaii)														
All Medical Units	1					1							1	
General Outpatient*		1	1	2	4	1		1	1	10	6	18	17	
Accident and Emergency*		1	1	2	4	4		1	1	10	6	18		

Public Health			1	1	2	2		1	1	20	10	32		
Paediatrics		1	1	2	4	4		1	1	5	4	11	11	
Obstetrics & Gynaecology		1	1	2	4	4		1	1	8	4	14	14	midwives
Inpatient (all wards)		1	1	2	4	4		1	1	10	6	18	18	
Anaesthesia/OT		1	1	1	3	3		*covered by inpatient nursing staff						
Mental Health			1	1	2	2		1	1	2	2	6	6	
Eye/Ophthalmology			1	1	2	2			1	2	2	5	5	
ENT			1	1	2	2			1	2	2	5	5	
Laboratory Services			1	1	2	2								
MIR Services			1	1	2	2								
Oral and Dental Services		1	2	2	5	3								
Total	**1**	**7**	**14**	**19**	**40**	**36**		**7**	**9**	**69**	**42**	**127**	**77**	
District Hospitals (DHs) and Health Centres (HC)														
Lufilufi HC			1	1	2	1		1		10	5	16	7	2 midwives
Lalomanu DH			1	1	2	1		1		10	5	16	1	2 midwives
Poutasi DH			1	1	2	1		1		10	5	16	12	2 midwives
Saanapu HC			1	1	2	1		1		10	5	16		2 midwives
Leulumoega DH			2	1	3	2		1	1	20	8	30	9	4 midwives
Faleolo HC			1	1	2	1		1		6	5	12	2	2 midwives
Foailalo DH			1	1	2	1		1	1	14	5	21	3	3 midwives
Safotu DH			1	1	2	1		1	1	15	5	22	9	4 midwives
Sataua DH			1	1	2	1		1	1	14	5	21	8	3 midwives
Satupaitea HC			1	1	2	1		1		15	5	21	8	2 midwives
Total			**11**	**10**	**21**	**11**		**10**	**4**	**124**	**53**	**191**	**59**	
Grant total (all facilities)	**16**	**30**	**59**	**78**	**182**	**100**		**29**	**25**	**429**	**175**	**658**	**226**	

b) Allied health workers

Similarly, Table 3 gives the current required number of allied health workers obtained from the consultations held from September to November 2019. The MoH is short of 226 allied health workers in total across the different service areas of allied health.

Table 3: Current required number of allied health workers
Source: MoH (2020)

Department/Unit/Section	TTM Hospital (Upolu)		MTII Hospital (Savaii)		10 DH & HC (Rural)		Total (All Health Facilities)		
	Current	Required	Current	Required	Current	Required	Current	Required	Shortfall
Dental	**25**	**40**	**3**	**7**			**28**	**47**	**19**
Therapist	22	30	3	4			25	34	9
Technician	2	5		2			2	7	5
Hygienist	1	5		1			1	6	5
Laboratory services	**16**	**51**	**5**	**9**			**21**	**60**	**39**
Scientist	4	15		2			4	17	13
Technician	12	36	5	7			17	43	26
Pharmaceutical services	**21**	**28**	**6**	**11**			**27**	**39**	**12**
Pharmacist	3	10		3			3	13	10
Technician	18	18	6	8			24	26	2
MIR Services	**28**	**46**	**4**	**8**			**32**	**54**	**22**
Radiographer	10	24	3	4			13	28	15
Sonographer	2	6		2			2	8	6
Technician	16	16	1	2			17	18	1
Other Allied Health Services	**70**	**121**		**33**		**50**	**70**	**204**	**134**
Audiologist		2		2				4	4
Physiotherapist	3	10		2			3	12	9
Occupational therapist	2	5		2			2	7	5
Speech and language therapist		2		2				4	4
Podiatrist		3		2				5	5
Echocardiographer		3		2				5	5
Prosthetist Orthotist	1	2		2			1	4	3

Prosthetist (lower limbs)	1	2		2			1	4	3
Orthotist (lower limbs)	1	2		2			1	4	3
Prosthetist Orthotist Technician	1	4		2			1	6	5
Biomedical Engineer	2	4		2			2	6	4
Biomedical Technician	1	3		2			1	5	4
Dietician	4	7		2		10	4	19	15
Nutritionist	3	7		2		10	3	19	16
Social workers / counsellor	2	5		2		10	2	17	15
Environmental Health (e.g. Health Inspector)	49	60		5		10	49	75	26
Administration Officer (for each DH/HC)						10		10	10
Total	**90**	**165**	**18**	**68**		**100**	**178**	**404**	**226**

2.1.3. A 10-year forecast for Samoa's population

The HSP 2019-2030 projected that Samoa's population will increase by 19,851 people, or nearly 10% (1% annually) over its 10 years lifespan. This growth in the population across different age groups will have direct implications for increased provisions of health service across different areas such as maternal, paediatric, rehabilitation, palliative and family care, including the need for other social welfare services.[vi] If the 1% annual increase based on the 2016 population census is used as a baseline, Table 4 gives Samoa's estimated populations over the next 10 years:

Table 4: 10-year increase in Samoa's population
Source: SBS (2018)

Year	Population	Increase (#)	Increase (%)	Status
2011	187,820			actual
2016	195,979	8,159	4.3%	actual (baseline)
2017	197,939	1,960	1.0%	annual estimate
2018	199,918	1,979	1.0%	annual estimate
2019	201,917	1,999	1.0%	annual estimate
2020/2021	203,937	2,019	1.0%	annual estimate
2021/2022	205,976	2,039	1.0%	annual estimate
2022/2023	208,036	2,060	1.0%	annual estimate
2023/2024	210,116	2,080	1.0%	annual estimate
2024/2025	212,217	2,101	1.0%	annual estimate
2025/2026	214,339	2,122	1.0%	annual estimate
2026/2027	216,483	2,143	1.0%	annual estimate
2027/2028	218,648	2,165	1.0%	annual estimate
2028/2029	220,834	2,186	1.0%	annual estimate
2029/2030	223,042	2,208	1.0%	10-year forecast

a) Medical doctors and nurses

Table 5 shows the current number of registered medical practitioners and nurses working in the MoH as at September 2019. The WHO suggested that a minimum health worker density to meet the SDG index threshold is **4.45 doctors, nurses & midwives per 1,000 population** (or 44.5 per 10,000 population) (WHO, 2016a).

Table 5 shows that this ratio for **MoH's doctors, nurses and midwives is 3.65 per 1,000 (or 36.48 per 10,000) population of Samoa**. Samoa is below the above WHO minimum threshold. If health workers (medical practitioners mainly) in the private sectors are included then the ratio per population is slightly higher – 3.89 per 1,000 or 38.88 per

[vi] For instance, health services for older people aged 60 years and above and for young people and children aged 12 years and below are provided for free (i.e. no hospital and outpatient fees) at the public hospitals. Some of the medication for older people with NCDs are subsidised by the government through the pension scheme.

10,000 population of Samoa. For the MoH (which is the main public health service in Samoa), the current gap of doctors, nurses and midwives (based on the WHO's defined ratio of 4.45 per 10,000 population) is 8.02. For Samoa, the current gap is 5.62 per 10,000 population, if private doctors/medical practitioners and nurses are included.

This ratio is however comprised mainly of nurses, with a ratio of 3.26 nurses to 0.39 for medical practitioners in the MoH. While the WHO does not state a required balanced composition between doctors and nurses, [vii] the existing ratio of 3.65 is obviously skewed towards the nurses – there are 3.26 nurses to 0.30 doctors (per 1,000 population) in the MoH, or 3.31 nurses to 0.48 doctors (per 1,000 population) in the whole of Samoa. It is difficult to say whether this is an imbalanced distribution given that there is still a shortage of nurses and medical doctors across health facilities and service areas, to service the whole population health needs of Samoa

Table 5: Current medical practitioners, nurses & midwives to population ratios, Sept 2019
Source: MoH (2020); WHO (2016b).

	Number	1,000 population	10,000 population	Gap/Shortfall	
				1,000 population	10,000 population
MoH					
Medical Practitioners	58	0.30	2.96		
House Surgeons	19	0.10	0.97		
Total doctors/physicians	***77***	***0.39***	***3.93***		
Nurses*	560	2.86	28.57		
Midwives	78	0.40	3.98		
Total nurses	***638***	***3.26***	***32.55***		
Total doctors and nurses	**715**	**3.65**	**36.48**	**0.08**	**8.02**
Samoa					
Medical Practitioners	95	0.48	4.85		
House Surgeons	19	0.10	0.97		
Total doctors/physicians	***114***	***0.58***	***5.82***		
Nurses*	570	2.91	29.08		
Midwives	78	0.40	3.98		
Total nurses	***648***	***3.31***	***33.06***		
Total doctors and nurses	**762**	**3.89**	**38.88**	**0.56**	**5.62**

** Exclude 47 Auxiliary Nurses.*
WHO's minimum health worker density to meet the SDG index threshold: 4.45 doctors, nurses & midwives per 1k population.

Using the above WHO defined minimum threshold, and if a minimum standard/threshold of **1 doctor/physician and 3.5 nurses and midwife per 1,000 population** is adopted for Samoa, for the purpose of forecasting the number of doctors, nurses and midwives[viii] based on Samoa's population needs, then Table 6 gives an estimated or projected required

[vii] There is currently no universal standard for a set required minimum number of physicians, even according to the WHO. A review of the literature (available online) shows that there is no consensus on the minimum number of physicians required for a health system. For instance, a 1:1,000 physician to population ratio is being cited by some scholars (in the health field) in India as the WHO recommended doctor to population (Deo, 2016; Pal & Kumar, 2018). One scholar (Dr Cooper) developed a 'demand based' model (USA based) to show how many physicians (by specialty) a given service area may be able to support economically (Hawkins, 2018a, 2018b). Dr Cooper's model suggested a ratio of 258.9 physicians per 100,000 (or 2.59 per 1,000) population. Suggested models, ratios and estimated number of health workers are only signposts/indicators; countries are recommended to develop their own thresholds. Whether suggested models are applicable to Samoa requires more research and analyses; many factors (e.g. population health needs and conditions, workloads, patient numbers, health workers' utilisation levels, etc.) need to be taken into account and which required more credible and reliable data, research and analytical grounding.

[viii] These numbers are aligned with the WHO's threshold of 4.45 doctors, nurses and midwives. The 2.59 physicians per 1,000 population (Dr Cooper's model) appeared as an *ideal* ratio. The 1 physician per 1,000 population seemed as a more *realistic* threshold/indicator for Samoa considering Samoa's current ratio of 0.58 physician per 1,000 population. Dr Cooper's threshold can be adopted but it is most likely that Samoa will never reach that threshold.

numbers of physicians (registered medical practitioners), nurses (registered) and midwives that Samoa needs over the next 10 years.

The current (i.e. current 2020/2021 financial year) shortfall of doctors, nurses and midwifes is 252.7 (108.9 physicians and 143.8 registered nurses and midwives). Assuming that the numbers of physicians and nurses and midwives in Samoa will remain around the same over the next 10 years (i.e. number of intakes remain constant), the number of physicians, nurses and midwives Samoa needs by 2029/2030 (over the next 10 years) is 338.7 to accommodate the 10% increase in its population.

Table 6: 10-year forecast number of medical doctors, nurses and midwives
Source: MoH (2020); WHO (2016b).

Year	Population	Required workforce numbers				Gaps/Shortfall		
		Physicians	Nurses & Midwives	Total		Physicians	Nurses & Midwives	Total
2020/21	203,937	203.9	713.8	917.7		108.9	143.8	252.7
2021/22	205,976	206.0	720.9	926.9		111.0	150.9	261.9
2022/23	208,036	208.0	728.1	936.2		113.0	158.1	271.2
2023/24	210,116	210.1	735.4	945.5		115.1	165.4	280.5
2024/25	212,217	212.2	742.8	955.0		117.2	172.8	290.0
2025/26	214,339	214.3	750.2	964.5		119.3	180.2	299.5
2026/27	216,483	216.5	757.7	974.2		121.5	187.7	309.2
2027/28	218,648	218.6	765.3	983.9		123.6	195.3	318.9
2028/29	220,834	220.8	772.9	993.8		125.8	202.9	328.8
2029/30	223,042	223.0	780.6	1,003.7		128.0	210.6	338.7

1 physician and 3.5 nurses = 4.5 per 1,000 population (4.45 WHO threshold round off to 4.5).
Included only 'registered' doctors & nurses. House surgeons, Enrolled Nurses and Auxiliary Nurses are excluded.

b) Allied health workers

There is no stipulated minimum number of required allied health workers. Each allied health professional may have its own minimum number of workers established according to its standards or scopes of practices. Samoa like many other countries have not developed a minimum number of required health workers for each allied health professional. During the 2019 consultations (see MoH, 2020), MoH staff were asked to provide the current and required (proposed) number of workers for their facilities/units/departments considering factors such as current health demographics, health services and demands, workloads, and others. The future projected numbers of allied health workers, disaggregated by professionals or occupational groups that Samoa will need over the next 10 years are provided in Table 7. For instance, Samoa will need a total of 441.8 allied health workers by the next 10 years to service its population numbers.

Table 7: 10-year forecast number of allied health workers
Source: Adapted from MoH (2020)

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30
Dental	**47.0**	**47.5**	**47.9**	**48.4**	**48.9**	**49.4**	**49.9**	**50.4**	**50.9**	**51.4**
Therapist	34.0	34.3	34.7	35.0	35.4	35.7	36.1	36.5	36.8	37.2
Technician	7.0	7.1	7.1	7.2	7.3	7.4	7.4	7.5	7.6	7.7
Hygienist	6.0	6.1	6.1	6.2	6.2	6.3	6.4	6.4	6.5	6.6
Laboratory services	**60.0**	**60.6**	**61.2**	**61.8**	**62.4**	**63.1**	**63.7**	**64.3**	**65.0**	**65.6**
Scientist	17.0	17.2	17.3	17.5	17.7	17.9	18.0	18.2	18.4	18.6
Technician	43.0	43.4	43.9	44.3	44.7	45.2	45.6	46.1	46.6	47.0
Pharmaceutical services	**39.0**	**39.4**	**39.8**	**40.2**	**40.6**	**41.0**	**41.4**	**41.8**	**42.2**	**42.7**
Pharmacist	13.0	13.1	13.3	13.4	13.5	13.7	13.8	13.9	14.1	14.2
Technician	26.0	26.3	26.5	26.8	27.1	27.3	27.6	27.9	28.2	28.4
MIR Services	**54.0**	**54.5**	**55.1**	**55.6**	**56.2**	**56.8**	**57.3**	**57.9**	**58.5**	**59.1**
Radiographer	28.0	28.3	28.6	28.8	29.1	29.4	29.7	30.0	30.3	30.6
Sonographer	8.0	8.1	8.2	8.2	8.3	8.4	8.5	8.6	8.7	8.7
Technician	18.0	18.2	18.4	18.5	18.7	18.9	19.1	19.3	19.5	19.7

Other Allied Health Services	204.0	206.0	208.1	210.2	212.3	214.4	216.6	218.7	220.9	223.1
Audiologist	4.0	4.0	4.1	4.1	4.2	4.2	4.2	4.3	4.3	4.4
Physiotherapist	12.0	12.1	12.2	12.4	12.5	12.6	12.7	12.9	13.0	13.1
Occupational therapist	7.0	7.1	7.1	7.2	7.3	7.4	7.4	7.5	7.6	7.7
Speech & language therapist	4.0	4.0	4.1	4.1	4.2	4.2	4.2	4.3	4.3	4.4
Podiatrist	5.0	5.1	5.1	5.2	5.2	5.3	5.3	5.4	5.4	5.5
Echocardiographer	5.0	5.1	5.1	5.2	5.2	5.3	5.3	5.4	5.4	5.5
Prosthetist Orthotist	4.0	4.0	4.1	4.1	4.2	4.2	4.2	4.3	4.3	4.4
Prosthetist	4.0	4.0	4.1	4.1	4.2	4.2	4.2	4.3	4.3	4.4
Orthotist	4.0	4.0	4.1	4.1	4.2	4.2	4.2	4.3	4.3	4.4
Prosthetist Orthotist Technician	6.0	6.1	6.1	6.2	6.2	6.3	6.4	6.4	6.5	6.6
Biomedical Engineer	6.0	6.1	6.1	6.2	6.2	6.3	6.4	6.4	6.5	6.6
Biomedical Technician	5.0	5.1	5.1	5.2	5.2	5.3	5.3	5.4	5.4	5.5
Dietician	19.0	19.2	19.4	19.6	19.8	20.0	20.2	20.4	20.6	20.8
Nutritionist	19.0	19.2	19.4	19.6	19.8	20.0	20.2	20.4	20.6	20.8
Social workers / counsellor	17.0	17.2	17.3	17.5	17.7	17.9	18.0	18.2	18.4	18.6
Environmental Health	75.0	75.8	76.5	77.3	78.0	78.8	79.6	80.4	81.2	82.0
Administration Officer	10.0	10.1	10.2	10.3	10.4	10.5	10.6	10.7	10.8	10.9
Total	**404.0**	**408.0**	**412.1**	**416.2**	**420.4**	**424.6**	**428.9**	**433.1**	**437.5**	**441.8**

2.2. Health workforce development needs

2.2.1. Workforce developments area

Table 8 summarises key workforce development areas needing consideration for improvements, those that were raised by MoH staff during the consultation process held from September to November 2019 on the development of the SHWDP (see MoH, 2020).

Table 8: Specific issues identified from the consultation processes, Sept/November 2019.
Source: MoH (2020)

Area	Specific issues and needed improvements
General outpatient services (GOS).	- 83% of the nursing staff have less than years of working experience in nursing. - Lack of incentives for medical staff to work and take up specialisations in GOS. - Limited career paths (big gaps between senior and young doctors in terms positions – e.g. no positions between Registrar & Consultant). - DHs/HCs to have their own medical doctors. - Lack emphasis on trainings in GOS specialised areas covered through the clinics.
Accident and Emergency Department (AED).	- Need for specialised trainings in AED areas. - Only 2 doctors have had proper formal training in emergency medicine. - Need for a Certificate in Emergency Care. - Need to upskill staff's skills in the AED areas.
Paediatrics.	- ICU Paediatric and Neonatal need a staff of their own. - There is not enough doctors to deal with many children with illnesses and health problems in Samoa. - Need training in the paediatric areas. - Samoa's infant mortality is high.
Surgical unit (Acute 7)	- Need trainings in the areas – e.g. endoscopy, acute care. - HoD post has been vacant since 2016. - Private Doctors in Samoa and in the region to assist with staff shortage.
Obstetrics and Gynaecology (O&G).	- Some services (e.g. breast and cervical cancer screening, family planning pap smear testing, and palliative care) are limited and are not provided (ad hoc) effectively due to limited staff. - Majority of midwives are reaching the retirement ages – there is a need for proper succession planning. - Some of the nurses with specialised trainings in the O&G areas are being

	transferred to work in other clinical areas, not utilising their training. - Uneven distribution of midwives across the different health facilities. - Need for development of sub-specialities in O&G – with the increased complications of maternal cases.
Intensive Care Unit (ICU).	- Need trainings on invasive and non-invasive treatments including other specialised areas such as Acute Care. - Need a protocol and guidelines on staff allocation. - Needs a HoD of its own. - Need to look at the on-call of doctors for ICU to ensure there is a doctor for the unit especially after hours.
Anaesthesia.	- Only one doctor with postgraduate degree in Anaesthesia. - Anaesthesia services need to be made available to Savaii. - Ongoing training of young doctors in the area is needed – succession planning.
Medical unit (Acute 8)	- Unit is critically understaffed with only Senior Registrar. - Decreasing number of senior doctors in the service. So the workforce is not improving
ENT	- Only one doctor working in the area for the whole of Samoa. Services is limited in scope and quality. - Need for more doctors including audiologists to service population needs. - Need for more doctors and specialised trainings in the area.
Eye/ Ophthalmology	- No doctor in the private sector. Only one working in the TTM hospital. - Services is limited in scope and quality, not able to expand to cover Samoa's population. - Need for more doctors and specialised trainings in the area.
Mental Health	- Only one doctor for the unit for the whole of Samoa. - Mental health services are limited and not fully effective due to limited staff.
Public Health (Inclusive of health promotion, education and enforcement - HPED).	- Need for more public health physicians. - The focus on strengthening public health needs to be supported with more staff and resources to be provided to the DHs/HCs. - Need for staff across the Ministry to understand what is need to implement and operationalise the MoH's vision to revise and strengthen public health at the community and national levels – what is involved in this process and what staff need to do. - Need to strengthen health promotion, education and enforcement roles. - No formal training on public health. A course was offered at NUS but it got suspended. - Lack of career pathways and structure to accommodate and entice graduates into the areas of public health.
Oral and dental health services.	- 62% of dental staff are at the ages of 38 years and over – 10% already retirees, 10% retiring within the next 5 years, 38% retiring within the next 6-10 years, and only 4% within the ages of 38-43. - Dental nursing course's discontinuation (at NUS) had led to the limited number of dental assistants/nurses graduating every year. - Urgent consideration of this succession issue is needed so that there are sufficient dental staff in place over the next 10 years. - Ongoing training is needed to upskill staff.
Clinical – Across and General Across all areas of health	- There is a lot of complaints with the services because of the shortage of staff. - Staff shortage - standards for staff: patient ratios are not met. - Increased number of patients and complications of illnesses and diseases meant there is a need for more medical staff and more specialised trainings. - Need to strengthen orientation programs for medical and nursing interns. - Disparities in salaries of doctors and nurses considering years of experiences. - Lack of proper, formal and accredited in-house training programs for

	medical and nursing staff. - Lack incentives and conditions for doctors to work in needed areas of services (e.g. DHs and HCs). - Young workforce – not enough senior staff in the medical and nursing fields. - High staff burnout and fatigue due to overwork. Staff turnover – unappreciated. - Staff are asking for more work life balanced working conditions. - There is a need for clinical research. - Need for succession planning – including training of young doctors due to take up roles of senior doctors leaving the services. - Not enough funding for postgraduate studies. - Need upskilling of staff - Need to account for attitudinal changes of new nursing and medical interns. - Need for accredited in-house training for doctors including fellowship programs. - Need to review the career and salary structure of medical doctors in order to provide incentives and conditions for doctors to work in the most needed clinical areas and to select those areas for further studies. - Strengthen medical students' exposure to clinical life. This includes having in place a buddy system so that students get more exposure to patients and treatments. - Need to consider the reoffering of the Postgraduate course in Acute Care. - Proper counselling for staff and patients is needed. - There is limited or no time for own training and professional development and to provide training of staff due to staff shortage. - Need for training in specialised areas of the different units. - Need to consider exams for doctors/nurses as part of reissuing practising license. - Proper administrative support is needed to be provided to every clinical unit including DHs/HCs for improved services and technical staff performances. - Need to revisit nursing curriculum to equip nursing and medical graduates with the right skills to enter the workforce. - Need to relook at the nursing and medical schools entry requirements in order to upgrade the quality of graduates. - Need to review career structure and pathways of all health professional groups.
Medical Imaging and Radiology (MIR) Services.	- The 6 Principal Radiographers will retire within the next 10 years`. - Only two radiographers are sonographers – not enough for Samoa's population. - 3 local doctors in the department are not yet fully fleshed radiologists. - Need for a clear professional development strategy, succession planning and scholarships allocation so that there is a consistent number of qualified technicians feeding into the services. - Proper credentialization of existing staff is needed. - Low pay of technicians comparing to other officers in less or non-technical areas (e.g. those in administrative roles). - The existing organisational structure does not support or facilitate the development of the leadership and management requirements for the department/unit.
Laboratory Services.	- Turnover rate for the unit is 16%. There is local competition for scientists. - The existing organisational structure does not support or facilitate the development of the leadership and management requirements for the department/unit. - Specialisations in the different areas are needed given the increased complications and specificity of diagnoses and testing.
Pharmaceutical Services.	- High turnover of pharmacists to private pharmacies. - No formal training and/or professional development programs for the unit.

	- Need to consider the outsourcing of some of the dispensary of drugs and medicine to private pharmacies in order to lessen workload of the unit and for the unit to be able to improve their services to cover the DHs/HCs where private pharmacies are not available.
Other Allied Health Services (OAHS).	- Development of allied health areas is limited – not given due consideration or emphasis MoH has never had more than 1 or 2 physiotherapists at most times – turnover issues. This is the same cases in OAHS areas such as biomedical, orthotics and prosthetics, podiatry, occupational therapy, speech therapy, and so on. - Poor remuneration and limited career pathways and structures for the different professionals of allied health. - Increased patients and complications of cases meant that there is a great need for more allied health professionals across the different areas of health services.
Hospital and corporate Support Services (Professional Standards, Quality Assurance, Policy, ICT, Sector Coordination, Finance, HRM, etc.)	- Upskilling of staff working in hospital support services is needed – some credentialization is needed. - Address duplications of functions and roles since the merge of the old NHS and MoH. - Health policy, planning, M&E, ICT, professional standards, HRM, financial and administration services and coordination need further strengthening. This included working systems, processes and procedures. - Corporate culture needs further improvement or strengthening.

2.2.2. Training needs

Table 9 outlines the training needs for MoH staff across the different areas of clinical and public health services and allied health services as well as the hospital and corporate support areas. These training needs were extracted from some of the available completed MoH staff performance appraisal forms, consultations held with staff and staff survey conducted in September/November 2019 (see MoH, 2020), and 2004/2005 MoH capability plan (this is still the latest version). The training needs are divided into technical skills and soft skills and are indicative (not a complete list) of the trainings and professional development areas of the health workforce staff.

Table 9: Training needs – health workforce
Source: (MoH, 2004, 2019)

Technical skills	
Area	**Training needs**
Clinical	- Long-term and short-term training on all clinical areas – GOS, emergency, paediatrics, surgery, mental health, O&G, anaesthesia, ENT, eye/ophthalmology, ICU, operating theatre, nursing, oral and dental health, laboratory services, medical imaging and radiology, pharmacy, other allied health services: e.g. ✓ Outpatient services ✓ Emergency management ✓ Acute care / critical care ✓ Specialised wound care ✓ Training in specialised clinics (diabetics, foot care, wounds care, etc.) ✓ Interplast trainings ✓ Palliative care ✓ Advanced cardio ✓ Trauma and life support ✓ Triage System ✓ APLS ✓ EPI training

	✓ First aid ✓ Resuscitation, airway management ✓ Echo cardiology ✓ Blood confusion, microbiology, serology, phlebotomy, etc. ✓ Peri-operative training ✓ Safety operating procedures ✓ Haematology, forensic care ✓ Lab quality management ✓ Midwife ✓ Maternal practices, breastfeeding, etc. ✓ Child development ✓ ICU specialised training ✓ Psychiatric training ✓ Counselling ✓ Ultrasound scanning , radiology, imaging science ✓ Medicine management ✓ Drug administration ✓ Prosthetic triaging ✓ Wheelchair training ✓ Club foot triaging ✓ Rehabilitation and mobility ✓ Occupational health and safety ✓ etc.
Public health	- Community care - Primary health care - Surveillance - Vector control - Epidemiology - Port Health - Infection control - Water testing - Healthcare Waste Management - Nutrition and healthy living - Health Education - Health Promotion (on different areas – tobacco, food safety, hygiene, nutrition, injury prevention, etc.) - Health Regulatory, Monitoring and Evaluation - Food safety
Professional standards and quality assurance	- Regulatory and monitoring - Clinical auditing - Clinical governance - Health and hospital standards - Quality control - Health Research
Hospital and Corporate support	- Health policy - Procurement - Health ICT - Health records and information/knowledge management - Patient information management - Auditing - M&E - Investigations for disciplinary matters. - Professional standards - Quality Assurance - Security
Soft skills	
Area	**Training needs**
- Management	- Team building

and leadership	- Health leadership, management and administration - Coaching and mentoring - Human resource management - Financial management - Partnership development
- Middle-management	- Leadership and management - Coaching and mentoring - Communication - Supervision - Human resource management - Financial management
- Across	- Health service delivery and customer service - Report writing - Project management - Report writing - Research - Communication - Time management - Computer/ICT skills

2.3. Health workforce priorities

2.3.1. Medical officers and specialists

Table 10 gives the number of medical specialists in Samoa (see MoH, 2020 section 3.1.4). With a 0.58 physicians/doctors per 1,000 population in Samoa, there is an apparent shortage of physicians across all areas of the hospitals and health centres, (see section 2.1.2a above). However, the clinical areas where there is a critical shortage of medical specialists are internal medicine, public health, radiology, pathology, mental, cardiology, general medicine, eye and mental health. There is currently only 1 to 2 or no doctor(s) with specialisations in these clinical/medical areas.

Table 10: Density of medical specialists in Samoa, Sept 2019
Source: Ministry of Finance payroll (Sept 2019); MoH Registry (2019); MoH (2020); SBS (2018)

Fully registered medical practitioners in specialised areas				Ratio (per 1,000 population)	Ratio (per 10,000 population)
Area of Specialisation	MoH	Operate as private GP	Total		
Surgery	6	5	11	0.06	0.56
Obstetrics & Gynaecology	5	5	10	0.05	0.51
Paediatrics	3	4	7	0.04	0.36
Anaesthesia	4	2	6	0.03	0.31
Internal Medicine	1	5	6	0.03	0.31
General Outpatient	4	1	5	0.03	0.26
Public Health	1	3	4	0.02	0.20
Emergency	2		2	0.01	0.10
Radiology	2		2	0.01	0.10
Pathology	1	1	2	0.01	0.10
Cardiology/General Medicine		1	1	0.01	0.05
Eye	1		1	0.01	0.05
Mental Health	1		1	0.01	0.05
Total	***31***	***27***	***58***	***0.30***	***2.96***
Others					
On study	3		3		
on leave	1		1		
Operate as a GP		7	7		
Academic		3	3		
MoH Management	3		3		

Resigned (recently)	5		5		
No area of specialty yet	15		15		
Total	***27***	***10***	***37***		
Grant Total	**58**	**37**	**95**		
Samoa total population is 195,979					

2.3.2. Nurses and midwives

Given the lack of available data on the current numbers of nurses with specialisations in different clinical areas, it is difficult to provide the current demands and needs for nurse specialists in the MoH. It is hoped that the MoH will address this gap in order to improve health workforce statistics and workforce development planning in the near future. Nevertheless, the consultations highlighted the following workforce development priorities for the nursing profession:

- The numbers of nurses are still relatively low when compared to other countries (e.g. New Zealand and Australia) - there is still need for more nurses to maintain the health services in hospitals, health centres and community outreach primary care.

- The nursing workforce is getting younger with more senior nurses reaching retirement, a big gap exists in the middle aged levels of the nursing workforce. A scale up of the development of the clinical experiences of young nurses and strengthening the orientation/internship program of new graduates are needed. This includes allocating more time for clinical experiences and improving the mentoring of nursing graduates.

- There is a need for a balanced distribution of midwives. While the number of midwives allocated to each DH/HC ranges from 2 to 4, most of the antenatal and post-natal services are still provided at the main hospitals (TTM and MTII), with people still prefer to come to the main hospitals for antenatal and post-natal care despite the availability of midwives at DHs/HCs. This has contributed to a heavier workload for midwives and nurses in the main hospitals compared to those in the DHs/HCs.

- There is a need for an ongoing development of nursing advanced practice with more nurses trained in various specialised areas; primary care, public health, acute and intensive care, midwifery, mental health, eye care, ear, nose and throat, neonatal, operating theatre, NCDs management, nursing education, dental nursing, and others.

- A formalisation of the position of Auxiliary Nurses (including training and credentialization of this role) to assist with the shortage of nurses is needed.

- Review of the nursing curriculum to incorporate a component of public health and primary care is needed, to align with the aim to strengthen public health and primary health across the community. Nurses and other health workers need proper training in public health and primary care given they are the health frontline workers and primary care givers out in the community, DHs, HCs and hospitals.

2.3.3. Allied Health Workers

Allied health workforce is perhaps one of the area that receives limited attention and priority for development. The ongoing increased complications of patient cases (e.g.

NCDs) will continuous to demand an increase in the scope and quality of services from allied health workers (such as in biomedical engineering, physiotherapy, counsellors, etc.), in addition to the services provided by medical and nursing teams. This means that there is a need to address the shortage of allied health workers in all areas – dental, laboratory, pharmacy, medical imaging and radiology, and other allied health service areas such as physiotherapy, therapy, audiology, prosthetics and orthotics, nutrition and dietary, and others. Section 3.3 of the Situational Analysis outlined a number of areas to consider for the allied health workforce, which include but not limited to the following:

- Improve remuneration levels and career pathways.
- Provide more formal training and professional development programs.
- Establish positions in allied health service areas to accommodate those expected to graduate and return to work in these areas.
- Address the need to retain qualified allied health workers given the limited number of existing workers in allied health areas.
- The OAHS needs more resources (e.g. computers, workshop and transport) in order for staff to improve the performances of their roles and services.
- A review of existing fees and charges for cost recovery and sustaining services (e.g. prosthetic/orthotic and mobile devices) given the high costs involved with providing those services.

2.3.4. Hospital support services and corporate support areas

Hospital support services (HSS) staff make up 23% of the MoH workforce; the second largest occupational group to the nursing profession (455). The majority of HSS staff are school leavers, only a few (trade workers) holding qualifications at the certificate or diploma levels. The work of HSS staff (porters, medical records staff, phone operators, transport and ambulance operators, kitchen staff, security personnel, domestic assistants and cleaners, administration assistants, trades and others) are critical for the effective and efficient functioning and maintenance of hospitals and health cares. Clinicians and other health workers cannot function properly without the effective performance of HSS. Some of the key complaints concerning hospital services (e.g. poor patient records keeping, late referrals of patients via ambulance, and poor maintenance of hospitals) can be attributed to the lack of attention given the development of the HSS areas.

Workforce development needs of HSS workers include their proper training and upskilling for improved performances and services. For patient and health worker safety and improved performances, upgrading the minimum entry requirements for HSS positions is needed. This will upgrade the standards and professional levels of HSS areas, including the professional conduct and image of this important workforce of the health system.

The clinical staff cannot function without the services and support of those working in the corporate support areas of health. Corporate support services should facilitate the development of an enabling working environment for the health workforce to thrive as effective and committed workers, through the provisions of good strategic policy advice,

planning, governance, coordination, regulatory and control, human resource management, financial management, quality assurance, professional standards, administration, and other support services.

A lot of staff complaints about their employment and workforce matters have been directed towards the corporate support areas because they see those matters as the key concerns of those working in the corporate support areas, for them to address through the management and leadership of health. Leading the development and implementation of this SHWDP is the role of the corporate support, hence attention to performance and workforce issues of corporate support functional areas is also needed. These issues include the need to address duplications of functions and duties of those working in corporate support areas (since the MoH and NHS merge), strengthen the performances of the different roles in these areas (policy and planning, HRM, ICT, etc.) and improve administrative and operating systems.

3. STRATEGY AND PLAN OF ACTION

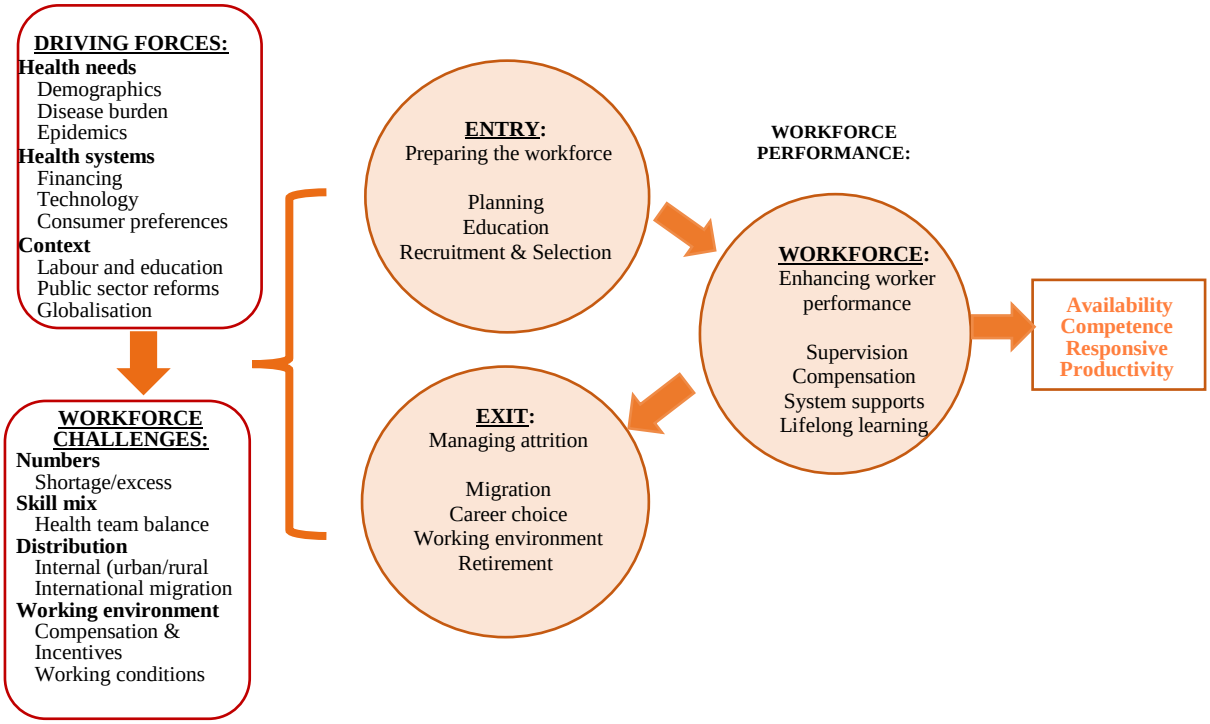
Section 1 provides the situational analysis for this Samoa Health Workforce Development Plan (SHWDP) for the Ministry of Health (MoH) for the period of July 2020 to June 2026. Section 2 analyses the current and future workforce needs and demands for the MoH. This section 3 outlines the strategies and a plan of action for the attainment of those workforce needs and for the development of the MoH's workforce. It is important that this SHWDP is aligned to the strategic directions of the MoH and health sector as set out in the Samoa Health Sector Plan's (HSP) 2019-2030, corporate plan and health policies and procedures.

3.1. Conceptual framework

This SHWDP should address key supply and demand factors/areas that are affecting and impacting on health workforce development (see Figure 2). Workforce development should include strategies aimed at preparing the workforce (i.e. supply of needed health workers), managing workforce attrition (i.e. staff retention, turnover and succession planning), and enhancing workforce performance (employees and organisational performances).

Workforce supply and demand are shaped by different but interrelated driving forces such as health needs (population health demographics, disease burden and epidemics), health systems (financing capability, technology and consumer preferences for health services) and context (labour market and education, public sector systems and reforms, and globalisation). These driving force shape existing and future health workforce issues/challenges (e.g. shortages in the numbers of health workers, imbalanced skills mix and worker distribution, and a less conducive working environment for health workers to realise their potentials).

Figure 2: Workforce supply and demand dimensions
Source: Adapted from WHO



Preparing the workforce, managing worker attrition and enhancing worker performances requires a better understanding of the interplay of these driving forces and workforce challenges, including the extent of the effectiveness of existing efforts that have been adopted and implemented to prepare the needed workforce, to manage attrition, and to enhance performances – for enhanced availability, competence, responsive and productivity of the health workforce. The Situational Analysis (MoH, 2020) which is further revisited in Sections 1 and 2 of this SHWDP provides such a needed and better understanding and inform the strategies of this SHWDP as outlined in the following sections.

3.2. Guiding principles

The same guiding principles identified for the Samoa Human Resources for Health Strategy (SHRHS) 2020-2026 also apply to this SHWDP 2020-2026 are reiterated in Figure 3 below:

Figure 3: SHWDP 2020-2026 guiding principles

3.3. Strategic direction

The Situational Analysis (in Section 1), Current & Future Health Workforce Needs (in Section 2) of this SHWDP and the workforce planning framework portrayed by Figure 2 provided a grounded evidence-based and holistic approach to the determination of this SHWDP's strategic direction including corresponding workforce development strategies and activities outlined in the following sections.

3.3.1. SHWDP vision 2026

The vision of this Samoa Health Workforce Development Plan (SHWDP) 2020-2026 is:

> ***"A trained and professional workforce that meet the needs of the population".***

3.3.2. SHWDP mission 2026

The mission of this SHWDP 2020-2026 is:

> ***"Visible improvements in health workforce numbers and performances".***

3.3.3. SHWDP goal 2026

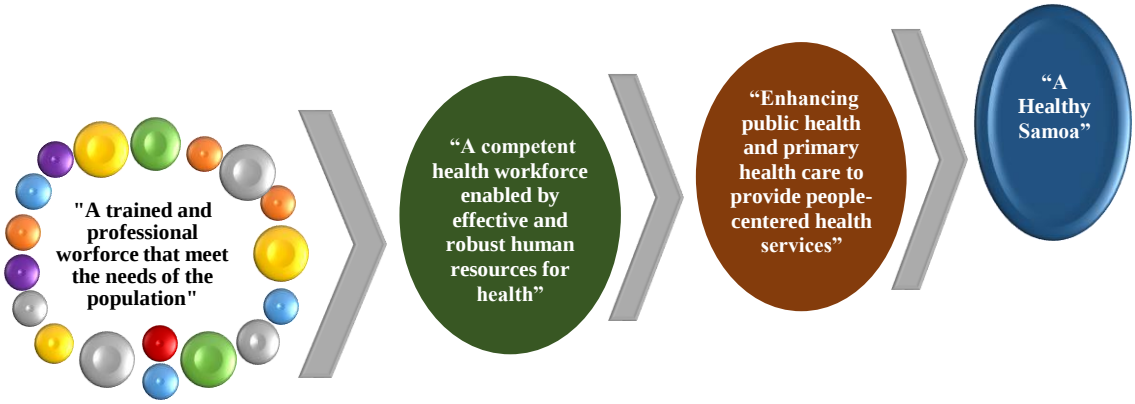
The goal of this SHWDP 2020-2026 is:

> ***"To improve the numbers, quality and performances of the health workforce"***

This SHWDP's vision, mission and goal are aligned to the Samoa Human Resources for Health's (SHRHS) (2020-2026) vision: '*A competent workforce enabled by effective and robust human resources for health'*, mission: *"To strengthen human resources for health capacity to equitably meet national and local health needs",* and goal: *"To improve human resources for health systems and practices in supportive of producing and sustaining a balanced and productive health workforce".*

Through this vision, mission and goal, this SHWDP aims to contribute to the achievement of the HSP 2019-2030 vision of '*A healthy Samoa*' and mission of 'Enhancing public health and primary health care to provide people-centered health services'. Figure 4 shows these linkages and alignment of the SHWDP and the Samoa health sector policy directions as stipulated in the HSP.

Figure 4: SHWDP's vision and alignment with the SHRHS and HSP



3.3.4. Strategic outcomes

The strategic outcomes of this 5-year SHWDP 2020-2026 are as follows:

- Availability and preparedness of health workers in response to population health needs improved.
- Work performances and professional development of the health workforce enhanced.
- A conducive working environment for a productive and committed health workforce is strengthened.

3.4. Activities

Strategic outcome 1: Availability and preparedness of health workers in response to population health needs improved.

The ongoing challenge for Samoa, and is a global phenomenon is not enough health workers in response to population health needs. However, Samoa's existing numbers of physicians/medical doctors, nurses and midwives are below international standards. This is similar to the dearth in the numbers of allied health workers across different areas of health services. There is an imbalanced composition of physicians/medical doctors, nurses, midwives, and allied health workers, including imbalanced distribution of health workers across different health facilities or service areas. There is a need to train more physicians, nurses, midwives and allied health workers; to prepare them well to become capable practitioners and professional health workers – able to deliver effective and efficient health services and to respond to the different health challenges of today and tomorrow.

These key activities (if implemented) will hope to assist with improving the availability and preparedness of health workers in response to Samoa population health needs:

Activity Result 1.1: Strengthen availability and alignment of education to meet health workforce development needs and demands.

The Situational Analysis (MoH, 2020) identifies the need to review and upgrade the existing curriculums of the various schools of health to ensure alignment to the health workforce development needs. In response to the key issues and gaps identified, the following initiatives and activities are proposed for implementation:

- Provide ongoing support for developing and strengthening of the NUS School of Medicine (FOM) and Oceania University of Medicine (OUM) in order to maintain a constant increased numbers of medical graduates.

- Introduce needed undergraduate and postgraduate programs/courses (with needed support provisions from government and development partners) in disciplines where increases in workforce numbers are required to response to health population demands, for examples:
  - Internal medicine;
  - Primary Care;
  - Public Health;
  - Mental Health; and
  - Intensive Care.

- Consider the development, re-instatement and revival of relevant programs/courses in the national education curriculum in order to ensure an ongoing supply of health workers to continue needed service provisions in different health areas:
  - Oral and dental health services
  - Medical laboratory services
  - Medical imaging services
  - Pharmaceutical services
  - Public Health – environmental health, primary care, health promotion and enforcement, etc.
  - Other allied health services – e.g. occupational therapy, audiology, nutrition and dietary, biomedical engineering

- Review and then incorporate a public health component into the existing medical and nursing programs/courses in order to accommodate and response to the ongoing emphasis on the revival and strengthening of public health and primary care across Samoa.

Activity Result 1.2: Scale up the numbers and improve the quality of trained and recruited health workers.

The numbers of trained health workers need to increase and the quality of those workers need enhancing. Financial, technical and leadership support is needed to ensure that this will happen. The following initiatives and activities are proposed to facilitate an increase in the numbers of quality health workers.

- Provide support to current and potential OUM medical students to ensure full utilisation of OUM and other scholarship offers and for students to successfully complete the OUM program.

- Conduct an active campaign to develop interests in students to take up medicine and allied health services as careers.

- Review of the existing scholarship scheme, study leave and other public service policies and procedures to ensure alignment with priority health workforce needs.

- Ongoing review of the MoH organisational structure, position establishment and occupational classification to ensure availability to ensure the incoming supply of needed health graduates.

- Review and strengthen the orientation and internship programs for medical, nursing and allied health students.

Activity Result 1.3: Improve the availability of health workers in the most critical health areas.

Another ongoing issue that needs to address is facilitating the availability of health workers in the most critical health areas, such as general practice, internal medicine, radiology, pathology, mental health, public health, and others. The following initiatives and activities are proposed to assist with addressing this issue in the health system:

- Ongoing reviews of career and salary structures of health professionals to ensure the attraction of qualified professionals in 'hard to fill' vacancies or roles/positions in the most critical health areas.

- Ensure full utilisation of private medical specialists in the hospitals and health clinics.

- Liaise with relevant regional partners and others organisations on how Samoa could benefit from the deployment of medical doctors, nurses, midwives and other needed health workers that are available in neighbouring countries.

- Carry out overseas recruitment and deployment for 'hard to fill' vacancies; where there is a critical shortage of health workers – such as radiology, pathology, mental health, cardiology, internal medicine, and others.

- Liaise with health partners and development partners on how Samoa could access and obtain health workers in the most critical health areas.

Activity Result 1.4: Ensure ongoing succession planning for the health workforce.

While this SHWDP provides a comprehensive and holistic framework for workforce planning and development of the MoH, each department, unit or section (general outpatient, obstetrics and gynaecology, paediatric, internal medicine, anaesthesia, ICU, survey, mental health, eye/ophthalmology, ENT, public health, etc.) in the MoH should ensure that they develop their own updated succession plans, detailing their specific workforce development needs and strategies. The following activities are proposed to support the MoH in the realisation of this activity result area:

- Establish and regularly review and update a National Health Workforce Account for Samoa which formally define and outline the minimum standards of health workers that Samoa require in order to improve and maintain health services.

- Mandate each department/section/unit of the MoH to develop and update their succession plans.

- Monitor the attainment of the numbers of health workers as specified in this SHWDP and continuously update this forecast of health workers.

- Monitor the implementation of this SHWDP including the specific succession plans of every department/section/unit.

Strategic outcome 2: Work performances and professional development of the health workforce enhanced.

Improving health services is premised on a well-performing workforce that is equipped with the necessary knowledge, skills and competencies and are motivated to perform their roles and utilise their potentials. Enhancing health worker performance is more than just the effective implementation of a good performance management system. It is about good supervision directing and providing guidance to employees especially with the young health workforce in Samoa. A proper remuneration system is needed to attract and retain needed health workers, and to compensate them for their services. It includes rewards, recognitions and sanctions for outstanding and bad performances.

Most employees would like to see a clear career path for ongoing progressions and promotions in services. This including ongoing learning through professional development, training and other capacity development opportunities – for staff to learn new skills, to upgrade their knowledge and skills about a specific area, to get exposure to a new, different or better way of operating, or to develop an interest in a newly developmental area. Credentialization of all health professionals especially those in allied health service areas is needed.

Activity Result 2.1: Enhance the career and salary structures of all health professionals.

The Situational Analysis (MoH, 2020) identifies that career and salary structures of key health professionals are out-dated and need continuously revisions and updating to ensure the establishment of appropriate career pathways, professional development and salary progressions for health staff. Effective implementation of existing approved career and salary structures such as that for the medical and nursing professions have been limited, which has led to salary disparities, frustrations and low morale among staff. The following activities are proposed to address this workforce gap:

- Incorporate as part of Activity 1.3.1, a review of career and salary structures of all health professionals to ensure relevance to workforce development needs and to respond to the need to attract and retain health workers in the most essential service areas.

- Ensure effective implementation of approved career and salary structures in order to address and facilitate career development pathways, appropriate salary increases and adjustments and progressions, as well as professional development of staff.

- Monitor and evaluate the implementation of health professional career and salary structures to map progress against effective and efficient implementation and to identify issues and lessons learnt for further improvement.

- Address existing salary disparities in order to respond to staff queries and frustrations concerning their working conditions and entitlements.

Activity Result 2.2: Ensure the implementation of a health performance management system across all sections of the Ministry for improved staff performances.

MoH has not implemented or operationalized a performance management system (PMS). A Public Service Commission developed PMS was recently introduced but has not been applied to all sections of the MoH, only those under the old MoH. The PSC PMS is generic and needs customisation and adaption to suit the health context. The PMS should be adopted and treated as a tool for managing staff performances providing a process where regular communications between managers/supervisors and staff take place formally about work performances and performance development areas. The following activities should be implemented to strengthen this workforce development area:

- Review the existing PSC PMS to ensure adaption to the health context.

- Design and implement a training package on the revised PMS for all health workers.

- Implement the revised PMS across the MoH.

- Monitor and evaluate the PMS and continuously revise the PMS to ensure relevance and practical application.

Activity Result 2.3: Improve the professional development and learning opportunities for health professionals.

Existing professional development, training programs and other capacity development provisions are limited and ad hoc. Frameworks, guiding policies, procedures and training packages are not yet fully developed. The professional development of medical doctors are limited to the CME (Continuous Medical Exchange) program. Fellowships and workplace attachments are limited. Developmental opportunities are left mostly to individuals to seek on their own. The accreditation of any existing professional development programs is limited and is slowly developing in some areas such as the laboratory and medical imaging. The following activities are proposed to address gaps in the areas of professional development, training and learning for staff:

- Develop a professional development framework that is encompassing of all health professionals. The framework should include a competency profiling of all required health workers.

- Design and implement a training package on the professional development framework for all health workers.

- Implement the revised Professional Development Framework.

- Monitor and evaluate the PMS and continuously revise the PMS to ensure relevance and practical application.

Activity Result 2.4: Strengthen the credentialization of health professionals.

The Situational Analysis (see section 2.2.7 of the MoH, 2020) identifies that some 32% of the existing MoH workforce are either school leavers or have no educational qualification while a total of 16% hold qualifications at the certificate and diploma levels. To enhance a professional health workforce, there is a need to upgrade the minimum requirements (above school leaving level) for entry into allied health professionals, especially those working as health technicians, therapists, assistants, auxiliary workers and other associates. This will assist with improving the standards and quality expected of health workers. The implication of this is that existing health workers who entered the service as school leavers and have gained in-service work experiences need upgrading in their qualifications. This includes the accreditation of any relevant training that they have completed as part of their employment. This will assist with enhancing career pathways and salary levels of allied health staff. The following activities are proposed to strengthen the credentialization of health professionals:

- Upgrade the minimum entry requirements for all allied health workforce positions to a relevant diploma level from the NUS, USP, APTC and other recognised institutions.

- All allied health workers (in MIR, laboratory, pharmaceutical services, oral and dental services, and other allied health services (physiotherapy, occupational therapy, kitchen staff, orthotics and prosthetics, etc.)) to undergo an accredited program as a basis for upgrading their qualification levels and as a requirement for their formal registration as health workers.

- Take into account this upgrade in the minimum entry requirements for allied health workers and credentialization process in the review of health professional career and salary structures (under AR 2.1).

Strategic outcome 3: A conducive working environment for a productive and committed health workforce is strengthened.

The evidence shown in the Situational Analysis (MoH, 2020) pointed to the fact that while there is an increased in the number of medical graduates over recent years, more senior doctors are leaving the service each year. The service is becoming younger with 43% of the total MoH workforce (58% for medical doctors and 57% for nurses for instance) aged 31 years and below (see section 2.2.3 of the Situational Analysis).

Attrition is high among clinical staff, with a turnover rate of 8% for medical doctors and 5% for nurses. Workforce development is inhibited if there is limited or no senior doctors to provide the necessary supervision, on-the-job training, mentoring and coaching for the

new and young doctors. The retention of senior doctors especially those in needed medical specialists must be given serious consideration.

The staff survey conducted in November 2019 identifies that all doctors who participated in the survey stated that they are overworked. The survey findings further show that 'a positive working environment' and 'job satisfaction' were selected by most participants as the two factors that motivate them to come and being at work. Obviously a conducive working environment where there is system support is needed for staff to feel motivated to come to work and to contribute positively to the services.

Activity Result 3.1: Facilitate the achievement of a balanced distribution of health workers.

The evidences presented in the Situational Analysis (see section 3 of MoH, 2020) show an imbalanced distribution of health workers across health facilities. For instance, the TTM hospital has a doctor density (per 1,000 population) of 0.98, compared to 0.14 for the MTII hospital and 0.02 for district hospital and health centres. For nurses, the density is 5.40 for the TTM hospital, compared to 2.33 for the MTII hospital and around 0.93 to 2.83 for district hospitals and health centres. The following activities are proposed for improving a balanced distribution of health workers:

- Take into account the current numbers of health workers (in different professionals and areas) that are required by the different health facilities and services as identified under section 2.1 of this SHWDP.

- Facilitate the availability of these required current numbers of health workers (doctors, nurses, allied health services and administrators) in district hospitals and health centres.

- Based on this identification of health workforce demands (current and future forecasts) in section 2.1 above, redistribute the existing staff in order to ensure a balanced distribution of health workers across different health facilities and service areas.

- Review and improve existing remuneration and working conditions and entitlements of health workers in order to address the imbalanced distribution and needed retention of health workers in needed health service areas especially in rural hospitals and health centres.

Activity Result 3.2: Address the retention of health workers that are critical for the maintenance of essential health services.

As stated in the above sections, there is a need to consider the retention of health workers in the most critical areas of health services areas (e.g. internal medicine, anaesthesia, pathology, radiology, etc.) that will deemed to be non-operational or losing quality in services, if there is a limited or absence of any qualified staff in the hospitals and in the local labour market.

- Consider the introduction of a market allowance as a retention strategy for limited health specialists (1 to 2 existing numbers).

- Continuous review and adjustment of salaries and other entitlements of health professionals in the most critical areas of health in order to assist with the needed retention of health workers in these areas.

- Redefine and redesign roles, duties and responsibilities for health workers in these critical areas of health as a way of providing more interesting and challenging work for them to remain with the services.[ix]

Activity Result 3.3: Strengthen the leadership, management and supervision for improved staff and organisational performances.

Staff frustrations with the system including a lack of support and appreciation of their services were some of the reasons mentioned by some health workers for staff to leave the service. Workers when overloaded, fatigue and working under pressure need to feel supported at work. Managing these workforce issues is a concern for health leadership and management. Leadership and management is needed for consideration of key workforce development issues and responding strategies identified under this SHWDP. The following activities or actions are proposed to assist with strengthening the required leadership and management for health workforce development including the effective adoption and implementation of this SHWDP:

- The HPAC to take on board the roles and responsibilities as a 'HRH multi-sectoral committee' to provide strategic direction, leadership and governance to human resources for health (HRH) inclusive of health workforce development issues and matters, including the implementation of this SHWDP 2020-2026.

- The 'HRH working group' (HRHWG) proposed for establishment in the SHRHS 2020-2026 to provide secretariat and technical support to the HPAC, including operational monitoring and evaluation of the implementation of this SHWDP 2020-2026.

- Continuously engage senior and middle managers (through regular meetings of the HPAC and HRH working group as well as MoH management and technical meetings and forums) on health workforce issues and matters, including collaborative leadership from all managers and supervisors on the adoption and effective implementation of this SHWDP 2020-2026, including discussions of progress made, lessons learnt and way forward.

- Ensure timely response and address of staff issues concerning their employment, remuneration, working conditions and entitlements, grievances, performance management and others.

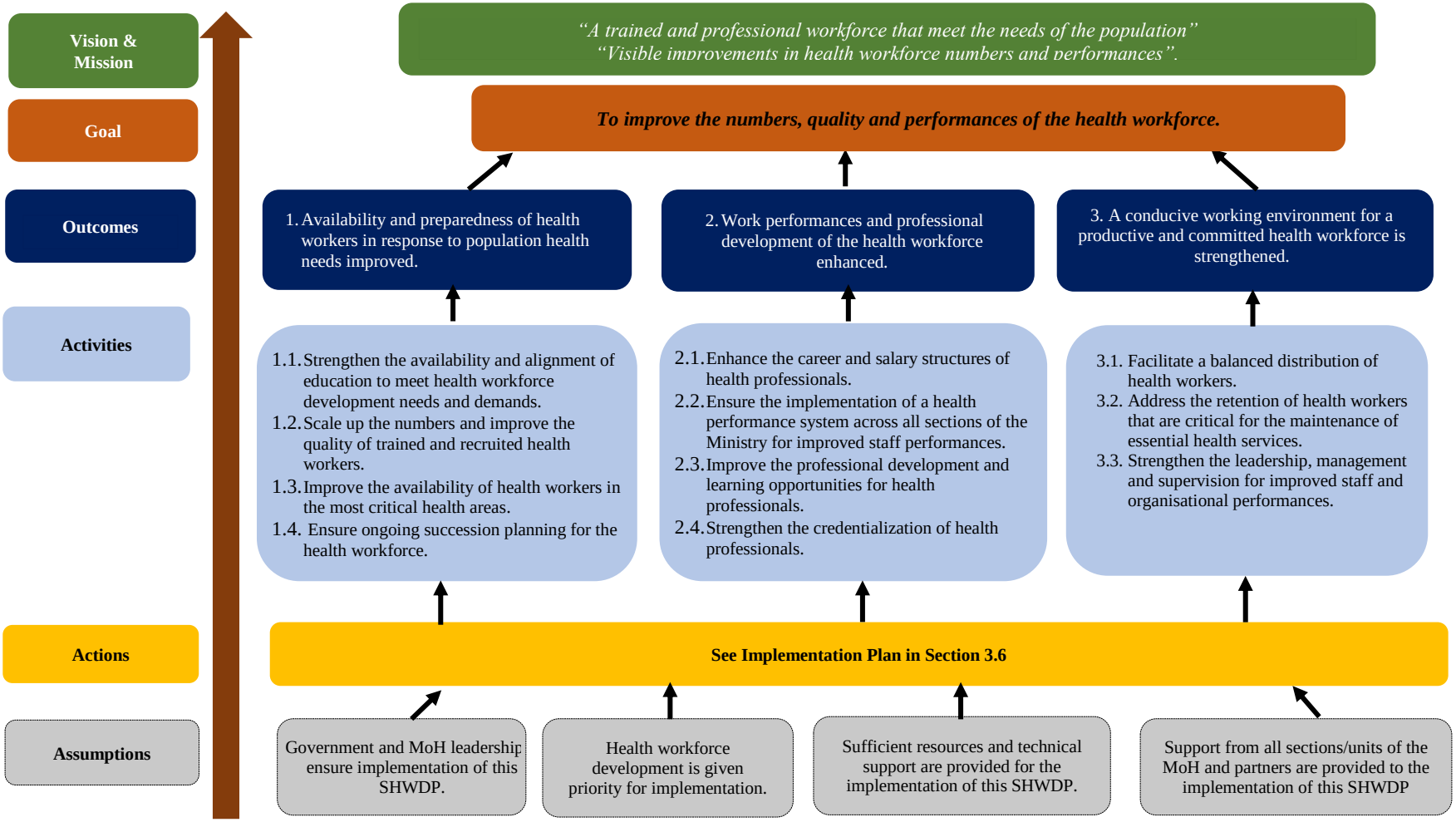
The SHWDP theory of change is portrayed by Figure 5 below. It outlines the linkages between the strategic outcomes and activities as well as to the vision, mission and goal of the SHWDP.

[ix] An example of this is to define the amount of time that a senior medical officer should spend on clinical work, research work, and administrative work. People are motivated to stay in roles that they found challenging and interesting and add to their personal and professional development.

The indicative action plan of this SHWDP is given in Table 11 below.

3.5. Theory of change

Figure 5: SHWDP Theory of change



3.6. Indicative action plan

Table 11: Action Plan

Vision: "A trained and professional workforce that meet the needs of the population"																							
Mission: "Visible improvements in health workforce numbers and performances".																							
Goal: "To improve the numbers, quality and performances of the health workforce".																							
	Year 1				Year 2				Year 3				Year 4				Year 5				Outputs	Responsible	Partners	Budget (ST$)	Inputs and Budget Descriptions
	20/21 - 21/22				21/22 - 22/23				22/23 - 23/24				23/24 - 24/25				24/25 - 25/26								
Strategies and Actions	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2					
Strategic objective 1: Availability and preparedness of health workers in response to population health needs improved.																									
1.1. Strengthen the availability and alignment of education to meet health workforce development needs and demands.																									
1.1.1. Provide ongoing support for developing and strengthening of the NUS School of Medicine (FOM) and Oceania University of Medicine (OUM) in order to maintain a constant increased numbers of medical graduates.	x	x	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	Budgetary support and more scholarship awards for FOM. Government support for OUM students.	MoH, OUM, NUS	NUS, OUM, APTC, PSC, MoF, MFAT, MPMC, other key health sector players.	500,000	$100k annual estimation for costs for increased number of students.
1.1.2. Introduce needed undergraduate and postgraduate programs/courses (with needed support provisions from government and development partners) in disciplines where increases in workforce numbers are required to response to health population demands (e.g. Internal medicine; Primary Care; Public Health; Mental Health; and Intensive Care).	x	x	x	x	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	Programs/courses made available. Budgetary support and scholarship awards for undergraduate and postgraduate programs/courses. Teaching staff made available.			1,000,000	$200k annual estimation for costs for increased number of students.
1.1.3. Consider the development, re-instatement and revival of relevant programs/courses in the national education curriculum in order to ensure an ongoing supply of health workers to continue needed service provisions in different health areas: Oral and dental health services, Medical laboratory services, Medical imaging services, Pharmaceutical services, - Public Health – environmental health, primary care, health promotion and enforcement, etc., Other allied health services – e.g. occupational therapy, audiology, nutrition and dietary,	x	x	x	x	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	Programs/courses made available. Budgetary support and scholarship awards for undergraduate and postgraduate programs/courses. Teaching staff made available.	MoH, OUM, NUS	NUS, OUM, APTC, PSC, MoF, MFAT, MPMC, other key health sector players.	1,000,000	$200k annual estimation for costs for increased number of students.

Vision: "A trained and professional workforce that meet the needs of the population"																							
Mission: "Visible improvements in health workforce numbers and performances".																							
Goal: "To improve the numbers, quality and performances of the health workforce".																							
	Year 1				Year 2				Year 3				Year 4				Year 5						
	20/21 - 21/22				21/22 - 22/23				22/23 - 23/24				23/24 - 24/25				24/25 - 25/26						
Strategies and Actions	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Outputs	Responsible	Partners	Budget (ST$)	Inputs and Budget Descriptions
biomedical engineering.																									
1.1.4. Review and then incorporate a public health component into the existing medical and nursing programs/courses in order to accommodate and response to the ongoing emphasis on the revival and strengthening of public health and primary care across Samoa.	x	x	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	Curriculum revised into medical, nursing and other health programs/courses.			500,000	$100k annual estimation for costs for increased number of students.
Total Budget for 1.1																								**3,000,000**	
1.2. Scale up the numbers and improve the quality of trained and recruited health workers.																									
1.2.1. Provide support to current and potential OUM medical students to ensure full utilization of OUM and other scholarship offers and for students to successfully complete the OUM program.	x	x	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	Additional support provided to students, full utilization of OUM scholarships.	MoH, OUM, NUS	NUS, OUM, APTC, PSC, MoF, MFAT, MPMC, other key health sector players.	500,000	$100k annual estimation for costs for increased number of students.
1.2.2. Conduct an active campaign to develop interests in students to take up medicine and allied health services as careers.		x	x			x	x			x	x			x	x			x	x		Increased number of health students	MoH, OUM, NUS		100,000	20k for campaign (annual program)
1.2.3. Review of the existing scholarship scheme, study leave and other public service policies and procedures to ensure alignment with priority health workforce needs.	x		x		x		x		x		x		x		x		x		x		Scholarship scheme reviewed with clear scholarship allocations for different health professions.	PSC, MFAT, MoH, NUS, OUM	APTC, MFAT, MPMC, other key health sector players.		Costs should be covered under the scholarship schemes.
1.2.4. Ongoing review of the MoH organizational structure, position establishment and occupational classification to ensure availability to ensure the incoming supply of needed health graduates.	x				x				x				x				x				Position establishment in place to accommodate needed health workers.	MoH, PSC	MoF, Remuneration Tribunal, MPMC, other health sector partners.	1,000,000	$200k annual estimation for costs for position establishment
1.2.5. Review and strengthen the orientation and internship programs for medical, nursing and allied health students.	x		x		x		x		x		x		x		x		x		x		positive feedback from nurses and nursing students on the program	MoH, NUS	MoF, PSC, APTC, other key health sector partners	100,000	10k annual costs for strengthening the program
Total Budget for 1.2																								**2,500,000**	

1.3: Improve the availability of health workers in the most critical health areas.																								
1.3.1. Ongoing reviews of career and salary structures of health professionals to ensure the attraction of qualified professionals in 'hard to fill' vacancies or roles/positions in the most critical health areas.			x				x				x				x				x		Revised career and salary structures approved.	MoH, PSC MoH, PSC MoH, PSC	MoF, Remuneration Tribunal, MPMC, other health sector partners.	500,000	100k annual costs to cover any increase in pay structures.
1.3.2. Ensure full utilization of private medical specialists in the hospitals and health clinics.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	More private doctors employed by MoH.			500,000	100k annual costs to cover any increase in pay structures.
1.3.3. Liaise with relevant regional partners and others organizations on how Samoa could benefit from the deployment of medical doctors, nurses, midwives and other needed health workers that are available in neighbouring countries.	x		x		x		x		x		x		x		x		x		x		Samoa able to recruit health workers from available regional workers.			500,000	100k annual costs to cover any increase in recruitment.
1.3.4. Carry out overseas recruitment and deployment for 'hard to fill' vacancies; where there is a critical shortage of health workers – such as radiology, pathology, mental health, cardiology, internal medicine, and others.	x		x		x		x		x		x		x		x		x		x		Samoa able to recruit health workers from overseas.			500,000	100k annual costs to cover any increase in recruitment.
1.3.5. Liaise with health partners and development partners on how Samoa could access and obtain health workers in the most critical health areas.	x		x		x		x		x		x		x		x		x		x		Samoa able to recruit health workers from available regional workers.				Covered under 1.3.4.
Total Budget for 1.3																								**2,000,000**	
1.4. Ensure ongoing succession planning for the health workforce.																								
1.4.1. Establish and regularly review and update a National Health Workforce Account for Samoa which formally define and outline the minimum standards of health workers that Samoa require in order to improve and maintain health services.	x	→																			National Health Workforce Account is in place.	MoH, PSC, TA (if needed).	PSC, MPMC, MoF, MFAT, key health sector players.	70,000	70k one off costs
1.4.2. Mandate each department/section/unit of the MoH to develop and update their succession plans.	x	→																			Succession plans in place.	MoH, PSC.		15,000	3k annual administrative costs

1.4.3. Monitor the attainment of the numbers of health workers as specified in this SHWDP and continuously update this forecast of health workers.		x		x		x		x		x		x		x		x		x		x	M&E reports on the SHWDP implementation/ progress.	MoH, PSC.		15,000	3k annual administrative costs
1.4.4. Monitor the implementation of this SHWDP including the specific succession plans of every department/section/unit.		x		x		x		x		x		x		x		x		x		x	M&E reports on the SHWDP implementation/ progress.	MoH, PSC.		15,000	3k annual administrative costs
Total Budget for 1.4																								**115,000**	
Total for Objective 1																								**7,615,000**	
Strategic objective 2: Work performances and professional development of the health workforce enhanced.																									
2.1. Enhance the career and salary structures of all health professionals.																									
2.1.1. Incorporate as part of Activity 1.3.1, a review of career and salary structures of all health professionals to ensure relevance to workforce development needs and to respond to the need to attract and retain health workers in the most essential services areas.	x	x																			Revised career and salary structures approved.	MoH, PSC	MoF, Remuneration Tribunal, MPMC, other key health sector partners.		Costs covered under 1.3.1
2.2.2. Ensure effective implementation of approved career and salary structures in order to address and facilitate career development pathways, appropriate salary increases and adjustments and progressions, as well as professional development of staff.			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Revised career and salary structures implemented.	MoH, PSC			Costs covered under 1.3.2
2.2.3. Monitor and evaluate the implementation of health professional career and salary structures to map progress against effective and efficient implementation and to identify issues and lessons learnt for further improvement.				x		x		x		x		x		x		x		x		x	M&E reports	MoH, PSC			
2.2.4. Address existing salary disparities in order to respond to staff queries and frustrations concerning their working conditions and entitlements.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	MoH Reports addressing existing disparities	MoH, PSC			
Total Budget for 2.1																								-	
2.2. Ensure the implementation of a health performance management system across all sections of the Ministry for improved staff performances.																									
2.2.1. Review the existing PSC PMS to ensure adaption to the health context.	x	x	x																		Customised PMS for MoH.	MoH, PSC	MoF, Remuneration Tribunal,		

2.2.2. Design and implement a training package on the revised PMS for all health workers.			x																	Training package in place.	MoH, PSC	MPMC, other key health sector partners.	15,000	3k annual costing
2.2.3. Implement the revised PMS across the MoH.				x	x															M& Report, completed Performance Management forms.	MoH, PSC		15,000	3k annual implementation costs
2.2.4. Monitor and evaluate the PMS and continuously revise the PMS to ensure relevance and practical application.					x		x		x		x		x		x		x				MoH, PSC		15,000	3k annual costing
Total Budget for 2.2																							**45,000**	
2.3. Improve the professional development and learning opportunities for health professionals.																								
2.3.1. Develop a professional development framework that is encompassing of all health professionals. The framework should include a competency profiling of all required health workers.	x	x																		Professional development framework in place.	MoH, PSC, TA (if needed).	MoF, Remuneration Tribunal, MPMC, other key health sector partners.	70,000	Consultation, logistics and TA (if needed) costs.
2.3.2. Design and implement a training package on the professional development framework for all health workers.		x	→																	Training package in place.	MoH, PSC		15,000	3k annual costing
2.3.3. Implement the revised Professional Development Framework.		x	x	→																M&E report on implementation of the Professional Development Framework. Revised framework.	MoH, PSC		25,000	3k administrative
2.3.4. Monitor and evaluate the PMS and continuously revise the PMS to ensure relevance and practical application.				x		x		x		x		x		x		x		x			MoH, PSC			Costs covered under 2.3.3.
Total Budget for 2.3																							**110,000**	
2.4. Strengthen the credentialisation of health professionals.																								
2.4.1. Upgrade the minimum entry requirements for all allied health workforce positions to a relevant diploma level from the NUS, USP, APTC and other recognised institutions.	x	x	x																	Revised JDs and career structures	MoH, PSC			This can become part of Activities 1.3.1, 2.1.1 and 2.2.2.
2.4.2. All allied health workers (in MIR, laboratory, pharmaceutical services, oral and dental services, and other allied health services (physiotherapy, occupational therapy, kitchen staff, orthotics and prosthetics, etc.)) to undergo an accredited program as a basis for upgrading their qualification levels and as a requirement for their formal registration as health		x	x	x	x	x	x	x	→											Accredited programs for all allied health professionals in place.	MoH, PSC, NUS, SQA, OUM	MoF, Remuneration Tribunal, MPMC, other key health sector partners.	25,000	5k annual costs

workers.																							
2.4.3. Take into account this upgrade in the minimum entry requirements for allied health workers and credentialisation process in the review of health professional career and salary structures (under AR 2.1).	x	x	x																	Revised JDs and career structures	MoH, PSC		This can become part of Activities 1.3.1, 2.1.1 and 2.2.2.
Total Budget for 2.4																						**25,000**	
Total for Objective 2																						**180,000**	
Strategic objective 3: A conducive working environment for a productive and committed health workforce is strengthened.																							
3.1. Facilitate the achievement of a balanced distribution of health workers.																							
3.1.1. Take into account the current numbers of health workers (in different professionals and areas) that are required by the different health facilities and services as identified under section 2.1 of this SHWDP.	x	x	→																	Approved SHWDP	MoH, PSC	MoF, Remuneration Tribunal, MPMC, other key health sector partners.		
3.1.2. Facilitate the availability of these required current numbers of health workers (doctors, nurses, allied health services and administrators) in district hospitals and health centres.		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Doctors and needed allied health workers working in DHs/HCs.	MoH, PSC		1,500,000	300k annual estimation costs
3.1.3. Based on this identification of health workforce demands (current and future forecasts) in section 2.1 above, redistribute the existing staff in order to ensure a balanced distribution of health workers across different health facilities and service areas.	x	x	→																	Noticeable balanced distribution of health workers from MoH reports	MoH, PSC			
3.1.4. Review and improve existing remuneration and working conditions and entitlements of health workers in order to address the imbalanced distribution and retention of health workers in needed health service areas especially in rural hospitals and health centres.	x		x		x		x		x		x		x		x		x			Revised remuneration and working conditions and entitlements for health workers.	MoH, PSC	MoF, Remuneration Tribunal, MPMC, other key health sector partners.	1,500,000	300k annual estimation costs
Total Budget for 3.1																						**1,500,000**	
3.2. Address the retention of health workers that are critical for the maintenance of essential health services.																							
3.2.1. Consider the introduction of a market allowance as a retention strategy for limited health specialists (1 to 2 existing	x	x																		Revised remuneration and working conditions and entitlements for	MoH, PSC	MoF, Remuneration Tribunal, MPMC, other	1,500,000	This can become part of Activity 2.1.1. 300k annual

numbers).																				health workers.		key health sector partners.		costs
3.2.2. Continuous review and adjustment of salaries and other entitlements of health professionals in the most critical areas of health in order to assist with the retention of health workers in these areas.	X	X	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	Revised remuneration and working conditions and entitlements for health workers.	MoH, PSC			this can become part of Activity 2.1.1
3.2.3. Redefine and redesign roles, duties and responsibilities for health workers in these critical areas of health as a way of providing more interesting and challenging work for them to remain with the services.	x	x	x	x	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	Revised JDs and career structures	MoH, PSC			
Total Budget for 3.2																							**1,500,000**	
Strategy 3.3: Strengthen the leadership, management and supervision for improved staff and organizational performances.																								
3.3.1. The HPAC as a 'multi-sectoral HRH committee' (HRHMC) to provide strategic direction, leadership and governance to health workforce development issues and matters, including the implementation of this SHWDP 2020-2026.	x	x	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	HPAC is considering this SHWDP.	MoH	PSC, MPMC, MoF, MFAT, key health sector players.		costs for HPAC already covered under the SHRHS
3.3.2. The 'HRH working group' (HRHWG) proposed for establishment in the SHRHS 2020-2026 to provide secretariat and technical support to the HPAC as the multi-sectoral HRH committee, including operational monitoring and evaluation of the implementation of this SHWDP 2020-2026.	x	X	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	HRHWG taking on responsibilities for the implementation of this SHWDP.	MoH	PSC, MPMC, MoF, MFAT, key health sector players.		costs for HRHWG already covered under the SHRHS
3.3.3. Continuously engage senior and middle managers (through regular meetings of the HPAC and HRH working group as well as MoH management and technical meetings and forums) on health workforce issues and matters, including collaborative leadership from all managers and supervisors on the adoption and effective implementation of this SHWDP 2020-2026, including discussions of progress made, lessons learnt and way forward.		x		x		x		x		x		x		x		x		x		x		Regular meetings of the MoH management, HPAC and HRHWG.	HRHWG, MoH	PSC, MPMC, MoF, MFAT, key health sector players.		costs already covered under the SHRHS

3.3.4. Ensure timely response and address of staff issues concerning their employment, remuneration, working conditions and entitlements, grievances, performance management and others.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	MoH Reports addressing existing disparities	MoH, PSC	MoF, Remuneration Tribunal, MPMC, other key health sector partners.		
Total Budget for 3.2																								**1,500,000**	
Total for Objective 3																								**3,000,000**	
Grand Total (All Objectives)																								**10,795,000**	

4. IMPLEMENTATION

4.1. Governance for implementation arrangements

This Samoa Health Workforce Development Plan (SHWDP) 2020-2026 addresses the Ministry of Health (MoH) workforce development needs and issues. The effective and efficient implementation of this Plan therefore requires the full leadership support and commitment of MoH management and staff across all levels, as well as key health sector partners and stakeholders. Given the alignment of this Plan to the SHRHS (Samoa Human Resources for Heath Strategy) 2020-2026, it is recommended that this SHWDP adopt the same implementation arrangements proposed for the SHRHS:

- Health Program Advisory Committee (HPAC) taking on the role of a 'HRH multi-sectoral committee' (HRHMC) and the 'HRH working group' (HRHWG) to take up responsibilities for leadership and governance of health workforce development, including the implementation of this SHWDP.

- The role of the HPAC (as the HRHMC) also includes providing support for resource mobilisation (financial and technical) to enable the implementation of this SHWDP.

- The MOH Human Resource Unit (HR Unit); the HRH Focal Point (HRHFP) as the Secretariat to the HPAC and HRHWG and lead facilitator of the implementation of this SHWDP. It provides secretariat work and needed analysis on workforce development to feed into the regular meeting agendas of the HPAC and HRHWG.

- The HRHFP through the HRHWG will be responsible for the M&E of this SHWDP, providing regular reports to the HPAC and HRHWG on the implementation progress of the SHWDP.

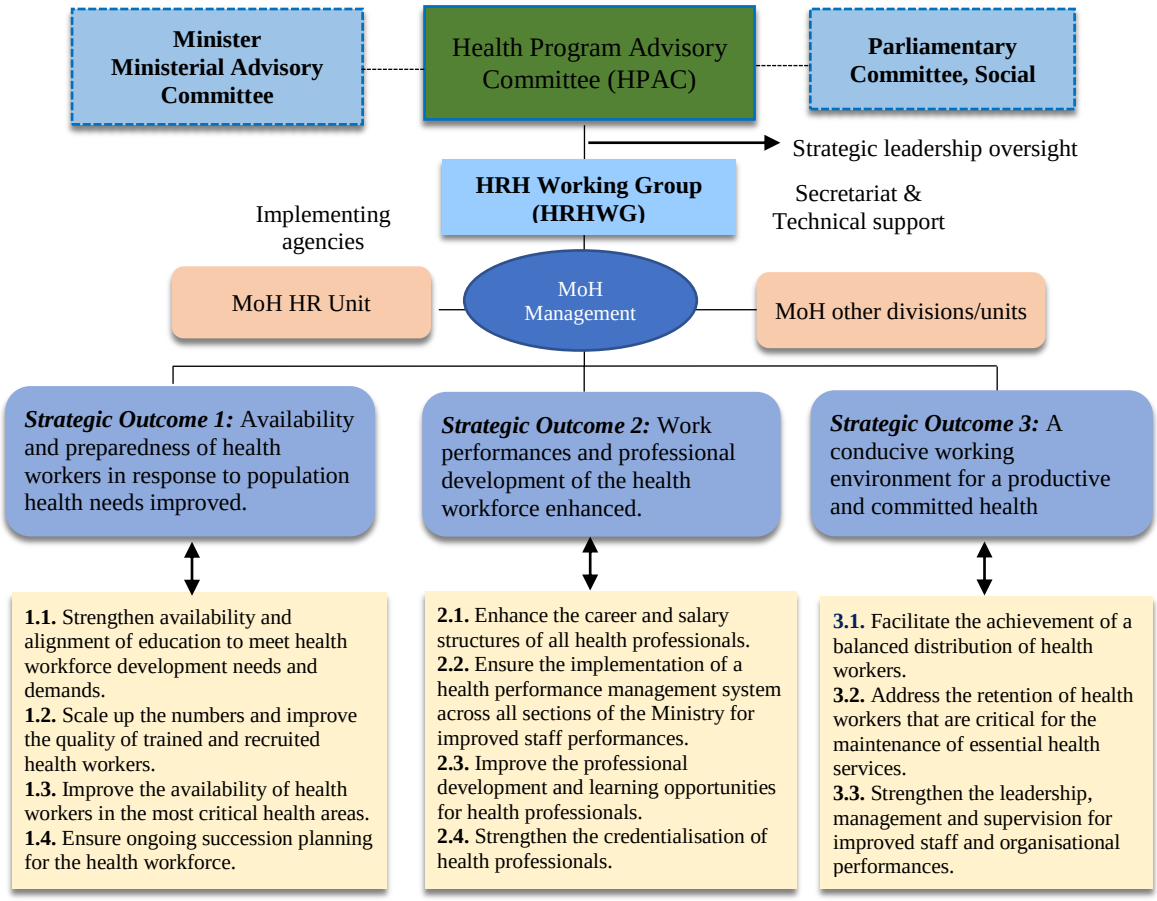
- Technical and financial support through bilateral and multilateral assistances are to be solicited through the relevant development partner mechanisms (e.g. MoF Aid Coordination, MFAT, development partners' focal points, etc.) to enable the full implementation of the activities outlined in this SHWDP.

- Representatives of health development partners should be invited to participate in HPAC and HRHMG meetings and discussions.

- Linkages between the HPAC and higher policy making authorities (Health Minister and Associate Minister, Cabinet and Parliament) to be facilitated through existing governance mechanisms such as the Minister Ministerial Advisory Committee and the Parliament Committee, Social.

Incorporating all of the above, the implementation governance structure of this SHWDP 2020-2026 is presented as Figure 6; the same implementation structure for the SHRHS:

Figure 6: SHWDP 2020-2026 implementation governance structure



4.2. Activity implementation plan and costing

Detailed annual work plans to implement this SHWDP must be prepared and submit to the MoH management, HPAC and HRHWG for deliberations and approval. The annual work plan should be based on the **indicative multi-year action plan** outlined in **section 3.6**.

The SHWDP **annual work plan** (for each year of the Plan: 2020-2021, 2021 – 2022, 2022 – 2023, 2023 – 2024, 2024 – 2025, and 2025 – 2026) must be integrated with MoH and other sector partners' (members of the HPAC & HRHWG) annual work plans and budgets – including budget forecasts, budget reviews, and evaluation processes and mechanisms. This integration will ensure that this SHWDP and implementation processes become part of the normal core business of the MoH – and its other heath sector's key implementing partners. It will also ensure that there is budgetary support made available to implement this Plan, especially funding for core implementing staff in the MoH HR Unit, who will have the primary responsibilities to implement this SHWDP.

The SHWDP **indicative action plan** in section 3.6 should be a **rolling plan**, it should be continuously reviewed, revised and updated to ensure relevancy, to reflect changes in the implementing environment, and taking into consideration lessons learnt from the previous years' implementation progress. The SHWDP annual work plan must reflect the changes made against the SHWDP indicative multi-year action plan under section 3.3. The indicative multi-year action plan (outlined in section 3.6) also outlines estimated **costing** of implementing this SHWDP 2020-2026.

4.3. Resourcing and financing

The Government of Samoa (GoS) leadership support and budget allocation should be sought on the implementation of this SHWDP 2020-2026. Financing options available to the government through the HPAC's resourcing mobilisation role to implement the SHWDP Action Plan will include:

- Reallocation of existing ministries and MoH's funded outputs and activities; and/or
- Financial and technical assistances sought from bilateral and multi-lateral arrangements with development partners – at the national, regional and global levels.

The MoH through the support of the HPAC and HRHWG should seek financial support from development partners (WHO, DFAT, MFAT, EU, UN agencies, etc.) and through relevant regional (SPC, PIFS, and health regional bodies) and global organisations, with a mandated role in health for the implementation of the 5-year SHWDP outlined in section 3.6.

4.4. Monitoring and evaluation

The M&E framework of this SHWDP 2020-2026 is provided in Table 12. Improvement in implementation and in the development of follow-up or subsequent SHWDP action plans (beyond this 2020-2026 SHWDP) require the sharing of information on the progress of implementation and lessons learned with relevant partners and stakeholders. M&E will be led by the MoH (HR Unit as the HRHFP). The HPAC and HRHWG provide coordination and technical support in the performance of the MoH leading role in the implementation of this SHWDP.

Annual work plan and budget: the annual work plan and budget will serve as the primary reference documents for the purpose of monitoring the achievement of results.

Sixth monthly and annual reporting: Sixth monthly and annual reports need preparation by the HRHFP. Reports also need to be submitted to Cabinet on a regular basis to inform leaders about achievements made. Reports should include updated information and narrative summary of results achieved against the SHWDP, lessons learnt and way forward.

Annual reviews: Based on the above reports, annual reviews should be conducted in the fourth quarter of the year or shortly after, to assess progress made against the SHWDP 2020-2026 and to review the annual work plan for the following year. In the last year of the SHWDP, this review will also be a final assessment/evaluation. This review is driven by the HPAC and HRHWG and should involve all key stakeholders for feedback. The review must focus on the extent to which progress is being made on the SHWDP 2020-2026.

Mid-term and completion reviews/evaluation: Ongoing improvements and maintaining momentum in the implementation of the SHWDP 2020-2026 require regular independent evaluation to assess progress and to map the way forward. The development (i.e. reforms) of HRH is a complex area because of the required attitudinal changes required in the MoH and health sector partners for any change to take rook. As such, ongoing reflections through reviews and evaluations are critical for feedback and ongoing improvements.

Table 12: SHWDP 2020-2026 Monitoring & Evaluation framework

Monitoring & Evaluation Framework						
Indicators	**Baselines**	**Targets**	**Means of Verification**	**Assumptions**	**Risks**	**Strategy to manage risks**
Vision: "A trained and professional workforce that meet the needs of the population". Mission: "Visible improvements in health workforce numbers and performances". Goal: "To improve the numbers, quality and performances of the health workforce".						
1. Improved health worker density (1 to 1,000 population).	*4.66* [2019]	50% increase in health worker density [2030]	Workforce analysis	Reliable and accurate data made available, strategies and activities outlined in this SHWDP are being implemented.	Lack of implementation of this SHWDP and the SHRHS. .	Solicit leadership support and commitment of the MoH, Cabinet and health sector partnering organisations.
2. Improved balanced in health worker distribution (1 to 1,000 population).	*8.90 (TTM)* *3.35 (MTII)* *0.67 to 2.78 (DH/HC)* [2019]	Equal health worker density across all health facilities/services. [2030]	Workforce analysis	Full decentralisation of health services will be completed before 2030.		
3. Improved professional health worker density (1 to 1,000 population).	*0.58 doctors* *0.1 to 0.06 (medical specialist)* *3.15 nurses* *0.42 midwives* *0.3 other health professions* [2019]	*50%* increase in professional worker density including clinical specialists. [2030]	Workforce analysis	Full decentralisation of health services will be completed before 2030. SHWDP and SHRHS are being implemented effectively.		
4. Enhanced health performance.	*HSP indicators*	Improved perceptions of the health services and system.	Public perception surveys.	Commitments made to implement the HSP and SHWDP.		
Strategic outcome 1. Availability and preparedness of health workers in response to population health needs improved.						
1.1. Strengthen the availability and alignment of education to meet health workforce development needs and demands.						
• Ongoing support – e.g. budgetary supply and more scholarship awards including further support for OUM students.	50 medical graduates. [2019]	10% increase in the number of medical students. [2026]	MoH Records/ documentation, HRMSC meeting papers.	There is leadership support for the proposed increase in the number of medical students and graduates.	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• Programs/courses for needed health disciplines developed/reinstated and made available.	Programs / courses for dental nursing, medical imaging/radiography, pharmacy, laboratory, public health, other allied health, etc. – discontinued. [2019]	Accredited programs/courses in place and are being offered locally. [2026]	NUS, OUM and other institutions curriculums and programs/courses.	There is commitment, resources and teaching staff and materials for these programs/courses		
• Public health incorporated into the curriculums of the medical and nursing programs/courses and relevant allied health programs/courses where applicable.	Weak incorporation in the current curriculums [2019]	Public Health incorporated [2026]	NUS, OUM and other institutions curriculums and programs/courses.	There is commitment, resources and teaching staff and materials for these programs/courses		

1.2. Scale up the numbers and improve the quality of trained and recruited health workers.						
• OUM scholarships fully utilised.	7 out of 20 utilised (i.e. 35%) [2019]	100% utilisation [2026]	OUM records	Additional support from government made available to support full utilisation of available scholarships by potential medical students.	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• Campaign to promote interests in health careers conducted.	Ad hoc [2019]	Annual campaigns [2020-2026]	MoH Records/ documentation.	Commitments from MoH government and partners on the implementation of these activities.		
• More clear scholarship awards allocation for courses/programs in the different health professionals.	Most scholarships geared toward medicine and nursing. Need to target allied health service areas. [2019]	Balanced allocation of scholarships to priority areas of health workforce development. [2026]	MoH, PSC and MFAT records			
• Study leave and other public service policies and procedures revised to ensure alignment with priority workforce needs.	Existing policies do not necessarily addressed the priority health workforce needs. [2019]	Alignment noted [2026]	MoH, PSC and MFAT records			
• MoH organisational structure contained position establishment to accommodate incoming graduates in health.	Lack of position establishment across different health professions [2019]	Clear positions establishment reflected in MoH approved organisational structure. [2026]	MoH and PSC records			
• Nursing, medical and allied health orientation or internship programs reviewed.	Need for more clinical/practical exposure [2019]	Orientation or internship programs strengthened [2026]	MoH, NUS, OUM & APTC records. Students and supervisors feedback.			
1.3. Improve the availability of health workers in the most critical health areas.						
• Career and salary structures of health professionals reviewed for attraction of qualified professionals in 'hard to fill' vacancies or roles/positions.	Career and salary structures not incorporating strategies and processes for attraction and recruitment of 'hard to fill' vacancies. [2019]	Career and salary structured upgraded [2026	MoH and PSC records	Commitments from MoH government and partners on the implementation of these activities	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector
• Full utilisation of private medical specialists in public hospitals and health clinics.	Not all private doctors (specialists) utilised in the public hospitals [2019]	More private specialists having contracts with MoH to work in hospitals. [2026]	MoH records			

• Negotiations and efforts made to recruit overseas health workers for 'hard to fill' vacancies and for Samoa to access and obtain health workers in the most critical health areas.	MoH still finds it hard to recruit from overseas for 'hard to fill' vacancies [2019]	Overseas specialists are working in the MoH to fill gaps in most critical health areas or 'hard to fill' vacancies [2026]	MoH records			committees.
2.1. Ensure ongoing succession planning for the health workforce.						
• National Health Workforce Accounts for Samoa is developed and is in place.	None [2019]	National Health Workforce Accounts is in place. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• All key MoH units, sections or departments have up to dated succession plans.	A few units have succession plans [2019]	All units, sections or departments have updated succession plans [2026]	MoH records, succession plans			
• Attainment of the numbers of health workers stipulated in this SHWDP including the monitoring of this SHWDP and succession plans of every department, unit, section monitored.	Lack of M&E on workforce development and HRH [2019]	Proper M&E reports on SHWDP, SHRHS and other policies on HRH and health workforce development. [2026]	MoH records, M&E reports			
Strategic Outcome 2: Work performances and professional development of the health workforce enhanced.						
2.2. Enhance the career and salary structures of health professionals.						
• Career and salary structures of all health professionals reviewed incorporating criteria, standards and processes for improving the attraction and retention of health workers in the most essential service areas.	Outdated career and salary structures of health professionals. [2019]	Revised career and salary structures of health professionals accommodated the need to attract and retain the most needed health workers. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• Approved career and salary structures of health professionals implemented, monitored and evaluated.	Lack of proper M&E of career and salary structures of health professionals. [2019]	Proper M&E reports on health professionals' career and salary structures. [2026]	MoH records & documentation.			
• Existing disparities in salaries of health workers addressed.	Queries concerning salary disparities exist and not yet fully resolved. [2019]	Reduction in the number of queries from staff on salary disparities [2026]				

2.3. Ensure the implementation of a health performance system across all sections of the Ministry for improved staff performances.						
• MoH PMS reviewed and customised.	PMS not applicable and lack consistent implementation across all units, sectors and departments of the MoH [2019]	PMS reviewed and customised to the health context. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• PMS training package developed and implemented.	No training package on the PMS [2019]	Training package developed and implemented. [2026]	MoH records & documentation.			
• PMS implemented, monitored and evaluated and continuously refined for improvement.	Lack of proper M&E of the PMS [2019]	PMS monitored and evaluated. [2026]	MoH records & documentation.			
2.4. Improve the professional development and learning opportunities for health professionals.						
• Professional development framework (inclusive of a competency profile of all health workers) developed.	No professional development framework encompassing all health professionals. [2019]	A professional development framework developed and is in place. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• Training package on the Professional development framework developed and implemented.	No training package. [2019]	Training package developed and implemented. [2026]	MoH records & documentation.			
• Professional development framework implemented, monitored and evaluated and continuously refined for improvement.	Lack of proper M&E on professional development of health workers. [2019]	Professional development of health workers monitored and evaluated. [2026]	MoH records & documentation.			
2.5. Strengthen the credentialization of health professionals.						
• Minimum entry requirements of allied health workforce positions revised and updated to a diploma qualification level.	Low entry requirements for allied health workforce (those at officer and below levels). [2019]	Upgraded minimum requirements for allied health professionals. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• All allied health workers are accredited/registered following completion of a required accredited programs.	All allied health workers not yet fully registered.	All allied health workers registered following completion of an accredited programs in their fields. [2026]	MoH records & documentation.			
• Upgrading of minimum entry requirements of all allied health workforce positions reflected in career	Lack of consideration of accreditation and registration of allied health professionals in their career and salary	Career and salary structures of allied health professionals updated reflecting upgraded minimum requirements and	MoH records & documentation.			

and salary structures of allied health professionals.	structures. [2019]	credentialisation or accreditation processes. [2020]				
Strategic objective 3: A conducive working environment for a productive and committed health workforce is strengthened.						
3.1. Facilitate a balanced distribution of health workers.						
• Required numbers of health workers in different professionals considered by MoH management & PSC.	Lack of attention to health workforce numbers and forecasts. [2019]	Consideration by MoH management and PSC of health workers requirements and forecasts outlined in this SHWDP. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• Staff reallocated to facilitate a balanced health workforce.	Imbalanced distribution of health workers. [2019]	Improvement noted with a more balanced distribution of health workers. [2026]	MoH records & documentation.			
• MoH remuneration, working conditions and entitlements and other relevant HRH policies reviewed and updated to address the imbalanced distribution as well as the needed retention of health workers in needed health service areas especially in rural hospitals and health centres.	Existing remuneration, working conditions and entitlements and other HRH policies do not necessarily encourage and support a more balanced distribution of health workers. [2019]	Updated remuneration, working conditions and entitlements and other relevant HRH policies in supportive of the reallocation, redeployment, recruitment and selection of a more balanced health workers distribution. [2026]	MoH records & documentation.			
3.2. Address the retention of health workers that are critical for the maintenance of essential health services.						
• Introduction of a market allowance for the retention of needed health specialists (that are short in supply) considered.	No deliberate attempt to retain needed health specialists. [2019]	A market allowanced considered. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities.	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• Salaries and other entitlements of health professionals in the most critical areas of health are continuously adjusted to assist with the needed retention of those professionals.	Lack of attention to address adjustment of remuneration and entitlements of health professionals in most critical health workforce areas.	Reviewed salaries and other entitlements to facilitate the needed retention of needed health professionals/ specialists. [2026]	MoH records & documentation.			
• Roles, duties and responsibilities of health workers redefined and redesigned to as a way of providing more interesting and challenging work for them to remain with the services.	Roles, duties and responsibilities of health workers not reviewed and reconfigured to make work more interesting for workers. [2019]	Revised role descriptions to make work more interesting for health workers as a way to attract and retain staff. [2026]	MoH records & documentation.			

3.3. Strengthen the leadership, management and supervision for improved staff and organisational performances.						
• HPAC taking on leadership and governance overnighting roles for the SHWDP.	No consolidated body taking on the coordinated leadership and governance of HRH and health workforce issues and matters. [2019]	HPAC taking on board multi-sectoral leadership and governance roles for the HRH and SHWDP and is meeting regularly. [2026]	MoH records & documentation.	Commitments from MoH, government and partners on the implementation of these activities.	Lack of resourcing commitments and priorities given to health workforce development priority needs.	Strong lobby and support provided through brokering mechanisms such as the MoH HR Unit, PSC and WHO through their participation in the HPAC and other health sector committees.
• HRHWG taking on the lead role in the implementation of this SHWDP.	Lack of coordinated response and policy advice on HRH and workforce development work.	HRHWG established and is meeting regularly [2026]	MoH records & documentation.			
• Noticeable engagement of senior and middle managers on workforce development issues including the implementation of the SHWDP.	Lack of engagement of senior and middle management on workforce development issues of the MoH. [2019]	Regular discussions of workforce development issues/matters by senior and middle management. [2026]	MoH records & documentation.			
• Staff issues concerning their employment, remuneration, working conditions and entitlements, grievances, performance management and others addressed.	Some long standing issues of staff concerning their employment and working conditions and entitlements not yet addressed. [2019]	Decreased complaints from staff on matters concerning their employment and working conditions and entitlements. [2026]	MoH records & documentation.			

Evaluation matrix						
Evaluation Title	**Purpose and criteria**	**Starting Date**	**Completion Date**	**Key Evaluation Stakeholders**	**Resources and Sources of Funding**	
Mid-term review of the SHWDP 2020-2026						
Other evaluations - E.g. effectiveness of workforce development initiatives.						
Other evaluations - E.g. effectiveness, efficiency and responsiveness of the workforce development plans, policies and systems.						
End of the SHWDP 2020-2026 Completion Evaluation						

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