SAMOA

1. CONTEXT

1.1 Demographics

In 2010, estimates put Samoa’s population at 184,032, with around 38.3% young people aged less than 15 years and only 5.0% aged 65 years and over. Life expectancy was 73.2 according to the 2006 census, compared with 72.8 years in 2001.

The country is divided into four major statistical regions: Apia Urban Area (AUA), North West Upolu, Rest of Upolu (including Manono and Apolima Islands) and Savaii. AUA represents the urban area, while the other three regions are rural.

Gender issues, such as the promotion and protection of women’s rights, gender equity and women and HIV/AIDS are of high importance in Samoan society. The level of women’s participation in the paid labour force is relatively high, and their access to education and achievement in the formal educational system is virtually equal to men. Women occupy a number of senior positions in the public sector. The church plays a key role in influencing public opinion and in education through the provision of schools at all levels.

The United Nations Development Programme (UNDP) Human Development Index (HDI) ranks Samoa 94th out of 182 countries. Based on the HDI, Samoa has one of the higher levels of social development in the Pacific, showing higher overall educational and health standards than other Pacific islands.

1.2 Political situation

Democratic traditions and a strong social system based on village communities and extended family ties continue to play a major role in maintaining peace in Samoan society. The extended family, the aiga, is the foundation of the fa’asamoa (traditional way of life). The head of each aiga is the matai (customary chief), who is elected by family members. Traditionally, the family matai is responsible for maintaining the family’s dignity and well-being by administering family affairs. More than 80% of the population lives under the matai system. Particularly strong in rural areas and at village level, it functions as a safety net in providing social and financial security. Many Samoans who are resident abroad continue to honour their ‘social obligations’ by sending significant amounts of money to their extended families and churches.

The national system of government is based on the British Westminster model, with a combination of traditional and democratic features. Universal suffrage has applied since 1991 but, with the exception of two seats reserved for voters considered to be outside the governance of the matai system (out of a total of 49 seats), only matai can stand for parliament. The Human Rights Protection Party has been in power continuously for almost 20 years. The coalition forming the opposition comprises the Samoan National Development Party and eight independent members.

During 40 years of independence, Samoa has been able to create a stable political environment and to stimulate economic growth through sound macroeconomic management. Over the past 10 years, it has sought to address the challenges of social and economic reforms. Since the early 1990s, the Government has committed itself to the promotion of good governance. Human rights are respected overall. The ongoing Economic and Public Sector Reform Programme (since 1996) has instigated institutional reforms in public services and in several public sector agencies, which has led to improvements in the governance framework. Performance budgeting has encouraged greater efficiency, accountability and transparency. Equally, economic reforms are considered to be crucial for Samoa in the pursuit of the Government’s goal to improve the living standards and the welfare of the people.

Since 1996/1997, the Government’s national policy framework and development strategies have been set out in statements of economic strategy, currently the Strategy for the development of Samoa 2008–2012, which highlight the vision of “improved quality of life for all”.

1.3 Socioeconomic situation

The economy of Samoa has traditionally been dependent on development aid, family remittances from overseas, and agriculture and fishing. Agriculture still plays an important role in the economy. Village agriculture provides food security and support to the agro-based industries, such as coconut cream, oil and desiccated coconut, which have been major export products in the past. The manufacturing sector mainly processes agricultural products. Tourism is an expanding sector. The Government has called for deregulation of the financial sector, encouragement of investment and continued fiscal discipline, while protecting the environment. Development efforts in the area of trade, at both national and international levels, are considered relatively advanced compared with other Pacific islands. However, Samoa is ecologically fragile and vulnerable to natural disasters, such as cyclones and disease infestations.

Gross domestic product (GDP) per capita at the end of March 2010 was US$ 2881.81. Economic growth in 2001 was estimated at 6.5%, with an annual rate of inflation of 4% by the end of the year. Manufacturing, transport and communications, and commerce contributed most to the growth. Agriculture production, on the other hand, dropped by 12% as a direct result of the limited market outlets for copra, cocoa, kava and coconut cream, while gross tourism receipts rose only marginally, by 0.7%. The sharp slowdown in growth was seen as a direct result of the 11 September 2001 terrorist attack in the United States of America. While exports improved by 16.8% compared with 2000, imports increased by 28% in 2001. As a result, the current account deficit widened to 11.2% of GDP. Remittance inflows continued to increase, but at a lower rate than in 2000. At the current level, they are equivalent to 18% of GDP. At the end of 2001, foreign reserves stood at WST 174.84 million (US$ 66.7 million), equivalent to approximately 4.1 months of import cover. Grants from development partners in 2000/2001 added up to WST 65.09 million (US$ 23 million), equalling some 25% of total revenue.

1.4 Risks, vulnerabilities and hazards

Rural-to-urban migration exacerbates the diminishing agriculture and fishing industry in rural areas. The settlement along the coastal areas of Samoa allows for potentially greater accessibility to services. However, tropical vegetation, tidal mudflats and mangrove areas situated along the coastline, with high humidity, create a prime environment for vectorborne diseases, such as dengue, and for complications of conditions such as wound-healing and tropical ulcers.

Samoa’s susceptibility to cyclones and other natural disasters raises the importance of developing well-planned mechanisms for disaster preparedness.

Rural-to-urban migration is also impacting upon the health of urban communities. The ready access to unhealthy food, combined with smoking, alcohol and physical inactivity, is contributing to the increasing prevalence of noncommunicable diseases.

2. HEALTH SITUATION AND TREND

2.1 Communicable and noncommunicable diseases, health risk factors and transition

The health status of the population has improved significantly, and Samoans now enjoy relatively good health. However, persistently high mortality and morbidity rates for communicable diseases call for a renewed surveillance, control and management commitment.

Typhoid and dengue are both endemic and periodically reach epidemic levels. Lymphatic filariasis is also endemic, with a standardized antigen prevalence rate of 1.6% in 2003. As the Government has made a firm commitment to eliminate lymphatic filariasis by 2005, intensive mass drug administration (MDA) campaigns have been carried out, with 96% coverage in 2001, 60.3% in 2002, 80% in 2003 and 74.2% in 2008.

There were 16 tuberculosis cases (all forms) diagnosed in 2009, eight with sputum-smear-positive pulmonary TB. The calculated case-detection rate was 51% in 2009. The directly observed treatment, short-course (DOTS) strategy has been established throughout the country and functions well.

The incidence of HIV/AIDS is low, with a cumulative total of 12 known infections since 1990. Other sexually transmitted infections (STI), however, are present at extremely high rates, with 38% of women attending antenatal
clinics being found to have at least one STI in a study carried out in Apia in 1999-2000. Women aged less than 25 years were significantly more likely to be infected. The surprising results of this study indicate the potential for rapid spread of HIV, but also the urgent need to tackle the STI epidemic in its own right. Given the high prevalence and death rates caused by noncommunicable diseases, such as diabetes and suicide, resources for HIV/AIDS programmes are often limited. Whilst the supportive policy and national structures are in place for the coordination and management of HIV/AIDS activities nationally, this infrastructure has been, until recently, with the release of funding from the Global Fund, severely underresourced.

Noncommunicable diseases (NCD), including obesity, diabetes, heart disease, high blood pressure, stroke and cancer, are a top health priority, with high and increasing prevalence rates: the obesity rate is currently 57.0%, the diabetes rate is 23.1% and the hypertension rate is 21.4%. NCD are now appearing in younger age groups and complications are becoming more common. NCD are very costly, accounting for 43.3% of total health care expenditure in 2000. If their prevalence continues to increase, the Government will be unable to continue financing the resultant rising health care costs; hence prevention must remain the mainstay of national NCD management and control. The four main risk factors are smoking (tobacco), poor nutrition, excessive alcohol consumption and physical inactivity. To reduce these risk factors, changes in the lifestyles and the behaviour of individuals, families and communities are necessary, requiring a coordinated, multisectoral national response.

The total prevalence rate for diabetes is 23.1%: 22.9% in males and 23.3% in females. Prevalence increases with age and overall has doubled since a previous survey in 1991. The disease is more common in urban areas, (Apia 27%, Rural Upolu 19.7% and Savaii 20.3%), and the trend is similar for males and females.

In general, for every known case of diabetes that is diagnosed, almost three remain undiagnosed, with the ratio a lot higher in the younger age groups, (in males, for every known case there are 12 unknown cases). Of those with a known history of diabetes, 56.8% of males and 68.5% of females are taking tablets, and only 4% of males and 5.3% of females are taking insulin.

The total prevalence of hypertension is 21.4%. The rate is higher in males (24.2%) than in females (18.2%) and increases with age in both. High blood pressure is more common in urban areas (Apia 23.5%; Rural Upolu 18.6%; Savaii 21.2%).

In general, for every known case of high blood pressure that is diagnosed, another four remain undiagnosed. This ratio is higher in the younger age group, (for every known case there are 22 unknown cases). Most people (more than 90%) with high blood pressure do not know that they have it.

The total prevalence of obesity is 57.0% (48.4% in males and 67.4% in females) and increases with age. It is more common in urban areas. (For males, Aipa 53.1%; Rural Upolu 48%; Savaii 40.2%. For females, Aipa 69.3%, Rural Upolu 65.9%, Savaii 65.4%).
Many risk factors for NCD are present among the Samoan population, including: smoking (40% of the total population are smokers: 56.3% of males and 21.8% of females); poor nutrition: (35.6% of the population eat virtually no fruit\(^1\)); alcohol consumption (current levels of alcohol consumption place 37.6% of males and 19.6% of females at moderate to high risk of developing an NCD); and lack of physical activity (21% of the population do very little or no physical activity). People in Apia are more likely to be inactive (28%) than people in rural areas (15%), and women (27.3%) are more likely to be inactive than men (14.8%). There is a lack of regular health checks. In the last 12 months, only 35% of the population have had a blood sugar check and only 44.9% have had a blood pressure check. Males and younger people are less likely to have checks.

The number of suicide attempts is increasing. However, the proportion resulting in death was only 43.2% in 2006/2007, compared with 60.5% in 1999/2000.

The ages of those attempting suicide ranged from 10 to 76 years during the period from 1999 to 2004, with most aged below 30. Paraquat ingestion is the most common mode of suicide. Its use decreased in 2000/2002 then increased to more than 60% in 2001/2002 before exhibiting a slow deceleration in the last few years.

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\(^1\) No fruit or less than one serving per day
2.2 Outbreaks of communicable diseases

No available information.

2.3 Leading causes of mortality and morbidity

In 2007-2008, the leading causes of morbidity in all public health facilities comprised both communicable and noncommunicable diseases, with pneumonia as top, followed by other complications of pregnancy and delivery; injuries and poisoning; infections of the skin and subcutaneous tissue; diabetes mellitus; acute bronchitis and acute bronchiolitis; essential (primary) hypertension; other maternal care related to the fetus and amniotic cavity; diarrhoea and gastroenteritis; and typhoid and paratyphoid fevers.

Most deaths over the same period were caused by noncommunicable diseases, such as diabetes mellitus; cancers (all sites), cerebrovascular diseases; other heart diseases; pneumonia; septicaemia; injuries and poisoning; ischaemic heart diseases; hypertension; and liver diseases.

2.4 Maternal, child and infant diseases

The infant mortality rate decreased from 19.3 per 1000 live births in 2001 to 9.0 in 2009. Likewise, the under-five mortality rate dropped from 17.8 per 1000 live births in 2000 to 15.0 per 1000 live births in 2009. The maternal mortality ratio dropped from 19.6 per 100 000 live births in 2002 to 3.0 per 100 000 live births in 2005-2006.

Tetanus and diphtheria have been virtually eradicated in Samoa, and the whole Pacific region is poliomyelitis-free.

2.5 Burden of disease

No available information.

3. HEALTH SYSTEM

3.1 Ministry of Health’s mission, vision and objectives

The Ministry of Health, as the principal agent of the Government in the area of health, takes the lead role in working with government agencies, NGOs, the private and traditional health sectors and consumers of health services to promote a high quality, comprehensive, sustainable, integrated national health system founded on the Samoan lifestyle. The Ministry is specifically charged with implementing health legislation pertaining to public health issues and advising the Government on issues related to health care delivery, health funding and health status. It is the major provider of publicly funded health services and is responsible for the management of the publicly funded health sector.

More specialized care not available in Samoa is provided to some patients through overseas treatment, either through programmes funded by the Samoan and New Zealand Governments or at personal expense.

3.2 Organization of health services and delivery systems

See Section 3.1.
3.3 Health policy, planning and regulatory framework

National priorities in health are identified in the *Strategy for the development of Samoa 2008-2012*. The *Health Sector Plan 2008–2018* presents the vision of “A healthy Samoa,” with the mission “to regulate and provide quality, accountable and sustainable health services through people working in partnership.” To realise the vision and fulfill the mission, four crucial challenges must be met:

- rapidly increasing levels of noncommunicable diseases (NCDs) and their impact on the health system, community mortality and morbidity, and the economy;
- ensuring reproductive and maternal and child health for the long-term health of the community;
- emerging and re-emerging infectious diseases; and
- injuries as a significant cause of death and disability

Six strategic areas have been identified to meet these challenges, underpinned by the guiding principles of accountable governance, sharing, accessibility, affordability and cultural appropriateness:

- Health promotion and primordial prevention (strengthened).
- Quality health care service delivery (access improved and quality strengthened).
- Governance, human resources for health and health systems (governance, human resources and leadership strengthened).
- Partnership commitment (health system strengthened).
- Health financing (financial management and long-term planning of health financing strengthened).
- Donor assistance (increased partner participation).

The publicly funded health system has been undergoing major reform since 1996. At the broadest level this has included a review of the Ministry of Health’s primary functions, roles and responsibilities and the suitability of the existing organizational structure to support these at both the strategic and service delivery levels. The themes of the reform have been: (1) Function before form; and (2) Client-based development. The reform process indicated a need for a more defined separation of the governance role from the service delivery role. This has culminated in the formal separation of the existing Ministry of Health into two new bodies, the revised Ministry of Health, as a governance and regulatory body, and the newly established National Health Service (NHS), to take responsibility for service delivery.

The Government’s reform agenda is not only about organizational reform, but is also focused on reorienting the sector towards a population-health approach. The introduction of the Integrated Community Health Services (ICHIS) model was a major step forward in that approach, the objective being to provide services closer to home, to strengthen primary health care services and to improve health services for the most vulnerable groups. Greater emphasis is also being placed on health promotion, protection and prevention services. It is acknowledged that this will be most effectively realized through partnerships with other groups in the health sector, other sectors, private enterprise and communities.

While increasing the focus on a population-health approach, there is a need to sustain, integrate and enhance the delivery of primary care services to the community. The Ministry of Health has developed a services planning model that is documented in the National Health Services Planning Framework.

3.4 Health care financing

Total national health expenditure in Samoa amounted to US$ 36.9 million in 2009, with per capita spending of US$ 205.5. In the same period, health spending as a share of GDP came to 7.0% (6% in 1998/1999), public expenditures for health comprised 87.3% of total health spending (62% in 1998/1999), and private spending for health comprised 12.7% of total health spending (23% in 1998/1999).
3.5 **Human resources for health**

In 2005, Samoa's health workforce comprised 50 physicians, 6 dentists, 3 pharmacists, 136 nurses, 37 midwives, and 73 other nursing/auxiliary staff.

3.6 **Partnerships**

A review of the *Health Sector Strategic Plan* for the period 2006–2010 highlighted some of the specific objectives and strategies that the Ministry was promoting to improve health services and health outcomes in partnership with other members of the sector. Partnership is thus a major theme of the *Health Sector Plan 2008–2018*, and is pertinent given the changes occurring within the sector. Government-funded health services are undergoing major reforms and there are rapid developments in the private health care industry. There is also a need to continue developing and strengthening collaboration with traditional health practitioners, as well as community-based and nongovernmental organizations.

3.7 **Challenges to health system strengthening**

No available information.

4. **Listing of major information sources and databases**

| Operator | Department of Health |
| Title 2 | Samoa National Health Accounts Report for FY 2002-2003; Samoa National Health Account for FY 2000/2001 (Executive summary) |
| Operator | Ministry of Health and the World Bank |
| Title 3 | Strategy for the Development of Samoa 2005-2007: Enhancing People’s Choices |
| Title 4 | Strategy for the development of Samoa 2008-2012 |
| Title 5 | Review of the Rural Health Services Plan 2006 (Draft) |
| Title 6 | Report of the PacELF 5th Annual Meeting 2003 |
| Title 7 | Samoa Suicide Prevention Strategy 2002-2006: An introduction ‘Faataua le Ola’ (FLO) |
| Title 8 | Collins V, Dowse GK, Toelupe et al. Increasing prevalence of NIDDM in Pacific Islands population |
| Title 10 | Dr Viali Lameko et al. Review of the National Tuberculosis Control Programme in Samoa from the internal medicine perspective, 20 June 2002. |
| Title 11 | Review of the National Tuberculosis Control Programme in May 2001 (WHO mission report by Dr Pierre Yves Norval). |
| Table 12 | Update of Samoa’s Country Overview – WHO Programme Budget 2010-2011 |
| Operator | Ministry of Health |
| Title 13 | WHO Global Health Observatory |
| Website | http://apps.who.int/ghodata/ |
| Title 14 | 2009 Statistical Abstract |
| Operator | Samoa Bureau of Statistics |
| Title 15 | The 2009 Human Development Report |
5. ADDRESSES

MINISTRY OF HEALTH
Office Address : Motootua
Postal Address : P.O Box 2268, Apia, Samoa
Official Email Address : ceo@health.gov.ws
Telephone : (685) 23330 or 21212 ext 502
Fax : (685) 26553

WHO REPRESENTATIVE IN SAMOA
Office Address : Office of the WHO Representative
Postal Address : P.O. Box 77 Apia, Western Samoa
Official Email Address : who@sma.wpro.who.int
Telephone : (685) 23756; (685) 24976
Fax : (685) 23765