The Health Sector Reform Programme consists of three main components. They are the institutional strengthening, primary health care and health promotion and quality health services. The ultimate aim of the reform programme is to improve the health status and health outcomes for the Samoan population.

The urban lifestyles of fast food, smoking, alcohol and physical inactivity are making Samoans less healthy. These changes have increased the demand for health care and other available services.

Maintaining control over communicable diseases needs to remain a priority as several important infectious diseases and respiratory infections continue to persist and are still among the primary causes of morbidity and mortality.

The Sāmoa health service is at a turning point.

CHAPTER 5

The health sector

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The Government of Sāmoa (GoS) makes a relatively high investment in its people's health as reflected in its last two development plans entitled "Statement of Economic Strategies" (SES 2002–2004) and "Strategy for the Development of Sāmoa" (SDS 2002–2004). The main aim of these development plans is the improvement of the quality of life for every Sāmoan. This emphasis on the people's health is recognized as the key component in human resource development which is critical in meeting the sustainable development needs of Sāmoa.

SUSTAINABLE DEVELOPMENT IS PROVIDING OPPORTUNITIES to enhance the people's potential and capacity, thereby enabling them to participate actively in their own development and live a healthy and productive life in harmony with nature. It is about putting people first (Bruntland 2002).

The current health policy statements and strategic directions for the health sector development reaffirm government's commitment to the Primary Health Care and Health Promotion principles of "*equity of access, equitable resource allocation, effective and sustainable health service provision and funding, appropriate and affordable health services, multi-sector and multi-disciplinary action for health and strengthening self-reliance and self-responsibility of individuals, groups and communities for their own health and well being*". The Health Sector Reform Programme (HSRP) consists of three main components. They are: institutional strengthening, primary health care and health promotion, and quality health services. The ultimate aim of the reform programme is to improve the health status and health outcomes for the Sāmoan population. A healthy population leads to greater work productivity and concomitant benefits to the country's economic and social development and well-being.

Emphasis on the people's health is recognized as the key component in human resource development which is critical in meeting the sustainable development needs of Sāmoa.

Health Status and Trends

There has been significant improvement in the health sector over the past decades as shown by indicators such as life expectancy, maternal, infant and child mortality rates, major reductions in infectious diseases and achieving high immunization coverage. The challenge now is not only to maintain those standards but better them.

The 2001 population census reported that life expectancy for Sāmoa has improved compared to previous years. The average life expectancy has increased from 63.5 and 64.5 in 1991 to 71.8 and 73.8 for males and females respectively. Sāmoa has a young population (more than half of the population is below 20 years) with an increasing ageing population of 65 years and over.

The achievement of the high immunization rate of 96.3 per cent is reflected in the almost non-

HEALTH DEPARTMENT OUTREACH AND COMMUNITY REALITY

PHOTOS BY SKIV JOHNSTON

existence of the six communicable diseases (acute respiratory infection, typhoid, unspecified viral infection, gastroenteritis, influenza and pneumonia) under the Expanded Programme of Immunization (EPI) in the country. Poliomyelitis, tetanus and diphtheria have been virtually eradicated in Samoa (World Health Organization (WHO) Report; http://www.wpro.who.int/countries/sma/). The main health indicators are shown in Table 1.

The significant changes in Sāmoa's urban region with its rapidly growing population through opening of new residential areas has brought new health and environmental pressures, sub-standard living conditions in particular areas and increasing the vulnerability of these groups to access health services and education (MoH 2005). At the same time, employment opportunities are not keeping pace with the growing number of young adults leaving schools and entering the labour force. With the new freehold housing developments, the role of traditional community support structures such as *pulenu'u* and women's committees is lessened and more urban households live without the support that the village community provided. The urban lifestyles of fast food, smoking, alcohol and physical inactivity are making Samoans less healthy. These changes have increased the demand for health care and other available services.

The Sāmoa population is undergoing epidemiological transition and faces severe threats in the rise of non-communicable diseases (NCDs) as major causes of ill health thus replacing infectious diseases as the main cause of death (Samoa MoH 1998; World Bank 1998). The rates of NCDs such as hypertension, diabetes, cardiovascular diseases, asthma and cancer are also increasing throughout the Sāmoan population. Uncontrolled diabetes resulting in renal failure is emerging as a major problem.

Poor nutrition is an ongoing national issue. Protein malnutrition is affecting a significant number of young children while over half of all adults are either overweight or obese. Rheumatic fever is another concern because of its effect on cardiac problems. The new communicable diseases that have already affected some Asian countries such as Severe Acute Respiratory Syndrome (SARS) and Rubella (German measles), Avian flu are another concern because of the potential impact they could have on our vulnerable environment and defend-less population. The main causes of inpatient morbidity are respiratory conditions notably asthma and pneumonia (14 per cent of admission), pregnancy and childbirth excluding single spontaneous deliveries (10 per cent), injury and poisoning (7 per cent), and infectious and parasitic diseases (7 per cent).

Maintaining control over communicable diseases needs to remain a priority as several important infectious diseases and respiratory infections continue to persist and are still among the primary causes of morbidity and mortality. These changing disease patterns and demographic profile imply that health care demands are increasing secondary and tertiary care costs to government. This situation places a great burden on government resources given the government's free health care policy for pensioners and the high cost of overseas tertiary care which rose from SAT308,758 in 1991 to SAT2.9 million in 1999 (MoH & World Bank 2002). This cost escalation over the past five years has raised concern that has led to discussion on alternative health financing especially health insurance and increase of user fees. It also highlights the need for strengthening the integrated health prevention and health promotion programmes to assist in a reduction of massive treatment costs in the future.

TABLE 1: KEY HEALTH INDICATORS

	1991	2001	2003/2004
Total population	161,298.0	176,710.0	
Population 0-15years	65,469.0	71978.0	
Population >65 years	6348.0	8207.0	
Total fertility rate	4.8	4.4	
Life expectancy	63.0	72.8	
Crude birth rate (CBR)/1000 population	30.0	29.0	20.8
Crude death rate (CDR)/1000 population	7.7	6.4	3.0
Infant mortality rate (IMR) /1000 live births	22.1	19.3	13.0
Maternal mortality rate (MMR)/100000 live births		19.6	5.3

Source: Ministry of Health Annual Reports 1991-2001, FY22003/2004; WHO Report of the Samoa Health Sector 2001.

Health and Millenium Development Goals (MDGs)

The MDGs which relate to health call for halving by 2015 the proportion of children under five who are underweight, reducing by three quarters the maternal mortality rate, halving and starting to reverse the spread of HIV/AIDS, and halting and beginning to reverse the incidence of malaria and other major diseases.

MGD 4: To reduce by two thirds between 1990 and 2015 the under five mortality rate

The child mortality rates are a measure of health services and a good overall indicator of a community's current health status. The three indicators by which progress is monitored in order to meet this target are: the under five mortality rate, infant mortality rate and the proportion of one-year-old children immunization rate. By 1975, Sāmoa had reached the stipulated target of fewer than fifty deaths per 1,000 live births. The infant mortality rate has decreased steadily from 50 per 1,000 live births in 1975 to 22.4 per 1,000 live births in 1990, 17.8 in 2000 and 13 in 2003. These figures represent an overall 85 percent decrease since 1975.

The children's mortality rates declined by 35 percent between 1999 and 2001 and this occurred across all childhood age groups (0-1, 1-4, 5-14 and 15-19 years). Nearly two-thirds of deaths in childhood occurred in the under one year age group. This suggested that the risk of dying declined rapidly after the first year of life. It was highlighted in the 2001 Population Census that the difference of Infant Mortality Rate (IMR) between males and females in the Apia Urban region and the Savai'i region is, Apia has the lowest whilst Savai'i has the highest, an indication that babies in the Apia urban area have better chances of survival in their first year of life than babies in the rural regions.

The immunization programme since its inception in 1981 has consistently achieved immunization coverage of between 92 to 96.3 per cent and this is reflected in the almost non-existent of the six immunizable diseases under the expanded programme of immunization. This situation is attributed to many factors such as the invaluable contribution of WHO and other international and bilateral development partners in health and the effective primary health care approach, which networks into every village through women's committees that have been vital to achieving the current health status.

However, despite the successful immunization programme for children, the rubella (German measles) outbreak in 2003 resulted in the sudden increase of rubella cases in 2003/2004 compared to previous years. A mass rubella immunization campaign was launched to cover the target population of children and young adults from the age of one year to 18 years and women of childbearing age. This was funded by the WHO, JICA and AusAID.

Rheumatic fever causes rheumatic heart disease. It is the most common cardiovascular disease in children and young adults (Adams 2001). Major cardiac problems often result in heart disease, which in turn require referral for treatment overseas.

The malnutrition problem among children is mainly due to underweight. Under one year old children affected by protein energy malnutrition and those of low birth weight are being monitored by the nutrition centre. The number of malnourished children in the centre has declined. The decline is attributed to the intensive Food and Nutrition Education and Promotional Programmes by the nutrition centre (MoH & NZAID 2004). At the same time there is great concern with the increasing number of children aged 10-16

TABLE 2: INFANT MORTALITY RATE IN SĀMOA PER 1,000 LIVE INFANTS FROM 1975-2003

Years	IMR per 1,000 live births
1975	50.0
1990	22.4
1994	19.8
2000	17.8
2003	13.0

Source: Ministry of Health Annual Reports 1975, 1990, 1993/1994, 2000, 2003/2004.

years being overweight due to changing lifestyles (Faculty of Nursing & Health Sciences (FoNHS), National University of Sāmoa (NUS) 2002).

Nutritional-related Conditions

Traditionally, Sāmoan women feed their babes up until they are two years of age or until they become pregnant again, a practice confirmed by Parkinson in 1951. Parkinson found that the average weaning age in Sāmoa is 20 months. However, studies by Quested (1978) and United Nations (1998) both showed that the average duration of breastfeeding had declined dramatically over the past thirty years. The United Nation study also found that rural women were more likely to breastfeed and to breastfeed for a longer duration than their urban contemporaries. The main reasons for the decrease in breastfeeding included lack of birth spacing, lack of appreciation of the value of breastfeeding, faulty breastfeeding techniques, women's involvement in the cash economy, pressure of modern living, child adoption and lack of encouragement of breastfeeding in the post-natal period (Adams and Sio 1997; UNICEP 1996; United Nations 1998).

Anaemia (Iron Deficiency)

The prevalence of iron-deficiency anaemia is high amongst children aged five years and under. It is linked to poor diet, poor child spacing, inadequate breast feeding, poor weaning food, and worm infestation (Adams and Sio 1997; National Food and Nutrition Council 1995). The Sāmoa National Nutrition Survey (SNN) 1999 showed that high proportions of anaemia occurred among children in the following age groups: six months to less than two years (61 per cent), 2-4 years (20 per cent) and in teenagers (20 per cent) (Mackerras and Kierman 2002).

MDG 5: To reduce by two thirds between 1990 and 2015 the maternity mortality ratio, and the proportion of births attended by skilled health personnel, and to reduce the maternal mortality by three quarters between 1990 and 2015.

The Maternal Mortality Rate (MMR) decreased from 140/100,000 in 1991 to 60/100,000 in 1996. It decreased further to 19.6/100,000 in 2001 (Ministry of Health Annual Report 1995/1996, 1999/2001,FY2002/2003-2003/04). Although Sāmoa has surpassed the MDG's target, there are still concerns about the low antenatal coverage of pregnant mothers and the ineffective management of mothers during labour and delivery. The MoH Annual Reports 2000/03 and 2003/04 show that pregnancy, normal deliveries and peurperium accounted for 20.5 per cent of all admissions, complications of labour and delivery accounts for 6.4 per cent, and other maternal disorders predominantly related to pregnancy accounts for 2.4 per cent.

The integration of reproductive health/family planning-sexual health (RH/FP-SH) into women's committees in villages has made possible full access for everyone to that public service. The adoption of the family oriented approach recognizes the importance of men and adolescents in the planning and implementation of reproductive health programmes.

Strong cultural childbirthing system provided by the social midwife or traditional birth attendants (TBAs) is recognized as an integral component of the Sāmoa health system (WHO 2000). There is a need in most health areas to establish formal links between the MoH and the TBAs. Between 1991 and 1994 there was a sharp

TABLE 3: NUMBER OF LIVE BIRTHS AND STILLBIRTHS FROM DELIVERIES IN GOVERNMENT FACILITIES, FY1999-2000

Year	Live Births	Stillbirths	TBA Births
FY1999/00	3388	51	
FY2000/01	3606	60	
FY2001/02	3467	41	328
FY2002/03	3405	49	377
FY2003/04	3395	50	335

Source: Ministry of Health Annual Report FY2002/2003-2003/2004

decline in the number of births at district hospitals as well as a decrease in the number of deliveries by TBAs while a continuous increase was reported at the National Hospital. Training programmes for TBAs is on-going focusing on safe delivery practice and mandatory reporting of births using a "card system".

As shown in Table 3, of the 377 deliveries by the TBAs in 2003, 17 were teenagers. Of the 335 TBAs deliveries in 2004, 14 were aged less than 20 years.

Teenage pregnancy is an emerging problem. Teenage pregnancy may be under-reported particularly the unmarried teenage births given the ethical and moral constraints in Sāmoa (Ministry of Youth, Sports and Culture (MESC) 2001). In 1991 about 4-5 percent of all known deliveries were to teen mothers aged 20 years and under. In1995 there were 316 births in the 0-19 year age group, representing 10 percent of all 3,292 births delivered in Government health facilities. Approximately one in eight births born to women aged 19 years or under were delivered by traditional birth attendants outside government facilities (DoH 1998).

In the year 2000, out of the total 2,026 antenatal mothers booked in 2000, 151 (7.5 per cent) were below 19 years of age. Of those 151 teenage pregnancies booked, 58 (38.4 per cent) were single, 51 (33.8 per cent) were in stable union relationships and 42 (27.8 per cent) were married.

Teenage births constitute a risk to the health and well being of both mothers and infants. These risks are associated with premature labour leading to premature birth, low birth weight. Infant mortality is high among infants born to teenagers as shown in Table 4.

Although women have full access to reproductive health services, the incidence of breast and cervical cancer seem to be on the rise, a situation exacerbated by the lack of screening procedures. There is a need to strengthen the cancer control and prevention programmes and create awareness and understanding regarding the consequences of these two conditions. There is also a need to develop protocols aimed at early identification of cervical and breast cancers. The integration of the Palliative Care Programme (PCP) into the Integrated Community Health Services (ICHS) by community nursing services ensures the follow-up and involvement of the patients and their families in the management of the client's care.

More than half of the Sāmoan population (55.2 per cent) use family planning methods. It is a result of the active participation of stakeholders in all the preventive programmes and workshops conducted at the community level in collaboration with the Health Education and Promotion Section (HEAPS) (MoH 2001/2002).

The prevalence of iron deficiency anaemia (<10g/dl) is high especially amongst pregnant mothers aged 20-29 years. It is linked to dietary inadequacy, poor child spacing and worm infestation which is common amongst both the school age children and mothers (Adams and Sio 1997). Therefore, there is a need to strengthen the promotion of nutrition education in terms of the kind of food mothers should eat to get more iron. There should also be extensive health education and health promotion programmes on anaemia in pregnancy.

Factors contributing to the status of reproductive and sexual health in Sāmoa because of the lack of appropriate RH/FP-SH programmes to cater for the needs of teenagers/adolescents include easy access to night clubs and the availability of alcohol leading to the promiscuous sexual behaviour among teenagers (which have in turn led to pregnancy), lack of communication between parents and ado-

TABLE 4: AGE AND NUMBER OF MOTHERS, WHO GAVE BIRTH IN THE NATIONAL HEALTH FACILITIES,1999-2004

Age of Mother	Financial Year				
	1999/2000	2000/01	2001/02	20002/03	20003/04
<20	330	317	327	341	303
20-24	1047	1091	1013	992	964
25-29	1005	1001	967	909	860
30-34	634	694	649	715	729
35-39	372	417	391	350	401
40-44	90	125	132	128	142
45+	12	4	9	9	8
TOTAL	3490	3649	3488	3444	3407

Source: Ministry of Health Annual Report FY2002/2003-2003/2004

lescents and lack of adequate and appropriate programmes and information on sexuality.

MDG 6: Combat HIV/AIDS, TB and other Diseases have halted by 2015 and begun to reverse the spread of HIV/AIDS and other major diseases

TABLE 5: TEN LEADING CAUSES OF MORBIDITY IN SĀMOA (1997 AND 2000)

Rank	Disease (Cause Groups)	1997		2000	
		Number	% of total illness	Number	% of total illness
1	Influenza and pneumonia	1268	10.5	1099	10.5
2	Complications of labour and delivery	765	6.4	781	6.4
3	Intestinal infectious disease	439	3.6	648	5.0
4	Infections of the skin and subcutaneous	367	3.0	404	3.1
5	Other acute lower respiratory infections	360	3.0	286	2.2
6	Maternal care related to the fetus and amniotic cavity and possible delivery problems	269	3.0	278	2.1
7	Other maternal disorders predominantly related to pregnancy	266	2.2	264	2.0
8	Chronic lower respiratory disease	261	2.2	261	2.0
9	Diabetes mellitus	248	2.1	259	2.0
10	Pregnancy with abortive outcome	215	1.8	259	2.0

Source: Ministry of Health Annual Report 1999 & 2002/2003

TABLE 6 : TEN LEADING CAUSES OF MORTALITY IN SĀMOA (1999 AND 2002)

Ranks	Diseases (Cause Groups)	1999		2002	
		Number	% of total illness	Number	% of total illness
1	Circulatory disease	65	25.4	70	38.0
2	Respiratory disease	35	13.7	19	10.3
3	Infectious & parasitic diseases	22	8.6	29	15.8
4	Certain condition originating in the perinatal period	22	8.6	8	4.3
5	Diseases of the digestive system	19	7.4	7	3.8
6	Injury, poisoning and certain other consequences of external causes	19	7.4	9	4.9
7	Endocrine, nutritional and metabolic disease	15	5.8	6	3.3
8	Neoplasm	14	5.4	14	7.6
9	Symptoms, signs and abnormal clinical and laboratory findings not elsewhere clarified	12	4.7	13	7.1
10	Diseases of the skin and subcutaneous tissue	11	4.3	9	4.9

Source: Ministry of Health Annual Report 1999 & 2002/2003

Non-Communicable Disease

Non-communicable diseases (NCDs) are lifestyle diseases associated with diet, lack of exercise and excessive use of tobacco and alcohol. More Samoans suffer from NCDs such as obesity, diabetes, hypertension and cancer (MoH 2002) now than from infectious diseases.

As shown in Table 5 and 6 below, a significant proportion of inpatient deaths are caused by NCDs such as those associated with the circulatory system, perinatal conditions, respiratory conditions and infectious and paretic diseases. The leading causes of inpatient deaths are diseases of the circulatory system; perinatal conditions; respiratory conditions and infectious and parasitic diseases. Motor accidents are another significant cause of death and injury. The rate of suicide deaths also remains high.

Separate studies in 1978, 1991 and 2002 to investigate the prevalence of diabetes, hypertension and obesity showed significant increases in the number of patients affected by both cases in both the rural and urban areas. Figure 1 shows an almost four-fold increase in the number of diabetic patients from 1978 to 2002. It is higher in the urban than in the rural areas and among females than males (Bruntland 2002). The high rate of pregnant diabetic mothers may have contributed to the high rates of miscarriages and stillbirths amongst these mothers. Figure 2 illustrates that diabetes increases with age.

Obesity is the most common factor associated with diabetes and hypertension as illustrated in Figures 2 and 3. The prevalence rate of obesity is 52.7 per cent, 48.4 per cent and 67.4 per cent in males and females respectively. These rates are similar to those recorded by Zimmet *et al* in the 1978 and 1991 surveys. The prevalence of obesity increases with age and is more common in the urban area. The high prevalence of diabetes and obesity, especially among the female population, is a major concern as they imply significant health costs. The GoS celebrates annually in November the Non-Communicable Diseases (NCD) Awareness Week to promote healthy lifestyles.

Suicide

The 1995 Apia Urban Youth Survey showed that

49 per cent of youth believe that suicide is the most serious problem facing them. Indeed the high number of suicide deaths among youths has become a major social and health concern. Between 1990 and 2004, an average of 33 attempted suicide cases and 15.2 deaths were recorded. Forty-three suicide deaths were recorded in 1990 and 42 in 2004 (MoH 1990-2000, 2002/3, 2003/4). More than 47 per cent of suicide attempts have resulted in death. Those involved were mostly males less than 29 years of age. Table 7 shows the number of reported cases of suicide that were admitted to the hospital between 1999 and 2004.

Paraguat has been one of the means of committing suicide. The government has taken this into account by passing a piece of legislation to change the way paraquat is purchased thus making it less easily accessible to potential suicide victims.

Communicable Diseases

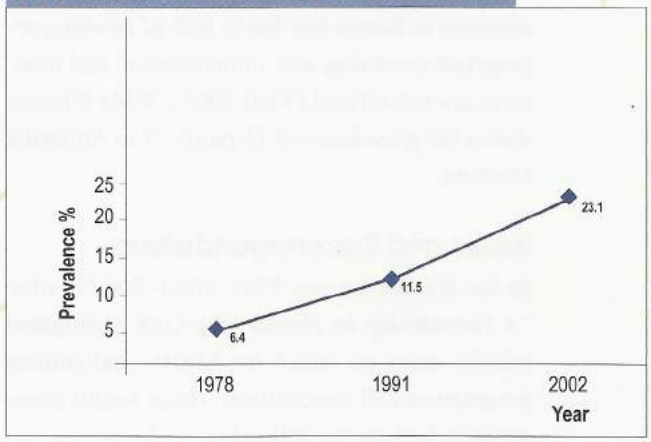
Communicable diseases are still prevalent but are no longer the leading cause of deaths.

Diseases such as acute respiratory infections, typhoid, unspecified viral infection and gastroenteritis were the main causes of inpatient morbidity between 1999 and 2004. The MoH also aims to eradicate filariasis, tuberculosis and leprosy in the near future.

Sexually Transmitted Diseases and HIV/AIDS

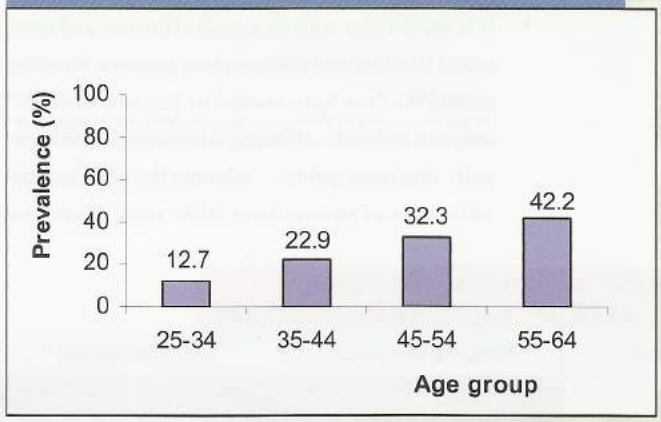
Sexually transmitted diseases are on the rise at present. They are a concern because they are the medium through which the HIV virus is transmitted. The incidence of HIV/AIDS is relatively low compared to other developing countries. The STD-HIV/AIDS/Prevention and Control Programme is integrated into RH/FP-SH programme at all levels including the primary health care level. Appropriate IEC materials and outreach activities on HIV/AIDS have been effectively disseminated through the coordination/cooperation of HEAPS, RH/FP-SH programme and the STD-HIV/AIDS unit, which is working closely with the Sāmoa Health Family Association. In response to the UNAIDS call for a regional strategy for the prevention and control of STD/AIDS in the Pacific Island countries and Territories the Sāmoa Ministry of Women's Affairs developed the National

FIGURE 1: DIABETES PREVALENCE IN SĀMOA (1978, 1991, 2002)



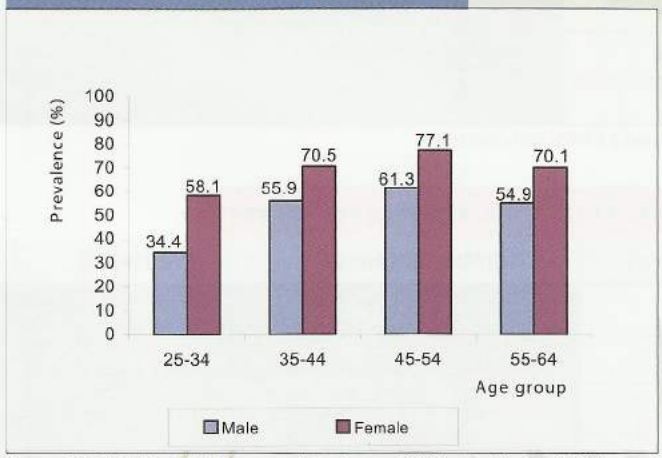
Source: MOH 2004, National Guidelines for the Prevention & Management of Diabetes in Samoa.

FIGURE 2: DIABETES PREVALENCE IN AGE GROUPS



Source: MoH & WHO 2002 Steps Survey

FIGURE 3: OBESITY PREVALENCE IN MALES AND FEMALES IN SĀMOA



Source: WHO 2002; STEP Survey on Prevalence of Diabetes, Obesity & Risk Factors

Strategic Plan 2001–2003 entitled "Responding to the Impact of HIV/AIDS on Women in Samoa". STI/Chlamydia, Hepatitis B and Hepatitis C are common in Sāmoa but due to lack of funding, appropriate screening test, immunization and treatment are not offered (Viali 2005). Table 8 below shows the prevalence of Hepatitis B in Antenatal Mothers.

Issues and Recommendations

In its Health Sector Plan 2004–2013 called "***A Partnership in Health***" the GoS highlighted priority areas on which the MoH's realignment programme will concentrate. Those health priority areas include the following.

1. Population Health Issues

Changing Behaviours

- It is known that with increased affluence and associated lifestyle and consumption patterns, environmental burdens have tended to become more diffuse and indirect – affecting a temporarily and spatially displaced public – whereas the environmental burdens of poverty have fallen more directly on "vulnerable" populations. Rural to urban migration deprives some people of more healthier food sources from the land and sea, instead relying on more convenient frozen and oily foods that are associated with diabetes and hypertension. Land is scarce to cultivate a more reliable and nutritious food supply which could also provide a good physical activity.
- Sāmoa is beginning to experience the worst of both worlds: traditional risks associated with "vulnerable groups" resulting in poverty and the new and emerging risks associated with more people moving from rural areas to the urban region, adopting urban lifestyles of fast food, smoking, alcohol and physical inactivity which are making Sāmoans less healthy. This increases the demand on healthcare and on the range of services available.

2. Sustainability – Resource Allocation

- In the 1998/99 financial year, 6.6 per cent of Samoa's GDP or 17 per cent of the government's total annual expenditure was spent on health. These figures are comparable to health expenditures of middle income countries. However, with the increase of chronic non-communicable diseases mainly relating to diabetes, heart diseases and cancer that require high technology and high cost health care, the total health care expenditure of Sāmoa as a percentage of GDP is expected to increase. This increase in high cost health care will affect the ability of government to provide health care services at the national level in terms of quality and quantity, given also that most primary and public health programmes are highly dependent on donor funding for routine activities. This situation raises sustainability issues regarding primary and public services should the do-

TABLE 7: NUMBER OF SUICIDE ATTEMPTS AND DEATHS, PARAQUAT INGESTION AND DEATHS

Financial year	Suicide attempts	Suicide deaths	Paraquat deaths
1999/2000	43	26	14
2000/2001	26	11	5
2001/2002	24	7	4
2002/2003	28	12	7
2003/2004	42	20	8
Total	163	76	38

Source: MoH Annual Report FY2002/2003-2002/2004

TABLE 8: HEPATITIS B IN ANTENATAL MOTHERS

(age 15-40 years)	Number antenatal	+ve Hep B	% +ve Hep B
Jan-Dec 2002	2656	90	3.4 %
Jan 03	356	24	6.7 %
Feb 03	236	31	13.1 %
Mar 03	233	41	17.6 %
Total	3481	186	5.3 %

Source: Dr Viali S. Presentations on Health Rights – Rights to Health Conference, September 2005.


Vailima
NATIONAL STADIUM
SVM
Fly Emira
AIR NEW ZEALAND
McDonald's
MAXKAR
Coolair
Vailima
ANZ
The Bank

nor partners withdraw assistance in the future.

- Primary health care and health promotion services receive less than 5 per cent of total public funding compared to expenditure on hospital based curative care, which received 59 per cent of total public expenditure. This is clearly contrary to national policy objectives of improving primary health care and health promotion services.
- The major issue facing rural health services is too many facilities but manned by only a few staff. The overall shortage of medical staff is not helping the situation. There are already changes made to staffing schedules to reflect patterns of demand, taking into account the declining rural population. Maintaining clinical staff at health facilities in rural areas, however, remains a challenge. A possible remedy for this situation is for government to increase the number of entries to health training programmes at NUS and for more students to be sent overseas to undertake medical training. An increase in the number of trained staff should help alleviate the staff shortage problem.

3. Expand and Support the Integrated Community Health Services (ICHS)

- The ICHS provides primary health care services, outreach services, health promotion and prevention and clinical services. These services are delivered through District Hospitals and community based services. To date, the ICHS has not fulfilled its expected role because services are still primarily clinical. Government commitment to strengthen primary health care services, expand rural and grassroot outreach of health promotion and prevention programmes and services are crucial in order to bring under control the increase of non-communicable diseases. There is also an urgent need to have extensive health education and health promotion activities targeting the youth and children to curb the threat of NCDs.

4. Strengthening Partnership with Key Stakeholders: (Intersectoral Action)

- It is important to strengthen partnerships between the Ministry and NGO's and between the Ministry and other sectors in relation to specific services they deliver to the rural communities, such as RH/FP-SH, adolescents' health, and so forth.
- Strengthening relationships with traditional healers and traditional birth attendants (TBAs): Traditional healers and TBAs continue to play a significant role in the health services. The annual household expenditure on traditional healers averaged SAT2.8million. For each visit around SAT8.52 is spent. Some traditional healers accept donations for their services. The patients often consult traditional healers before or in addition to visits to public health centres. There is a need to strengthen training for both the traditional healers and TBAs to recognize signs of serious illness and the limits of their own services, thus assisting the people to seek the best care.
- The Ministry of Health needs to continue to work in collaboration with the United Nations Family Planning Association (UNFPA) funded Adolescent Reproductive Health project and the Sāmoa Family Health Association to provide RH/FP-SH service to youth in the rural areas. These services aim to reduce the prevalence of teenage pregnancy and sexually transmitted diseases, increase awareness and knowledge of reproductive and sexual health, and conduct suicide awareness programme for the youth through workshops and road shows.

5. Equity

- There appears to be inequity in access to health care amongst people in different income groups. Those in the highest income quintile use more health care per capita than those in the lower quintile. Similarly there appears to be inequity in access between populations in different regions. Residents in urban areas use more health care per capita than those in rural areas. These inequities in access and utilization of public health funding clearly contradict the existing government policies on equity of access to health services regardless of ability to pay and geographical location.
- Fees charged by women committees in rural health facilities vary between members and non-members of the women committees. This practice discriminates against the most "vulnerable group" in terms of financial access to health services that are close to them. There is a need to examine these policies to address equity issues.

Conclusion

The Sāmoa health service is at a turning point. The introduction of performance budget mechanisms ensures an improvement in internal managerial efficiency and effectiveness at the health ministry. The Health Sector has a key role in providing solid evidence of health risks relating to non-sustainable development. This evidence would help shape effective policies and strategies to address these health risks. It would also help with capacity building activities inside and outside the health sector. Health professionals also have a role to implement future policies for sustainable development. It would be a daunting but exciting challenge.

New Minister for Health Hon Gatoloaifaana Amataga Alesana with former Minister for Health Mulitalo Siafausa Vui ready to tackle the health sector and the many peripherals

Photos by Skiv Johnston