COUNTRY PRESENTATION –

(SAMOA)

(By Hon. Tuisugaletaua Aveu Sofara, Minister of Natural Resources Environment and Meteorology of Samoa for and on behalf of the Samoan Delegation and in particular for and on behalf of Hon. Misa Telefoni, Deputy Prime Minister and former Minister of Health for Samoa)

"THE EXPERIENCE OF SAMOA IN BUILDING AN APPROPRIATE SKILL MIX ON HEALTH PROVIDERS AT THE PRIMARY CARE LEVEL AND STRENGTHENING THE LEADERSHIP AND MANAGEMENT CAPACITY"

1. INTRODUCTION

Samoa, an independent island nation in the South Pacific Ocean with an area of 1100 square miles and a population of 176,710 has been successful in finding the most optimal skill mix of health providers at the primary care level and strengthening the leadership and management capacity of its professionals. It has achieved these within the context of a national public sector reform program while adhering to its core values of equity, sustainability, quality and appropriateness of health services.

Health services are financed largely by government through taxation (68-83%), by external donors (14-27%), NGOs and users (3-5%). Approximately 5.8% of GDP and 17.8% of the total government expenditure are spent on the health sector. The per capita health expenditure is equivalent to US$86 – about 44% of the total health expenditure occurred in the public sector, 18% in the private sector, 19% in the pharmacies (private and public) and 19% related to overseas treatment (renal failure and dialysis treatment, cardiac surgery and ophthalmology).

2. HEALTH SECTOR ISSUES

The Health Sector is based on four broad values – equity, sustainability, quality and appropriateness of health services including the concept of culturally friendly services. The UNDP Development Index ranks Samoa the 75th out of 177 countries (HDP 2004).

- Samoa has one of the higher levels of social development rankings among the Pacific island countries showing higher overall education and health standards. Gender issues are of high importance in the Samoan society.
Samoa health status generally good

- increasing life expectancy (72.8 for total; 73.7 for females and 71.8 for males)
- declining infant and under-five mortality rates (19.3 and 13.7, respectively)
- declining maternal mortality ratio (19.6)
- high rates of immunization coverage (96% of infants)
- DOTS coverage and enrolment rate is 100% for all TB cases but case detection rate was 78% of all types and 52% of smear positive in 2000 based on WHO estimates.
- the first case of HIV/AIDS was reported in 1990; there have been 12 HIV/AIDS cases (10 adults and 2 infants); 8 have died
- Cardiovascular diseases is the number one killer; cancer was the 4th leading cause; diabetes prevalence was 11.5% of the adult population aged 25-74 years (1991); over 53% of the population suffers from overweight or obesity; smoking prevalence continues to increase despite quit- and anti-smoking campaigns; substance abuse is a growing problem; high prevalence of suicide particularly among the youth
- the percentage of population served with safe water is 65% for total in 2002, 77% for urban and 23% for rural
- the percentage of population with adequate sanitary facilities: percentage for total in 2002 is 55% for urban and 45% for rural

The Ministry of Health comprising five (5) hospitals, 12 health centers and 15 sub-centers is the major provider and financier of health services. It has delegated much responsibilities in the planning and management of its financial resources since the output-based budgeting was introduced in 1996. It provides some health services for free while nominal fees are charged for a few services depending on the patient’s ability to pay.

The private sector, NGOs, women’s committees and traditional healers (900) have a small role in health care. All the private sector facilities (21 bed hospital, five (5) medical clinics, two (2) dental clinics and two (2) pharmacies) are in the capital city of Apia. An extensive network of women’s committees co-manage publicly funded rural health services. Traditional birth attendants (200+) play an important role in the country’s birth system and conduct a significant number of births.

Complicated public and private tertiary care patients are usually referred to New Zealand. A large portion of the government’s health budget is spent on overseas care

The main challenge to Samoa is to sustain and deepen past achievements in the health sector. The government in its "Strategy for the development of Samoa 2002-2004 – Opportunities for All" has set the following national priorities in the health sector:

- Improve primary health care and health promotion services;
- Improve community services;
- Improve health facilities;
- Strengthening partnership with private sector; and
- Strengthening Ministry of Health's management.

3. **BUILDING AN APPROPRIATE SKILL MIX OF HEALTH PROVIDERS AT THE PRIMARY CARE LEVEL**

The following are contributing factors to the Skill Mix at the Primary Care Level:

- High number of preventable deaths even if other measures have been taken such as working with traditional birth attendants and capacity building programmes;

- Persistent shortage of doctors in rural areas (in 1997 and 1998, only three doctors served in the rural areas where 70% of the population reside) while there is concentration in urban centers – the problem is aggravated by the transfer of doctors from public to private sector and emigration. The main known contributing factor to shortage is emigration of personnel to overseas countries. Owing to shortage of doctors, particularly in rural areas, the nurses often provided care beyond the scope of their training. Nurses and other frontline workers at the primary care levels, (even if they face the most number of patients) have the least training.

- The Government is committed to addressing key primary health care needs and health promotion strategies. In 1987, the Government of Samoa officially recognized the need for a clinical primary care course for nurses. The aim of the course would be to upgrade the skills of selected senior nurses who, because of the shortage of physicians, provide the bulk of curative as well as preventive services in the communities,

- International commitments to maximize the contribution of nurses and midwives to earn achievements in the field of health.

- Other factors – Traditional chiefs believe in having a nurse in every village and demand health services for communities. Physical access of community to health services was hampered by limited transport facilities.

3.1 **Improvements in the nursing field**

- In 1990, the nursing function was reviewed and re-defined using the primary health care model and not the bio-medical model. The "Five-Year Nursing Education and Service Development Plan" was approved.

- In 1991, a 12-month Enrolled Nurses Programme was established and the traditional hospital-based three-year certificate pre-registration programme was discontinued.

- In 1992, a 12-month Advanced Diploma of Nursing (ADN) Programme commenced to enhance the clinical assessment and decision-making skills of experienced nurses as community-based practitioners. The curriculum was developed a year earlier with WHO cooperation.
In 1993, the Faculty of Nursing at the National University of Samoa (NUS) was established. The pre-registration general nursing diploma was offered.

In 1998, the Enrolled Nurses Programme was approved as a certificate level programme at the National University of Samoa.

3.2 Formal process to assess and recognize the competence and capability of nurses to practice as Clinical Nurse Consultants

- Plans to provide Credentialing (a formal process to assess and recognize the competence and capability of nurses to practise as Clinical Nurse Consultants), particularly in health centers and district hospitals.

- Parliament endorsement of the New Nursing Act, which includes provisions governing the prescription and administration of government supplies such as medicines by any nurse, class of nurse or credentialed nurse.

3.3 Overall objectives and outcomes of nursing reforms

- The overall goal is to provide high-quality health services to rural areas in the most cost-effective manner.

- The objective of introducing the ADN Course in Clinical Primary Care is to expand the nurses' skills in the diagnosis and treatment of common health problems to enable them to provide comprehensive primary health care services in medically under-served communities and facilities.

- The shortage of skilled health providers at the primary care level was addressed.

- The graduates from the School of Nursing at the University of Samoa are well utilized. They play a key leadership role as nurse managers and nurse consultants in the provision of community based and hospital-based services in the outlying districts.

- The Advanced Diploma of Nursing trains nurses to deal with life threatening situations either in hospital or in the fields.

- The Integrated Community Health Nursing Services reaches vulnerable groups. It is seen as a very effective and efficient way to deliver services to the population.

- There were un-intended consequences such as the Advanced Diploma of Nursing course was opened to other South Pacific island countries; the advancement of nursing practice in Samoa requires 20 hours of ongoing education for renewal of the annual practising certificates for nurses; some of the nurses assumed managerial responsibilities that took them away from the primary care level facilities.

4. THE PACIFIC HEALTH LEADERSHIP AND MANAGEMENT DEVELOPMENT PROGRAMME (HL&MD)
4.1 The leadership and management capacity – background:

- Doctors with no management training are given management responsibilities with little administrative support.

- Most health facilities are under-utilized. For example, the bed occupancy rate at the Tupua Tamasese Meaole (TTM), the national referral hospital is 56% even if it accounts for more than 75% of all in-patient admissions in the country.

- Priority areas lack adequate funds and costs are projected to rise. Government policy favours cost-effective preventive services but the bulk of public resources are directed towards less cost-effective hospital services.

- Health providers are not always used properly.

4.2 Factors leading to the introduction of the Leadership and Management Development Program:-

- Improvement in health services management has been prioritized by Pacific health leaders and endorsed by the important Pacific Declarations – the Yanuca Island Declaration 1995, the Rarotonga Agreement 1997 and the Palau Action Statement 1999

- The role of government in the health sector is changing with the Ministry of Health emerging as a strategic planner, regulator, monitor and evaluator of the sector including its operational budgets and human resources;

- The effective functioning of the primary care level is premised on regular medical supervision.

- The precipitating factor is the response to the need to reform the region's health sector and improve the planning and deliver of quality health-care services through the Pacific.

4.3 What made HL&MD different from other attempts in the past?

- Most educational and training programs in the past which have been modified from programs developed elsewhere for other purposes, have at best, led to capacity development and, at worst, facilitated ad-hoc training course that only treat the symptoms of development without planning for sustainable action or evaluating the impact.

- The HL&MD Program focuses more on the requirements of the Ministry of Health and less on educational imperatives and traditions. The curriculum provides the competencies for effective performance at mid-level management while recognizing the influence of Pacific cultures within the workplace.
The course is 14 weeks long. It uses participatory learning approaches. It includes a two-week compulsory residential program that introduces the fundamental management concepts applied in health services management and public sector development. The program comprises four (4) course themes of Managing in an Organization, Managing Programs, Managing People and Managing in a Changing Environment. The multi-disciplinary team of trainers comprises academic teachers, health professionals, government ministries, community agencies and sporting organizations.

During the remaining 12 weeks of the course, the trainee is based in the workplace. Each trainee is provided with a workplace mentor on top of his academic supervisor at the training institution. The role of the work-based mentor is to provide advice and guidance in developing the trainee’s project assignment. Hence, the training immediately and directly contributes to strengthening the management capacity and the delivery of public health services.

The trainees do not merely attend training programs; they apply the training to achieve outcomes within the workplace.

4.4 Initial undertakings in the HL&MD Program – four phases:-

- Phase 1 (1999-2000) – planning and preparation;
- Phase 2 (2001) – program design and pilot;
- Phases 3 and 4 – (2002-2003) - institutionalization of HL&MD (the idea was to transfer and institutionalize the HL&MD program within a regional consortium of academic institutions).

4.5 The players who initiated and supported the HL&MD Programme at the regional level:-

- Initiative of the Secretariat of the Pacific Community and supported by Pacific health leaders;
- Funded by New Zealand Aid for five (5) years, WHO and Taiwan/Republic of China;
- Support for curricula development came from the Sustainable Management Development Program, Centre for Disease Control (Atlanta), Curtin University (Australia), University of the South Pacific (Fiji) and the Fiji School of Medicine.

4.6 Objectives and outcomes of the initiatives:

- HL&MD goal is to improve public health services through sustainable Health Services Management training and development;
- HL&MD objective is to develop a sustainable management and leadership training program for the Pacific health professionals;
Training objective – to update and extend or reorient the knowledge and skills of mid-level managers, and to broaden the scope of their management practice;

Intended trainees were health professionals – doctors, nurses, policy planners, administrative personnel and health specialists.

5. **INFLUENCE OF OTHER POLICY MEASURES**:-

5.1 **Health Sector Reforms (HSR)**:-

- Ministry of Health World Bank Health Sector Reforms – Management Project – the objective was to strengthen the capacity of the Ministry of Health to develop and implement appropriate health policies, legislation and regulation, and to improve the functional and technical quality of health facilities within the health sector reform strategy. Fund amounting to $5 million from the World Bank for 2001-2007 for policy development and infrastructure upgrading (including transportation facilities). AUSAID provided funding to improve the quality of the hospital clinical services; improving the quality and increasing the reach of rural health services; and reducing the incidence of Non-Communicable Disease particularly diabetes.

- The Public Service Commission pursues a "Right-Sizing" policy throughout the public service.

6. **CONCLUSIONS**

6.1 **Lessons learned or insights gained:**

- Building an Appropriate Skill Mix through the:
  - Commitment of government to establish the Faculty of Nursing at the National University of Samoa and sponsorship of students to undertake nursing at the National University.
  - Presence of an experienced full-time WHO nurse practitioner
  - Support from the South Pacific Nurses Forum Education Committee in opening the post-basic degree course to candidates from the South Pacific Region
  - Legislation to define conditions for which nurses may prescribe and the types of drugs they may prescribe.

- Establishment of the HL&MD programme:
  - The universities saw the HL&MD as a priority;
  - The Secretariat of the South Pacific Community allocated funds;
The process of initiating HL&MD was appropriate culturally. The donors promoted the active participation of the Pacific people in the development and implementation of HL&MD.

Finding the right providers for the HL&MD that share the institutional flexibility in adjusting to the model of training and experiential learning.

Lessons learned in implementing the initiatives:

- Mid-level practitioners or nurses can be taught to provide the whole range of primary health care services.
- The quality of services provided depends very much on the quality of their training. The training requires a highly skilled and clinically expert faculty to facilitate both in and outside the classroom, adult learning in a participatory and interactive way, focused on critical thinking and problem solving.
- Importance of ensuring the quality of medical supervision over the mid-level practitioners.
- To develop and maintain a competent mid-level practitioner workforce, health service policies and systems should include legal protection, standard treatment guidelines, ongoing clinical supervision, continuing education, career ladder, and favourable working conditions.

In conclusion, Mr. Chairman, I would like to thank the Government of Japan for the excellent work that has gone into the hosting of this High Level Forum and the hospitality shown to all the delegates. I also want to convey the gratitude of my government and the people of Samoa to all the donor countries and agencies who have given generously to promote health standards in all countries of the world including Samoa, and to make the world a better place to live.

GOD BLESS AND THANK YOU!