90090

Independent State of Samoa

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2013

Policy Goals	Status
1. Establishing an Enabling Environment Laws and regulations exist to provide access to health and child protection interventions, and they are being drafted for nutrition interventions. Coordination is low between government actors and there is no multi-sectoral ECD policy. ECD services are free of charge in Samoa, however the level of public resources is low to ensure that all children have access to services.	Emerging
2. Implementing Widely Despite policy designed to ensure access to health, nutrition and child protection services, coverage remains low and access is inequitable by socioeconomic status and urban/rural location. Early childhood care and education services are not publicly provided and consequently coverage is low.	Emerging
3. Monitoring and Assuring Quality More comprehensive survey and administrative data are required to evaluate the full spectrum of ECD services and outcomes. Infrastructure and service delivery standards are established and complied within early childhood care and education.	Emerging

Systems Approach for Better Education Results

THE WORLD BANK

This report presents an analysis of the Early Childhood Development (ECD) programs and policies which affect young children in the Samoa. This report is part of a series of reports prepared by the World Bank using the SABER-ECD framework[1]. The Country Report includes analysis of early learning, health, nutrition, social and child protection policies and interventions in Samoa, along with regional and international comparisons.

Samoa and Early Childhood Development

Samoa is an independent, Polynesian Pacific island country comprised of ten islands, two of which are relatively large (Upolu and Savaii). The total land area is 2,934 square kilometers and over 70% of the population lives in small villages located along the narrow coastal plains. The country's population is nearly 200,000, with approximately 34 percent below the age of 14. From December to March the islands are vulnerable to hurricane and cyclones and in 1990 and 1992 suffered drastically from two cyclones and again in 2002.[2]

The language Samoan is the main language spoken and used in Parliament and in the communities. This makes communication easy and is a uniting factor for all Samoans. However, English is also widely spoken and is another medium for international and commercial communication within Government and the private sector. Both Samoan and English are used as languages of instruction in educational institutions.

Each of the relevant ministries operating in the ECD system has a sectoral focus and there is little coordination. Improvements in coverage and data availability are required to ensure that all young children are receiving the necessary services and care to develop fully and reach their potential in life.

SABER – Early Childhood Development

SABER – ECD collects, analyzes and disseminates comprehensive information on ECD policies around the world. In each participating country, extensive multi-sectoral information is collected on ECD policies and programs through a desk review of available government documents, data and literature, and interviews with a range of ECD stakeholders, including government officials, service providers, civil society, development partners and scholars. The SABER-ECD framework presents a holistic and integrated assessment of how the overall policy environment in a country affects young children's development. This assessment can be used to identify how countries address the same policy challenges related to ECD, with the ultimate goal of designing effective policies for young children and their families.

Box 1 on the following page presents an abbreviated list of interventions and policies that the SABER-ECD approach looks for in countries when assessing the level of ECD policy development. This list is not exhaustive, but is meant to provide an initial checklist for countries to consider the key policies and interventions needed across sectors.

Snapshot of ECD Indicators in Samoa with Regional Comparison	Samoa	Fiji	Solomon Islands	Tonga	Vanuatu
Infant Mortality (deaths per 1,000 live births)	17	15	23	13	12
Under-5 Mortality (deaths per 1,000 live births)	20	17	27	16	14
Maternal Mortality Ratio (deaths per 100,000 births)	29	34	100	140	150
Gross Preprimary Enrollment Rate (2010)	38%	No data	49%	21%	59%
Birth registration 2000-2010	48%	No data	80%	98%	26%

Source: UNICEF Country Statistics, 2010, UNESCO Institute for Statistics, WHO, 2010

[1] SABER-ECD is one domain within the World Bank initiative, Systems Approach to Better Education Results (SABER), which is designed to provide comparable and comprehensive assessments of country policies.

[2] Source: CIA World Fact book, Samoa country page, 2011

Box 1: A checklist to consider how well ECD is promoted at the country level

What should be in place at the country level to promote coordinated and integrated ECD interventions for young children and their families?
Healthcare
• Standard health screenings for pregnant women • Skilled attendants at delivery • Childhood immunizations • Well-child visits
Nutrition
• Breastfeeding promotion • Salt iodization • Iron fortification
Early Learning
• Parenting programs (during pregnancy, after delivery and throughout early childhood) • High quality childcare, especially for working parents • Free preprimary school (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms)
Social Protection
• Services for orphans and vulnerable children • Policies to protect rights of children with special needs and promote their participation and access to ECD services • Financial transfer mechanisms or income supports to reach the most vulnerable families (could include cash transfers, social welfare, etc.)
Child Protection
• Mandated birth registration • Job protection and breastfeeding breaks for new mothers • Specific provisions in judicial system for young children • Guaranteed paid parental leave of least six months • Domestic violence laws and enforcement • Tracking of child abuse (especially for young children) • Training for law enforcement officers in regards to the particular needs of young children

Three Key Policy Goals for Early Childhood Development

SABER-ECD identifies three core policy goals that countries should address to ensure optimal ECD outcomes: Establishing an Enabling Environment, Implementing Widely and Monitoring and Assuring Quality. Improving ECD requires an integrated approach to address all three goals. As described in Figure 1, for each policy goal, a series of policy levers are identified, through which decision-makers can strengthen ECD.

Strengthening ECD policies can be viewed as a continuum; as described in Table 1 (on the following page), countries can range from a latent to advanced level of development within the different policy levers and goals.

Figure 1: Three core ECD policy goals

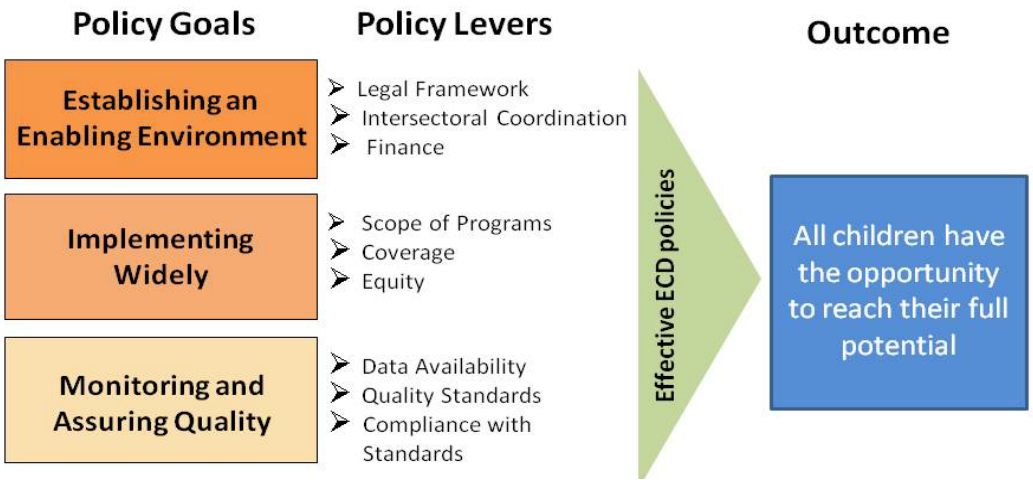


Table 1: ECD policy goals and levels of development

ECD Policy Goal	Level of Development			
	Latent	Emerging	Established	Advanced
Establishing an Enabling Environment	Non-existent legal framework; ad-hoc financing; low inter-sectoral coordination.	Minimal legal framework; some programs with sustained financing; some inter-sectoral coordination.	Regulations in some sectors; functioning inter-sectoral coordination; sustained financing.	Developed legal framework; robust inter-institutional coordination; sustained financing.
Implementing Widely	Low coverage; pilot programs in some sectors; high inequality in access and outcomes.	Coverage expanding but gaps remain; programs established in a few sectors; inequality in access and outcomes.	Near-universal coverage in some sectors; established programs in most sectors; low inequality in access.	Universal coverage; comprehensive strategies across sectors; integrated services for all, some tailored and targeted.
Monitoring and Assuring Quality	Minimal survey data available; limited standards for provision of ECD services; no enforcement.	Information on outcomes at national level; standards for services exist in some sectors; no system to monitor compliance.	Information on outcomes at national, regional and local levels; standards for services exist for most sectors; system in place to regularly monitor compliance.	Information on outcomes from national to individual levels; standards exist for all sectors; system in place to regularly monitor and enforce compliance.

Policy Goal 1: Establishing an Enabling Environment

➢ Policy Levers: Legal Framework • Inter-sectoral Coordination • Finance

An Enabling Environment is the foundation for the design and implementation of effective ECD policies.[3] An enabling environment consists of the following: the existence of an adequate legal and regulatory framework to support ECD; coordination within sectors and across institutions to deliver services effectively; and, sufficient fiscal resources with transparent and efficient allocation mechanisms.

Policy Lever 1.1: Legal Framework

The legal framework comprises all of the laws and regulations which can affect the development of young children in a country. The laws and regulations which impact ECD are diverse due to the array of sectors which influence ECD and because of the different constituencies that ECD policy can and should target, including pregnant women, young children, parents, and caregivers.

National laws mandate the provision of health care for pregnant women and young children. The Government of Samoa (GoS) has taken measures to build on existing legislation and improve the availability of health services for pregnant women and young children. Policy states that all women are entitled to antenatal and post-natal care free of charge at all public health facilities. Furthermore, the Nursing and Midwifery Act of 2007 states that the "nursing and midwifery services provided to all person in Samoa must meet accepted international standards and are consistent with the human rights applying to all persons in Samoa". Although it is not mandatory, the National Health and Aids Policy 2011-2016 encourages HIV and STD testing for pregnant women for the purpose of identifying mother-to-child transmission of infection. If a pregnant mother is identified with HIV or an STD, follow-up referrals are provided.

According to the national health services, young children are required to receive a complete course of childhood immunizations[4] and well-child visits[5]. At each check-up there is a list of four developmental milestones that must be assessed. If a child does not meet the standards they may be referred to a medical officer if necessary.

Steps are being taken to develop and adopt national laws and regulations that promote appropriate dietary consumption by pregnant women and young children. Regulations for the iodization of salt and iron fortification of foods can promote better nutrition for young children. In Samoa, the draft National Food Standards Bill, which is expected to be passed in 2013, will include measures to ensure the iodization of salt and fortification of iron.

Another important dietary aspect for young children is breastfeeding. International evidence shows that exclusive breastfeeding for the first 6 months of life, followed with complementary feeding until 2 years of age, is required to ensure the nutritional well-being of children and can be an effective strategy to reduce infant mortality rates and promote healthy development. In Samoa, the Ministry of Health adopted a Breastfeeding Policy in 1995. The policy aims to protect, promote, and support breastfeeding in all Government health care facilities (i.e. hospitals, clinics, community care services and baby care centers). The policy does reflect in full the International Code of Breast Milk Substitutes, which is an international health policy framework for breastfeeding promotion adopted by the World Health Organization. The draft Employment and Labor Relations Bill will build on the Breastfeeding Policy of 1995.

Policies do not offer suitable opportunities for parents and caregivers to provide care to newborns and infants in their early years. Table 2 compares parental leave policy in Samoa, Fiji, Tonga, and Vanuatu. In Samoa, Section 44 of the draft Labor and Employment Bill states women are entitled to either four weeks of pay at 100% of

[3] Brinkerhoff, 2009; Britto, Yoshikawa, & Boller, 2011; Vargas-Baron, 2005

[4] List of immunizations includes: Hepatitis B; Diphtheria; Tetanus; Pertussis; Measles; Mumps; Rubella; Polio; Hamemophilis Influenza type B; and Tuberculosis.

[5] Well-child visits take place at the following ages: 1 week; 6 weeks; 10 weeks; 14 weeks; 6 months; and 12 months of age.

Table 2: Regional Comparison of Parental Leave Policies

Samoa	Fiji	Tonga	Vanuatu
Minimum of 4 weeks paid leave at 100%, up to an additional 22 unpaid; 5 days paternity leave.	All workers: 12 weeks at 17% of wage, 547 days unpaid; paid by employer	No parental leave guaranteed for all workers; 12 weeks at 100% wage for government workers only, paid by government	All workers: 14 weeks at minimum 66% of wage; paid by employer (new legislation will regulate across employers)

salary or 6 weeks and two-thirds of normal salary, plus additional unpaid leave up to a maximum of 26 weeks (total combined paid and unpaid leave). The policy does not adhere to the ILO Maternity Protection Convention, however it does suggest adequate time and accommodation should be provided to encourage women to breastfeed. In addition to maternity leave, fathers are entitled to 5 days of unpaid leave.

Free publicly provided early childhood education does not exist in Samoa. According to the Education Act 2009, the formal education system in Samoa includes primary and secondary education, which is for children aged 6 to 18, and tertiary education. There are no public preprimary education services in Samoa, but rather they are offered through non-governmental organizations and private sector organizations under the umbrella of the National Council of Early Childhood Care and Education of Samoa. Early childhood care and education is discussed in more detail in Policy Goal 2 of this Country Report.

Child protection policies and services have been established to ensure the well-being of children. The Births and Deaths Registration Ordinance of 1961 was replaced with the Births, Deaths and Marriages Act 2001. The Act states that notice of a birth must be provided within seven days, and that the birth must be formally registered within six months or a monetary fine is imposed (although this aspect of the law is not widely enforced). Another specific measure taken is the development of a national judicial system that puts the welfare of the child at the forefront by providing specialized training for judges, lawyers and law enforcement officers.

Furthermore, specific actions have been taken to promote the reduction of family violence, including training for ECCE teachers to identify child abuse and neglect, tracking and reporting of child abuse activities, and creation of a taskforce called "Men Against Violence Advocacy Group" which is supported by the Ministry of Women, Community, and Social Development. The main objective is for the Ministry to help engage men to take the lead in eliminating violence within the Samoan home.

Policy exists to provide support to persons with disabilities and to support orphans and vulnerable children. The National Policy for Persons with Disability and Plan of Action was developed in 2009. The Policy states that interventions must be available to support children with disabilities and their families. This includes early interventions, as well as education, health, and community awareness programs. Furthermore, the Special Needs Education Policy 2006 aims to provide specific support to individuals with physical disability, hearing impairment, intellectual disability, visual impairment, and severe behavior disorder, however this only applies to the formal education system and therefore captures children at age 6, but not before. There is no specific policy to support orphans and vulnerable children, but rather this area is included within the National Policy for Children of Samoa 2010-2015. Specifically, policy outcome 3 aims to ensure the provision of adequate, flexible and effective support services that caters to the needs of vulnerable children.

Policy Lever 1.2: Intersectoral Coordination

Development in early childhood is a multi-dimensional process[6]. In order to meet children's diverse needs during the early years, government coordination is essential, both horizontally across different sectors as well as vertically from the local to national levels. In many countries, non-state actors (either domestic or international) participate in ECD service delivery; for this reason, mechanisms to coordinate with non-state actors are also essential.

[6] Naudeau et al, 2011; UNESCO-OREALC, 2004; Neuman, 2007

The Government of Samoa does not have an explicit ECD policy, however it does have the National Policy for the Children of Samoa 2010-2015, which was approved by Cabinet in 2010. Although the National Policy covers the age spectrum 0 to 18, there are specific measures for ECD aged children. The National Policy recognizes that the development of children from early years onwards is the primary determinant for a person's success later in life. As such the policy is an overarching framework that provides the direction for the care, protection and development of children from birth to 18 years of age. It takes into account the various services and programs for children and multi-level interventions. Although the policy is not specific to ECD-aged children, it does provide strong policy focus on child health, protection, and education.

The three primary objectives of the National Policy are as follows: 1) to develop and implement a national agenda for children in line with Government's national vision for development; 2) to strengthen coordination, monitoring and evaluation of all programs and services targeted at children; and 3) to enhance cross sectoral commitment and ownership of the focus on child development and child protection in Samoa.

Box 2: Key Laws and Regulations Governing ECD in Samoa

- National Policy for Children of Samoa 2010-2015
- National Health and Aids Policy 2011-2016
- Draft Education Sector Plan 2012-2014
- Draft Labor and Employment Relations Bill 2012
- National Policy for Persons with Disability and Plan of Action 2009
- Health Care Professional Registration and Standards Act 2007
- Nursing and Midwifery Act 2007
- National Health Services Act 2006
- National Curriculum Policy Framework 2006
- Births, Deaths and Marriage Act 2002
- United Nations Convention on the Rights of the Child (ratified November 11, 1994)

No Ministry is tasked to oversee ECD in Samoa. Three ministries work in ECD in Samoa: Ministry of Women, Community and Social Development; Ministry of Health; and Ministry of Education, Sports and Culture. The Ministry of Women Community and Social Development is mandated by the GoS to facilitate issues on children at the national level as well as report on behalf of the GoS on all national issues pertaining to children in relation to the Convention on the Rights of the Child. Due to the size of Samoa no officer is responsible for ECD, but rather there is an officer for all children and youth.

No integrated service delivery manual exists in Samoa; there is a coordination committee for all childhood interventions, but not one specific to ECD aged children. Samoa does not have an integrated service delivery manual for ECD interventions. Coordination is achieved through the National Council on the Rights of the Child. As noted previously, the council is not specific to ECD aged children, but rather is for all children and adolescents in Samoa. Members include a combination of state and non-state organizations, which has lead to instances of effective coordination between all entities. The members include: Ministry of Women, Community and Social Development; Ministry of Education, Sports and Culture; Ministry of Health; Ministry of Justice Courts and Administration; Office of the Attorney General; Samoa Law Reform Commission; Ministry of Justice Courts and Administration; Mapusaga O Aiga (NGO); and the National Council of Early childhood care and education of Samoa. The National Council meets at least 6 times every financial year (July 1 to June 30) and on a needs basis. The Convention on the Rights of the Child Partnership Committee, which provide technical advice to the Council, also adjourns at least 6 times every financial year.

The Convention on the Rights of the Child Partnership Committee is a technical advisory group to the National Council and consists of individuals from the following organizations: Ministry of Health; Ministry of Education; Ministry of Justice Courts and Administration; Ministry of Police; National Health Services; Office of the Attorney General; Samoa Law Reform Commission; Loto Taumafai (NGO); Aoga Fiamalamalama School (NGO);

Mapusaga O Aiga (NGO); Samoa Victim Support Group (NGO); Nuanua o le Alofa Council for Disabilities; and the National Council for Churches (NGO).

Policy Lever 1.3: Finance

While legal frameworks and inter-sectoral coordination are crucial to establishing an enabling environment for ECD, adequate financial investment is key to ensure that resources are available to implement policies and achieve service provision goals. Investments in ECD can yield high public returns, but are often undersupplied without government support. Investments during the early years can yield greater returns than equivalent investments made later in a child's life cycle and can lead to long-lasting intergenerational benefits[7]. Not only do investments in ECD generate high and persistent returns, they can also enhance the effectiveness of other social investments and help governments address multiple priorities with single investments.

There is no clear method or criteria for determining and forecasting ECD expenditures in health, nutrition, or child protection; preprimary school is privately provided. To fully evaluate the strengths and areas for improvement within an ECD system, it is necessary to have a comprehensive, systematic methodology for calculating investment in ECD. Currently, it is difficult to disaggregate spending in health, nutrition, and social and child protection by ECD age group. In order to maximize the efficiency of expenditure and capture economies of scale, it is necessary to coordinate budgets across ministries, delineating responsibilities and enlarging purchasing power. Despite coordination at the service delivery level, there is no evidence of coordination between budgets in Samoa. In the education sector there are explicit criteria and allocations for expenditure, however this applies to the primary and secondary levels, and not preprimary school, which is private provision.

Public sector financial policies are designed to promote free access to health services and are supported with strong government commitment. In education, policy and government support are limited. According to the UNESCO UIS Statistics in Brief document, approximately 13.5 percent of government expenditure are allocated to education, which amounts to 5.8 percent of GDP (as of 2008). However, only 2 percent of education funding is allocated towards preprimary education, which is provided as a grant to service provider. Depending on the service provider, parents and communities are required to pay fees per usage, including tuition, matriculation, and contributions to parent committees, amongst other.

In the health sector, the National Health Service Act 2006 states that health services related to pregnancy and young children are officially free. These services include: labor and delivery; immunizations; well-child visit; growth monitoring and promotion; antenatal check-ups for pregnant women; and treatment for various illnesses, including diarrhea, upper respiratory tract infection, pneumonia, and tuberculosis. In practice, this policy is fairly effective.

Table 3 illustrates overall out-of-pocket expenditure as a percentage of all private health expenditure and out-of-pocket expenditure as percentage of total health expenditures. In both measures, Samoa does well by international standards and by comparison with regional countries. Individuals and families pay only 8 percent of out-of-pocket expenditure as a percentage of total expenditures, which is significantly lower than the rates in Fiji and Tonga, but above the rates in Solomon Islands and Vanuatu. The Government finances 100 percent of routine EPI vaccines, which demonstrates complete ownership of the intervention.

The level of remuneration for ECD service personnel is low. There are no government guidelines or policy pertaining to the remuneration for preprimary teachers, nor is there information available on the level of pay. For this reason it is not possible to assess whether the level of remuneration is competitive with primary teachers and provides incentives for teachers entering the field. Furthermore, community-based childcare centers are paid by communities and private sources. Government Women Representatives assist health and wellbeing programs in villages such as immunization programs and registration of births. They are compensated at a rate of 125 Samoan Tala per day.

[7] Valerio & Garcia, 2012; WHO, 2005; Hanushek & Kimko, 2000; Hanushek & Luque, 2003

Table 3: Select health expenditure indicators, compared with region

	Samoa	Fiji	Solomon Islands	Tonga	Vanuatu
Out-of-pocket expenditure as a percentage of total health expenditures	8%	20%	4%	13%	5%
Government expenditure on health as a percentage of GDP	5.7%	3.4%	8.0%	4.1%	4.8%
Routine EPI vaccines financed by government, 2010	100%	N/A	45%	90%	N/A

Source: WHO Global Health Expenditure Database, 2011; TransMonEE Database, 2010; Source: UNICEF Country Statistics, 2010.

Policy Options to Strengthen the Enabling Environment for ECD in Samoa

- **Legal Framework –** Laws are in place to ensure that young children have access to essential health interventions. To address and improve the nutritional status of young children, the Government should ensure that the National Food Standards Bill is passed and implemented in an efficient and effective manner to ensure that young children consume iodized salt and fortified iron.

- **Legal Framework –** The maternity leave framework in Samoa provides insufficient time and financial resources to parents caring for infants. This is a formative period in a child's development, one in which adequate care is essential. The GoS could consider revising maternity leave using a phased approach, during which a greater leave allowance and more financial support are afforded to families.

- **Inter-sectoral Coordination –** The GoS should consider development of a national ECD strategy to reflect the importance and unique nature of ECD. A national ECD strategy could enhance the coordination and efficacy of the ECD system, as well as articulate the services provided to children and key stakeholders involved, including each of their respective responsibilities. A well-developed national ECD policy should be a collaborative effort that includes a set of goals or objectives and an implementation plan to outline how the policy will be achieved. As part of developing a multi-sectoral ECD strategy, the GoS should consider appointing an institutional anchor as the lead agency to champion ECD.

- **Finance –** To fully evaluate the strengths and areas for improvement within an ECD system, it is necessary to have a comprehensive, systematic methodology for calculating investment in ECD. Currently, it is difficult to disaggregate spending in health, nutrition, and social and child protection by ECD age group. Because early childhood care and education is provided by non-public entities, it is not possible to evaluate the full cost and effectiveness of the system. In developing a comprehensive methodology it could also be useful to work closely with non-state ECD stakeholders to capture the full spectrum of ECD investment. This will provide policy makers with detailed information to evaluate and effectively cost ECD interventions, and shift financial allocation to the interventions with the greatest return on investment.

Policy Goal 2: Implementing Widely

Policy Levers: Scope of Programs • Coverage • Equity

Implementing Widely refers to the scope of ECD programs available, the extent of coverage (as a share of the eligible population) and the degree of equity within ECD service provision. By definition, a focus on ECD involves (at a minimum) interventions in health, nutrition, education, and social and child protection, and should target pregnant women, young children and their parents and caregivers. A robust ECD policy should include programs in all essential sectors; provide comparable coverage and equitable access across regions and socioeconomic status – especially reaching the most disadvantaged young children and their families.

Policy Lever 2.1: Scope of Programs

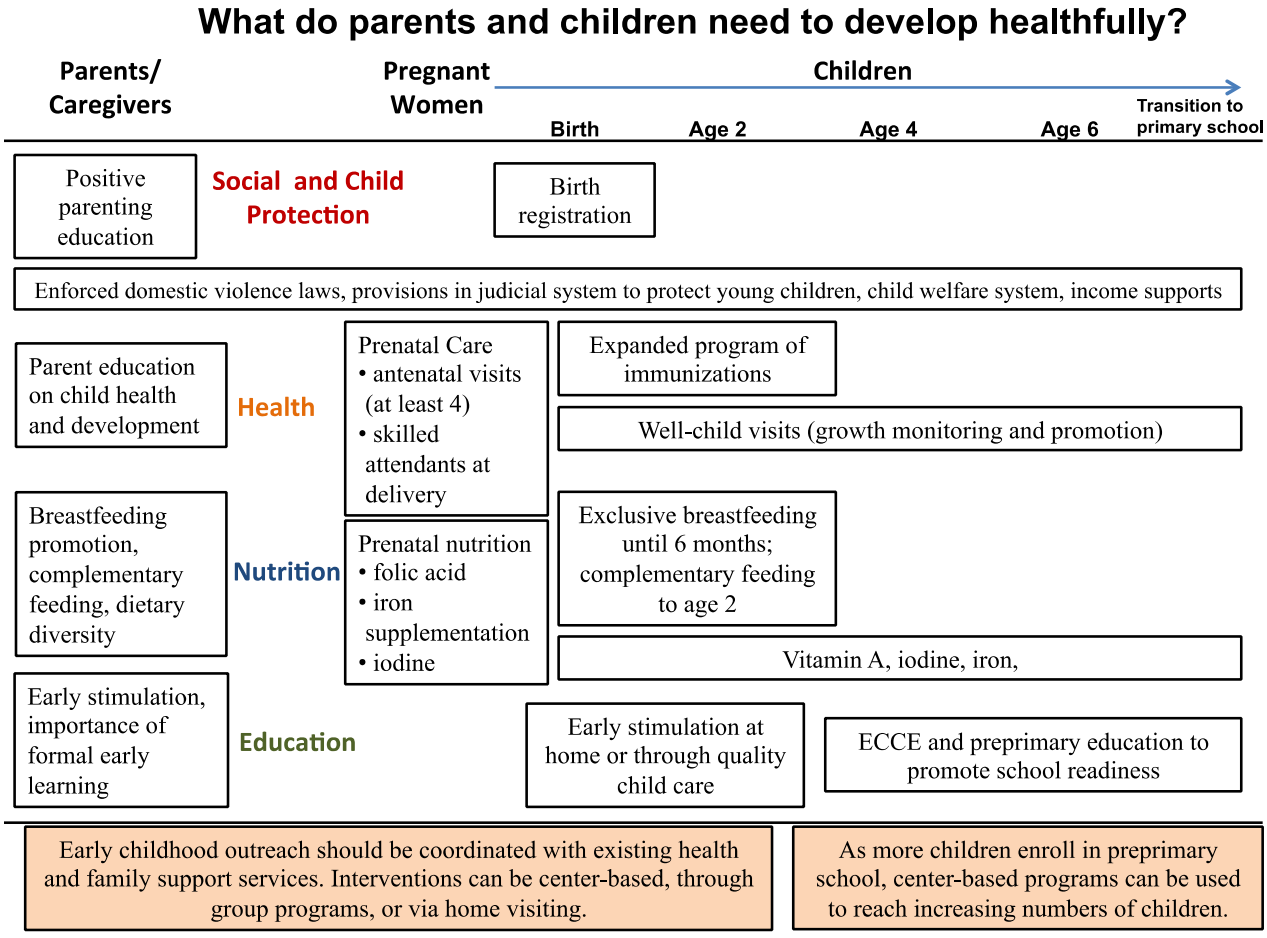
Emerging

Effective ECD systems have programs established in all essential sectors and ensure that every child and expecting mothers have guaranteed access to the essential services and interventions they need to live healthfully. The scope of programs assesses the extent to which ECD programs across key sectors reach all beneficiaries. Figure 2 presents a summary of the key interventions needed to support young children and their families via different sectors at different stages in a child's life.

ECD programs are established in each of the core ECD areas of focus: education, health, nutrition, and social and child protection. Coverage varies by intervention. There are programs that target the three main ECD groups – children aged 0 to 83 months, pregnant women, and caregivers. Figure 3 presents a selection of ECD interventions in Samoa. Preprimary schools are operated by the non-public entities and include private, Methodist, Catholic, Congregational Christian Church of Somoa, and Village Women Committees schools.

Within health and nutrition, community health nurses visit the villages on a regular basis and work with the health committee (or village women) to follow-up with pregnant women and nursing mothers, carry out hygiene and sanitation checks of the village, as well as conduct "well baby" clinics. As part of the well-child visits, growth charts are maintained to track the child's development progress. The villages are also the focal point for health program at the local level including immunizations for children, identifying nutritional problems, and helping mothers and care givers gain an understanding of their role in caring for the children.

Figure 2: Essential interventions during different periods of young children's development



There are programs that aim to improve health and nutrition outcomes through educational messages. The Family and Community Wellbeing program (*Aiga ma Nuu Manuia Program*) is implemented by the Ministry of Women, Community and Social Development and services 4,390 householders. The program aims to improve the physical and social environment of families and communities by promoting and ensuring clean and safe homes, including access to hygienic facilities and promotion of healthy habits, such as the smoke free living premises. The *Faalapotopotoga Atinae Komiti Tumama Samoa* (FAKTS) Program is an innovative healthy lifestyles intervention that targets mothers, children, and teachers in preschools. The underlying premise is that, by targeting role models and young children, it is possible to instill a deep understanding of healthy habits in children at a young age which they will continue to practice as they grow older. Since 2007 the program has grown to encompass 16 preschools in the following villages: *Solosolo, Saoluafata, Saanapu-uta, Saanapu–tai, Samata, Laulii, Sauano* and *Siumu*.

While Figure 3 displays some of the interventions in Samoa, it does not depict coverage levels. Table 4 on the following page presents the range of interventions in Samoa, number of regions in which they operate, and level of coverage using four categories: low, moderate, approaching universal, and universal. Complete data are not available for many of the interventions. Poor data availability is noted as a challenge and area for improvement. This topic will be discussed in more detail in Policy Goal 3.1 of this Country Report.

Figure 3: ECD programs in the Samoa

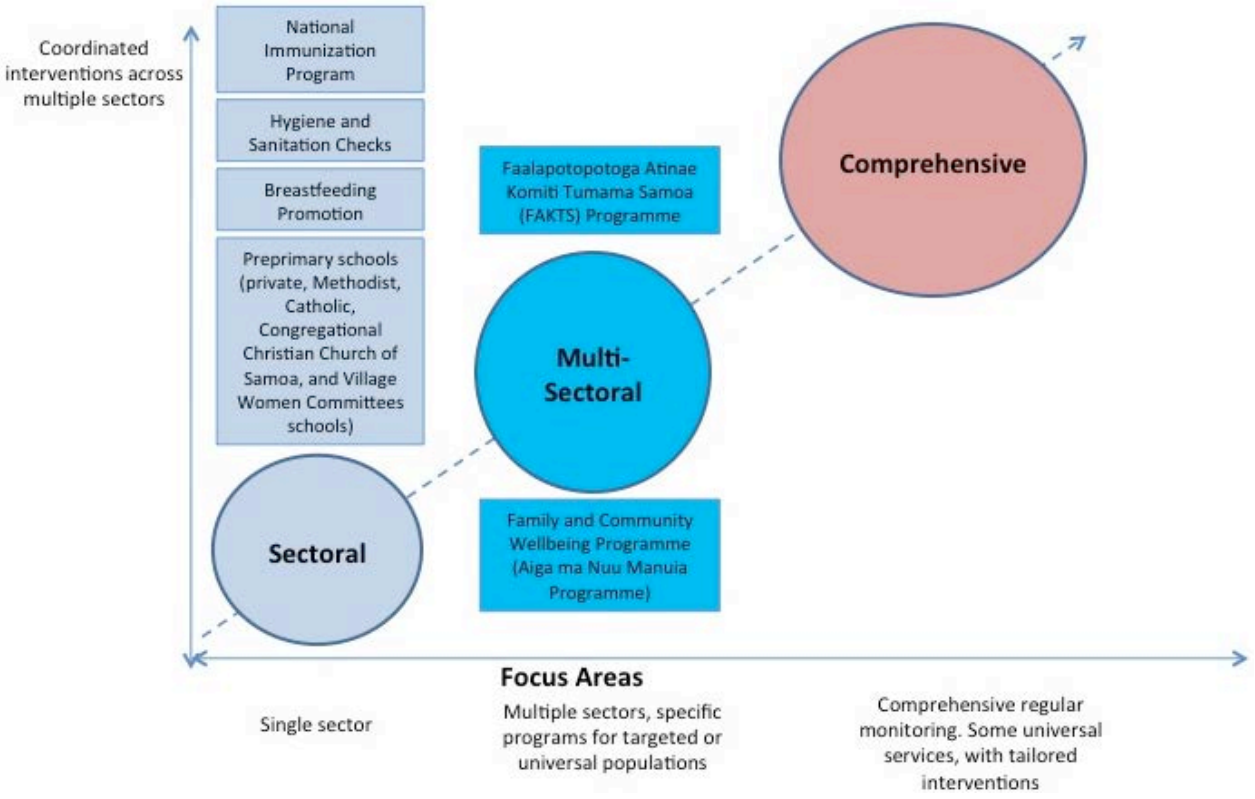


Table 4: ECD programs and coverage in the Samoa

ECD Intervention	Scale		
	Pilot programs	Islands covered[8]	Total coverage
Education			
State-sponsored preprimary/kindergarten education,	No intervention		
State-sponsored ECCE	No intervention		
Community-based ECCE			Low
Health			
Antenatal and newborn care			Approaching universal
Integrated management of childhood illnesses and care for development	No data		
Childhood wellness and growth monitoring	No data		
National immunization program			Approaching universal
Nutrition			
Micronutrient support for pregnant women	No data		
Food supplements for pregnant women	No data		
Micronutrient support for young children	No data		
Food supplements for young children	No data		
Food fortification	No data		
Breastfeeding promotion programs (*breastfeeding promotion*)			Moderate
Anti-obesity programs encouraging healthy eating/exercise	No data		
Feeding programs in preprimary/kindergarten schools			Low
Parenting			
Parenting integrated into health/community programs	No data		
Home visiting programs to provide parenting messages	No data		
Special Needs			
Programs for OVCs (*Boarding schools & children's homes*)	No intervention		
Interventions for children with special (*emotional and physical*) needs	No data		
Anti-poverty			
Cash transfers conditional on ECD services or enrollment	No intervention		
Comprehensive			
A comprehensive system that tracks individual children's needs	No intervention		

Source: SABER-ECD Policy Data Collection Instrument and SABER-ECD Program Data Collection Instrument.

[8] Disaggregated data were not provided at the island level. For this reason, this section of the ECD programs and coverage table is left blank.

Policy Lever 2.2: Coverage

A robust ECD policy should establish programs in all essential sectors, ensure high degrees of coverage and reach the entire population equitably – especially the most disadvantaged young children – so that every child and expecting mother have guaranteed access to essential ECD services.

There are insufficient data to evaluate coverage in Samoa. For the set of indicators presented in Tables 5, 6, and 7, there are large data gaps which limit the full evaluation of coverage in the country. This challenge is discussed in more detail in Policy Lever 3.1 on this Country Report.

The level of access to essential health interventions is unknown for young children in Samoa. Table 5 presents the level of access to a selection of essential ECD interventions for young children in Samoa and select countries in the region. The only indicator for which there are data is the percent of one year olds immunized against DPT[9]. At 87 percent, the level of immunization is high in Samoa, however it is vital that universal immunization be provided to all children. Both Fiji and Tonga have the highest rates of immunization with 99 and 98 percent coverage in each country, respectively. Data are not available to measure the percentage of children with diarrhea who receive oral rehydration and continued feeding or the percent of children suspected of pneumonia who receive antibiotics. Both of these indicators are important because they represent critical interventions required to ensure the health of young children.

The level of access to essential health interventions is relatively low for pregnant women. Table 6 presents the level of access to a selection of essential ECD interventions for pregnant women in Samoa and select countries in the region. Currently, 81 percent of births are attended by a skilled attendant, which is significantly higher than the rates in Solomon Islands (70 percent) and Vanuatu (68 percent). However, this rate remains well shy of the leaders in the region. Fiji, Samoa, and Tonga all have a very high level of pregnant women receiving antenatal care at least once. However, international best practice shows that pregnant women should receive antenatal care at least four times. In Samoa only 58 percent of pregnant women benefit from a minimum of four antenatal visits. The only comparison country with data is Solomon Islands, which has a rate of 65 percent for this indicator. No data are available on the percentage of HIV+ pregnant women and HIV exposed infants who receive ARVs (anti-retroviral drug) for PMTCT (prevention to mother-to-child transmission).

Further data are required to fully assess the level of access to essential nutrition interventions for young children and pregnant women. Table 7 presents the level of access to essential nutrition interventions for young children and pregnant mothers. The rate of children who are exclusively breastfed until six months of age is 51 percent. By international standards, this rate is considered high, however it remains important to improve this rate to ensure that all young children receive the full benefits of exclusive breastfeeding until six months of age and on a complementary basis until two years of age.

The level of access to preprimary education is low in Samoa. Early childhood care and education has been available in Samoa since the 1970's. In 1998, Government and non-governmental organizations already working in the field collaborated to establish the National Council for Early childhood care and education in Samoa (NCECES). The NCECES operates as an autonomous NGO with membership comprised of groups who run early childhood care and education centers and with representatives from the MESC and has the mandate of promoting and overseeing early childhood care and education.

There are 104 non-publicly operated early childhood care and education and care centers in Samoa, which provides coverage to 4,137 young children. Access to preprimary education is low across the pacific region. This is particularly true in Samoa, where Government does not publicly provide preprimary school or any form of early childhood care and education. Figure 4 displays the available data on preprimary GER in the region. The data reveals a troubling trend. Since 1998, gross enrollment has decreased from a previous high of near 55 percent to below 40 percent. Of the countries presented, Solomon Islands Is the only country that has made substantive

[9] DPT refers to a class of combination vaccines against three infectious diseases in humans: diphtheria, pertussis (whooping cough) and tetanus.

improvements in enrollment, increasing from mid 30's to 50 percent over the same time period.

Table 5: Level of access to essential health interventions for young children

	Samoa	Fiji	Solomon Islands	Tonga	Vanuatu
Children below 5 years of age with diarrhea who receive oral rehydration and continued feeding, 2006-2010	N/A	N/A	N/A	N/A	43%
1 year olds immunized against DPT, 2010	87%	99%	70%	98%	74%
Children below 5 years of age suspected of pneumonia who receive antibiotics, 2006-2010	N/A	N/A	23%	N/A	N/A
Percentage of children less than 5 years of age sleeping under Insecticide-Treated Net (ITN)	N/A	N/A	N/A	N/A	56%

Source: UNICEF Country Statistics, 2010

Table 6: Level of access to health interventions for pregnant women

	Samoa	Fiji	Solomon Islands	Tonga	Vanuatu
Births attended by skilled attendants, 2006-2010	81%	99%	70%	99%	68%
Pregnant women who benefit from at least four antenatal visits, 2006-2010	58%	N/A	65%	N/A	N/A
Pregnant women who benefit from at least one antenatal visit, 2006-2010	93%	99%	70%	98%	74%
HIV+ pregnant women and HIV-exposed infants who receive ARVs for PMTCT.	N/A	87%	N/A	N/A	N/A

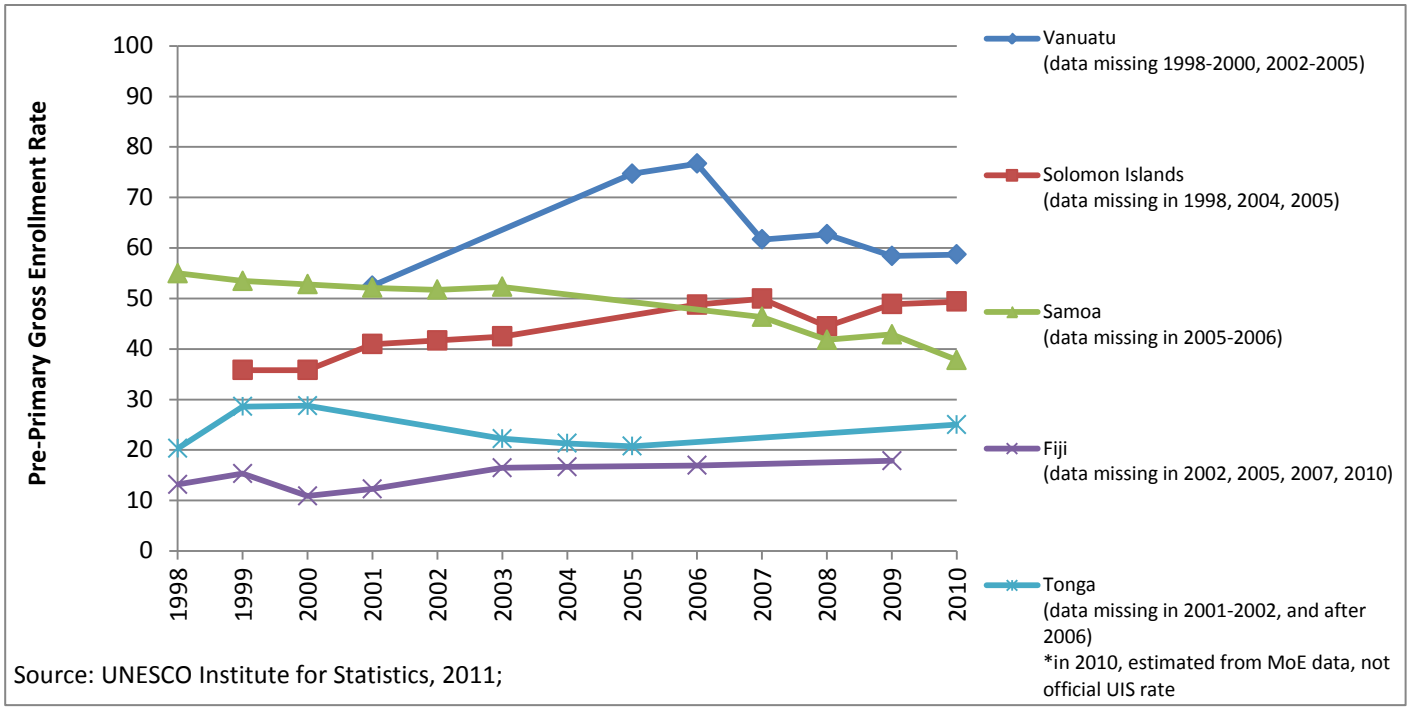
Source: UNICEF Country Statistics, 2010; UN Aids, 2011

Table 7: Level of access to essential nutrition Interventions for young children and pregnant mothers

	Samoa	Fiji	Solomon Islands	Tonga	Vanuatu
Vitamin A supplementation coverage for children 6-59 months of age, 2010	N/A	N/A	N/A	N/A	N/A
Children who are exclusively breastfed until 6 months of age, 2006-2010	51%	40%	74%	62%	40%
Population that consumes iodized salt, 2006-2010	N/A	N/A	N/A	N/A	23%
Percentage of pregnant women with anemia	33%	56%	51%	34%	57%

Source: UNICEF Country Statistics, 2010; WHO World Wide Prevalence of Anemia 1993-2005

Figure 4: GER for preprimary (age 3-5) in the Pacific



Source: UNESCO Institute for Statistics, 2011;

Policy Lever 2.3: Equity

Emerging

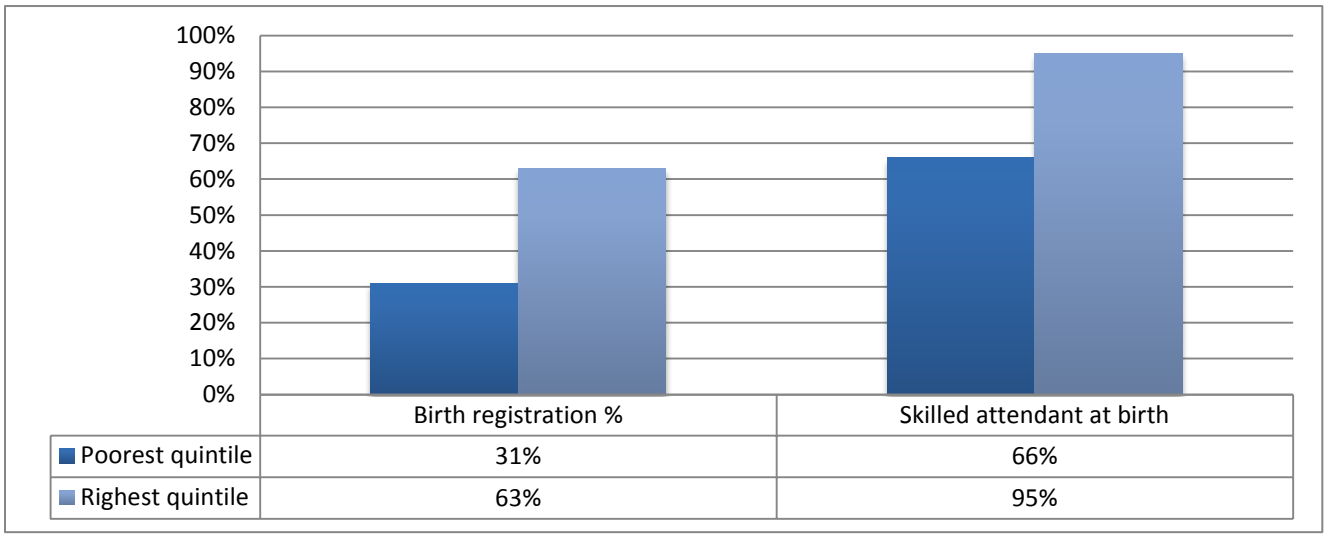
Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every government should pay special attention to equitable provision of ECD services[10]*. One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families*.

There is high inequity in access to ECD interventions by rich and poor families. As demonstrated in Figure 5, for selected interventions, women and children from the poorest quintile have less access than those in the wealthiest quintile. Specifically, only 31 percent of children from the poorest quintile of families are registered at birth, whereas this rate is 61 percent for children from richest quintile. These data represent high inequality, as well as overall low coverage, regardless of wealth quintile. The second indicator presented looks at the percentage of births attended by a skilled attended. There is nearly universal skilled attendance of births for families from the richest quintile, whereas this rate is only 66 percent for the poorest families

High inequity in access to ECD services is observed by geographic location. Figure 6 presents access to three ECD indicators by urban and rural location. Similarly to wealth, there is high inequity in access to birth registration and skilled attendants at birth for individuals living in urban and rural locations. The data demonstrate that 62 percent of children born in urban locations are registered at birth, compared with 44 percent in rural locations. Furthermore, 94 percent of births are attended by a skilled attendant in urban locations, while this rate is only 75 percent in rural locations. All children, regardless of geographic location, have access to improved sanitation facilities.

[10] Engle et al, 2011; Naudeau et al., 2011

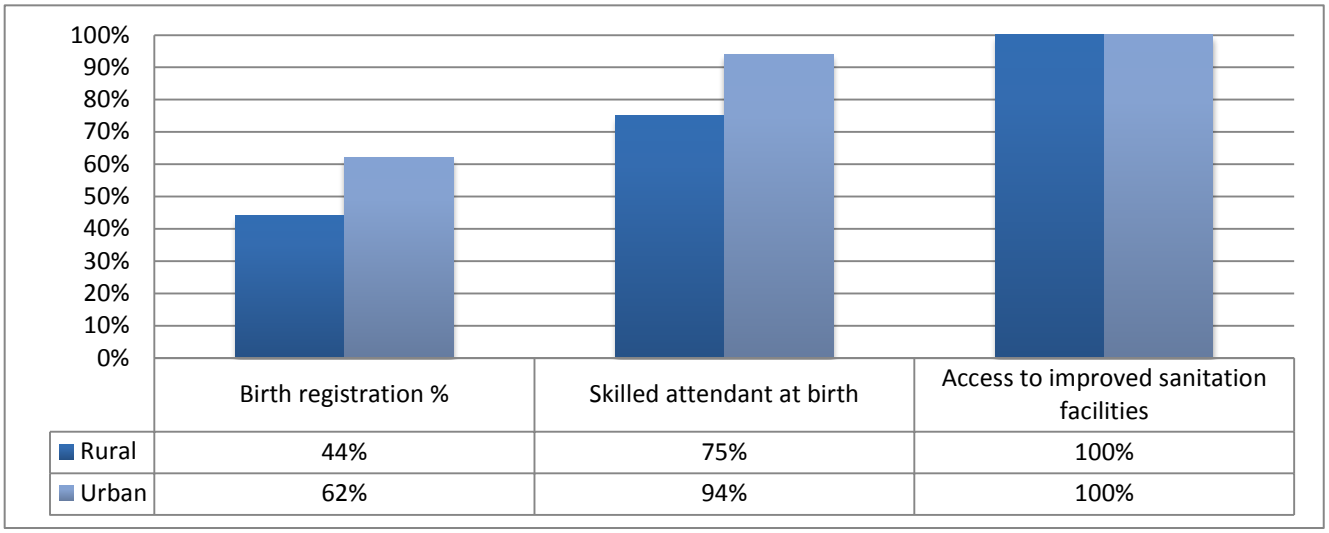
Figure 5: Equity in access to ECD services by income quintile in Samoa



	Birth registration %	Skilled attendant at birth
Poorest quintile	31%	66%
Righest quintile	63%	95%

Source: UNICEF Country Statistics, 2010.

Figure 6: Equity in access to ECD services by geographical location in Samoa



	Birth registration %	Skilled attendant at birth	Access to improved sanitation facilities
Rural	44%	75%	100%
Urban	62%	94%	100%

Source: UNICEF Country Statistics, 2010.

No inclusive education policy for ECE exists, however native languages are used and access by gender is near equal. Samoa has an inclusive education policy, however it applies at the primary school level and above. Of the 4,137 children enrolled in ECE services, 32 are categorized as having special needs.

The curriculum and teaching materials are translated into the two major language groups (Samoan and English). Although enrollment is relatively low, boys and girls are equally represented in ECE.

Policy Options to Implement ECD Widely in Samoa

- **Scope of Programs** – There are large gaps in knowledge in terms of what interventions exist and their level of coverage. This is at least partially due to

the sectoral approach of Government towards ECD and the high number of NGOs providing services in Samoa. It would be useful to undertake a mapping exercise to develop a database of ECD interventions. Such an initiative would enable policy makers and ECD stakeholders to both raise awareness and improve targeting mechanisms, especially for education interventions. Direct communication strategies would be one way to disseminate knowledge to families regarding the main services that children require and which interventions are offered in their geographical area.

- **Coverage –** Increasing coverage is required in essentially all interventions and ECD sectors in Samoa. With acknowledgement of the financial constraints, the Government must be very creative with its approach to ensure that more children benefit from ECD services. One component could be to strengthen and empower the roles of NGOs. To this end, it is critical to work in close partnership with NGOs to share information and experiences and lead to creation of an inclusive ECD system. The Government should also design interventions that reach children aged 0 to 3 and provide parents with educational messages.

- **Equity –** Equity remains a challenge in Samoa. More data disaggregated by socioeconomic status, location, sub-national division and special needs are required to fully assess the equity of service provisions and potentially enable better coordination between public and non-public entities.

Policy Goal 3: Monitoring and Assuring Quality

- **Policy Levers: Data Availability • Quality Standards • Compliance with Standards**

Monitoring and Assuring Quality refers to the existence of information systems to monitor access to ECD services and outcomes across children, standards for ECD services and systems to monitor and enforce compliance with those standards. Ensuring the quality of ECD interventions is vital because evidence has shown that unless programs are of high quality, the impact on children can be negligible, or even detrimental.

Policy Lever 3.1: Data Availability

Accurate, comprehensive and timely data collection can promote more effective policy-making. Well-developed information systems can improve decision-making. In particular, data can inform policy choices regarding the volume and allocation of public financing, staff recruitment and training, program quality, adherence to standards and efforts to target children most in need.

Survey data are collected on access to health and child protection for young children; survey data are inadequate in all sectors. The availability of survey data varies by sector in the Samoa. As illustrated in Table 8, survey data exist for the health and child protection sectors and include access to immunizations, antenatal care and birth registration, for example. Survey data are not robust in the nutrition and education sectors. Administrative data are sparse in all sectors. Of the select indicators presented in Table 8, the only indicator for which there are administrative data is the ratio of children per teacher.

Data exists for select indicators to differentiate ECCE access and outcomes for special groups. To some degree, data are available to differentiate ECCE access and outcomes for special groups, including rural / urban location, socioeconomic status and by gender. More data are required to assess special groups in full.

Physical child development is measured, however the other interrelated domains of child development (cognitive, linguistic, and socio-emotional) are not measured in Samoa. The physical development of children is monitored and measured during well-child visits. There is no individual tracking for children to measure their cognitive, linguistic, and socio-emotional development.

Table 8: Availability of data to monitor ECD in Samoa

Administrative Data:	
Indicator	**Tracked**
Special needs children enrolled in ECCE (number of)	X
Children attending well-child visits (number of)	X
Children benefitting from public nutrition interventions (number of)	X
Women receiving prenatal nutrition interventions (number of)	X
Children enrolled in ECCE by sub-national region (number of)	X
Is ECCE spending in education sector differentiated within education budget?	X
Average number of children per teacher?	✓
Survey Data	
Indicator	**Tracked**
Population consuming iodized salt (%)	X
Vitamin A Supplementation rate for children 6 -59 months (%)	X
Anemia prevalence amongst pregnant women (%)	✓
Children below the age of 5 registered at birth (%)	✓
Children immunized against DPT3 at age 12 months (%)	✓
Pregnant women who attend four antenatal visits (%)	✓
Children enrolled in ECCE by socioeconomic status (%)	X

Policy Lever 3.2: Quality Standards

Established

Ensuring quality ECD service provision is essential. A focus on access – without a commensurate focus on ensuring quality – jeopardizes the very benefits that policymakers hope children will gain through ECD interventions. The quality of ECD programs is directly related to better cognitive and social development in children.[11]

Standards and curricula exist for early childhood care and education. In 2002, the NCECES and the MESC launched the first set of Standards for Pre-Schools in Samoa, which provides the criteria for Pre-Schools to follow to ensure that children in pre-schools enjoy and benefit from the learning therein in all aspects. Specially, the standards focus on the following domains: literacy, numeracy, motor skills, cognitive development, and socio-psychological development.

Developed in collaboration by the NCECES and MESC, the Guide to Preschool presents the curriculum which must be followed by early childhood care and education centers. The Guide to Preschool sets out the specific topics that teachers should introduce to the children, including: the person; health and safety; animals; independence; sea and air; sports; Samoa history and culture; and traditions.

Learning outcomes of the child, methods of teaching the topics and suggested activities are addressed. It also provides examples of work plans and timetables for teacher use. Through the National Curriculum Policy Framework, the Guide to Preschool recognizes the role and importance of ECE and that ECE programs must be linked with the primary education system to ensure successful transition of the child.

Requirements to become an ECCE professional exist and are regulated by the NCECES. The Education Act 2009 establishes that the Minister of Education has the authority to setup, manage, and modify accreditation systems for all teachers in the education system. In ECE, the minimum education level for the teacher trainee is the successful completion of Year 13 or Form 6, and the minimum professional qualification for the ECE teacher is the NCECES Certificate. The certificate is a 2 semester (1 year) program that is administered by the NCECES and includes more than 11 subjects, including: child development; language; special needs; the arts; toy making; observation skills and history; and theory of early childhood care and education. The program also includes a pre-service practicum component, which consists of 5 weeks of in classroom time.

[11] Taylor & Bennett, 2008; Bryce et al, 2003; Naudeau et all, 2011; Victoria et al, 2003

ECCE professionals working are also required to complete in-service training at least three times per year. The areas of training include: children's service and safety, health, and first aid.

Some health workers are required to complete specific training in ECD. Doctors, nurses, housewives, and traditional birth attendants are required to complete training in delivering messages on early childhood development, such as on the topics of developmental milestones, approaches to promote positive parenting, and early stimulation activities for young children.

There are established infrastructure and service delivery standards for ECCE facilities. The Education Act 2009 outlines the requirements for operating an ECCE center. According to the act, the following criteria are required: provision of curriculum that meets national curriculum guidelines for ECE; provision of an adequate building and appropriate facilities and equipment for young children (covers all aspects of structural soundness, including access to hygienic facilities and potable water); provision of adequate furniture, educational play equipment and materials; employment of sufficient appropriately qualified and experienced staff; and, existence of an adequate management system. ECCE centers operate 4-5 days per week for an average of 3 hours per day. The suggested child to teacher ratio is 15:1.

According to these regulations, ongoing inspections are conducted to ensure compliance. Furthermore, the Minister reserves the right to inspect any center and their discretion and to close the center if it is found not to comply with the above noted requirements.

There are rigorous construction standards for all health facilities. According to the National Planning and Urban Management Authority Act 2006, similar to education facilities, all health facilities (including health posts, health centers, and hospitals) must be built and maintained subject to rigorous construction standards that include all aspects of the building and access to potable water and hygienic facilities.

Policy Lever 3.3 Compliance with Standards

Established

Establishing standards is essential to providing quality ECD services and to promoting the healthy development of children. Once standards have been established, it is critical that mechanisms are put in place to ensure compliance with standards.

Data are available to assess whether ECE professionals comply with established pre-service training standards and professional qualifications. According to the Education Statistics Digest 2012, there are 321 ECE teachers in Samoa. Of which, 241 have obtained certificates from the NCECES, and the remaining 80 staff are categorized as helpers with no certificate.

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ECCE facilities are required to comply with established service delivery, infrastructure, and registration standards, however data are incomplete. There are 104 ECCE centers in Samoa. According the UNESCO World Data on Education 2011 report, the number of ECE centers registered with the NCECES has declined in recent years due to a lack of compliance. The average child to teacher ratio is 12, however there is large variance by center, with this rate being as high as 25 in some centers. No data are available to ensure that centers operate for at least 15 hours per week.

Policy Options to Monitor and Assure ECD Quality in Samoa

- **Data Availability –** High quality data are required to inform rational and effective policy making. The current level of data availability in Samoa is very low. The GoS should consider various avenues to address this area. First, the Government could consider participating in international surveys, such as UNICEF's Multiple Indicator Cluster Survey which would strengthen knowledge about the status of ECD, especially in health and nutrition sectors. Furthermore, the Government could consider expanding the education and health information systems to include a particular focus on access and outcomes in the ECD sector. It would be beneficial to be able to disaggregate this data by special interest group in order to fully

evaluate the breadth of the ECD system and identify areas for improvement and special groups that are underserved. Lastly, in conjunction with a shift to a more holistic ECD system, the GoS could move towards the development of an individual child tracking system across the different sectors in order to measure a child's overall ECD outcomes and respond accordingly with specific services as required.

- **Quality Standards and Compliance –** In recent years Samoa has taken measures to strengthen the standards governing ECD sectors and develop capacity to ensure compliance. However, this is significantly easier to achieve when coverage is low. As the number of ECCE centers expand, the NCECES will need to be very proactive to ensure that all new and existing center meet standards or else the quality of ECE will decrease. In addition, actions should be taken to address the schools that have high child to teacher ratios. If a class is too large the focus of the ECE professional shifts from education to care and management of the classroom environment. Expansion of facilities and more ECE professionals are required.

Comparing Official Policies with Outcomes

Table 9 compares select policies which affect ECD with related outcomes in the Samoa. The GoS has policies and laws promoting exclusive breastfeeding and birth registration, however the implementation remains low. The GoS is reviewing the National Food Standards Bill which will include mandatory iodization of salt. In order to ensure this bill is effective, the GoS should advance data collection to include this indicator and therefore provide a metric on implementation. Lastly, preprimary education is not compulsory in Samoa and there is no public provision. Not surprisingly, enrollment is very low as a result.

Table 9: Comparing ECD policies to outcome

ECD Policies	Outcomes
Nutrition	
❖ National laws encourage breastfeeding →	Rate of exclusive breastfeeding until the age of 6 months 51%
❖ National Food Standards Bill is being designed and will mandate salt iodization →	Percentage of households consuming iodized salt: data not available
Child Protection	
❖ National policy mandates the registration of children at birth →	Birth registration rate: 48%
Education	Enrollment: 38%
❖ Preprimary education is not compulsory →	

Table 10: Comparing ECD policies to outcomes in the Samoa and select countries

	Samoa	Tonga	Vanuatu
Immunizations			
National Immunization Policy mandates a complete course of childhood immunizations	Yes	Yes	Yes
Children immunized with DPT (1 year old)	87%	91%	68%
Breastfeeding			
Compliance, Code of Marketing of Breast Milk Substitutes	Policy encourages breastfeeding	National Food and Nutrition Policy encourages breastfeeding	National Breast milk Policy
Exclusive Breastfeeding (6 Months)	51%	62%	40%
Preprimary Education			
Preprimary School Policy	Not compulsory; 100% non-public provision	Not compulsory	Not compulsory
Preprimary School Enrollment Rate	38%	33%	59%
Birth Registration			
Birth Registration Policy	Mandated	Mandated	Mandated
Birth Registration Rate	48%	98%	26%

Table 10 compares ECD policies to outcomes in Samoa, Tonga, and Vanuatu. The existence of laws and policies alone do not guarantee a strong correlation with desired ECD outcomes. In many countries, a disconnect exists between policies on paper and the reality of access and service delivery on the ground. For example, each of the countries presented has a law mandating immunizations, and in Samoa and Tonga the rate is high or nearly universal. However, in Vanuatu, the rate is only 68 percent. A similar disconnect exists for the rate of birth registration. Each of the three countries mandate birth registration, however only Tonga has achieved near universal implementation, where as the rates are 48 percent and 26 percent in Samoa and Vanuatu, respectively. All three of the countries have also taken measures that encourage breastfeeding. The rates of exclusive breastfeeding until six months vary from 40 percent to 62 percent. None of the three countries mandates compulsory preschool education and enrollment is low across the region.

Preliminary Benchmarking and International Comparison of ECD in Samoa

Table 11 presents the findings from the SABER-ECD assessment of ECD policy in Samoa. The country has an emerging *Legal Framework,* highlighted by strong national laws and regulations that promote healthcare for pregnant women and young children. The *Legal Framework* is less development in the education and nutrition sectors. *Coordination* is classified as emerging. There is no multi-sectorial ECD strategy or institutional anchor to coordinate ECD activities across sectors, however there are mechanisms to promote collaboration between state and non-state stakeholders. *Finance* is classified as emerging as further investment is required to achieve higher coverage and improve quality. *Scope of Programs* is emerging. Interventions target all groups of stakeholders; however availability of interventions is low in education. Both *Coverage* and *Equity* are emerging. *Data Availability* is poor and classified as latent. *Monitoring and Assuring Quality* are classified as

established. Table 12 presents the preliminary regional and international comparison. On the one end of the spectrum, Sweden is the gold standard for ECD systems and achieves "advanced" for all policy levers. The level of development on most policy levers in Samoa is comparable to other countries in the region, with the main exception being that Samoa has superior standards and compliance mechanisms.

Table 11: Benchmarking Early Childhood Development Policy in Samoa

ECD Policy Goal	Level of Development	Policy Lever	Level of Development
Establishing an Enabling Environment	●●○○	Legal Framework	●●○○
		Inter-sectoral Coordination	●●○○
		Finance	●●○○
Implementing Widely	●●○○	Scope of Programs	●●○○
		Coverage	●●○○
		Equity	●●○○
Monitoring and Assuring Quality	●●○○	Data Availability	●○○○
		Quality Standards	●●●○
		Compliance with Standards	●●●○
Legend:	Latent ●○○○	Emerging ●●○○	Established ●●●○ Advanced ●●●●

Table 12: International Classification and Comparison of ECD Systems

ECD Policy Goal	Policy Lever	Level of Development					
		Samoa	Australia	Chile	Tonga	Turkey	Vanuatu
Establishing an Enabling Environment	Legal Framework	●●○○	●●●●	●●●○	●●○○	●●●○	●●○○
	Coordination	●●○○	●●●●	●●●○	●○○○	●●○○	●●○○
	Finance	●●○○	●●●●	●●●○	●●○○	●●○○	●○○○
Implementing Widely	Scope of Programs	●●○○	●●●○	●●●●	●●●○	●●●○	●●○○
	Coverage	●●○○	●●●●	●●●○	●●●○	●●○○	●●○○
	Equity	●●○○	●●●○	●●○○	●●○○	●●○○	●●○○
Monitoring and Assuring Quality	Data Availability	●○○○	●●●○	●●●○	●●○○	●●○○	●●○○
	Quality Standards	●●●○	●●●○	●●○○	●○○○	●●●○	●●○○
	Compliance with Standards	●●●○	●●●○	●●○○	●○○○	●●○○	●●○○
Legend:		Latent ●○○○		Emerging ●●○○		Established ●●●○ Advanced ●●●●	

Conclusion

The SABER-ECD initiative is designed to enable ECD policy makers and development partners to identify opportunities for further development of effective ECD systems. The SABER-ECD classification system does not rank countries according to any overall scoring; rather, it is intended to share information on how different ECD systems address the same policy challenges. This Country Report presents a framework to benchmark the Samoa's ECD system; each of the nine policy levers are examined in detail and some policy options are recommended.

In recent years, ECD has gained increased attention and prominence in Samoa, as is evident through the draft National Food Standards Bill and the greater role of early childhood care and education within the education strategy. However, the ECD system remains largely disjointed. There is no unifying ECD policy, nor is there a lead sector tasked with convening and coordinating ECD interventions. Substantial resources and efforts are required to improve the availability of services. The most glaring issue is the absence of administrative and survey data. Data are critical to build and maintain a robust ECD system and is required to inform strong policy.

Table 13 below summarizes many of the discussion points and policy options that have been identified through this analysis.

Table 13: Summary of policy options to improve ECD in Samoa

Policy Dimension	Policy Options and Recommendations
Establishing an Enabling Environment	• Ensure that the National Food Standards Bill is approved and implemented • Modify maternity leave policy to provide flexibility to parents and ensure adequate financial support during early stages of a child's development • Consider development of a National ECD Strategy development, with contributions from all relevant Government and non-government stakeholders • Appoint a lead agency to convene and coordinate ECD activities • Develop methodology to effectively measure and track financial investments in ECD • Consider increasing financial commitment to ECD system, with particular focus on supporting equitable access to early childhood care and education services
Implementing Widely	• Undertake stocktaking exercise to document and map existing interventions • Reach children 0 to 3 with multi-sectoral services and reach their parents with education messages • Strengthen and empower NGOs' ability to provide services in Samoa • Increase coverage of preschool education by supporting development and promotion of new facilities • Eliminate inequity in access to interventions in all sectors by increasing service provision and targeting children from lower socioeconomic families and rural locations
Monitoring and Assuring Quality	• Consider participating in international survey, such as UNICEF's Multiple Indicator Cluster Survey stocktaking exercise to document and map existing interventions • Expand the education and health information systems to include a particular focus on access and outcomes in the ECD sector • Disaggregate data by special interest group in order to fully evaluate the breadth of the ECD system and identify areas for improvement and special groups that are underserved • In conjunction with a shift to a more holistic ECD system, move towards development of an individual child tracking system across the different sectors in order to measure a child's overall development in the four interrelated domains • In response to low coverage, develop capacity in all sectors to ensure quality in light of need increases in access

Acknowledgements

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www.worldbank.org/education/saber

The **Systems Approach for Better Education Results (SABER)** initiative produces comparative data and knowledge on education policies and institutions, with the aim of helping countries systematically strengthen their education systems. SABER evaluates the quality of education policies against evidence-based global standards, using new diagnostic tools and detailed policy data. The SABER country reports give all parties with a stake in educational results—from administrators, teachers, and parents to policymakers and business people—an accessible, objective snapshot showing how well the policies of their country's education system are oriented toward ensuring that all children and youth learn.

This report focuses specifically on policies in the area of Early Childhood Development.

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