REGIONAL SEXUAL REPRODUCTIVE HEALTH PROGRAMME

KIRIBATI | SAMOA | SOLOMON ISLANDS | TONGA | VANUATU

SAMOA

Sexual and Reproductive Health Rights Needs Assessment

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CHARTS AND GRAPHS

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AFPPD	Asian Forum of Parliamentarians on Population and Development
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHNIS	Community Health Nursing Information System
CPR	Contraceptive prevalence rate
DHS	Demographic and Health Survey
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HDI	Human Development Index (UNDP)
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IMR	Infant mortality rate
IUCD	Intrauterine contraceptive device
LAM	Lactational Amenorrhoea (contraceptive) Method
MAVAG	Men Against Violence Advocacy Group
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
MWCSD	Ministry of Women, Community and Social Development
NACC	National AIDS Coordinating Committee
NZ-MFAT	New Zealand Ministry of Foreign Affairs and Trade
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PoA	Plan of Action
PSRO	Pacific Sub-regional Office (UNFPA)
SFA	Samoa Fa'afafine Association
SFHA	Samoa Family Health Association
SNYC	Samoa National Youth Council
SPC	Secretariat of the Pacific Community
SRCS	Samoa Red Cross Society
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
SVSG	Samoa Victims Support Group
TBA	Traditional Birth Attendant
TFR	Total fertility rate
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization

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EXECUTIVE SUMMARY

As the periods for the International Conference on Population and Development (ICPD) Plan of Action and the Millennium Development Goals (MDGs) come to an end, the United Nations Population Fund, Pacific Sub-Regional Office (UNFPA – PSRO) has commissioned a technical needs assessments for Sexual and Reproductive Health and Rights (SRHR) to explore Samoa's progress in its delivery of rights-based sexual and reproductive health programs and interventions, particularly in relation to their effectiveness in meeting the needs of key vulnerable populations.

The SRHR Needs Assessment, conducted in March 2015, comprised a comprehensive desk review and analysis of data, followed by consultations with government and non-government health service managers and providers, and key informant interviews with non-government agencies, program managers and technical advisers. Consultations were guided by UNFPA's *SRHR Needs Assessment Tools for SRHR, and HIV* (Appendix 2), and collected information on family planning, prevention and management of sexually transmitted infections (STIs), HIV, and gender based violence, all of which were verified through site visits to rural and urban health facilities.

Commitment to rights-based health and social development: Samoa remains committed to upholding the human rights of its citizens regardless of *'...descent, sex, language, religion, political or other opinion, social origin, place of birth [and/or] family status...'*, through its Constitution, and signing of a range of international conventions and treaties, including the *International Covenant on Civil and Political Rights* (2008), the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW - 1992), the *Convention on the Rights of the Child (1994), the Convention on the Rights of Persons with Disabilities* (2014) and a number of conventions under the auspices of the International Labour Organization.

A strong commitment to human rights has also been demonstrated through the establishment of a National Human Rights Institution of Samoa, to investigate and respond to national issues, legislation and practices which impact on human rights.

Samoa's commitment to upholding SRHR was recently strengthened through the Moana Declaration 2013 and the *Pacific Sexual Health and Well-being Shared Agenda 2015-2019*. The *National Sexual and Reproductive Health Policy 2011-2016* identifies the following strategies, approaches and priorities:

- Promotion and delivery of quality family planning services.
- Prevention and management of STIs, including HIV.
- Improved delivery and access to SRH services for adolescents, including prevention of the rising prevalence of adolescent pregnancy.
- Working through cross-sectoral partnerships (inclusive of non-government organisations and the private sector).

- Increasing awareness and demand for SRH services through education and promotional activities.
- Procurement and maintenance of reproductive health commodities supplies.

At the core of these SRHR priorities is a commitment to ensuring all individuals and couples have the right to make informed decisions about the number, spacing and timing of pregnancy, and that they are provided with the information and means to do so, in order to choose and maximise their potential to develop as individuals, and within households and communities.

A young and growing nation: Rising fertility poses significant challenges for the health and development sectors in Samoa, where large families place a considerable economic and development burden upon households (and on young women in particular, of whom those under 25 years of age make up 27.2% of the population).

Health Priorities and Status: Reproductive, maternal and child health, and emerging and re-emerging infectious diseases (including HIV) are identified as national health priorities by the Ministry of Health. Infant and child mortality are reducing (Infant Mortality Rate is 15.6/1,000 live births, and the Under Five Mortality Rate is 19.4/1,000 live births) due to improvements in health sector management and support of birthing and post-natal care, however national targets remain elusive. Maternal mortality remains steady, but again rates exceed established 2018 targets.

HIV prevalence in the country remains low, however incidence of other STIs is rising, especially amongst young people up to 25 years of age.

Contraceptive use amongst married women in Samoa is steady at 28.7% (for any method, 26.7% for any modern method), and there is a good mix of contraceptives procured at the national level which should support effective family planning, however attitudes of some service providers and in some cases, women themselves, have resulted in limited availability of contraceptives at service delivery points. Without the immediate introduction of contraceptive implants and the re-introduction of intra-uterine contraceptive devices (IUCDs), Samoa's women who are not willing to undergo tubal ligation surgery (or who are located far from such services) cannot access contraceptive protection beyond a three month period. This situation is reflected in the unmet need for family planning, which illustrates that 45.5% of women of child bearing age (who are married or in a union) who either do not want, or wish to delay child bearing, are currently not using contraceptives.

Young people are particularly vulnerable to limited availability of contraceptives, as few services cater for their specific contraceptive needs. This is reflected in Samoa's adolescent birth rate (39 live births to adolescent women per 1,000 women), which is higher for young women in rural areas compared with their urban peers who have greater access to anonymous services.

Gender equity and equality: Strong gains towards female empowerment in Samoa through improved legislation and supportive representation on governance bodies have positively influenced these determinants of improved health, however many women are still denied access to economic development opportunities. Women occupy a disproportionate number of Parliamentary seats and have lower economic status and participation in the labour force compared with males of the same age.

Gender-related workplace discrimination has been addressed through improved legislation, and revisions to the law have facilitated more favourable legal protections for women exposed to sexual assault and domestic violence in all its forms. Gender violence remains a significant issue for Samoa, where 46.4% reported to have experienced physical, emotional and/or sexual abuse from their partner.

Findings - Policy: Samoa has established a comprehensive policy platform upon which to plan and implement gender- and rights-based advocacy and deliver health services which promote and uphold SRHR. The *National Sexual and Reproductive Health Policy 2011-2016* provides direction and guidance to all agencies engaged in the delivery or promotion of SRH services and information in Samoa, and advocates for integration with services for the prevention and management of STIs and HIV, which in turn are guided by the *National HIV and AIDS Policy 2011-2016.*

Clinical protocols and under-graduate training courses have been developed to guide service providers in the implementation of the policies, however limited resources exist to guide systematic delivery of refresher training for in-service personnel.

Despite the heavily rights-based policies and protocols guiding implementation of SRH and STI/HIV programming and service delivery in the country, some prohibitive laws remain which could impact on key, vulnerable groups being unable or unwilling to access services for fear of legal reprisals. These inhibit Samoa's international commitments to SRHR for all.

System: A number of development partners support SRHR programming in Samoa through funding mechanisms and technical assistance. The Ministry of Health leads policy development and oversight, and program coordination, monitoring, training and staffing. UNFPA, UNAIDS, SPC, WHO and GFATM each provide a mix of financial revenue and technical assistance to programming, protocol, policy and strategy development, data analysis and training.

Multi-sectoral steering committees and working groups comprising Ministry of Health and other government personnel, representatives from non-government organisations, civil society groups and/or affected communities are engaged to provide technical and/or managerial oversight and potentially planning of SRH and HIV interventions in Samoa. Civil society organisations also play a significant role in promoting and delivering clinical SRH services, including interventions for the prevention of STIs and HIV, and gender based violence.

Youth-focused SRH services are a key strategic area of the health sector, but despite investment in equipment, infrastructure and capacity building of clinical staff, the interventions are not operating effectively to meet the SRH needs of young people.

Suitable systems are in place for procuring and distributing reproductive health commodities to the rural health facility level, however these have been hampered recently by attitudinal barriers of Pharmacy Managers at the national level, and in some cases, unwillingness of clinical staff to promote and dispense some contraceptives. These examples pose significant challenges to supporting individuals and couples to make informed choices about the number, spacing and timing of their children.

Monitoring and evaluation remains a challenge for the National SRH and HIV/STI Programs, as there is a limited commitment to recording youth attendance at health facilities, and the collection of age and gender disaggregated data is hampered by a non-functioning, computerised Community Health Nursing Information System, which consequently has lapsed into a time-consuming, paper-based manual data recording process with little scope for useful analysis. This needs to be rectified as soon as possible to provide more timely, useful information to inform program planning and direction.

Service delivery: All health facilities in Samoa are offering antenatal care and family planning services, both from within the centres and through community outreach. STI treatment is available for antenatal care mothers and from outpatients departments, however on Savai'i, a reported lack of available reagent for testing has resulted in suspected cases being referred to doctors for syndromic management. All facilities have private consulting rooms, and most have in stock the WHO-recommended 'Seven Life-Saving Reproductive Health Medicines'.

Reflecting the low HIV prevalence in Samoa, all treatment services are offered from the TTM National Referral Hospital in Apia. Eleven voluntary confidential counselling and testing (VCCT) sites have been established, however there are few designated spaces in any of the clinics. Awareness messages for prevention of mother to child transmission (PMTCT) of HIV are communicated to all antenatal care mothers, along with gender-based violence awareness and prevention messages. No facilities are providing HIV information services for specific, vulnerable groups such as men who have sex with men.

No rural health facilities provide direct response to gender violence; clients are usually referred to either of the two main hospitals. The TTM National Referral Hospital does not have specific protocols or procedures for responding to these acute cases (nor for management and response to unsafe abortion). There are no sexual assault evidence collection or response kits available in any of the health facilities in the country, nor are there consent forms available for responding to these cases. The emergency contraceptive pill (for post-exposure prophylaxis) is not available outside of the outpatients department of the TTM National Referral Hospital in Apia.

Peer Education: Peer educators operate throughout the country via a number of different mechanisms, for a range of organisations. Samoa Family Health Association, Samoa Red Cross Society, the Division for Youth within the Ministry of Women, Community and Social Development, the Samoa Fa'afafine Association and the Samoa National Youth Council all support various forms of peer education. Male condoms are distributed by peer educators during outreach activities and via fixed condom dispensers in night clubs, public toilets and other identified locations in Apia.

Conclusions and recommendations: Cultural and attitudinal barriers continue to challenge the health sector's progress towards achieving universal access to SRHR, however champions and advocates who support and promote access to SRHR are present at all levels of government, service provision and within the civil society sector. Areas requiring attention include the effective delivery of youth friendly services, improved STI testing and management and structured management of gender-based violence and assault. Health sector capacity development, health service rehabilitation, guidelines and protocol development, coordinated, multi-sectoral program planning and monitoring, and more structured approaches to peer education training, programming, monitoring and reporting would all serve to better meet the SRHR of all Samoans.

1. INTRODUCTION

With the conclusion of the International Conference on Population and Development (ICPD) Plan of Action in 2014, and the Millennium Development Goals (MDGs) in 2015, the United Nations Population Fund, Pacific Sub-Regional Office (UNFPA – PSRO) has commissioned technical needs assessments for Sexual and Reproductive Health and Rights (SRHR) in a number of Pacific Island Countries and Territories in 2014-15.

These needs assessments would explore country/territory progress in the delivery of rights-based sexual and reproductive health programs and interventions, particularly in relation to their effectiveness in meeting the needs of key vulnerable populations. The needs assessments would identify strengths and weaknesses in relation to program planning, delivery, monitoring and evaluation, and contribute recommendations for improved SRHR as the region heads towards adoption of the forth-coming Sustainable Development Goals.

The Independent State of Samoa (herewith referred to as 'Samoa'), has made substantial international and national commitments to the upholding of the human rights of its citizens, and in particular, has articulated its direct engagement in the promotion and assurance of SRHR.

This report provides a detailed desk review of Samoa's rights-led approach to health and social development, and sexual and reproductive health (SRH) in particular, and the findings from a comprehensive, in-country field visit to conduct a national SRHR Needs Assessment. The data and analysis presented in the report are punctuated with recommendations for overcoming identified challenges and bottlenecks which stand to limit Samoa's meeting its international commitment to ensuring universal access to reproductive health.

1.1 National commitment to rights-based health and social development

Since achieving independence in 1962, Samoa has remained committed to upholding the human rights of its citizens through its Constitution, within which *'all persons are equal before the law and entitled to equal protection under the law'*, and in which no person should be discriminated against on the basis of *'...descent, sex, language, religion, political or other opinion, social origin, place of birth [and/or] family status...'*[1].

The Government of Samoa has actioned its commitment to the fundamental principles of the Universal Declaration of Human Rights through its signing and/or ratifying a number of international conventions/treaties which prioritise individuals' rights in the establishment and upholding of laws, legislation and practices in all areas. These include the *International Covenant on Civil and Political Rights* in 2008, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW - 1992), the *Convention on the Rights of the Child* (1994), the *Convention on the Rights of Persons with Disabilities* (2014) and a number of conventions under the auspices of the International Labour Organization.

1 Independent State of Samoa, 2009; Constitution of the Independent State of Samoa 1960: Consolidated Act of Samoa 2008; source: http://www.wipo.int/wipolex/en/..., accessed 19th March 2015.

In addition, following its signing of the Samoa Declaration in 2009, Samoa established the Office of the Ombudsman *(Komesina O Sulufaiga)* as the National Human Rights Institution of Samoa, which would *'promote the highest standards of human rights and respect for the person; and ensure dignity and respect of the person, and equality for all'* through investigating and monitoring national issues, legislation and practices which impact on human rights, through educating government and the wider population about the importance of human rights and how they can be upheld, and through collaborative action with national, regional and international bodies to ensure adherence to human rights in all actions, commitments and laws[2].

Of particular relevance to health and social development, Samoa was an original signatory to the 1994 Plan of Action (PoA) of the International Conference on Population and Development (ICPD). This commitment seeks to reduce poverty and hardship and promote economic and social development through multi-sectoral engagement which upholds the rights of couples and individuals (women in particular) to make informed, voluntary decisions about the number, spacing and timing of planned pregnancy. The PoA extends beyond recommendations for access to services and family planning information and commodities, to uphold gender equality as the key element for improved health, including reproductive health, of a nation.

The PoA therefore advocates for cross sectoral engagement beyond health, to the justice, education and a number of other key social sectors in order to:

- Advance gender equality and empowerment of women.
- Eliminate violence against women (also referred to as gender-based violence).
- Eliminate discrimination.
- Achieve full, equal participation of women in civil, cultural, economic, political and social life.
- Enable women to control their fertility.

The PoA also informed the development of the MDGs, which likewise advocate strongly for rights- and gender-based approaches to poverty alleviation at the national level. Table 1.1 presents the MDGs with particular relevance to population health and social development.

Table 1.1: MDGs with particular relevance to population health and social development.

			
Promote gender equality and empower women	Reduce child mortality	Improve maternal health • 5A: Reduce by ¾ … the maternal mortality ratio • 5B: Achieve … universal access to reproductive health	Combat HIV/AIDS, malaria and other diseases

2 Ombudsman Samoa, 2013; *National Human Rights* Institution; source: http://www.ombudsman.gov.ws/, accessed 19th March 2015.

These international commitments, conventions and plans of action were more recently re-affirmed by the Government of Samoa's signing of the Moana Declaration in 2013[3], and the subsequent *Pacific Sexual Health and Well-being Shared Agenda 2015-2019*[4], which re-commits to the upholding of SRHR. The latter serves as a revised framework for strategy and policy development which prioritises integrated sexual health and reproductive health services, and will support the Government of Samoa to further develop its already established series of sectoral, rights-based policies for health, education and justice, informed by the *Strategy for the Development of Samoa 2012-2016*, which guides the implementation, measurement and reporting of rights-based actions towards national development priorities[5].

1.2 Sexual and Reproductive Health and Rights (SRHR)

Two sectoral documents which have been heavily influenced by the ICPD PoA are the *Health Sector Plan 2008-2018*[6] and the *National Sexual and Reproductive Health Policy 2011-2016*[7], both of which advocate for a rights-based approach through which to guide the development, implementation, monitoring and reporting of interventions designed to improve reproductive health of Samoan citizens. The *National Sexual and Reproductive Health Policy 2011-2016* identifies the following strategies, approaches and priorities for working towards its vision of *'ensuring a safe sexual and reproductive health environment for all Samoans'*:

- Promotion and delivery of quality family planning services.
- Prevention and management of sexually transmitted infections (STIs), including HIV.
- Improved delivery and access to SRH services for adolescents, including prevention of the rising prevalence of adolescent pregnancy.
- Working through cross-sectoral partnerships (inclusive of non-government organisations and the private sector).
- Increasing awareness and demand for SRH services through education and promotional activities.
- Procurement and maintenance of reproductive health commodities supplies.

The *National Sexual and Reproductive Health Policy 2011-2016* sets out a number of Key Strategic Areas for promoting SRHR for all Samoan citizens. It also articulates the responsibility of the Strategic Development and Planning Division of the Ministry of Health to conduct regular, evidence-based and consultative reviews of the policy to ensure it remains relevant in the ever-changing SRH environment. As the Policy's period of implementation draws to a close, a final review will be conducted to determine the Ministry of Health's progress in meeting its SRHR targets, and to identify implementation bottlenecks to be considered in the development of a revised Policy. The detailed, consultative needs assessment of SRHR will be the first step in this policy review process.

3 Pacific Conference of Parliamentarians for Advocacy on ICPD beyond 2014, 2013; *Moana Declaration: Outcome Statement of Pacific Parliamentarians for Population and Development*; Suva; UNFPA, AFPPD and IPPF.
4 SPC, 2014; *Pacific Sexual Health and Well-being Shared Agenda 2015-2019*; Suva; SPC.
5 Economic Policy and Planning Division, 2012; *Strategy for the Development of Samoa 2012-2016*; Apia; Ministry of Finance.
6 Government of Samoa, 2008; *Health Sector Plan 2008-2018*; Apia; Ministry of Health.
7 Government of Samoa, 2011a; *National Sexual and Reproductive Health Policy 2011-2016*; Apia, Ministry of Health.

1.3 Country Context

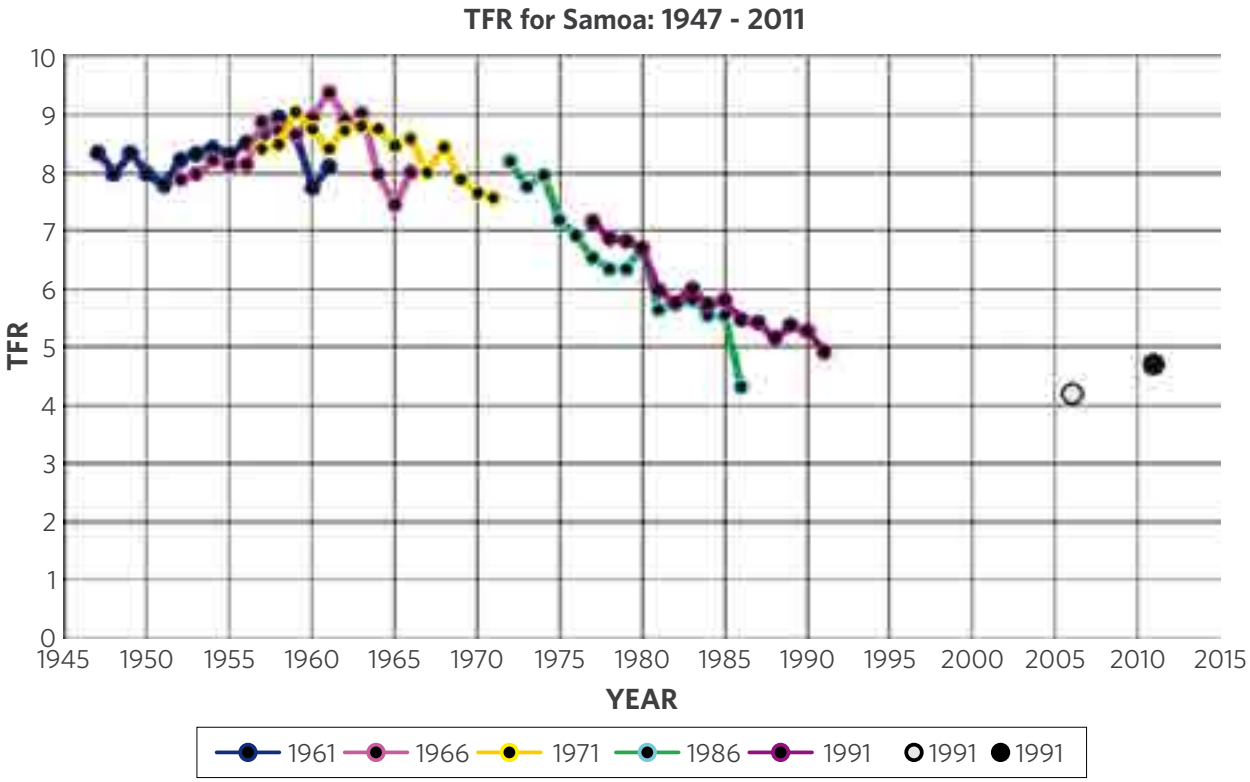
Samoa represents a low-income, yet developing economy thanks largely to a stable political environment, and a homogenous population free from ethnic tension and conflict. Samoa is ranked 106 out of 187 countries under the UNDP Human Development Index (HDI), which is calculated based on life expectancy at birth (having risen over the last decade by 2.4 years), access to education and information, and standards of living as a reflection of Gross National Income per capita[8]. This last indicator is somewhat skewed by the substantial national income which is derived through familial remittances from the significant diaspora of Samoans living abroad (predominantly in New Zealand, Australia and the United States of America); income which reaches families directly, but which does not feature in the Government of Samoa's public expenditure capacity to provide services to its citizens.

Rising fertility: During its most recent national household census in 2011, Samoa recorded a total population of 187,820 people, comprising 90,830 females and 96,990 males. This demonstrates a population increase of 3.9% (7,079 persons) during the preceding five years[9], and based on this trend, UNFPA estimates the population in 2014 to be 190,000[10].

This population growth is caused by a 2011 Total Fertility Rate (TFR) of 4.7 children per woman entering the period of child bearing age - the highest in the Pacific region[11]. This constitutes a 0.1 rise in the TFR since a national Demographic and Health Survey (DHS) was conducted in 2009[12], suggesting that Samoa has entered into a phase of reversed fertility transition, in which the decline in fertility that commenced in the early 1980s has now troughed, and begun to increase (see Figure 1.1). A new DHS was conducted in late 2014, in which a larger sample was reached to further monitor this fertility trend (amongst other things), however the report and data from this activity is not scheduled to be released until mid-2015[13].

8 UNDP, 2014; *Human Development Reports*, Samoa; http://hdr.undp.org/en; accessed 20th March 2015.
9 Census Survey Division: Samoa Bureau of Statistics, 2012; *Population and Housing Census 2011: Analytical Report*; Apia, Samoa Bureau of Statistics, Government of Samoa.
10 UNFPA, 2014; *Population and Development Profiles: Pacific Island Countries*; Suva, Fiji; UNFPA Pacific Sub-Regional Office.
11 UNFPA, 2014 op cit.
12 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010; *Samoa Demographic and Health Survey 2009*; Apia; Ministry of Health.
13 Personal communication, Keneti Vaigafa, Principal Health Information Officer, Ministry of Health, Apia, 9th March 2015.

Figure 1.1: TFR for Samoa, 1961-2011[14]



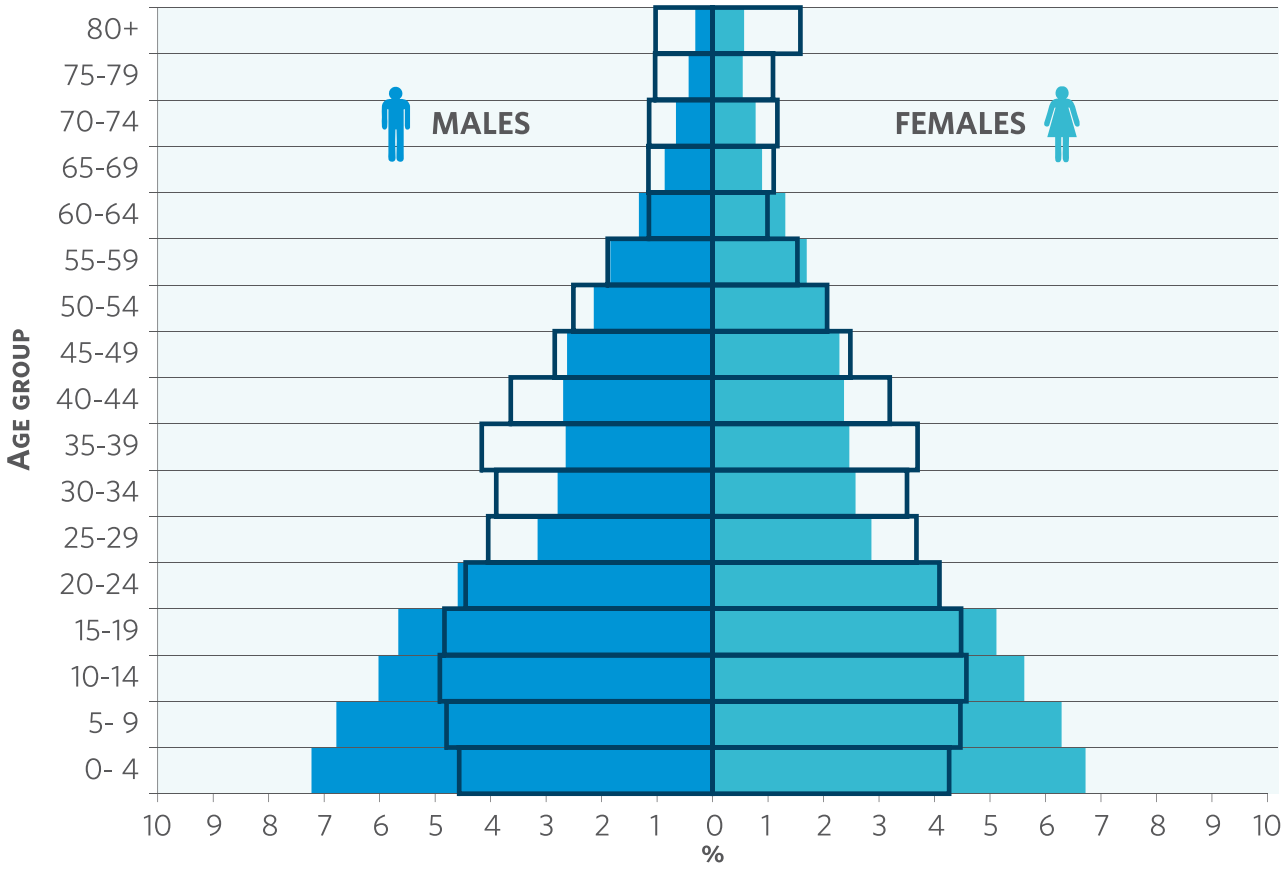
Young, dispersed population: The most noticeable demographic shift to have resulted from declining fertility in the last fifty years has been the reduced proportion of children aged 0-15 years, and a growing, proportionate number of females and males of reproductive age (15-49 years – see Figure 1.2). The 2011 census indicates that 47.0% of all females, and 47.9% of males are of reproductive age (15-49 years), however these numbers will swell in the coming decade as a greater proportion of young people will enter the period of reproductive age (24.1%) compared with those who will reach the end of their reproductive years (10.3%)[15].

As women and men of reproductive age represent a growing, significant proportion of the population, there is an emerging urgency to ensure sufficient programmatic and financial investment to promote and provide SRH, including family planning services in Samoa. Furthermore, as 56.7% of the population are under 25 years of age, such investment must ensure services are relevant and accessible to younger people.

Considering this from a gender and rights perspective, given that 27.2% of Samoa's population in 2011 were females under the age of 25, and that the proportion of females of child bearing age (15-49 years) is expected to increase by 2050, improved development outcomes for households, and especially for individual females will be heavily influenced by the extent to which SRH and family planning services succeed in empowering women to make informed choices about the number, spacing and timing of their children.

14 Table sourced from Andreas Demmke, Population and Development Adviser, UNFPA Pacific Sub-Regional Office, Suva, 7th March 2014.
15 Census Survey Division: Samoa Bureau of Statistics, 2012 op cit.

Figure 1.2: Samoa Population by age and sex: 2015 (shaded area) and 2050 (outlined)[16].



In addition to ensuring SRH, including family planning services are youth- and gender-friendly, a further challenge for the Ministry of Health and service providers will be to ensure they are accessible to the 80.0% of the population which resides in rural areas. The 2011 Population and Housing Census identifies higher fertility rates and teenage (15-19 years) pregnancy amongst rural communities[17], highlighting the need for investment in suitable, decentralised services which are available outside the capital, Apia.

1.4 Health Priorities and Status in Samoa

A situational analysis of the health sector in Samoa in 2007 identified the following priorities to be addressed by the Ministry of Health and the National Health Service:

- Rapidly increasing levels of Non-Communicable Diseases (NCDs).
- Reproductive, maternal and child health.
- Emerging and re-emerging infectious diseases.
- Injury as a significant cause of death and disability[18].

16 UNFPA, 2014 op. cit.
17 Census Survey Division: Samoa Bureau of Statistics, 2012 op. cit.
18 Ministry of Health, 2013; *Mid-term review of the Health Sector Plan: 2008 – 2018*; Apia, Samoa Ministry of Health.

NCDs are emerging as an increasing cause of early death in Samoa, as well as being a significant contributor to morbidity, which places a substantial burden on health system resources. Lifestyle risk factors relating to an increasingly high-fat diet and sedentary behaviours are contributing to rising incidence of cardiovascular disease (including stroke and hypertension), diabetes and cancers of the digestive organs.

Maternal and child health remains a significant focus of the Ministry of Health and its donor partners. Improved antenatal care service provision throughout the country has been achieved through a commitment to:

- Improved infrastructure, equipment and resources within the National Health Service to deliver facility-based and outreach antenatal care services.
- A technically trained and supported cadre of nursing and midwifery staff through regular, in-service training and a Post-Graduate Diploma in Midwifery for qualified nurses (offered through the National University of Samoa).
- Establishment of regular community outreach activities through which nurses work with community-level volunteers (such as representatives of the Komiti Tumama – village women's committee) to identify new pregnancies and facilitate early (and subsequent) booking of the mother/parents for attendance at antenatal clinics.

The Infant Mortality Rate (IMR) in Samoa, at 15.6/1,000 live births has significantly reduced since 2001, largely due to improvements in health sector management and support of birthing and post-natal care. However there is still much to be done to achieve the Ministry of Health's 2018 IMR target of 10.0/1,000 live births. The child (<5 years) mortality rate, at 19.4/1,000 live births, has also reduced since 2001, however this decline has not been a steady one, as an increase to 24.6/1,000 was recorded for the period 2001 - 2006. It should be noted that due to the small population size, these figures may be influenced as much by cultural practices and social factors which impact on accurate reporting, such as adoption and child fostering, as by actual child deaths[19]. Despite improvement over the last decade, Samoa's 2018 child mortality rate target of 12.0/1,000 live births remains elusive.

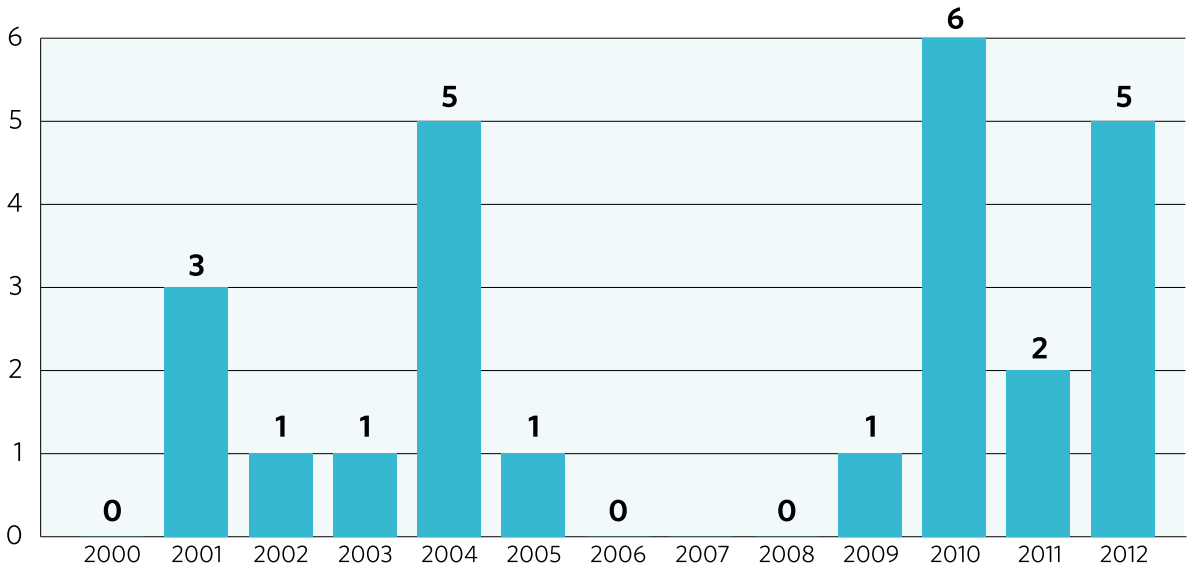
Samoa's Maternal Mortality Ratio (MMR)* has increased in the period 2006-2012, from 46/100,000 births to 50/100,000 live births, and is still some way from reaching the Health Sector Plan target for 2018 of 23/100,000 live births.

It should be noted, however that Samoa's small population masks the extent to which the number of maternal deaths significantly influences the MMR, and that a rise in MMR does not adequately reflect whether deaths are a result of unpredictable, unrelated and/or unpreventable events. For example, in the three years from 2010-2012 (inclusive), a total of 13 maternal deaths resulted from ante-partum haemorrhage (2), post-partum haemorrhage (2), amniotic embolism (2), internal bleeding due to injury (2), obstructed labour (1), ectopic pregnancy (1), severe hyperemesis (1), septicaemia (1) and eclampsia (1), of which some may have been preventable through early detection of complications and access to emergency obstetric care, but for which most could not have been predicted.

19 Census Survey Division: Samoa Bureau of Statistics, 2012 op. cit.
*Note: the baseline and target MMR presented in the Health Sector Plan are incorrectly labelled as maternal mortality rate, not ratio.

Figure 1.3 demonstrates the actual number of maternal deaths annually for the period 2000-2012[20]. There have been 2 maternal deaths in Samoa in 2014, which would bring the MMR down substantially from the 2012 figure, to approximately 20/100,000 live births, which is on-track for meeting the 2018 target.

Figure 1.3: Maternal deaths in Samoa, 2000-2012[21].



Despite success in having eradicated communicable diseases such as poliomyelitis, tetanus and diphtheria through focused immunisation campaigns, others such as tuberculosis, dengue fever, chikungunya, typhoid, pneumonia and skin infections remain prevalent, while others are increasing substantially.

The *Strategy for the Development of Samoa 2012–2016* articulates reproductive, maternal and child health as a strategic priority, and lists appropriate indicators for measuring effectiveness of interventions[22]. Amongst these is the percentage of births at which a skilled attendant is present. In Samoa, a skilled attendant is a trained doctor, midwife or reproductive health nurse, however unofficially, the health sector recognises the contribution that traditional birth attendants (TBAs) play in supporting birthing at the village level. The *Health Sector Plan 2008-2018* articulates a target of 95% of births taking place with a skilled attendant (100% with TBAs)[23], however no accurate, updated data has been collated since the 2009 DHS, which identified 81% skilled attendance at births (97% with TBAs)[24].

While HIV prevalence in the country remains low (there are currently 12 people living with HIV out of a total of 23 cases ever detected)[25], there is increasing evidence to suggest that incidence of other STIs is rising, especially amongst young people up to 25 years of age.

20 Ministry of Health, 2013 op. cit.
21 Ibid.
22 Economic Policy and Planning Division, 2012 op cit.
23 Ministry of Health, 2013 op cit.
24 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op cit.
25 Personal communication, A'aone Tanumafili, Principal, National HIV/AIDS Capacity Support - HSCRMD, Ministry of Health, Apia, 9th March 2015.

The Ministry of Health, in a number of its annual reports from 2009 - 2013, reports chlamydia prevalence of between 24.0 and 28.0%[2627], while a 2008 Second Generation Surveillance activity reported positive chlamydia tests amongst 40.9% of women aged 15-24 years who attended antenatal care[28].

Gender-related SRHR: Gender equity and equality is a key component of SRHR and a significant determinant of improved SRH, and while there have been some strong gains towards female empowerment in Samoa through improved legislation and supportive representation on governance bodies, there is still much to be done to ensure true equity and equality, particularly in relation to access to economic development opportunities, and the prevalence and acceptance of gender-based violence.

The female to male ratio for Samoa's HDI is 0.95, suggesting females have a lower life expectancy at birth, limited access to education and information and generally lower standards of living (as a reflection of Gross National Income per capita) compared with males. The country's gender inequality index, at 0.52 suggests that adult women occupy a disproportionate number of Parliamentary seats and have lower economic status and participation in the labour force compared with males of the same age. In fact, the national labour force in Samoa comprises 23.4% of the female population, while 58.4% of males are employed[29].

There are currently three Parliamentary seats held by women (reflecting 6.1% of the Parliament's 49 seats), and in an effort to promote greater Parliamentary representation and participation of women in political processes, a quota has been passed for the next election for a minimum 10% female representation (five seats)[30]. There are also quotas established for female representation on local council and other sub-national governance structures.

Within legislation, the *2013 Labour and Employment Relations Act* prohibits workplace sexual harassment and discrimination, and the Crimes Act 2013 criminalises various forms of sexual violence (including rape). The *Family Safety Act 2013* provides protection for families and the handling of domestic violence and related matters within the law, encompassing a broad definition of 'domestic violence' which includes physical, sexual, emotional, verbal and psychological abuse, intimidation, harassment and stalking[31].

The link between gender-based violence and health, well-being and economic development has been firmly established[32], and yet violence against women (be it physical, emotional and/or sexual violence) remains a significant issue for Samoa, where 29.5 % of women between the ages of 15 and 49 believe it is acceptable for a man to physically abuse her if she argues with him, where 18.4% of women consider abuse acceptable if she goes somewhere without telling her partner, and where 17.2% of women consider physical abuse a reasonable response from her male partner if she refuses to have sex with him[33].

26 Ministry of Health, 2010; *Annual Report: Financial Year 2009-2010*; Apia, Ministry of Health.
27 STI data reports provided during personal communication, Ms Perive Lelevaga, Principal, National SRH Section, Ministry of Health, 13th March 2015.
28 Ministry of Health and SPC, 2008; *Second Generation Surveillance Surveys of antenatal women in Samoa*; Apia, Ministry of Health.
29 UNDP, 2014 op. cit.
30 Pacific Islands Forum Secretariat, 2013; 2013 Pacific Regional MDGs Tracking Report; Suva, Fiji : Pacific Islands Forum Secretariat.
31 Pacific Islands Law Officers' Network (PILON), 2015; SAMOA: *New legislative provisions in relation to sexual offences; introduction of family protection legislation*; http://www.pilonsec.org/index.php..., accessed 5th April 2015.
32 Pacific Islands Forum Secretariat, 2013 op cit.
33 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op cit.

In the only comprehensive survey carried out in Samoa which specifically addresses gender-based and domestic violence, the 2006 Samoa Family Health and Safety Study, 46.4% of the 1,646 women surveyed who had been in a relationship reported to have experienced abuse from their partner. This comprised 37.6% who had experienced physical abuse, 18.6% who had experienced emotional abuse and 19.6% who had experienced sexual abuse. Of those respondents who had experienced physical abuse by their partner, 23.8% had done so while pregnant, and in 96% of these cases, the perpetrator had been the father of the unborn child[34].

1.5 Reproductive Health and Family Planning in Samoa

Reproductive health is recognised as a priority in the Strategy for Development of Samoa 20012-2016[35], and the Health Sector Plan 2008-2018 identifies access to family planning services (and contraceptives in particular) as a key strategy for reducing the TFR and improving reproductive, maternal and child health[36]. The National Sexual and Reproductive Health Policy 2011-2016 aims to improve the family planning program in all areas of the country and amongst all age groups through promoting awareness and use of modern contraceptive methods[37]. Implicit within this is a national commitment to achieving MDG Target 5B (achieve by 2015, universal access to reproductive health), and the following section of this report outlines Samoa's progress against the appropriate global indicators, namely:

- Contraceptive method mix.
- Contraceptive Prevalence Rate (CPR).
- Adolescent birth (or fertility) rate.
- Antenatal care coverage.
- Unmet need for family planning.

The Ministry of Health maintains the regulatory and strategic oversight of SRH services in the country, while the National Health Service, the Samoa Family Health Association (SFHA), the Samoa Red Cross Society (SRCS), the Ministry of Women, Community and Social Development (MWCSD) and some private practitioners are responsible for the delivery of those services, both from within health facilities and through community-based outreach.

1.5.1 Contraceptive method mix.

In Samoa, a range of modern contraceptives and other family planning methods are available from various sources. Injectable and oral contraceptives are the most common form of modern methods used, followed by male condoms, and to a lesser extent, female condoms. Female and male sterilization and Intrauterine contraceptive devices (IUCDs) have been used as family planning methods in the past, but have been less commonly available or utilised in the last five years. The emergency contraceptive pill and contraceptive implants, while featured in national pharmaceutical stock lists, are not available outside of the National Referral Hospital in Apia, reportedly to discourage 'abuse' by either nurses or clients. The 2009 DHS reports widespread use of the lactational amenorrhoea method (LAM) as a form of contraception[38].

34 SPC, 2006; *The Samoa Family Health and Safety Study; Apia*; MWCSD, SPC and UNFPA.
35 Economic Policy and Planning Division, 2012 op cit.
36 Ministry of Health, 2008; *Health Sector Plan 2008 – 2018*; Apia, Ministry of Health.
37 Government of Samoa, 2011a op cit.
38 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.

This contraceptive method mix results in a large proportion of family planning users in Samoa being unable to access methods which provide reliable contraception beyond a three month period. Efforts to reduce the TFR and meet the SRHR of individuals and couples would benefit substantially from the introduction of contraceptive implants and the re-introduction of IUCDs, which would provide reliable contraception for 5-10 years.

Table 1.2: Contraceptive method mix in Samoa.

Modern contraceptive methods	Traditional contraceptive methods
Oral contraceptives	Rhythm (periodic abstinence) method
Injectable contraceptives	Withdrawal method
Condoms (female and male)	LAM**
Sterilization (female and male)	Other 'folk' method
Emergency oral contraceptive pill*	
Contraceptive implants*	
IUCDs*	
LAM**	

** Rarely available or used.*

*** LAM is considered by some as a traditional method, while others categorise this as a modern method.*

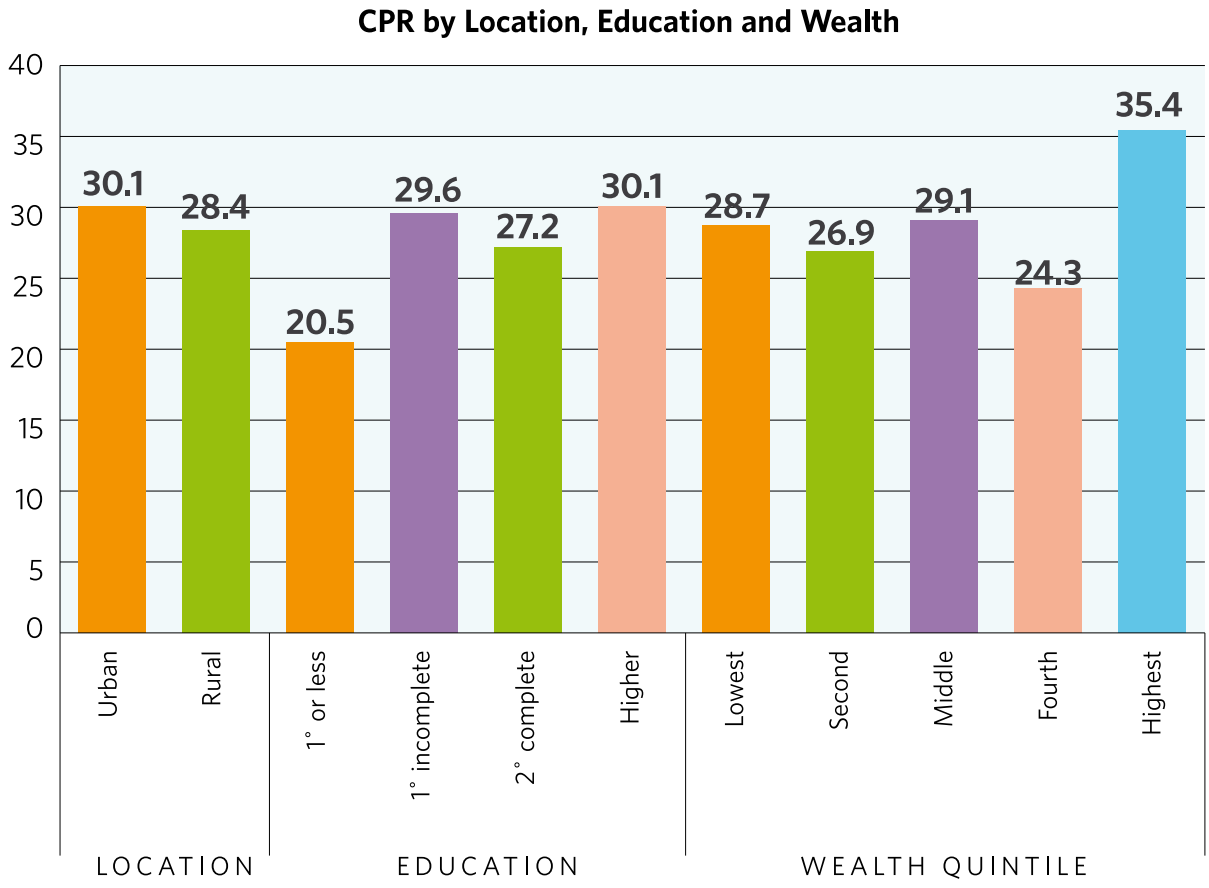
1.5.2: Contraceptive prevalence.

Considerable variation exists in Samoa between awareness of available contraceptives and their use, and this is reflected amongst both females and males. 70.7% of females and 82.9% of males who took part in the DHS in 2009 were aware of at least one method of contraception, of which most of these identified a modern method (as listed in Table 1.2, in contrast to a traditional method such as the rhythm, withdrawal or other 'folk' method). Despite the high level of awareness, the number of females and males reporting to have ever used a modern method of contraception was considerably lower (29.6% and 15.2% of females and males respectively aged 15-49 years)[39].

As a more appropriate measure of contraceptive use, the DHS articulates the percentage of women of reproductive age (15-49 years) who are married or in a union using contraceptives at the time of the survey (known as the contraceptive prevalence rate – CPR). The 2009 DHS identified 28.7% of married women using some form of contraceptive method at the time of the survey (26.7% for any modern method), which is considerably lower than the 2018 Health Sector Plan target of 75.0-80.0%[40]. CPR is highest amongst women in the 30-39 year age bracket, and lowest amongst 15-24 year olds. However there was little variation in CPR between urban and rural-dwelling women. While women whose education concluded in primary school demonstrated a low CPR, there was little appreciative difference amongst secondary- and tertiary-educated women, nor was there a significant trend of CPR amongst rising wealth quintiles (although overall, women in the highest quintile demonstrated a higher CPR than those in the lowest quintile – see Figure 1.4)[41].

39 Ibid.
40 Ministry of Health, 2013 op cit.
41 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.

Figure 1.4: CPR by Location, Education and Wealth[42].



It should be noted that the 2009 CPR of 28.7% is significantly lower than those reported in the *Reproductive Health Commodity Security Status Assessment Report for Samoa, 2008*, which stated CPRs of 48.5, 46.7 and 47.9 for the years 2005-2007 respectively[43]. The figures on contraceptive use for these calculations came from annual reports of the National Reproductive Health Program, and were calculated over a period of one year (rather than there being an indication of contraceptive use at a given point in time). As such, they appear to have been over-estimated, and less accurate than those obtained through the DHS.

Current use of modern methods of contraception amongst all women (not only married women) in Samoa in 2009 (at 17.8%) is considerably less than that identified within a 1998 Reproductive Health Knowledge and Services Survey (23.0%). This reduced figure is observed across all age groups, and provides an important picture of the extent to which reproductive health and family planning services are not meeting the contraceptive needs of the population[44].

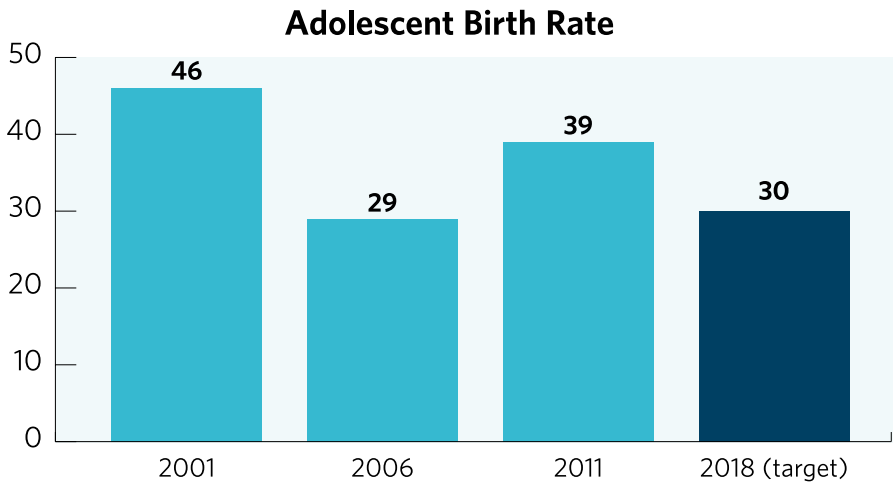
42 Data sourced from Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.
43 Taylor, V, 2008; *Reproductive health commodity security status assessment report*; Suva, UNFPA Office for the Pacific (sic).
44 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.

1.5.3: Adolescent birth rate.

In 2009, 9.0% of teenagers (aged 15-19 years) in Samoa had commenced child bearing. Pregnancies during adolescence have been demonstrated to pose a higher risk than those amongst older mothers, with teenagers being more likely to experience complications during labour, and resultant higher morbidity and mortality for themselves and their children. Socially, there is a significant, potential adverse impact on pregnant adolescent women through stigma from within communities and families, and commonly, disruption or conclusion of the mother's attainment of higher education[45].

The adolescent birth (or fertility) rate is a measure of the annual number of live births to adolescent women per 1,000 adolescent women. The 2018 Health Sector Plan target is 30, and in 2011, the national census recorded an adolescent birth rate of 39 (down from [46] in 2001)46[47]. Rural teenage women are more likely to experience pregnancy than their urban counterparts, and there is a considerable weighting towards teenage pregnancy within the lower socio-economic strata[48]. The forth-coming report from the 2014 DHS (expected in mid 2015) will be pivotal to demonstrating the health sector's progress in reducing the adolescent birth rate.

Figure 1.5: Adolescent Birth Rate/1,000 live births to adolescent women in Samoa[49].



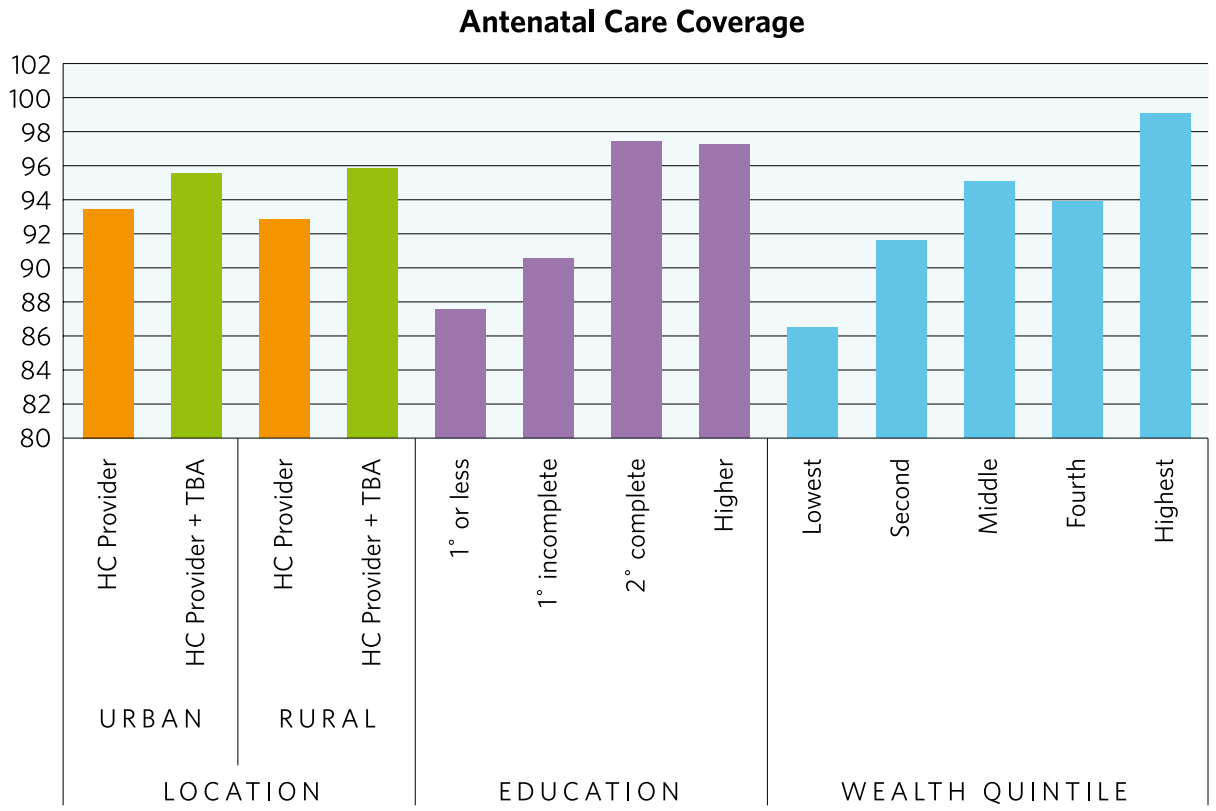
1.5.4: Antenatal care coverage.

The main objectives of antenatal care are to identify and treat problems during pregnancy which threaten the development of the baby and/or the health of the mother, and to identify complications and make preparations for safe birthing. Indeed, there is a strong correlation between a safer, healthier birth and baby, and the timing of a pregnant woman's initial antenatal care visit, and the number of subsequent visits. A further, indirect benefit of antenatal care is to reach a larger cohort of women and their partners with post-birth, child spacing messages and options, and to sensitise them to the health service environment which encourages their return for contraceptives and further family planning information in the future.

45 Ibid.
46 Census Survey Division: Samoa Bureau of Statistics, 2012a op. cit.
47 Ministry of Health, 2013 op. cit.
48 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.
49 Data sourced from Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.

In alignment with MDG Target 5B, the Samoa Health Sector Plan has set a 2018 target of 100.0% of women accessing antenatal care at least once during each pregnancy, and a target of 70.0% accessing antenatal care at least four times during a single pregnancy[50]. The 2009 DHS reports that 92.7% of women who had a live birth in the five years preceding the survey, received during their most recent birth, at least one antenatal care consultation from a doctor, nurse, midwife or nurse aide. If TBAs are considered for provision of antenatal care, the antenatal care coverage rises to 96.2%[51], while the MOH reports a figure of 98.0% coverage of at least one antenatal care visit during the most recent pregnancy in the last five years[52]. Figure 1.6 demonstrates that this increase in antenatal care coverage with TBAs is particularly relevant for women in rural areas, demonstrating a strong case for the formal health system to improve antenatal care coverage through the development of TBAs' capacity to either refer clients to, or provide quality antenatal care services.

Figure 1.6: Antenatal Care Coverage in 2009 for at least one visit to a formal health care provider (and a TBA by urban and rural location) by education level and wealth quintile[53].



There is a notable difference in antenatal care coverage across education levels of the mother (where those who completed secondary school are more likely to access antenatal care than those with limited education), and across socioeconomic status, where those in the highest wealth quintile are more likely to access antenatal care than those in the lowest quintile[54].

50 Ministry of Health, 2013 op. cit.
51 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.
52 Ministry of Health, 2013 op. cit.
53 Data sourced from Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.
54 Ibid.

Younger women are less likely than older women to access antenatal care. However there is a significant reduction in attendance at antenatal care relating to birth order, where antenatal care is accessed for the first or second child, but less so for the sixth or greater child.

WHO recommends that women should receive at least four antenatal care visits during pregnancy. The 2009 DHS demonstrates that 58.4% of women who delivered a live birth in the preceding five years attended antenatal care at least four times during their most recent pregnancy, however no subsequent data has since been reported to identify progress towards the 2018 target of 70.0%[55]. One of the factors which limits the number of times a woman will access antenatal care during a given pregnancy is the timing of her first visit. In Samoa, 72.2% of women do not access antenatal care until the fourth to seventh month of pregnancy, while a further 9.4% first present in their eighth or ninth month. In 2009, only 13.2% of women accessed antenatal care in their first trimester, which is the best opportunity for them to receive the WHO-recommended minimum of at least four visits[56].

1.5.5: Unmet need for family planning.

A significant indicator used to measure performance towards universal access to reproductive health is the extent to which women of child bearing age (who are married or in a union) either do not want, or wish to delay child bearing, and yet are currently not using contraceptives. This is referred to as the unmet need for family planning, and in Samoa in 2009, this was estimated at 45.5%, comprising 26.4% of women with an unmet need to limit childbearing, and 19.1% with an unmet need for birth spacing[57]. This has been cited as the highest unmet need for family planning in the region[58].

There is a considerable increase in the unmet need for family planning with increased age of married women. However there is also a strong indication that the unmet need amongst women aged 15-19 years could be as high as 49.9% (note that due to a limited sample size, this figure needs verification).

There appears to be little variation in the unmet need for family planning between urban and rural dwelling women in Samoa. However there is a higher unmet need (for birth spacing) amongst women with a lower education, than those with tertiary level education (who presumably are able to meet their need for birth spacing). There is inconclusive evidence to suggest that women in the lowest wealth quintiles have a higher unmet need for family planning than those in the higher quintiles.

The 2009 DHS is the only documented indication of Samoa's unmet need for family planning, and it is unclear if there is an articulated national target for this indicator. The 2014 DHS (scheduled for release in mid-2015) will provide an excellent indication of progress towards meeting this unmet need.

55 Ministry of Health, 2013 op. cit.
56 Ibid.
57 Samoa Ministry of Health, Samoa Bureau of Statistics, ICF Macro, 2010 op. cit.
58 UNFPA, 2014 op cit.

1.6: Summary of Reproductive Health Status in Samoa.

The Samoa Ministry of Health has established a solid framework of health policies, strategies and indicators and targets against which to measure the progress of programs and services to meet the nation's SRHR commitments to its citizens. Some work needs to be done to establish more realistic and achievable SRHR-related targets against some indicators, and the means and processes through which to collect and analyse data, and to monitor progress and effectiveness.

Progress towards Samoa achieving its MDG/Health Sector Plan targets for infant and child mortality appear to be on track, however due to the small population size, maternal mortality targets are likely to remain elusive while MMR is used as the measure of effectiveness.

Targets for achieving MDG 5B; *universal access to reproductive health*, reflect mixed success. Significantly more needs to be done to lift CPR and reduce the unmet need for family planning, particularly amongst younger people, which in turn will contribute to a reduced adolescent birth rate. Adequate progress for women attending antenatal care at least once during pregnancy is being made, and this should go some way to promoting future family planning and birth spacing, however the longer-term uptake of family planning will result from a greater number of antenatal care visits during pregnancy, and more should be done to increase the number of women attending antenatal care at least four times during pregnancy.

Table 1.3: Summary of indicators for SRH status in Samoa.

Indicator		2018 Target	Baseline	Interim (year)	Recent (year)
IMR (per 1,000 live births)		10	19.3 (2001)	20.4 (2006)	15.6 (2011)
>5 mortality rate (per 1,000 live births)		12	22.8 (2001)	24.7 (2006)	19.4 (2011)
MMR (per 100,000 live births)		23*	46 (2006)		50 (2012)
TFR (total/urban/rural)		4.0	4.4 (2001)	4.2 (2006)	4.7 / 4.0 / 4.9 (2011)
CPR (%)		70-80		28.7 (2009)	
Adolescent birth rate (per 1,000 live births) (total/urban/rural)		30	46 (2001)	29 (2006)	39 / 30 / 42 (2011)
Skilled attendants at birth (%)	Doctors, midwives, nurses	95.0		81.0 (2009)	
	With TBAs	100.0		97.0 (2009)	
Antenatal care coverage (%)	≥ 1 visit	100.0		92.7 (2009)	98.0 (2012)
	≥ 4 visits	70.0		58.4 (2009)	
Unmet need for family planning (%)				45.5 (2009)	

Source:
Ministry of Health, 2013; Mid-term review of the Health Sector Plan: 2008 – 2018; Apia, Samoa Ministry of Health.
UNFPA, 2014; Population and Development Profiles: Pacific Island Countries; Suva, Fiji; UNFPA Pacific Sub-Regional Office.
** Note: the target MMR presented in the Health Sector Plan is incorrectly labelled as maternal mortality rate, not ratio*

2 PURPOSE AND METHODOLOGY

2.1: Purpose

The purpose of this SRHR Needs Assessment was to review progress on Samoa's ICPD and MDG commitments to achieving universal access to reproductive health (MDG Target 5B), with particular focus on ensuring Samoan citizens' SRHR are prioritised and maintained through all aspects of service planning and delivery.

Areas of focus included access to family planning information and services, and to a range of appropriate commodities to meet the needs of all groups within communities. The Needs Assessment also explored the extent to which HIV prevention, counselling and management services are integrated with wider reproductive health services, and the availability and composition of services and processes within the formal health system for preventing and responding to gender-based physical and sexual violence.

The consultative review and needs analysis sought to identify the extent to which SRHR are prioritised within the delivery of reproductive health, family planning and more general primary health care services, and to document gaps in SRHR service delivery (by location and intervention type) with a view to informing the consultative review and development of a revised National Sexual and Reproductive Health Policy scheduled for 2016.

2.2 Desk review

A comprehensive desk review of the reproductive health and family planning environment in Samoa was conducted by a technical consultant to ascertain the current status of program implementation, and to measure progress against national SRHR and service delivery commitments, articulated within ICPD, the *Strategy for the Development of Samoa 2012-2016*, the *Health Sector Plan 2008-2018* and the *National Sexual and Reproductive Health Policy 2012-2016.*

This desk review explored available data from demographic and household surveys and the national health information system on reproductive health status, service provision and utilisation, fertility, awareness and utilisation of family planning services, barriers to accessing services, preferences for reproductive health commodities and the extent to which services are meeting the population's reproductive health needs.

National census and household demographic and health survey data for the past 10 years were reviewed and analysed to identify reproductive health and family planning trends. Findings were collated against existing reports and data form a range of sources, including the Ministry of Health and regional technical reports and reviews, so as to verify individual data sets and to limit sampling bias where only a small number of reliable data sources were available.

Gender equity and equality, and the prevalence of gender-based physical and sexual violence in the country were also explored as a basis for determining whether available health services and interventions are of sufficient scale to facilitate the rights of Samoa's women.

For a comprehensive list of resources used to complete the desk review, see *Appendix 1: References.*

2.3 Consultative Needs Assessment

The consultative needs assessment was conducted by the technical consultant, with support from the Principal, National SRH Section of the Health Sector Coordination, Resourcing and Monitoring Division of the Ministry of Health, over one week in March 2015, and included a visit and assessment of 10/11 government health facilities in the country, and key informant interviews with non-government providers/facilitators of reproductive health services.

Tools development and provincial consultation: UNFPA-PSRO provided the templates and tools to facilitate data collection for the SRHR Needs Assessment. The *Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV* (see Appendix 2) guided exploration of the national policy and legislative environment, health system structure and function and service delivery as it relates to SRHR (inclusive of family planning commodities and information, treatment and management of STIs, response and management of gender-based violence, HIV prevention and response services and the extent to which the latter are integrated with more general SRH services).

The consultative review of service availability at each government facility was designed to identify SRHR and service gaps, and where indicated, discussion sought to establish the reasons for these gaps. This was complemented through engagement with other, non-government service providers/facilitators during subsequent key informant interviews.

Key informant interviews: Key informant interviews with service and program managers/implementers within the Ministry of Health and National Health Service were conducted, and likewise with representatives from non-government organisations such as SFHA, Samoa Fa'afafine Association (SFA), and the Samoa National Youth Council (SNYC). A number of United Nations agencies (namely UNFPA, UNICEF and UNESCO/UNAIDS) were also consulted, as were representatives of the MWCSD's Divisions for Women and Youth and the Ministry of Police and Prisons. These discussions were used to explore, clarify and verify issues identified during the health facility site visits, and to finalise a comprehensive picture of SRH service provision and SRHR promotion in the country.

For a full list of consultation participants and key informants, see *Appendix 3: List of Participants and Key Informants.*

2.4: Analysis and Limitations

Section 3 of this report provides the summary and analysis of data collected through the consultative needs assessment. Information is presented in the order established by UNFPA-PSRO, within the *Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV* (see Appendix 2). Data, discussion and summary tables are presented in the following subsections:

- ***Policy:*** HIV and STI strategies and policies; gaps and factors which prevent or enable service integration; clinical protocols and service guidelines; stakeholder participation; legislative and legal frameworks which enable/inhibit service development/delivery.
- ***System:*** Development partners, funding and coordination mechanisms; civil society and stakeholder engagement; planning and management of programs; human resourcing; capacity development processes and needs; reproductive health commodities; laboratory and program support services; data management, monitoring and reporting.
- ***Service Delivery:*** availability of essential SRH and HIV services; current status of service integration; prevention and management of abortion; response to gender-based violence and sexual assault; peer education and outreach services; condom programming.

Limitations: Although there are numerous, internationally-tested resources and guidelines available to assist national reproductive health programs to conduct effective, comprehensive SRH needs assessments[59], many of these require a long-term commitment of dedicated survey managers and field assessment teams. For the Samoa SRHR Needs Assessment, there was limited time available during which to conduct the activity as a result of a combination of factors, and only a single, dedicated personnel resource.

Despite this, it was still possible to complete site visits to almost all formal health facilities in the country, and to conduct a comprehensive round of consultation with key informants. The technical consultant's knowledge and experience of the SRHR environment assisted the flow of consultations by enabling rapid verification of updated information.

In terms of assessing SRHR, a further limitation of this assessment is that it sources data from service providers and facilities only, and neglects to consult with service users and other key target groups to ascertain if and how their SRHR are being met or neglected. Insufficient time and resources limited the opportunity to consult widely during this activity, however consultation for the forth-coming revision of the National Sexual and Reproductive Health Policy in 2016 should seek to engage with such informants to ensure the revised policy adequately reflects SRHR.

Recommendation: Consultation for the forth-coming revision of the National Reproductive Health Policy should seek to engage with service users and other key target groups to ascertain if and how their SRHR are being met or neglected to ensure the revised policy adequately reflects SRHR.

59 UNFPA, 2010; *A Guide to Tools for Assessments in SRH*; www.unfpa.org/webdav/.../publications/2010/srh_guide/index.html; accessed 18th November 2014.

Information collected during the desk review, provincial consultations and key informant interviews has informed the findings of this needs assessment. In accordance with the articulated tools and report format provided by UNFPA-PSRO, the findings are presented in terms of their relevance to reproductive health and family planning programs and services, particularly in relation to SRHR as articulated within Government of Samoa and MOH policies and strategies.

Identified within the findings are a number of service gaps and the barriers/challenges which impact on effective delivery of comprehensive, rights-based reproductive health and family planning services in Samoa, and where appropriate, recommendations have been made to address these.

3 FINDINGS

3.1 Policy

The prioritisation of SRH within the *Samoa Health Sector Plan 2008-2018* has been described in significant detail earlier in this report (see *1.2: Sexual and Reproductive Health and Rights*), and the link between the indicators within the of the Health Sector Plan's *Work Programme and Strategies 2008-2018*, and the SRHR priorities and outcomes of the *National Sexual and Reproductive Health Policy 2011-2016* has been clearly demonstrated.

The *National Sexual and Reproductive Health Policy 2011-2016*[60] provides direction and guidance to all agencies engaged in the delivery or promotion of SRH services and information in Samoa. It sets out a number of Key Strategic Areas for promoting SRHR, and identifies the following strategies, approaches and priorities for working towards its vision of *'ensuring a safe sexual and reproductive health environment for all Samoans'*:

- Promotion and delivery of quality family planning services.
- Prevention and management of STIs, including HIV.
- Improved delivery and access to SRH services for adolescents, including prevention of the rising prevalence of adolescent pregnancy.
- Working through cross-sectoral partnerships (inclusive of non-government organisations and the private sector).
- Increasing awareness and demand for SRH services through education and promotional activities.
- Procurement and maintenance of reproductive health commodities supplies.

As the Policy's period of implementation draws to a close, a final review will be conducted to determine the Ministry of Health's progress in meeting its SRHR targets, and to identify implementation bottlenecks to be considered in the development of a revised Policy. This detailed, consultative needs assessment of SRHR will be the first step in this policy review process.

Recommendation: Revision of a comprehensive, evidence-based *National Sexual and Reproductive Health Policy 2017-2021* informed through quantitative data analysis and wide consultation with government and non-government program managers, service providers and users, partner agencies and community stakeholders.

Recommendation: Revised Policy to include a detailed, evidence-informed strategy with measurable outcomes linked to monitoring and evaluation plans and indicators, informed through stakeholder consultation.

60 Government of Samoa, 2011a op cit.

Of the two documents, the *National Sexual and Reproductive Health Policy 2011-2016* takes the lead over the *National HIV and AIDS Policy 2011-2016*[61] in terms of integration of SRH with HIV programming. The former does so through identifying 'prevention and management of STIs, including HIV' as an SRHR priority, however there is no specific mention of HIV treatment, care and support which is covered within the *National HIV and AIDS Policy* (the Government of Samoa avoids duplication across national policies by referencing related policies for specific issues). The *National HIV and AIDS Policy* makes reference to the predominant mode of HIV transmission in Samoa being sexual, but does not articulate integrated programming with SRH as such.

There is no National Strategic Plan for HIV and STIs in Samoa, although the *National HIV and AIDS Policy 2011-2016*[62] does present a costed HIV/AIDS Plan of Action 2010, which focuses on governance and service delivery. A number of key areas are presented, namely: rights of persons living with HIV/AIDS; prevention of HIV sexual transmission; HIV testing; care for people living with HIV/AIDS; research; sectoral roles and financing.

The delivery of family planning services within the country is guided by the rights-based principles outlined within the *National Sexual and Reproductive Health Policy 2011-2016*[63], which aim to empower individuals and couples to choose the number, spacing and timing of their children through services and information delivered without judgement or coercion, and integrated with wider SRH and STI/HIV programming. All registered nurses and midwives in Samoa are trained in the principles and strategic objectives of all Ministry of Health policies related to the delivery of health care, and this information is further enhanced for National Health Service nursing personnel who are provided with *Guidelines for Nursing and Midwifery Services*[64]. These feature a clinically-focused section on family planning outlining the types, purpose and side effects of various contraceptive methods and commodities, as well as clinical algorithms with which to guide consultations.

While Samoa's Constitution and associated legislative and legal frameworks prioritise the upholding of individuals' human rights, there is ambiguity within the law regarding the rights of some individuals and groups who are particularly vulnerable to HIV and STIs. Drug use is illegal in all its forms, and injecting drug use is not widely practiced in the country.

During a recent legislative review, advocacy groups representing men who have sex with men, particularly *fa'afafine* (such as SFA) campaigned strongly to have the charges of sodomy and indecent assault removed from the legislature. These items were eventually left within the legislature in favour of a third charge being removed, that of female impersonation, which stakeholders pragmatically agreed was more specific to their needs, especially given that few law enforcers had charged *fa'afafine* with sodomy or indecent assault in the last ten years[65]. While acceptable to some groups at this time, the presence of these charges within the law could, at a later date, infringe on the rights of some groups in Samoa, and possibly limit their willingness to present to SRH services.

61 Government of Samoa, 2011b; *National HIV and AIDS Policy 2011-2016*; Apia; Ministry of Health.
62 Government of Samoa, 2011b op cit.
63 Government of Samoa, 2011a op cit.
64 Nursing and Midwifery Division, 2014; *Guidelines for Nursing and Midwifery Services; Apia*, National Health Service Board of Management.
65 Personal communication, Vaialia Iosua, Principal Community Development Officer MWCSD Division for Women and Secretary, Samoa Fa'afafine Association; 12th March 2015.

Recommendation: The Office of the Ombudsman, as the National Human Rights Institution of Samoa, to advocate for, and lead consultative revision of the law to remove any provisions which infringe on the SRHR of individuals and groups.

Table 3.1: Summary of SRHR Needs Assessment Findings for Section A: Policy.

Summary Table for Policy Environment	Yes/No ✓/✗	Details
1. Is there a national HIV strategy/policy	✓	
2. What is the title of strategy and timeframe		National HIV and AIDS Policy 2011-2016
3. Is there a national SRH strategy/policy?	✓	National Sexual and Reproductive Health Policy 2011-2016
4. Does the country also have an evidence based National Health Sector policy that Incorporates RH and HIV?	✓	Identifies as priorities: reproductive and maternal health, and emerging and re-emerging infectious diseases (implicit in this is STIs and HIV, given specific, detailed reference in Annex 1: Health Sector Analysis).
5. What is the title of strategy and timeframe		Health Sector Plan 2008 – 2018
6. Are there any direct policy relevance to linkages between SRH and HIV in the country?	✓	National Sexual and Reproductive Health Policy 2011-2016: strongly links STI and HIV detection, management and data recording to the reproductive health program. National HIV and AIDS Policy 2011-2016: advocates for combining HIV programming with STI prevention and management and working through antenatal care.
7. Does SRH policy include HIV prevention, treatment, care and support issues? (eg: VCCT, BCC on HIV-SRH)	✓	HIV prevention in antenatal care. Testing of STIs (HIV implicit in this).
8. Has SRH policy been made a priority in term of – Funding, legislation, or health sector strategy	✓	Reproductive health identified as a priority within Health Sector Plan 2008-2018, and STI (and HIV implicitly) prevention, detection and management presented as a strategic indicator.

9. - Does the country have a protocol for family planning services in place? - Which stakeholders are responsible for carrying out the protocol? List. - Are the procedures in line with human rights standards? - Are the procedures for delivering FP services free from discrimination, coercion and violence?	✓	Guidelines for Nursing and Midwifery Services 2014. Family planning provided by registered nurses and midwives. Clinical guidelines not explicit regarding rights and lack of coercion.
10. List any service protocols, policy guidelines, manuals, etc, that are specifically geared towards increasing SRH and HIV link		Health Sector Plan 2008-2018. National Sexual and Reproductive Health Policy 2011-2016. SRH and STI/HIV Sections of the Ministry of Health work together for data collection and M&E.
11. Is there a participatory platform that advocate for increased investments in marginalized adolescents and youth, within development and health policies and programmes? Y/N .If so, describe.	✗	There is no such platform, however the Key Stakeholders Meeting, held 1-2 times/year could provide this forum.
12. Determine whether there is a legislative framework to supports (or does not support) the implementation of SRH and HIV linkages.	✓	National SRH and HIV/AIDS Policies provide this legislative framework.
13. What are the laws affecting key groups (SWs, IDUs, MSM, other) and what is their impact?		Drug use of any kind is illegal and prosecutable, as is sex work. Laws against sodomy and indecent assault could impact on some key vulnerable groups, however key informants report little harassment from law enforcement.
14. What are the main of funding source for SRH and HIV. If possible, give a break down		Two-year funding (2014-15): - UNFPA (for SRH services): USD 220,000. - UNFPA (for youth-targeted SRH): USD 230,000. - UNFPA (for SRH data and policy): USD 205,000. - WHO (for STIs – chlamydia): USD 23,000 (WST 56,000). - GFATM (for HIV): USD 45,000 (WST 109,485).
15. Are there specific cases of donors putting restrictions on HIV programmes regarding SRH components or vice versa	✗	

16. Within the budgets for specific SRH services, what is the proportion allocated to HIV prevention and care?	✗	No allocation under SRH services, however the national STI/HIV section coordinates prevention and care through the GFATM grant.

3.2 System

Development partners: A number of development partners support the SRHR sector in Samoa, through a variety of funding mechanisms and technical assistance interventions. The Government of Samoa, through the Ministry of Health, leads policy development and oversight, and meets the costs of clinical and programmatic staffing, and some monitoring activities.

Multi-lateral agencies provide a mix of financial revenue and technical assistance to programming, protocol and policy development, data analysis and training. UNFPA is the main agency supporting SRH programming, through funding for the National SRH Program and the MWCSD's youth-focused SRH awareness and STI/HIV prevention activities. WHO funds a program to initiate presumptive treatment for chlamydia, and GFATM is the main donor supporting HIV programming. Technical assistance to integrated SRH and HIV programing is also provided by UNFPA, WHO and SPC, while UNAIDS delivers technical assistance to the development of HIV programming and monitoring systems and global AIDS reporting.

Coordinating mechanisms: While not specifically working on linkages between SRH and HIV programming, there are a number of multi-stakeholder coordinating mechanisms which exist to guide planning and monitoring of SRH and HIV programs respectively.

The Key Stakeholders Meeting is held twice annually (previously the intention had been that it would be held quarterly) to facilitate monitoring of output progress of the National SRH Program, and to inform the National SRH Section of how it might support stakeholders in their activities. It has been recognised that this forum could facilitate improved, integrated program planning across agencies, to reduce duplication and ensure planned activities are in accordance with agencies' capacity. Membership of this group includes:

- National SRH Section (Ministry of Health).
- Community nursing section, National Health Service.
- MWCSD Division for Youth.
- SFHA.
- SRCS.
- SFA.
- Samoa AIDS Foundation (not currently active).
- Religious Youth Directors (various churches).
- Ministry of Education, Sports & Culture (MESC).
- Samoa Victim Support Group (SVSG).

Recommendation: The Key Stakeholders Meeting to be formalised for twice-yearly meetings, and structured to facilitate multi-agency, coordinated planning to avoid duplication and to reflect agencies' capacity to deliver.

The National AIDS Coordinating Committee (NACC) is emerging from a one-year hiatus, and will meet quarterly to monitor and coordinate the national response to HIV. This multi-sectoral steering committee is chaired by the Ministry of Health, which also provides secretariat support. NACC comprises:

- Director General/Chief Executive Officer, Ministry of Health (Chair).
- Chief Executive Officer, MWCSD.
- Chief Executive Officer, Ministry of Finance.
- Chief Executive Officer, Ministry of Education, Sport and Culture.
- Attorney General's Office – Attorney General.
- Commissioner, Ministry of Police and Prisons.
- Secretary, Samoa National Council of Churches.
- Executive Director, SFHA.
- Secretary General, SRCS.
- Representative, People living with HIV (PLHIV).
- Assistant Chief Executive Officer, Health Promotion and Enforcement Division (HPED), Ministry of Health (Secretariat).

Civil Society engagement: A number of civil society organisations contribute to SRH programming in the country, be it through advocacy, planning, implementation and monitoring. SRCS advocates for PLHIV, and conducts youth peer education for awareness and prevention of STIs (including HIV) amongst church groups and communities through a drama performed by Red Cross Volunteers. These activities focus on awareness and prevention of STIs and HIV, but also messages designed to reduce stigma and discrimination associated with HIV and AIDS.

SRCS supports PLHIV through retreats and assistance for accessing antiretroviral therapy (monthly), and CD4 cell counts (quarterly). Workshops are held annually for the support group. SRCS leads a large, community activity (Candle in the Water) on World AIDS Day[66].

SFHA is a Member Organisation of the International Planned Parenthood Federation (IPPF). Their SRH services are delivered from the clinic in Apia, and from outreach visits to communities on Upolu (and soon to commence on Savai'i). These services include:

- Antenatal care.
- Family planning counselling and services, including the distribution/administering of a range of contraceptives.
- STI/HIV prevention.
- Awareness and community mobilisation to promote SRH services. These include a range of interventions targeting women, communities generally, men and boys, and young people.

66 Personal communication, Ms Goretti Wulf, First Aid Business Officer and Ms Peati Maiava, HIV Officer, SRCS; 11th March 2014.

In addition to service delivery, SFHA is a strong advocate for SRH awareness and knowledge, and has campaigned to improve the delivery of SRH-information within the formal school curriculum[67].

Samoa Faafaine Association (SFA) is predominantly an advocacy organisation, campaigning to promote rights and equality for *fa'afafine* (the most recognisable group of men who have sex with men in Samoa, although not all *fa'afafine* identify with this practice). It does this through a number of annual events, including Fa'afafine Forums on Upolu and Savai'i, which bring together approximately 100 participants to promote information on health, HIV and STI prevention; information on human rights; and vocational training.

SFA campaigned strongly to improve the legal environment for *fa'afafine* in recent years, but was unable to have the crimes of sodomy and indecent assault removed from the law[68].

Planning, Management and Administration: As discussed in the previous section, youth-focused STI and HIV prevention interventions are delivered by civil society organisations such as SFHA, SRCS and to a certain extent, SFA. SFHA's and SRCS' activities are funded through the MWCSD Division for Youth through its UNFPA grant, and SFA has been supported by the Ministry of Health through its GFATM funding.

The MWCSD Division for Youth also conducts a number of its own, youth-focused STI and HIV prevention activities, including:

- Young Couples programs (two per year; one each on Upolu and Savai'i).
- Father/Sons programs (two per year on Savai'i).
- Teen Mothers programs (actually run by the Division for Women, but with support from the Division for Youth).
- Mother/Daughters programs (also run by the Division for Women, but with support from the Division for Youth)[69].

Youth-focused SRH services (including prevention and management of STIs and HIV) is a key strategic area of the *National Sexual and Reproductive Health Policy 2011-2016*, and the National SRH Section has invested heavily in the establishment of youth friendly services in all government clinics through grants from GFATM and UNFPA. The intervention included training for health facility staff in the development and delivery of Youth Friendly Services through which to promote young people's accessing health services, including (but not exclusively) SRH services. Training took place in 2010 and implementation was rolled out during 2011 and 2012[70].

Despite the large scale of equipment and resourcing that went into this initiative, there have been some challenges in providing appropriate data for the number, gender and age of young people accessing the services, and during visits to health facilities as part of this SRHR Needs Assessment, none had maintained a designated place for meeting and engaging with young people; most of the audio-visual equipment provided by the project was being used in the general patient waiting area of the antenatal care clinic.

67 Personal communication, Li'ai Si'itia, Executive Director, SFHA; 9th March 2015.
68 Personal communication, Vaialia Iosua, Principal Community Development Officer MWCSD Division for Women and Secretary, Samoa Fa'afafine Association; 12th March 2015.
69 Personal communication, Ana Leau Vaasa, Senior Youth Officer and Florence Samuelu, Youth Development Officer, MWCSD Division for Youth; 9th March 2015.
70 Personal communication, Maria Ah Dar, Adolescent Health and Development (AHD) Coordinator, National SRH Section, Ministry of Health; 11th March 2014.

In accordance with the *National Sexual and Reproductive Health Policy 2011-2016*, SRH services are to include prevention and management of STIs, including HIV. Integrated, joint planning for SRH and STI/HIV is facilitated by both the National SRH and STI/HIV Sections sitting within the Health Sector Coordination, Resourcing and Monitoring Division of the Ministry of Health. Together these Sections make joint, quarterly monitoring visits to service delivery points.

A number of civil society organisations are delivering gender programs targeting men and boys, particularly in relation to violence against women. The MWCSD Division for Youth supports the Men Against Violence Advocacy Group (MAVAG), comprising male village representatives with a passion for preventing community and domestic violence, to raise awareness of, and advocate against gender-based violence through Father/Sons and Young Couples programs[71].

Samoa Victims Support Group (SVSG) has been providing care and support to victims of crime in Samoa for over 10 years. It is a strong advocate for prevention of gender-based violence in the country.

While there is not a policy in Samoa which specifically addresses gender-based violence, the *National Policy for Women of Samoa 2010-2015* presents outcomes related to reducing violence against women and improving the health of women and girls[72]. The *Crimes Act 2013* criminalises various forms of sexual violence (including rape), and the *Family Safety Act 2013* provides protection for families and the handling of domestic violence and related matters within the law, and together these policies and legislation work to protect women, girls and other vulnerable individuals from domestic violence and abuse[73].

Human Resources and Capacity Development: Structured refresher training for nursing and medical personnel in the delivery of rights-based SRH services, particularly in regards to delivery of youth-friendly services is certainly needed in Samoa where 57.1% of Samoa's population are under the age of 25[74].

Formal training of nurses (who are the predominant providers of SRH services in Samoa) is delivered by the Faculty of Applied Science at the National University of Samoa, through:

- A Diploma of Nursing: a two year course which trains Enrolled Nurses.
- A Bachelor of Nursing: a three year course which trains Registered Nurses – this is essentially the Diploma, with an additional year for specialisation in particular fields of nursing care[75].

The courses are taught through a comprehensive approach to address the entire Scope of Practice for nurses. This includes a course on SRH, which itself incorporates nine hours of applied clinical practice. Another related course on 'child bearing' incorporates antenatal care and family planning practice and delivery, which introduces contraceptives, emergency contraceptives and the insertion of IUCDs (which is still taught, although rarely used). A unit on 'Concepts of Nursing' compliments these practical courses, giving a community-focused, social aspect to the delivery of these clinical services, with the aim to sensitise students to the issues they will face from religious and cultural values.

71 Personal communication, Ana Leau Vaasa, Senior Youth Officer and Florence Samuelu, Youth Development Officer, MWCSD Division for Youth; 9th March 2015.
72 Government of Samoa, 2010; National Policy for Women of Samoa 2010-2015; Apia, Ministry of Women, Community and Social Development.
73 Pacific Islands Law Officers' Network (PILON), 2015 op cit.
74 Census Survey Division: Samoa Bureau of Statistics, 2012 op. cit.
75 Personal Communication, Ms Eseta Hope, Dean, Faculty of Applied Science, National University of Samoa; 14th March 2014.

Beyond this basic nursing training, Registered Nurses can undertake Post-Graduate Diplomas in:

- Midwifery.
- Mental health (which includes an applied SRH component).
- Intensive Care.
- Primary Health Care (this is usually sponsored by WHO).

Post graduate nurses are required to attend clinical refresher training each month (equating to approximately nine training activities/year), either in Apia (for nurses on Upolu), or in the clinics on Savai'i[76]. Refresher training is scheduled to cover various topics, including SRH, however while delivered by senior nurses, the training is not structured, and therefore the quality is subject to the awareness or commitment of the presenter. In the case of rights-based, youth-friendly SRH services, a structured training module which highlights and promotes understanding of rights-based approaches to care would be beneficial to improved engagement of nurses with young people.

Recommendation: The National SRH Section to work with the Nursing and Midwifery Division of the National Health Service to develop a refresher training module on SRH and family planning, with emphasis on rights-based, and youth-friendly delivery of services, which can be delivered by nurse managers on at least an annual basis.

UNFPA also supports two-four nurses each year (up until 2013) to attend the four-month regional Reproductive Health Training Program at the Fiji National University.

Reproductive Health Commodities Security: A detailed review was undertaken in 2014[77] in which it was determined that there are suitable national reproductive health commodities procurement systems in place, but that supply to health facilities is sometimes hampered by inefficient protocols for ordering supplies from the Central Medical Store. In order to respond to this, the Central Medical Store took advantage of improved transport infrastructure and weekly doctors' visits to rural facilities and now undertakes weekly stocktakes on behalf of the rural facilities, replacing stock as required and removing expired or near-expired stock.

Nurses report this system is more or less effective, with requests for additional stock needing to be made only rarely.

Despite the success of the approach in contributing to Reproductive Health Commodity Security, it appears that the rationale behind the revised stock management system is not in line with a rights-based approach to SRH. It was reported by a National Health Service Pharmacy Manager that the approach was specifically designed to prevent 'abuse' by rural health nurses who, it was reported, were dispensing prescription-only medication. In fact, this had been the case for years in Samoa as there was previously not enough doctors to visit rural facilities, and had been managed through remote engagement with doctors and senior nurse managers. While the specifics of such 'abuse' were not provided, it appears that the emergency contraceptive pill and levonorgestrel-releasing implants (Jadelle) are considered items that would be 'abused' by nurses if available in rural facilities, and therefore these items

76 Personal communication, Laga'au Savea, Senior Nurse Specialist, MTII Hospital; 12th March 2015.
77 Hagarty, C, 2014; Family Planning and Reproductive Health Commodity Security Needs Assessment, Samoa (DRAFT); Apia, UNFPA PSRO.

are only available in the TTM National Referral Hospital Pharmacy, and only with a doctor's prescription.
This attitude appeared to be the catalyst to another impediment to Samoa's ICPD commitment to universal access to family planning and SRHR during the period of the Needs Assessment (see text box above).

Such attitudes and prejudices towards nursing personnel from Pharmacy Managers serve to simply deny many people in rural communities their SRHR, and is certainly not in accordance with the rights-based *National Sexual and Reproductive Health Policy 2011-2016* or the *Health Sector Plan 2008-2018*.

Recommendation: The oral contraceptive pill and Jadelle should be made available at all health facilities and nursing staff trained in their use. IUCD should be re-introduced and promoted, and nurses trained in its insertion and removal.

Recommendation: All clinical and ancillary service managers and staff to be trained in the specifics of SRHR, in particular the need to promote access to contraceptives and to create an enabling environment for Samoans to access SRH services and family planning commodities.

Recommendation: The National Health Service Chief Pharmacist must clarify her directive regarding payment for family planning commodities immediately to ensure individuals and couples have access to family planning whenever they require it, and to avoid further, involuntary defaulting of contraceptive use.

Laboratory Services: There are two medical laboratories in the country; one at MTII Hospital on Savai'i, and the main laboratory located at the TTM National Referral Hospital in Apia. Only the latter has the capacity to conduct CD4 counts and viral load testing for PLHIV, however this appears satisfactory given that all known cases reside on Upolu,

A dangerous impediment to Family Planning: In March 2015, nurses on Savai'i had received a directive from the National Health Service Chief Pharmacist that in order to cover the cost of dispensing and transporting family planning commodities, these must now be dispensed by the Pharmacy only, and only with a prescription from a doctor (at a cost of WST5 and WST10 = WST15 to the client, where they had otherwise been provided free-of-charge through the antenatal clinic).

In response to the written directive, the Pharmacy refused to provide the antenatal clinic with any further stocks of contraceptives, and many had run out of Mircogynon. Nurses had informed clients that they would have to wait to see a doctor to get a prescription, and then wait at the pharmacy window, and would have to pay at both stages. The midwives and reproductive health nurses were very concerned for their clients, believing they would not follow through with the process, and would simply default on their contraceptive.

When the issue was raised with a senior Pharmacist at the National Health Service, there seemed to be little recognition that the commodities had ever been provided free of charge from antenatal care clinics, and that the directive was for medicines dispensed via a doctor's prescription at the pharmacy window only. When the regular practice was explained, the Pharmacist suggested that there should be no change, and that the Savai'i Pharmacy should be providing the regular stock supplies to the antenatal care clinics. She conceded that perhaps there has been a miscommunication, however the directive had not been clarified by the time the consultant completed the Needs Assessment mission to Samoa.

and there are resources available to bring PLHIV in from Savai'i for their tests should cases be detected there in future.
There are 11 Voluntary Confidential Counselling and Testing (VCCT) sites for HIV (and STIs more generally), and two of these are accredited within the regional standard. In practice, however, STIs are generally diagnosed syndromically, especially on Savai'i, where it was said that a shortage of reagent prevented their being able to send specimens to the laboratory in MTII Hospital, Tuasivi.

Monitoring and Evaluation (M&E): M&E for the National SRH and STI/HIV Programs is facilitated through a combination of patient usage data from the Community Health Nursing Information System (CHNIS), and quarterly (or at least 4-monthly) integrated monitoring visits with the HIV/STI and SRH Programs to all health facilities.

The latter seeks to capture age/gender disaggregated data relating to: laboratory and clinical diagnosis and treatment of STIs; attendance and services at antenatal care clinics; attendance and services provided through youth friendly services. Stocktake data for reproductive health commodities is also recorded during these visits.

Ongoing client registration data relating to SRH is captured using the CHNIS, however this computer-based system was damaged in 2007, and has since been paper-based, with head nurses of health facilities manually collating all information on a monthly basis, submitting this to the Principal Nurse, Upolu and Savai'i, who in turn manually collate and analyse data before submission to the Manager of Nursing and Midwifery in Apia. Data gathered through the CHNIS should provide a breakdown of acceptors, re-acceptors and defaulters of family planning, however it is unclear if this information is presented in the current, paper-based collation and analysis.

Recommendation: The National Health Service to repair and re-establish a computer-based CHNIS which allows more detailed and timely analysis of integrated SRH and STI/HIV service data to inform program effectiveness.

Table 3.2: Summary of SRHR Needs Assessment Findings for Section B: System.

Summary Table for System Support	Yes/No ✓/✗	Details
1. Who are the major development partners for SRH?		Ministry of Health (Government of Samoa), UNFPA, WHO, SPC
2. Who are the major development partners for HIV?		Ministry of Health (Government of Samoa), GFATM, UNAIDS, UNFPA
3. If any, who are the major champions supporting (policy, financial and/or technical) SRH and HIV linkages?		Ministry of Health, UNFPA, SPC.
4. Is there any multi-sectoral technical group working on linkages issues?	Unknown	The Key Stakeholders Meeting which is brought together by the National SRH Section, and the NACC are multi-sectoral groups informing and steering the national SRH and HIV responses respectively, but they do not specifically focus on linkages of the two.
5. What is the role of civil society in SRH programming e.g. Advocacy, planning, implementation, and monitoring		A number of civil society organisations contribute to SRH programming in the country: SRCS advocates for PLHIV, and conducts youth peer education for awareness and prevention of STIs (including HIV). SFHA is an SRH service provider, an advocate for policy and programming, and a promoter of SRH awareness, services and STI prevention. SFA conducts peer education for its members, and advocates for policy and legislative changes in the interests of *fa'afafine*.
6. Are the following elements of civil society involved in the SRH and/or HIV responses? PLHIV, Young people, key populations,	✓	SRCS advocates for, and supports PLHIV, and conducts youth peer education for awareness and prevention of STIs (including HIV). SFHA works with young people to promote SRH awareness, services and STI prevention. SFA engages with *fa'afafine* for awareness and prevention of HIV and STIs.

7.	What programmes (national/ donor funded) are in place to prevent STI's and HIV among young people? List.		National HIV/STI and Reproductive Health Programs within the Ministry of Health (donors as above). Youth-focused HIV and STI prevention program through the MWCSD Division for Youth (UNFPA). Youth drop-in centres through SFHA and the MWCSD Division for Youth (NZ-MFAT).
8.	Is there a joint planning of HIV and SRH programmes?		Key Stakeholders Meeting held twice annually monitor Reproductive Health Program, and potentially to conduct coordinated planning.
9.	To what extent have SRH services integrated HIV and have HIV services integrated SRH		Joint planning and M&E between national STI/HIV and SRH programs. STI (including HIV) prevention and management and antenatal care integrated.
10.	Are three any CSOs supporting the institutionalization of programmes to engage men and boys on gender equality (including GBV), SRH and RR? If so describe status and list CSOs.		The MWCSD Division for Youth supports MAVAG to raise awareness of, and advocate against GBV for its Father/Sons and Young Couples programs. SVSG is a CSO providing care and support to victims of crime, and conducts advocacy against GBV.
11.	What institutions are providing integrated services for HIV and SRH? (eg. government facilities? NGOs, FBO, private sector.)		National Health Service, within the TTM National Referral Hospital. SFHA, in terms of prevention of HIV (not treatment, care and support).
12.	Is there a policy on GBV or VAW? Is the health sector referred to in national Domestic Violence legislation?	✓	*National Policy for Women of Samoa 2010-2015* presents outcomes related to reducing violence against women and improving the health of women and girls. *Crimes Act 2013* criminalises various forms of sexual violence (including rape). *Family Safety Act 2013* provides protection for families and the handling of domestic violence and related matters within the law.
13.	What are the highest priority training needs in the health sector, i.e. who needs to be trained on what subjects or skills?		Pre-service and refresher training for registered nurses and midwives in SRHR, particularly in relation to delivery of youth-friendly services, and confidential service delivery. Training for promotion and insertion of IUCDs could be considered.

14. Where is SRH training offered (pre service, post service)		Undergraduate training for nurses through Faculty of Applied Science at the National University of Samoa, either 2 year Diploma or 3 year Bachelor. All nurses are required to attend clinical refresher training each month (equating to approximately 9 training activities/year), either in Apia, or in clinics on Savai'i.
15. What is the enrolment for the training?		Through the Faculty of Applied Science at the National University of Samoa.
16. Does capacity building on SRH and HIV integrate guiding principles and values? (ex. Stigma, gender, male involvement, attitude with key population...etc)	✓	Undergraduate nursing training does address these SRHR issues, however post-graduate refresher training is not structured, and inclusion of rights-based issues is at discretion/capacity of senior nurses.
17. Are there training materials and curricula on SRH which include HIV prevention, treatment and care at programme and service-delivery levels and as part of pre-service training?	✓	Undergraduate nursing training include all rights-based policies of the Ministry of Health and National Health Service. Also includes units on SRH (including STI and HIV prevention and management), Child Bearing (antenatal care, family planning), and Concepts of Nursing (community-focused, social aspect to delivery of clinical services)
18. Are curricula and training materials revised and updated regularly	✓	Under-graduate materials are regularly revised.
19. In relation to staff for SRH and HIV programmes, what are the biggest challenges?		Significant workloads impact on the effective delivery of services, especially in regards to youth-friendly services, which usually require more time with each client. There is insufficient set-up of a suitable space in most facilities to encourage access by young people, and lack of engagement from nurses on the appropriate, youth-friendly delivery of services, be it for SRH or a range of other health issues.
20. What solutions have you found to those challenges?		See recommendations.
21. To what extent do logistics systems support service-delivery integration? (separate supply, planning, recording and monitoring)		Logistics systems work well to supply reproductive health commodities to rural facilities, however the limited range of commodities at the facility level needs review.

22. Do laboratory facilities serve the needs for both SRH and HIV services? (Haemoglobin, Blood grouping and typing, STI diagnosis, HIV diagnosis, including rapid tests, CD4 count? HIV viral load, liver function tests, urinalysis, random blood sugar, and pregnancy testing)		Only the medical laboratory of the TTM National Referral Hospital in Apia has the capacity to provide services for both STIs and HIV. Limited supplies of reagent on Savai'i limits the extent to which the laboratory at MTII Hospital, Tuasivi, can support diagnosis of STIs.
23. How do the monitoring and evaluation structures capture results of SRH programmes? (Access to services, uptake of services, Quality, client satisfaction, client profile)		Integrated quarterly (or at least 4-monthly) monitoring visits to all health facilities captures information on STI treatment, contraceptive stocks and age/gender disaggregated attendance data for youth friendly services.
24. What indicators are being used to capture integration between SRH and HIV (e.g. HIV clients receiving SRH services, SRH clients receiving HIV services)	✗	Integrated quarterly (or at least 4-monthly) monitoring visits to all health facilities provides some integrated data, but the low HIV prevalence limits opportunities for monitoring integration.
25. Is the data collected on SRH and HIV disaggregated by sex, age and HIV status?	✓	Laboratory and clinical data for STIs, antenatal care visits and youth friendly service usage data is disaggregated by age and gender.
26. Does the current HIS capture all essential information on SRHR	✓	Yes, however issues with the CHNIS results in no computerised collating and analysis of raw data.
27. Describe the information flow		(see text)
28. Does the essential SRH indicator are capture in the clinic report form	✓	Yes, however issues with the CHNIS results in no computerised collating and analysis of raw data.
29. Are client registers for use of SRHR/GBV/ YFHSs services established in the various health clinical outlets, SDPs, and community centres? List places having this data collection register for clients.	✓ / ✗	Client registers for family planning and youth friendly services do exist for all rural health facilities, but are not always used effectively. Gender-based violence registers not in place -see Section 3.3 below.

3.3 Service delivery

Table 3.3: Service delivery points/health facilities in Samoa.

Upolu	Savai'i
1. TTM Hospital (including Apia Urban Clinic)	8. Malietoa Tanumafili II (MTII) Hospital – Tuasivi
2. Lalomanu District Hospital	9. Safotu District Hospital
3. Poutasi District Hospital	10. Sataua District Hospital
4. Leulumoega District Hospital	11. Foailalo District Hospital
5. Lufilufi Health Centre	
6. Sa'anapu Health Centre	
7. Faleolo Medical Centre	

Essential SRH Services: All health facilities in Samoa are offering antenatal care and family planning services, both within the centres (clinics held on all or a combination of weekdays, although family planning clients will be seen at any time), and through daily/2-daily community outreach visits.

STI treatment is available for antenatal care mothers, either directly from nurses (most facilities have azithromycin in stock), or in some instances, from doctors who visit rural facilities once a week. In these cases (for Foailalo, Sataua and Safotu District Hospitals on Savai'i) it is was reported that there was a lack of available reagent for testing, so the nurses have been referring cases of suspected STIs to the visiting doctors for syndromic management. At Lalomanu and Leulumoega District Hospitals (on Upolu), it was reported that the Ministry of Health's Communicable Disease Control Committee has directed that only doctors can treat STIs. Rural nurses raised understanding about forth-coming Presumptive Treatment protocols for STI treatment which could be used by nurses delivering antenatal care, but no training has been conducted as yet.

STI treatment is available to all clients from outpatients clinics (possibly only on visiting doctor days).

Table 3.4: Availability of contraceptives and 'Seven Life-Saving Reproductive Health Medicines' from government health facilities.

Type	Name	Lalomanu	Lufilufi	Poutasi	Saanapu	Lelumoega	Faleolo	Apia Urban	MTII	Sataua	Foailalo	Safotu	Details
OCs	Microgynon	✓	✓	✓	Not assessed	✓	SO	✓	✓	✓	✓	✓	SO = Stock out
	Microlut	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Injectables	Depo-Provera	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Implants	Jadelle	×	×	×		×	×	×	×	×	×	×	Is available from Central Medical Store.
IUCD		×	×	×		×	×	×	×	×	×	×	Only available from SFHA.
Condoms	male	✓	✓	SO		✓	✓	✓	✓	✓	✓	✓	
	female	×	Exp	✓		✓	×	×	×	✓	✓	✓	Exp = Expired stock. Poor demand for these.
Emergency Contraceptives		×	×	×		×	×	×	×	×	×	×	Most nurses knew to use high dose Microgynon
Life saving maternal/ RH medicines													
Oxytocin Inj		✓	✓	✓		✓	✓	Mat'y	✓	✓	✓	✓	
Misoprostil tabs			✓	✓		✓	✓		✓	✓	✓	×	
Magnesium Sulphate Inj		✓	✓	✓		✓	✓		✓	✓	✓	✓	
Antibiotics													
Gentamicin Inj		✓	✓	✓		✓	✓	Ward	✓	✓	✓	✓	
Metronidazole inj		P	P	Tabs		Tabs	Tabs		✓	✓	✓	✓	Tabs = tablets only available
Cystalline Penicllin Inj		✓	✓	✓		✓	✓		✓	✓	✓	✓	
Ante-natal cortico-steroids:													
Hydrocortisone inj		✓	✓	✓		✓	✓	Only	✓	✓	✓	✓	
Prednisolone inj		✓	✓	?		Tabs	✓		✓	✓	✓	✓	
Chlorhexidine		✓	✓	✓		✓	✓		✓	✓	✓	✓	
Resuscitation devices		✓	✓	✓		O_2	O_2		✓	✓	✓	✓	$O_{2 =}$ oxygen only

All facilities have private consulting rooms, and one Senior Nurse Specialist made specific mention of her directives to staff to keep all client matters confidential. Client/patient files are kept and stored in locked areas.

The WHO-recommended 'Seven Life-Saving Reproductive Health Medicines' are mostly present in all centres, however not all the medicines were available during assessment visits (see Table 3.4).

Essential HIV Services: HIV prevalence in Samoa is low and therefore all services are offered from the TTM National Referral Hospital in Apia. Currently, all known PLHIV are residing on Upolu, and are brought to TTM for treatment and testing. There are therefore no HIV services such as treatment of opportunistic infections and home-based care available from rural facilities.

Eleven VCCT sites have been established, however there are few designated VCCT rooms in any of the clinics visited (there are, however, private consulting rooms in all facilities).

New antenatal care booking clients receive a detailed awareness package of information which includes basic prevention of STIs and HIV, and prevention of mother to child transmission (PMTCT) of HIV through breastfeeding and from the mother to her inborn baby. These information sessions are the main way in which HIV prevention services are integrated with others at rural facilities, which also include gender-based violence awareness and prevention messages.

No facilities are providing HIV information services for specific, vulnerable groups such as men who have sex with men, however SFHA does deliver targeted outreach through SFA, and welcomes *fa'afafine* to its Apia clinic during regular clinic hours.

Responding to gender-based violence and sexual assault: No rural health facilities provide direct response to gender violence; they receive occasional clients, take histories, perhaps provide counselling (although what exactly this involves is not clear), conduct a non-invasive examination and initiate immediate referral to TTM or MTII Hospitals. In regards to the latter, few acute cases are received, but they are always immediately referred to police for transfer to TTM Hospital in Apia.

The Emergency Department at the TTM National Referral Hospital does not have any specific protocols or procedures for responding to these acute cases, although doctors received training from a visiting medical team from New Zealand sometime in 2012 or 2013, and therefore reportedly know what to do[78].

Non-acute cases of gender-based and/or sexual violence are more commonly seen in rural clinics, brought in by police some time after the incident.

There are no sexual assault evidence collection or response kits available in any of the health facilities in the country, nor are there consent forms available for responding to these cases. The emergency contraceptive pill is not available outside of the outpatients department of the TTM National Referral Hospital in Apia, although most nurses are aware of family planning protocols which advise high dose Microgynon (ethinylestradiol and levonorgestrel) in place of the emergency contraceptive pill (however it was acknowledged that there is limited demand for this).

78 Personal communication, Dr Penehuro Tapelu, Head Consultant, Emergency Department, TTM Hospital; 13th March 2015.

Recommendation: The National Health Service to develop and train all emergency department medical and nursing personnel in protocols and clinical guidelines for receiving, examining, managing and reporting cases of sexual assault.

Recommendation: The National Health Service to establish sexual assault evidence collection and response kits, inclusive of post-exposure prophylaxis for HIV, STIs and pregnancy, and have these and protocols for their use and re-stocking available in emergency departments of all health facilities.

Prevention and management of unsafe abortion: The response to unsafe abortion within the health system is similar to that for any acute trauma. Referral to doctors is the usual response, and there are no specific protocols for reporting. Even within the TTM National Referral Hospital, there are no protocols as such, however the Head of Obstetrics and Gynaecology is usually notified should any legal action need to be enacted (this usually referring to the legal reporting of a private medical practitioner who performed the abortion)[79].

Peer Education: Peer educators operate throughout the country via a number of different mechanisms, for a range of organisations. SFHA has 31 trained peer educators who are mostly students, and are therefore only active on school holidays and during Sunday programs (which are common). When available, peer educators join with SFHA's clinical outreach visits on Upolu (and soon to be Savai'i), and are supported by the Youth Officer. Peer educators receive refreshment and transport costs for their work, but no formal remuneration.

SNYC is made up of 205 members aged 18-35, of which some are trained as peer educator youth representatives to deliver health messaging, including information on SRH and prevention of domestic violence. The nationally-adapted Lifeskills manual is used to structure the key messages. Youth Representatives do not systematically record how many people they reach with their messages, nor their gender or age.

SRCS youth volunteers deliver SRH awareness to church groups and communities through drama which includes awareness and prevention of STIs and HIV, and messages designed to reduce stigma and discrimination associated with HIV and AIDS. These peer educators are managed by formal structures within the SRCS.

MWCSD Division for Youth trains peer educators on an annual basis and engages them during awareness events each year. Once trained, peer educators are sent to their communities with referral cards. When they find peers in need, they counsel them, and if necessary, provide them with a referral card to return to MWCSD, where they will present themselves and from where they may be referred to an appropriate health or social service. Peer educators are also encouraged to deliver awareness activities for young people in their villages and communities, and are provided with support and resources to do so from the Division. During annual training, the Division informally collects information about the number of activities conducted by peer educators in the previous twelve months, but this information is not specifically, or uniformly collected (in particular, the number, gender and age of young people participating in peer education activities is not meticulously recorded).

79 Personal communication, Dr Penehuro Tapelu, Head Consultant, Emergency Department, TTM Hospital; 13th March 2015.

SFA uses a peer education approach to providing HIV and STI awareness and prevention amongst *fa'afafine* both at the local level and during annual national events/forums. These activities are not formally recorded, nor data collected about the number of people reached.

Male condoms are distributed by peer educators at events and all peer educator activities. Peer educators from SFHA and SRCS also re-stock fixed condom dispensers in night clubs, public toilets and some other identified locations in Apia.

Community outreach: All government health facilities provide outreach at least a number of times a week. Clinical teams deliver SRH awareness to communities, and run antenatal care and family planning clinics. School programs and community immunization activities deliver vaccinations, and provide awareness (but not structured SRH awareness for students). Home care and home visits (mostly for diabetic foot sepsis treatment) are conducted. Often outreach teams will enlist the support of the *Komiti Tumama* (village women's committee) and the *Suiomalo* (village mayor) for mobilization of the community to attend outreach visits.

SFHA delivers outreach services to communities of Upolu (and soon to include Savai'i) a number of times each week. Outreach visits are coordinated and staffed by a clinical reproductive health nurse (also the Program Manager), who is supported by other nurses or the Program Youth Officer as required. Outreach services include:

- SRH awareness and education (this includes youth-focused activities, presentations to the general community, and presentations to men and boys/women and girls about SRHR).
- School programs (run by the Program Youth Officer): for secondary school and tertiary students to discuss SRH (including prevention of STIs).
- Provision of treatment for STIs and delivery of family planning services and information.

School-based curriculum on SRHR: While the Physical and Health Education curriculum unit is supposed to cover SRH education, it is more focused on health and physical education, and is, in the opinion of SFHA, not adequately meeting the SRHR education needs of Samoa's students. SFHA and the Ministry of Health have been advocating to introduce an SRH component to the national curriculum (similar to Family Life Education) for some years. The process has stalled somewhat, and SFHA is looking to the Ministry to take the lead on this.

SFHA has been engaged in promoting SRH in schools through awareness, and while this has been successful, it does require SFHA to approach each school individually to request the opportunity to run awareness activities.

Recommendation: With technical support from UNFPA, the Ministry of Health to engage with the Ministry of Education, Sport and Culture to review the school curriculum in relation to life skills and SRH, and to make recommendations in line with regional standards.

Youth Leadership: While the country does not have a specific strategy for the delivery of youth friendly services, youth-focused SRH services (including prevention and management of STIs and HIV) is a key strategic area of the National Sexual and Reproductive Health Policy 2011-2016. Youth Friendly Services were established in all rural health facilities in the country (10), and a template was developed and distributed to document all young people visiting clinics, including their concerns and needs.

In practice, however, this initiative was not well supported by senior nursing personnel within the National Health Service, and during facility visits as part of this SRHR Needs Assessment, none of the facilities had a designated youth friendly space or specific approaches to meeting the clinical and health service needs of young people.

Recommendation: With technical support from UNFPA, the Ministry of Health to undertake a review of its youth friendly health services and to make recommendations and plans for resourcing and training health workers ahead of the revised National Sexual and Reproductive Health Policy in 2016.

Table 3.5: Summary of SRHR Needs Assessment Findings for Section C: Service Delivery.

Summary Table for Service Delivery	Yes/No ✓/✗	Details
Peer Education		
15. Which Organizations are involved in Peer Education Programs?		SFHA, SRCS, SFA, SNYC, MWCSD Division for Youth
16. Are Peer educators supported by an administrative structure? If so, what is the structure?	✓	SRCS volunteers are supported by a structure. SFHA provides support and guidance through a Youth Officer. MWCSD Division for Youth provides support from office in Apia. SFA and SNYC use their peer educators for formal, structured events only.
17. Do peer educators receive financial support for their work?	✓	Generally this is refreshments and cost of transport only.
18. Do Peer educators cover the entire country? If not, which parts?	✓	Yes. Often youth are brought from all parts of the country for event days and national training activities led by peer educators. SFHA is working to expand its outreach and peer education to Savai'i in the near future.
19. Do the peer educators keep a record/register of the above people that they educate? If so, how many of the people from the above groups have peer educators reached or provided services to over the last two years? What is the target number of young people to be reached by peer educators per annum?	✓ / ✗	Some organisations keep a register of the number of young people reached, but many do not. MWCSD Division for Youth tries to capture this information at annual, national forums, but the results are recalled (not recorded). SNYC has the only detailed database of its 205 youth members in the country, however this was not made available to the consultant. SFHA Youth Officer keeps records.

20. Do Peer educators work with: Young people Sex workers LGBT		Young people. *Fa'afafine* (LGBT)
21. Are materials available on SRH issues for peer educators to use and distribute?	✓	SRH and HIV flipchart for use with the national peer education, Lifeskills manual. MWCSD Division for Youth develop their own IEC materials. SFHA develops their own IEC materials from generic IPPF materials.
22. Do the peer educators distribute condoms (male/female) and/or lubricant?	✓	Male condoms distributed at events and all peer educator activities. Peer educators from SFHA and SRCS also re-stock fixed condom dispensers in Apia.
23. How many peer educators have been trained in SRHR over the last two years? How many more needs to be trained per annum?		SFHA: 31 (these are students and not always active). SRCS: unknown SNYC: not provided MWCSD Division for Youth: 19 in 2015 (5F:14M). SFA: unknown.
24. Are peer educators offered regular training? If so how often and by whom?	✓	All organisations offer training at least once each year.
25. Are there trained trainers in country?	✓	MWCSD Division for Youth and SNYC have trainers who use the national Lifeskills manual
26. How many peer education trainers are there? how many of them are female? How much more trained trainers does the country need?		Unknown.
Community Outreach		
28. List the organizations/ institutions provide outreach on SRH to communities. And list the target groups		National Health Service (youth and all community). SFHA (youth and all community).
29. List the organizations/ institutions provide outreach on HIV to communities. And list the target groups		SFHA (youth and all community – for prevention only).

30. Are there existing SRH committees in the communities consisting of community members and religious leaders? Y/N Explain and list. How many community leaders, gatekeepers and religious leaders have been trained on SRHR?	✗	The Komiti Tumama (village women's committees) and Suiomalo (village mayors) are supportive of health activities and often provide focal points for mobilization of their communities.
31. Do the community outreach reach out to the key population (SWs, MSM and transgender)	✓	Only in regards to awareness and prevention (see peer education section above)
32. Does the country have a SBCC (Social Behavioural change Communication) Strategy for adolescents, youth and those from key populations? Y/N	✓	Not a youth- or population-specific strategy, however the National Health Promotion Policy 2010-2015 provides guidance for development and implementation of SBCC to all groups.
33. Are there any IEC materials on SRHR available in the country	✗	Not specifically SRHR; SRH only
34. Any available IEC materiel focus on linkages (SRHR and HIV)	✗	
35. Is the national CSE/FLE education curriculum aligned with international standards? Y/N	✗	Physical and Health Education unit is supposed to cover SRH education, however more focused on health and physical education - not adequately meeting the SRHR education needs of Samoa's students.
36. Do the outreach program provide Comprehensive sexuality education at primary and secondary	✗	Schools outreach from government rural health facilities are for health checks and immunisation, and some health awareness (but not structured SRH education).
Youth Leadership		
37. Does the country have a strategy/policy /guidelines/ national standard on YFHS? If so, describe	✗	National Sexual and Reproductive Health Policy 2011-2016 prioritises delivery of youth friendly services.
38. How many facilities offer some form of youth friendly health services? List them		10. All facilities except TTM Hospital, however none currently have a working, designated space for youth friendly services.
39. Have YFHS facility assessments been done? If so, in which facilities?	✓	Conducted on a quarterly (or at least 4-monthly) basis. Mainly involves collecting the youth friendly services data forms.

40. How are organizations of young people involved in responses to HIV and in SRH programming (part of situation analysis, planning, budgeting, implementing, evaluation, youth engagement)		See peer education section above.
41. Is there a youth advisory committee on SRH, HIV in the country?	✗	
42. Does the national youth council deal with SRH issues? If so, how?	✓	Young people attending health activities and sports days receive health messaging, including information on SRH and prevention of domestic violence from SNYC peer educators.
43. Are young people consulted in health sector policy development, planning and/or reporting?	✗	Not to date, but now that the SNYC has been established, there is an intention for them to join the Key Stakeholders Meeting (for SRH).
Condom Programming		
44. Where are condoms (male and female) available?		In the community from peer educators. Private pharmacies and government health facilities. SFHA, SRCS and the clinic at the National University of Samoa. Fixed dispensers in Apia nightclubs and bars, public toilets and other public places.
45. Are condoms for sale in the country?	✓	See above
46. Is lubricant available in the country? Where?	✓	From private suppliers and from all other providers on an irregular basis (excluding fixed dispensers).
47. Are there community-based distributors in the country?	✗	Yes, most peer educators have these, but not consistently
48. Are condoms available equally in rural areas as in urban areas?	✗	

3.4: Humanitarian

Samoa does not have a specific humanitarian response plan which addresses key health needs in a time of national crisis, nor any document that particularly relates to SRHR. However, for the Small Island Developing States Meeting held in Apia in August and September 2014, a draft *Mass Casualty Response Plan* was produced[80]. This document articulates the roles and responsibilities of various agencies, including the Ministry of Health and the National Health Service in the event of an emergency or disaster during the international meeting, for the various stages and types of national and sub-national alerts.

SRHR is not specifically mention within the plan, however there is enough scope within it to enable the various sections of the Ministry of Health to respond appropriately as needed.

80 Government of Samoa, 2014; Mass Casualty response Plan for the Small Island Development (sic) States Meeting: Hosted by Samoa 25th August – 5th September 2014; Apia; Ministry of Health.

4 CONCLUSION AND RECOMMENDATIONS

Samoa remains committed to upholding the human rights of its citizens regardless of *'... descent, sex, language, religion, political or other opinion, social origin, place of birth [and/or] family status...',* through its Constitution, through ratifying international conventions and treaties, through development of gender- and rights-based laws and sectoral policies, and through the establishment of mechanisms for monitoring and addressing abuses of human rights in the country.

Despite these commitments and gains, cultural and attitudinal barriers continue to challenge the health sector's progress towards achieving universal access to SRHR. These attitudinal barriers are present at all levels, including individuals and communities, village and church leaders, school management committees, within all levels of government, and even within Ministries and service providers. Fortunately, each of these levels also produces champions and advocates who support and promote access to SRHR, and through the actions and knowledge of many of these advocates and leaders, Samoa is showing some important gains towards enabling couples and individuals to choose the number, spacing and timing of their children.

These gains are evident in Samoa's recent development of rights-based, sectoral policies, plans and guidelines for SRH service delivery, and in the development of processes which support decentralised outreach activities. A significant number of agencies are supporting awareness and prevention of STIs and HIV, and others are providing clinical and counselling services. Young people and other key target populations are being engaged in, and supported to work with their peers on promoting SRHR, and there are some encouraging developments in the areas of legal and policy reform which are addressing gender inequality and the unacceptable rates of gender-based violence in the country.

Work still needs to be done to address awareness and attitudes of many service providers and ancillary staff to embrace rights-based approaches to SRH service delivery, particularly in regards to the provision of youth friendly services. STI testing and management is under resourced and utilised, and the health system has much ground to make up so as to more appropriately respond to, and manage gender-based violence and assault. Health sector capacity development, health service rehabilitation, guidelines and protocol development, coordinated, multi-sectoral program planning and monitoring, and more structured approaches to peer education training, programming, monitoring and reporting would all serve to improve Samoa's performance in meeting its international SRHR commitments.

4.1: Summary of Recommendations.

Integrated policy and strategy development:

- Consultation for the forth-coming revision of the National Reproductive Health Policy should seek to engage with service users and other key target groups to ascertain if and how their SRHR are being met or neglected to ensure the revised policy adequately reflects SRHR.
- Revision of a comprehensive, evidence-based *National Sexual and Reproductive Health Policy 2017-2021* informed through quantitative data analysis and wide consultation with government and non-government program managers, service providers and users, partner agencies and community stakeholders.
- Revised National Reproductive Health Policy to include a detailed, evidence-informed strategy with measurable outcomes linked to monitoring and evaluation plans and indicators, informed through stakeholder consultation.
- With technical support from UNFPA, the Ministry of Health to undertake a review of its youth friendly health services and to make recommendations and plans for resourcing and training health workers ahead of the revised National Sexual and Reproductive Health Policy in 2016.

Improved rights-based legislation:

- The Office of the Ombudsman, as the National Human Rights Institution of Samoa, to advocate for, and lead consultative revision of the law to remove any provisions which infringe on the SRHR of individuals and groups.

Coordination for integrated SRH and HIV/STI programming:

- The Key Stakeholders Meeting to be formalised for twice-yearly meetings, and structured to facilitate multi-agency, coordinated planning to avoid duplication and to reflect agencies' capacity to deliver.
- With technical support from UNFPA, the Ministry of Health to engage with the Ministry of Education, Sport and Culture to review the school curriculum in relation to life skills and SRH, and to make recommendations in line with regional standards.

Improved SRHR service delivery:

- The oral contraceptive pill and Jadelle should be made available at all health facilities and nursing staff trained in their use. IUCD should be re-introduced and promoted, and nurses trained in its insertion and removal.
- The National Health Service Chief Pharmacist must clarify her directive regarding payment for family planning commodities immediately to ensure individuals and couples have access to family planning whenever they require it, and to avoid further, involuntary defaulting of contraceptive use.

Prevention and response to gender-based violence:

- The National Health Service to establish sexual assault evidence collection and response kits, inclusive of post-exposure prophylaxis for HIV, STIs and pregnancy, and have these and protocols for their use and re-stocking available in emergency departments of all health facilities.

Training and capacity building for SRHR:

- The National SRH Section to work with the Nursing and Midwifery Division of the National Health Service to develop a refresher training module on SRH and family planning, with emphasis on rights-based, and youth-friendly delivery of services, which can be delivered by nurse managers on at least an annual basis.
- All clinical and ancillary service managers and staff to be trained in the specifics of SRHR, in particular the need to promote access to contraceptives and to create an enabling environment for Samoans to access SRH services and family planning commodities.
- The National Health Service to develop and train all emergency department medical and nursing personnel in protocols and clinical guidelines for receiving, examining, managing and reporting cases of sexual assault.

M&E:

- The National Health Service to repair and re-establish a computer-based CHNIS which allows more detailed and timely analysis of integrated SRH and STI/HIV service data to inform program effectiveness.

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APPENDIX 2: NEED ASSESSMENT TOOLS FOR SEXUAL REPRODUCTIVE HEALTH AND RIGHTS, AND HIV

Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV

Purpose

This Needs Assessment Tools is looking at the broad range of linkages issues, such as policy, systems and services.

Assessment components

Components	Key areas of assessment
1. Policy	- Political Positions--National Policies/Guidelines - Funding/Budgetary Support - Policy: Leadership (Champions)/Political Will
2. System	- Partnerships - Planning, Management and Administration - Staffing, Human Resources and Capacity Development - Logistics/Supplies - Laboratory Support - Monitoring and Evaluation - Health information system
3. Service delivery	- HIV integrated into SRH - Overall Perspective on Linkages in SRH and HIV Services - Peer education program - Community engagement/outreach/ youth leadership and engagement - Family planning services - YFHS and - Condom programming - VAW survivor services and support
4. Humanitarian	- Availability of the policy - System to support SRHR - Guideline and protocol

Source: Draft tools provided by UNFPA, Pacific Sub-Regional Office, November 2014

Methodology

- Stakeholder consultation
- Conduct desk review
- Conduct interviews: formal, informal, or group discussion
- Data collection/information

Target Audiences

1. Policy: Coordinator, Program managers, director for health services
2. System: Coordinator, Program managers
3. Service delivery: target for any type of health care workers working at the clinical level, youths, and communities (clients)

Guidance documents:

- SARA and EMONC
- A Guide to Tools for Assessments in Sexual and Reproductive Health
- Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages, A Generic Guide
- Responding to Intimate Partner Violence and Sexual Violence against Women, WHO clinical and policy guidelines

Measurable:

Components	Information collection
Service Availability: look at the physical presence of services	- Facility density - health worker density - service utilization
Service readiness: Look at Capacity to deliver services	- Basic amenities - equipment & supplies - diagnostics - essential medicines & commodities - Human resource Capacity: capacity at facility level, Training need (RH, FP), and training curriculum
Specific service readiness areas	Family planning, antenatal care, Obstetric care, Neonatal care and child health (curative, immunization) HIV, PMTCT, TB, Malaria, YFHS and Chronic Diseases, VAW
EmOC indicators	Availability and distribution of facilities fully functioning at EmONC levels: - Institutional delivery rate - Met need - Population-based cesarean rate - Direct obstetric case fatality rate - Intrapartum stillbirth and early neonatal death rate - % maternal deaths due to indirect causes

Assessment Questionnaire

A. Policy

SECTION 1: Political Positions National Policies/Guidelines				
			Comments	**Source of information**
1. Is there a national HIV strategy/policy	Yes ☐	No ☐	Add colum for countries	
2. What is the title of strategy and timeframe				
3. Is there a national SRH strategy/policy?	Yes ☐	No ☐		
4. Probe question for Q5 Does the country also have an evidence based National Health Sector policy that Incorporates RH and HIV? (For SRHR Results matrix indicator 3.2a)				
5. What is the title of strategy and timeframe				
6. Are there any direct policy relevance to linkages between SRH and HIV in the country?	Yes ☐	No ☐		
7. Does SRH policy include HIV prevention, treatment, care and support issues? (VCCT-FP, BCC on HIV-SRH)				
8. Has SRH policy been made a priority in term of – Funding, legislation, or health sector strategy				
9. Probe question for Q10 - Does the country have a protocol for family planning services in place? - Which stakeholders are responsible for carrying out the protocol? List. - Are the procedures in line with human rights standards? - Are the procedures for delivering FP services free from discrimination, coercion and violence? *(For SRHR Results framework indicator 1.4a)*				

10. List any service protocols, policy guidelines, manuals, etc, that are specifically geared towards increasing SRH and HIV link				
11. Is there a participatory platform that advocate for increased investments in marginalized adolescents and youth, within development and health policies and programmes? Y/N .If so, describe. *(For SP/MCP5 Output 3.1 Indicator 4)*				
12. Determine whether there is a legislative framework to supports (or does not support) the implementation of SRH and HIV linkages.				
13. What are the laws affecting key groups (SWs, IDUs, MSM, other) and what is their impact?				
SECTION 2: Funding/Budgetary Support				
14. What are the main of funding source for SRH and HIV. If possible, give a break down				
15. Are there specific cases of donors putting restrictions on HIV programmes regarding SRH components or vice versa				
16. Within the budgets for specific SRH services, what is the proportion allocated to HIV prevention and care?				

B. System

SECTION 1: Partnership				
			Comments	**Source of information**
1. Who are the major development partners for SRH				
2. Who are the major development partners for HIV				
3. If any, who are the major champions supporting (policy, financial and/or technical) SRH and HIV linkages?				
4. Is there any multi-sectoral technical group working on linkages issues?	Yes ☐	No ☐		
5. What is the role of civil society in SRH programming e.g. Advocacy, planning, implementation, and monitoring				
6. Are the following elements of civil society involved in the SRH and/or HIV responses? PLHIV, Young people, key populations,				
SECTION 2: Planning, Management and Administration				
7. Probe question for Q8 What programmes (national/donor funded) are in place to prevent STI's and HIV among young people? List. *(For SP/MCP5 output 3.1 indicator 3)*	Yes ☐	No ☐		
8. Is there a joint planning of HIV and SRH programmes?				
9. To what extent have SRH services integrated HIV and have HIV services integrated SRH				

10. Probe question for Q11 - Are thre any CSOs supporting the institutionalization of programmes to engagemen and boys on gender equality 9including GBV), SRH and RR? If so describe status and list CSOs. *(For SP/MCP5 output 2.1 indicator 6)*				
11. What institutions are providing integrated services for HIV and SRH? (ex. government facilities? NGOs, FBO, private sector.)				
12. Is there a policy on GBV or VAW? Is the health sector referred to in national Domestic Violence legislation?				
SECTION 3: Staffing, Human Resources and Capacity Development				
13. What are the highest priority training needs in the health sector, i.e. who needs to be trained on what subjects or skills?				
14. Where is SRH training offered (pre service, post service)				
15. What is the enrolment for the training				
16. Does capacity building on SRH and HIV integrate guiding principles and values? (ex. Stigma, gender, male involvement, attitude with key population...etc)	Yes ☐	No ☐		
17. Are there training materials and curricula on SRH which include HIV prevention, treatment and care at programme and service-delivery levels and as part of pre-service training?	Yes ☐	No ☐		
18. Are curricula and training materials revised and updated regularly	Yes ☐	No ☐		

19. In relation to staff for SRH and HIV programmes, what are the biggest challenges? (retention, recruitment, task shifting, Workload and burnout, Quality)				
20. What solutions have you found to those challenges?				
SECTION 4: Logistic and Supply (Summary of RHCS Assessment)				
21. To what extent do logistics systems support service-delivery integration? (separate supply, planning, recording and monitoring)				
SECTION 5: Laboratory Support				
22. Do laboratory facilities serve the needs for both SRH and HIV services? (Haemoglobin, Blood grouping and typing, STI diagnosis, HIV diagnosis, including rapid tests, CD4 count? HIV viral load, liver function tests, urinalysis, random blood sugar, and pregnancy testing)	Yes ☐	No ☐		
SECTION 6: Monitoring and Evaluation				
23. How do the monitoring and evaluation structures capture results of SRH programmes? (Access to services, uptake of services, Quality, client satisfaction, client profile)				
24. What indicators are being used to capture integration between SRH and HIV (e.g. HIV clients receiving SRH services, SRH clients receiving HIV services)				
25. To what extent does supportive supervision at the health service-delivery level support effective SRH Services				
26. Is the data collected on SRH and HIV disaggregated by sex, age and HIV status?	Yes ☐	No ☐		

27. Is the current HIS captured all essential information on SRHR				
28. Describe the information flow				
29. Does the essential SRH indicator are capture in the clinic report form				
30. Are client registers for use of SRHR/GBV/ YFHSs services established in the various health clinical outlets, SDPs, and community centres? List places having this data collection register for clients.				

C. Service delivery

SECTION 1: Mapping facilities and service available	
1. Which of the following essential SRH services are offered at this facility?	1. Family planning ☐ 2. Prevention and management of STI ☐ *(For SRHR results matrix indicator 3c)* 3. Maternal (ANC) and newborn care ☐ *(For SRHR results matrix indicator 3c)* 4. Prevention and management of gender-based violence ☐ 5. Prevention of unsafe abortion and management of post-abortion care ☐ 6. Other (specify):..... 7. None ☐ 8. Unsure, don't know 9. 7 lifesaving maternal/ RH medicines from the WHO list. ☐ *(For SRHR results matrix indicator 1.2a)*
2. Which of the following essential HIV services are integrated with SRH services at this facility?	1. HIV counselling and testing ☐ (if yes) a. VCT ☐ b. PICT ☐ 2. Treatment for OIs and HIV ☐ 3. Home-based care ☐ 4. Psycho-social support ☐ 5. HIV prevention information and services for general population ☐ 6. Condom provision ☐ 7. PPTCT(four prongs) ☐ a. prong 1: prevention of HIV among women of childbearing age and partners ☐ b. prong 2: prevention of unintended pregnancies in HIV+ women ☐ c. prong 3: prevention of HIV transmission from an HIV+ woman to her child ☐ d. prong 4: care & support for the HIV+ mother and her family ☐ 8. Specific HIV information and services for key populations a. IDUs (e.g. Harm Reduction) ☐ b. MSM ☐ c. SWs ☐ d. Other key populations (specify): ..... 9. Other services (specify):..... 10. No integration ☐ 11. Unsure, don't know ☐

SECTION 1: Mapping facilities and service available		
3. How does your facility offer HIV services within:	1. Prevention and management of STI services ☐ 2. Maternal and newborn care services ☐ 3. Prevention and management of gender-based violence ☐ 4. Prevention of unsafe abortion and management of post-abortion care ☐ 5. Family planning? ☐	
4. Are the privacy and confidentiality of clients maintain at services delivery	Yes ☐ No ☐ Please clarify:	
5. Are the following equipment available Nationally	a. Sanitary towels in the examination room	Yes ☐ No ☐
	b. Consent forms	Yes ☐ No ☐
	c. Sexual assault evidence collection kits	Yes ☐ No ☐
	d. Clean clothes for survival use if they have to leave clothes for the forensics/ evidence	Yes ☐ No ☐
6. Is the emergency contraceptive available at the clinic	Yes ☐ No ☐	
7. Problem experienced with the sexual assault evidence collection kits	a. Keep evidence locked away	Yes ☐ No ☐
	b. Share the rape kits and see if medical staff have comments on the contents	Yes ☐ No ☐
	c. Availability of treatment in examination room	Yes ☐ No ☐
8. Available of tests and treatment a. Where people who have been raped first present (OB/GYN, ER, other) b. Triage or reason of delays in examination of patient c. Where do patient normally wait d. Who examine the patients e. How the patient information normally collected and stored		
f. Do you have forensics training or protocol	Yes ☐ No ☐	
g. Has staff been involved in giving evidence in court? What was the experienced?		

SECTION 1: Mapping facilities and service available			
9.	What was the comment reaction of the staff toward rape cases		
10.	Where does the victims normally refer to:	a. Legal b. Psychological c. Shelter	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
11.	Are the following testing and treatment are available for the victims	a. Pregnancy test b. PEP for HIV c. PEP for STI	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
12.	Do the staff have undergo training on	a. Sexual violence (adult) b. Sexual assault (children) c. Physical assault	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
13.	Is VAW integrated in ANC care	Yes ☐ No ☐	
14.	Is VAW integrated in family planning services	Yes ☐ No ☐	

SECTION 2: Peer Education Programme			
		Comments	**Source of information**
15.	Which Organizations are involved in Peer Education Programmes?		
16.	Are Peer educators supported by an administrative structure? If so, what is the structure?		
17.	Do peer educators receive financial support for their work?		
18.	Do Peer educators cover the entire country? If not, which parts?		
19.	**Probe question for Q20** Do the peer educators keep a record/ register of the above people that they educate? If so, how many of the people from the above groups have peer educators reached or provided services to over the last two years? What is the target number of young people to be reached by peer educators per annum? *(For SRHR results matrix indicator 2.2a)*		
20.	Do Peer educators work with: • Young people • Sex workers • LGBT		
21.	Are materials available on SRH issues for peer educators to use and distribute?		

SECTION 2: Peer Education Programme		
	Comments	**Source of information**
22. Do the peer educators distribute condoms (male/female) and/or lubricant?		
23. Probe question for Q24 How many peer educators have been trained in SRHR over the last two years? How many more needs to be trained per annum? *(For SRHR results matrix indicator 8a)*		
24. Are peer educators offered regular training? If so how often and by whom?		
25. Are there trained trainers in country?		
26. How many peer education trainers are there? How many of them are female? How much more trained trainers does the country need? *(For SRHR results matrix indicator 8b and 8c)*		
27. If available get list of all peer educators in the country, their location, age, and gender.		

SECTION 3: Community outreach		
	Comments	**Source of information**
28. List the organizations/ institutions provide outreach on SRH to communities. And list the target groups		
29. List the organizations/ institutions provide outreach on HIV to communities. And list the target groups		
30. Are there existing SRH committees in the communities consisting of community members and religious leaders? Y/N Explain and list. How many community leaders, gatekeepers and religious leaders have been trained on SRHR? *(For SRHR results matrix indicators 10b and 10d)*		
27. Do the community outreach reach out to the key population (SWs, MSM and transgender)		

28. Probe question for Q29 Does the country have a SBCC (Social Behavioural change Communication) Strategy for adolescents, youth and those from key populations? Y/N *(For SP/MCP5 Output 1.1 Indicator 11)*		
29. 28. Are there any IEC materials on SRHR available in the country?		
30. Any available IEC materiel focus on linkages (SRHR and HIV)?		
31. Probe question for Q32 Is the national CSE/FLE education curriculum aligned with international standards? Y/N *(For SP/MCP5 Output 3.1 indicator 5)*		
32. Do the outreach programme provide Comprehensive sexuality education at primary and secondary		

SECTION 4: Youth leadership		
	Comments	**Source of information**
33. Does the country have a strategy/policy/ guidelines/national standard on YFHS? If so, describe.		
34. How many facilities offer some form of youth friendly health services? List them.		
35. Have YFHS facility assessments been done? If so, in which facilities?		
36. How are organizations of young people involved in responses to HIV and in SRH programming (part of situation analysis, planning, budgeting, implementing, evaluation, youth engagement)		
Youth Involvement		
35. Is there a youth advisory committee on SRH, HIV in the country?		
36. Does the national youth council deal with SRH issues? If so, how?		
37. Are young people consulted in health sector policy development, planning and/ or reporting?		

SECTION 5: Condom Programming		
38. Where are condoms (male and female) available?	☐ health centers ☐ bars & nightclubs ☐ shops Other: _____	
39. Are condoms for sale in the country?		
40. Is lubricant available in the country? Where?		
41. Are there community-based distributors in the country?		
42. Are condoms available equally in rural areas as in urban areas?		

D. Humanitarian

1. Does the policy reflect some kind of needed response in times of crisis/ disaster?	
2. Does the system enable or support SRHR in times of crisis?	
3. Are there service delivery guidelines for SRHR during humanitarian crisis?	
4. Does the country have a humanitarian contingency plan that include elements for addressing SRH needs of women, adolescents and youth including services for survivors of sexual violence in crises? Y/N. If possible obtain contingency plan document. *(For SP/MCP5 indicator 12 output 1.1)*	

APPENDIX 3: LIST OF PARTICIPANTS AND KEY INFORMANTS

Name	Title	Organisation
Toleafoa Leausa Dr Take Naseri	CEO / Director General of Health	Ministry of Health (MOH)
Faaifoaso (Aso) Moala,	Child Health, Health Promotion Coordinator	Health Education And Promotional Services Unit (HEAPS), Health Promotion and Enforcement Division (HPED), MOH
Perive Lelevaga	Principal National SRH Section	Health Sector Coordination, Resourcing and Monitoring Division (HSCRMD), MOH
Faafetai A. Mulipola	SRH Procurement Officer	HSCRMD, MOH
Aa'aone Tanumafili	Coordinator, STI/HIV/AIDS	MOH
Keneti Vaigafa	Principal Health Information Officer	MOH
Josephine Afuamua	Principal Policy Analyst	MOH
Dr Penehuro Tapelu,	Head Consultant,	Emergency Department, TTM Hospital, National Health Service (NHS)
Ava'ia Lautasi	Principal Nurse, Upolu	NHS
Fa'atafa Tavita E'etau	Principal Nurse, Savai'i	NHS
Moanamarie Westerlund	Principal Pharmacist	NHS
Saifagaloa (Loa) Sala	Principal	Clinical Audit and Policy Improvement, NHS
Leveti Auva'a	ACEO	Health Service Performance & Quality Assurance – Midwifery & Nursing (HSPQM&N), MOH
Li'ai Sitia	Executive Director	Samoa Family Health Association
Tupepepa-Esera Aumua	Child Protection Officer	UNICEF
	Gender Based Violence Officer	UNFPA
Andrew Peteru	National Programme Officer in HIV and AIDS Education	UNESCO/UNAIDS

Name	Title	Organisation
Saunoa Karen Komiti	UNFPA Programme Officer	UNFPA
Ana Leau Vaasa	Senior Youth Officer	Youth Division, Ministry of Women, Community and Social Development (MWCSD)
Florence Samuelu,	Youth Development Officer	Youth Division, MOWCSD
Vaialia Iosua	Principal Community Dev't Officer	Division of Women, MOWCSD
	Secretary	Samoa Fa'afafine Association
Mathew Tofilau		Samoa National Youth Council
Moataoali'i Kaioneta Ali'isolia Kitiona	Detective Inspector	Community Engagement Unit (CEU), Ministry of Police and Prisons
Tautala Utaia'ane	Senior Nurse Specialist (SNS) and Midwife	Lalomanu District Hospital
Nila Lene	Nurse Manager	Lufilufi Health Centre, NHS
Seara Pe'a	Registered Nurse	Poutasi District Hospital, NHS
Tufosa Tulilo Afoa	SNS and Midwife	Leulumoega District Hospital, NHS
Ana Leaso	Registered Nurse and Midwife	Faleolo Medical Centre
Fuata'I Tuese	SNS	Foailalo District Hospital, NHS
Mu Aumalaga	Senior Registered Nurse	Sataua District Hospital, NHS
Luse Tauvale	Senior Registered Nurse	Safotu District Hospital, NHS
Dr Loudeen Lam	Head, Clinical Services MTII/ Savai'i	MTII Hospital, NHS
Laga'au Savea	SNS	MTII Hospital, NHS
Naifoua Sala Asiata	Midwife (Part time)	MTII Hospital, NHS

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