

GENDER & HEALTH

– FACTS AND IMPLICATIONS

The Samoa Gender Monograph (SGM) 2020 is a detailed analysis of the differences that exist between females and males, based on national census data, administrative data and other existing available research and studies. This Policy Brief provides a snapshot of the key findings of the SGM highlighting the main differences between the lived experiences of men and women and the persistent gender inequalities. The brief can be used to inform evidence-based policy, programmes and further research.



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1. INTRODUCTION

Males and females have different roles, needs and interests based upon socially-ascribed norms which inform gendered attitudes and behaviours. These can be measured in a variety of ways including by an analysis of census data. In order to achieve gender equality, it is critical to both understand these gendered social norms and develop laws and policies that address the power imbalances which some norms serve to sustain and enforce. Sustainable Development Goal 5: “Achieve gender equality and empower all women and girls” recognizes that realizing gender equality is a foundation for sustainable and inclusive development. The Government of Samoa acknowledges the existence of gender inequality in Samoa and that equality can support national development as evidenced by the Strategy for the Development of Samoa 2016-2020, Outcome 8.1, which stipulates that the *‘inclusion of vulnerable groups (women, youth, people with disabilities, children, elderly and disadvantaged people) in community planning and governance activities will be enhanced’*.



2. GENDER AND HEALTH IN SAMOA

Timely access to quality reproductive, maternal, newborn, child and adolescent health care is critical to ensure progress towards the equitable social and economic status of women and children and national development aspirations

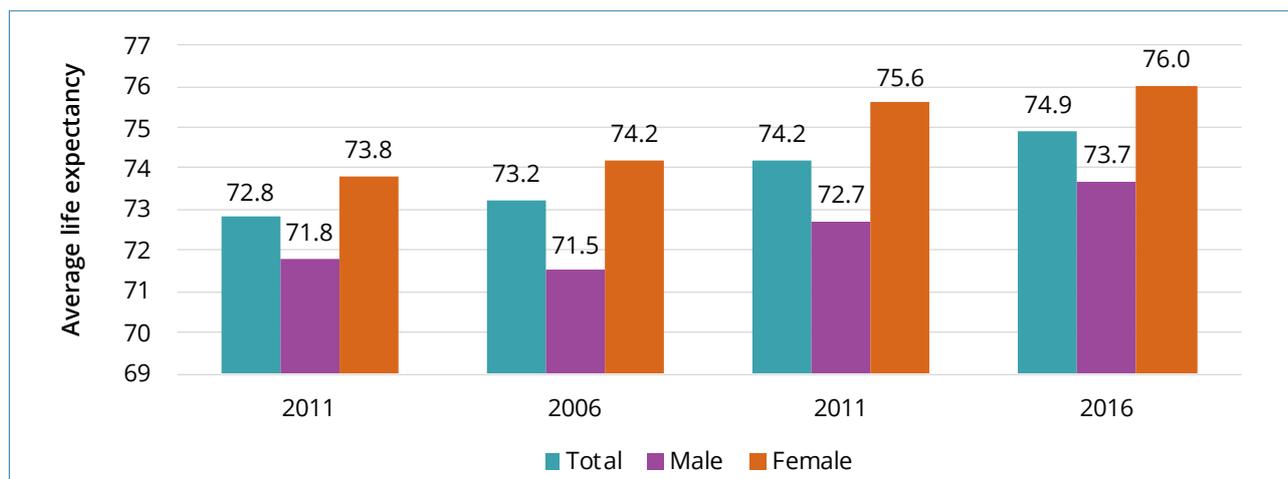
The government recognizes the priority areas of “reproductive and maternal and child health” as well as the “rapidly increasing levels of non-communicable diseases (NCDs)” in the health system that require specific attention in order to ensure strong national development (Ministry of Health, 2008, p. 11). Timely access to quality reproductive, maternal, newborn, child and adolescent health care is critical to ensure progress towards the equitable social and economic status of women and children and national development aspirations.

Fertility, mortality, life expectancy, and disability are some key indicators commonly used to profile the health and well-being status of a population and are used in this brief. Other indicators that relate to Samoa’s health status (not analysed in this brief due to data unavailability) are the levels of NCDs and associated risk factors such as smoking, alcohol, nutrition, and other health and lifestyle behaviours of people and communities in Samoa.

To support evidenced-based policies, it is critical to determine from a gendered perspective, the country’s population health demographics, trends and dynamics. The following sections of this brief analyse the health and well-being profiles of males and females in Samoa.

2.1 Life expectancy

Figure 1: Life expectancy at birth, 2016 Census



The life expectancy¹ of Samoa's population has improved over the 15 year period 2001 to 2016, with an increase in life expectancy from 74.2 years in 2001 to 74.9 years in 2016 (see Figure 1). The life expectancy of both males and females has increased over the years from 71.8 years in 2001 to 73.7 years in 2016 for males, and from 73.8 years in 2001 to 76.0 years in 2016 for females.

Samoa's life expectancy in 2016 was higher than the average for Pacific island small states, however, it was lower compared to the average for upper-middle income countries (current country income classification using World Bank methodology).²

According to data from the World Health Organization, NCDs account for 81 per cent of all deaths in Samoa, with the risk of premature deaths from NCDs notably higher for males.³ Males also have a higher prevalence of NCD risk factors (hypertension and smoking), while females have a higher prevalence for obesity, a key risk factor for NCDs.

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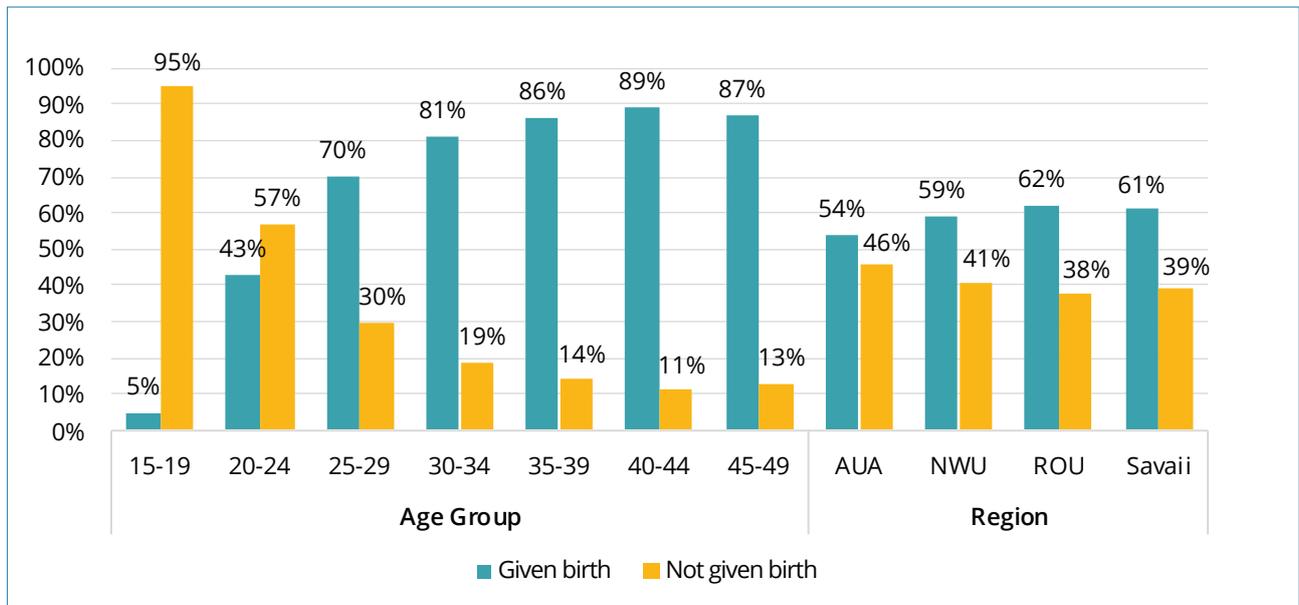
2.1 Fertility

Fertility refers to the childbearing of an individual (usually women) measured for a specified age group or population, which is usually for the reproductive ages of 15 to 49 years.

Females already given birth

Based on the 2016 Census, females of reproductive age (15 to 49 years) make up 46 per cent of the total female population in Samoa. Approximately three out of every five females in this age group have given birth (59 per cent) (see Figure 2). The proportion of females of reproductive age that have given birth is lowest in the adolescent years (15 to 19 years; 5 per cent) and increases by age cohort, with the largest increases in the 20 to 24 year and 25 to 29 year age groups. Geographical patterns of females of reproductive age that have given birth show spatial variations with the lowest proportion in Apia Urban Area (AUA) (54 per cent) and relatively higher proportions in the rural regions of Upolu (59 per cent for North West Upolu (NWU); 62 per cent for Rest of Upolu (ROU)) and Savaii (61 per cent).

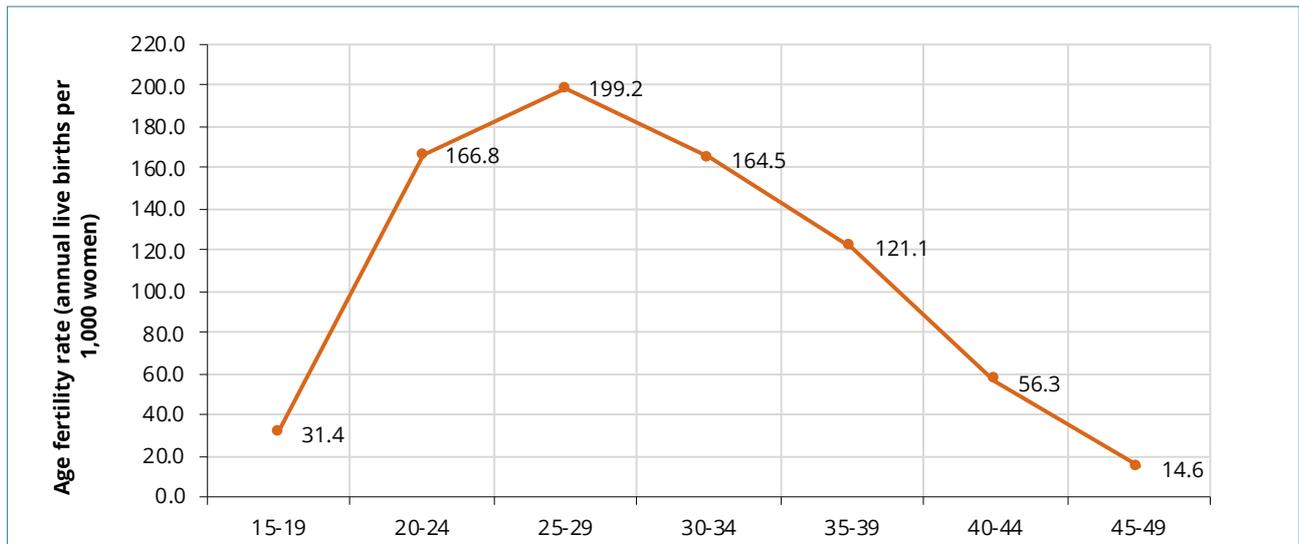
Figure 2: Females aged 15 to 49 ever given birth by age, 2016 Census



The mean childbearing age for Samoan females was estimated at the 2016 Census as 23 years. This is similar to other Pacific island countries,⁴ but females in the Pacific region give birth earlier than those in Organisation for Economic Co-operation and Development (OECD) countries where the mean childbearing age is 30.⁵ United Nations data for 2015 show that the global mean childbearing age is 28 with women globally postponing childbearing to later ages. Earlier childbearing yields younger populations (as is the case in Samoa and other Pacific countries), while delayed childbearing slows the pace of population growth, yielding smaller future populations and structures that can spur economic development.⁶

Age-specific fertility

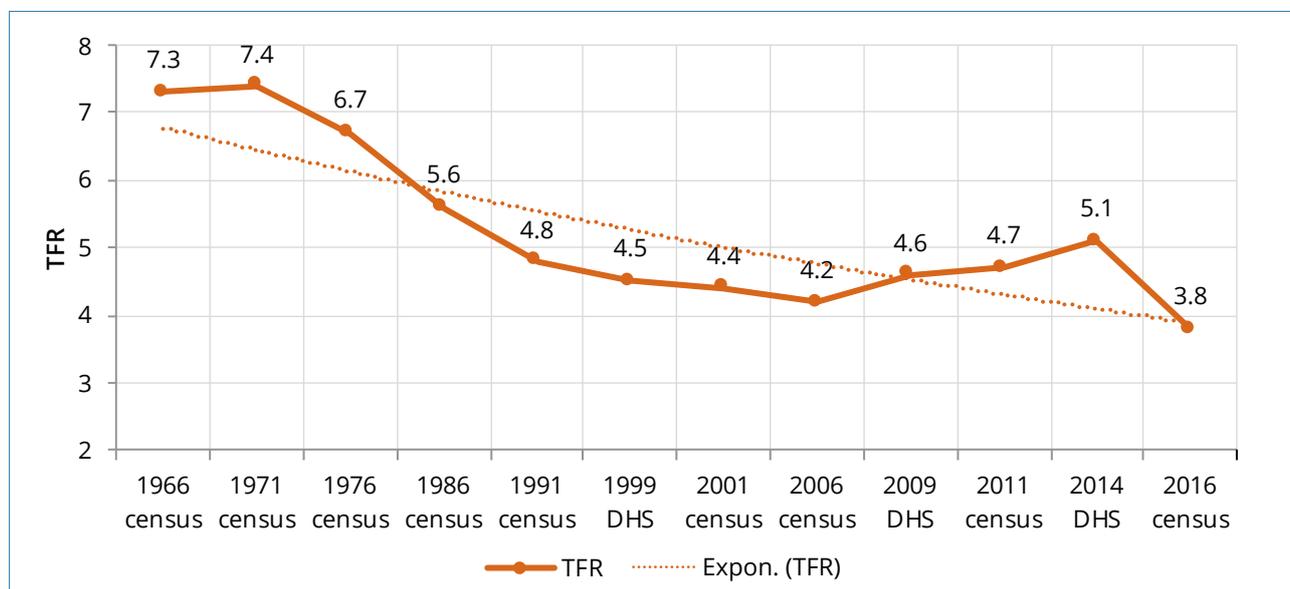
Figure 3: Age-specific fertility rate, 2016 Census



The age-specific fertility rate (ASFR), the annual number of live births per 1,000 females of a specified age, is highest for females in the 25 to 29 year age cohort and lowest in the youngest (15 to 19 years) and oldest (45 to 49 years) age groups – as females enter and end their reproductive life (see Figure 3). The ASFR peaks among females aged 25 to 29 years, which has been consistent across census figures for the last 25 years (1991 to 2016). The high ASFR between the ages of 20 and 34 years can partly be attributed to behavioural and structural factors including a low contraceptive prevalence rate and a high unmet need for family planning, cultural and behavioural norms where couples are opposed to/unwilling to use contraception, and women’s empowerment around sexual and reproductive health and rights.⁷ In 2016, geographical patterns of ASFR in Samoa reflected national patterns except in Savaii, where the ASFR peaked in the 20 to 24 year age cohort in contrast to other regions.

Total fertility rate

Figure 4: Total fertility rate, 2016 Census



The total fertility rate (TFR) is the average number of live births each female will have over her reproductive life. Samoa’s TFR between the 1960s and the 2000s has declined from approximately seven children per female in 1966 to four children in 2016, giving an overall picture of a downward trend in fertility in Samoa (see Figure 4). The TFR of four for Samoa is still relatively high compared to the global average of just below 2.5 children, the regional average for Pacific Small Island Developing States (PSIDS) of 3.6 and the average for upper-middle income countries of 1.9.⁸

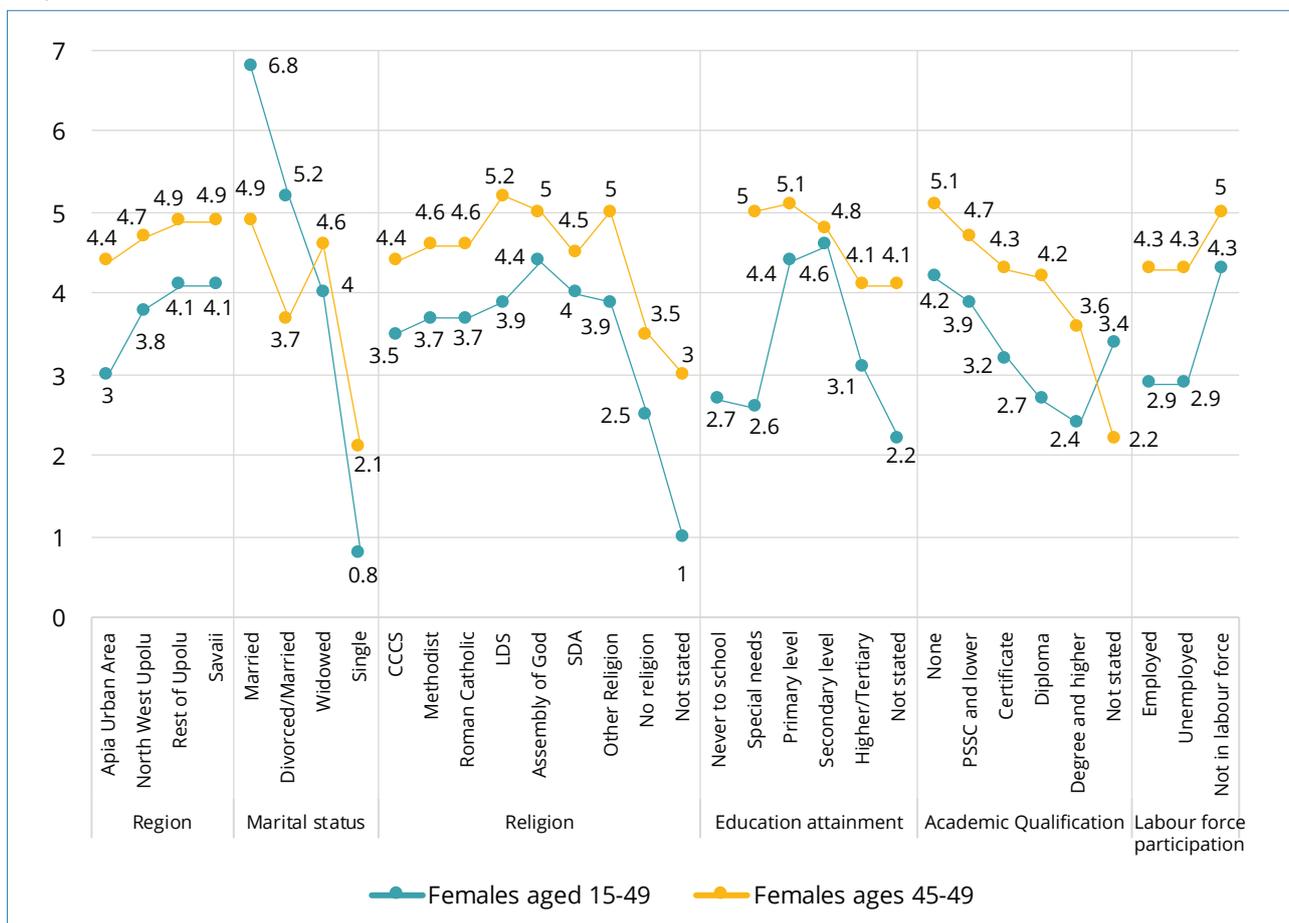
Geographical differences exist in the TFR, which is lower in urban compared to rural areas (3.31 children per female in Apia Urban Area compared to 3.46 in North West Upolu, 3.73 in Rest of Upolu, and 3.67 in Savaii).

Other key differentials that impact on fertility include marital status, religion, educational attainment, and labour force participation.

Figure 5 shows key fertility differentials in Samoa and highlights that:

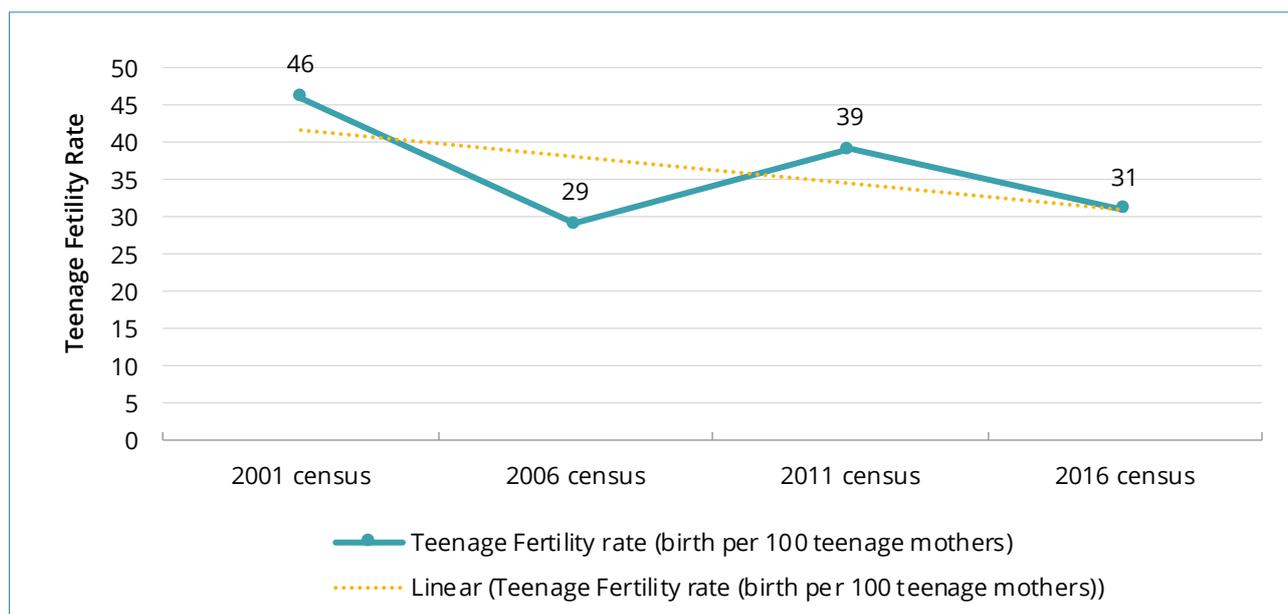
- Females in rural areas have a TFR of 4.9 children compared to females in urban areas where the TFR is 4.4 children.
- Females who are married have a TFR of 4.9 children compared to single females who have a TFR of 2.1 children.
- Females attending the Latter Day Saints church have a TFR of 5.2 children compared to females attending the Congregational Christian Church in Samoa who have a TFR of 4.4.
- Females with a primary education have a TFR of 5.1 children compared to 4.1 for females with a tertiary education; females with no qualifications have a TFR of 5.1 children compared to females with a higher degree where the TFR is 3.6.
- Females not in the labour force or engaged in domestic duties end fertility with 5.0 children compared to the 4.3 children of their employed counterparts.

Figure 5: Current fertility differentials of females aged 15 to 49 and 45 to 49 years, 2016 Census



Teenage fertility

Figure 6: Teenage fertility rate, 2001-2016



The overall teenage fertility trend since 2001 has declined from 46 children per 1,000 women aged 15 to 19 years in 2001, to 31 children per 1,000 women aged 15 to 19 years in 2016 (see Figure 6).

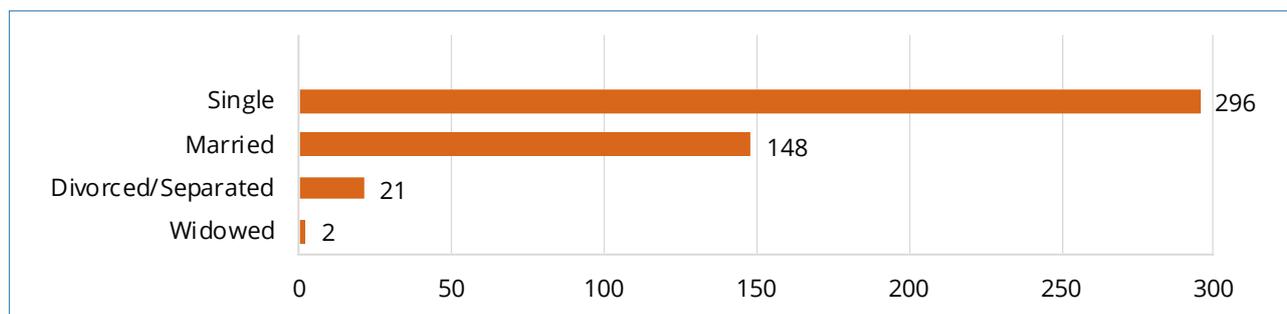
A total of 467 teenagers (5 per cent of the 8,984 female population aged 15 to 19) were pregnant or had given birth at the time of the 2016 Census. Geographical differences are noted in the distribution of teenage mothers; teenage fertility is lower in Apia Urban Area (15 per cent) and in Savaii (18 per cent) compared to North West Upolu (44 per cent) and Rest of Upolu (22 per cent).

As measured by the 2016 Census, Samoa's teenage fertility rate is lower than the regional average for Pacific SIDS of 50 children per 1,000 women aged 15 to 19 years and comparable to the average for upper-middle income countries at 31 births per 1,000 women aged 15 to 19 years.⁹ Similarly, the teenage fertility rate for Samoa may be deemed low in comparison to the high total fertility rate of the country.¹⁰ This fertility pattern underscores the importance of further qualitative studies to understand drivers of fertility including preferences and behaviours within different age cohorts in Samoa.

Based on 2016 Census data, 32 per cent (or 148) of teenage mothers were married, 63 per cent (or 296) were single and the rest (23) were divorced/widowed (see Figure 7). This indicates that differentials in teenage fertility rates are not limited to early age at first marriage. In addition, examples of high parity among teenage mothers were also recorded. Although the majority of teenagers aged 18 to 19 years had given birth to one child, four teenagers aged 17 had two children, two teenagers had given birth to three children, nine teenagers had given birth to three children by the age of 19, and five teenagers had three children by the age of 18. One teenager aged 18 had four children.

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Figure 7: Marital status of teenage mothers, 2016 Census



This pattern highlights the need for a stronger focus on access to age-appropriate and adolescent-friendly sexual and reproductive health services and information in Samoa due to the health and population risks posed by teenage motherhood; as well as the negative impacts on teenage mothers themselves. Globally, the risks for maternal mortality for teenage mothers have been shown to exceed the average and children of young mothers also tend to have higher levels of morbidity and mortality.¹¹ Therefore, there is an urgent need to scale up adolescent and youth-friendly services in Samoa including access to comprehensive sexuality education and information both in and out of school to avoid unintended teenage pregnancies and to support young women who become pregnant.

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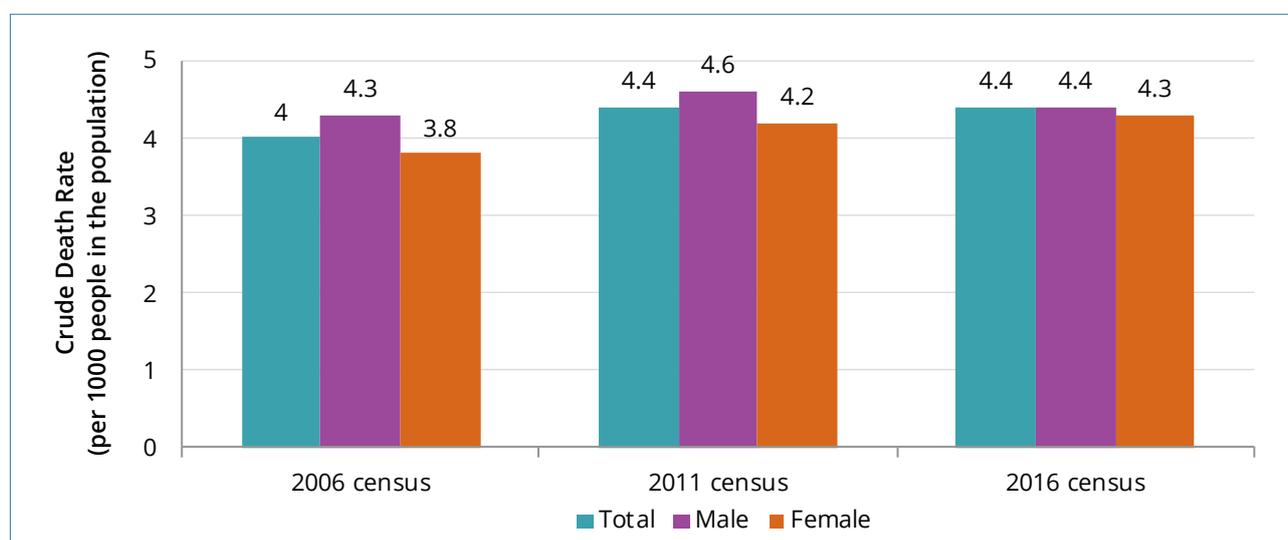
2.3 Mortality

Population mortality by sex

The rate at which death occurs during a year is measured by the crude death rate (CDR), which is expressed as deaths per 1,000 people in a population. Since 2006 the rate at which death occurs in Samoa has been four deaths per 1,000 people per year.

The death rate (per 1,000 people) increased slightly from 4.0 in 2006 to 4.4 in 2011, but remained the same at 4.4 in 2011 and 2016 (see Figure 8). The mortality rate remains higher for males than females across all census years. However, the rate for males decreased slightly in 2016, from 4.6 in 2011 to 4.4 in 2016, while it increased for females from 4.2 to 4.3 over the same period.

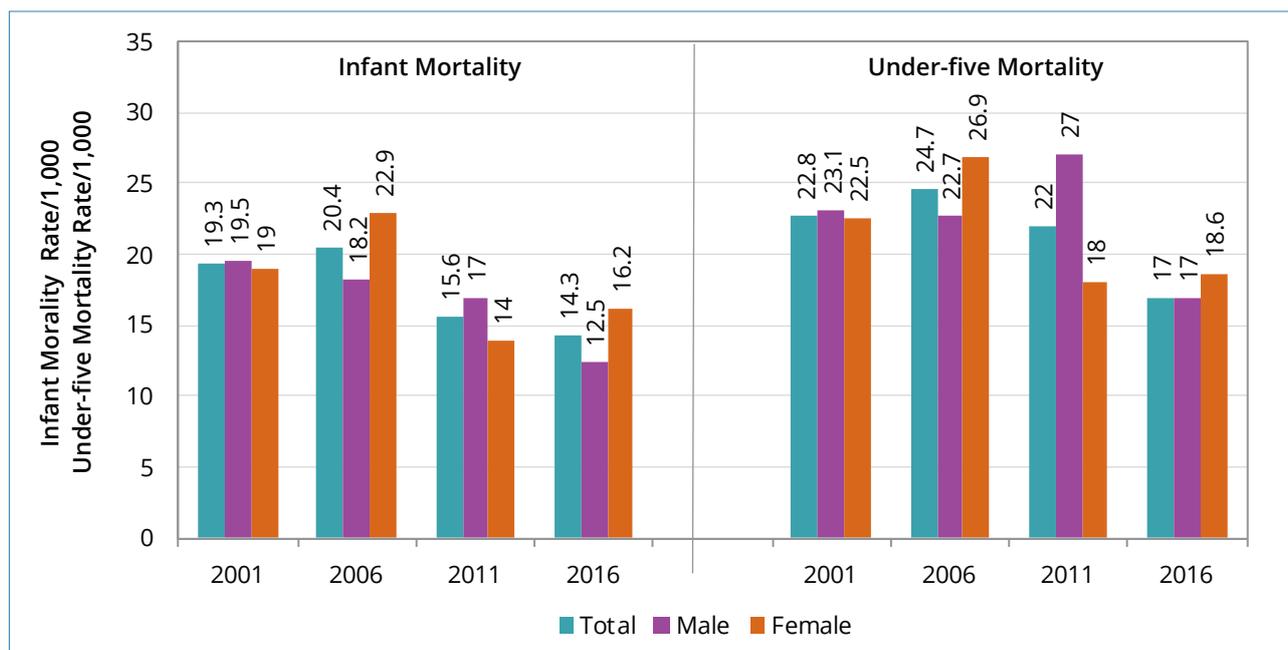
Figure 8: Mortality rate, 2006 - 2016



Child mortality by sex

As shown at Figure 9, the infant mortality rate (IMR) (the number of deaths per 1,000 live births of infants who die before reaching their first birthday) for Samoa declined from 20.4 in 2006 to 14.3 in 2016. The under-five mortality (U5MR) (the number of deaths per 1,000 live births of children who die before reaching their fifth birthday) for Samoa declined from 22.8 in 2006 to 17.0 in 2016. The IMR for females increased from 14.0 in 2011 to 16.2 in 2016, but decreased for males from 17.0 to 12.5 over the same period. Similarly, the U5MR for females increased slightly from 18 in 2011 to 18.6 in 2016, but declined significantly for males from 27.0 to 17.0 over the same period.

Figure 9: Infant mortality rate and under-five mortality rate, 2001-2016



Disability

An analysis of the 2016 Census data shows the trends for disability in Samoa (see Figure 10). A total of 7,134 persons (or 8 per cent of the 167,676 population aged five years and over) in Samoa 'cannot' and have 'a lot of difficulty' with mobility, self-care, vision, memory, hearing and the communication domains of disability. The male-to-female distribution is 4 per cent male to 2.3 per cent female.

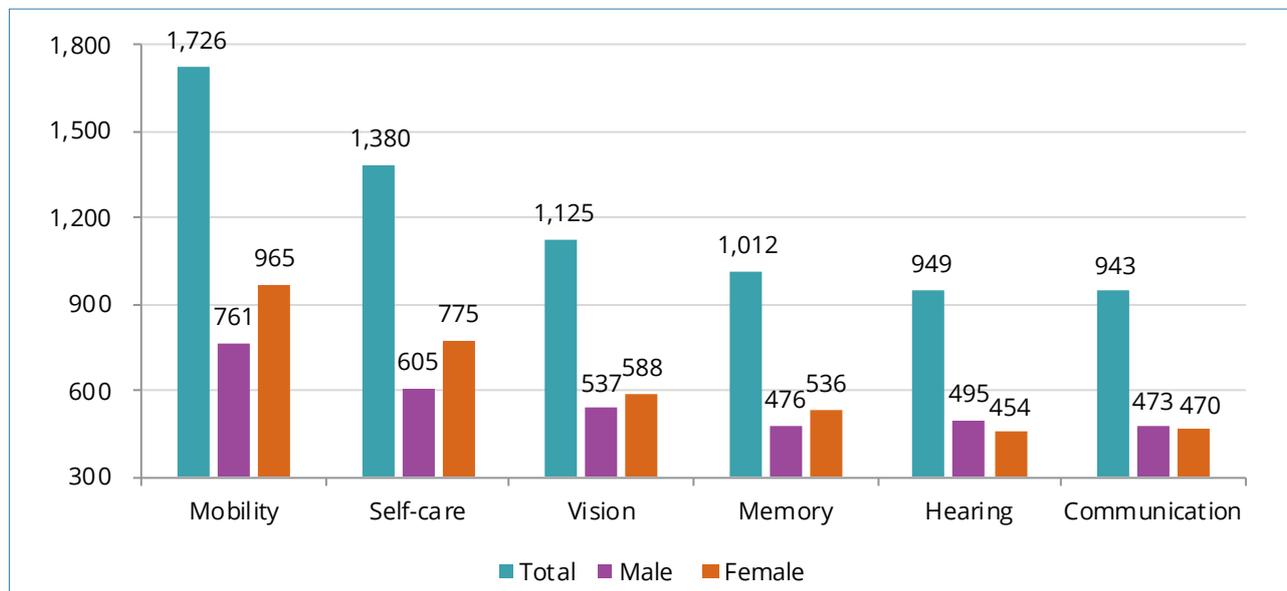
Mobility is the most prevalent form of disability, followed by self-care and vision. A total of 1,726 (24 per cent of 7,134 persons with a disability) either 'cannot do' or have 'a lot of difficulty' with mobility. A total of 761 (or 23 per cent of 7,134 persons with a disability) either 'cannot do' or have 'a lot of difficulty' with self-care. While a total of 1,125 (or 16 per cent of 7,134 persons with a disability) 'cannot' see or 'had a lot of difficulty' with vision.

'Cannot' or have 'a lot of difficulty' with, mobility, self-care, vision, memory, hearing and communication is higher among females. A total of 965 females either 'cannot' or have 'a lot difficulty' with mobility, compared to 761 males. In addition, a total of 775 females either 'cannot', or have 'a lot difficulty' with self-care compared to 605 males. The disparity between males and females is much wider in the mobility and self-care domains of disability, compared to the other domains of disability of vision, hearing, memory, and communication.

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The prevalence of all domains of disability (mobility, self-care, vision, memory, hearing, and communication) is higher among older persons (aged over 70 years) and higher among females than males at older ages, given the longer life expectancy of females. More males experience disability, however, than females at younger ages including as children and adolescents.

Figure 10: Population with a lot of difficulty' and 'cannot do' in the six domains of disability, 2016 Census



3. RECOMMENDATIONS

3.1 Population dynamics

The total fertility rate of four children per woman and the adolescent birth rate in Samoa are both high for a small developing island country, resulting in a high dependency population ratio which will continue for a number of years. This could also impact on economic development and sustainable and inclusive development. Policies and interventions should target the low contraceptive prevalence rate and high unmet need for family planning – those couples who would like to space or end childbearing but are not using any method of contraception – to enable women and couples to have rights and choices around their sexual and reproductive health, particularly in rural areas, and for the most vulnerable and marginalized.

Policies and interventions should target the low contraceptive prevalence rate and high unmet need for family planning

Initiatives should include:

- Increasing access to rights-based and comprehensive sexual and reproductive health services and information to enable decision-making and informed choice around voluntary family planning and the utilization of services including services that meet the specific sexual and reproductive health needs of adolescents and youth.
- Conducting in-depth assessments with females who have over five children, including youth and teenage mothers who are most likely to have more than five children in the next 10 years, with a specific focus on those in rural areas. These assessments will help identify females who are most vulnerable.

3.2 Adolescent pregnancy

The findings presented above highlight that teenage pregnancy is an issue in Samoa, with 467 teenagers either pregnant or having already given birth at the time of the 2016 Census. Most mothers are single parents with one to four children. Teenage pregnancy is also higher in rural than in urban areas.

Programmes and strategies should focus on:

- Scaling up the provision of adolescent and youth friendly sexual and reproductive health services to ensure information and services are appropriate, available and accessible to young people and adolescents to allow them to make informed choices and a healthy transition from adolescence to adulthood as productive citizens, with a particular focus on rural areas.
- Accelerating the integration of quality and comprehensive sexuality education/Family Life Education (aligned to global standards) into school curricula for all grades at primary and secondary levels.
- Providing comprehensive sexuality education through out-of-school/community platforms for surrounding communities including parents, village and church authorities, teachers and other government and community leaders.
- Supporting the provision of information through a range of media to support adolescent and young people's access to quality and age-responsive sexual and reproductive health information.

3.2 Differentials that impact on fertility

The higher fertility rates in rural areas as well as among unemployed mothers need special consideration. Data indicates that mothers who have a limited education are also vulnerable to having more children than mothers who are working and those who have higher educational attainment.

The following strategies and programmes should be implemented to ensure that all women and girls, wherever they live, have access to rights-based and high-quality sexual and reproductive health services and information:

- Scaling up the provision of adolescent and youth friendly sexual and reproductive health services
Implementing campaigns on sexual and reproductive health education targeting rural areas, particularly where fertility rates are high.
- Integrating, as part of ongoing programmes, advocacy around female empowerment and domestic/gender-based violence which focuses on sexual and reproductive health and rights.
- Conducting research to address gaps in knowledge about sexual and reproductive health issues in Samoa, including determining social and behavioural norms that impact on sexual and reproductive health and rights, and understanding the differences in fertility rates between women and geographic regions to devise appropriate programming support, including the link between fertility and maternal and infant/child mortality rates.

3.3 Addressing the needs of women with disabilities

Data above indicates that 1 percent of the population of Samoa is living with a disability (mobility, self-care, vision, memory, hearing and communication), and the proportion is higher among females. Mobility and self-care are the most common domains of disability and more females experience these domains of disability at older ages. ►

It is recommended that:

- The Samoa Disability Policy should be revised to incorporate the findings of this monograph – to ensure that the Policy reflects the needs of the population with a disability, in particular females living with a disability and the higher number of females living with a disability at older ages.
- Initiatives should target the mobility and self-care disability domains as these are the most common forms of disability in Samoa and among females.

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ENDNOTES

¹ Life expectancy indicates the average number of additional years a person would live if the current mortality trends were to continue.

² Based on data from the World Development Indicator database, the average life expectancy for Pacific Island Small states in 2016 was 69.6 (total), 71.5 (female), 67.8 (male), while the median for upper-middle-income countries was 75.2 (total), 78.0 (female), 72.7 (male).

³ World Health Organization, 2018.

⁴ 2015 United Nations. *World Fertility Patterns 2015*. Available at: https://www.un.org/development/desa/pd/sites/www.un.org/development/desa/pd/files/files/documents/2020/Feb/un_2015_worldfertilityreport_highlights.pdf.

⁵ 2017 OECD. *Family Database. Age of mothers at childbirth and age-specific fertility*. Available at: <http://www.oecd.org/els/family/database.htm>.

⁶ 2019 United Nations. *Population Facts. Potential impact of later childbearing on future population*. https://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2019-5.pdf.

⁷ Based on trends and patterns of data on contraceptive use, determinants of fertility and women's empowerment from Demographic and Health Survey 2014 – see Samoa Bureau of Statistics 2015

⁸ Based on 2016 data points from World Bank Open Data (<https://data.worldbank.org/>). Samoa is currently classified as an upper-middle income country using World Bank income classification methodology. Also see United Nations 2015. *World Fertility Patterns 2015*.

⁹ Based on 2016 data points for the adolescent birth rate (teenage fertility rate) from World Bank Open Data. Available at: <https://data.worldbank.org/>.

¹⁰ 2019 Pacific Community and University of New South Wales.

¹¹ 2014 UNFPA.