



Ministry of Health

GLOBAL AIDS RESPONSE PROGRESS
REPORT 2016

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Statement by the Ministry of Health

This is Samoa's fifth Global AIDS Response Progress Report since 2011, evidence of Samoa's commitment to the global response to HIV/AIDS and adhering to the "Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS" adopted by the United Nation member states at the high level meeting held in New York 2011.

The Global AIDS Response Progress Report is a highly regarded report with an in-depth analysis of core indicators that provides insight into our national efforts to alleviating HIV/AIDS through collective prevention initiatives and programs carried out by our various committed stakeholders and health sector partners.

In addition, Sexually Transmitted Infections (STIs) still pose considerable threats to morbidity and possible mortality in both adults of reproductive age and newborns. STIs also can significantly increase the risk of HIV transmission if un-prevented among our populations.

Conversely, if STIs are not managed and prevented, they can contribute negatively to healthcare costs attributed to treatment and care, program management and others, that will in turn affect our health budget overall.

While much has been done by our various partners, there is still room for more strategic interventions to be in place to counteract these preventable diseases. Samoa's current National Policy and National Strategic Plan on HIV/AIDS 2011-2016 will come to an end in Dec 2016, and already work has been done by our national partners to start looking at developing a new policy and NSP factoring in issues and challenges encountered over the lifespan of the existing policy and plan.

Over the years Samoa receives financial support from several international and regional partners. Our government on the other hand contributes significantly through supporting our Human Resource for HIV/AIDS plus logistics aspects of national program.

The ongoing treatment, care and support offered by the NHS for our PLWHA is greatly appreciated, and the Government of Samoa through the Ministry of Health acknowledges the continuous support rendered by the Global Fund for HIV of whom without it our people living with HIV/AIDS would have not receive their treatments for free. Thank You.

May this report continues to provide even more strategic direction and options to all our national, regional and international partners whom we are working together to fight HIV/AIDS now and into the future.

Faafetai,



Leausa Toleafoa Dr Take Naseri

Director General of Health

SAMOA MINISTRY OF HEALTH.



I. Status at a glance

(a) The inclusiveness of the stakeholders in the report writing process;

The preparation of the 2016 Global AIDS Response Progress Report (GARP) for Samoa was facilitated and compiled by the Ministry of Health (MoH), with relevant government ministries and non-government organization (NGO) partners involved in the response to HIV/AIDS and STIs in Samoa.

Collection of data for this report was carried out in consultation with various stakeholders and health sector partners. Data were collated and analyzed by MoH for the development of this report.

2015 GARPR Team (MOH)

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Stakeholders Contribution through submission of reports of activities implemented in 2015:

- i. Ministry of Women, Community and Social Development
 - a. Division for Youth and Division for Women.
- ii. Samoa Family Health Association
- iii. National Health Services
 - a. Public Health Clinic (HIV/AIDS Patient Register Summary)
 - b. Laboratory Services (National Surveillance STIs Data)
 - c. Pharmaceutical Services (ARV Drugs Supply Record)
- iv. Samoa Red Cross Society
- v. Ministry of Health- HIV/AIDS National Program & Sexual Reproductive Health Unit

(b) The status of the epidemic

The first case of HIV recorded in Samoa was in 1990. Since then, 24 cumulative cases have been reported. Currently there are 11 living cases of HIV. Though this is a low prevalence, low testing rates (4-5%) indicate that there are many more cases likely undetected. The high prevalence of other STI's (Chlamydia 26% in 2015) are also a concern and pose risks for increasing HIV transmission (Kilmarx 2001).

The primary mode of HIV transmission in Samoa is through heterosexual sex. There are currently 6 cases of mother-to-child transmission (3 adults, 3 children). Of the living cases of HIV, 9 are receiving treatment from the public health sector, while 2 receive private treatment from overseas. There have been 2 cases of successful prevention of MTC transmission through the administration of ARV regimens in pregnant women. The last reported case of HIV was reported in 2013.

STI's generally have low voluntary testing rates (apart from ANC STI testing which is mandatory). Table 1 shows that Chlamydia, which has the highest prevalence, also has the low testing rate. This is a particular concern considering that a high prevalence of 26% is detected in only 1% of the population.

Table 1 - STI Surveillance Data at a Glance

	2015 Prevalence	2015 Testing Rate
Chlamydia	26%	1.0%
Hepatitis B	2%	4.6%
Syphilis	0.3%	4.4%
Hepatitis C	0.1%	2.0%
HIV	0%	4.6%
Gonorrhoea	Not tested	Not tested

(c) The policy and programmatic response

Samoa Ministry of Health, being the National Focal point for HIV/AIDS, has the responsibility for the strategic oversight and acts as the Monitoring and Evaluation entity for the country's response to HIV/AIDS. Samoa's National Strategic Plan for HIV/AIDS covers the period 2012-2016, and a review of this National Strategic Plan and Policy took place in November 2015 with stakeholders and health sector partners. The new policy is expected to be drafted in mid 2016 to cover 2016-2020, pending a final consultation with stakeholders.

Furthermore, under the Ministry of Health, a National AIDS Coordinating Council (NACC) was established in 1987. This is an equivalent to the Country Coordinating Mechanism (CCM). In 1988, a Technical AIDS Committee (TAC) was established as the working arm of NACC. TAC is tasked to provide technical advice to the NACC on policy, to manage and monitor the programmatic aspects of HIV/AIDS interventions, and to suggest appropriate actions to further strengthen policy and programmatic response to HIV/AIDS through a multi-sector approach.

Overall, the Ministry of Health provides clear policy guidance and relevant, technical assistance, to ensure HIV/AIDS and STI interventions are delivered in accordance within national policies and appropriate frameworks, and to minimize fragmentation and duplication of programs.

A Health Sector Monitoring and Evaluation (M&E) framework was operationalized in 2010, which includes some indicators relevant to HIV/AIDS and STIs. A specific M&E framework for HIV/AIDS was developed in late 2015 and was reviewed by staff and management at MoH. It is expected to be finalized in June 2016, with implementation to take place later in that year.

(d) Indicator data overview

	GARP Indicators	2015 Data
	Target 1. Reduce sexual transmission of HIV by 50% by 2015	
	A. General population	
1.1	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<p>A) Youth ages 15-24- 85.7% have heard of AIDS; 86% female and 78% male, which is somewhat less than older respondents (95-84%)</p> <p>B) Knowledge of HIV prevention methods is lowest among the 15-24 age group. When asked about prevention methods, respondents indicated that HIV can be reduced through 1. using condoms (63.1% female and 63.6% male) 2. limiting sexual intercourse to one uninfected partner (78.9% female 71.9% male) 3. using condoms AND limiting intercourse to one uninfected partner (61.1% female, 59.3% male) 4. abstaining from sexual intercourse (66.7% female, 55.1% male).</p> <p>C) Transmission: Comprehensive knowledge about HIV transmission was lowest among youth age 15-19 in Savaii. Percent who say a healthy looks person can have the virus and reject the two most common local misconceptions about transmission was 7% in females, and 7.8% in males. Percentage of those with comprehensive knowledge about HIV/AIDS was 5.1% female, 5.7% male.</p>
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	For women ages 15-19 and 20-24, 0.9% and 1.1% respectively had first sexual intercourse by age 15. For men ages 15-19 and 20-24, 3.2% and 1.8% respectively had first intercourse by age 15.
1.3	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	The DHS does not capture number of sexual partners in the past 12 months. Instead it captures the timing of the last sexual intercourse. For women age 15-49 had sexual intercourse in the past month, and 14.7% within the past year. For men ages 15-54, 47.9% had sex within the past month, and 18.7% had sex within the past year.
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	Data not available. However general condom use rates are available in the DHS 2014 (1.5% women regularly use condoms, 14.4% men have ever used a male condom)
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	0.7% of women and 0.1% of men out of the total population have been tested for HIV and received results within the past year according to surveillance reports and DHS 2014 population estimates.
1.6	Percentage of young people aged 15-24 who are living with HIV	0%, None of the HIV cases are currently in this age group
	B.1. Sex workers	No data available for this section.
1.7	Percentage of sex workers reached with HIV prevention programmes	No data available for this section
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	No data available for this section
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	No data available for this section
1.10	Percentage of sex workers who are living with HIV	No data available for this section
	B.2. Men who have sex with men	No data available for this section.
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	No Data available for this section.
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data available for this section
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	No data available for this section

1.14	Percentage of men who have sex with men risk who are living with HIV	No data available for this section
	C. Testing and counselling	
1.15	Number of health facilities that provide HIV testing and counselling services (UA)	There is only one testing facility in Samoa ie: national Laboratory Services, and 2 accredited VCCT clinics in operation
1.16	HIV Testing and counselling in women and men (UA)	8870 Total number of those 15+ years old recorded as having a HIV test for 2015
1.16.1	Rapid HIV test kits stock-outs (UA)	not available
1.17	1.17 Sexually Transmitted Infections (STIs)	<u>STI Prevalence 2015:</u> HIV 0% Syphilis 0.3% Hepatitis B 2.4% Hepatitis C 0.1% Chlamydia 26%
1.17.1	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit (UA)	98.7%. Numerator=2885, Denominator=2915
1.17.2	Percentage of antenatal care attendees who were positive for syphilis (UA)	0% of positive syphilis cases are from ANC visits/clinics
1.17.3	Percentage of antenatal care attendees positive for syphilis who received treatment (UA)	100%, no new data, testing still mandatory and treatment free
1.17.4	Percentage of sex workers with active syphilis (UA)	no data available
1.17.5	Percentage of men who have sex with men (MSM) with active syphilis (UA)	no data available
1.17.6	Number of adults reported with syphilis (primary/secondary and latent) during the reporting period (in the past 12 months) (UA)	10 positive (primary,secondary, and latent not available)
1.17.7	Number of reported congenital syphilis cases (live births and stillbirth) during the reporting period (in the past 12 months) (UA)	0
1.17.8	Number of men reported with gonorrhoea during the reporting period (in the past 12 months) (UA)	no data available
1.17.9	Number of men reported with urethral discharge during the reporting period (in the past 12 months) (UA)	no data available
1.17.10	Number of adults reported with genital ulcer disease during the reporting period (in the past 12 months) (UA)	no data available
1.19	Diagnosis of HIV and AIDS cases (UA)	0
	Target 3. Eliminate mother- to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	* Estimated # of Pregnant Women at any point in time during 2015= 9615.7
3.1	Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-	100%

	to-child transmission	
3.1.a	Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	100%,
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100%
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	0
3.3.a	Mother-to-child transmission of HIV (based on programme data)	3 cases of mother to child transmission
3.4	Percentage of pregnant women who know their HIV status (tested for HIV and received their results-during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status (UA)	96.8%. In 2015, 2915 women reported for ANC visits and received the panel of mandatory blood tests. 2822 tests for HIV were processed by the lab.
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months (UA)	No data available for this section
3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing (UA)	Not applicable, no HIV cases that are pregnant
3.7	Percentage of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks (UA)	0
3.8	Infants born to HIV-infected women who are provided with ARVs to reduce the risk of HIV transmission during breastfeeding	0
3.9	Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth (UA)	0
3.10	Distribution of Outcomes of HIV-Exposed Infants (UA)	No data available for this section
3.11	Number of pregnant women attending ANC at least once during the reporting period (UA)	2915
3.12	ANC and EID Facilities (UA)	12
	Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015	
4.1	Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	100%
4.2.a	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral	100%

	therapy	
4.2.b	HIV Treatment: 24 months retention (UA)	100%
4.2.c	HIV Treatment: 60 months retention (UA)	100%
4.3.a	Health facilities that offer antiretroviral therapy (UA)	1 public health clinic that offers ARV
4.3.b	Health facilities that offer paediatric antiretroviral therapy (UA)	1 public health clinic that offers ARV
4.4	ART stockouts (UA)	none
4.5	Percentage of HIV positive persons with first CD4 cell count < 200 cells/ μ L in 2014 (UA) (" <i>Late HIV diagnoses</i> ")	33%, 3 out of 9 living cases had a CD4 count under 200 at time of diagnosis 0 PLWHIV's CD4 counts were below 200 cells in 2015 0 new HIV diagnoses since 2013
4.6	HIV Care (UA) (Total number of adults and children enrolled in HIV care at the end of the reporting period)	100% All those PLWHA are receiving treatment as needed
4.7	Viral load suppression	viral load testing every 6 months, sent to New Zealand for processing
4.7.a	Percentage of people on ART tested for viral load (VL) who were virally suppressed in the reporting period (UA)	not available
4.7.b	Percentage of people on ART tested for viral load (VL) with VL level \leq 1000 copies/ml after 12 months of therapy (UA)	not available
4.7.c	Percentage of people on ART tested for viral load (VL) with undetectable viral load in the reporting period (UA)	not available
	Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	
5.1	Co-Management of Tuberculosis and HIV Treatment	no detected cases of TB/HIV coinfection
5.2	Health-care facilities providing ART for PLHIV with demonstrable infection control practices that include TB control	1
5.3	Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT))	0 new cases
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	None of the cases of HIV are tested for TB because clinicians have not detected symptoms
	Target 6. Close the resource gap	
6.1	AIDS Spending - Domestic and international AIDS spending by categories and financing sources	International Contribution is 64% (\$80,368 USD) while National Government contributed 36% (\$45,000 USD). International is made up of Global Fund for HIV, UNFPA – SFH/FP, SFHA-IPPF
	Target 7. Eliminating gender inequalities	
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No data available for this specific measurement, however relevant data is included in the narrative.
	Target 8. Eliminating stigma and discrimination	

8.1	Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	Only 2.6% of women and 3.3% of men expressed acceptance of PLWHA on all four indicators of accepting attitudes towards PLWHA. Those indicators are 1) willingness to care for a family member with the virus in respondent's home 2) would buy fresh vegetables from a shop owner who has AIDS 3) would say that a female teacher who has AIDS and is not sick should be allowed to continue teaching 4) would not want to keep secret that a family member got infected with the AIDS virus.
	Target 9. Eliminate Travel restrictions	
9.1	Travel restriction data collected by Human Rights and Law Division at UNAIDS HQ, no data collected needed	Foreigners up until 2016 were asked to declare their HIV status on immigration forms. This section of the form was replaced with questions about Zika exposure. There are no short term stay restrictions regarding HIV status, however foreigners applying for a residency or work permit and who would like to stay in Samoa for more than 12 months are required to undergo a medical examination, which may include an HIV-test. Those citizens going abroad to live/work in other countries are required to have an HIV test for clearance. Testing is administered by Immigration.
	Target 10. Strengthening HIV integration	
10.1	Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age)	no data available
10.2	Proportion of the poorest households who received external economic support in the last 3 months	no data available

II. Overview of the AIDS epidemic

The first case of HIV recorded in Samoa was in 1990. Since that time, the recorded prevalence of the virus has remained low in prevalence (0.005%) with 0 new cases being captured between 2012-2015. However, testing rates are low with around only 4 to 5% of the population being tested each year according to quarterly surveillance reports (see Table 2.).

Table 2 - HIV Testing Rates

Year	HIV Tests	Percent of Population
2012	9394	4.9%
2013	8443	4.4%
2014	7461	3.9%
2015	8870	4.6%

Most of those tests come from routine antenatal blood panels in mothers having their first antenatal care visit. Voluntary testing, and testing in males are low. For these reasons, the full impact of HIV/AIDS on Samoa remains relatively unknown. However, Table 3 shows that a quarter of the documented HIV cases are mother to child transmissions, which suggests that HIV may be more prevalent than what current surveillance systems are detecting. All documented living cases are currently receiving ARV treatment, which is free at all health sector partners of the Ministry of Health.

Table 3 - HIV/AIDS Summary

HIV/AIDS Profile		
Cumulative Cases	24	
People Living with HIV	11	
Deceased	13	
Mother to child transmission	6	Quarter of the cases are made up of children.
Children living with HIV	2	
Deceased	4	
Successful Prevention of MTCT	2	Not getting the virus from their HIV+ mothers, because of successful treatment ie: ARVs
Gender Disaggregation		
Males	18	(6 are children and 12 and adult males) - overall 3/4 of cases are males.
Females	6	(all are adult females)

The high rates of Chlamydia in Samoa also potentially increase the risk for HIV transmissions. Chlamydia is primarily transmitted sexually like HIV, and has been known to increase infectiousness in people with HIV by increasing viral shedding in the cell walls of genitals. Chlamydia is a major problem in Samoa with a high prevalence in pregnant women, who are supposed to be low risk for the disease. Of 2,025 individuals tested at hospitals and health clinics in 2015, 26% had Chlamydia. This rate is made up of predominantly antenatal women. The prevalence may be higher in rural areas with one study with women age 18-29 estimating a prevalence of 36.7%. Chlamydia also has a low testing rate for the general population (only 1% in 2015).

Regarding HIV prevention and knowledge of HIV and AIDS, the Demographic Health Survey 2014 found that condom use (of male condoms) is low, although higher in males (14-15%, see Table 4). The amount of youth that know condoms prevent HIV rose 10.1% in women and 5.3% in men between 2009 and 2014. Though increasing, the percent of individuals that have comprehensive knowledge of HIV and AIDS transmission/prevention is still low (6.5% of women and 6.4 % of men).

Table 4 - Select DHS 2009 and 2014 Findings

DHS Findings	2009		2014	
	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Male</i>
Condom Use (Current)	0.1%	unavailable	0.1%	unavailable
Condom Use (Ever)	1.1%	14.3%	1.5%	15%
Percent of youth age 15-24 that know condoms prevent HIV	53%	56.3%	63.1%	61.6%
Percent of individuals having comprehensive knowledge of HIV and AIDS transmission and prevention	3.9%	7%	6.5%	6.4%
Percent of individuals expressing acceptance of PLWHA on all 4 indicators	2.1%	3.4%	2.6%	3.3%

Regarding the acceptance of persons living with HIV or AIDS (PLWHA) only 2.6% of women and 3.3% of men express acceptance of PLWHA on all 4 indicators. This has remained roughly the same since 2009. This illustrates the stigma that is still associated with HIV and AIDS and previous programming has not effectively addressed it.

III. National response to the AIDS epidemic

A. Prevention, Treatment, Care and Support

Samoa's first known HIV+ case was recorded in 1990 Over the years policies were developed, National Strategic Plans were designed, and National Councils and Technical Committees were established to plan out the architecture of our national HIV/AIDS response. To date, a considerable number of initiatives responding to HIV/AIDS in Samoa are well underway. These are summarized in the below. In 2015 the national response was hindered in terms of program implementation. The delay in disbursement of funds resulted in the delay and reduced number of programs that were able to be implemented.

Table 5 below provides a summary of the HIV and STI programme activities conducted during 2015 amongst MOH stakeholders.

Table 5 - Summary of Activities Implemented Incl. Stakeholders and Partners Jan – Dec 2015

<u>Implementing Organization</u>	<u>Programs Implemented</u>	<u>Target Population</u>	<u>Partner(s)</u>
Ministry of Health	Behaviour change programmes	General	SFHA/MWCSD/GF
	Condom promotion	General	SRCS/SFHA/IPPF
	Programmes for transgender people	Transgender	SFA/SFHA/IPPF
	Programmes for children and adolescents	Children and Adolescents	MWCSD/SNYC/UNFPA
	Community mobilization	General	SFHA/SRCS/MWCSD/UNFPA/GF/IPPF
	Strategic information	Stakeholders and Health Sector Partners	Stakeholders and Health Sector Partners
	Planning and coordination	Stakeholders and Health Sector Partners	Stakeholders and Health Sector Partners
	Procurement and logistics	Healthcare Facilities	n/a
	Health systems strengthening	Healthcare facilities	n/a
	Policy dialogue	General	Stakeholders and Health Sector Partners
	Stigma reduction	PLWHA	Stakeholders and Health Sector Partners
Social protection programmes	Key Populations	Government of Samoa and Other International Partners	

<u>Implementing Organization</u>	<u>Programs Implemented</u>	<u>Target Population</u>	<u>Partner(s)</u>
	Gender programmes	Women	Government of Samoa and Other International Partners
	Education programmes	General	Government of Samoa and Other International Partners
	Workplace programmes	Workers	Government of Samoa and Other International Partners
	Synergies with health sector	General	Government of Samoa and Donor Partners
	Conduct assessment on youth-friendliness of SRH services provided at district hospitals & Training of Trainers for SRH Service Providers on Youth Friendly Service & other priority issues.	Registered Nurses, enrolled nurses, peer educators	Stakeholders and Health Sector Partners
	Six monthly consultation with stakeholder	Government Ministries and Non Government Organization	Stakeholders and Health Sector Partners
	Production & airing of Multimedia Campaign on SRH priority issues	General population	Stakeholders and Health Sector Partners
	Monitoring of SRH/HIV activities and commodities	Healthcare Facilities in both Upolu and Savaii	Health Sector Partners
	Printings of Clinical data Log Books and Ante-Natal brochures	Healthcare Facilities in both Upolu and Savaii	Health Sector Partners
Ministry of Women Community and Social Development	Mothers and Daughters Program on STIs/HIV	Young women of 13 years upwards and mothers	Stakeholders and Health Sector Partners
	National Peer Education Program on SRH issues STIS , HIV/AIDS, teenage pregnancy, role of peer educator	Young men and women with the age group of 18-35 years, teenagers	Stakeholders and Health Sector Partners
	Young couples program on SRH issues STIs, HIV/AIDS and Gender Based Violence and Life skill's manual	Young couples with the age group of 16-25	Stakeholders and Community Social Structures
	Fathers and Sons program on SRH issues of STIs / HIV AIDS and Gender Based Violence, Mental Health Issues and Laws helped address SRH and GBV issues	Fathers(men) and their sons (young men) of 13 years upwards	Stakeholders and Community Social Structures

<u>Implementing Organization</u>	<u>Programs Implemented</u>	<u>Target Population</u>	<u>Partner(s)</u>
	and Communication Skills		
	Teen Mums program on CEDAW and its relation to violence, gender roles and responsibilities, good relationship between teen mums and their families and SRH rights and issues	Adolescent mothers 18 years below.	Stakeholders and Community Social Structures
Samoa Family Health Association	Community Outreach	Young people	Stakeholders and Community Social Structures
	Condoms Distributions	Young people	Stakeholders and Community Social Structures
	Inmates sessions	mothers	NGOs
	STI Screening, Tests and Treatment	young people & pregnant mothers	NGOs and Health Sector Partners
	I.E.C Dissemination	People 18 yrs and over	MoH and Partners
	TV spots	all people	MoH and Partners
	Peer Educators Training	Young people	MoH and Partners

Beyond the National AIDS Coordination Committee (NACC) and the Technical AIDS Committee (TAC) composition that included multi-sector partners from government ministries and non-government and civil society sectors, the donor partners ie: Global Fund to fight AIDS, TB and Malaria (GFATM) provided financial support to allow Health Sector partners from government ministries and non-governmental organizations (NGOs) to become more actively engaged in the HIV/AIDS and STI response in Samoa. NGOs such as the Samoa Faafafine Association (SFA), Samoa Family Health Association (SFHA), and Samoa Red Cross Society (SRCS) have been remarkable in strategizing ways to combat the spread of HIV/AIDS, including (i) addressing vulnerable groups such as men who have sex with men (MSM); (ii) mobile clinics promoting safer sex and distributing condoms; (iii) and ensuring safe blood is provided to the blood banks. Red Cross continues to advocate for safe blood donors thus contributing to a greater pool of voluntary blood donations (VNRBD). The majority of blood provided is from family replacement donors. All blood donors are continuously screened for HIV, syphilis, HepB, and HepC.

Samoa National HIV/AIDS Policy and Plan of Action 2012-2016 is the guiding document of all sector's and stakeholders' interventions. This policy links with the National Sexual Reproductive Health Policy and Plan of Action 2011-2016 that also highlights the need for stringent approaches to reversing increasing STIs targeting the ANC mothers in particular and young people as well. The new version of the policy covering 2017-2022 will be drafted pending consultations with stakeholders and health sector service delivery partners.

Over the years gender awareness programmes have increased opening up the opportunities to more openly addressing sensitive issues of sexual behaviour and related underlying factors affecting risk and vulnerability to HIV and STIs. Despite this, gender inequality and in particular sexual and domestic violence remain a problem that is commonly highlighted in the media to date.

Most recently, the State of the Human Rights Report 2015 made national headlines with its findings which detailed that a majority of men and women see domestic violence as acceptable and justified.

In order to address these issues from a health perspective, open dialogue through community consultations throughout the year, healthy lifestyle advocacy at the political level, the inclusion of the church in health dialogue processes with the youth and communities are the mainstay of interventions carried out each year. Building partnerships and affiliation with the Ministry of Education Sports and Culture using the Health Promoting Schools approach, in order to gauge in the attention of young and active people at secondary and tertiary level education.

Mass media campaign and peer education programs that mobilizes young girls and women about their rights for their safety and health, inclusion of men in discussion of sexual reproductive health issues with emphasis on STIs/HIV and AIDS, the strong involvement of Samoa Faafafine Association in many other activities that targets faafafine populations is crucial, and many other programs carried out by the sector partners. A documentary “E te silafia”, which described the status of the HIV/AIDS epidemic in Samoa is regularly aired on World AIDS Day each year

2015 World AIDS Day Activities



Support from our local politicians and church ministers and others – WAD Mass

For this year’s activities, Samoa’s Ministry of Health and its multi-sectoral partners launched World AIDS Day in Apia, Samoa with a holy mass at Mulivai Cathedral commemorating those who have died from HIV/AIDS. There was a candlelit process held before the actual ceremony proceeded where candles were blessed and placed in front of the altar. The service was led by Archbishop Afioga Alapati Lui Metaeliga. Red ribbons were distributed in town and during the mass with the assistance of the Samoa Red Cross Society.



Participants in the WAD Mass candle ceremony



World AIDS Day 2015 Banner

MOH launched multiple media campaigns during the following week. This included multiple radio and TV spots as well as an airing of the documentary “E te silafia”, which described the status of the HIV/AIDS epidemic in Samoa on national television.

The Samoa Fa’afafine Association held several awareness activities targeting their own groups and branched out to assist with condom distribution in the town area. They also held the National Forum for Fa’afafine, which was a platform for the community to discuss human rights, sexual health, and community awareness of these issues within the fa’afafine (third gender) community. In keeping with the World AIDS Day Theme of “Getting to Zero” (particularly new infections), a representative from the Ministry of Health presented on STI prevention with a focus on reducing high risk sexual behaviour. There was also a community discussion among fa’afafine about the impact of discrimination on the fa’afafine community and how that impacts their sexual health and HIV risk. Relating to the future of HIV/AIDS prevention, the forum gave the opportunity for the community to discuss future directions for leadership and advocacy. The forum also sought to discuss the integration of international human rights with fa’asamoa cultural rights as they relate to discrimination.

The Samoa Family Health Association distributed red ribbons and condoms in to promote awareness of HIV, especially with young people. They also offered free testing services, specifically targeted young people. Additionally, Samoa’s Ministry of Women, Community and Social Development and the Ministry of health together promoted HIV awareness via information booths during the events of National Youth Week.

In 2013, both HIV/AIDS and SRH came together and established their own set of stakeholders instead of two programs having their own separate sets. The underlining objective is for both components to work together and complementing each others, and do programs together to avoid duplication of activities and program fragmentation. This will also allow for provision of strategically planned and well-coordinated technical support that both programs can offer to its stakeholders

Despite these efforts, an entity dedicated solely to the fight against HIV/AIDS does not exist after the programmes carried out by the Samoa AIDS Foundation and Samoa Plus ceased since 2012.

List of SRH & HIV/AIDS Stakeholders

1. Ministry of Health – Chairperson of SRH & HIV/AIDS Stakeholders
2. Samoa Family Health Association – Executive Director
3. Samoa Faafafine Association – Chairperson

4. Ministry of Education, Sports and Culture (CEO, Curriculum Development Unit Rep)
5. Ministry of Police (Commissioner, Rep from Domestic Violence Unit, Rep from Community Program Unit)
6. Ministry of Women, Community and Social Development (Division for Women Rep, and Division for Youth Rep)
7. National Health Services – Integrated Community Health Services, STIs/HIV and AIDS Clinical Nurse
8. Samoa Law Reform Commission – CEO
9. Samoa Red Cross Society – Executive Director
10. Ministry of Health – ACEO Health Protection and Enforcement Division, ACEO Strategic Policy, Planning Division; ACEO Health Sector Coordination Resourcing and Monitoring Division and ACEO Health Information Systems & ICT Division, ACEO IHR & National Surveillance Division
11. Congregational Christian Church – Youth Director
12. Methodist Church – Youth Director

Peati Maiava, the only PLHIV who has publicly declared her HIV status and worked with other PLHIV under the SRCS, passed away in 2015 at the age of 65. Thus far none of the PLWHIV have been willing to take her place as spokesperson and work with the national councils on issues of confidentiality.

The NGOs namely the Samoa Family Health Association (SFHA) and Samoa Red Cross Society (SRCS) are active in implementing many HIV/AIDS and STI interventions, and can seek support from the MOH for funding, current data and information, and technical training. This resource/policy and strategic development, monitoring versus implementer' type of relationship is emphasized in the Health Sector Plan. The *Health Ordinance 1959 MOH Act* and *NHS Act 2006* articulates this relationship with regards to the expectation that sector partners will implement, record and report data to ensure progress against national health targets and health-related policies is informed by evidence.

The Ministry of Women, Community and Social Development (MWCSO) has developed a "*Strategy: For the Reproductive and Sexual Health of women of Samoa 2014-2018*" with the emphasis on further advocating the SRH rights of women of Samoa in line with the CEDAW. This strategy is premised on previous policies that the MWCSO had in the past years. Their youth division lead the celebration of the National Youth Week in November. One of the issues discussed was STIs/HIV/AIDS amongst our young people, and how it will affect their lives in the long run.

The Ministry of Education Sports and Culture (MESC) also plays a vital role in incorporating Health and Physical Education into their Secondary Schools curriculum since 2008. The latest update on the progress towards realising that fundamental reproductive health issues are included in the school's curriculum and is scheduled to take place in 2015. This review of the current curriculum will take into account SRH as a whole to be taught in schools, and the need to have it a compulsory subject rather than as an optional subject. UNFPA and UNESCO are also currently working towards addressing this area with the MESC.

Police officers do not undergo mandatory HIV or STI screening before or after their overseas peacekeeping missions, whereas seafarers have a structured process for HIV, syphilis, HepB. Ministry of Police also conducted several health interventions with the assistance from the Ministry of Health and SFHA on activities highlighting STIs/HIV and AIDS for new police recruits in both Upolu and Savaii.

The primary sources of funding for Samoa's HIV programs for this reporting period are from: (i) the Global Fund to fight AIDS, TB and Malaria (GFATM) (ii) funding from UNFPA for the Sexual and Reproductive Health (SRH) program and Adolescent Health Development (AHD). The AusAID has earmarked SAT2m for SRH programs, highlighting the increasing prevalence of STIs that needs dire attention from all different health sector partners. The government of Samoa assisted tremendously in financing human resource for HIV/AIDS program, and some activities are well mainstreamed into the MOH budget at the end of 2013.

Even though there are many intervention programs implemented by our sector partners in such prevailing conservative contexts, there is still a lot more efforts that needs to be directed at changing behaviour of our people, addressing stigma surrounding sexual health and HIV,

B. Care, Treatment and Support

The public funded National Health Service (NHS) is the main service delivery point for all health care services in Samoa, including for HIV/AIDS care and treatment. The NHS laboratory is responsible for all diagnostic procedures to ensure quality of HIV testing. It is also involved in external quality assurance (EQA programmes) which ensures the quality of all tests done in the laboratory. The Communicable Diseases Public Health Clinic is also under the NHS jurisdiction and proper care and treatment for HIV/STI is also offered free of charge to those who require it.

Treatments of STIs are offered free of charge by the Public Health Clinic at the NHS, SFHA clinics, and all national health centers. Towards the end of 2014, presumptive treatment of STIs offered to all visiting ANC mothers, a strategy responding to increasing STIs in Samoa began its implementation in most District Hospitals in both Upolu and Savaii. Full implementation of this strategy in all health centres is yet to come into fruition.

Patients' information regarding voluntary testing and counselling remains confidential. Homecare visits for HIV+ are offered free of charge. These visits encompass health education talks, ARV drug regimen sessions, and offering support where necessary.

Continuing VCCT monitoring visits are conducted every 3 months. The objectives behind these visits are to ensure that i) clinics that were refurbished under GF support are well maintained, ii) determining the treatment rates of STIs in Samoa iii) furnish IEC materials for all healthcare centres and iv) tracking of utilisation of Family planning commodities. Reports of these visits are submitted to MoH management for strategic advice and so forth.

Counselling services remain a challenge to date. Those who were trained in 2009 by the Pacific Counselling and Social Service (PCSS) of counselling capacities are either being re-designated to other areas of the healthcare system, or have left the service for other opportunities.

Treatment guidelines for both STIs and AIDS are to be drawn for the updated versions of the Oceania Society for Sexual Health and Medicines (OSSHM) and technical guidelines periodically updated by WHO. The OSSHM Guidelines 2013 provided assistance in terms of treatment and care in all STIs and HIV/AIDS.

CD4 counts for 2015 were done for all ten (10) registered HIV+ cases at the Public Health Clinic. CD4 counts tests are done at the National Laboratory. For Viral Load tests five HIV people had their viral load done in this reporting period, except 4 other cases because their CD4 counts were above the recommended WHO threshold. One other positive person died within this reporting period.

ANC care for HIV+ mothers is offered at all healthcare centres. For in the case of PPTCT, Samoa still does not have any policies or guidelines addressing this issue, but utilise WHO guidelines and policies as guiding principles in these areas. In case of any emerging case of MTCT, authorities are alert and preventive measures are practiced. Prophylaxis had not been administered on pregnant women with HIV due to a range of logistical and non adherent purposes, but ARV regimens recommended by WHO for pregnant women and women breastfeeding infants are practiced.

Nutrition care for PLWHA is not addressed in the current National Nutrition Policies; however, health talks on proper nutrition care for PLWHA is given on one to one consultation with anyone who requires it. Breastfeeding issues with HIV+ mothers is covered under the Baby Friendly Hospital initiative extensively, but there still need a lot of work to ensure that these are carried out efficiently.

All ANC visiting mothers both public and private healthcare facilities are mandated to undergo HIV testing on first visit. Results are all treated confidentially, and pre and post counselling are offered when required by a mother. Other mandatory STI tests included in this blood panel for ANC visits are Chlamydia, Syphilis, Hepatitis B and Hepatitis C.

There is only one dispensing clinic for ARV treatments and that is the Public Health Clinic. In cases of common STIs such as Chlamydia, treatments are offered in all healthcare facilities with a prescription from the physician on board.

To date there is no known case of TB/HIV co-infection reported. However, there is currently no HIV testing of TB infected, as well as no TB of HIV infected. This issue has been raised in 2015 reports and activities and procurement of resources are currently being mobilized in the 2016 work plan. The main issues in providing these challenges center around the capacity of the STI clinic (in both human resources and testing kits) to conduct this testing. The MoH through donor funding is in the process of procuring 1 physician, 1 nurse specialist, and 1 student nurse intern to supply the clinic with staff to provide the treatment and report the data.

ARV and STI treatments are generously provided for free of charge under the Global Fund for HIV facility.

C. Knowledge and Behaviour Change

The majority of HIV Knowledge amongst social groups in Samoa comes from the Demographic Health Survey 2014. This survey is conducted every 4 years, with the most current report being published in mid 2014. The main key population group the DHS provides data on is youth ages 15-24. The DHS found that youth ages 15-24- 85.7% have heard of AIDS; 86% female and 78% male, which is somewhat less than older respondents (95-84% respectively).

Knowledge of HIV prevention methods is lowest among the 15-24 age group. When asked about prevention methods, respondents indicated that HIV can be reduced through; 1) using condoms (63.1% female and 63.6% male), 2) limiting sexual intercourse to one uninfected partner (78.9% female 71.9% male), 3) using condoms AND limiting intercourse to one uninfected partner (61.1% female, 59.3% male), 4) abstaining from sexual intercourse (66.7% female, 55.1% male).

Comprehensive knowledge about HIV transmission was lowest among youth age 15-19 in Savaii. Comprehensive knowledge is defined by DHS as knowing condoms and limiting sexual partners to 1 uninfected reduce risk, knowing healthy looking people can have the virus, and

rejecting 2 common misconceptions about transmission. The following results are the percent of respondents who agreed with statements about HIV transmission; 1. a healthy looking person can have the AIDS virus (53.2% female, 46.7% male) 2. AIDS Cannot be transmitted by mosquito bites (18.1% female, 18.5% male) 3. AIDS cannot be transmitted by supernatural means (51.3% female, 47.8%male) 4. cannot become infected by sharing food with a person who has AIDS (26.1% female, 27.0% male) 5. Percent who say a healthy looks person can have the virus and reject the two most common local misconceptions about transmission (7% female, 7.8% male). Considering the answers to all of these statements about HIV transmission and misconceptions, the percentage with comprehensive knowledge about HIV/AIDS was 5.1% in females, and 5.7% in males.

Regarding attitudes of stigma towards PLWHA, the DHS 2014 found that only 2.6% of women and 3.3% of men expressed acceptance of PLWHA on all four indicators of accepting attitudes towards PLWHA. Those indicators are 1) willingness to care for a family member with the virus in respondent's home 2) would buy fresh vegetables from a shop owner who has AIDS 3) would say that a female teacher who has AIDS and is not sick should be allowed to continue teaching 4) would not want to keep secret that a family member got infected with the AIDS virus.

The table 6 below provides an overview of how HIV and AIDS Knowledge, Attitudes and Behaviours have changed since the previous DHS survey.

Table 6 – Demographic and Health Survey 2014

DHS Findings	2009		2014	
	Female	Male	Female	Male
Condom Use (Current)	0.1%	unavailable	0.1%	unavailable
Condom Use (Ever)	1.1%	14.3%	1.5%	15%
Percent of youth age 15-24 that know condoms prevent HIV	53%	56.3%	63.1%	61.6%
Percent of individuals having comprehensive knowledge of HIV and AIDS transmission and prevention	3.9%	7%	6.5%	6.4%
Percent of individuals expressing acceptance of PLWHA on all 4 indicators	2.1%	3.4%	2.6%	3.3%

These results indicate that preventive practices have improved slightly, but still remain at low rates. Knowledge seems to have increased among females, but still remains low and male respondents have reported less comprehensive knowledge. The same changes were observed with acceptance of PLWHA. This may indicate that programs may be successful in reaching at certain populations (like fa'afafine, sexually active adults and populations with higher educational attainment), but when it comes to the general population, rural populations and youth (which make up the majority of the DHS's sample), these programs have not had a sufficient impact.

D. Impact Alleviation 2015

The following section presents all data, quantitative and qualitative on the impact the National Program for HIV/AIDS has had on achieving the Global Fund targets.

Due to the majority of implemented programmes including key populations in their scope, the impact of these programs on sexual health awareness, knowledge and prevention is likely observed in these groups. However, data on these groups are currently lacking due to lack of resources, technical expertise on monitoring these groups, and an overall fragmented health information and

surveillance system. Efforts to improve M&E systems for measuring impact have been ongoing. The Ministry has completed several planning activities for developing the M&E infrastructure;

- Compiling a list of required functionalities for the procurement of an electronic health information system (sector wide)
- The development of an M&E framework and plan for HIV/AIDS
- Procurement of Fulbright and Yale University consultants in the areas of research, M&E, surveillance and health information
- Enhanced quality assurance practices with ongoing monitoring visits to health sector partners
- The development of M&E policies for multiple divisions

Though rising rates of Chlamydia and low testing rates remain challenges to prevention, MoH has been very successful in providing universal access to ARV to PLWHIV, managing their care, and ensuring adherence to ARV regimens. The main objective for future prevention will be to detect more cases and link them to care.

Target 1. Reduce sexual transmission of HIV by 50% by 2015

1. Prevention of Sexual Transmission of HIV

The primary mode of transmission for HIV in Samoa is through sexual intercourse. The last known HIV infection in Samoa was in 2009. Since then 0 new cases have been detected. There is still the ongoing challenge of increasing testing rates to link undetected cases to treatment.

1.1 HIV Testing/VCCT

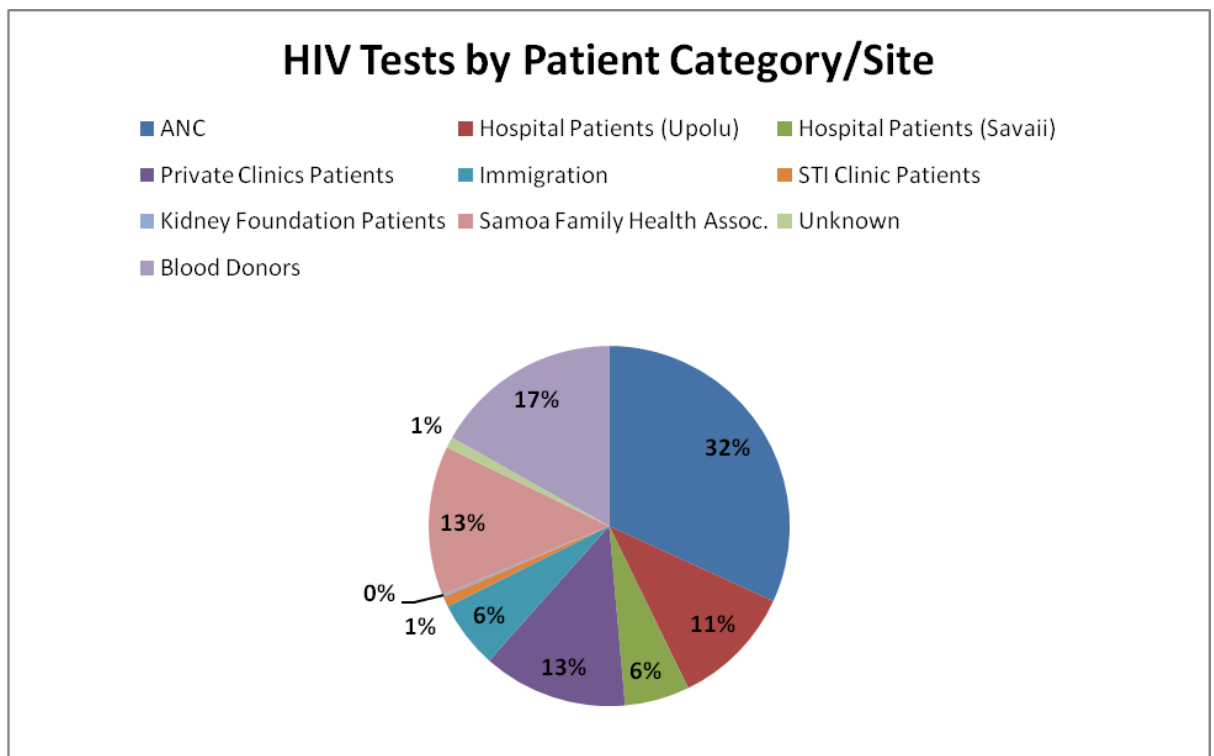
HIV testing is mandatory for all ANC mothers during their first visit to any ANC clinics, be it private or public facility. There are only two (2) accredited Voluntary Counselling and Confidential Testing facilities in Samoa; one is housed at the Samoa Family Health Association and one at the National Health Services as part of the Public Health Clinic. All healthcare centres (public owned) that offer ANC services have allocated an area in their facility as a VCCT. Patients are counselled appropriately when required. For Chlamydia, ANC mothers and their partners are treated presumptively with Azithromycin on their first ANC visit as of May 2015.

Table 7 - HIV Tests by Age

Age Group	Number of HIV Tests	Percent of Tests
0-4 yrs	266	3.0%
5-9 yrs	232	2.6%
10-14 yrs	252	2.8%
15-19 yrs	936	10.5%
20-24 yrs	2070	23.3%
25-29 yrs	1807	20.4%
30-34 yrs	1248	14.1%
35+ yrs	1608	18.1%
unknown	450	5.1%
Total	8870	

It is noted that mostly females made up the majority of those being tested at any healthcare facilities between the ages of 20-34, and the assumption is, is that most females are ANC visiting mothers. It is mandated that all ANC mothers must undergo HIV testing to ensure positive health conditions for both mother and child. Figure 1 below shows that the majority of cases come from ANC visits and the NGO Samoa Family Health Association. SFHA's caseload is made up of mostly ANC visits. Males usually make up a lower percentage of those tested (however disaggregation by sex is not available for the full 2015 period). Overall for HIV testing amongst the general population is significantly low. HIV testing captured here is not representative of the whole country per se as data are only from the National Health Service Laboratory, the only testing facility in country.

Figure 1. HIV Testing and Location



1.2 Condom Promotion and Distribution

There is no clear data on condom distribution during reporting period. Condoms are procured under the UNFPA facility every year and distribution prevalence is never accurate, as facilities who distribute condoms do not have records of how many condoms they'd given out. Condom promotion is advocated by the NGO sectors, NHS ANC clinics and Ministry of Health as one of the preventive measures for STIs/HIV and AIDS. Promotion on media is seldom ever happened due to cultural and religious perspectives. The Samoa Fa'afafine also promotes condom use during their various events and activities.

1.3-1.4

No current data to respond to these targets.

1.5 Programmes for MSM

Samoa's MSM population has not been identified by any research studies. Although male-to-male sex remains illegal in Samoa, a BSS of young people in 2005 reported that 21.8% of male participants had ever had sex with a man, with 14.7% having had male-to-male sex in the past 12

months (WHO 2006). Such statistics indicate that there is a significant community of MSM in Samoa, part of which may remain hidden in comparison to *fa'afafine*.

Conversely, a 2005 HIV surveillance survey indicated that only 4.2% of STI clinic attendees were men reporting sex with men in the past 12 months, while 7% of attendees had experienced sex with another male in their lifetime (WHO 2006). While the variance in rates of self-reported MSM between these two different demographics could be caused by a number of factors – location of the clinic, age groups involved, and so on – it is highly likely that there is an underreporting of STI symptoms among MSM communities, which corresponds to the low level of MSM attendance at the clinic. As homosexual sex still remains illegal in Samoa, there is potential that this underreporting is due to fear of exposure and lack of confidentiality in the screening process.

1.6 Programmes for Sex Workers and their Clients

Samoa's sex worker population has not been identified by any research studies. Sex workers in Samoa are widely invisible, and there is currently no information related to them. This is largely due to the illegal nature of sex work in the community. Seafarers have reported that sex workers are easily available in Samoa (McMillan 2013), and anecdotal evidence suggests that there are hidden populations on the rise. Many informal accounts suggest that key clients are Chinese builders and other international workers, and that sex workers operate out of hidden places such as empty buildings. It is also understood that sex in exchange for cash or goods has existed for a while, and often takes place in situations and places where alcohol is involved (Samoa Ministry of Health 2013). In the Apia urban area, there are identified groups of sex workers near the main ports. The 2013 Global Aids Progress Report indicates that sex work is prominent among unemployed young people, which may be a way to supplement their incomes when other work is not available. Sex workers have access to condoms via dispensers in nightclubs and free distribution by the Samoa Victim Support Group, however it is unknown how many utilize these resources.

1.7 Programmes for transgender people

Indicator relevant, unfortunately data is not available to respond to indicator.

1.8 Programmes for children and adolescents

Programs are in place for children and adolescents in general. Youth Friendly Services which offer a variety of health information on adolescent health in particular SRH, STIs/HIV and AIDS are in place in all public healthcare facilities, and NGOs namely the SFHA. The National Youth Council also builds capacities of young people on issues of economic development and linking it to health overall.

1.9 Community mobilization

Programs that mobilise communities are ongoing. Our stakeholders are very instrumental in strategising effective activities targeting several sectors of our communities from their own perspectives.

1.10 STI diagnosis and treatment

STIs diagnosis and treatment are offered for free to anyone who accesses any of the national health centers. There are more issues with turnout for healthcare services amongst the general population. In 2015, only 2,915 pregnant women out of an estimate 9,616 pregnant women in that year (or 30.3%) accessed health centers for antenatal care¹. This is indicative of a larger trend in the general population of not accessing care.

¹ Estimate was calculated using the formula $WRA/1,000 * \{(B*Pb) + (A*Pa) + (D*Pd)\}$, where areas WRA = women of reproductive age in Samoa 2015, B= Fertility Rate, A=Abortion Rate, D=Fetal Loss (death) rate per 1,000 women, and Pb, Pa, and Pd representing the proportion of the year a woman is pregnant; 9months=.75, 2 months=.167, 3 months=.25,

Target 2. Behaviour Change Programs

A myriad of behaviour change programs being implemented by our stakeholders, but unfortunately data is not available to respond to the indicator. The data from the DHS 2014 in the previous section can be used to infer the impact of these programs on the population.

Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

3. Prevention of mother-to-child transmission

In this reporting period, there was only one case of and HIV positive mother giving birth. However, the birth was premature at 7 months and was stillborn. Preventive measures according to WHO/OSSHM guidelines of PMTCT is well adhered to in this case. The mother had also already been on ARV treatment since her diagnosis.

3.1 ARVs for PMTCT

ARV for PMTCT is well administered, and 100% assured. All antenatal mothers that report for care receive HIV testing and counselling.

3.2 Non-ARV-related component of PMTCT

Indicator not relevant

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

4. Universal access to treatment

Samoa still enjoys a 100% Universal access to treatment for all PLWHA which is support by Global Fund for HIV facility. Please note that 2 of these cases are in overseas private treatment for their ARV regimen.

Table 8 - ARV Coverage

Indicator 4.1	All (15+)	Males (15+)	Females (15+)
Percentage (lower bound 1)	100	100	100
Numerator : Number of people living with HIV receiving ART	11	8	3
Denominator : Estimated number of people living with HIV	11	8	3

respectively. Values for Samoa: WRA=7,393, B=163, A=0 (abortion is illegal and inaccessible in Samoa), D=8. Fertility stats come from the demographic health surveys of 2014 (closest estimates).

4.1 Pre-ART care and palliative care

Palliative care is always offered during pre-ART phase for those tested positive for HIV.

4.2 Adult antiretroviral treatment

A 100% of adult ART treatment supported and offered.

4.3 Paediatric antiretroviral treatment

A 100% of paediatric ART treatment supported and offered.

4.4 Support and retention

Support and Retentions is 100%.

Target 5. Reduce tuberculosis (TB) deaths in people living with HIV by 50 percent by 2015 TB

Indicator cannot be reported as Samoa has no known HIV case that received treatment for both TB and HIV this reporting period. No TB related deaths have been reported in 2015.

Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$22-24 billion in low- and middle-income countries

The funding provided for implemented programs amounts to \$123,252 USD (which does not include the human resource costs i.e. salaries paid by MoH). Roughly 22% (\$27,500 USD) of this funding was provided by the government of Samoa and 61% (\$95,752 USD) was provided by international development partners (See Figure 2). All other multilateral sources are DFAT, World Bank and NZAID.

Figure 2 – Total Expenditures for National HIV/AIDS Program Jan – Dec 2015.

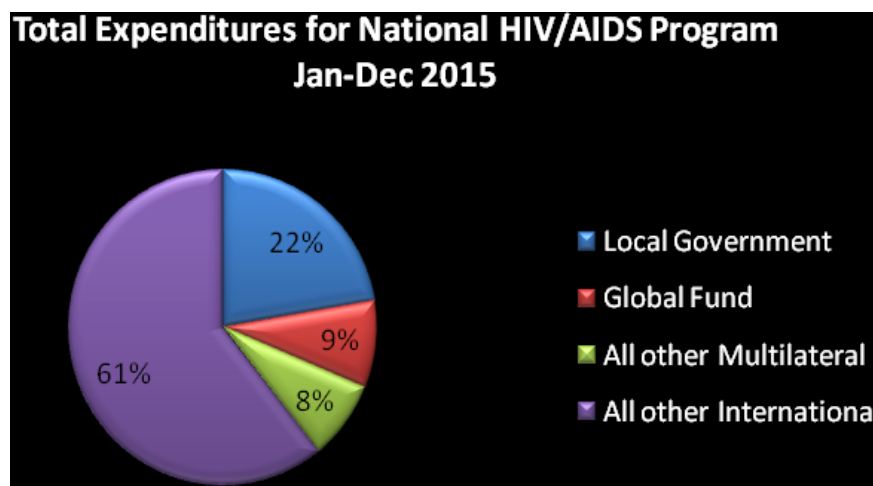


Table 9, illustrates the breakdown of funding spent by the local government and donor partners in achieving the 10 Global Fund targets to be achieved by 2015.

Table 9 - Funding by Target

	TARGETS	LOCAL GOVERNMENT	GLOBAL FUND	ALL OTHER MULTILATERAL	ALL OTHER INTERNATIONAL
1	Reduce Sexual Transmission of HIV by 50% by 2015	\$17,500.00	\$3,384.00	\$10,000.00	\$50,944.00
3	Eliminate new HIV infections among children by 2015 and substantially reduce AIDS related maternal deaths		in-kind		
6	Close the global AIDS resource gap by 2015 and reach annual global investment of US\$22-24 billion in low and middle income countries	\$12,500.00	\$7,584.00		\$17,840.00
8 & 9	Eliminate stigma and discrimination against people living with HIV through promotion of laws and policies that ensure the full realisation of all human rights and fundamental freedoms; Eliminate HIV related restrictions on entry, stay and residence	\$3,500.00			
7 & 10	Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV; Eliminate parallel systems for HIV related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems	\$11,500.00			\$6,000.00
	TOTAL	\$27,500.00	\$10,968.00	\$10,000.00	\$74,784.00

There currently is no M&E program for HIV/AIDS/STI's/TB, however an M&E framework and plan have been developed and will be finalized by June 2016. Upon consultation with MoH management and stakeholders it will then be operationalized.

Target 7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

Indicators pertaining to this target are relevant, unfortunately cannot be reported due to absence of national baseline data. However, studies have shown that gender inequality is quite common and becoming a real problem in Samoa. Domestic violence is highly prevalent. Many women in Samoa feel domestic violence is justified with 70% stating it is permissible for a husband to beat his wife if she is unfaithful to him, doesn't do housework, or disobeys him (State of the Human Rights Report Samoa, Ombudsman 2015). Overall, 46% of Samoan women who have ever been in a relationship have experienced one or more kinds of partner abuse (UN Women 2011). The most common form of spousal abuse is physical abuse (38%), followed by sexual abuse (20%) and emotional abuse (19%). The kinds of abuse experienced by women include: being slapped or having objects thrown (35%); being punched (18%); being forced to have sex (17%); insults (14%); being coerced into having sex (11%); and being kicked, dragged or beaten (11%) (UN Women 2011). About 30% of women who had been physically abused reported being injured, with the most common injury being abrasions and bruises (22%), followed by damage to eye or ear (9%); cuts, punctures and bites (9%); and losing consciousness (8%) (UN Women 2011).

Women who reported abuse were significantly more likely to report that their partner was opposed to contraception (15% compared with 5%) (UN Women 2011). A multi-country study conducted by WHO from 2000-2003 found that in Samoa that 10% of all women who had ever been pregnant were beaten during at least one pregnancy. Among women that were ever physically abused in their lifetime, 24% reported the abuse occurred during pregnancy. In 96% of those cases, the perpetrator was the father of the child. In terms of the health of these women, abused women who had ever been pregnant were significantly more likely to have had stillborn children (16% versus 10%) and miscarriages (15% versus 8%).

A legal analysis of violence against women found that there is a range of factors that increase women's vulnerability to violence, including economic opportunities, poverty, status and dependency. In patriarchal societies the status of women is determined by the social ranking system of the family and the kin group, with customary practices determining how women are treated. Female abuse is not seen as a violation of women's human rights as it is often justified as a means of discipline and correction, and dismissed as a private dispute within the family. Law enforcement agencies and the courts, until recently, have traditionally taken a hands-off approach to VAW, deferring to family privacy and the traditional dispute resolution processes. In small closeknit communities where members are closely related, law enforcement agencies are reluctant to arrest perpetrators. Reconciliation of the parties is encouraged in both law and customary practice. The social costs of domestic violence on health care, the justice system, the economy, and on families remains high.

Faafafine community in Samoa are well accepted in our society. Faafafine (transgender) although very visible and vocal in their own way, they are also being faced with problems from particular the males of our communities. Sexual abuse, with physical abuse that these people experience is not properly recorded. Measures needs to be formalised in order to gauge in a clear perspective of issues facing these group. A pilot study is currently being conducted to provide baseline data on fa'afafine experiences of violence, and to inform larger population studies.

Target 8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

Target 8 – cannot be responded to without data to support it.

Target 9. Eliminate HIV-related restrictions on entry, stay and residence

Samoa as a sovereign country has its own laws and policies in place for protection of its own people from being infected with the HIV virus from a foreigner. Anyone entering the country as a long term resident are encouraged to declare his/her HIV status but not required, and they are not stopped from entering and staying in Samoa for a short time (visitor's visa).

Same procedures are done in other countries of the world, and so in Samoa. This is to ensure that our health authorities are alert of any new incoming HIV+ case and what needs to be done with regards to his/her tests, treatment, care and support while in Samoa. Laws and policies only apply when a HIV+ person is found to be knowingly engaged in sexual activity with any local without protection.

As of 2015, the immigration form has removed the question on HIV status and replaced it with Zika virus monitoring questions.

Target 10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

Target 10 cannot be responded to as there are no known orphans in Samoa.

Synergies with development sectors

10.1 Social protection

There are several initiatives supported by the government and development partners to ensure social protection of Samoa citizens.

10.2 Gender programmes –

Several gender based programs had been conducted targeting Faafafine populations, Women, Children and Men. These programs are conducted by our stakeholders, namely Ministry of Women, Community and Social Development and Samoa Victim Support Group (not currently an active stakeholder). The MWCSO heavily involved with advocacy of human rights among children, and women of Samoa pushed for several crucial legislations and policies that ensures that our children and women entertains the same rights as any other human being. Their work is guided by the Convention of the Rights of a Child and Convention on the Elimination of any sort of Discrimination against Women (CEDAW) that Samoa ratified in the past years.

A recent initiative being passed by the government under the Constitution Amendment to include introduction of a 10% quota of women representatives into the National Legislative Assembly, a move which saw a successful acceptance of our women into politics a role dominated by our male counterparts only.

10.3 Education

The government endorsed compulsory education for every child of Samoa, and is on track to achieving universal primary education as one of the MDGs targets.

MESC is planning a review of the school curriculum to include SRH subject as one of the compulsory subjects to be taken by every child in Secondary level education, and not as an option. Comprehensive Sexuality Education is part of this review.

HIV+ children are allowed to attend school of their choice without fear of being discriminated. If and when a HIV+ child is reported to have been discriminated in their school, a call for counselling between teachers, parents of positive child and counsellor is recommended. Like all other children, HIV+ children have the right to proper education like every other child.

10.4 Workplace

Policies stipulate that HIV+ people have the same rights to employment any other non-HIV person without discrimination.

10.5 Synergies with health sector

The Health Sector is in a better position to encounter any emerging new HIV+ case. As for the current HIV+ cases that Samoa has, the work undertaken by the health sector in terms of treatment,

care and support is to be commended. Although there are caveats in the system like any other system, the health sector ensures that PLWHA are well taken care of. Together with its NGO partners, work related to HIV/AIDS interventions are well coordinated.

IV. Best practices

2015 marked important policy advancements in addressing HIV/AIDS/STI's. 2016 will be the last year of the current policy and MoH and its stakeholders are looking to move in a new direction for best practices in dealing with the HIV and STI epidemic.

- i. The extensive consultation with stakeholders and health sector partners for the 2015 review of the National Policy on HIV/AIDS was critical in the development process for the 2017-2021 policy. NGO's and healthcare service providers were all invited to analyze the contents of the current policy and how the next iteration should be implemented and address key prevention and service delivery issues. Attendance for this review consisted of representatives of all stakeholders and partners. One final review will take place in 2016. The new policy will serve as the impetus to scale up prevention efforts and provide the key strategic areas to be addressed by the 2017-2021 National Strategy.
- ii. The Ministry of Health has made progress on numerous projects to build capacity around health information systems, monitoring, evaluation and surveillance. The largest, the e-Health project, aims to make all health records past and present electronic. Officers from the HIV/TB/STI program have attended numerous consultations in order to inform implementation and to ensure the new system will have features necessary to improve STI surveillance and reporting. In addition, the newly developed 2016 HIV/STI Monitoring and Evaluation manual details the M&E plan and framework for improve HIV/STI information systems. This manual is to be finalized in June 2016.
- iii. Infrastructure development- Tuasivi hospital in Savai'i was renovated at the end of 2015. This major project involved the separation of Accidents and Emergencies from General Outpatient services; renovations to improve services related to Dental, Pharmacy, Eye Clinic, Community Outreach and Medical Records; and renovations and extensions of X-Ray and laboratory services. In addition to being a major improvement to the service delivery infrastructure to Samoa's most rural area (Savai'i), the renovations to laboratory services will be a critical increase in the capacity for STI surveillance. Particularly, it will help the health sector address low testing rates and prolonged specimen processing due to limited resources have been challenges in obtaining surveillance data on STI's.
- iv. Political leadership is very crucial in preventing further transmission of HIV/AIDS in Samoa. An example of this political leadership is Samoa's commitment and being one of the signatory to the Political Declaration on HIV/AIDS declared in a high level meeting in New York 2011. In a local context, the drive by the Samoa Parliamentary Advocacy Group for Healthy Living (SPAGHL) continues to be part of the advocacy program on prevention of STIs/HIV and AIDS within their own political group and within their constituencies.
- v. Supportive policy environment plays a crucial role in the up-scaling of HIV intervention from clinical intervention to preventive measures that are suitable to all who are HIV+ and to the general public at large. The existing National HIV/AIDS Policy informs various strategies in place. To complement this policy are the National Sexual and Reproductive Health Policy and Infection Control Policy which both play vital roles in the overall prevention of these preventable disease.

- vi. Scale-up of effective prevention programmes is a continuous collaborative work of our stakeholders. Leading the HIV/STI awareness initiatives, Samoa Faafafine Association is active in implementing activities for fa'afafine groups and consulting with various service delivery organizations. The annual fa'afafine pageant, which has been funded by the MoH since 1981, is used as a platform for HIV awareness. The September 2015 pageant was the largest to date and took place around the time of the 2015 Commonwealth Youth Games. Steva Auina, the newly crowned Miss Fa'afafine Samoa, has since advocated for HIV and STI prevention. Her speech at the Oct. 2015 Bilateral Health Summit with American Samoa, highlighted the need for prevention and the recognition of sexual health issues.
- vii. World AIDS Day (WAD) Dec. 1, 2015 also marked a scale-up in HIV awareness efforts. More media outlets were utilized than previous years, giving WAD more publicity. Radio spots, a documentary, online advertisements on popular message boards, and the distribution of WAD pamphlets were key to scaling up the reach of HIV awareness. A WAD mass was held at Mulivai Catholic Cathedral to commemorate those living with HIV and those who have lost their lives to the virus. The archbishop of Samoa delivered messages of prevention and reducing stigma against PLWHIV/AIDS. There was an excellent turnout for the event, and the mass was televised on the national network.



Participants lighting candles for those who have died from AIDS at the WAD mass



WAD 2015 mass at Mulivai Cathedral

- viii. Quarterly monitoring visits have been crucial in improving M&E and developing a working relationship with providers to foster compliance with MoH. In 2015, monitoring visits

became more involved, due to the evaluation of the Presumptive Treatment for Chlamydia Protocol that was implemented in May 2015. Since Chlamydia has been very prevalent and a persistent sexual health issue, data regarding its effectiveness, coverage and impact was of priority interest to the MoH. Ensuring the collection of this data, also improved the data collected on other performance indicators. Monitoring visits also provided MoH an opportunity to informally assess facility maintenance and quality of service delivery. This helped inform reporting and oversight of the health sector. MoH staff also made assessments of each facility's data systems so as to inform the development of the electronic M&E tool and the M&E manual.



HIV/STI/TB program staff during an M&E visit to Savai'i hospitals

V. Major challenges and remedial actions

a. *Progress made on key challenges reported in the 2013 Country Progress Report response*

- i. Increasing STI's (particularly Chlamydia) is still a challenge in the background of our HIV/AIDS intervention. Despite prevention efforts, Chlamydia is been gradually rising in the past few years (see Table 8).

Table 10 - Chlamydia from 2013-2015

	2013	2014	2015
Chlamydia Prevalence	24%	25%	26%

Around mid 2015, a Presumptive Treatment for Chlamydia protocol was implemented to address the high prevalence in ANC women and their partners. The protocol dictated that on a woman's first ANC visit, both she and her partner would receive a 100 mg. dose of Azithromycin to treat a Chlamydia infection, regardless of whether she had been tested. Cook Islands, Nauru, and Vanuatu had implemented this protocol and witnessed decrease in Chlamydia prevalence.

Implemented in May 2015, the protocol implementation has been monitored. The 6 month report found that an estimated 10% of the antenatal population (including male partners) was presumptively treated for Chlamydia infection (See Appendix X). The full year report should be

available in July 2016. The impact on Chlamydia rates should be shown in the first quarter of 2016 surveillance data (to be released next month).

- ii. Data management and reporting was a problem reported in the progress report of 2013. In 2015, multiple consultations were made throughout the year to resolve these issues. HIV/STI/TB staff were able to assist health sector partners at NHS with the collection and reporting of this data, however data collection still remains a challenge. M&E activities and capacity building in 2016 budget have been prioritized to address the issue of health sector capacity to monitor and report quality data. These issues are further discussed in the M&E section of this report.
- iii. M&E framework for HIV/AIDS national programs has been drafted in October 2015 and has since undergone consultation with MoH management. Further consultation with NHS and stakeholders is still ongoing. The framework is expected to be finalized in a manual by June 2016, with implementation to take place later in the year.

b. Challenges faced throughout the reporting period (-2015) that hindered the national response;

i. The baseline data to support most GARPR indicators has improved, but remains an issue.

The release of the DHS 2014 provided updated data for a lot of indicators that previously could not be responded to. However, baseline data for other indicators are still lacking. A few studies are currently underway to address missing data on key populations and the M&E infrastructure is being updated to include more indicators. The M&E 2016 framework for HIV/AIDS/STI's should also provide data collection measures for more indicators.

ii. The delayed disbursement of funds from UNDP for 2015 budget activities

Due to internal processes within UNDP, funding for 2015 activities were delayed. This was due to the transition of funding from SPC to UNDP. This greatly impacted how long it took MoH to receive funding. Many activities were delayed, pushed to the next fiscal year, scaled down or cancelled.

iii. Time constraints in filling online data and writing the narrative report versus other commitments to other crucial health issues.

iv. Little or almost no concrete research conducted on several issues, such as gender equality, transgender or fa'afafine population, and other imperative HIV/AIDS related issues.

v. No TB/HIV testing in TB/HIV cases

The STI/TB clinic is staffed by one nurse specialist who states that her caseload is currently too high to conduct TB testing in HIV cases and HIV testing in TB cases. This is a critical gap in national monitoring and has been made a priority for the next funding cycle.

vi. Low ANC testing and ANC visits

The data for the 2015 indicators revealed that 2822 out of an estimated 9616 pregnant women (29%) report for ANC visits, and therefore mandatory ANC screening at national health centers. Increasing the coverage for this population is critical to protect antenatal health. The low turn-out for ANC services means that interventions implemented through healthcare facilities do not reach a majority of the targeted population.

vii. HIV Stigma

The DHS 2014 revealed that stigma against PLWHIV is still very much prevalent in Samoa. This indicates one of the reasons for why voluntary testing is so low, why confidentiality concerns may deter people from care, and why HIV awareness campaigns may not be well received by the public. Unfortunately, stigma is also one of the most difficult issues to address in prevention and behaviour change.

viii. Stigma Associated with Sexual Reproductive Health (SRH) Services and Research

Sex is a contentious subject in Samoa. This makes sexual health promotion and prevention of STI's challenging. Pre-marital sex is extremely taboo, and youth are discouraged from marrying until their late 20's. Some people are banished from their villages for extra-marital pregnancies, and the religious leaders have been quite vocal about youth not engaging in sex.

Therefore, most youth would likely not report for services or respond to SRH research studies, due to fear of someone finding out (which they usually do in Samoa's small interpersonal community settings). Sexual health prevention and promotion constantly have to strategize on how to deliver interventions in a manner that doesn't conflict with religious and cultural values. Public health officers are constantly dealing with the question, "How to we improve the sexual health for key populations (like youth), when the culture dictates that they shouldn't be having sex?"

For population studies (like the Demographic Health Survey), data would be more accurate if collected in a clinical setting, where people are more likely to answer honestly to assist their treatment. Many Samoans don't understand the utility and purpose of collecting personal information for research, or don't agree with it entirely. Health based reasons for collection would be better received, as it is collected for a clear purpose of assisting one's treatment. One example of this is with age of sexual intercourse. In the DHS 2014, only 1.0% of respondents reported having their first sexual intercourse before age 15. This is suspiciously low and most likely due stigma causing a reporting bias.

c. Concrete remedial actions that are planned to ensure achievement of agreed targets.

- i. Ensure quality data are collated and analysed for next GARPR round.
- ii. Ensure funding processes are streamlined for timely implementation and seek out alternative sources of funding for activities. One grant proposal for delayed TB activities is currently being reviewed by funders.
- iii. Ensure implementation of the M&E framework for STI's by funding capacity of providers and training clinicians on new data collection strategies.
- iv. Advocate for more intervention programs and research targeting most at risk and vulnerable populations.
- v. Increase screening interventions for the general population and targeted vulnerable groups for TB, HIV and STI's. A TB screening program grant proposal has been submitted.
- vi. Budget items to increase the human resource capacity of the STI and TB clinic for screening and treatment have been submitted for 2016 grant activities and are ready to be implemented pending UNDP approval.
- vii. Advocate for getting more antenatal women into ANC visits.

- viii. Consult with stakeholders, NHS, and community leaders in order to design interventions addressing HIV stigma and stigma towards sexual health prevention and family planning.

VI. Support from the country's development partners

Global Fund is the main funder of Samoa's national HIV/AIDS programs. The UNFPA puts emphasis on SRH issues with family planning being one of the main initiatives supported. The IPPF supports mostly the work carried out by the SFHA, and International Red Cross Society injected funds for Samoa Red Cross Society work for HIV/AIDS.

The ultimate objective of these donors is in line with what our government had as its vision in its Strategy for the Development of Samoa (SDS 2012-2016) ie: "Healthy Samoa". Taken from this vision the development partners are vigilant on where the country needs are and assist in achieving that vision, at the same time achieving targets for a HIV/AIDS free Samoa.

VII. Monitoring and evaluation environment

A) M&E system

M&E data comes from multiple sources;

- Patient records and reports from NHS
- Population surveys such as the DHS, PATIS, STEPS, etc.
- Data collected by ministries involved in service delivery
- Small scale research studies
- Regional reports from donors

In 2010, a health sector M&E framework was developed and then implemented in 2011. The indicators were taken from multiple donor requirements, and then organized according to the sources of population data available from MoH, Samoa Bureau of Statistics, and other ministries. The framework contains 2 indicators pertinent to HIV/STI's; 1) HIV prevalence and 2) HIV/AIDS related deaths. For both donor reporting and program planning needs, this was insufficient.

For HIV and STI's, there has been progress in 2015 for improving M&E. After consultation with management and staff at MoH and stakeholders, a HIV/STI specific M&E manual was drafted that included instruments for consolidating and refining the data collection process. The M&E manual for HIV and STI's will have an online form for data collection from the national reference lab, a hierarchical map of indicators (including data for donors and MoH specific M&E data), and a plan for implementation. The manual is expected to be finalized in June 2016 and to be operationalized by the drafting of the next HIV/AIDS national policy. This will help organize M&E activities and help navigate challenges to data collection.

B) Challenges

There have been multiple challenges to improving monitoring and evaluation in the health sector;

1. The national reference lab, thus far the only facility on the island capable of processing test results, is understaffed, leading to limited surveillance reports that they are able to deliver to MoH. This has resulted in surveillance data periods for which disaggregation by sex and

age are not available. Program staff at MoH have taken the lab's raw data to supply the aggregation and analysis themselves in order to meet reporting needs, but this is time consuming and has not remedied all the data gaps.

2. Low voluntary testing rates from the general population also limit the generalizability of our current surveillance data. Most of the cases come from antenatal women, which represents only 29.4% of the estimated ANC population. Improving the lab's capacity is foundational to being able to increase testing rates
3. Compliance from the health sector has also hindered data collection for M&E. Quarterly M&E visits to providers are conducted to collect data and ensure quality of data. Providers are often reluctant to report the data, state that they don't have time to collect certain data, or haven't been told by management about MoH's visit and purpose. This puts MoH in a precarious position in which MoH does not want to burden a fragile health delivery system, but at the same time needs data for monitoring and regulation. Many providers are also of an older generation and do not understand the importance of data collection as well as how to store the information electronically.
4. The health information in Samoa is currently paper based. Providers record individual patient files, and on a monthly to bi-monthly basis, they fill out logbooks in an MoH template with specific cases and variables of interest for monitoring and regulation. This system is slow, resource intensive and has a high risk of error.
5. Key populations are not recorded by laboratory intake forms that produce surveillance data. Therefore disaggregation by key population is not available.

C) Remedial Actions

For the next grant year, the National Program for HIV/AIDS/STI's has budgeted for several activities to address the current challenges to M&E operation.

1. MoH is working to fund a health information specialist at the NHS reference lab to increase its capacity to collect data, process specimens, and report to MoH. NHS has begun recruitment for this position.
2. MoH is also working to seek financial support from Global Fund NFM Phase to support 1 current nurse specialist position, create an additional nurse specialist position, fund a physician, and one nursing student internship positions at the national STI clinic to improve screening for HIV/STI's and also to implement testing of all TB cases.
3. Several screening outreach events have been proposed and submitted for grant funding for 2016 in order to expand testing to vulnerable populations for STI's and TB.
4. An electronic data collection tool for STI data has been developed and currently being trialled with health sector partners. The purpose of this e-form is to streamline data collection reducing the burden on providers, providing real time surveillance, and reducing error.
5. A health sector wide e-health system has been proposed by the MoH's IT division and is currently consulting each division on user requirements. The staff at the National Program for HIV/STI/TB have been very diligent and comprehensive in communicating M&E requirements for surveillance needs.
6. To address to absence of data for key populations, 2 studies are currently being conducted by HIV/STI/TB program staff to provide pilot data for larger population studies; 1) a study on the impact of domestic violence and Chlamydia on birth outcomes, and 2) a community

health needs assessment of fa'afafine (third gender individuals). Both studies are expected to be complete by September 2016 and are funded by Global Fund for HIV/TB and UNFPA.

Bibliography

1. State of Human Rights Report for Samoa. 2015 Office of the Ombudsman
2. WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Samoa. 2005. World Health Organization.
3. "Legal Analysis on Violence Against Women: Drafting Options for Legislative Reform". 2013. Secretariat of the Pacific Community and the Ministry of Women, Community, and Social Development.
4. Walsh, M. S. (2012). "Prevalence of Chlamydia trachomatis infection in rural Samoan women aged 18-29 and assessment of associated factors: a population based study" (Thesis, Master of Public Health). University of Otago. Retrieved from <http://hdl.handle.net/10523/4067>
5. UN Women. "Ending Violence Against Women and Girls: Evidence Data and Knowledge in Pacific Island Countries, Literature Review and Annotated Bibliography" 2011.
6. McMillan, K. (2013). Sex work and HIV/STI prevention in the Pacific region, including analysis of the needs of, and lessons learnt from, programs in four selected countries. Suva: Secretariat of the Pacific Community.
7. World Health Organization (WHO) (2006). Second generation surveillance surveys of HIV, other STIs and risk behaviours in 6 Pacific Island countries (2004–2005). Manila: World Health Organization Regional Office for the Western Pacific.
8. Heather Worth, Karen McMillan and Rachael Connors 2015. Pacific multi-country mapping and behavioural study: HIV and STI risk vulnerability among key populations. University of South Wales
9. Effect of Chlamydia trachomatis Coinfection on HIV Shedding in Genital Tract Secretions. Kilmarx, Peter H. MD*†; Mock, Philip A, and; Levine, William C. MD, MSc. Sexually Transmitted Diseases: June 2001 - Volume 28 - Issue 6 - pp 347-348. URL: http://journals.lww.com/stdjournal/Fulltext/2001/06000/Effect_of_Chlamydia_trachomatis_Coinfection_on_HIV.8.aspx