



Ministry of Health

S A M O A

GAM

(Global AIDS Monitoring)

REPORT 2018



GLOBAL AIDS MONITORING REPORT FOR SAMOA 2018
REPORTING PERIOD: JANUARY-DECEMBER 2017

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Key Abbreviations

- **AIDS**- acquired immune deficiency syndrome
- **ANC**- Antenatal Care
- **ART or ARV** – Anti-retroviral treatment or therapy
- **DOTS**- directly observed treatment, short-course (for TB treatment services)
- **EXP TB**- extra pulmonary TB (TB infection occurring outside of the lungs)
- **GF**- The Global Fund to Fight HIV, Malaria and TB
- **HIV**- human immunodeficiency virus
- **ICHAP**- Integrated Community Health Approach Program
- **MoH**- Samoa Ministry of Health
- **MSM**- men who have sex with men
- **MT2**- Malietoa Tanumafili II Hospital, Savai'i
- **MTC**- Mother to Child Transmission of HIV
- **NCD's**- Non-communicable diseases
- **NHS**- National Health Service, Samoa
- **PLWHIVA** – people living with HIV or AIDS
- **PMTCT**- Preventing Mother to Child Transmission of HIV
- **SS**- sputum smear negative (patient tests negative for TB via sputum smear testing, but has latent TB infection)
- **SS+** - sputum smear positive (patient tests positive for TB via sputum smear testing)
- **STI**- Sexually Transmitted Infection
- **TB**- tuberculosis
- **TTM**- Tupua Tamasese Meaole Hospital, Apia
- **UNDP**- United Nations Development Program
- **WHO**- World Health Organization

FOREWORD

Leausa Toleafoa Dr. Take Naseri
Director General/CEO,
Ministry of Health



Samoa's Ministry of Health is proud to present seventh annual report to UNAIDS since 2010 this year entitled Global AIDS Monitoring (GAM) Report and is evidence of Samoa's commitment to the global response to HIV, AIDS, STI's, and TB. This commitment stems from the "Political Declaration on HIV/AIDS: Intensifying Our Effort to Eliminate HIV/AIDS" adopted by the United Nation member states at the high level meeting held in New York in 2011. In 2016, the commitments were reaffirmed

when Samoa signed the new political declaration agreeing to end the HIV epidemic by 2030 within the framework of the Sustainable Development Goals.

The Global AIDS Monitoring Report is a highly regarded report with an in-depth analysis of core indicators that provide insight into our national efforts in 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 (STI's) pose considerable threats to morbidity and possible mortality in both adults of reproductive age and newborns. STI's can also significantly increase the risk of HIV transmission if not addressed in our population. If STI's are not managed and prevented, they can contribute negatively to healthcare costs attributable to treatment and care, program management, and other costs that will in turn affect the government's overall health budget.

2017 was a year of considerable achievements for all entities involved in the national response. We seek to maintain and expand these advancements as we work to eliminate HIV and STI's. Samoa's new HIV, AIDS and STI Policy 2017-2022 was launched in 2017 to guide the national response to combat new and ongoing challenges.

Over the years, Samoa has received financial support from several international and regional partners. The Government of Samoa also contributes significantly through providing human resources and managing the logistical aspects of the National Programme for HIV, AIDS, STI's and TB. The on-going support and care offered by the National Health Service for our PLWHA and our STI and TB patients is greatly appreciated. Additionally the Government of Samoa through the Ministry of Health acknowledges the continuous support rendered by the UNDP/ Global Fund to Fight HIV, Tuberculosis and Malaria and World Health Organization. Without this support, our people wouldn't receive subsidized prevention services. We sincerely thank you.

May this report continue to provide strategic direction to all of our national, regional, and international partners whom we are working with to fight HIV/AIDS now and into the future, as well as an education resource for the public on these issues.

Ma lo'u fa'aaloalo lava,

Leausa Toleafoa Dr. Take Naseri
Director General/Chief Executive Officer of Health
Ministry of Health

I. STATUS AT A GLANCE

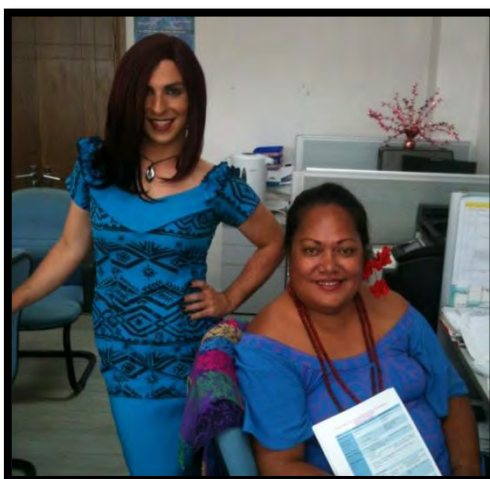
Stakeholders in the Report Writing Process

The preparation of the 2017 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 throughout 2017 and January to February 2018. Data were collated and analyzed by MoH for the development of this report.

2018 GARPR Team (Ministry of Health)

- ✘ Ms. Aaone Tanumafili Taveuveu- Principal HIV/AIDS National Capacity Support Officer, Health Sector Coordination, Resourcing and Monitoring Division (HSCMRD) (contact person for this report)
- ✘ Ms. Robert Carney (Robina)- Research, M&E Officer HIV, STI's and TB, Office of the CEO

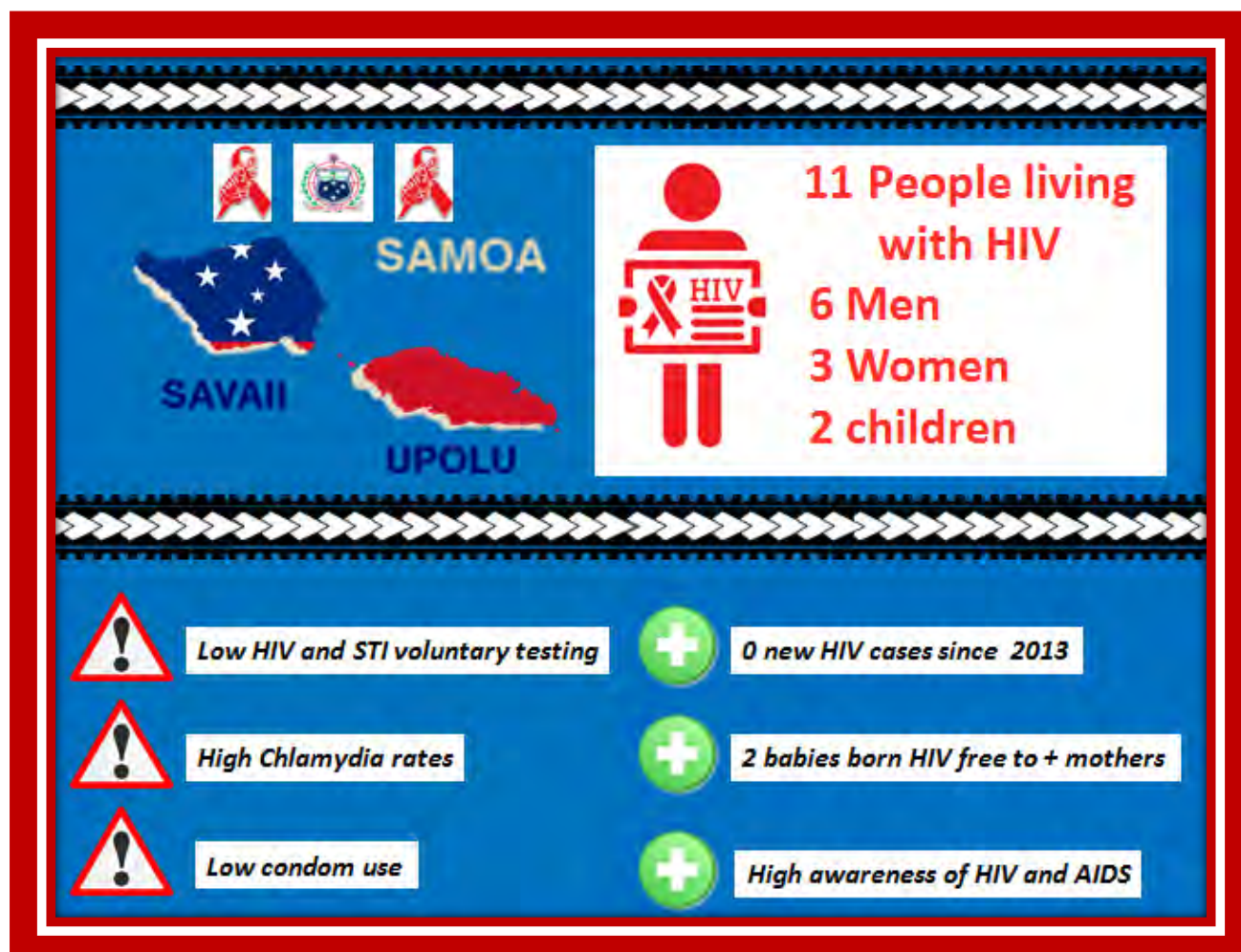


The staff of HIV, STI, and TB National Programme at Ministry of Health

Stakeholders Contribution through submission of reports of activities implemented in 2017:

- ✘ Ministry of Health- Health Promotion and Enforcement Division
- ✘ Ministry of Women, Community and Social Development – Division for Youth and Division for Women
- ✘ National Health Services
 - Public Health Clinic (HIV/AIDS Patient Register Summary)
 - Laboratory Services (National Surveillance STIs Data)
 - Pharmaceutical Services (ARV Drugs Supply Record)
- ✘ People living with HIV or AIDS
- ✘ Samoa AIDS Foundation
- ✘ Samoa Fa'afafine Association
- ✘ Samoa Family Health Association
- ✘ Samoa Red Cross Society
- ✘ Teen Challenge Samoa
- ✘ Young Women's Christian Association

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 at 20.7% in 2017), are also a concern and pose risks for increasing HIV transmission.

The primary mode of HIV transmission in Samoa is through heterosexual sex. There are currently 7 cases of mother-to-child transmission (3 adults, 4 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. In 2014, a stillbirth occurred to an HIV positive mother.

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 one of the lowest testing rates (23% positive, 1% of the population tested).

Table 1. STI Surveillance Data at a Glance

STI	2017 Prevalence	2017 Testing Coverage (% of population)
HIV	0.00%	6.0
Syphilis	0.68%	5.8
Hepatitis B	2.44%	6.1

STI	2017 Prevalence	2017 Testing Coverage (% of population)
Hepatitis C	0.10%	5.2
Hepatitis A	14.6%	0.1
Chlamydia	22.93%	1.1
Gonorrhoea	10.00%	1.1



Policy and Programmatic Response

Samoa Ministry of Health, being the National Focal point for HIV, AIDS and STI's, has the responsibility for the strategic oversight and acts as the coordination, monitoring and evaluation entity for the country's response to all related health issues. Samoa's National Strategic Plan and Policy was launched in August 2017 and covers the period 2017-2022. 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.

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. The NACC was absorbed under the Sexual Reproductive Stakeholders Group in 2014, but is set to be revived in 2018 as the stakeholder's group is to be discontinued and there is a need to expand the national response efforts.

The HIV, AIDS, STI and TB Monitoring and Evaluation Reference Manual 2017 was launched in August 2017 in order to provide results based decision making for the national response. It serves as a guide for all stakeholders and partners regarding the data that the Ministry of Health needs to regularly collect, report, and use to support intervention design and implementation.

Indicator Data Overview

 Key UNAIDS Indicators 	Value
1. PLWHIV that know their status	100%
1.2 PLWHIV on ARV therapy	100%
1.3 Retention on ARV at 12 months	100%
1.4 PLWHIV with suppressed viral loads	63.6%
1.5 Late HIV Diagnosis	0 new cases
1.6 Antiretroviral medicine stock-outs	None reported
2.1 Early infant diagnosis	0 new cases
2.2 Mother to child transmission of HIV	0 new cases
2.3 Preventing mother to child transmission of HIV	0 new cases
2.4 Syphilis among pregnant women	
a. Coverage of syphilis testing in women attending antenatal care	91.1%
b. Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology	0.14%
c. Percentage of antenatal care attendees during with a positive syphilis serology who were treated adequately	100%
3.1 HIV incidence	0 new cases
3.2 Size estimates of Key Populations	
a. sex workers	400
b. men who have sex with men (MSM)	25,000-30,000
c. transgender	25,000-30,000
3.3A HIV prevalence among sex workers	0%
3.3B HIV prevalence among men who have sex with men (MSM)	0%
3.3D HIV prevalence among transgender people	0%
3.4A Knowledge of HIV status among sex workers	100%
3.4B Knowledge of HIV status among MSM	100%
3.4D Knowledge of HIV status among transgender people	100%
3.6A Condom use among sex workers	35.3%
3.6B Condom use among MSM	50%
3.6D Condom use among transgender people	17.7%
3.7A Coverage of HIV prevention programmes among sex workers	100%
3.7B Coverage of HIV prevention programmes among MSM	100%
3.7D Coverage of HIV prevention programmes among transgender	100%
3.11 Active syphilis among sex workers	13.3%
3.12 Active syphilis among men who have sex with men	0%
4.1 Discriminatory attitudes towards people living with HIV	Only 2.6% of women and 3.3% of men expressed acceptance of people living with HIV or AIDS (2014).
5.1 Young people: Knowledge about HIV prevention	5.2% (2014)
5.2 Demand for family planning satisfied by modern methods	15.10% (2014)
10.5 Gonorrhoea among men	0.1%


II. OVERVIEW OF THE AIDS EPIDEMIC

HIV Epidemiology

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 detected between the years 2014-2017. However, testing rates are low with around only 4 to 6% of the population being tested each year according to quarterly surveillance reports (see Table 2). Other STI's, particularly Chlamydia, are high in prevalence (26%) with low testing rates.

Table 2. HIV Testing Rates

Year	HIV Tests	Percent of Population
2010	3765	1.9%
2011	4909	2.6%
2012	9394	4.9%
2013	8443	4.4%
2014	7461	3.9%
2015	8870	4.6%
2016	7408	3.8%
2017	11882	6.0%



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. This means there is likely a high proportion of undetected cases. Therefore, the full impact of HIV/AIDS on Samoa remains relatively unknown. A quarter of the documented HIV cases are mother to child transmissions, which suggests that HIV affects general populations as well as key populations (sex workers, transgender, prisoners, etc.). All documented living cases are currently receiving ARV treatment, which is free at all health sector partners of the Ministry of Health.

As of 2017 there were 24 cumulative cases of HIV in Samoa (MoH Surveillance Data). 11 of these cases are currently living. All are recorded as adhering to ARV regimens. The primary mode of transmission of HIV in Samoa is heterosexual sex. Results from the 2008 Second Generation Surveillance Survey reveal that HIV in Samoa occurs at a rate of 10.4 cases per 100,000 with a male to female ratio of 2:1. Surveillance data comes from all patients on Upolu and Savaii, Private provider offices, health clinics, Immigration, various NGO's, Samoa Family Health Association, and blood donors that have testing services requisitioned by a clinician with specimens sent to the National Laboratory. However funding and staffing shortages at all of these organizations has limited the amount and frequency of data that can be collected for HIV and other STI's. Table 3 shows selected demographic characteristics and Table 4 shows the number of infections by year. 13 of the 24 cumulative cases are deceased.

Table 3. HIV/AIDS Summary

HIV/AIDS Profile		
Cumulative Cases	24	
People Living with HIV	11	
Deceased	13	
Primary Transmission	Heterosexual sex	
Mother to child transmission	6 births	
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)

Table 4. HIV Cases by Date, Gender and Age 1990-2017

Date Registered	0-4	20-24	25-29	30-34	35-39	40-44	50+	Total
1990					M (d)			1
1994				M (d)				1
1995	U (d)		F (d)					2
1996	M (d)		F (d)		M (d)	F (d)		4
1999					M (d)			1
2000		M (d)				M		2
2001				M				1
2007			M	M, F, M (d)				4
2008	M			M (d)				2
2009	M (d), M		F	F				4
2013							M	1
2015	U (d) - stillbirth							1
2016-2017								
Total								24

*M- Male; F-Female; U-Unknown, (d)-deceased

The high rates of Chlamydia in Samoa also potentially increase the risk for HIV transmissions. Chlamydia is a major problem in Samoa with a high prevalence in pregnant women, who are supposed to be low risk for the disease. This indicates higher rates for other population groups. Of 2,207 individuals tested at hospitals and health facilities in 2017, 22% 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% (Walsh 2012). Chlamydia also has a low testing rate for the general population (only 1% in 2017).

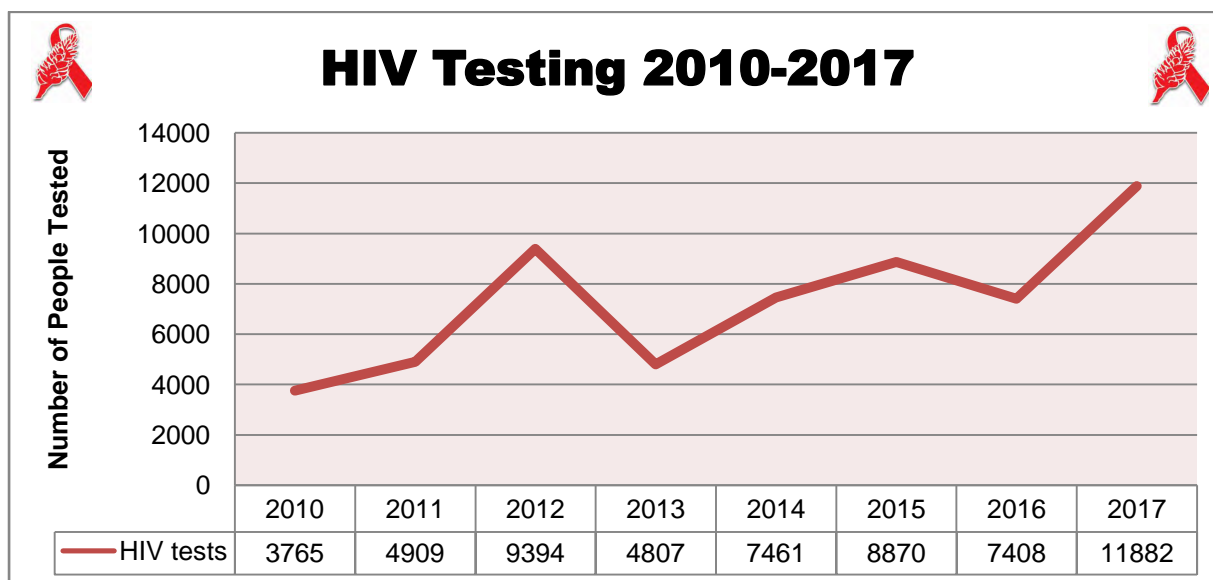
STI's generally have low voluntary testing rates (apart from ANC STI testing which is mandatory). Table 5 shows that Chlamydia, which has the highest prevalence, also has one of the lowest testing rates. Testing stopped in 2016, due to stock-outs of testing kits. This is a particular concern considering that a high prevalence of 22% is detected in only 1% of the population. Testing coverage is also not significantly increasing

Table 5. STI Surveillance Data 2015-2017

	2015 Prevalence	2015 Testing Coverage Rate	2016 Prevalence	2016 Testing Coverage Rate	2017 Prevalence	2017 Testing Coverage Rate
Chlamydia	26%	1.0%	Not Tested	Not Tested	22.93%	1.1
Hepatitis B	2%	4.6%	2.4%	3.9%	2.44%	6.1
Syphilis	0.3%	4.4%	0.4%	3.6%	0.68%	5.8
Hepatitis C	0.1%	2.0%	0.5%	1.9%	0.10%	5.2
Hepatitis A	Unavailable	Unavailable	Unavailable	Unavailable	14.6%	0.1
HIV	0%	4.6%	0%	3.8%	0.00%	6.0

Although HIV and STI testing is still relatively low in recent years, trends show that the coverage of testing has greatly increased since 2010. HIV testing is the highest it has been since 2010, which had the lowest testing coverage. 2017 testing rate increase can be attributed to the multiple media awareness campaigns aimed at increasing voluntary testing.

Figure 1. Samoa HIV testing trends



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 6). 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 6. Select Demographic Health Survey 2009 and 2014 Findings

Samoa 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%

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.

Though Samoa has a low prevalence of HIV and good case management of the identified cases of PLWHIV, there are multiple findings that suggest HIV in particular could potentially be a bigger problem for Samoa.

1. HIV has a low testing rate of 6% of the population being tested in hospitals and clinics in 2017. The Demographic Health Survey (2014) reveals that only 4% of women and 3% of men have ever been tested for HIV. So the true prevalence may be much higher, especially in rural areas where access to testing is lower.
2. Of women who have given birth in the past 2 years, only 23.9% have received HIV counselling in prenatal care visits, and only 4.1% percent received counselling, testing, and testing results, suggesting high risk for mother-to-child infections (DHS 2014)
3. Youth are also at risk with only 5% of women and 6% of men having comprehensive knowledge of HIV. Urban youth are also more likely to have sex before the age of 15 than rural youth (DHS 2014). Youth ages 15-19 are less likely to know where to access condoms (25.1 compared to 34.7 for all age groups). Youth ages 15-24 account for 40.7% of all Chlamydia infections in 2015, which has a syndemic relationship with HIV (MoH STI Surveillance 2017).
4. Chlamydia, which has a high prevalence in Samoa, is also primarily transmitted sexually, and has been known to increase infectiousness in people with HIV via increase viral shedding in the cell walls of genitals. High Chlamydia rates increase HIV transmission.
5. Condom use is low. Only 1.5% of women have ever used a male condom and only 0.1% have used a female condom. For men only 14.4% have used a male condom during sex (DHS 2014)
6. Men in particular may be more vulnerable to HIV exposure than women, due to their lower age of first sexual intercourse, and higher rates have having first intercourse before the age of 15, both of which are risk factors for HIV (DHS 2014).
7. Increasing teenage pregnancy rates
8. Highly mobile population including seafarers, police engaged in UN operations, residents returning from overseas, and tourists.
9. Low access to prevention materials and condoms

Other STI's Epidemiology

Additionally, Samoa faces challenges in sexual health regarding Chlamydia, Gonorrhoea, Syphilis, and Hepatitis B&C. As mentioned previously, Chlamydia is a major problem in Samoa, and the most prominent sexual health issue in terms of STI's. Chlamydia occurs at a high prevalence in pregnant women, who are supposed to be low risk for the disease. Of the 2,207 individuals tested at hospitals and health clinics in 2017, 22% had Chlamydia. The prevalence may be higher in rural areas with one study with women age 18-29 finding a prevalence of 36.7%. Ages 15-24 represented 40.7% of all Chlamydia infections in 2017, which suggests youth are at particular risk. Chlamydia also has a low testing rate for the general population (only 1.1% in 2017). Chlamydia if left untreated can lead to sterility and blindness (for infants born to mothers with Chlamydia). Testing for Chlamydia has stopped due to lack of funding for testing kits in 2016, and resumed in 2017 with fewer tests. Therefore the reduction in prevalence between 2016 and 2017 is likely due to decreased testing leading to a reduction in detection of positive cases.

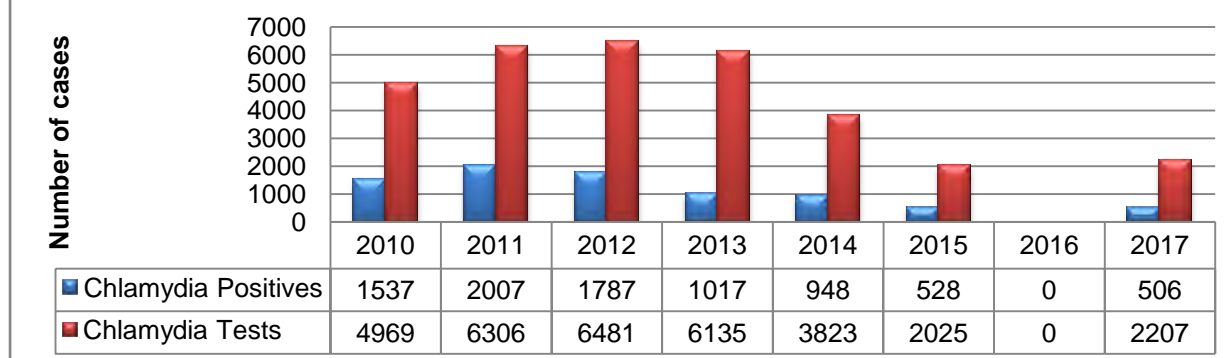
Table 7. STI's from 2015-2017 (in order of prevalence)

STI	2015	2016	2017	Status
Gonorrhoea	Not Tested	Not Tested	21.2%	High prevalence
Chlamydia	26%	Not Tested	20.7%	Not significantly changed
Hepatitis A	Not available	Not available	14.6%	-
Hepatitis B	2%	2.4%	2.3%	Not significantly changed
Syphilis	0.30%	0.4%	0.7%	Increasing
Hepatitis C	0.10%	0.5%	0.1%	Decrease
HIV	0%	0%	0%	0 incidence

Hepatitis A has the next largest prevalence compared to gonorrhoea and chlamydia, however testing is too low to produce accurate estimates of prevalence with only 103 recorded tests in 2017. Syphilis, though lower in prevalence, has been steadily increasing. Hepatitis B has not changed significantly in the past 3 years.

For most of the past 7 years, Chlamydia has persisted as a high prevalence STI from 31% in 2010 to 22% in 2017. Though the rates have slightly reduced in the past 7 years, so has testing. Testing in 2017 is among the lowest of all years since 2010. This means that the actual prevalence in the population is higher and has remained relatively unchanged since 2010. The reduction in the number of tests each year is also a concern, because it indicates that less positive patients are being linked to treatment services. Most of the gonorrhoea positive cases are actually co-infections with Chlamydia. Addressing the high rates of both chlamydia and gonorrhoea remains a top priority. There is a lack of evidence world-wide on what interventions are most effective at preventing Chlamydia infections and reducing prevalence rates. The Pacific generally has some of the highest rates of Chlamydia in the world. New, up-scaled, multi-sectoral and comprehensive initiatives are needed to address these rates.

Figure 2. Chlamydia Testing and Detected Cases in Samoa 2010-2017



Knowledge of Chlamydia transmission and prevention is severely lacking in both general and key populations in Samoa. The ICHAP 2017 Survey tested the knowledge of participants about key misconceptions about Chlamydia. The majority (74%) had low knowledge about Chlamydia.

Less than 30% of people knew that Chlamydia may show no symptoms in both men and women. Only 43% knew that Chlamydia was curable, and only 50% knew that wearing condoms prevents infection. This shows some insight into why rates of Chlamydia infection are so high, and why many people don't access prevention and treatment. Only 33% knew Chlamydia could affect women's fertility and only 27% knew it could affect men's fertility. Additionally, only 23% knew that Chlamydia can cause eye infections if left untreated. This indicates that more education about the long term effects of infection is needed as well. All of these findings support the need for increased testing paired with prevention education to lower the rates, and link more people to treatment services. From a health education and communication perspective, messages need to focus on encouraging detection through testing in the absence of visible symptoms, how Chlamydia can be prevented and treated, and the effects on health that can occur if left untreated.

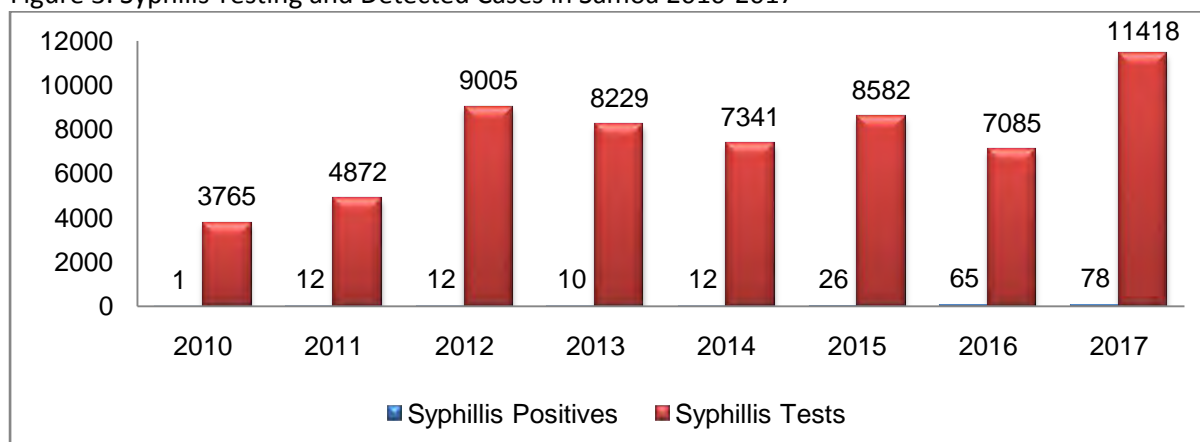
Table 8. Chlamydia Knowledge of Respondents to the ICHAP Survey 2017

Statement	Answer	Correct Responses	Correct Percent
You can catch Chlamydia from toilet seats.	FALSE	114	23.2%
Men with Chlamydia might not have symptoms.	TRUE	69	14.1%
Most women will NOT develop symptoms of Chlamydia.	TRUE	133	27.1%
Only women get Chlamydia.	FALSE	252	51.3%
Chlamydia can affect men's fertility.	TRUE	133	27.1%
Chlamydia can affect women's fertility.	TRUE	160	32.6%
Chlamydia can cause eye infections.	TRUE	115	23.4%
Once you get Chlamydia, you can't get rid of it.	FALSE	210	42.8%
You can get Chlamydia more than once.	TRUE	70	14.3%
Wearing a condom prevents Chlamydia.	TRUE	249	50.7%
Birth control pills prevent Chlamydia.	FALSE	143	29.1%

Syphilis, in contrast to Chlamydia and gonorrhoea, has remained very low in prevalence over the years with similar testing coverage to HIV. However, cases are on the rise. The number of positive cases has tripled since 2015. This is due partly because of increased testing (especially in 2017). However in 2016, testing decreased, but the number of positive cases detected still rose

significantly. This suggests that syphilis may be genuinely increasing in the population. This means prevention, testing and treatment need to be scaled up in order to respond.

Figure 3. Syphilis Testing and Detected Cases in Samoa 2010-2017



Multiple factors, including stigma around sexual health, low access to condoms, confidentiality concerns, and stigma around the prevention and treatment of STI's all pose challenges to addressing STI prevalence and encouraging regular testing. The Ministry has also documented low level of knowledge of STI prevention and transmission, particularly with regards to Chlamydia.

In addition to these factors, gender violence may also play a role in exacerbating the health burden of STI's. 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 Human Rights Report 2015). 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%).

STI's among antenatal women remain very prevalent with 26% of ANC women testing positive for Chlamydia in 2017. This is likely due to multiple barriers in linking male partners to testing and treatment. However there may also be a component of this that is related to the high prevalence of domestic violence, as women in abusive relationships are not able to demand condom use or STI treatment for fear of further violence. Accessing treatment services is also met with stigma. Despite the high prevalence of Chlamydia, the actual figure is likely higher, as only 4,825 out of an estimated 9,616 pregnant women (50.1%) reported for ANC visits and were screened for STI's in 2017 (MoH STI Surveillance 2017). This rate has increased from 46.9% of ANC females being screened for STI's in 2016, but this progress needs to be sustained and expanded.

Key Populations

The main source of data for key populations comes from the Pacific Multi-country Mapping and Behavioural Study 2016. For fa'afafine (transgender), the study found that though knowledge of HIV was generally high, condom use was low (43.9% never used a condom) and only 16.3% had an HIV test in the last month. The main reason for not using condoms was that fa'afafine felt they were safe from HIV. About 32% were paid for sex within the past month.

For female sex workers in the study, most engage in sex work for economic reasons. Sex work currently is illegal in Samoa. About 58% of the women had children and no other source of employment. The average sexual partners in the past month was 10, with 9 of those being paying

clients. Condom use was low (33%) at the last occasion of vaginal sex. None of the women had accessed a sexual health service within the last 12 months nor had been tested for HIV.

Drug use is largely un-documented in Samoa outside of law enforcement. The main form of drug use occurs with non-injected opiates. The needs of drug users have not been defined by any research studies at this time.

The prison population consists of inmates at Tafaigata Prison Facility on Upolu, and Olomanu Prison Facility on Savai'i. Outside of outreach visits conducted by government and NGO's, inmates have limited access to health and healthcare services. Routine screening programs have not yet been established for inmates. Outreach surveys have collected data on the health needs of this population, which is covered in Commitment 3.

The Multi-sectoral Response to HIV and STI's

Under the Ministry of Health, a National AIDS Coordinating Council (NACC) was established in 1987 after the AIDS crisis. This is an equivalent to the Country Coordinating Mechanism (CCM) and addresses HIV/AIDS, STI's and TB. In 1988, a Technical Advisory 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.

Ministry of Health's role has been to provide 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. Due to the relatively low prevalence of HIV, the Ministry of Health has taken a broad sexual health approach, addressing all STI's and sexual health threats in order to prevent HIV and safeguard the population from future epidemics. TB interventions have also been integrated into this programming as well due to the deadly nature of co-infection and the structure of funding mechanisms.

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.

MoH's programme activities are mainly implemented through the National Health Service (NHS) and NGO stakeholders. NGOs such as the Samoa Fa'afafine 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. 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. Samoa AIDS Foundation was revived in 2017, and is rebuilding and reinventing its role within the national response.

In 2017, Teen Challenge Samoa and the Young Christian Women's Association (YWCA) joined the Ministry of Health list of implementing partners. Both are religious organizations that work with youth populations (males with Teen Challenge and women with YWCA).

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 fa'afafine populations is crucial, and many other programs carried out by the sector partners. A 2011 documentary "E tesilafia", which described the status of the HIV/AIDS epidemic in Samoa is regularly aired on World AIDS Day each year. 2017

marked the launching of the T3 Campaign, aimed at making people aware of prevention and treatment services.

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. This poses a challenge to advocating for the rights of PLWHA.

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.

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

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 (GF) (ii) funding from UNFPA for the Sexual and Reproductive Health (SRH) program and World Health Organization (WHO). The government of Samoa assisted tremendously in financing human resource for HIV/AIDS program, and some activities were well mainstreamed into the MOH budget by the end of 2013.

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 centres. Patients' information regarding voluntary testing and counselling remain 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. Presumptive treatment for Chlamydia is currently offered free to all ANC mothers and their partners.

Continuing VCCT monitoring visits are conducted every 3 months. The objectives behind these visits are to ensure that tracking of utilisation of Family planning commodities. ii) Ensure that all

facilities are offering treatment for STIs where needed, iii) Identify any gaps with the DOTS strategy. Reports of these visits are submitted to MoH management for strategic advice and so forth.

Counselling services remain a challenge to date. There needs to be continuous counselling training for all healthcare workers dealing directly with cases of STIs/HIV/AIDS and TB as well. 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. Presumptive Treatment Guidelines and Protocols in both English and Samoan languages were distributed to all healthcare facilities for clinicians use.

CD4 counts are done consecutively every 4 months for all 9registered HIV+ cases at the Public Health Clinic. CD4 counts and viral load tests are done at the National Laboratory. ANC care for HIV+ mothers is offered at all healthcare centres. For in the case of PPTCT, Samoa utilizes 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, which needs continuous promotion and expansion of coverage.

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. There is however a noted improvement of TB/HIV co-infection testing in the last reporting period i.e; 93% of people with TB were tested for HIV a target reached and achieved significantly after many years of trying to mobilise TB patients to test for HIV as well.

ARV and STI treatments are provided for free of charge under the Global Fund. All HIV, STI, and TB clinical care is headquartered at the Communicable Disease Clinic, located at the new Primary Healthcare Centre in Apia (opened in November 2016).

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Prevention

The activities for the national response in 2016 focused heavily on prevention, knowledge and behavior change, and improvements to monitoring and evaluation. Programming became more focused on outreach to key populations. MoH was able to coordinate with the National Health Service (NHS) to implement prevention activities complimentary to clinical interventions during the same period.

T3: Talk it, Test it, Treat it (Siaki, Talanoa, Togafitiga) Multimedia Campaign

The T3 Campaign started with a partnership activity initiated by UNDP that delivered HIV, STI, and TB awareness through text messages. It has since been expanded by the Ministry of Health as a multimedia platform to engage general and key populations in HIV, STI, and TB awareness. In January 2017, UNDP proposed a partnership to the Ministry of Health (MoH) and Digicel (pacific phone service provider) to deliver texts messages on HIV, AIDS, STI's, TB, teen pregnancy, and


addressing stigma in Samoa. These messages would link to informational web pages (landing pages) developed by MoH and refer people to testing and treatment services. The messages would target Digicel subscribers, an estimated 110,000 people (55% of Samoa's population) for the duration of 12 months. The activity was funded by UNDP, implemented by Digicel Samoa, with content developed and monitoring provided by the HIV, STI, and TB program at Ministry of Health. This was part of a multi-country campaign in the Pacific funded by UNDP with a limit of 1,183,500 text messages for the country.

In order to both market this campaign in a way that will appeal to and clearly communicate the campaign's messages to Samoans, and extend the campaign beyond the UNDP/Digicel activity, the programme was entitled of "T3: Talk it, Test it and Treat it." The title is meant to capture the key health messages that HIV, STI's and TB have in common 1) talk about these issues as a community to promote awareness and learning, 2) get tested for free at all NHS and NGO facilities to improve screening rates and surveillance of these disease, 3) get treated to reduce transmission and ensure a healthy life. A press release of T3 was launched to raise awareness of the campaign and generate positive reception prior to the official launch and implementation. The branding of the campaign as "T3" was to generate public interest, clearly communicate the purpose of Ministry of Health in launching this campaign, and to reduce negative reactions by the public during implementation. The fa'asamoa version of the campaign was, "TST: Talanoa, Siaki, Togafiti". T3 messages focus on communicating the following;

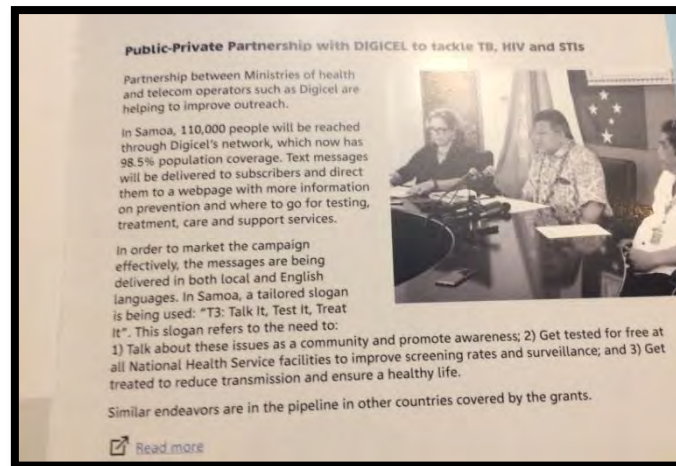
- Importance of accessing screening and treatment services
- Reducing stigma to those affected by these diseases
- Using condoms and family planning services
- Knowledge on how these diseases are transmitted
- Recognizing symptoms of these diseases

T3 launched in March 2017 during the week of World TB Day (24th of March) and messages were blasted to Digicel users monthly for the entire year. A total of 495,135 messages were scheduled to be distributed to 100,000+ estimated Digicel subscribers after World TB Day. Below is the reported progress of text messages as of July 2017.

Table 9. Digicel-UNDP-MoH Text Message Campaign Implementation Status

	Category	Messages Sent	Visits to landing page
	<i>HIV and STI's</i>	235,600	8,070
	<i>TB</i>	80,000	4,083
	<i>Total</i>	315,600	12,153

The partnership received international attention throughout the Pacific region as Samoa was the first country to implement the initiative. T3 has been mentioned at multiple committees and working groups amongst development partners and Pacific island countries.



Mention of T3 Campaign in UN programme brief

T3 continued throughout the year via TV commercials, radio spots, digital billboard promotions, as well as a billboard established in the Apia urban area. IEC materials with an STI self-assessment and contact information for service providers were also developed using the T3 messages.



T3 Billboard in Apia Urban Area

The HIV, AIDS, STI, and TB Programme at Ministry of Health also developed a Facebook page as part of promoting T3 across digital platforms. The page is followed by 75, and receives regular messages about testing and treatment services from people viewing T3 promotions.



You can follow this page at <https://www.facebook.com/HIVSTITBMoH/>

In November, the Health Sector Coordination, Resourcing, and Monitoring Division was tasked with coordinating the first Physical Activity and Nutrition Expo, funded by WHO and the Government of Samoa. Sports organizations, gyms, businesses, and community initiatives were invited to set up booths and engage attendees to promote wellness, fitness, and healthy lifestyles. The HIV/STI/TB programme used this platform to engage sports organizations in promoting the T3 Campaign.



Nobesity Samoa staff promoting T3 messages



CrossfitFatu Toa Gym coaches and members promoting T3 messages



Samoa Body Building Federation promoting T3 messages

✦ T3 Promotion at SCOPA Netball Kings and Queens Tournament



T3 Safe space testing and counseling booth at Netball Kings and Queens Tournament

The annual netball tournament in November attracts a lot of youth and community organizations. This was seen as a good opportunity to deliver IEC's, condoms, testing, and education on HIV and STI's. A T3 booth was set up to offer tournament participants a chance to learn about HIV and STI's, as well as to get screened. 18 individuals accessed testing, 4 of which were members of key population groups. There were no detected positives. T3 business cards with an STI self-check symptom list and the numbers of clinics with services were developed and distributed throughout the event.



Posters with health messages on HIV and STI's

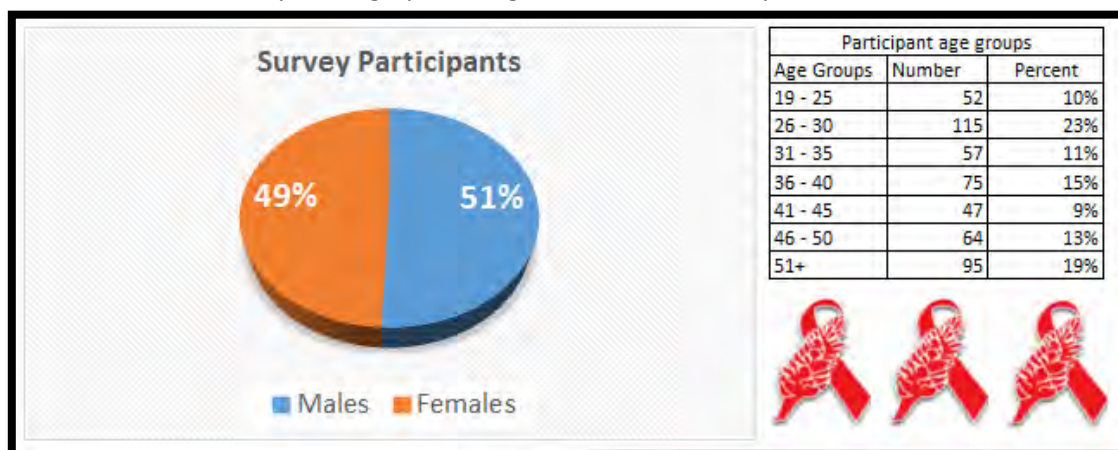
Throughout 2017, the call volume to the STI Clinic and the Ministry of Health HIV programme office increased significantly after T3 was launched. More clients were contacting staff to learn more about services and sexual health. According to surveillance data, people tested for at least 1 STI increased from 7,853 in 2016 to 14,727 in 2017 (or by 87.5%). Although this increase can only be ecologically inferred as a result of the T3 campaign, HIV testing rates have never been higher, nor have increased by such a significant amount in previous years.

✘ T3 HIV Phone Survey with Digicel and Trend Media

The Ministry of Health partnered with Digicel/Trend Media to deliver a text message survey assessing HIV knowledge to Digicel subscribers in urban and rural areas. Over a period of 6 weeks, 40,000 SMS (text) messages with survey questions were sent to both urban and rural areas. Completing the survey awarded users free data, and the correct answers to HIV questions were sent to all participants. A total of 505 people completed the survey.

The participants were roughly equal male and female, ages 19-75;

Figure 4. HIV Phone Survey Demographics, Digicel/Trend Media Report



The SMS survey consisted of 5 questions to test HIV knowledge specific to transmission. The survey was designed to pilot knowledge testing questionnaires about prevention and transmission, so that the Ministry of Health could assess launching future surveys in the future that assess population health indicators via SMS. The questions were delivered in Samoan and were multiple choice, with the respondent to select the correct answer from 4 choices. At the end of the survey, respondents were given the correct answers for their knowledge as well as a link to an HIV and STI informational page developed by MoH and Trend Media.

The results were similar to the findings of the 2014 Demographic Health Survey, in which only about 6% of respondents answered all questions correctly about HIV transmission. In the phone survey, 0% of the 505 respondents were able to answer all 5 questions correctly about HIV. Many respondents indicated that they believed mosquitoes and saliva could transmit HIV, which illustrates a need for detailed HIV education about how infection occurs. Less than half (48%) were aware that condoms were highly effective (98%) at preventing HIV transmission.

Table 10. HIV Phone Survey Results

Digicel/Trend Media Survey Questions	Correct Responses Only	
	Number	Percent
Correct Answer		
▪ HIV is NOT ONLY transmitted through sexual contact	310	61.4%
▪ HIV CANNOT be transmitted through mosquitoes, even if the mosquito has bitten an infected person	19	3.8%
▪ Saliva CANNOT transmit HIV	29	5.7%
▪ HIV attacks the immune system of the body	100	19.8%
▪ Condoms are 98% effective at preventing HIV	243	48.1%
Correctly answered all 5 questions	0	0%

The results highlight the need for a technically oriented, and practical sexual health education that delivers transmission knowledge and prevention methods. Ages 26-30 were more likely to report correct answers. This indicates a need to target youth and older age groups when addressing HIV knowledge. Females were also more likely to report correct answers for all 5 questions, which may suggest a need for programing amongst male populations.

Annual Fa'afafine Forum and Outreach Events



Voluntary HIV/Syphilis Screening with SFA

The fa'afafine community in 2017 made multiple headlines in their work promoting HIV and STI prevention. Led by the Samoa Fa'afafine Associatio (SFA), the Ministry of Health and the National Health Service supported HIV/Syphilis screening at the Annual Fa'afafine Forum, as part of Miss Fa'afafine Pageant Week. The screening initiative was also taken out into rural villages. 95 individuals were screened, with 0 testing reactive. News outlets reported on the event, raising awareness about the importance of regular voluntary testing.

In December as part of National Fa'afafine Week and World AIDS Day, the Samoa Fa'afafine Association held a forum in which all members were given the opportunity to voluntarily test for HIV and syphilis. 75 were screened and 0 tested positive. These two screening initiatives were the first and largest of their kind.

In January 2018, the fa'afafine community and the national response to HIV and STI's experienced a great loss with the passing of So'oaloTo'oto'oali'o Roger Stanley, affectionately known as "Mama Acha". As the president of the Samoa Fa'afafine Association, So'oalo was a powerful and essential leader in uniting all fa'afafine that had previously organized themselves clubs, groups, and pageants throughout the early 90's. With a united fa'afafine community, So'oalo continued the tradition of fa'afafine pageants which were not only social calendar fixtures, but platforms for national awareness of fa'afafine issues. She built a decade long partnership with Ministry of Health to sponsor the pageants which would then be used as opportunities to promote HIV and STI prevention and awareness. Funds raised from these pageants would go to Mapuifagalele Home of

the Aged, HIV awareness programmes and those living with HIV such as the late PeatiMalaki. In 2006, So'oalo entered the pageant to become Miss TuttiFruttiFa'afafine Pageant for that year, and has since been one of the most memorable contestants.



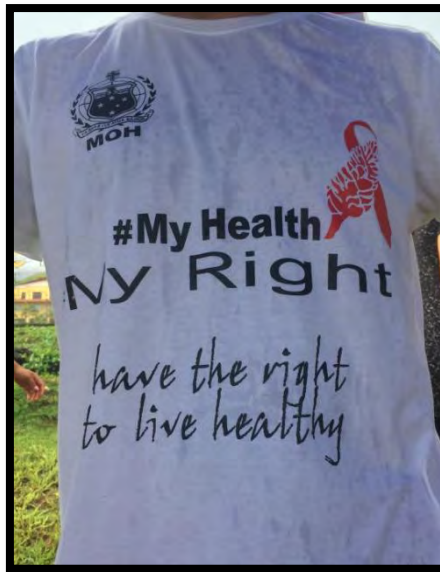
In Loving Memory of So'oaloTo'oto'oali'o Roger Stanley, "Mama"

So'oalo also played a vital role during the inauguration of the Samoa AIDS Foundation from 2004 – 2012 and was very supportive of its HIV Awareness Programmes and Community Activities such as schools outreach, nightclub condom distribution and Fashion Extravaganza events. So'oalo continued the work of HIV Awareness Programmes with the Samoa Fa'afafine Association with the collaboration, funding and support from the Ministry of Health and UNDP/Global Fund. This highlights So'oalo's managerial, marketing skills and administrative prowess in the delegation and upscaling the implementation of community projects. The Pacific Sexual Gender Diversity Network was established in Apia Samoa in 2007 prior to the 2007 South Pacific Games, of which So'oalo was a founding member. She was the most active member of the PSGDN Board and the Secretariat with great contributions to decision making & strategic planning within the board.

So'oalo was a close and crucial partner of the Ministry of Health in all aspects of its work with the fa'afafine community. Personally and professionally she embodied sexual health advocacy, and served as a major mobilizer of the community. So'oalo was deeply and integrally involved in all HIV and STI prevention work done in Samoa, even before the period of the UNDP/Global Fund projects. The Ministry of Health is grateful for all her work and will deeply miss her partnership as the ministry, SFA, and the national response continues the fight built on her legacy.

World AIDS Day 2017

The Ministry of Health coordinated all health sector partners and NGO's in implementing World AIDS Day activities during the week leading up to Friday 1st December. The HIV team took the global theme "Right to Health" and localized it to synergize with the T3 campaign.



World AIDS Day T3 t-shirts



My Health My Right posters

Samoa AIDS Foundation led the memorial mass for those lost to HIV on November 30th. Samoa Fa'afafine Association held the candlelight memorial service to open World AIDS Day at daybreak on December 1st. The Health Promotion team from Ministry of Health and STI nurses from NHS set up T3 booths at health centres and location in town to distribute condoms/lubricants, IEC's, and screening. Vouchers for school supplies were also given to people living with HIV to support their children's education.



Samoa Fa'afafine Association World AIDS Day Memorial Service 2017

National Young Women's Forum

In August 2017, YWCA partnered with MoH and Teen Challenge to deliver the Integrated Community Health Approach Program (ICHAP). The success of the programme in delivering sexual health education and prevention to youth in something YWCA wants to expand to its members through the National Young Women's Forum. This was integrated into World AIDS Day 2017.



YWCA members promoting T3 campaign

The World AIDS Day theme 'Right to Health', aligned with the purpose of the National Young Women's Forum and the inclusion of issues such as Sexual and Reproductive Health & Rights aligns with achieving the objective of the World HIV Aids Day. The Ministry of Health has identified youth as a vulnerable population to HIV and STI infections, as they have high prevalence and the lowest access to prevention methods (Global AIDS Monitoring Report 2017, MoH). The Ministry has also launched the T3 Campaign: Talk it, Test it, Treat it (Talanoa/Siaki/Togafitiga) as a means of engaging vulnerable populations which include youth and young women.



T3 Safe space testing and counseling booth at National Young Women's Forum

The YWCA sought to support these initiatives by mobilizing young women to partner with MoH in engaging youth in T3. The National Young Women's Forum's objectives included building awareness for female youth by promoting the World AIDS Day theme that talking, testing, and treatment as both a strategy and right to health. The forum had the following sessions integrated into the program;

- Sexual health education seminar with Q&A session with health educators
- Confidential HIV/STI testing and counselling T3 booths
- Talanoa session on protecting sexual health rights and the rights of PLWHIV in Samoa (how can youth advocate for rights to health in their communities?)
- Activities to engage youth in living a healthy lifestyle

The HIV, AIDS and STI Policy 2017-2020, The Monitoring and Evaluation Manual for HIV, STI's and TB 2017, and Health Guidelines for Tattooing 2017 were all launched in a ceremony with the Minister of Health. The target number of attendees (100) comprised young women from age 19-35 from the YWCA member network. 25 participated in voluntary Syphilis/HIV screening, out of which 0 tests were reactive.



Launching of HIV/STI/TB documents with the Minister of Health

Treatment, Care and Support

Presumptive Treatment for Chlamydia Monitoring and Evaluation

In order to address the high prevalence of Chlamydia, the Ministry of Health implemented a presumptive treatment program for antenatal women and their partners. Antenatal women, who are normally at low risk for Chlamydia, have dangerously high rates of the infection. Compounding matters, the national lab that processes Chlamydia testing and screening specimens is under-resourced to provide timely results to patients, which is critical for the antenatal population.

The Presumptive Treatment for Chlamydia (PTFC) Infections Protocol 2015 was developed as a clinical intervention to address these high rates in the interim period before behavioral interventions are developed and implemented. Similar interventions have been administered by health authorities in multiple countries in the South Pacific, with successful reduction in Chlamydia prevalence. The protocol provides guidelines for providers to administer the recommended dose of Azithromycin to all antenatal women and their partners upon their first antenatal visit to a healthcare facility. The protocol came into effect in May 2015, and involved the entire health sector in its implementation.

A retrospective analysis was conducted using patient logbooks at healthcare facilities. The Presumptive Treatment for Chlamydia (PTFC) Protocol came into effect in May 2015 after extensive consultation amongst the health sector and its partners. At multiple facilities, presumptive treatment had started as early as January 2015 given an advance directive from the facility management (who had discussed and lobbied for the protocol before it was officially endorsed). Therefore the period for the analysis is from April 2015 (or earlier depending on facility) to April 2017 when data collection was finalized for the analysis.

Logbooks at all healthcare facilities were consulted for presumptive treatment data. Cases from these logbooks were included in this analysis starting from whichever month the facility began recording PTFC. The sites that provided this data are as follows;

- Faleolo Health Centre
- Foailalo Health Centre
- Lalomanu Health Centre
- Leulumoega Health Centre
- Lufilufi Health Centre

- Poutasi Health Centre
- Saanapu Health Centre
- Safotu Health Centre
- Samoa Family Health Association
- Sataua Health Centre
- TTM Hospital Apia, Upolu
- Tuasivi Hospital (MTII) Savai'i

In accordance to the protocol, Azithromycin is to be administered to the female patient and her partner on her 1st antenatal visit to the facility. The number of antenatal visits and record of Azithromycin treatment are therefore the primary means of selected eligible cases from medical records. Staff at each facility were consulted to find the best source of data, and explain the facility's recording practices.

The final data on presumptive treatment for Chlamydia infections was collected during regular quarterly monitoring visits July 19th-26th. The data was used for an overall evaluation of the protocol, completed in September 2017. Data was captured on 7,230 patients from TTM Hospital, MT2 Hospital, Samoa Family Health Association, and all rural district hospitals and health centres.

Evaluating the Effectiveness of Presumptive Treatment

How many people were reached?

Female ANC Patients & Partners	2015	2016	2017
Coverage Rate	28.7%	20.3%	33.2%

What was the impact?

Between 2015-2017, there was a small 5.3% decrease in Chlamydia prevalence. However, it cannot be determined if there was any substantial impact on Chlamydia rates attributable to PTFC, and rates remain high.

What are the challenges?

- Male partners typically don't report to ANC and which makes it difficult to deliver verify treatment
- Low ANC attendance can reduce the maximum achievable impact of PTFC
- Azithromycin stock-outs can delay or prevent treatment for ANC mothers
- It's impossible to track prescription of antibiotics between facilities, making it hard to monitor over-prescription of antibiotics, which increases the threat of anti-microbial resistance for women receiving PTFC. 26 cases were treated 2-3 times during the evaluation period with Azithromycin.

What is the way forward?

1. Interventions, procedures, and strategies aimed at ensuring the treatment of male partners of ANC women need to be added to the design of the protocol and implemented immediately to ensure the protocol is implemented fully before the end date.
2. An aggressive education and awareness campaign on STI prevention needs to be implemented in order to fully implement presumptive treatment to its optimal impact.
3. Chlamydia testing needs to be re-incorporated into routine testing in ANC. Otherwise impact cannot be effectively evaluated.
4. A working group needs to spear head the intensification of improving PTFC which includes increasing ANC attendance, increasing treatment rates of male partners, launching a comprehensive awareness/education campaign, ensuring that treatment protocols are adhered to with special focus given to controlling over prescription of antibiotics.

5. Specific targets need to be set nationally and by individual healthcare facilities to ensure PTFC coverage rates are increased to at least 46.9% of 9,635 estimated pregnant women (the percentage of those who attend ANC).
6. Recording of presumptive treatment in patient records needs to be improved in order to increase the accuracy of coverage estimates, but also to ensure the protocol is fully implemented.
7. Record data on treatment of male partners of ANC
8. Report raw data on treated ANC to include demographic information for verification (see Appendix A for requirements)
9. Interventions, procedures, and strategies for increasing ANC attendance nationally need to be implemented to support PTFC, expand its coverage, and realize its impact.
10. Since re-infection and therefore antibiotic resistance due to re-treatment is a considerable threat, STI prevention and condom use should be a routine part of patient counselling.
11. Support and training should be provided to improve data collection and reporting.

TB DOTS Visits

For TB, midyear reporting revealed that performance indicators were lacking in critical areas of treatment success rates and co-infection testing coverage for TB and HIV. This was mainly due to the lead nurse at the Communicable Disease Clinic lacking support for monitoring of TB treatment visits and contact tracing. The national programme proposed funding for Direct Observation of Treatment visits (DOTS visits) to support data collection and treatment monitoring for TB. This allowed for needed contact tracing of TB cases in rural areas of Upolu and Savai'i and critical data collection.

Table 11. TB Performance Measures

Indicator	Target Value	Jan-Dec. 2016	Jan-Dec. 2017	Achievement
TB2a and DOTS2a- Treatment success rates of all forms of TB	85%	89%	85%	<i>Achieved</i>
TB2b and DOTS2b- treatment success rates of bacteriologically confirmed TB	85%	89%	80%	<i>Decreased due to patient deaths and increase cases</i>
TBHIV1- Percent of TB cases screened for HIV	65%	82%	90%	<i>Exceeded</i>

The result was that data collection and reporting processes were improved between MoH and the CD clinic, more patients were reached by contact tracing, and critical areas of poor performance exceeded regional targets set for their respective indicators. TB care was greatly improved by implementing HIV screening procedures to increase co-infection screening coverage. Though treatment indicators were affected by patient deaths, the case detection rates of TB were greatly improved by the expansion of TB testing by the CD clinic and partners.

HIV and Syphilis SD/DUO Test Kit Training and Pilot



Clinical staff from NHS practicing with the SD/DUO test kit

The need for rapid test kits as means of expanding voluntary testing coverage, as well as expanding the settings of HIV testing for improved outreach, has been identified as a priority area in the HIV, AIDS, and STI Policy 2017-2022. UNDP/Global Fund had procured the SD/DUO test kit for rapid (20 min.) HIV and Syphilis testing for the Pacific region. As part of launching the SD/DUO Syphilis HIV test kit in Samoa, a training was held with key clinicians who would then train their staff nationally. This training was held as part of the review of the updated WHO STI, HIV, and TB guidelines conducted as part of a 2-week process through September-October. Both the training and guidelines review were part of a technical assistance package from WHO, the SPC, with funding for facilitation from UNDP/Global Fund.

The pilot of the test SD/DUO test kit took place immediately after the training in October to the close of the year in December. Antenatal clinics nationally were determined to be the sites of the pilot. The initiative was headed by Nurse Serafi Moa and Doctor Sarah Brown of the Communicable Disease Clinic at the National Health Service, located at TTM Hospital in Apia. 834 patients were screened using the test kit. 16% of those patients were from sites in Savai'i.

Review of the Updated WHO HIV, STI and TB Guidelines



A review of the updated WHO service guidelines for HIV, STI's, and TB was conducted as part of a two weeks process from September-October with technical assistance from Dr. Madeline Salva and Dennie Akinwala, and Dr. Yadav Subhash from WHO with financial support from UNDP. Clinical management from the National Health Service and NGO's were invited to be trained on HIV/STI testing, treatment, PMTCT, and TB programme management guidelines.

The guidelines were contextualized to Samoa with the input of attendees. A national review of these guidelines is planned for 2018 before they are finalized for endorsement by parliament, and then implementation among providers.

Knowledge and behavior change

Integrated Community Health Approach Program (ICHAP) March-August 2017



Integrated Community Health Approach Program (ICHAP) was series of health outreach programs conducted by the Ministry of Health in 2017 with various partners. Originally, ICHAP was first implemented in September 2016. The Samoa Red Cross Society (SRCS), the National Health Service (NHS), and the Ministry of Women, Community and Social Development (MWCSD) partnered

with the HIV, STI, and TB National Programme and the Health Education and Promotion team at the Ministry of Health. The goal was to bring prevention education out into the communities on infectious diseases, climate change resilience, maternal and child health, sexual health, and family wellness. All of these areas of health were integrated into one programme to overcome the challenges posed by cultural and religious stigma of sensitive health issues which if delivered alone would not be as effectively received by the communities. Prevention and wellness messages were delivered together as a holistic approach to as a non-partisan way of uniting individuals and community structures in improving the health of villages.

The program was successful and well received by participating communities. 10 villages (5 in Upolu, and 5 in Savai'i) participated in the program and 1 prison facility on Upolu. Programs were delivered to the colleges and village women and men's committees separately. A pre and post test evaluation was conducted with village committees and schools, generating data on 232 participants. A general health questionnaire was distributed to prisoners to assess health needs (77 respondents).

In late March to early April 2017, ICHAP was launched again with 10 more villages (committees and primary schools) and the prison facility on Savai'i. 377 individuals attended the program. Samoa Red Cross Society, the National Health Service, Samoa Family Health Association (SFHA) partnered with the Ministry of Health in delivering this program. The villages targeted by the second round program were rural and had the least access to healthcare services. Topics covered in this round were Typhoid, Malaria, hand washing hygiene, Tuberculosis, HIV and STI's. Due to the monitoring challenges experienced in September 2016, the ICHAP monitoring tool was changed. All respondents were given a behavioural health questionnaire as a cross-sectional assessment of health needs. This report presents the results of the data collected during the April 2017 implementation of ICHAP.

The MoH integrated the World TB Day programme into the community outreach programme, ICHAP. Instead of launching event in Apia, the World TB Day celebration was brought into the community to include rural and low access communities. The TB awareness messages of the T3 campaign were also launched during this week in order to maximize community awareness and engagement in TB prevention.

In August 2017, ICHAP was implemented in partnership with Teen Challenge Samoa, in order to reach more youth with programming on education on breastfeeding, TB, STI's, HIV and sexual reproductive health. In the first day of the programme, 81 youth from various villages in Upolu participated in health education seminars, along with small group question and answer sessions with panelists. The second day programme involved a sports day and STI trivia contests with 100 participants. Teen Challenge hosted the event and mobilized it newly established network of youth to attend the program. The survey results document participants in day 1 of the programme.



ICHAP physical activity Day 2 Zumba program with Teen Challenge Samoa

Also in August 2017, the Samoa Fa'afafine Association (SFA) launched an HIV/STI screening program in multiple villages and health centres in both Upolu and Savai'i. The goal was to increase testing rates among the fa'afafine community. SFA offered to support the ICHAP initiative and distribute the survey as part of the program, and clinicians involved in ICHAP screenings partnered with SFA to deliver testing services. 72 individuals participated in SFA's program and responded to the survey.

The total survey responses from these programs were 491, which comprise the sample for the analysis in this report. The results represent the populations reached by ICHAP in 2017 from targeted villages across the country.



ICHAP program at a rural primary school with Samoa Red Cross Society

Overall the ICHAP outreach events have reached 20 villages, 20 Primary schools and colleges, 2 prison facilities, 1 youth organization. The estimated attendance for the programme is 767 for community members and 2,000 for school students. The ICHAP programme has been well received by all participating communities and organizations. All communities and institutions that participated have requested similar programmes in the future for continued awareness and education. MoH staff have also identified a large number of new villages that want to participate in the programme. Teen Challenge Samoa was the first NGO to partner with MoH on the delivery of ICHAP for specific populations (in this case high risk youth). The ICHAP programme has been a key opportunity for the MoH to improve its monitoring data and M&E on multiple health issues (NCD's, TB, STI's, HIV, etc). Overall this programme has provided a community based approach to health education, prevention, and awareness while improving the M&E data on critical health areas. ICHAP has been incorporated into work plans for 2018 and will seek to expand its implementation in following years. Presented below are the monitoring results for sexual and reproductive health indicators.



ICHAP 2017 Summary of Key Results



Family Planning

Only 17.9% of respondents reported using family planning services. Fa'afafine were more likely to report using family planning services. Men and women had lower rates of family planning utilization (16.2% and 16.7% respectively). The age groups of 30-34 were most likely to report current use of family planning. The most common source of family planning was hospitals.



ICHAP 2017 Summary of Key Results



HIV and STI Testing

HIV testing overall was low. Only 12% had a test in the past 6 months. Fa'afafine had the highest testing rates for HIV out of all gender groups (20.8%). Testing rates were lower for men and women (9.1% and 10.5% respectively). Testing rates for other STI's was even lower than for HIV amongst all groups in the past 6 months (8.7%). Fa'afafine had the highest testing rate (16.7%) followed by men, then women.

Respondents were asked what makes it difficult to test for HIV. The most common barriers reported were 1) Not having enough money to access testing services (29.7%), 2) not having enough time (24%) and 3) that it is not difficult for respondents they are just unwilling.

Condom Use

84.9% of respondents reported being sexually active (417). The number of respondents reporting wearing a condom during their last sexual intercourse was very low in all groups (12%), though highest in fa'afafine (17.7%).

Knowledge of Chlamydia Transmission

The majority of respondents (74.1%) scored Low to Very Low on these scales.

Knowledge of TB Transmission

TB knowledge scores were also Low to Very Low (56.2% scoring in this range).

Key Populations

Sexual Health Indicators	Sex Workers	Fa'afafine	Prisoners
Condom Use	35.3%	17%	13%
Tested for HIV	47.1%	20.8%	13%
Tested for STI	35.3%	16.7%	4.3%
Very Low to Low Chlamydia Knowledge	82.4%	68%	56.5%

Accessing HIV Testing Services

364 out of 491 (74.1%) respondents answered a question about what makes it difficult to test for HIV. Respondents reported multiple barriers, with a total of 408 answers. The most common barriers reported were 1) Not having enough money to access testing services (29.7%), 2) not having enough time (24%) and 3) its not difficult for respondents they are just unwilling. Though HIV testing is offered for free at all national hospitals and health centres, transport and service fees may be a barrier to access in those cases. Family and community obligations in addition to work may also prevent people from accessing testing. A significant number of people reported simply not wanting to access the service. The unwillingness was further explored with other questions.

Table 12. Barriers to Testing Services

Barrier to HIV Testing	Number	Percent
No money	121	29.7
No time	98	24.0
No barriers just don't want to	79	19.4
Don't know where services are available	45	11.0

Barrier to HIV Testing	Number	Percent
Other	42	10.3
Fear people will find out	23	5.6
Total answers	408	100

Respondents were also asked if they were planning on getting an HIV test. A follow-up question to “No” responses was used to determine the reasons why a person would be unwilling to get testing. About 39% of respondents answered that they did not plan on having an HIV test.

Table 13. Planning to Test for HIV

Plan to test for HIV	Number	Percent
Yes	259	52.7
No	190	38.7
No response	42	8.6
Total	491	100

190 people were not planning to test for HIV. 127 (66.8%) of those people provided a response as to why they were not accessing testing services. From these 127 respondents, the most common reasons for not planning to test for HIV were that 1) respondents believe that they are not affected or at risk of HIV (30.7%), 2) respondents limit their sexual intercourse to 1 or a few sexual partners, 3) respondents currently have no symptoms or are in good health. The belief that a person is simply not at risk of HIV and that no symptoms means no infection are very dangerous and common misconceptions about HIV. Future education interventions need to emphasize that HIV and some STI's often have no symptoms for long periods of time.

Table 14. Reasons for Declining HIV Testing

Reason for not wanting an HIV test	Frequency	Percent of Responses
Don't believe they are or could be affected by it	39	30.7
Have only 1 or few partners	25	19.7
No symptom or are currently in good health	21	16.5
Not having sex	15	11.8
Don't care or unwilling	11	8.7
Other	10	7.9
No money or no time	6	4.7
Total	127	100



Programme with village committee members

IV. Changes in National Commitments and Policy

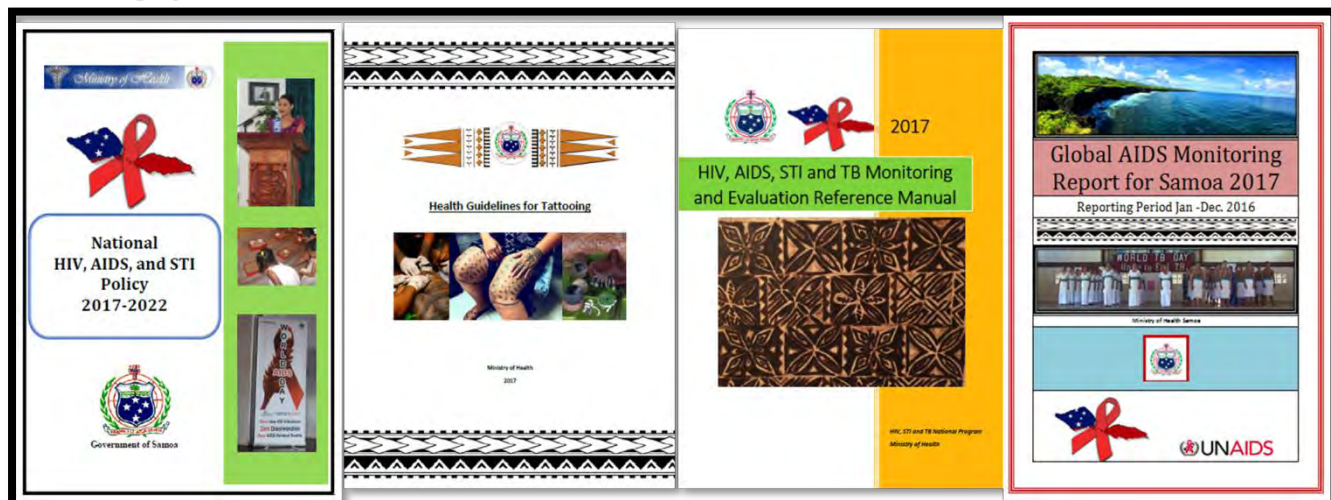
2016 marked the development and consultation of 4 key documents; 1) the updated HIV, AIDS, and STI Policy for 2017-2021, 2) the HIV, AIDS, STI and TB Monitoring and Evaluation Reference Manual, 3) the Health Sector Monitoring and Evaluation Manual (redraft), and 4) 2017 Health Guidelines for Tattooing. All documents were finalized for launch in 2017 with the exception of the Health Sector M&E Manual.

Table 15. Key Document Development

Document	Number of Consultations with Stakeholders, Community and Partners	Consultation with MoH Staff
HIV, AIDS, and STI Policy 2017-2021	4	4
HIV, AIDS, STI and TB M&E Reference Manual	3	3
Health Sector M&E Manual	0	1*
Health Guidelines for Tattooing	1	1

**not funded by Global Fund but facilitated by National Programme Staff*

Launching of National Documents Related to HIV, AIDS, STI's and TB



4 key documents launched in 2017 available online at www.health.gov.ws

Though endorsed and published at multiple points throughout 2017, the launching ceremony for these documents was held as part of the National Young Women's Forum on World AIDS Day. As the 2011-2016 HIV and AIDS Policy period drew to a close, the HIV, STI, and TB National Programme had reviewed existing documents and determined that 3 key policy and reference documents were needed to better coordinate the national response. Numerous consultations with stakeholders and partners and recommendations from technical advisors were used to develop the HIV, AIDS, and STI Policy 2017-2022, Health Guidelines for Tattooing 2017, and the HIV, AIDS, STI and TB Monitoring and Evaluation Manual 2017. These documents were approved by cabinet and launched in 2017. The Global AIDS Monitoring Report 2017 (covering Jan. to Dec. 2016) was also released and received media attention for disseminating new HIV and STI data, as well as data on key populations.

❏ HIV, AIDS, STI Policy 2017-2022

After several consultations held in 2015, 2016 and 2017, the HIV, AIDS and STI Policy 2017-2022 was completed and approved by cabinet in June 2017. The document was linked to the HIV, AIDS, and STI M&E Reference Manual 2017 and distributed to all stakeholders and partners.

❏ Health Guidelines for Tattooing 2017

Drawing from data and information gathered from multiple infection control consultations with doctors and tattooists, MoH launched its Health Guidelines for Tattooing in late February 2017. The document is the first of its kind in the Pacific Region. It covers both indigenous and modern tattooing for tattoo artists and clients alike. It was originally conceived by the Director General and Chief Executive Officer of the Ministry of Health, Leausa Toleafoa Dr. Take Naseri. For years, Dr. Naseri had given presentations on infection control, tattooing, and the risk of blood borne pathogens (including HIV) to doctors and local communities. In 2016, a foreign worker contracted from overseas was discovered to have HIV after a traditional Samoan tattoo the individual recently commissioned had become infected. The patient was determined to have contracted HIV years before, but the tattooing process resulted in an opportunistic infection. The public health concern was that the instruments used to tattoo this patient could be contaminated and pose transmission risk. Dr. Naseri then directed the Ministry of Health to respond by consulting the tattoo artists, deliver infection control education, and develop health guidelines to improve infection control. The guidelines have been translated into Samoan and are being distributed. The document is designed to be clear and simple for all populations to access the material.

✘ HIV, AIDS, STI, and TB Monitoring and Evaluation Reference Manual 2017

The Monitoring and Evaluation manual for the HIV, AIDS, STI's and TB National Programme was completed in February 2017 after being consulted on in 2016. The endorsement was received in April 2017, and the document was published. Multiple activities used the manual as a reference for data collection on key indicators.

✘ Global AIDS Monitoring Report for Samoa 2017


The sixth annual report to the UN, The Global AIDS Monitoring Report 2017, was published in March 2017. It detailed the complete status update on sexual health and prevention within the country. The report was widely distributed and was the feature of numerous articles by the Samoa Observer and other media outlets. The report sparked national debates and discussion around sexual health, sex work, and the future direction for prevention and protecting key populations.

COMMITMENT 1: ENSURE THAT 30 MILLION PEOPLE LIVING WITH HIV HAVE ACCESS TO TREATMENT THROUGH MEETING THE 90-90-90 TARGETS BY 2020

Out of 24 cumulative cases of detected HIV infections, 13 are currently deceased. There are currently 11 detected cases of PLWHIV. All currently living cases were diagnosed between 2002-2013. ART is coordinated through the Communicable Disease Clinic, with procured handled through the Ministry of Health.

Table 16. ART Register Profile as of 2017


ART Demographics	Number	Percent
PLWHIV on public ART	9	81.8
PLWHIV on private ART treatment	2	18.8
<i>Out of PLWHIV on public treatment...</i>		
Males	6	62.5
Females	3	33.3
Started ART Same year as diagnosis	4	44.4
Had a CD4 test in 2017	8	88.9
Healthy CD4 counts (500-1,600)	2	22.2
Low CD4 Counts (200-500)	4	44.4
Progressed to stage 3 infection (AIDS) <200	2	22.2
No CD4 test in 2016	1	11.1
Had viral load testing in 2017	9	100.0
Have suppressed viral load in 2017	6	66.7



The first case of HIV was detected in 1990. The 8 cases registered since then in the 90's died without registering for ART treatment. All other cases were linked to ART after their confirmed cases leaving 5 deceased cases that died while receiving ART. 2 male cases are on treatment overseas leaving 9 cases that disaggregated ART data by sex and age is available.

Table 17. Public ART Enrolment by Age and Sex

Age Group	Males	Females	Total
5-9	1	0	1
10-14	1	0	1
15-19	0	0	0
20-24	0	0	0
25-29	0	0	0
30-34	0	1	1
35-39	1	0	1
40-44	1	2	3
45-49	1	0	1
50-54	0	0	0
55-59	1	0	1
Total	6	3	9



ART regimens are aligned with WHO recommendations. The ART recommended regulations taken from the policy are included below;

Regimen Type	Approved for...
First Line	
TDF/3TC or (FTC)/EFV Fixed dose 3 drugs as 1 pill once a day	Adults, adolescents, and pregnant women
Second Line	
AZ/3TC or (FTC)/ATV/r or LPV/r	Adults and Adolescents
NRTI: LPV/r and AZT	children less than 3
Third Line	
LPV/r based-regimens	all infants and children <36 months with HIV (regardless of NNRTI exposure)
NNRTI: Efavirenz (EFV)	treatment initiation in children aged three and older
AZT+3TC or FTC	recommended NRTI backbone for treatment initiation in children aged 3–10 years

ART regimens are subject to availability and regional procurement processes. Clinical equivalents are always used in stock-out situations or lack of availability. Below is the ART regimen for all PLWHIV by age and sex during 2016.

Table 18. ART Guidelines

Regimen	ART Patients
Zidovudine (AZT) 300 mg PO BD + lamivudine (3TC) 150 mg PO BD + lopinavir 200 mg/ritonavir 50 mg (LPV/r) 2 tablets PO BD	3 Males age 40-44 1 Male age 45-49
Zidovudine (AZT) 11 ml PO BD + lamivudine (3TC) 6 ml PO BD + lopinavir 200 mg/ritonavir 50 mg (LPV/r) 1 tablet PO BD	1 Male age 10-14
Zidovudine (AZT) 300 mg PO BD + lamivudine (3TC) 150 mg PO BD + nevirapine (NVP) 200 mg PO BD	1 Female age 30-34
Tenofovir (TDF), Emtricitabine, Lopinavir/Ritonavir	1 Male age 5-9

Regimen	ART Patients
Tenofovir (TDF) 300 mg PO OD + lamivudine (3TC) 300 mg PO OD + nevirapine (NVP) 200 mg PO BD	2 Males ages 35-39 and 55-59

Through the Communicable Disease Clinic based at TTM Hospital in Apia, ART treatment is provided to all PLWHIVA free of cost. Treatment visits are coordinated by the Senior Nurse of the clinic to ensure adherence and access. Based on the SPECTRUM estimates provided for Samoa by the SPC, there should be an estimated 12 PLWHIV between 2016 and 2019. With the current ART caseload (11), the ARV coverage would then be 91.7%. The main challenge for ART is assisting PLWHIV achieve health CD4 counts through adherence and healthy lifestyles to support ART.

COMMITMENT 2: ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2020 WHILE ENSURING THAT 1.6 MILLION CHILDREN HAVE ACCESS TO HIV TREATMENT BY 2018

Historically there have been 6 children born to 5 mothers living with HIV that were not on preventative ART regimens. Currently there are 2 children living with HIV from these mother-to-child (MTC) transmissions and 1 stillbirth to an HIV positive mother occurring in 2015. There have also been 2 successful cases of PLWHIV given proper ARV regimens to prevent HIV transmission that were successful. This low incidence of MTC transmission is largely due to the work of the Communicable Disease Clinic in ensuring treatment is brought to all cases to support adherence.

Preventing mother to child transmission (PMTCT) of HIV and STI's has always been a national priority in Samoa. Screening of all women who report to Antenatal Care (ANC) are mandatorily screened for HIV and STI's, in addition to HIV and STI testing be included as part of infant blood panels. For pregnant women, Samoa has used WHO Option B+ (i.e. treat all ANC women free of cost) which has been implemented country-wide. Below are the recommended ARV regimens for pregnant women in accordance with WHO guidelines.

Table 19. PMTCT ART/ARV Regimens

First Line ARV for PMTCT	Specifications
TDF/3TC(FTC)/EFV	For women nursing
Infant Prophylaxis	
6 week neonatal zidovudine prophylaxis regimen duration 6 weeks	For exposed infants
AZT/NVP x 6 weeks	Dual prophylaxis for high risk exposed infants

The challenge remains with encouraging higher rates of ANC attendance by pregnant women. Out of all estimated pregnant women in the country, 26% reported for ANC care in 2016.¹ This increased significantly in 2017 to 50.2%. This is tremendous progress but more work remains to be

¹This measure was calculated using the following 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, respectively. According to the calculation, approximately **9,615.7** women were pregnant at any given point in time in 2015. Assuming that each pregnant woman has only 1 partner, the estimated target population that includes both antenatal mothers and their male partners would be **19,232** at any given time in 2015 (based on the point-in-time estimate of antenatal women).

done with access to antenatal care and birth services. The Apia Birth Health Study conducted in 2016 by the HIV, STI, and TB National Programme revealed that out of all the births that occurred at TTM between 2014-2015, 71.2% of women (4,280) had at least 1 recorded antenatal care visit at a healthcare facility (and therefore had HIV/STI screening). However, only 47.1% (2,829) had the minimum recommended number of ANC visits (4). Married women are more likely to have less than 4 recommended antenatal visits. Birth cases that reported to TTM between 2014-2015 were mostly from Upolu (specifically the Apia Urban Area and North West Upolu regions. This indicates the women that do receive mandatory HIV and STI testing are largely representative of the Apia Urban Area and Northwest Upolu and have access to TTM Hospital in Apia for their births. Though this may not be adequate access as the study also found that majority of birth complications between 2014-2015 were related to not accessing healthcare services at the right time for labour. This may also have implications for ANC HIV and STI testing.

A mapping analysis of the ANC cases that received mandatory HIV and STI screening between January and June 2016 revealed that:

- Most of the ANC women screened for STI's resided in coastal village or areas of low elevation vulnerable to natural disasters.
- ANC STI screening and ANC attendance is lower in Savai'i.
- Coastal disaster situations would directly impact STI screening and access to STI services.

Figure 5. ANC Patients Screened for STI's in Upolu

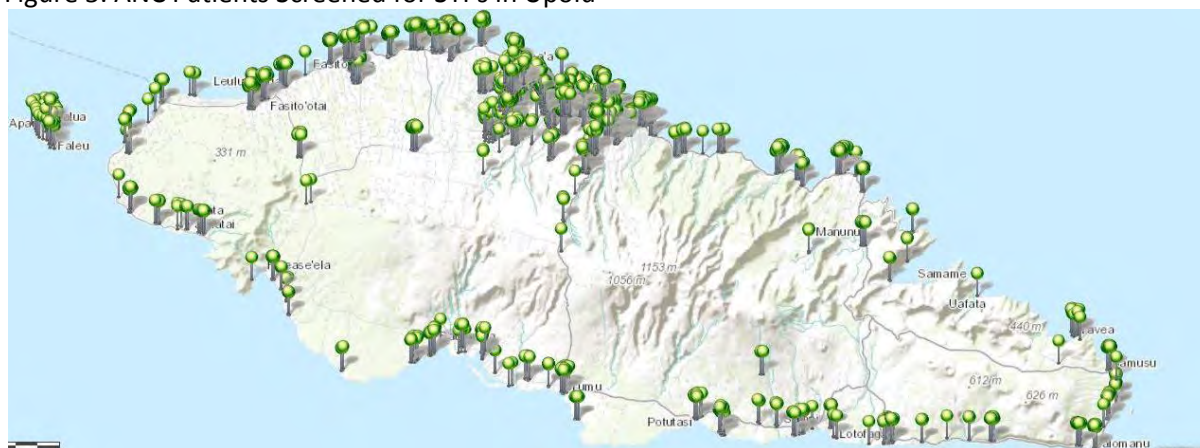


Figure 5 shows the clusters of ANC STI screening cases on Upolu. Most cases reside in villages in areas of low elevations near the coast. This matches the general population distribution as most Samoans reside in villages within or in close proximity to coastal regions. Figure 2 below shows the Apia Urban Area, which is where the majority of ANC women screened for STI's are located.

Overall the threats to ensuring continued strong achievements to PMTCT of HIV and STI's are;

- Low ANC attendance and therefore low HIV and STI screening
- Low access to ANC and testing services in rural areas of Samoa, especially Savai'i
- Women accessing ANC testing services are located in regions vulnerable to disasters which can pose access issues in disaster situations

COMMITMENT 3: ENSURE ACCESS TO COMBINATION PREVENTION OPTIONS, INCLUDING PRE-EXPOSURE PROPHYLAXIS, VOLUNTARY MEDICAL MALE CIRCUMCISION, HARM REDUCTION AND CONDOMS, TO AT LEAST 90% OF PEOPLE BY 2020, ESPECIALLY YOUNG WOMEN AND ADOLESCENT GIRLS IN HIGH-PREVALENCE COUNTRIES AND KEY POPULATIONS—GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN, TRANSGENDER PEOPLE, SEX WORKERS AND THEIR CLIENTS, PEOPLE WHO INJECT DRUGS AND PRISONERS

Following the increased national focus of programming on key populations, the Ministry of Health began monitoring the risk factors of key populations that participate in outreach programs. This was to gauge community needs and inform further interventions after initial studies had estimated the population sizes. The ICHAP survey was the instrument for collecting this data, and provides data on key populations unavailable through the Census and Demographic Health Surveys. For the first time, the survey asked questions that would allow respondents to be identified by key population group. A key population is defined as a group that is vulnerable to certain diseases due to behavioural factors and have unique needs of prevention programming. With regards to HIV and STI's key population groups include fa'afafine (transgender), sex workers, prisoners, people who have sex with members of the same sex, and people with multiple sexual partnerships. ICHAP managed to engage more of these populations in 2017 outreach, but more work remains to be done to reach more of these communities. This is especially important with ICHAP outreach programs, because participants receive a holistic package of services including education, testing, treatment, condoms and lubricants.

Table 20. Key Populations Reached by ICHAP in 2017

Key Population Group	Number	Percent of Sample	Estimated population	Estimated population as percent of Samoa's total population
Multiple Sexual Partnerships	77	15.7	unavailable	unavailable
Ever engaged in sex work	17	3.5	400	0.20%
Had sex with member of the same sex	14	2.9	unavailable	unavailable
Males reporting ever having sex with males (MSM)	7	1.4	unavailable	unavailable
Fa'afafine	96	19.6	30,000	15%
Fa'afafine and MSM	103	21.0	30,000	15%
Prisoners	23	4.7	unavailable	unavailable

According to population estimates of these key populations provided by the Pacific Multi-country Mapping Study 2016, fa'afafine and MSM represent about 15% of the total population (30,000). In the ICHAP survey sample, the distribution is slightly higher (19.6%). Sex workers are

estimated to make up 0.2% of the general population (400). In the survey sample, they make up 3.5% of all respondents. This group is also measured by “ever engaged in sex work” as opposed to “current sex work”, which make explain why the sample distribution is higher. Other key population groups do not have estimates for comparison.

Fa’afafine

The majority of fa’afafine were in their 20’s or above age 50. There were no fa’afafine surveyed in the 10-14 age group.

Table 21. Fa’afafine by Age Group

Age Group	Number	Percent
10 to 14	0	0
15 to 19	3	3.2
20 to 24	12	12.6
25 to 29	15	15.8
30 to 34	13	13.7
35 to 39	5	5.3
40 to 44	13	13.7
45 to 49	6	6.3
50+	25	26.3
Unknown	3	3.2
Total	95	100

Only 17% of fa’afafine used condoms during their last sexual intercourse. 20.8% have been tested for HIV in the past 6 months, and 16.7% for other STI’s. Many plan on having an HIV test however (64.6%).

Table 22. Fa’afafine Sexual Health Risk Factors

HIV, STI Risk	Number	Percent
Condom Use	17	17.7
Have multiple sex partners	30	31.3
Binge Drinking	33	34.4
Tested for HIV in past 6 months	20	20.8
Tested for STI's	16	16.7
Plan to test for HIV	62	64.6

Like the majority of the sample, fa’afafine cite the same top 3 reasons that prevents them from HIV testing; time, money, and just not wanting the service.

Table 23. Barriers to HIV Testing for Fa'afafine

Barrier to HIV Testing	Frequency	Percent
No time to access services	34	35.4
No money to access testing services	20	20.8
No barriers just don't want to	18	18.8
Don't know where services are available	9	9.4
Other	8	8.3
Fear someone will find out	7	7.3
Total	96	100

When assessed for their knowledge of Chlamydia, 68% of fa'afafine scored Very Low to Low. However they did score higher on average than the general population for Chlamydia knowledge.

Table 24. Fa'afafine Chlamydia Knowledge

Chlamydia Knowledge Scores	Number	Percent
Very Low (0-2)	35	36.5
Low (3-5)	30	31.3
Moderate (6-8)	27	28.1
High (9-11)	4	4.2
Total	96	100
Mean	Standard Dev.	Variance
5.1	3.2	10.1

Sex Workers

Sex work is defined as those who reported ever in their lifetime engaged in sex work for money, goods or other favors on the survey. Respondents reporting sex work were mostly males ages 20-24.

Table 25. Sex Workers by Gender

Gender	Number	Percent
Female	3	17.6
Male	9	52.9
Fa'afafine	4	23.5
Unknown	1	5.9
Total	17	100.0

Table 26. Sex Workers by Age Group

Age Group	Number	Percent
10 to 14	0	0.0
15 to 19	1	5.9
20 to 24	7	41.2
25 to 29	1	5.9
30 to 34	1	5.9
35 to 39	1	5.9
40 to 44	0	0.0

Age Group	Number	Percent
45 to 49	0	0.0
50+	4	23.5
Unknown	2	11.8
Total	17	100

Condom use was low with sex workers (35.3%). 47.1% had been tested for HIV in the past 6 months, and 47.1% percent were planning on testing for HIV. Respondents reporting sex work were more likely to use condoms, report binge drinking, have an HIV test in the past 6 months, have an STI test, and have plans for an HIV tests compared to fa'afafine.

Table 27. Sex Workers and Sexual Health Risk Factors

HIV, STI Risk	Number	Percent
Condom Use	6	35.3
Have multiple sex partners	6	35.3
Binge Drinking	7	41.2
Tested for HIV in past 6 months	8	47.1
Tested for STI's	6	35.3
Plan to test for HIV	14	82.4

82.4% of sex workers scored Very Low to Low on Chlamydia knowledge scales, which was higher compared to fa'afafine and the general population indicating a need to educational outreach.

Table 28. Chlamydia Knowledge of Sex Workers

Chlamydia Knowledge Scores	Number	Percent
Very Low (0-2)	7	41.2
Low (3-5)	7	41.2
Moderate (6-8)	3	17.6
High (9-11)	0	0.0
Total	17	100.0
Mean	Standard Dev.	Variance
3.14	2.41	5.81

Community Advocacy and Linkage to Prevention Services for Sex Workers



Dignity Kits for Sex Workers

On Oct. 4th and again on Dec. 13th in the Apia town area, HIV Program staff and NHS staff held a sexual health education and talanoa session with sex workers. The objectives were;

1. Deliver sexual health education and prevention training
2. Link sex workers to testing and treatment services
3. Deliver condoms and lubricants
4. Deliver dignity kits that contain toiletries and hygiene supplies to compliment condom distribution
5. Build the trust of the sex worker community for future MoH programs

The MoH HIV Program staff in addition to the nurse specialist of the Communicable Disease (CD) Clinic facilitated the process. A total of 14 sex workers attended the program and received all objective services.

Result

- 11 females and 3 fa'afafine attended
- 3 tests were reactive for HIV, 1 test was reactive for syphilis
- 1 HIV reactive case was lost to follow-up
- There have been 0 confirmed positives for HIV and Syphilis
- All 4 were screened for HIV and Syphilis with the new SD Duo test kit
- Follow up appointments were booked with the nurse specialist for reactive cases at the CD Clinic. Confirmatory testing was conducted.
- All participants received a dignity kit with condoms, lubricants, sanitary pads, toothbrushes and paste, undergarments, soap, and deodorant.
- Staff were able to build trust with this community for future programming
- Sex workers want to continue with programming efforts

The following actions have been identified for the way forward;

1. Include similar activities in the 2018 work plan
2. Work with the nurse specialist of the CD Clinic to ensure follow-up testing and care for reactive cases
3. Propose to Global Fund funding for a drop in centre in town to support linking this community to testing and treatment services as well as condom/lubricant distribution.
4. Continue to engage the community in the planning of programs

People who had sex with a member of the same sex

MSM or men who have sex with men, is a foreign donor category of key population group that programs are asked to report on. Since this demographic category does not exist in a Samoan cultural context, a question was asked about same sex sexual activity to identify people who would behaviorally fall under this category, but not asked as term for personal identity. These cases were grouped separately from fa'afafine. About 50% were male and 21% were female. Only 7 cases fit the description for MSM. Most people who reported engaging in same sex sexual activity were between the age of 15-24 (42.9%).

Table 29. Gender of people who have had sex with a member of the same sex



Gender	Number	Percent	
Female	3	21.4	
Male	7	50.0	
Unknown	4	28.6	
Total	14	100.0	
Female	3	21.4	

Table 30. Age of people who have had sex with a member of the same sex


Age Group	Number	Percent
10 to 14	1	7.1
15 to 19	2	14.3
20 to 24	4	28.6
25 to 29	1	7.1
30 to 34	1	7.1
35 to 39	1	7.1
40 to 44	1	7.1
45 to 49	0	0.0
50+	1	7.1
Unknown	2	14.3
Total	14	100



50 percent used condoms and 21% tested for HIV and 28% for STI's. This was lower compared to fa'afafine and respondents who reported sex work. The majority (64.3%) planned to test for HIV.

Table 31. Sexual health risk factors for same sex partners

HIV, STI Risk	Number	Percent
Condom Use	7	50.0
Engaged in sex work (ever)	7	50.0
Binge Drinking	6	42.9
Tested for HIV in past 6 months	3	21.4
Tested for STI's	4	28.6
Plan to test for HIV	9	64.3



The majority (57.1%) had Very low to Low Chlamydia knowledge scores.

Table 32. Chlamydia knowledge among people who have had sex with a member of the same sex

Chlamydia Knowledge Scores	Number	Percent
Very Low (0-2)	3	21.4
Low (3-5)	5	35.7
Moderate (6-8)	6	42.9
High (9-11)	0	0.0
Total	14	100.0
Mean	Standard Dev.	Variance
4.4	<i>too few cases for significance</i>	<i>too few cases for significance</i>

Prisoners

The survey was also administered in the prison facility located on Savai'i. This survey was conducted with male prisoners only. The majority of inmates were between the ages of 20-39 (57% roughly).

Table 33. Prison inmates by gender


























Gender	Number	Percent	
Female	0	0	
Male	18	78.3	
Fa'afafine	2	8.7	
Unknown	3	13.0	
Total	23	100	

Table 34. Prison inmates by age group

Age Group	Number	Percent	
10 to 14	0	0	
15 to 19	0	0	
20 to 24	2	8.7	
25 to 29	4	17.4	
30 to 34	2	8.7	
35 to 39	5	21.7	
40 to 44	0	0	
45 to 49	2	8.7	
50+	6	26.1	
Unknown	2	8.7	
Total	23	100.0	







Only 13% of inmates were tested for HIV in the past 6 months and only 4.3% were tested for STI's. 78.3% were planning to test for HIV. Only 13% used a condom at their last sexual intercourse.

Table 35. Sexual health risk factors of inmates

HIV, STI Risk	Number	Percent	
Condom Use	3	13.0	
Have multiple sex partners	4	17.4	
Binge Drinking	7	30.4	
Tested for HIV in past 6 months	3	13.0	
Tested for STI's	1	4.3	
Planning to test for HIV	18	78.3	

Chlamydia knowledge was mixed and was split roughly equal between Very low to Low and Moderate to High.

Table 36. Distribution of Chlamydia Scores

Chlamydia Knowledge Scores	Number	Percent	
Very Low (0-2)	7	30.4	
Low (3-5)	6	26.1	
Moderate (6-8)	7	30.4	
High (9-11)	3	13.0	
Total	23	100	
Mean	Standard Dev.	Variance	
4.3	3.33	11.11	

COMMITMENT 4: ELIMINATE GENDER INEQUALITIES AND END ALL FORMS OF VIOLENCE AND DISCRIMINATION AGAINST WOMEN AND GIRLS, PEOPLE LIVING WITH HIV AND KEY POPULATIONS BY 2020

Studies have shown that gender inequality is quite common and a growing issue 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%).

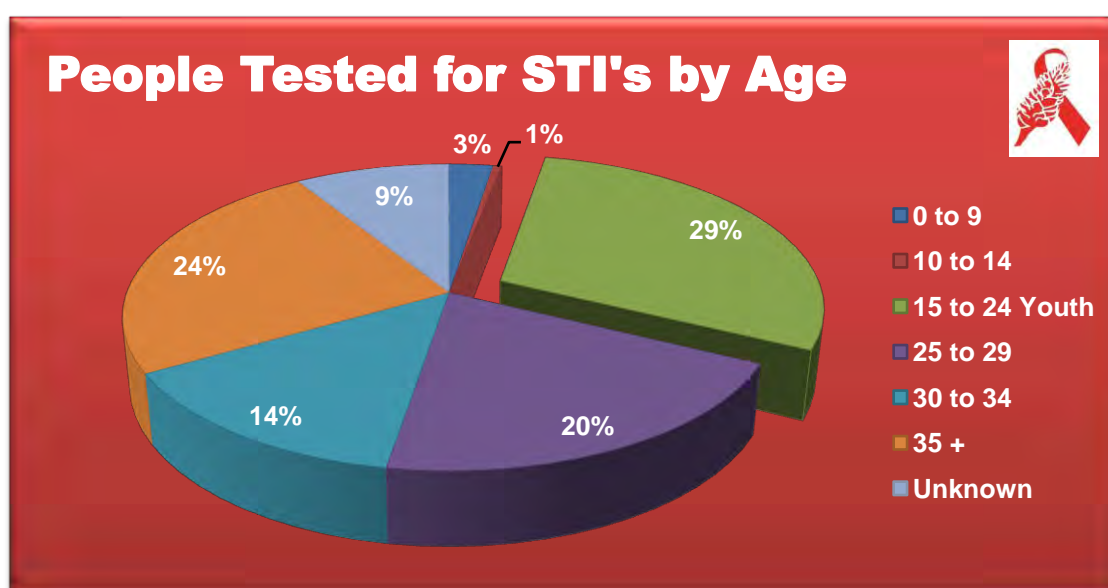
A legal analysis of violence against women found that there is a range of factors that increase women's vulnerability to violence, including economic opportunities, poverty, status and dependency. In patriarchal societies the status of women is determined by the social ranking system of the family and 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 close-knit 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.

Fa'afafine 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 need to be formalised in order to gauge in a clear perspective of issues facing these group.

COMMITMENT 5: ENSURE THAT 90% OF YOUNG PEOPLE HAVE THE SKILLS, KNOWLEDGE AND CAPACITY TO PROTECT THEMSELVES FROM HIV AND HAVE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY 2020, IN ORDER TO REDUCE THE NUMBER OF NEW HIV INFECTIONS AMONG ADOLESCENT GIRLS AND YOUNG WOMEN TO BELOW 100, 000 PER YEAR

In 2017, 29% of all people tested for STI's were youth ages 15-24, according to surveillance data (MoH 2017). Youth ages 10-14 represented only 1% tested. There were many interventions done in 2016-2017 to increase youth screening coverage as they had the highest prevalence of STI's (particularly Chlamydia recorded at 31% in 2015 among ages 15-24).

Figure 6. Youth STI Testing 2017



Particularly youth ages 20-24 make up most of this voluntary testing in youth ages groups for HIV and all STI's. Voluntary testing among youth age 15-19 is particularly low.

Table 37. Testing in Youth by Age Group and STI

Age Group	HIV Tests	Percent of Tests	Syphilis Tests	Percent of Tests	Hep.B Tests	Percent of Tests	Hep. C Tests	Percent of Tests
10-14 yrs	29	0.2	27	0.2	67	0.6%	61	0.6
15-19 yrs	818	6.9	772	6.8	831	6.9%	668	6.6
20-24 yrs	2735	23.0	2665	23.3	2724	22.5%	2176	21.4
Total 10-24yrs	3582	30.1	3464	30.3	3622	29.9%	2905	28.6

Age Group	Hep A tests	Percent of Tests	Chlamydia Tests	Percent of Tests	Gonorrhea Tests	Percent of Tests
10-14 yrs	10	9.7	4	0.2	4	0.2
15-19 yrs	12	11.7	137	6.2	136	6.2
20-24 yrs	8	7.8	517	23.4	515	23.4
Total 10-24yrs	30	29.1	658	29.8	655	29.8

Testing in youth for Hepatitis A is too low to produce reliable prevalence estimates. Additionally age group 10-14 has too low a number of tests to produce accurate prevalence estimates within that age group. Therefore, Hepatitis A testing and youth 10-14 are excluded from analysis of prevalence.

When directly comparing prevalence, Youth ages 15-24 have higher prevalence of both Chlamydia and gonorrhoea when directly comparing their rates to all age groups. Chlamydia remains significantly higher in youth. Youth that test positive for Chlamydia make up 40.5% of all detected infections.

Table 38. 2017 Analysis of Prevalence in Youth Ages 15-24

Age Group	STI			HIV			Syphilis			Hep B		
	Total tests	Positive	% Positive	Total tests	Positive	% Positive	Total tests	Positive	% Positive	Total tests	Positive	% Positive
15-19 yrs	818	0	0.00%	772	2	0.26%	831	3	0.36%			
20-24 yrs	2735	0	0.00%	2665	3	0.11%	2724	25	0.92%			
Total 15-24	3553	0	0.00%	3437	5	0.15%	3555	28	0.79%			
All ages	11882	0	0.00%	11418	78	0.68%	12128	296	2.44%			

Age Group	STI			Hep C			Chlamydia			Gonorrhea		
	Total tests	Positive	% Positive	Total tests	Positive	% Positive	Total tests	Positive	% Positive	Total tests	Positive	% Positive
15-19 yrs	668	0	0.00%	137	49	35.77%	136	16	11.76%			
20-24 yrs	2176	2	0.09%	517	156	30.17%	515	76	14.76%			
Total 15-24	2844	2	0.07%	654	205	31.35%	651	92	14.13%			
All ages	10152	12	0.12%	2207	506	22.93%	2201	220	10.00%			

Male youth tend to have higher rates of Chlamydia than females. Less males report for testing which also skews prevalence estimates. Though Chlamydia appears to have decreased between 2015 and 2017, testing data is missing for January to June of 2015, which is likely the true cause of the decrease in the number of positive males and females detected through testing. Chlamydia prevalence remains high in both males and females in 2017, however higher in males. More males were reached through voluntary testing in 2017 than 2015, but testing coverage remains low. Chlamydia data from 2016 is unavailable as no testing was conducted during that year.

Table 39. Youth Chlamydia testing by Sex 2015 and 2017

Year	2015 (July to December Only)				2017			
Gender	Females		Males		Females		Males	
Age Group	Tests	% Positive	Tests	% Positive	Tests	% Positive	Tests	% Positive
15-19 yrs	71	31.0%	3	33.3%	126	36.5	11	27.3
20-24 yrs	248	41.1%	17	58.8%	448	29.2	63	36.5
Total 15-24	319	38.8%	20	55.0%	574	30.8	74	35.1

These high rates of Chlamydia are directly related to knowledge and prevention capacity of Samoa's youth. The Demographic Health Survey 2014 surveyed 1,891 youth on their knowledge of HIV/AIDS and for male youth only, their knowledge of the source of condoms. Knowledge was defined by the survey as; 1) knowing that using condoms and limiting sexual intercourse to 1 uninfected person are prevention methods, 2) being aware that a healthy looking person can have the virus, 3) and rejecting 2 most common local misconceptions about the virus. HIV knowledge was relatively the same between male and female youth and very low. Male youth age 20-24 were more likely to know where to access condoms than those ages 15-19. However, that knowledge was still low.

Table 40. Youth Knowledge of HIV/AIDS and Prevention

DHS 2014	Female		Male
Age	Comprehensive Knowledge of HIV/AIDS	Comprehensive Knowledge of HIV/AIDS	Percent who know a source of condoms
15-19	3.6	3.5	25.1
20-24	7.3	8.3	52.7


Youth also have high rates of awareness of contraceptive methods. Particularly youth ages 20-24 have heard of modern methods of contraception. This knowledge has increased over the years across all age groups, especially regarding male condoms (37-51%).

Table 41. Youth Awareness of Contraception (DHS 2014)

Age Group	Percent of female youth who have heard of any method of contraception	Percent of female youth that have heard of any modern method of contraception	Percent of male youth that have heard of any method of contraceptive	Percent of male youth that have heard of any modern method of contraception
15-19	76.1	73.7	n/a	n/a
20-24	91.5	91.2	90.3	88.7

The ICHAP Survey 2017 also captured data on youth that participated in outreach programming by MoH and partners. The majority of youth surveyed had very low knowledge of Chlamydia when it came to transmission and prevention (81%). Only 8.1% had been tested for HIV and only 8.2% had been tested for STI's in the past 6 months. A startling amount of youth (60%) did not plan on seeking testing services because they felt they were not at risk of HIV. However, a mere 16.3% stated that they used condoms during their last sexual intercourse. This indicates that youth need comprehensive sexual health education covering 1) HIV and STI transmission, 2) prevention methods, 3) the importance of condom use, and 4) the importance of regular voluntary testing.

Table 42. ICHAP Survey 2017 Youth Age Group Findings

Characteristic	Percent of Youth ages 13-24		Chlamydia Knowledge Scores	Number	Percent
Use family planning	16.3%		Very Low (0-2)	42	42.86%
Tested for HIV in past 6 months	9.1%		Low (3-5)	38	38.78%
Planning to test for HIV	44.9%		Moderate (6-8)	17	17.35%
Not planning to test because they don't feel they are at risk for HIV	60%		High (9-11)	1	1.02%
Tested for STI's in past 6 months	8.2%		Total	98	100%
More than one sexual partner in the past year	28.5%		Mean	Standard Dev.	Variance
Condom use at last sex	16.3%		3.07	2.48	6.17

Sex education is a mandatory part of public college level curriculum enforced and monitored by the Ministry of Education, Sports and Culture (MESC). However, due to cultural and religious stigma towards sex and sexuality, in addition to poor curriculum enforcement and development by MESC, sex and sexual reproductive health (SRH) education is poorly implemented nation-wide. In recent years, the health sector and its partners have been advocating for a comprehensive sexual reproductive health education in public schools to address HIV, STI's and sexual reproductive health awareness.

The stigma around sex, sexual reproductive health, and family planning services is largely tied to religion. Samoa is a predominantly Christian nation, with the majority of denominations advocating for youth to not engage in sex until marriage. Family planning services are also to a large extent discouraged due to conflict with religious values. This stigma prevents all age groups from accessing services, discussing SRH, discussing STI's, and hinders STI prevention.

For youth this is a particular barrier, as it is not socially permissible to be sexually active at younger age. Youth are therefore concerned about accessing SRH services, worried that it will affect how they are perceived by their communities or conflict with their families' values. Confidentiality is therefore also a major concern in Samoa, as with most small island nations. Youth accessing condoms at a health centre could easily be seen by a relative or village member, who may also work at the district health centre. So while youth awareness of contraception (including condoms) is high, youth utilization is low.

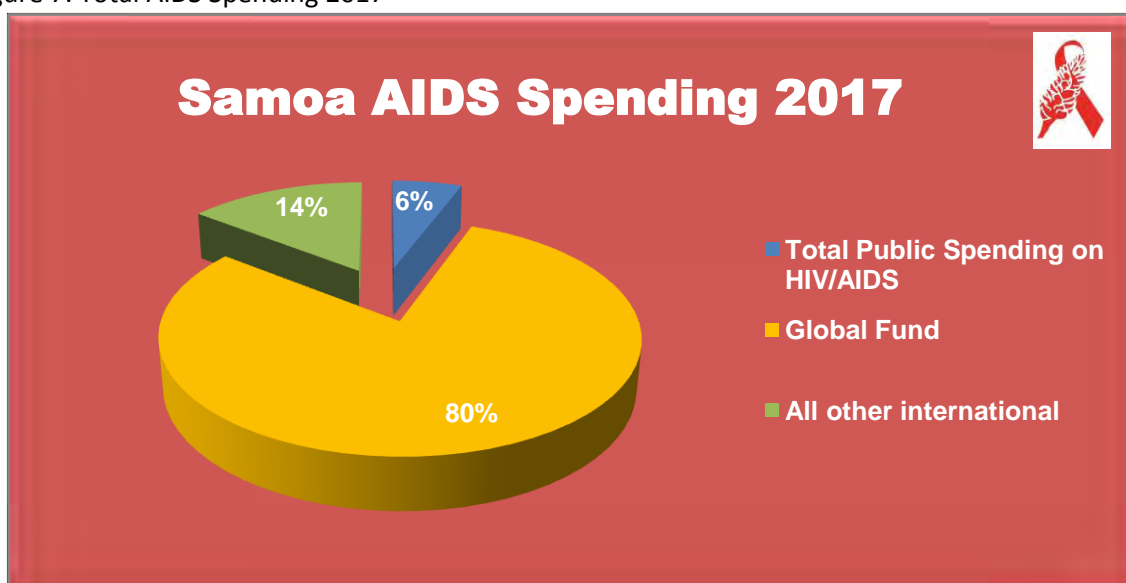
Table 43. Youth Use of Contraception from DHS 2014

Age Group	Female		Males	
	Ever use of any contraception	Ever use of Modern contraception	Ever use of any contraception	Ever use of Modern contraception
15-19	0.8	0.8	8.6	5.6
20-24	17.6	16.9	22.1	20.5

COMMITMENT 8: ENSURE THAT HIV INVESTMENTS INCREASE TO US\$ 26 BILLION BY 2020, INCLUDING A QUARTER FOR HIV PREVENTION AND 6% FOR SOCIAL ENABLE

AIDS spending in 2017 decreased dramatically. AIDS expenditures this year excludes the human resources cost, however human resources are catered for by the government of Samoa. All international includes IPPF, WHO and UNFPA. IPPF is the main donor of Samoa Family Health Association AIDS related activities, whereas WHO and UNFPA support both SFHA and the Ministry of Health activities as well. UNDP Global Fund to fight HIV/TB in Samoa is the main donor of our HIV/AIDS implementation plan. Values are given in Samoa Tala (WST).

Figure 7. Total AIDS Spending 2017



AIDS Spending 2017 (in WST)	
Total Public Spending on HIV/AIDS	\$ 27,500.00
Global Fund	\$ 383,053.00
All other international	\$ 69,500.00
TOTAL	\$ 480,053.00

COMMITMENT 10: COMMIT TO TAKING AIDS OUT OF ISOLATION THROUGH PEOPLE-CENTRED SYSTEMS TO IMPROVE UNIVERSAL HEALTH COVERAGE, INCLUDING TREATMENT FOR TUBERCULOSIS, CERVICAL CANCER AND HEPATITIS B AND C

Testing and treatment for TB, Hepatitis B and C, and all STI's are coordinated through the Communicable Disease Clinic of the National Health Service. The National Reference Lab at TTM Hospital in Apia serves to process all testing specimens, notify providers of new cases, and provide surveillance data for public health. Testing and treatment services for TB and STI's are all provided for free of cost to all citizens. HIV and TB co infection screening is currently fully implemented with TB detected cases. Co infection for Hepatitis (B&C), diabetes and TB has yet to be fully implemented among all detected cases.

Hepatitis B&C

The majority of screening for Hepatitis B comes from mandatory ANC blood testing (36.2%), blood bank and blood donor screening (32.6%), and immigration mandatory screening (14.3%). The overall prevalence of Hepatitis B was 2.4%. The highest case detection rate among categories of patient visits are Private provider and NGO patient visits (4.6%) and Upolu National Health Service Patient screenings (4.5%). The overall prevalence of Hepatitis B is 2.4% and has been slowly but steadily increasing since 2015 (2.0% prevalence).

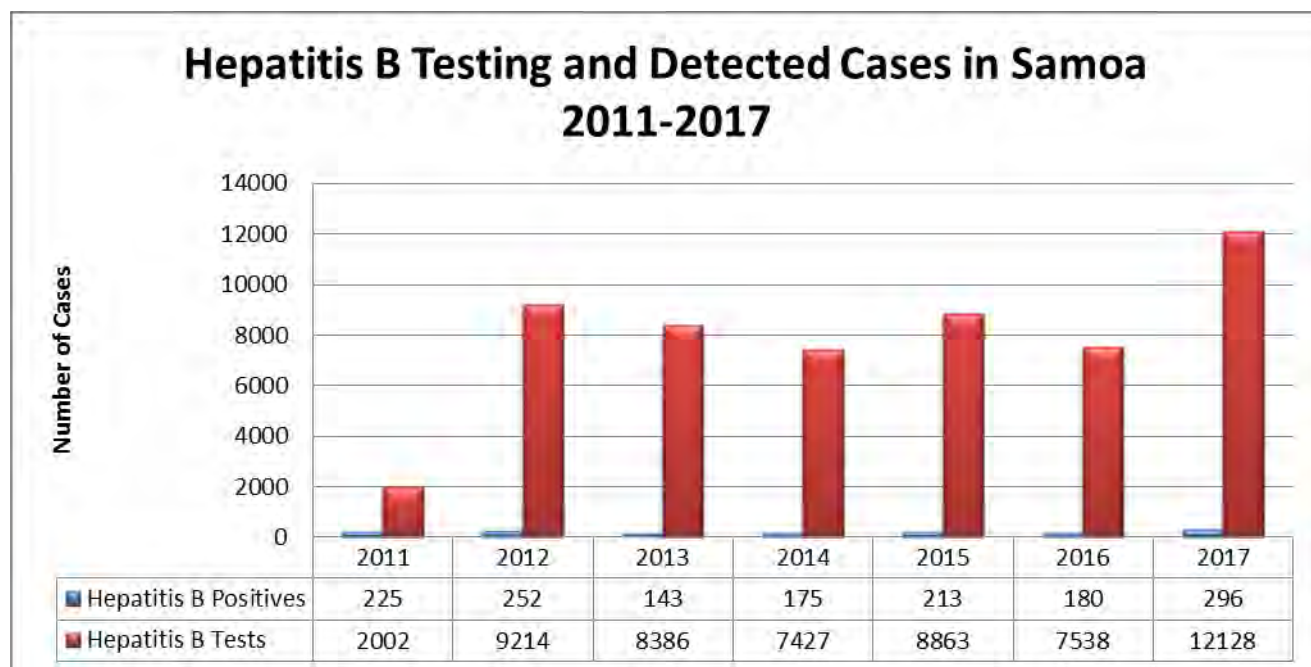
Hepatitis C is currently 0.1% prevalence, with the majority of positive patients coming from antenatal and blood bank screenings. The highest case detection rate among categories of patient visits proportionate to their caseload are Upolu NHS patient screenings and STI clinic patients (0.5%, 0.4%). However both Hepatitis B&C have low screening coverage in the population (6.1% and 5.2% respectively). This indicates there are significant numbers of undetected cases in the population.

Table 44. Hepatitis B&C Testing by Patient Category 2017

2017 Patient Category	Hepatitis B			Hepatitis C		
	Total tests	Positive	% Positive	Total tests	Positive	% Positive
ANC Testing (from all service providers)	4386	59	1.35%	3012	0	0.00%
Upolu NHS Patient Screening	1221	55	4.50%	993	5	0.50%
Savaii NHS Patient Screening	3	0	0.00%	3	0	0.00%
Private & NGO Patient Screening	541	25	4.62%	324	1	0.31%
STI Clinic	203	2	0.99%	231	1	0.43%
Immigration Testing (public and private)	1737	39	2.25%	1609	1	0.06%
Unknown	82	2	2.44%	60	0	0.00%
Blood Bank (NHS Lab Services Division)	2573	71	2.76%	2573	1	0.04%
Blood Donors (Serology Patients)	1382	43	3.11%	1379	1	0.07%
Total Tests	12128	296	2.44%	10184	10	0.10%

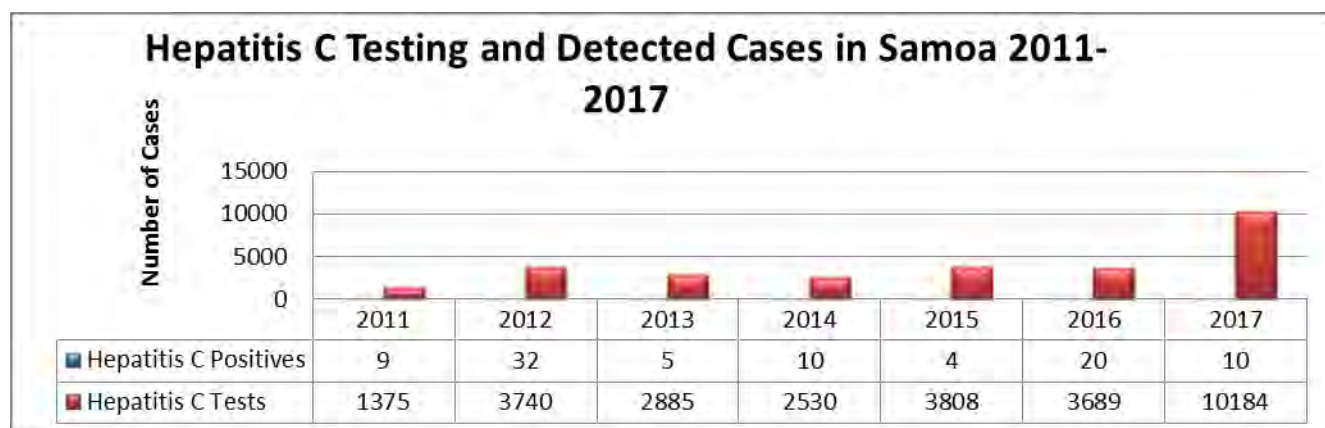
Hepatitis B testing has been increasing over the past 7 years. Despite the increase in testing between 2011 and 2016, the number of detected positives remained relatively stable. In 2017, there was a 64% increase in the number of positives. This is likely due to the increase in the coverage of testing (which increased by 87.5%). However referral pathways for Hepatitis B from antenatal care, and blood donation screening need to be strengthened to ensure proper treatment and prevention.

Figure 8. Hepatitis B Trends



Hepatitis C testing coverage has been fairly low between 2011 and 2016, but in 2017 increased dramatically by 176%. The number of positives cases remained low despite this increase, suggesting a low prevalence of undetected Hepatitis C positive cases.

Figure 9. Hepatitis C Trends



The age groups that make up the majority of testing for Hepatitis B are 30+ (26.8%), 15-24 (29.3%), and 25-29 (20.2%). The age group with the highest prevalence rate is 35+ years. 53.7% of positive cases are above age 35. In comparison, 28% of people screened for Hepatitis C were youth age 15-24 and 28.7% were age 35+. Adults age 35+ and children 0-4 had the highest prevalence rates and represented the majority of positive cases for Hepatitis C. 33.3% of positive cases were ages 35+ and 25% of positive cases were ages 0-4.

Table 45. Hepatitis B&C Screening by Age Group 2017

2017 STI Surveillance Age Group	Hepatitis B			Hepatitis C		
	Total tests	Positive	% Positive	Total tests	Positive	% Positive
0-4 yrs	249	7	2.81%	182	3	1.65%
5-9 yrs	45	0	0.00%	41	0	0.00%

2017 STI Surveillance Age Group	Hepatitis B			Hepatitis C		
	Total tests	Positive	% Positive	Total tests	Positive	% Positive
10-14 yrs	67	0	0.00%	61	0	0.00%
15-19 yrs	831	3	0.36%	668	0	0.00%
20-24 yrs	2724	25	0.92%	2176	2	0.09%
25-29 yrs	2451	38	1.55%	1951	1	0.05%
30-34 yrs	1738	46	2.65%	1454	1	0.07%
35+ yrs	3253	159	4.89%	2912	4	0.14%
unknown	770	18	2.34%	707	1	0.14%
Total Tests	12128	296	2.44%	10152	12	0.12%

More females are screened for Hepatitis B and more males are screened for Hepatitis C. Females age 20-29 made up the majority of females screened for Hepatitis B, and of females screened for Hepatitis C. For males, patients above age 30 made up the majority of cases screened for both Hepatitis B&C. Females age 35+ had the highest prevalence of Hepatitis B, and females age 0-4 had the highest number of positive tests for Hepatitis C. In males, Hepatitis B and Hepatitis C was most prevalent in ages 35 and older. This indicates a need for improved prevention and treatment in older age groups and increased testing and referrals for youth when it comes to Hepatitis B&C.

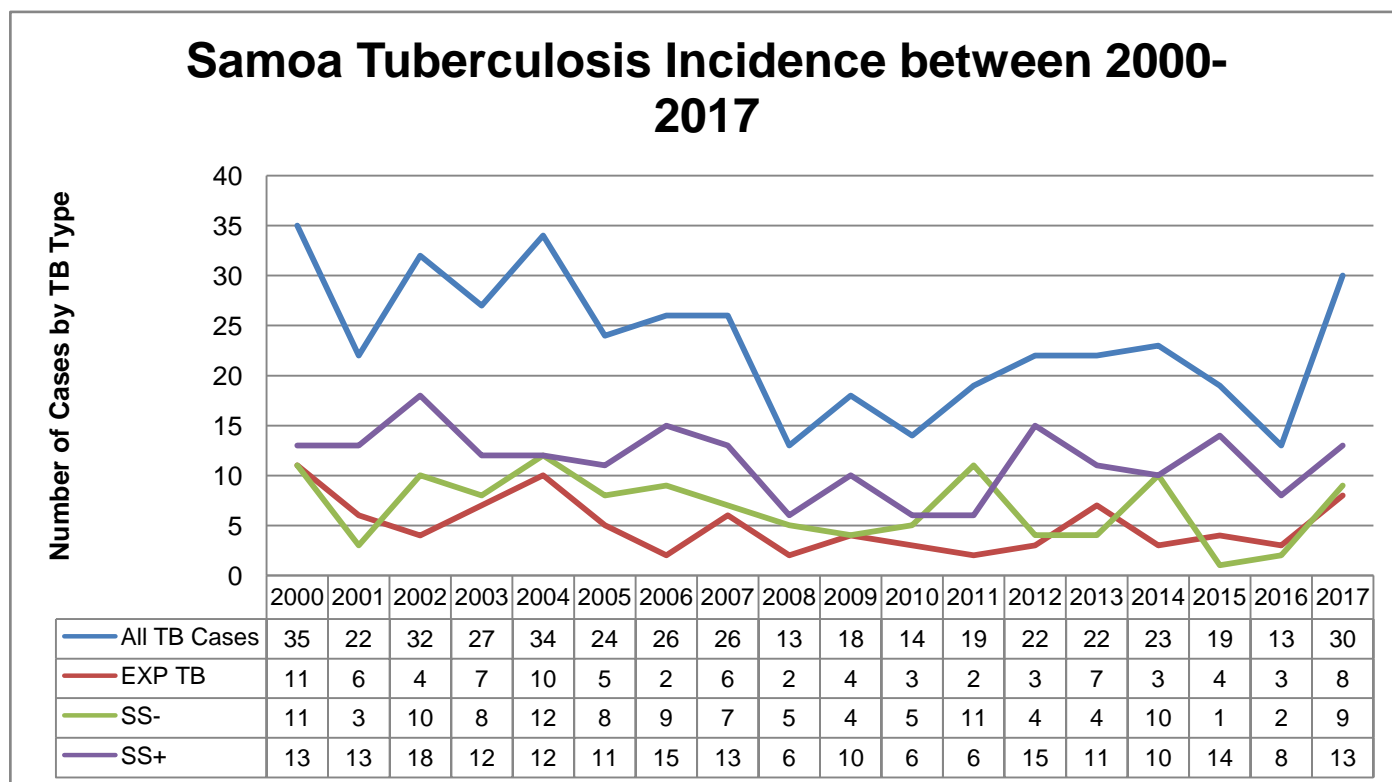
Table 46. Hepatitis B&C by Age and Sex 2017

Sex	Females						Males					
	Hepatitis B			Hepatitis C			Hepatitis B			Hepatitis C		
STI	Tests	Pos+	%	Tests	Pos+	%	Tests	Pos+	%	Tests	Pos+	%
Age Group												
0-4 yrs	103	3	2.9%	69	3	4.4%	95	4	4.21%	81	0	95
5-9 yrs	19	0	0.00%	17	0	0.0%	26	0	0.00%	24	0	26
10-14 yrs	37	0	0.00%	31	0	0.0%	30	0	0.00%	30	0	30
15-19 yrs	548	2	0.36%	401	0	0.0%	280	1	0.36%	265	0	280
20-24 yrs	1815	10	0.55%	1305	0	0.0%	900	15	1.67%	864	1	900
25-29 yrs	1552	16	1.03%	1079	2	0.2%	898	23	2.56%	870	0	898
30-34 yrs	999	22	2.20%	734	1	0.14%	737	24	3.26%	718	0	737
35+ yrs	1217	43	3.53%	962	1	0.1%	2031	115	5.66%	1946	3	2031
unknown	289	3	1.04%	236	0	0.0%	336	13	3.87%	332	1	336
Total Tests	6579	99	1.50%	4834	7	0.14%	5333	195	3.66%	5130	5	5333

Tuberculosis (TB)

In Samoa, TB is an important public health issue despite low prevalence. In 2017, the annual number of new TB cases more than doubled since 2016. This is partly due to improved screening and contact tracing by healthcare providers. More clinically diagnosed cases (suspected to have TB by clinician by not yet confirmed through testing) were detected in 2017. Though the number of cases remains relatively low compared to the estimated population, this increase is cause for concern and represents nearly double the incidence of the record lows in 2008-2010. Identification and diagnosis of TB remains low in coverage of the population (especially in remote villages). The number of the infectious TB cases (SS+) has been steadily rising since 2011.

Figure 10. TB Incidence Trends



**All types includes clinically diagnosed cases that are not bacteriologically confirmed*

**EXP TB is extrapulmonary TB, or a TB infection occurring anywhere outside of the lungs*

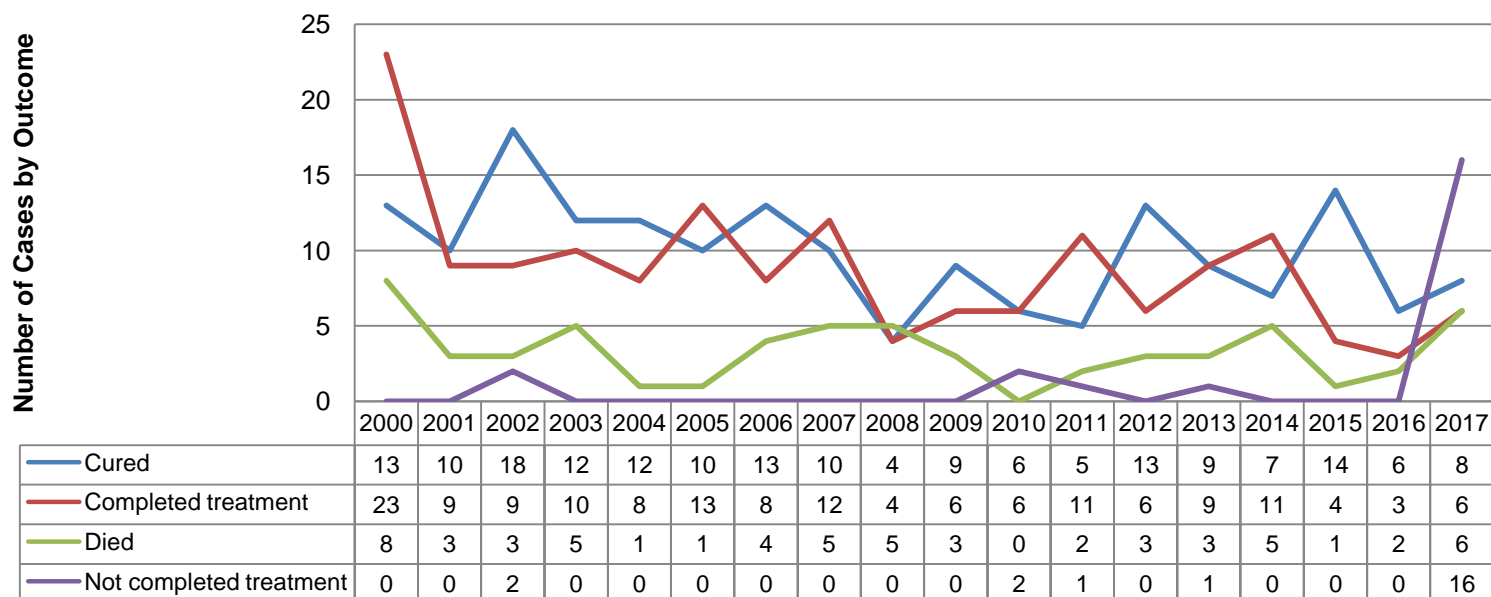
**SS- is Sputum Smear Negative, meaning patient is less infectious with less TB bacteria detected in sputum*

**SS+ means patient is more infectious, with more TB bacteria detected in sputum*

In terms of outcomes, deaths from TB in Samoa fluctuate between clusters of years. Since 2014 TB deaths have been increasing and in 2017 were at their highest since 2000. This highlights the critical need for early detection and adherence to treatment regimen. The majority of TB deaths occurred in patients that had a pre-existing non-communicable disease prior to their TB infection in 2017 (ex. High blood pressure, diabetes, liver or kidney complications). This highlights the need for co-infection screening interventions with Samoa Kidney Foundation, the Diabetes Clinic, Samoa Cancer Society and general primary healthcare. Since 2017 saw a dramatic rise in the number of cases, the majority of cases are still on treatment (as treatment takes 6-9 months to complete). Therefore cure rates in 2018 are expected to greatly increase if patients complete the treatment regimens.

Figure 11. TB Outcome Trends

Samoa TB Treatment Outcomes 2000-2017



The main challenges in eliminating TB in Samoa include increasing testing, training of providers to accurately diagnose and treat TB, linking individuals to treatment, and increasing public awareness and education of prevention, transmission and treatment, and ensuring all TB cases are tested for HIV. Although TB shares some social determinants in common with HIV and STI's, there are a few social contexts that are unique. Since Samoan families are typically large and live in close proximity to each other, exposure to TB usually occurs between family members. Families are often large, and share close proximity sleeping areas which allows for increased TB transmission. The lack of knowledge of TB prevention also increases TB transmission.

The ICHAP Survey 2017 (Ministry of Health) found that the common misconception about TB that respondents reported was that all people that get infected with TB will get sick or show symptoms (87.4%). However, knowledge of TB and transmission was low across all categories. TB knowledge scores were also commonly Very Low to Low (56.2%). More respondents were able to obtain a high knowledge score for TB (14.1%) than Chlamydia where only 2% achieved a High score. A significant number of respondents scored a moderate level of knowledge of TB (about 30%).

Table 47. TB Knowledge of All Respondents

TB Knowledge Scores	Number	Percent
Very Low (0-1)	181	36.9%
Low (2-3)	95	19.3%
Moderate (4-5)	146	29.7%
High (6-7)	69	14.1%
Total	491	100%
Mean	Standard Deviation	Variance
2.76	2.22	4.91

The common misconception about TB that respondents reported was that all people that get infected with TB will get sick or show symptoms (87.4%). Though correct responses were more common with TB questions compared to Chlamydia, TB knowledge scores remain low.

Table 48. TB Knowledge Responses from ICHAP 2017 Survey

Item	Answer	Percent of Correct Responses
TB is spread by one person to another through the air	TRUE	55.0%
Everyone who gets infected with TB will get sick.	FALSE	12.6%
Some people can get TB disease easier than others	TRUE	37.3%
TB disease can be cured	TRUE	58.0%
TB can affect other parts of the body besides the lungs	TRUE	37.5%
TB bacteria have a hard time living in fresh air and sunlight	TRUE	26.5%
If you have TB infection you may have to take medicine, even if you don't feel sick	TRUE	48.7%

TB cases and their family members are also highly mobile between villages, which poses significant challenges to contact tracing (testing of individuals exposed to a TB case), testing and treatment. Gaps in contact tracing often leads to undetected TB in the population that the Communicable Disease Clinic lacks resources to address. Co-infection testing is also lacking for the same reason.

However major improvements or TB/HIV co infection testing have been made between 2015-2017. Screening coverage went from 0% in 2015 to 82% in 2016, and increased to 93% in 2017 due to improvements made in TB monitoring, direct observation of treatment visits to patients, and improvements in case management made by the Communicable Disease Clinic. TB testing has yet to be implemented with PLWHIV, and none have reported any symptoms.

Table 49. Co infection Testing Coverage.

	Target	2015	2016	2017
TB-HIV1: TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	65%	0%	82%	93%

Treatment for TB is aligned with WHO guidelines;

Table 50. TB Regimens by Population

TB Type	Preferred Treatment Regimen
TB Disease in HIV- person	6-9 months of isoniazid (INH), rifampin (RIF), ethambutol (EMB), pyrazinamide (PZA)
TB Regimen for Drug Susceptible TB	Initial Phase: Daily INH, RIF, PZA, and EMB* for 56 doses (8 weeks), Continuation: daily INH and RIF for 126 doses (18 weeks) or two times weekly INH and RIF for 36 doses (18 weeks)
Drug Resistant TB (Resistant to INH or RIF)	Drug resistance is proven by drug-susceptibility testing. However, since this testing can take weeks, treatment should be started with an empirical treatment regimen based on expert advice as soon as drug-resistant TB disease is suspected. When the testing results are known, the treatment regimen should be adjusted according to the results.
Multiple Drug	Bedaquiline

TB Type	Preferred Treatment Regimen
Resistant TB	
TB Disease in HIV+ person	Cannot take RIF if on ARV, regimen determined by provider
Latent TB Regimens by Drug	
Isoniazid	9 month Regimen: Daily, Preferred treatment for: Persons living with HIV, Children aged 2-11; Twice Weekly for Pregnant Women (with pyridoxine/vitamin B6 supplements)
Isoniazid (Alternative)	6 months Regimen: Daily or twice weekly
Isoniazid and Rifapentine	3 month Regimen: Once weekly, Treatment for: Persons 12 years or older Not recommended for persons who are: Younger than 2 years old, Living with HIV/AIDS taking antiretroviral treatment, Presumed infected with INH or RIF-resistant M. tuberculosis, and Women who are pregnant or expect to become pregnant within the 12-week regimen.
Rifampin	4 month regimen: Daily

Cervical cancer

Cervical cancer is low in prevalence, but like many other diseases, this is due to low screening rates and poor population screening strategies. There were 6 per 1,000 admissions for cervical cancer in 2016. Cervical cancer is the third highest type of cancer admission. Treatment is largely done through the overseas treatment scheme and most therapies are not available in Samoa.

The HPV vaccine is of great interest to health sector procurement due to the cost-effectiveness of preventing HPV transmissions in a context where access to treatment is challenging and non-existent for families of low socio-economic status. A national screening program, paired with universal access to treatment has not yet been realized. However the shift in the health sector's focus to primary healthcare as a means of combating NCD's has become a national priority and is the impetus behind the current health sector reforms and restructuring in 2017-2018. All types of cancer are a part of this initiative and will likely see more developments in the coming years.

THE SITUATION WITH HUMAN RIGHTS IN RELATION TO HIV

In 2009, a legal review was conducted by UNAIDS to identify gaps in current legislation regarding HIV and STI's. Many findings are still relevant with a few areas that have been addressed in newer legislation (like the Crimes Act 2013). This section uses that analysis and more recent legislation to provide information on human rights law in relation to HIV and STI's. Much of the law in Samoa does not have specific legislation to address HIV and STI's, but general powers grant by the current legislation can be used to protect rights in the absence of specific clauses.

Public Health Law

There is no legislation that specifically empowers public health authorities to provide services for HIV and STI's. The Health Ordinance 1959 enables health authorities to quarantine, test and treat individuals on the basis of protecting population health. There is also a general power to medically examine, also supported by the Healthcare Professions Registration and Standards Act 2007. Generally there is no regulation for informed consent of individuals for testing. However, informed consent is clearly defined with all relevant guidelines in the HIV, AIDS and STI Policy 2018-2022 for all

service providers involved in the National Response to HIV, AIDS and STI's. This document also states that testing should ideally be voluntary or provider initiated. However, mandatory testing of any group is not prohibited by law. Pregnant women and infants are required by policy and practice to have HIV and STI screenings. However, this is not mandated by law.

Immigration Law

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. For temporary and permanent resident applications, blood testing which includes HIV and Hepatitis B is mandatory. A visitor's visa does not require any screening. Screening is done in compliance with International Health Regulations (IHR). This is to ensure that our health authorities are alert of any new incoming HIV+ case and can then arrange testing, treatment, care and support while in Samoa. There are no legal grounds to deny residency on the basis of sero-status. Laws and policies only apply when there is willful and therefore criminal transmission of HIV. In such a case, malicious intent must be proven (Crimes Act 2013). As of 2015, the immigration customs form has removed the question on self-reported HIV status and replaced it with Zika virus monitoring questions.

Criminal law

Sex work is currently illegal in Samoa with no immunity for carrying condoms. Homosexual acts and transvestism are no longer criminalized under the Crimes Act 2013. However the establishment of business or public spaces that promote homosexual acts are identified in the current Crimes Act. There is also no legislation that specifically criminalizes the transmission of HIV. However it can be prosecuted under the Crimes Act as "causing grievous bodily harm", where areas malintent must be established. There is also no specific legislation regarding blood safety and accountability for such transmissions.

Criminalization of sex work and pervasive negative cultural attitudes towards those who engage in sex work are the most difficult challenges for health workers to reach commercial sex workers. It prevents sex workers from going to providers for fear of discrimination or legal action.

Prison and Correctional Law

There are no legal provisions for provided testing or treatment services to prisoners, or confidentiality of prisoners' health information. In terms of early release, HIV is not a valid legal reason because ill-health is not an identified criterion for early release.

Anti-discrimination

Vulnerable groups are not identified in the law, and therefore do not have non-discrimination protections. This includes fa'afafine, MSM, sex workers, prisoners, youth, people with disability, and PLWHIV. There are also no laws granting women the right to non-discriminatory access to health services. Same sex relationships are not legally recognized.

Abortion is illegal except if the birth poses serious physical or mental health threats to the mother, the mother is really young, the pregnancy is a product of rape or incest. However, access to abortion services is non-existent in the country, so even in legal circumstances abortions are not procured.

No laws exist that require children to be provided with information and education about HIV and STI, or to be provided with condoms and prevention materials.

Mandatory HIV screening for employment is not prohibited, but is universally not practiced as no distribution mechanism exists outside of health sector testing and treatment services for patients. There are also no universal infection control measures for health services, but international guidelines and standards are used in the absence of law. The Occupational Safety and Health Act 2002 requires that employers provide safe working conditions for employers which includes infection control. There are no unfair dismissal rights for HIV positive workers, and there are no

confidentiality provisions of employee health information. There is also no recognition of occupational HIV transmission or grievance recourse.

Privacy and Confidentiality

There is no legislation that governs health information privacy and confidentiality. Health data is owned by the service providers that create the patient record. However, the Healthcare Professions Registration and Standards Act 2007 dictates that patient and provider confidentiality is to be observed in professional ethics and practice. Common law allows providers to disclose medical records in limited public interest situations to prevent injury of third parties. HIV is classified as a notifiable disease and therefore reported to relevant health authorities.

BEST PRACTICES

2017 marked the last year of the UNDP / Global Fund 2012-2017 cycle in Samoa. This urged the programme to integrate the work of HIV, AIDS, STI's and TB prevention with multi-sectoral approaches to implementation and community development. By involving more partners, nationally and bilaterally, the work of the national programme can be sustained past the end of donor programs. By involving more entities in the work, HIV, AIDS, STI, and TB prevention can be maintained and expanded through the next policy period of 2017-2022. Valuable practices were highlighted in 2017 that are being carried forward as the health sector is restructured, health resources change, and public health seeks to update its methods for a quickly changing Samoan population.

i. T3- Reaching people through SMS, TV, Radio, and digital marketing

In an effort to overcome barriers to testing and treatment services, the MoH National Programme for HIV, AIDS, STI's and TB mobilized the T3 campaign to reach as many people as possible with messages of health and prevention while ensuring the highest standard of confidentiality. Media allows health messages to be promoted without singling out individuals. It equips people with the knowledge of services, prevention and care without associating them with service delivery entities. It is also easier to have wider coverage with media interventions.

The T3 campaign attracted a lot of attention to the issues surrounding HIV, STI's and TB in 2017. Text messages, TV ads, radio spots, and digital marketing were used to promote T3. This resulted in increased calls to service delivery points, an 87.5% (ecological inference) in voluntary testing from 2016 to 2017, and other media outlets discussing the T3 campaign and the health issues the campaign targeted. Implementation revealed that media costs of TV and radio were very high. Going forward, the T3 Campaign will seek to utilize more SMS and digital platforms. Digital marketing in particular has much lower costs and is easier to monitor and estimate the reach of campaign messages.

ii. Holistic health outreach

The Integrated Community Health Approach Programme (ICHAP) received overwhelmingly positive reception in the communities that participated, due to how sexual health prevention was delivered. Sexual health topics are very sensitive in Samoa and have to be marketed in a way that they do not conflict with cultural and religious values. One method of accomplishing that is to deliver sexual health education with other health issues. In ICHAP's case, education on climate resilience, maternal and child health, family health, Tuberculosis prevention, Typhoid prevention was delivered alongside screening for STI's and non-communicable diseases. This made communities more receptive to the intervention as sexual health was delivered as an integral part of overall good health.

Additionally ICHAP was an excellent opportunity to reach youth and key populations without targeting them through services, which could jeopardize their confidentiality in their communities. Key populations and youth could therefore participate with the general population, accessing the same services, and anonymously identify themselves through the ICHAP Survey. This allowed for better monitoring of key populations, as well as clinical referring key populations to other needed services. Integrating key and vulnerable populations groups into general population outreach allows for better confidentiality (especially in Samoa's high stigma context) and better engagement of groups that wouldn't normally come forward.



National Health Service Staff screening attendees of outreach for blood pressure and blood glucose

iii. Expansion of partnerships with community organizations

In an effort to reach youth with programming, the Ministry of Health added two more non-government civil society organizations to its list of implementing partners; The Young Women's Christian Association (YWCA), and Teen Challenge Samoa. The YWCA has a large network of young women, who also can serve as peer educators for their villages. Teen Challenge Samoa targets troubled young men who have offended or re-offended. As both are run by religious leaders, they have great influence in communities which allows for improved mobilization and implementation.

Both participated in ICHAP outreach in August 2017, which focused on engaging youth in prevention. All organizations involved in the activities agreed that the outreach was successful and needs to be sustained in coming quarters to expand the reach of the program. Youth greatly benefitted from the education and prevention services, but continued programming is needed to sustain the outcomes of ICHAP. Health and prevention are growing priorities for youth in the NGO sector, and both YWCA and Teen Challenge look forward to building upon the partnership with MoH in the coming years.



ICHAP Q&A session for HIV, STI's and TB with Teen Challenge members

iv. Scale up of prevention efforts with Sex workers and fa'afafine

Major advances in prevention programming were made in 2017 with fa'afafine and sex workers. The Ministry of Health supported Samoa Fa'afafine Association (SFA) in obtaining a sub-recipient agreement with the UNDP/Global Fund for support and funding. This allowed UNDP/Global Fund funding, which was increased due to Ministry of Health's satisfactory performance, to be channelled directly to SFA to support their increasing efforts on health and prevention.

Additionally, there was much work done in gaining the trust and rapport of the sex worker community. This population is highly stigmatized and harassed by the police due to the illegal nature of sex work in Samoa. They are therefore very distrusting of participating in government programs for these reasons. The staff of the Ministry of Health HIV, STI, and TB Programme met groups of sex workers in order to consult them on what programmes they need, as well as to demonstrate that the Ministry of Health is there to support them in making the best choices for their health and healthcare. After several informal meetings and discussions, the first sex worker outreach events were conducted in 2017, bringing testing, education and referral services directly to this population. These efforts were well received by the sex worker community, who have agreed to expand programming and outreach in 2018. Although this took an incredible amount of time, effort, and extensive work to ensure confidentiality, Ministry of Health was able to begin the process of engaging this key population group.



MoH Staff promoting T3 and HIV awareness during civil servants march

MAJOR CHALLENGES AND REMEDIAL ACTIONS

(a) progress of key challenges reported in 2016

The challenges identified in the 2016 reporting period were addressed in 2017. This section summarizes the current status of those challenges during the 2017 reporting period and progress made.

Table 51. Key Challenges

<u>2016 Key Challenge</u>	<u>Progress</u>
1. Delay in funding disbursement from UNDP/Global Fund until July 2016	The national programme delayed activities until later quarters and focused on expanding partnerships to implement activities as well as accessing WHO funding. Activities were reprogrammed so that funding was fully acquitted.
2. Female sex worker distrust of programming	Through multiple consultations, staff were able to gain the trust of this community and implement initial programs
3. Discontinued Chlamydia testing	Testing resumed in 2017, albeit with less test kits. Chlamydia is no longer a part of ANC panels, and is screened by request of providers.

2016 Key Challenge	Progress
4. Barriers to condom distribution in prisons	ICHAP was launched with prison facilities for the second time in 2017. Facility personnel were more aware of the programme and more receptive to distributing condoms to inmates.
5. Lack of co-infection testing for TB/HIV	Co-infection testing is currently fully implemented. Contact tracing remains an on-going challenge.
6. Service delivery barriers to case management and treatment of TB patients	Lack of staff and geographic dispersion of cases continues to be an on-going challenge for the programme. More aggressive contact tracing by the CD Clinic, as well as involvement of community nurses has helped reduce this burden.
7. On-going low voluntary testing coverage	The significant increase in testing in 2017 indicates that progress will be made over the next few years to reach adequate testing coverage.
8. Low knowledge, awareness, and coverage of programming in rural populations	Including the expansion of ICHAP to rural communities, primary healthcare initiatives across the health sector are also planning outreach to rural villages, which can be used as a mechanism for HIV, STI and TB programming.
9. Lack of M&E data and reporting	Data collection for M&E and reporting purposes has been greatly improved in 2017, with more activities planned in 2018.

(b) challenges faced throughout 2017

In 2017, prevention efforts faced mostly challenges within the health resourcing environment, both at the national and regional level.

- ❖ ***At the regional level, funding allocations for PLWHIV have been reduced and shifted to focus on key populations.*** This has made it difficult to offer support to the HIV cases living in country.
- ❖ ***Funding allocations for general population outreach and service delivery are still needed*** to obtain adequate population coverage and use as a mechanism to confidentially reach key populations. Socially and politically, engaging key populations through anonymous participation in outreach programming is the most direct way to reach these populations that are resistant to participate in targeted programmes due to stigma. This is especially true with sex workers and MSM.

- ❖ **Data quality challenges and reporting from NGO's and rural health facilities are on-going issues.** Lack of electronic recording and reporting of data continue to create limitations for surveillance between facilities. Providers are also resistant to take up electronic reporting tools.
- ❖ **The HIV, STI, TB National Programme lacks staff** to drive the full work of prevention and enforcement at the government level, as well as competing responsibilities to the Ministry of Health especially in disaster situations.
- ❖ **Funding for health in Samoa prioritizes non-communicable diseases**, while ignoring low prevalence infectious diseases like HIV and TB. However, STI rates are incredibly high and, when paired with low prevention knowledge in the population, increase the risk of HIV transmission. Additionally, high rates of NCD's pose major risks and challenges for co-infection of TB and Diabetes.



Traditional dancing at Physical Activity and Nutrition Expo 2017

(c) concrete remedial actions

The numerous actions have been added to the 2017 work plan to address challenges that have been ongoing for many years in addition to those encountered in 2016.

Challenge	Remedial Activities in 2018 Work Plan
<i>At the regional level, funding allocations for PLWHIV have been reduced and shifted to focus on key populations</i>	Ministry of Health funding has been mobilized to help revive Samoa AIDS Foundation, and partnership activities have been planned with Samoa Red Cross Society to deliver programs to PLWHIV and establish advocacy networks.
<i>Funding allocations for general population outreach and service delivery are still needed</i>	ICHAP is planned again for 2018 in order to engage general populations and key populations
<i>Data quality challenges and reporting from NGO's and rural health facilities are on-going issues</i>	MoH is working to negotiate reporting of all raw patient data to improve national M&E indicators and targets
<i>Sex worker community distrust of government programming</i>	Previous outreach initiatives will be expanded upon in 2018, with the target of reaching more individuals
<i>Low voluntary testing rates</i>	T3 will continued to be used as a platform for mobilizing the population through media, especially digital formats

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

The Global Fund to Fight HIV, TB and Malaria is the main funder of Samoa's national HIV/AIDS programs, with management provided by UNDP. 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. WHO provides occasional funding for specific allocations and this year helped to fund the infection control in traditional tattooing initiatives. 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 2017-2021) 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.

In March 2017, UNDP/Global Fund initiated the SMS health messages partnership with Ministry of Health and Digicel. This was incorporated into the T3 campaign, and was the initial launch of the multimedia effort to promote HIV, STI and TB prevention.

WHO in partnership with SPC and UNDP/Global Fund also delivered technical assistance in September and October to review the WHO updated HIV/STI/TB guidelines, train clinicians on implementing them, as well as contextualizing the guidelines to the health system in Samoa.



World AIDS Day Banner 2017

For World AIDS Day 1 Dec. 2016, UNDP also provided the national programme with a media package for awareness and advertisement of testing services. Documentaries, T3 promotions, dengue awareness promotions, and MoH clips were also aired during that week with the media package budget.

MONITORING AND EVALUATION ENVIRONMENT

Monitoring and evaluation for HIV, STI's and TB is a multi-sectoral effort. Data collection is coordinated by MoH with all stakeholders and partners involved in the national response. The primary source of data comes from the national lab located at TTM Hospital in Apia. All laboratory testing in the country is conducted there, with samples sent to New Zealand labs when kits or assays are unavailable.

Programming through HIV, STI and TB National Programme always involves an NGO or government ministry as implementing partner. In 2017, MoH partnered extensively with;

- Samoa Fa'afafine Association
- Samoa Family Health Association
- Samoa Red Cross Society
- The Ministry of Women Community and Social Development
- The National Health Service: Communicable Disease Clinic- Laboratory Services - Pharmaceutical Services

In addition to monitoring data collected on programmes by the MoH, data is also reported from all partners and stakeholders (especially those listed above for 2016).

Data is also collected every 5 years on HIV knowledge, awareness, and sexual behavior within the Demographic Health Survey through Samoa Bureau of Statistics. Research studies also provide indicator data for M&E on an irregular basis.

Until 2016, the National Programme had no M&E framework for sexual health data outside of the framework of the UNDP/Global Fund program management. The health sector M&E framework (2010) contained only prevalence indicators relevant to HIV and STI's. A framework and M&E manual for HIV, STI's and TB was drafted in 2016 and is set to launch in March 2017. This manual sought to

create a universal list of indicators that satisfied the needs of the health sector, donor partners, and was formatted to the data collection processes already in place for HIV, STI's and TB.

Data collection for sexual reproductive health in general faces several ongoing issues;

- Stigma surrounding sexual health, family planning, STI's, HIV, and therefore prevention services prevents attendance, access, and public discussion and promotion of need services to populations
- Lack of a comprehensive sexual health education and population awareness of disease risk and healthy behaviour
- Reporting bias is highly prevalent as the island community is small and socially interconnected. People do not feel confidentiality can be maintained around sensitive issues in this context, and are more likely to report behaviours and feelings that do not conflict with religious and cultural beliefs. This makes it difficult to monitor accurate behavioural risk factors due to reporting bias.
- Research, M&E, statistics, and survey data collection are all areas where the health sector's human resource capacity and training are lacking. In addition to lack of skilled data officers, there is also a lack of general human resources in health. This results in very few personnel do data collection that would optimally involve a whole team of people (clinical, technical, and administrative). Most personnel in the health sector are tasked with numerous other functions, and therefore lack the time needed for data collection.

Challenges

The HIV, STI, and TB Monitoring and Evaluation Reference Manual (2017) was consulted with the health sector on numerous occasions. This clarified and highlighted challenges moving forward with the implementation of the M&E Manual;

1. Both donors and health sector organizations rely heavily on population based surveys for performance measures and indicator data. These data are available every 4-5 years through surveys implemented through Samoa Bureau of Statistics. However, as the health sector moves from awareness campaigns to programming aimed more at behaviour change, new data are need more frequently to track the impact of interventions. Annual schedules are preferred for many indicators.
2. Many health sector partners, particularly NGO's, lack capacity for data reporting and collection. However, rural health centres often have few staff with little to no capacity for data collection and reporting.
3. The targeted age groups of 0-14, and 15-19 include youth that fall below the national age of consent for accessing health services. This makes both data collection and service delivery an issue where parental consent is needed while simultaneously the youth's confidentiality must be protected.
4. Collecting data on key populations is difficult when they do not have legal status. In the case of sex workers, commercial sex work is illegal making it very difficult to get research studies and interventions approved, because of the confidentiality risk. For fa'afafine (transgender males), third gender status is not nationally recognized. Therefore data that includes that gender category is captured in program records and cannot yet be monitored nationally in surveillance. In the case of fa'atamaloa (transgender females), this label is usually one that the community uses to identify an individual rather than a term for personal identity. Therefore, service providers are faced with the challenge of identifying these patients during clinical data collection.

5. Without health information confidentiality and privacy legislation in place, M&E data collection poses serious risks and ethical dilemmas. Sensitive health data is legally the property of the clinician or officer that creates the record or database. This poses serious risks as there is no legal framework of accountability if such data were to be made public. Exposure of an individual's sexual health information could result in severe social repercussions, due to the heavy stigma against HIV, STI's and sexual health. There is a concern that expanding data collection without legal protection methods is unethical.
6. There is also no mechanism or infrastructure for a national electronic system of health data. This leads to duplication, loss to follow-up, unavailable health/treatment histories. Since M&E data collection from the health sector is all paper based, the data collection process is more time-consuming and resource expensive.

Remedial actions

Several remedial actions to address M&E challenges have been planned for 2018-2020 period;

1. Encourage donors to accept small scale, sub-national monitoring research studies for population estimates in reporting. MoH plans to deliver data collection alongside program implementation so that health data is collected during community events throughout the year. Implementation with the National Programme is always on a sub-national level, targeting key and at-risk communities. Obtaining a sample from targeted villages rather than national is therefore appropriate.
2. In addition to conducting health sector M&E trainings, MoH plans to conduct trainings with key stakeholders and partners to develop M&E capacity.
3. MoH has also planned several programmes targeting youth with capacity building behaviour change interventions, to support clinical screening.
4. Key population data will come from informal, small scale outreach programmes to protect confidentiality. A drop-in centre for these groups is also to be established in 2017, as a means of delivering condoms, lubricants and IEC materials. Further programming will seek to confidentially link these individuals to doctors once rapport has been established.
5. Legal reviews for gaps in legislation to protect key populations are scheduled for the end of 2017. Confidentiality and privacy regulations are currently being developed and reviewed as part of forthcoming National Hospital Standards.
6. The staff of the National Programme continue to provide technical assistance to the team at MoH responsible for implementing an e-health system. The timeline for procurement and operationalization is still uncertain. The National Programme also is developing an electronic data collection and reporting tool with the Communicable Disease Clinic and the National Lab.
7. Since many indicators within the national and donor M&E frameworks have not had any data collected in the past 5 years, MoH is preparing to launch a sub-national data collection exercise to collect a lot of this missing data in Sept. 2017. This exercise is meant to trial core indicators, establish baseline data, and see how M&E can be tailored to existing systems.

Improving M&E Capacity

As previously mentioned, the main barrier to improving M&E is the lack of capacity for data collection, analysis and quality assurance. This can be sustainably remedied with the following;

- Training for MoH personnel on M&E methods and scholarship programs for Samoan nationals in health information sciences and statistics to create a health workforce with specialized skills
- Committed funding at the government and donor level for data officers to support all units at the ministry of health, and funding for the placement of data officers at key partner organizations, stakeholders and NGO's
- Updating MOU's and building inter-organizational relationships around data sharing within the health sector could provide many gaps within the current data and minimize duplication

In addition to capacity building of the health sector, data collection tools designed for the health sector could improve current M&E procedures. This includes the implementation of statistical analysis and data collection software, in addition to training personnel in its applications. This would be especially useful for mobile, or tablet based data collection software that is user friendly for both analysts and research participants alike.

At the political level, evidence-based medicine must be a priority throughout the health sector with a strong emphasis on M&E data as a mechanism for quality assurance. This can be accomplished through both policy and the establishment of outcome-based funding.



Honourable Tuitama Dr Talalelei Tuitama speaking at World AIDS Day Ceremony

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