Situation Analysis of Children in Samoa

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This report was written by Kirsten Anderson, Ruth Barnes, Awaz Raoof and Carolyn Hamilton, with the assistance of Laura Mertsching, Jorun Arndt, Karin Frode, Safya Benniche and Kristiana Papi. Maurice Dunaiski contributed to the chapters on Health and WASH. Further revision to the Child Protection chapter was done by Shelley Casey.

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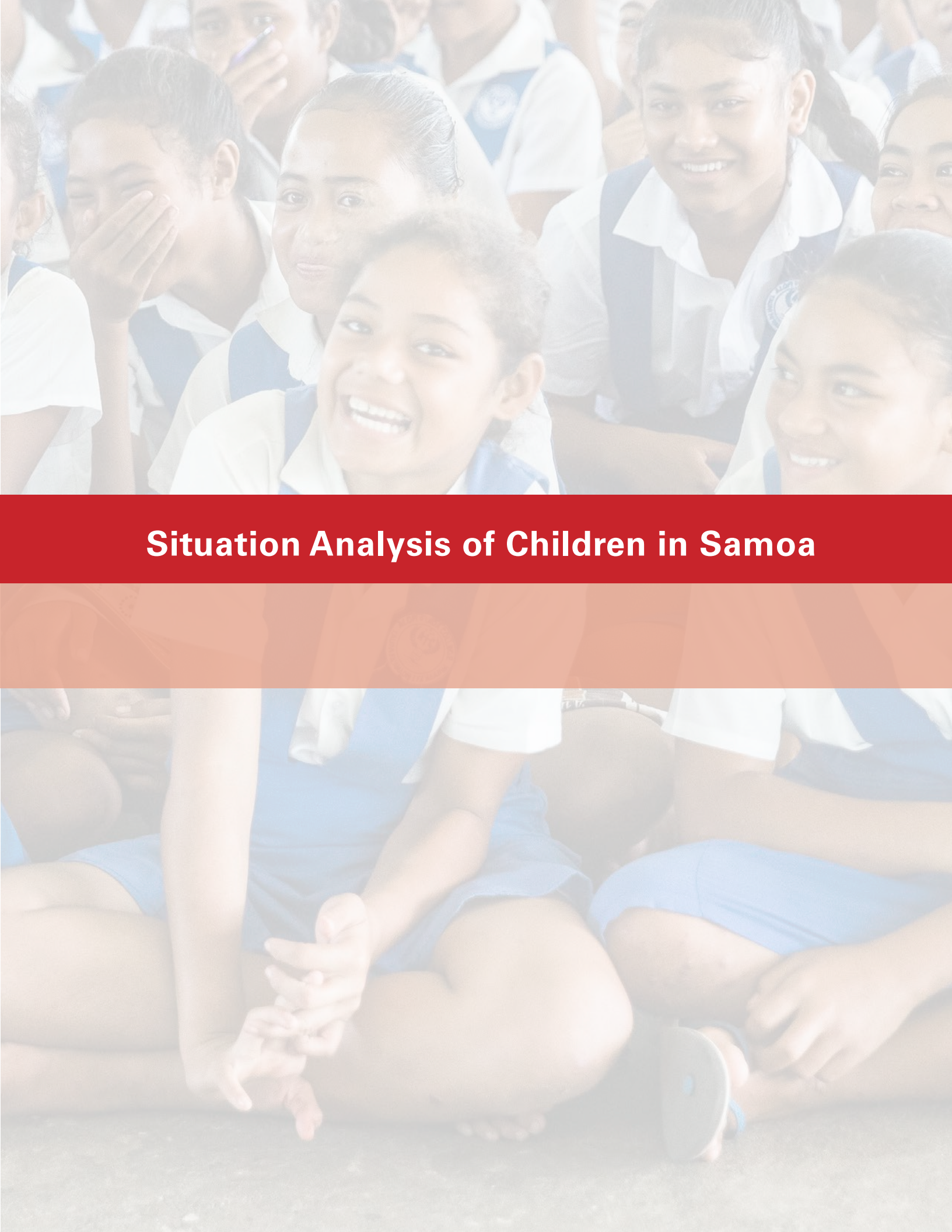

Situation Analysis of Children in Samoa

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Executive Summary

Introduction

This report presents a comprehensive assessment and analysis of the situation of children and women in Samoa. It provides an evidence base to inform decision-making across sectors that are relevant to children and women, and, in particular, is intended to contribute to the development of programmes and strategies to protect, respect and fulfil the rights of children and women Samoa.

Samoa comprises 10 islands, of which the largest two are Upolu and Savaii, and is located in the Polynesian part of the Pacific Ocean. Samoa had a population of around 193,000 as per the 2015 census, an estimated 85,000 of whom are below the age of 18. Samoa is classified as a lower-middle-income country. Overseas development aid funded an estimated 40 per cent of government expenditure as of 2014. Samoa is vulnerable to natural disasters such as cyclones, flooding and earthquakes, all of which climate change exacerbates. A total of 70 per cent of Samoa's population is located in low-lying coastal areas, which are particularly vulnerable to natural disasters.

This report covers the child outcome areas of health (including nutrition), water, sanitation and hygiene (WASH), education, child protection (including child justice) and social protection. By assessing and analysing the situation for children and women in relation to these outcomes and in relation to relevant Sustainable Development Goals (SDGs), this report seeks to highlight trends, barriers and bottlenecks in the realization of children's and women's rights in Samoa.

Key barriers and bottlenecks

The following key barriers and bottlenecks were identified from the full situation analysis of children and children in Samoa.

Climate change and disaster risks: Samoa is vulnerable to natural hazards such as tropical cyclones, floods and droughts. A key finding of this report is that climate change and disaster risks have a considerable impact on all sectors in relation to the realization of children and women's rights in Samoa. Children, older women and households in coastal regions are particularly vulnerable to disaster and climate risks, including in the areas of health and WASH.

Financial and human resources: Samoa is a lower-middle-income country, and financial constraints act as a barrier to the realization of rights in several sectors. A lack of available resources across nearly all government departments translates into a lack of financial resources for the delivery of services and systems for children, but is also linked to a lack in human resources (training and expertise) in several sectors. Rapid urbanization in Samoa has placed urban service delivery centres such as hospitals and schools under strain. Funding shortages affect the delivery of education, including ECE, as centres are reliant on parents' fees and community and donor funding.

Equity: Several important findings in relation to equity were made, but lack of disaggregated data also prevents a comprehensive equity analysis. In education, hidden costs act as a barrier to the enrolment of children from socio-economically deprived families and remote areas. This is linked to the phenomenon of child street vendors, who

engage in vending in order to fund schooling or as an alternative. Children with disabilities lack adequate access to tailored educational resources and facilities, particularly at secondary level and in rural areas, where 'special schools' are unavailable, resulting in children being kept in the home. Social assistance measures targeted at vulnerable populations are limited.

The **impacts of poverty** are significant in Samoa, and children and families are highly exposed to risk and economic shocks, particularly those caused by natural disasters. Lack of comprehensive social protection and other social welfare services represents a significant gap and limits the ability of the government to lift vulnerable persons out of poverty and support economic growth. Lack of opportunities for adolescents and young people perpetuates cycles of poverty and has led to unhealthy behaviours, such as drug and alcohol abuse, as well as mental health issues.

Cultural norms and approaches: Cultural attitudes within Samoa are changing, with younger parents understanding that corporal punishment of children is not acceptable. However, this stands in contrast with attitudes about violence against women in marriages, which were shown to be permissive and accepting of violence. Reliance on and preference for informal justice lead to the under-reporting of cases involving child sexual abuse, violence against children or other crimes against children, and to such cases being handled within villages. Traditional social support systems are diminishing as a result of monetization and increasing rural-to-urban and overseas migration.

Data availability: There are useful data sources in some sectors in Samoa. However, this report also identified several data gaps, and the absence of this data is, in itself, a key finding. There are notable data gaps in relation to education, such as disaggregated data on the situation of children who do not enrol in or drop out of secondary school. There is also limited to no information on WASH in schools, menstrual hygiene management and access to WASH for vulnerable groups. There is a lack of data on children with disabilities, other vulnerable groups and out-of-school-youth.

Snapshot of outcome areas

Health	Samoa's child mortality rates have been declining steadily over the past decades. As of 2015, it had already met international child mortality reduction targets for 2030, and mortality rates are among the lowest in the PICTs region. Samoa has significant gaps in immunization coverage for all 12 universally recommended vaccines, and has experienced a worrying decline in immunization coverage since 2000 for certain types of vaccines. As of 2013, Samoa had an estimated 29 TB cases per 100,000 population, which places it at the lower end of the regional TB prevalence range. Samoa's adjusted maternal mortality ratio stands at 51 deaths per 100,000 live births, which is already below the SDG target for 2030. Antenatal coverage for at least one visit stands at only 73 per cent, which is in the middle range of the PICTs group. A majority of pregnant women in Samoa give birth in the presence of a skilled health professional (83 per cent) and in a health facility (82 per cent), but significant coverage gaps remain, especially in rural areas. At 27 per cent, Samoa's contraceptive prevalence rate is the fourth lowest in the PICTs region. 35 per cent of married women have an unmet need for family planning. Even though HIV/AIDS prevalence is low in Samoa, rates for sexually transmitted infection are very high, which indicates that the underlying behavioural risks for HIV transmission are also high. Worryingly, 60 per cent of school children aged 13–15 indicated that they had attempted suicide – by far the highest rate in the PICTs group – suggesting that mental health is a serious problem among Samoan adolescents.
Nutrition	In Samoa, around 6 per cent of children under five years are stunted, which compares favourably to regional rates. Up-to-date data on childhood wasting are not available. 2017 survey data from Upolu found that, among the overweight or obese children included in the survey, 29 per cent were also stunted and 43 per cent were anaemic, which indicates dual and/or triple burdens of malnutrition. 10 per cent of Samoa's children have low birthweight, which is in the middle range of the PICTs region. Obesity and associated non-communicable diseases represent a significant health concern. Samoa is witnessing almost epidemic rises in coronary heart disease, stroke, high blood pressure and mature-onset diabetes. 19 per cent of school children aged 13–15 were found to be obese, with higher rates among girls. 51 per cent of children in Samoa receive exclusive breastfeeding for the first six months after birth, which is just above the 50 per cent World Health Organization target for 2025. However, limited maternity leave (currently only four paid weeks) and limited breastfeeding breaks at work discourage exclusive breastfeeding among women in Samoa, who increasingly participate in the labour force.

WASH	Improved water coverage in Samoa stands at a universal 99 per cent, which is significantly above the PICTs average. However, access to improved sanitation facilities is somewhat more restricted, at only 91 per cent. Worryingly, Samoa has experienced a slight decline in sanitation coverage since 1990, when it stood at 93 per cent. Open defecation is no longer practised in Samoa. Climate change and rising sea levels threaten bores with saltwater intrusion, although this primarily affects the northern and eastern parts of Savaii Island.
Education	The net enrolment ratio (NER) for early childhood education (ECE), which is voluntary in Samoa, stood at a low 27 per cent as of 2016. Samoa achieved a 100 per cent primary education NER in 2015 and 2016 – a significant step towards the attainment of universal primary education. The NER for secondary school stood at a lower 68 per cent as of 2016, with a higher proportion of girls enrolled than boys. Repetition of primary schooling is an area of concern, particularly for boys. Teachers are in short supply in primary schools, resulting in multi-grade classes.
Child protection	Despite a relatively robust legal framework that seeks to protect children from violence, available data indicate that children in Samoa experience violence in several contexts, including within the home, in schools and in the community. 41 per cent of school children reported being physically hurt by a teacher at school. 77 per cent of parents reported using physical violence to discipline their children. Sexual abuse is reported to be prevalent; however, there is a lack of up-to-date statistical data on its nature, extent and causes. Child labour in Samoa includes vending, agriculture, domestic work and garbage scavenging. The Child Care and Protection Bill 2015, if enacted, would fill some child protection and child justice gaps, including by setting out an authoritative definition of a child as a person below the age of 18 and by prohibiting child marriage, but it has not yet been passed.
Social protection	Incidence of food poverty in Samoa is low, at only 4.3 per cent as of 2013–2014. However, 19 per cent of the population was found to be living below the basic needs poverty line as of 2013–2014. Households with children and young people are particularly at risk of poverty, as are households in Apia and North-West Upolu. A recent assessment of Samoa's social protection system ranks it at the lower end of the range within the PICTs group in terms of its comprehensiveness and impact. Social insurance is limited to (mostly male) formal sector workers, and excludes the majority of workers who operate in the informal economy. A relatively high proportion of the population receives social assistance benefits, though the value of these is small.

Acronyms

ADB Asian Development Bank
AIDS Acquired Immune Deficiency Syndrome
AusAID Australian Agency for International Development
BCG Bacillus Calmette-Guérin
CAT Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment
CED Committee on Enforced Disappearances
CEDAW Convention on the Elimination of Violence Against Women
CEFM Child, Early and Forced Marriage
CERD Committee on the Elimination of Racial Discrimination
CPIS Child Protection Information System
CRC United Nations Convention on the Rights of the Child
CRPD Convention on the Rights of Persons with Disabilities
DHS Demographic and Health Survey
DTP1 Diphtheria and Tetanus toxoid and Pertussis vaccine first dose
DTP3 Diphtheria and Tetanus toxoid and Pertussis vaccine third dose
EAPRO East Asia and Pacific Regional Office
ECE Early Childhood Education
ECOSOC United Nations Economic and Social Commission
EFA Education For All
FSM Federated States of Micronesia
GADRRRES Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector
GDP Gross Domestic Product
GER Gross Enrolment Ratio
GNP Gross National Product
GSHS Global School-Based Health Survey
HIES Household and Income Expenditure Survey
HIV Human Immunodeficiency Virus
ICCPR International Covenant on Civil and Political Rights
ICESCR International Covenant on Economic, Social and Cultural Rights
ILO International Labour Organization
IPU Inter-Parliamentary Union
ISF Institute for Sustainable Futures
JMP UNICEF/WHO Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
MCV1 Measles Containing Vaccine first dose
MDG Millennium Development Goal
MESC Ministry of Education, Sports and Culture
MHM Menstrual Hygiene Management
MoCIL Ministry of Commerce, Industry and Labour
MP Member of Parliament
MWCSD Ministry of Women Community and Social Development
NCD Non-Communicable Disease
NER Net Enrolment Ratio

NGO Non-Governmental Organization
NHRI National Human Rights Institution
NMDI National Minimum Development Indicator
ODA Official Development Assistance
OECD Organisation for Economic Co-operation and Development
OHCHR Office of the United Nations High Commissioner for Human Rights
PCP Pacific Children's Programme
PICTs The fourteen Pacific Island Countries and Territories that are the subject of the Situational Analyses
PNG Papua New Guinea
PSET Post-School Education and Training
SDG Sustainable Development Goal
SENESE An inclusive education organisation focussing on including children with disabilities into mainstream schools
SitAn Situational Analysis
SOWC State of the World's Children
SPC Secretariat of the Pacific Community
SPI Social Protection Indicator
SPECA Samoa Primary Education Certification Assessment
SPELL Samoa Primary Education Literacy Levels
SP Strategic Programme
SPI Social Protection Indicator
STI Sexually Transmitted Infection
TB Tuberculosis
UN United Nations
UNDP United Nations Development Programme
UNESCAP United Nations Economic and Social Commission for Asia and the Pacific
UNESCO United Nations Educational, Scientific and Cultural Organization
UNICEF United Nations Children's Fund
UNICEF SitAn Procedural Manual UNICEF's 'Guidance on Conducting a Situation Analysis of Children's and Women's Rights' (March 2012)
UNISDR United Nations International Strategy for Disaster Reduction
UPR Universal Periodic Review
US$ United States Dollar
WASH Water Sanitation and Hygiene
WHO World Health Organization

1.

Introduction

1.1. Purpose and scope

This report presents a comprehensive assessment and analysis of the situation of children in Samoa. Its intent is to offer an evidence base to inform decision-making across sectors that are relevant to children and instrumental in ensuring the protection and realization of children's rights. It is, in particular, intended to contribute to the development of programmes and strategies to protect, respect and fulfil the rights of children in the Pacific Island Countries and Territories (PICTs).

In accordance with the approach outlined in UNICEF's Procedural Manual on 'Conducting a Situational Analysis of Children's and Women's Rights' ('UNICEF's SitAn Procedural Manual'), the specific aims of this Situation Analysis (SitAn) are as follows:

- To improve the understanding of all stakeholders of the current situation of children's rights in the Pacific, and the causes of shortfalls and inequities, as the basis for developing recommendations for stakeholders to strengthen children's rights;

- To inform the development of UNICEF programming and support national planning and development processes, including influencing policies, strategies, budgets and national laws to contribute towards establishing an enabling environment for children that adheres to human rights principles, particularly with regard to universality, non-discrimination, participation and accountability;

- To contribute to national research on disadvantaged children and leverage UNICEF's convening power to foster and support knowledge generation with stakeholders; and

- To strengthen the knowledge base to enable assessment of the contribution of development partners, including UNICEF and the UN, in support of national development goals.[1]

This SitAn report focuses on the situation of children (persons aged under 18 years old), adolescents (aged 10–19) and youth (aged 15–24).[2] In addition, it includes an assessment and analysis of the situation relating to women, to the extent that it relates to outcomes for children (e.g. regarding maternal health).

1.2. Conceptual framework

The conceptual framework is grounded in the relationship between child outcomes and the immediate, underlying and structural determinants of these outcomes, and is adapted from the conceptual framework presented in UNICEF's SitAn Procedural Manual. A rights-based approach was adopted for conceptualizing **child outcomes**, which this SitAn presents according to rights categories contained in the UN Convention on the Rights of the Child (CRC). These categories also correspond to UNICEF's Strategic Programme (SP) Outcome Areas. Child outcomes are therefore grouped into Health/nutrition; Water, sanitation and hygiene (WASH) ('survival rights'); Education ('development rights'); Child protection; and Social protection ('protection rights').

The aim of the **child outcomes assessment** component of this SitAn was to identify trends and patterns in the realization of children's rights and key international development targets; and any gaps, shortfalls or inequities in this regard. The assessment employed an equity approach, and highlighted trends and patterns in outcomes for groups of children, identifying and assessing disparities in outcomes according to key identity characteristics and background circumstances (e.g. gender, geographic location, socio-economic status, age or disability).

A number of analytical techniques were employed in the effort to **analyse** immediate, underlying and structural causes of child outcomes. These included:

- **Bottlenecks and barriers analysis:** A structured analysis of the bottlenecks and barriers that children/groups of children face in the realization of their rights, with reference to the critical conditions/determinants[3] (quality; demand; supply and enabling environment) needed to ensure equitable outcomes for children).

1 UNICEF, 'Guidance on Conducting a Situation Analysis of Children's and Women's Rights', March 2012, pp. 5–6, on http://www.unicefinemergencies.com/downloads/eresource/docs/Rights%20based%20equity%20focused%20Situation%20Analysis%20guidance.pdf [30.01.17].

2 These are the age brackets UN bodies and agencies use for statistical purposes without prejudice to other definitions of 'adolescence' and 'youth' adopted by Member States.

3 Based on the 10 critical determinants outlined in Table 3 on page 20 of UNICEF's SitAn Procedural Manual.

The analysis is also informed by:

- **Role-pattern analysis:** The identification of stakeholders responsible for/best placed to address any shortfalls/inequities in child rights outcomes; and

- **Capacity analysis** – to understand the capacity constraints (e.g. knowledge; information; skills; will/motivation; authority; financial or material resources) on stakeholders who are responsible for/best placed to address the shortfalls/inequities.

The analysis did not engage in a comprehensive causality analysis, although immediate and underlying causes of trends, shortfalls or inequities are considered throughout.

The analysis was deliberately risk-informed and took an equity approach. An **equity approach** seeks to understand and address the root causes of inequality so that all children, particularly those who suffer the worst deprivations in society, have access to the resources and services necessary for their survival, growth and development.[4] In line with this approach, the analysis included an examination of gender disparities and their causes, including a consideration of the relationships between different genders; relative access to resources and services; gender roles; and the constraints facing children according to their gender.

A **risk-informed analysis** requires an analysis of disaster and climate risks (i.e., hazards; areas of exposure to the hazard; and vulnerabilities and capacities of stakeholders to reduce, mitigate or manage the impact of the hazard on the attainment of children's rights). This is particularly relevant to the PICTs where climate change and other disaster risks are present. A risk-informed analysis also includes an assessment of gender and the vulnerabilities of particular groups of children to disaster and climate risks.

A rights-based framework was developed for measuring child outcomes and analysing role-patterns, barriers and bottlenecks. This incorporates the relevant rights standards and development targets (in particular the Sustainable Development Goals [SDGs]) in each of the child outcome areas.

Table 1.1: Assessment and analysis framework by outcome area

Outcome area	Assessment and analysis framework
Health and Nutrition	- CRC (particularly the rights to life, survival and development and to health) - SDGs (particularly SDG 3 on ensuring healthy lives and promoting well-being) - Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) - WHO's Global Nutrition Targets (child stunting; anaemia; low birthweight; obesity/overweight; and breastfeeding)

4 UNICEF NYHQ, 'Re-focusing on Equity: Questions and Answers', November 2010, p. 4.

WASH	- CRC (Article 24) - SDGs (particularly SDG 6 on ensuring availability and sustainable management of water and sanitation for all)
Education	- CRC (Articles 28 and 29) - Article 13 of ICESCR - SDGs (particularly SDG 4 on ensuring inclusive and quality education for all and promoting lifelong learning) - Comprehensive School Safety Framework[l]
Child protection	- CRC (Articles 8, 9, 19, 20, 28(2), 37, 39 and 40) - SDGs (particularly SDGs 5, 8, 11 and 16)
Social protection	- CRC (Articles 26 and 27) - ICESCR rights to social security (Article 9) and adequate standard of living (Article 11) - SDG target 1 (end poverty in all its forms everywhere)

1.3. Methods and limitations

This SitAn includes a comprehensive review, synthesis and examination of available data from a variety of sources. The assessment of child outcomes relied primarily on existing datasets from household surveys; administrative data from government ministries and non-governmental organizations (NGOs); and other published reports.[5] Key datasets were compiled from the UNICEF Statistics database (available on https://data.unicef.org/) and the Secretariat of the Pacific Community's (SPC's) National Minimum Development Indicators (NMDI) database (available on https://www.spc.int/nmdi/).[6] The 2016 State of the World's Children (SOWC) report was utilized as it offered the latest available reliable data (available on https://www.unicef.org/sowc2016/). SPC's NMDI database also compiles data produced through national sources.[7] Other institutional databases, such as those of the World Bank, the UNICEF/World Health Organization (WHO) Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP), WHO and the UNESCO Institute of Statistics were also found to be relevant.

The analysis phase required a synthesis and analysis of secondary data and literature, including small-scale studies and reports. It also included a mapping and analysis of relevant laws, policies, and government/SP Outcome Area strategies.

One of the limitations of the methodology is the lack of recent, quality data in relation to some of the areas the analysis covers. Gaps in the availability of up-to-date, strong data are noted throughout the report. The analysis of causes and determinants of rights shortfalls relied heavily

5 These datasets were reviewed and verified by UNICEF.

6 Data from national sources and other reputable sources are compiled and checked for consistency before being registered in the UNICEF Statistics database and used for the annual State of the World's Children Report (SOWC).

7 The database is updated as new data become available.

on existing published reports, some areas in the analysis were not subject to robust and recent research. Gaps are highlighted as necessary.

A further limitation was the tight timeframe and limited duration of this SitAn process. This required the authors to make determinations as to priority areas of focus, which entailed the exclusion of some issues from the analysis. This also led to limitations in the extent of, for example, the causality analysis (which was conducted but does not include problem trees), and the role-pattern and capacity gap analyses, for which information is presented but which were not necessarily performed for all duty-bearers in a formal manner.

1.4. Governance and validation

The development and drafting of this SitAn was guided by a UNICEF Steering Committee (comprising Andrew Colin Parker; Gerda Binder; Iosefo Volau; Laisani Petersen; Lemuel Fyodor Villamar; Maria Carmelita Francois; Settasak Akanimart; Stanley Gwavuya [Vice Chair], Stephanie Kleschnitzki; Uma Palaniappan; Vathinee Jitjaturunt [Chair] and Waqairapoa Tikoisuva), which supported the assessment and analysis process by providing comment, feedback and additional data and validating the contents of this report. This governance and validation the Steering Committee provided was particularly important given the limitations in data-gathering and sourcing set out above.

2. Context

Figure 2.1: Map of Samoa

Source: World Atlas.[8]

8 http://www.worldatlas.com/webimage/countrys/oceania/lgcolor/wscolor.htm [29.06.17].

2.1. Geography and demographics

Samoa is a Polynesian Pacific island country comprising 10 islands, the largest two being Upolu and Savaii. Of the remaining eight smaller islands, three, Manono, Apolima and Namua, are inhabited.[9] Upolu and Savaii are 1,694 km^2 and 1,091 km^2, respectively, and the country's capital, Apia, is located on the main island of Upolu.[10] According to the most recent census (2015), in the 2016 SOWC, Samoa has a population of approximately 193,000, with 85,000 recorded as being under the age of 18. According to the most recent data from the World Bank (2015), men make up 51.6 per cent of the population and women 48.4. Children aged 0–14 make up 37 per cent of the population and people aged 15-64 account for 57 per cent of the population. People over 65 years of age account for only 5 per cent of the total population.[11] Recent assessments from the Pacific Community (SPC) identify a population growth rate of -0.1 per cent in 2015.[12]

The country's official languages are English and Samoan, with an estimated 91 per cent of the population using Samoan as the primary means of communication in the home.[13] Samoa is a Christian majority country. In 2011, 54.7 per cent of Samoans identified as Protestant Christians, 19.4 per cent as Catholic, 15.2 per cent as Mormon, 1.7 per cent as Worship Centre Christians and 5.5 per cent as 'other' Christian.[14]

2.2. Main disaster and climate risks

Similar to many other Pacific Island nations, Samoa experiences increased vulnerability to natural disasters such as cyclones, flooding and earthquakes, all of which are exacerbated by climate change. The risks from climate change and extreme weather conditions are particularly pronounced, as 70 per cent of the population and infrastructure in Samoa is located in low-lying coastal areas.[15]

In the past decade alone, Samoa has experienced four significant natural disasters. In 2009, a tsunami devastated the south-eastern coast of the island of Upolu, leaving 148 dead and affecting a total of 5,584 people. The tsunami caused US$124,040 in damages. Just a few years later, in 2012, Samoa experienced its strongest cyclone since 1991, killing 23 people, affecting

9 MWCSD and UNICEF, 'Child Protection Baseline Report for Samoa', 2013, p. 10, on https://www.unicef.org/pacificislands/Samoa_baseline_27Nov.pdf [19.06.17].

10 Samoa Bureau of Statistics, 'Samoa Demographic and Health Survey 2014', p. 1, on www.sbs.gov.ws/index.php/new-document-library?view=download&fileId=1648 [22.08.17].

11 http://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?locations=WS [23.06.17].

12 SPC, 'Annual Growth Rate in 2015', 2015 Pocket Statistical Summary, on http://prism.spc.int/images/downloads/2015_Pocket-Statistical-Summary.pdf [22.08.17].

13 MWCSD, 'Child Protection Baseline Report for Samoa', 2013, p. 10

14 CIA, 'The World Factbook', 2017, on www.cia.gov/library/publications/the-world-factbook/geos/ws.html [22.08.17].

15 Flores-Palacios, X., 'Samoa: Local Knowledge, Climate Change and Population Movements', May 2015, *Forced Migration Review*, p. 1, on www.fmreview.org/sites/fmr/files/FMRdownloads/en/climatechange-disasters/florespalacios.pdf [22.08.17].

12,703 and causing US$133,000 in damages.[16] The consequences of such disasters have had a significant impact on life in Samoa, affecting transportation infrastructure and water supplies across the islands.[17]

Samoa's most recent National Disaster Management Plan (2011–2014) was approved by the National Disaster Council under Part III Section 9 of the Disaster and Emergency Management Act 2007. The Plan details disaster risk management arrangements to ensure the sustainable mitigation of, preparedness for, response to and recovery from the impact of hazards.[18]

2.3. Government and political context

Samoa achieved independence on 1 June 1962, ending almost 50 years of administration by New Zealand. It is now a parliamentary democracy, with a unicameral legislature, the Fono; a prime minister who selects the Cabinet; and a head of state, elected by the Fono for a period of five years.

Samoa's political landscape is characterized by the coterminous application of both traditional customary legal frameworks and the legislative branch of government. The country is made up of 11 *itumalo* (political districts), each possessing its own constitutional foundation (*faaveae*) and adhering to the traditional orders of precedence found in each district's *faalupega* (traditional salutations).[19] Each of these 11 political districts enjoys a degree of administrative autonomy from the central government.

Equal gender representation in Pacific national parliaments has not yet been achieved. As of March 2017, women members represent 7 per cent of Pacific parliaments. In Samoa, of the current 50 MPs, only five are women. These five are made up of the four elected women representatives, and also the next highest polling woman, included pursuant to the Constitutional Amendment Act (2013), requiring a minimum 10 per cent quota of women's representation in parliament.[20]

The most recent effort to involve young people in governance and decision-making processes in Samoa was the re-establishment of the Samoan National Youth Council, initiated by the Ministry of Women Community and Social Development (MWCSD) through the Division for Youth. Funded by the Australian Agency for International Development's (AusAID's) Pacific Leadership Program in 2009, the initiative began in 2011 and seeks to 'mobilise responsible youth citizenship to lead and help with the implementation of youth development projects and programs'. It places an emphasis on reaching out to young people across Samoa at the village level, drawing on networks

16 CRED database.

17 Pacific Climate Change Science Program, 'Current and Future Climate of Samoa', p. 2, on www.pacificclimatechangescience.org/wp-content/uploads/2013/06/3_PCCSP_Samoa_8pp.pdf [22.08.17].

18 http://www.pacificdisaster.net/pdnadmin/data/original/WSM_2012_NDMP_Final_20111215.pdf [22.08.17].

19 www.samoagovt.ws/about-samoa/ [22.08.17].

20 Pacific Women in Politics, 'National Women MP's', on www.pacwip.org/women-mps/national-women-mps/ [22.08.17].

of young people that already exist within each village to mobilize a national network of young people across the country.[21]

2.4. Socio-economic context

Samoa's most recent national development plan is the Strategy for the Development of Samoa 2016/17–2019/20. This Plan builds on the previous vision of 'an improved quality of life for all', adding 'accelerating sustainable development and broadening opportunities for all'. It has four key priority areas: economic, social, infrastructure and environment.[22]

Samoa's gross domestic product (GDP) per capita was US$761,037,916 in the 2015 fiscal year, exhibiting a growth rate of 1.6 per cent.[23] In the first three quarters of 2016, the country saw increased investment in the main international airport and in the tourism industry and the start of two deep-sea fishing operations.[24] It is projected that real GDP growth will slow from 6.5 per cent in 2016 to an average of 2.3 per cent in 2017–2018.[25]

Samoa is classed as a lower-middle-income country, and received US$93.7 million in official development assistance (ODA) in 2015.[26] In 2014, the net ODA received equalled 40.8 per cent of central government expenses, compared with 56.9 per cent in 2013.[27] As illustrated in Figure 2.2, Samoa received the largest contributions of ODA from Australia (US$27.83 million) and New Zealand (US$17.47 million), followed by significant contributions from Japan (US$13.13 million), the International Development Association (US$11.88 million) and EU institutions (US$10.85 million).[28]

Furthermore, as outlined in Figure 2.3, the largest segment of bilateral ODA received by Samoa in 2014–2015 was spent on economic infrastructure development (32 per cent). A further 21 per cent was allocated to education services.

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21 Samoa National Youth Council Strategic Plan 2013–2016, on www.snyc.org.ws/images/CORE_documents/SNYC_Strategic_Plan_2013-16.pdf [22.08.17].

22 Strategy for the Development of Samoa 2016/17–2019/20, on https://www.mof.gov.ws/Portals/195/EPPD/SDS%201617-1920_Eng.pdf [03.08.17].

23 World Bank, 'Samoa, GDP', on http://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=WS [22.08.17].

24 ADB, 'Asian Development Outlook 2016 Update, Meeting the Low-Carbon Growth Challenge', on https://www.adb.org/sites/default/files/publication/197141/ado2016-update.pdf

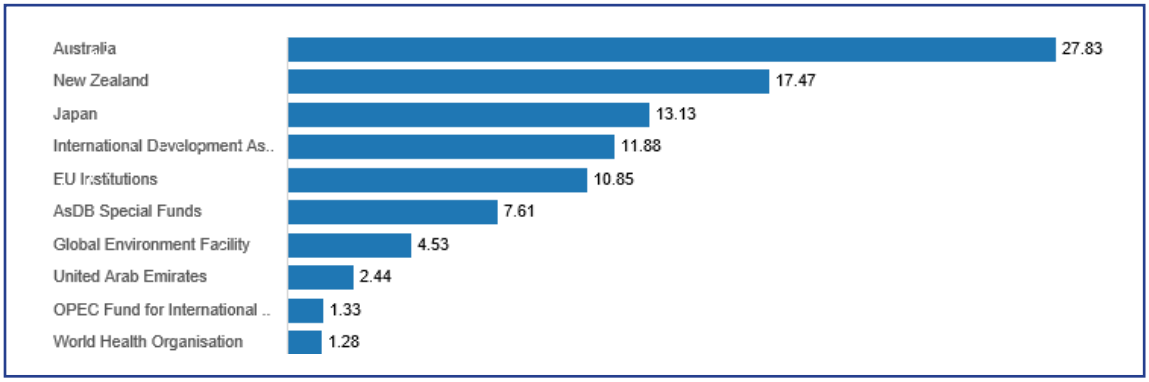
25 Economist Intelligence Unit, cited in The Economist, 'Samoa Country Overview', on http://country.eiu.com/Samoa [22.08.17].

26 OECD, 'Figures by Aid (ODA) Recipients', on www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm [22.08.17].

27 World Bank, 'Net ODA Received', on http://data.worldbank.org/indicator/DT.ODA.ODAT.XP.ZS?end=2013&locations=WS&start=2010&view= Figure [22.08.17].

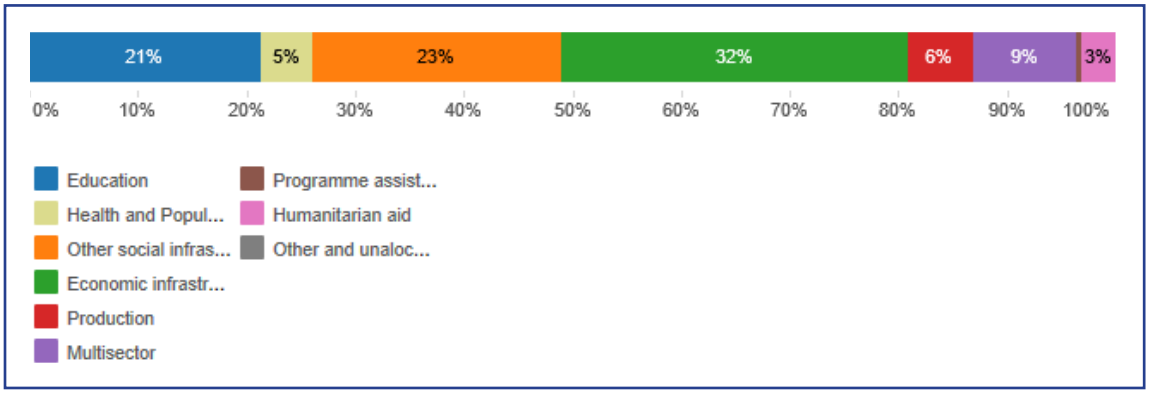
28 OECD, 'Top Ten Donors of Gross ODA for Samoa', on http://www.oecd.org/countries/samoa/aid-at-a-glance.htm [22.08.17].

Figure 2.2: Top ten donors of gross ODA for Samoa, 2014–2015 average (US$ million)



Source: OECD data.

Figure 2.3: Bilateral ODA received by sector for Samoa, 2014–2015 average



Source: OECD data.

The Samoan economy relies heavily on subsistence agriculture, growing cash crops for export alongside remittances from the large numbers of Samoans living abroad, mainly in New Zealand.[29] Samoa ranks as one of the leading recipients of remittances, receiving US$154,243,932 in personal remittances in 2015,[30] accounting for 20.3 per cent of national GDP.[31] This can be attributed to the fact that there are now more ethnic Samoans living abroad than there are in the country.[32]

Like other Pacific Island nations, Samoa's economic prosperity is at risk as a result of natural disasters such as cyclones, earthquakes and tsunamis. At various instances throughout Samoa's recent history, agricultural output and exports (on which the country relies heavily) have been

29 The Commonwealth, 'Samoa: Economy', on http://thecommonwealth.org/our-member-countries/samoa/economy [22.08.17].

30 World Bank, 'Personal Remittances, Received (Current US$)', on http://data.worldbank.org/indicator/BX.TRF.PWKR.CD.DT?end=2015&locations=WS&start=1977&view= Figure [22.08.17].

31 World Bank, 'Personal Remittances, Received (Per Cent of GDP)', on http://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?end=2015&locations=WS&start=1977&view= Figure [22.08.17].

32 Browne, C. and Mineshima, A., 'Remittances in the Pacific Region', Asia and Pacific Department Working Paper, Washington, DC: IMF, 2007, p. 11, on http://www.imf.org/external/pubs/ft/wp/2007/wp0735.pdf [22.08.17].

seriously affected by crop failures caused by serious cyclones. Serious cyclone damage in 1990, 1991 and 1998 had severe impacts on coconut and banana crops, leading to drops in agricultural output and exports. The Samoan government, however, instituted a set of reforms during the 1990s, encouraging privatization and reducing reliance on the agriculture sector. As a result, Samoa experienced an economic turn-around and saw significant growth following this period of downturn. Proving how vulnerable the country is to external shocks, in 2008–2009, a period of positive growth was interrupted by both the global economic recession and, in September 2009, a serious tsunami, which led the economy to contract by 4.8 per cent. Following these events, the economy made positive progress, improving in the years following 2009.[33]

According to the latest data, from the 2016 SOWC, 0.8 per cent of Samoa's population lives below the international poverty line (US$1.90 per day). Samoa's latest Household and Income Expenditure Survey (HIES), conducted in 2013/14, identified that 18.8 percent of the population were living under the national basic needs poverty line.[34]

Of those living below the national poverty line, North-West Upolu and Apia urban areas recorded basic needs poverty levels of 26.8 per cent and 24.4 per cent of the population, respectively. Levels of basic needs poverty among the populations of North-West Upolu and Apia have experienced no significant changes since the previous survey conducted in 2002. There has, however, been an increase in basic needs poverty in rural areas, with levels in the rest of Upolu having risen from 15.1 per cent to 26.6 per cent and those on Savaii from 16.1 per cent to 28.8 per cent.[35]

Levels of inequality in Samoa are high compared with in other countries in the Pacific, as measured by the Gini coefficients.[36] The Gini coefficient in Samoa was 0.56 according to the 2013–2014 HIES. This measurement is generally thought to represent an unreasonable level of inequality (with 0.30–0.35 generally accepted as being 'reasonable'),[37] and is one of the highest among the PICTs. The level of inequality has risen significantly 2002, when it was calculated to be 0.43.[38] The increase in inequality has been attributed to an undermining of traditional systems that promote equitable sharing of resources among community members and a trend towards increased monetization, resulting in the widening of 'the gaps between those operating in the cash economy and those depending on traditional subsistence activities.'[39]

In Samoa, men represent the majority of the labour force, at 39.9 per cent; women account for 24.4 per cent. In the most recent survey, the services sector accounted for the vast majority of

33 The Commonwealth, 'Samoa: Economy', on http://thecommonwealth.org/our-member-countries/samoa/economy [22.08.17].

34 Samoa Bureau of Statistics and UNDP Pacific Centre, 'Samoa Hardship and Poverty Report, Analysis of the 2013/14 Household Income and Expenditure Survey', 2016, on http://www.sbs.gov.ws/index.php/new-document-library?view=download&fileId=2014 [22.08.17].

35 Ibid.

36 The Gini coefficient is a number between 0 and 1, where total equality is equal to 0 and total inequality (one person has everything) is equal to 1.

37 UNESCAP, 'The State of Human Development in the Pacific: A Report on Vulnerability and Exclusion at a Time of Rapid Change', 2014.

38 HIES 2008, p. 34.

39 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific – Samoa Country Case Study', Pacific Social Protection Series, 2012.

total employment, at 79.9 per cent, with 14.4 per cent employed in the industrial sector and a further 5.4 per cent in agriculture. Unemployment in Samoa was most recently recorded at 8.7 percent, with the youth unemployment rate at 19.1 per cent. Furthermore, according to 2012 statistics, the share of youth not in employment, education or training sat at 41.1 per cent.[40]

2.5. Legislative and policy framework

Samoa's judiciary is made up of the Court of Appeal, the Supreme Court, the Magistrates Court, the Land and Titles Court and several specialized district courts, including the Family Court and the Youth Court. Operating alongside the courts are village councils (*fonos*), which may rule on customary matters, as well as some civil and criminal cases.[41] Access to justice is an area that has been given significant attention in recent years. The Samoan Law and Justice Sector was formed in 2008, initiating a process of sector reform. Furthermore, the government of Samoa is in the process of establishing a Community Law Centre, working to provide equal access to justice to all Samoans.[42]

Samoa's Constitution enshrines fundamental human rights for all people, mirroring the Universal Declaration of Human Rights. These include a range of rights provisions: the right to life (Article 5), to personal liberty (Article 6), to freedom from inhumane treatment (Article 7), to freedom from forced labour (Article 8), to a fair trial (Article 9), to freedom of religion (Articles 11, 12), to freedom of speech, assembly, association, movement and residence (Article 13) and to freedom from discriminatory legislation (Article 15).[43]

Understandings of human rights in Samoa are tied to traditional notions of respect, dignity, love, protection and service, called *Fa'asamoa* or 'the Samoan way of life'. Though similar to principles understood to be universal human rights, there is ongoing disagreement over the acceptance of human rights as they are understood universally by much of the Samoan population. Much of the conflict stems from concerns that an acceptance of individualized rights undermines the traditional authority of village leaders.[44]

Samoa's adoption and ratification of international human rights legal frameworks has been uneven. The government ratified the International Covenant on Civil and Political Rights (ICCPR) in 2008; however, it has not yet signed the International Convention on Economic, Social and Cultural Rights (ICESCR). Of particular concern is the fact that Samoa is not party to the Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (CAT) or the International Convention on the Elimination of All Forms of Racial Elimination (CERD).

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40 ILOStat, 'Country Profiles, Samoa', on www.ilo.org/ilostatcp/CPDesktop/?list=true&lang=en&country=WSM [22.08.17].

41 Regional Rights Resource Team, '*Human Rights in the Pacific*', 2016, on http://www.spc.int/wp-content/uploads/2016/12/Human-right-Pacific.pdf [22.08.17].

42 Ibid. See also Human Rights Commission, 'National Report, Samoa', 17 February 2016; Samoa Law and Justice Sector, 'Establishment of a Community Law Centre', 2014, on http://www.samoaljs.ws/english [22.08.17].

43 Regional Rights Resource Team, 'Human Rights in the Pacific'.

44 Office of the Ombudsman and National Human Rights Institution, 'State of Human Rights Report, 2015', on http://www.ombudsman.gov.ws/images/20150806_stateofhumanrightsreport_english.compressed.pdf [22.08.17].

The government has signed and ratified the Convention on the Rights of Persons with Disabilities (CRPD) since 2 December 2016.

Samoa has a long-standing commitment to women's rights, being the first Pacific Island country to ratify the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) without reservation. Furthermore, the government instated the Family Safety Act 2013 to enhance provision for the protection of domestic violence survivors, establishing protection orders and setting out guidelines for police officers dealing with cases of domestic violence.[45]

Samoa has signed and ratified the CRC 1990 and 1994, respectively), and in 2016 ratified the Optional Protocol on the involvement of children in armed conflict and that on the sale of children, child prostitution and child pornography. Importantly, however, Samoa has a reservation to Article 28 (1) (a) of the CRC – the commitment to 'make primary education compulsory and available free to all' – a concern highlighted in the Committee on the Rights of the Child's 2016 Conclusion Observations for Samoa.[46]

2.6. Child rights monitoring

Samoa's record of treaty body reporting has often been poor. As Table 2.1 shows, although the country submitted a report on the CRC in April 2014, it has failed to keep various other treaty body reporting commitments. The most recent records show that it has failed to submit reports on the ICCPR, CEDAW and the Convention on Enforced Disappearances (CED).

Table 2.1: Samoa's treaty-body reporting requirements

Treaty	Date of Signature (S)/ Ratification (R)/Accession (A)[751]	Declaration/ Reservation	Latest Report Submitted	Reporting Status as of March 2016[752]
ICCPR	15 February 2008 (A)	Declaration: compatibility of Art 8(3) and 10(2), (3) with domestic instru-ments	-	Initial report overdue since 15 August 2009

45 State of Human Rights Report 2015.

46 Committee on the Rights of the Child, 'Concluding Observations on the Combined Second to Fourth Period Reports of Samoa, 2016', on http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fWSM%2fCO%2f2-4&Lang=en [22.08.17].

CEDAW	25 September 1992 (A)	-	Combined IV-V report submitted 11 August 2010	VI report due 1 July 2016
CRC	30 September 1990 (S)	Reservation: modification of Art 28(1)(a) requirement	Combined II-IV report submitted 23 April 2014	-
CRPD	24 September 2014 (S)	-	N/A	N/A
CED	6 February 2007 (S) 27 November 2012 (R)	-	-	Initial report overdue since 27 December 2014
1951 Refugee Convention & 1967 Protocal	21 September 1988 (A) 29 November 1994 (A)	-	-	-
CRC OP SC, CP and Child Pornography	29 April 2016 (A)	-	-	-
CRC OP Communications procedure	29 April 2016 (A)	-	-	-

Source: OHCHR[47]

Samoa has also undergone two Universal Periodic Review (UPR) processes (in 2011 and 2016).[48]

47 http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=149&Lang=EN [22.08.17].

48 https://www.upr-info.org/en/review/Samoa [22.08.17].

3.

Health and Nutrition

The situation analysis of child and maternal health in Samoa is framed around the CRC (particularly the rights to life, survival and development and to health) and the SDGs, in particular SDG 3 on ensuring healthy lives and promoting well-being. The following assessment and analysis covers the following broad areas: child mortality, child health, immunization/communicable diseases, maternal health and adolescent health. Furthermore, the situation of child and maternal nutrition in Samoa is analysed regarding the six thematic areas described in WHO's Global Nutrition Targets: childhood stunting; anaemia; low birthweight; obesity/overweight; breastfeeding; and wasting/acute malnutrition. The respective sub-sections set out the specific international development targets pertaining to each thematic area.

Key Health and Nutrition-related SDGs

SDG	Target	Indicator
2.2	By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age
		Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type
3.1	By 2030, reduce the maternal mortality ratio to less than 70 per 100,000 live births	Maternal mortality ratio
		Proportion of births attended by skilled health personnel

3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	Under-5 mortality rate
		Neonatal mortality rate
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases	Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
		TB incidence per 1,000 population
		Malaria incidence per 1,000 population
3.7	By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
		Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group

The analysis here takes a 'health systems approach'. A country's health system includes 'all organisations, people and actions whose primary intent is to promote, restore or maintain health'.[49] According to WHO/UNICEF guidance, the following six building blocks make up a country's health system: 1) leadership and governance; 2) health care financing; 3) health workforce; 4) information and research; 5) medical products and technologies; and 6) service delivery.[50] The analysis of underlying causes of shortcomings and bottlenecks in relation to child (and maternal) health and nutrition in Fiji takes these building blocks of the health system into account (where relevant). Furthermore, cross-references to other relevant parts of the SitAn (e.g. WASH) are made where necessary, given that the causes of shortcomings in health systems are often multifaceted and interlinked with other areas covered in the SitAn.

3.1. Child mortality

Neonatal mortality (0–28 days), infant mortality (under one year) and under-five mortality have been declining in Samoa since the early 1990s. According to the latest national estimates summarized

49 UNICEF and WHO, 'Building Block, Nutrition Integration, and Health Systems Strengthening', 2016, on https://www.unicef.org/supply/files/GLC2_160615_WHO_buildling_blocks_and_HSS.pdf [02.03.17].

50 Ibid.

in the 2016 SOWC dataset, the under-five child mortality ratio in Samoa stands at 18 deaths per 1,000 live births as of 2015, which represents a 44 per cent reduction since 1990. Note that the ratio in Samoa remains somewhat higher for boys (19/1,000) than for girls (16/1,000). According to WHO, half of the deaths of children under age five occur in the first four weeks of life.[51]

The 18/1,000 average under-five mortality ratio means Samoa has already reached SDG 3.2 on under-five child mortality: reduction to at least 25/1,000 by 2030. However, national averages tend to high disparities that may exist across the country.

The infant mortality rate (for under one year olds) was estimated to stand at 15/1,000 as of 2015, which represents a reduction from 26/1,000 in 1990. The SDGs and MDGs do not include an explicit target linked to infant (under-one) mortality, but instead focus on under-five and neonatal mortality. Neonatal mortality in Samoa is estimated to stand at 10 deaths per 1,000 live births. This means the country has also met the SDG 3.2 target for neonatal mortality, which aims for a rate of 12/1,000 by 2030.

As of 2015, the most prominent causes of death in under-five children were pre-term complications (24 per cent), congenital anomalies (24 per cent), other 'unspecified' causes (16 per cent) and pneumonia (9.7 per cent). Other causes were intra-partum complications (7.7 per cent), injury (7 per cent) and neonatal sepsis (5.7 per cent).[52] According to the Institute for Health Metrics, the leading health risk factor for children under five in Samoa, as of 2010, was household air pollution from solid fuels.[53]

According to the most recent UN estimates, from the 2016 SOWC, 78 per cent of children under five with suspected pneumonia in Samoa are taken to a health provider. This rate of health provider access in cases of suspected pneumonia is just above the regional average for East Asia and the Pacific (74 per cent). In Samoa, around 63 per cent of children under five with diarrhoea are estimated to receive oral rehydration salts, which is significantly above the regional average of 47 per cent for East Asia and the Pacific (excluding China).

While the above indicators of child health suggest most Samoan children have adequate access to health care when needed, significant data gaps in relation to child health remain. For example, there appear to be no data on disparities between urban and rural areas (or wealth quintiles) in relation to diarrhoea treatment in Samoa. There are also no quantitative data on the proportion of children with fever receiving antimalarial treatment, the availability of insecticide-treated nets or the proportion of children sleeping under nets in Samoa. The gaps in the data in relation to malaria may not be too problematic, given that there is no risk of malaria transmission in Samoa.[54] However, dengue fever, chikungunya and Zika virus are risks in Samoa.[55]

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51 WHO Country Cooperation Strategy for Samoa 2013–2017, p .38, on http://iris.wpro.who.int/handle/10665.1/7874 [19.04.17].

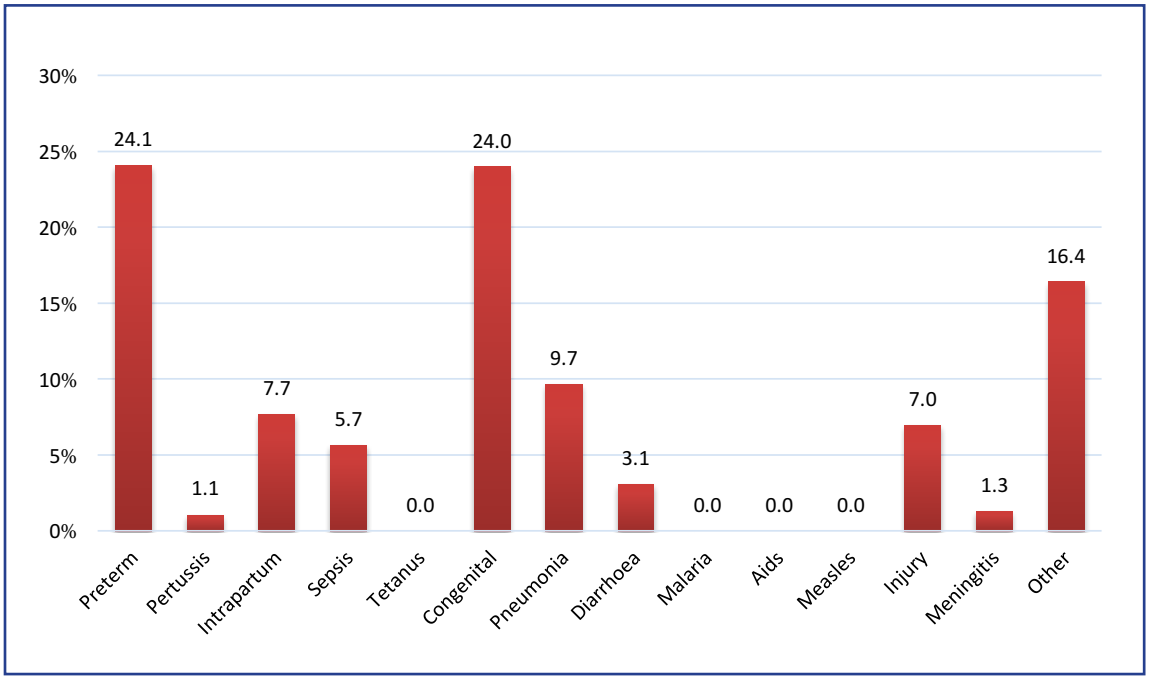
52 UNICEF 2015 data, on https://data.unicef.org/topic/child-survival/under-five-mortality/ [05.06.17].

53 Institute for Health Metrics, 'Global Burden of Disease Study 2010', on http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_samoa.pdf [19.04.17].

54 US Centers for Disease Control, on https://wwwnc.cdc.gov/travel/destinations/traveler/none/samoa [02.03.17].

55 Safe Travel, 'Dengue Fever, Chikungunya and Zika Virus', on https://www.safetravel.govt.nz/news/dengue-fever-chikungunya-and-zika-virus [29.06.17].

Figure 3.1: Causes of death (percentage of all deaths in under-five children)



Source: UNICEF SOWC data 2016.

3.2. Child health, immunization and communicable diseases

Estimates provided by the WHO Global Health Observatory suggest Samoa has significant gaps in immunization coverage for all 12 universally recommended vaccines.[56] For seven out of 12 recommended vaccines, Samoa has reached a less than 70 per cent coverage rate, and none of the recommended vaccines have reached coverage rates of over 90 per cent. The WHO data also suggest Samoa has experienced a worrying decline in immunization coverage since 2000, at least for certain types of vaccines (e.g. BCG, DTP1, DTP3 and MCV1).

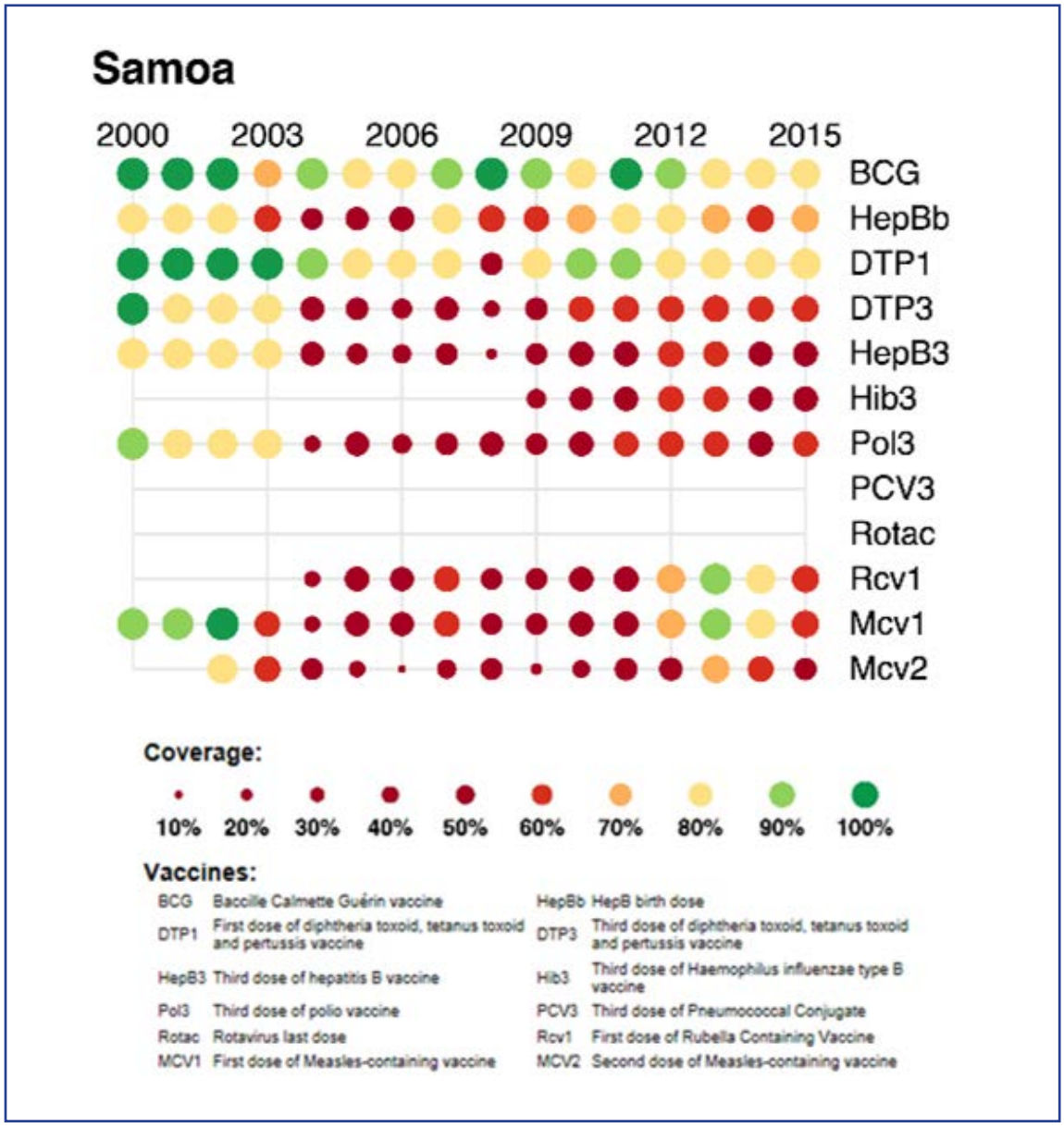
SDG target 3.3 encourages all countries to eradicate TB by 2030. The total number of TB cases in Samoa is estimated to stand at 19, as of 2015.[57] NMDI data estimate Samoa's TB prevalence rate at 29 per 100,000, as of 2013, which is at the very low end of the prevalence range within the PICTs group.[58]

56 These WHO estimates are based on data officially reported to WHO and UNICEF by UN Member States as well as data reported in the published and grey literature. The WHO's immunization coverage data are reviewed and the estimates updated annually. See http://apps.who.int/gho/data/node.wrapper.immunization-cov?x-country=WSM [02.03.17].

57 WHO, 'Tuberculosis Country Profile for Samoa', on http://www.who.int/tb/country/data/profiles/en/ [10.04.17].

58 https://www.spc.int/nmdi/communicable_diseases [10.04.17].

Figure 3.2: Immunization coverage in Samoa (percentage of target population)



Source: WHO Global Health Observatory, Immunization Punch Charts, 2017.[59]

3.3. Maternal health

According to SDG 3.1, countries should aim to reduce the maternal mortality ratio to less than 70 per 100,000 live births. According to latest UN estimates, from 2016, Samoa's ratio stands at

59 http://apps.who.int/gho/data/node.wrapper.immunization-cov [25.05.17]. Note that the target population differs depending on the specific vaccine. For more information see https://data.unicef.org/topic/child-health/immunization/ [25.05.17].

51 per 100,000 live births, which is already below the SDG target for 2030.[60] MDG 5 (target 5.1) encouraged countries to reduce their ratio by 75 per cent between 1990 and 2015. As of 2015, according to the 2016 SOWC, Samoa had reduced its ratio by 67 per cent, compared with the 1990 rate of 156/1,000, which means the country missed this MDG target. It was not possible to obtain data on the immediate causes of maternal death in Samoa.[61]

Under Article 24(2)(d) of the CRC and CRC General Comment No. 15 on the Right of the Child to the Highest Attainable Standard of Health, paragraphs 51–57, Samoa has an obligation to ensure appropriate pre- and post-natal health care for mothers. Estimated antenatal coverage for at least one visit stands at 93 per cent in Samoa, according to the 2016 SOWC dataset, which is near-universal coverage but suggests there are still some gaps in coverage. Antenatal coverage for at least four visits is estimated to stand at a lower 73 per cent, which suggests families need to be incentivized to make more regular visits to clinics for antenatal checks. The 2016 SOWC data also suggest that an overwhelming majority of pregnant women in Samoa give birth in the presence of a skilled health professional (83 per cent in 2015) and in a health facility (institutional delivery in 82 per cent of cases), but that significant gaps in coverage remain. Caesarean sections are carried out in 5 per cent of births in Samoa.

Importantly, there are large disparities between urban and rural areas in relation to births attended by a skilled health professional. While 97 per cent of births in urban areas are attended by a skilled health professional, this percentage drops to a much lower 79 per cent in rural areas of Samoa. Overall, pre- and post-natal health care coverage for mothers in Samoa thus appears to have significant gaps, which are primarily concentrated in rural areas of the country.

The data suggest disparities also exist between rich and poor inhabitants of Samoa. For example, the UN estimates that 94 per cent of pregnant women in the richest wealth quintile[62] give birth in the presence of a skilled health professional, while only 72 per cent of pregnant women in the poorest wealth quintile do so.

3.4. Violence against women and girls

Violence against women and girls is a key public health concern, and the data that exist suggest it is a significant problem in Samoa. According to a Samoa Family Health and Safety study in 2006, 38 per cent of ever-partnered women experience physical violence at the hands of an intimate partner, 19 per cent experienced emotional abuse and 20 per cent experience sexual violence in their lifetime (see Chapter 6 on 'Child Protection' below for a more detailed discussion of violence

60 https://data.unicef.org/topic/maternal-health/maternal-mortality/ [03.03.17]. Note that these UN estimates do not necessarily match with the ratio recorded in the SOWC 2016, which is based on data reported by national authorities. The World Bank and the United Nations Population Division produce internationally comparable sets of maternal mortality data that account for the well-documented problems of under-reporting and misclassification of maternal deaths, and are therefore preferable.

61 WHO and Asia Pacific Observatory on Health Systems and Policy, 'Samoa Health Systems Review', 2015, on http://iris.wpro.who.int/handle/10665.1/11355 [30.03.17].

62 The richest 20 per cent of households in Samoa.

against women and girls).[63] The report found that ever abused respondents were significantly more likely to report pain compared to those who have never been abused while emotional and sexual abuse could have contributed to low self-esteem and a heightened perception of health problems.

3.5. Adolescent health

Adolescents aged 10–19 make up 22 per cent of the total population of Samoa, which, according to the 2016 SOWC data, is a significantly higher proportion than the regional average of 13 per cent for East Asia and the Pacific.

3.5.1. Fertility and contraceptive use

According to the most recent World Bank estimates from 2015, the adolescent fertility rate in Samoa stands at 24 (births per 1,000 women aged 15–19), which is slightly higher than the regional average of 22/1,000 for East Asia and the Pacific. In Samoa, the adolescent fertility rate has decreased drastically since the 1960s, when it stood at 77/1,000, and, after a short increase from 33 to 45/1,000 in the mid-1990s, it has been further declining since.[64]

2016 SOWC data on marriage rates among the adolescent population group highlight significant inequities between genders: while the percentage of adolescent men currently married or in union is estimated to be at 1 per cent, the percentage increases to 13 per cent when looking at women in this age group. The marriage rate for adolescent girls is significantly higher than the regional average of 6 per cent for East Asia and the Pacific. Previous research has shown that early marriage reduces the likelihood that married women will have equal decision-making power in relation to family planning and contraceptive use.[65] Pregnancies are also quite common among under-18 year olds in Samoa. The 2016 SOWC data suggest that, by the age of 18, roughly 6 per cent of girls have become mothers, with consequent impacts on their educational and economic prospects and those of their children, as children of teenage mothers tend to have poorer health and education outcomes.

It is estimated in the 2016 SOWC dataset that contraceptive prevalence[66] in Samoa stands at around 27 per cent of the population, which is significantly lower than the regional average of 64 per cent for East Asia and the Pacific and the MDG target of 56 per cent.[67] DHS data from 2014 suggests contraceptive use is somewhat higher among women in urban areas (33 per cent) than in rural areas (26 per cent).[68]

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63 Pacific Community, 2006, 'The Samoa Family Health and Safety Study', on http://pacific.unfpa.org/sites/default/files/pub-pdf/SamoaFamilyHealthandSafetyStudy.pdf [11.04.17].

64 http://data.worldbank.org/indicator/SP.ADO.TFRT?locations=WS [07.03.17]. The regional average includes China.

65 Plan International, 'Getting the Evidence: Asia Child Marriage Initiative', on https://plan-international.org/publications/getting-evidence-asia-child-marriage-initiative [29.03.17].

66 Contraceptive prevalence is typically defined as the percentage of women of reproductive age who use (or whose partners use) a contraceptive method at a given point in time. Women 'of reproductive age' is usually defined as women aged 15–49. See e.g. http://indicators.report/indicators/i-29/ [21.03.17].

67 The regional average excludes China.

68 DHS 2014.

Low contraceptive prevalence (and, as a result, high fertility rates) in Samoa appear, in part, to result from supply-side constraints. DHS data from 2014 suggest that 62 per cent of women married or in union have a need for family planning services, and that, overall, 35 per cent of women have an *unmet* need for family planning, with the unmet need for limiting (18 per cent) being greater than the unmet need for spacing (17 per cent). In addition to supply-side constraints, there appear to be important demand-side constraints restricting access to reproductive health and family planning services. For example, the 2014 DHS found that 57 per cent of non-users of contraception were opposed to family planning *in principle*, 3 per cent indicated that their husbands or partners were opposed to family planning and 11 per cent cited health concerns to justify not using contraceptives. These findings highlight the importance of increasing knowledge and awareness about modern family planning methods among current non-users.

3.5.2. HIV/AIDS and sexually transmitted infections

According to the 2016 Global AIDS Response Progress Report, Samoa is a low-HIV prevalence. The total number of Samoans estimated to be living with HIV in 2016 was 11, and the prevalence rate was estimated to be 0.005 per cent.[69] According to the SOWC 2016 dataset, HIV prevalence among young people (aged 15–24) in Samoa was estimated to stand at 0 per cent as of 2013. HIV transmission in Samoa appears to be primarily heterosexual and, as of 2016, there were six cases of mother-to-child transmission. The last reported new case of HIV was reported in 2013.

While a substantial majority (86 per cent) of young people aged 15–24 in Samoa have heard of HIV/AIDS, knowledge of HIV prevention methods is lowest among this age group. Overall, the percentage of individuals with comprehensive knowledge of HIV/AIDS transmission and prevention is still very low in Samoa (with only 6.5 per cent of women and 6.4 per cent of men).[70] As suggested above in relation to family planning methods, these figures highlight the importance of increasing knowledge and awareness about HIV/AIDS, especially among young Samoans.

Sexually transmitted infection (STI) rates are very high in Samoa, which may indicate that the underlying behavioural risks for HIV transmission are high. This raises concerns about potential future increases in HIV/AIDS cases. In particular, chlamydia rates in Samoa are high compared with the regional average for the Pacific.[71] Data presented in the 2016 Global Aids Progress report for Samoa suggest chlamydia prevalence stood at 26 per cent as of 2015. Apart from STI testing during antenatal consultations, STI testing is not compulsory in Samoa, which may to some extent explain the very low testing rate.[72]

3.5.3. Substance abuse

According to SDG target 3.5, Samoa should strengthen the prevention and treatment of substance abuse, covering narcotic drug abuse and harmful use of alcohol, including among adolescents. To

69 Ministry of Health, 'Samoa Global AIDS Response Progress Report 2016', on http://www.aidsdatahub.org/samoa-global-aids-response-progress-report-2016-ministry-health-2016 [08.03.17].

70 Samoa Global AIDS Response Progress Report 2016.

71 NDMI data, on https://www.spc.int/nmdi/sexual_health [19.04.17].

72 Samoa Global AIDS Response Progress Report 2016, p. 6.

our knowledge, the most important data source here is the Global School-Based Health Survey (GSHS), implemented in Samoa in 2011 using a nationally representative sample of 2,418 pupils aged 13–15 (in Grades 9–10).[73] The GSHS data suggest alcohol consumption among adolescents is quite common in Samoa: around one in three pupils (34 per cent) indicated they had consumed alcohol in the 30 days before the survey was implemented. Of those who had ever consumed alcohol, 87 per cent reported having consumed it before the age of 14 years. Alcohol consumption appears to be significantly higher among boys (43 per cent) than among girls (25 per cent).[74]

A 2010 study in rural Samoa (Savaii) confirmed significant gender differences in reported alcohol consumption, although this covered over-40 year olds only.[75] While almost all females in the random sample (97 per cent) reported abstaining from all alcohol in the past year, only 59 per cent of male respondents reported doing so. The authors attribute this to dominant cultural practices in rural Samoa, which tend to financially disempower women and girls. For example, money women receive through commerce, employment or remittance often must be given to the (male) chief of the family, which, according to the study, strongly discourages alcohol purchases by women.

According to the 2011 GSHS data, more than half of all pupils (77 per cent) indicated they had used drugs before the age of 14, with rates the same for boys and girls. A total of 33 per cent indicated that they had previously consumed marijuana, with boys (again) significantly more likely to report consuming marijuana (43 per cent) than girls (25 per cent).[76] And 34 per cent of pupils indicated that they had used tobacco products during the previous 30 days, with boys more likely to use tobacco (42 per cent) than girls (25 per cent). Tobacco use is the only risk factor common to all four main non-communicable diseases (NCDs) and exacerbates virtually all of them.[77]

3.5.4. Mental health

The Legislative Assembly of Samoa enacted the Samoan Mental Health Bill in early 2007, making provisions for the care, support, treatment and protection of persons with a mental disorder.[78] Yet mental health continues to be a significant problem in Samoa, especially among adolescents. For example, the 2011 GSHS data indicate that around two in three pupils (60 per cent) had attempted suicide during the 12 months before the survey was implemented. Male pupils were slightly more likely to report having attempted suicide (67 per cent) than female pupils (54 per cent).[79] WHO also acknowledges that suicide remains a major problem in Samoa, particularly among young people.[80]

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73 2011 GSHS Samoa Factsheet, on http://www.who.int/chp/gshs/Samoa_2011_GSHS_FS.pdf?ua=1 [19.04.17]

74 This difference is statistically significant at the 95 per cent threshold.

75 Barnes, S. et al., 'Alcohol Consumption and Gender in Rural Samoa', *Substance Abuse and Rehabilitation*, 2010, on https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3819185/ [21.03.17].

76 This difference is statistically significant at the 95 per cent threshold.

77 The four main NCDs are diabetes, cardiovascular disease, cancer and chronic respiratory disease. See World Bank, 'Pacific Possible: Health & Non-Communicable Diseases', on http://pubdocs.worldbank.org/en/942781466064200339/pacific-possible-health.pdf [21.03.17].

78 WHO, 'Mental Health in Samoa', on http://www.who.int/mental_health/policy/country/samoa/en/ [21.03.17].

79 Note that the difference is not significant at the 95 per cent threshold.

80 WHO, 'Mental Health in Samoa'.

Beyond the GSHS data, it appears there are no quantitative data on the mental health of adolescents and children in Samoa. As a result, little is known about the mental health of Samoan youth outside of the 13–15 age range captured in the GSHS. Furthermore, there are no quantitative data on mental health indicators among out-of-school youth.

WHO's Country Cooperation Strategy for Samoa 2013–2017 notes that there has been limited progress in mental health care in the Pacific during the past decade, while trends for substance abuse, addictive behaviours, depression and suicide have been increasing. It also suggests that one of the main barriers preventing the successful implementation of mental health programmes relates to the social stigmatization of mental illness.[81]

Confirming this narrative in the context of Samoa, a 2009 qualitative situation analysis of youth mental health in Samoa found dominant socio-cultural norms stigmatized mental health and often prevented young people from accessing mental health services for fear of 'tainting' the image of their family. The study suggests that, in Samoan society, shame is frequently apportioned to the whole family rather than the individual, which appears to put additional stress on both parents and young people in need of help.[82]

3.6. Nutrition

According to WHO's Global Nutrition Targets, Fiji should, by 2025, aim to, achieve results in relation to stunting, anaemia, low birthweight, childhood overweight, exclusive breastfeeding in the first six months and childhood wasting.[83]

WHO Global Nutrition Targets

	Target	Indicator
1	By 2025, achieve a 40 per cent reduction in the number of children under 5 who are stunted	Prevalence of stunting (low height-for-age) in children under 5 years of age
2	By 2025, achieve a 50 per cent reduction of anaemia in women of reproductive age	Percentage of women of reproductive age (15–49 years of age) with anaemia
3	By 2025, achieve a 30 per cent reduction in low birthweight	Percentage of infants born with low birthweight (< 2,500 g)

81 P. 14

82 Foundation of the Peoples of the South Pacific International, 'Youth and Mental Health in Samoa: A Situational Analysis', 2009, on https://fspiblog.files.wordpress.com/2011/08/samoa-youth-and-mental-health-situational-analysis-09.pdf [08.03.17].

83 WHO, Nutrition, on http://www.who.int/nutrition/global-target-2025/en/ [02.03.17].

4	By 2025, ensure there is no increase in childhood overweight	Prevalence of overweight (high weight-for-height) in children under 5 years of age
5	By 2025, increase the rate of exclusive breastfeeding in the first 6 months up to at least 50 per cent	Percentage of infants less than 6 months of age who are exclusively breastfed
6	By 2025, reduce and maintain childhood wasting to less than 5 per cent	Prevalence of wasting (low weight-for-height) in children under 5 years of age

3.6.1. Child stunting and wasting

According to the most recent UN-validated data, prevalence of moderate or severe child stunting (short height-for-age or 'chronic malnutrition') in children under five years in Samoa is estimated to stand at 6.4 per cent.[84] This compares favourably with the regional average for East Asia and the Pacific, which stands at 11 per cent as of 2015 (2016 SOWC dataset). However, a recent cross-sectional community-based survey implemented on the island of Upolu found moderate or severe stunting in 20 per cent of children, which is significantly higher than the UN estimate. The study also found that stunting was significantly less likely among girls than among boys.[85]

No up-to-date national data appear to exist on childhood wasting (low weight-for-height or 'acute malnutrition') in Samoa. Out-dated UN estimates (from 1999) suggest childhood wasting stood at around 1.3 per cent at the start of the millennium, which would mean Samoa has already accomplished WHO's childhood wasting reduction target for 2025, assuming rates have remained stable since then.[86]

3.6.2. Anaemia

Globally, it is estimated that maternal anaemia (low levels of functioning red blood cells) accounts for around 20 per cent of maternal deaths,[87] increasing the risk of blood loss at delivery and post-partum haemorrhage.[88] The nutritional status of the mother during pregnancy and lactation can also affect the health and nutritional status of the child. For example, anaemic mothers are at greater risk of delivering premature and low-birthweight babies, who also have an increased risk of dying.[89] De-worming and iron supplementation can be effective in reducing anaemia in pregnant women as well as children.[90]

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84 UNICEF statistics, on https://data.unicef.org/country/wsm/ [20.04.17].

85 Choy et al., 'Child, Maternal and Household-Level Correlates of Nutritional Status: A Cross-Sectional Study among Young Samoan Children', *Public Health Nutrition*, 2017, on www.ncbi.nlm.nih.gov/pubmed/28162141 [19.04.17].

86 World Bank data, on http://data.worldbank.org/indicator/SH.STA.WAST.ZS?locations=WS [19.04.17].

87 Black, R.E. et al. 'Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences', *Lancet*, 2008.

88 See e.g. K4Health, 'Anaemia Prevalence, Causes, and Consequences', on https://www.k4health.org/toolkits/anemia-prevention/anemia-causes-prevalence-impact [13.08.17].

89 Ibid.

90 See e.g. WHO, 'The Global Prevalence of Anaemia in 2011', 2011, p. 5, on http://apps.who.int/iris/bitstream/10665/177094/1/9789241564960_eng.pdf [31.05.17].

Anaemia, child stunting and overweight appear often to go hand-in-hand in Samoa. For example, the 2017 survey study implemented in Upolu, mentioned above, found that, among the overweight or obese children included in the survey, 29 per cent were also stunted and 43 per cent were anaemic, which indicates a dual and/or triple burden of malnutrition. The study also found that anaemia was more likely in children with an anaemic mother.[91]

3.6.3. Low birthweight and underweight

The SOWC 2016 data indicate that 10 per cent of Samoan children have low birthweight. There appear to be no up-to-date national estimates of underweight prevalence in children under five or of disparities between urban and rural areas in relation to underweight prevalence. Out-dated NMDI data from 1999 suggest underweight affects 1.9 per cent of children under five years, but it is not clear whether rates have remained stable since then.[92]

3.6.4. Obesity

According to WHO, obesity is the single most serious threat to health in Samoa, contributing to the high burden of NCDs, especially diabetes, cardiovascular disease and hypertension.[93] Estimates provided by the Institute of Health Metrics show the leading causes of ill-health and death in Samoa in 2010 were NCDs (diabetes: 9 per cent of years of life lost; stroke: 5 per cent; ischemic heart disease; 4 per cent; chronic heart disease: 2.5 per cent), followed by some communicable diseases (lower respiratory infections: 6 per cent), pre-term birth complications (3 per cent) and injuries (interpersonal violence: 2 per cent, road injuries: 2 per cent). While the overall disease burden of injuries, communicable diseases and pre-term birth complications has been on the decline since the 1990s, the disease burden of NCDs has increased rapidly, with Samoa witnessing almost epidemic rises in coronary heart disease, stroke, high blood pressure and mature-onset diabetes.[94]

WHO attributes the rise in obesity rates and the dramatic increase in the burden of associated NCDs to changing diets, the increased use of tobacco and alcohol and limited public understanding of the associated health risks.[95]

National estimates of obesity prevalence in children and adolescents appear to be very limited. According to the 2011 GSHS, 19 per cent of school children aged 13–15 can be considered obese, with obesity prevalence somewhat higher among girls (22 per cent) than among boys (15 per cent). This places Samoa in the middle range among countries in the PICTs region (see Figure 3.3).

91 Choy et al., 'Child, Maternal and Household-Level Correlates of Nutritional Status'.

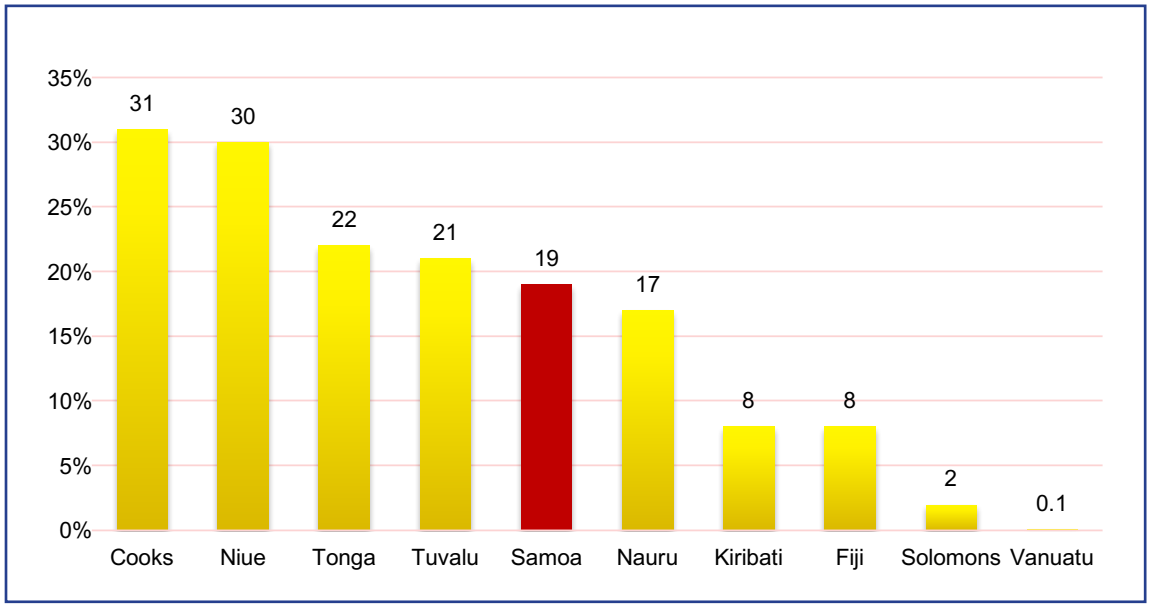
92 https://www.spc.int/nmdi/child_health [19.04.17].

93 WHO Country Cooperation Strategy for Samoa 2013–2017.

94 Institute of Health Metrics, 'Global Burden of Disease Study 2010'; see also WHO Country Cooperation Strategy for Samoa 2013–2017, p. 38.

95 WHO Country Cooperation Strategy for Samoa 2013–2017, p. 38.

Figure 3.3: Obesity prevalence in school children aged 13–15



Source: GSHS 2010–2016.[96]

The 2014 DHS contains nationally representative estimates of obesity in 15–49-year-old women, which suggests obesity is a significant problem in Samoa. The DHS found that more than every second women in Samoa (57 per cent of 15–49 year olds) were obese. Prevalence of obesity among 15–19 year olds was found to be somewhat lower (21 per cent), increasing for subsequent age groups, which the report attributes to retention of pregnancy weight gain. The DHS also found obesity rates to be significantly higher in rural areas (compared with urban areas), and higher among more educated and wealthier individuals.

3.6.5. Breastfeeding

WHO recommends that infants be exclusively breastfed for the first six months of life to achieve optimal growth, development and health.[97] According to the most recent UN estimates, in the 2016 SOWC dataset, 51 per cent of children in Samoa receive exclusive breastfeeding for the first six months after their birth, which is just above the 50 per cent target set out in WHO's 2025 Global Nutrition Targets. The SOWC estimates also suggest that, in 88 per cent of births in Samoa, breastfeeding is initiated within one hour. Continued breastfeeding rates (for the first two years after birth) are estimated to stand at 74 per cent.[98]

According to a 2017 study on breastfeeding practices in Samoa, exclusive breastfeeding rates have declined significantly over the past century. The study suggests that, traditionally, nearly all babies in Samoa were breastfed, and young mothers would rely on their extended families for financial

96 GSHS data were collected from 13–15-year-old school children between 2010 and 2016. Data were compiled from 10 GSHS factsheets. See http://www.who.int/chp/gshs/factsheets/en/ [30.05.17].

97 http://www.who.int/elena/titles/exclusive_breastfeeding/en/ [13.04.17].

98 See https://data.unicef.org/country/wsm/ [08.03.17].

support during this time. Nowadays, the study argues, limited maternity leave (currently only four paid weeks) and limited breastfeeding breaks at work discourage exclusive breastfeeding among women in Samoa, who increasingly participate in the labour force. On a positive note, study respondents identified doctors and health care workers as the two factors that most encouraged breastfeeding, which suggests health professionals have the potential to increase breastfeeding rates through awareness-raising.[99]

3.7. Barriers and bottlenecks

3.7.1. Climate and disaster risks

Samoa is vulnerable to natural hazards such as tropical cyclones, floods and droughts.[100] Climate change and extreme weather increase the threat of both communicable and non-communicable diseases, and can exacerbate existing bottlenecks and create additional barriers for Samoans wanting to access health care.[101] According to a recent WHO assessment report, the key climate-sensitive health risks in Samoa are vector-, water- and food-borne diseases, malnutrition, NCDs and mental health issues. The report identifies children, older women and individuals living in coastal regions as being particularly vulnerable to climate-sensitive-health risks.[102]

WHO's Country Cooperation Strategy for Samoa 2013–2017 also anticipates that climate-related health problems will be borne disproportionately by certain vulnerable sectors of the population – the very poor, young children, the elderly, people with disabilities, people with pre-existing illnesses (e.g. NCDs) and individuals in certain occupations (e.g., farmers, fishers and outdoor workers).[103]

3.7.2. Health care financing

The fundamental barrier to more rapid progress for Samoa's health system is the inadequate financing of its health services. Overall, health financing in Samoa is insufficient, and per capita spending is below the regional average for the PICTS group.[104]

Samoa's health care system is mainly publicly financed, with the government contributing 91 per cent of all health expenditure and private expenditure accounting for 9 per cent. Samoa's expenditure on health as a percentage of GDP stood at 7 per cent in 2014, the latest year for which

99 Archer et al., 'Breastfeeding in Samoa: A Study to Explore Women's Knowledge and the Factors which Influence Infant Feeding Practices', *Hawaii J Med Public Health*, 2017, on www.ncbi.nlm.nih.gov/pmc/articles/PMC5226017/ [08.03.17].

100 WHO, 'Human Health and Climate Change in Pacific Island Countries', 2015, p. 86, on http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303_eng.pdf [13.03.17].

101 WHO Country Cooperation Strategy for Samoa 2013–2017.

102 WHO, 'Human Health and Climate Change in Pacific Island Countries', p. 88. http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303_eng.pdf [13.03.17]. p. 88.

103 WHO Country Cooperation Strategy for Samoa 2013–2017, p. 12.

104 NMDI data, on https://www.spc.int/nmdi/health_systems [12.04.17].

estimates are available.[105] This places Samoa in the middle of the range on health expenditure as a percentage of GDP, compared with other countries in the PICTS region, and means it performs just above the WHO-recommended 5 per cent of GDP.

As a percentage of total government expenditure, health expenditure stands at 14 per cent as of 2013, the most recent year included in the NMDI database. This puts Samoa in the middle of the range of government health expenditure, compared with other countries in the PICTS region. Based on information provided in the National Health Plan for 2008–2018, most of the Ministry of Health budget goes into curative, treatment and rehabilitation, with only 6 per cent of expenditure going into health promotion and prevention of diseases.[106]

The WHO data indicate that total health expenditure per capita has increased steadily since the mid-1990s: in 1995 it stood at US$61 and by 2014 it stood at US$301. The latest NMDI regional data suggest Samoa's per capita expenditure on health is **at the lower end of the range in the PICTS group**, with only Solomon Islands, Tonga, Kiribati, Fiji, Papua New Guinea (PNG) and Vanuatu spending less.

The National Health Sector Plan 2008–2018 anticipates that rising costs associated with overseas treatment, rising health care expectations among the Samoan population and additional costs related to the growing disease burden of NCDs represent critical bottlenecks for Samoa's health care budget. The Plan warns that, if NCD prevalence continues to increase at current rates, the Samoan government and health care system will not be able to sustain financing at current levels.[107]

3.7.3. Health workforce

Health workforce shortcomings also pose a significant threat to the successful implementation of Samoa's health programmes and to the achievement of health-related development goals.[108] The ratio of medical providers to population in the country is quite low. Samoa has about 1.5 nurses per 1,000 individuals, compared with the PICTS regional average (including PNG) of 3.6. Samoa also only has 0.5 physicians per 1,000 individuals, which is significantly below the PICTS average (including PNG) of 0.9.[109]

There is little information on the underlying causes of Samoa's low health workforce coverage, but it appears that shortages are related to insufficient investment in training facilities and that the Samoan government is aware of this problem. For example, the National Health Sector Plan for 2008–2018 highlights the important roles of the 'National University of Samoa, School of Nursing and Natural Science and The Oceania University of Medicine in meeting the challenge of ensuring adequate numbers of trained health professionals to meet the demand for health care services in Samoa'.[110]

105 WHO, Global Health Expenditure Database', on http://apps.who.int/nha/database/ViewData/Indicators/en [21.03.17].

106 http://www.wpro.who.int/health_services/samoa_nationalhealthplan.pdf?ua=1 [21.03.17].

107 P. 43.

108 WHO Country Cooperation Strategy for Samoa 2013–2017, p. 18.

109 NMDI data, on https://www.spc.int/nmdi/health_systems [20.03.17].

110 P. 45.

3.7.4. Service delivery

Tertiary-level health services in Samoa are delivered primarily through the National Tupua Tamasese Meaole Hospital located on the main island of Upolu, which also functions as a referral point for all cases requiring treatment outside of Samoa (mostly in New Zealand). The Malietoa Tanumafili II Hospital in Savaii is the main referral hospital for that island, but this provides only limited tertiary health care. Community health centres located in the villages are responsible for health promotion and some preventative care services.[111]

Outside of the public health service, there are 14 general medical practitioners' offices in Samoa, two private dentists, one private nursing service and four private pharmacies. NGOs, traditional healers and traditional birth attendants also play an important role in providing care, especially in rural areas of the country.[112]

It appears that health services in the urban Apia area have come under increasing pressure as a result of Samoa's rapid urbanization, with the Tupua Tamasese Meaole Hospital reportedly having a congested outpatient and emergency unit.[113]

111 Ibid, p.44.

112 Ibid.

113 Ibid., p .33.

4.

Water, Sanitation and Hygiene

Ensuring all children have access to safe and affordable drinking water, as well as adequate sanitation and hygiene, is crucial to achieving a whole range development goals related to health and nutrition as well as education. For example, a lack of basic sanitation, hygiene and safe drinking water has been shown to contribute to the spread of water-related diseases (including diarrhoea), which are in turn a significant cause of under-five child mortality in the Pacific region.[114] Existing evidence also suggests that poor WASH access is linked to growth stunting.[115] Furthermore, there is growing evidence that clean water and sanitation facilities (at home and in schools) can improve school attendance and even learning outcomes for boys and girls.[116] This chapter assesses and analyses the situation in Samoa regarding children's access to improved water sources and sanitation facilities, as well as children's hygiene practices, using SDGs 6.1, 6.2 and 1.4 as set out in the below table as benchmarks.

The WHO/UNICEF JMP has produced estimates of global progress (WASH) since 1990.[117] The JMP was previously responsible for tracking progress towards MDG 7c on WASH and now tracks progress towards the SDGs' WASH targets.[118] The JMP uses a 'service ladders' system to benchmark and compare progress across countries, with each 'rung' on the ladders representing progress towards the SDG targets.[119] The sub-sections below utilize the relevant service ladders to assess Fiji's progress towards meeting the SDG targets.

114 WHO, 'Sanitation, Drinking-Water and Health in Pacific Island Countries', 2016, on http://iris.wpro.who.int/bitstream/handle/10665.1/13130/9789290617471_eng.pdf [05.06.17].

115 UNICEF, 'Looking Back, Moving Forward. A Snapshot of UNICEF's work for Pacific Island children 2015–16', 2015.

116 Ibid.

117 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', 2017, p. 6.

118 Ibid.

119 Ibid., p. 2, p. 7.

Key WASH-related SDGs

WASH sector goal[II]	SDG global target	SDG indicator
Achieving universal access to basic services	1.4 By 2030, ensure all men and women, in particular the poor and vulnerable, have equal rights to economic resources, as well as **access to basic services**	1.4.1 Population living in households with access to basic services (including **basic drinking water, sanitation and hygiene**)
Progress towards safely managed services	6.1 By 2030, achieve universal and equitable **access to safe and affordable drinking water** for all 6.2 By 2030, achieve access to **adequate and equitable sanitation and hygiene** for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	6.1.1 Population using **safely managed drinking water services.** 6.2.1 Population using **safely managed sanitation services**, including a hand-washing facility with soap and water
Ending open defecation	6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and **end open defecation**, paying special attention to the needs of women and girls and those in vulnerable situations	

4.1. Access to improved water sources

In order for a country to meet the criteria for a **safely managed drinking water service, SDG 6.1**, the population should use an improved water source fulfilling three criteria: it should be accessible on premises; water should be available when needed; and the water supplied should be free from contamination. If the improved source does not meet any one of these criteria, but a round trip to collect water takes 30 minutes or less, it will be classified as a **basic drinking water service (SDG 1.4)**. If water collection from an improved source takes longer than 30 minutes, the source is categorized as giving a **limited service**.[120] The immediate priority in many countries is to ensure universal access to at least a basic level of service.[121]

No estimate of the proportion of the population using safely managed drinking water services is available for Samoa, as data are not available in relation to the proportion of the population using an improved source that is free from contamination. 2017 JMP data estimates for 2015 do show, however, that 97.5 per cent of the population uses an improved drinking water source. While 95.5

120 Ibid., p. 8.

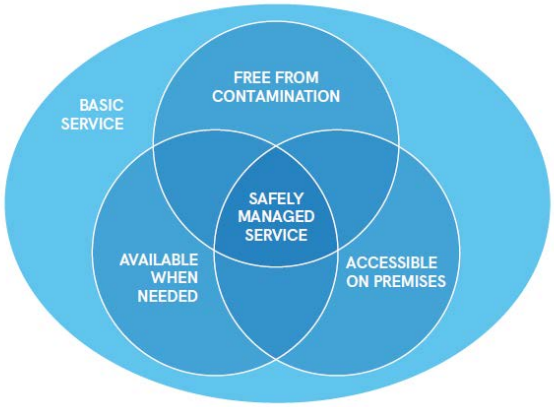
121 Ibid., p. 10.

per cent of the population was estimated to have access to a source within 30 minutes (thus qualifying as a basic service), 1.9 per cent had access to a source that was further away (qualifying as a limited service). A total of 2.2 per cent of the population was estimated to have access only to an unimproved source in the same year.[122] Thus, although Figure 4.2 shows below regional average performance on basic water services for Samoa, the country is close to providing basic drinking water services for all its population, in line with SDG 1.4.

Figure 4.1: JMP service ladder for improved water sources

SERVICE LEVEL	DEFINITION
SAFELY MANAGED	Drinking water from an improved water source that is located on premises, available when needed and free from faecal and priority chemical contamination
BASIC	Drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing
LIMITED	Drinking water from an improved source for which collection time exceeds 30 minutes for a round trip, including queuing
UNIMPROVED	Drinking water from an unprotected dug well or unprotected spring
SURFACE WATER	Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal

Note: Improved sources include: piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater, and packaged or delivered water.



Source: JMP Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines.

Of all Samoans with access to an improved drinking water source in 2015, the majority, 82.5 per cent, uses a piped drinking water supply. Further, 94.3 percent of those with access to an improved water source are estimated to have access to an improved water source on premises.[123]

Disaggregated data for urban and rural areas show minor disparities in relation to overall access to improved water sources only. Though urban rates are universal (100 per cent), rural rates are slightly lower, at 96.9, according to 2017 estimates for 2015.[124] This slight disparity may be related to the rapid urbanisation experienced in some parts of Samoa, especially in Apia, according to the 2016 SOWC. The same data also provide that the section of the population with access only to unimproved water sources is located in rural areas, indicating that this is where Samoa will need to prioritize resources and efforts.[125]

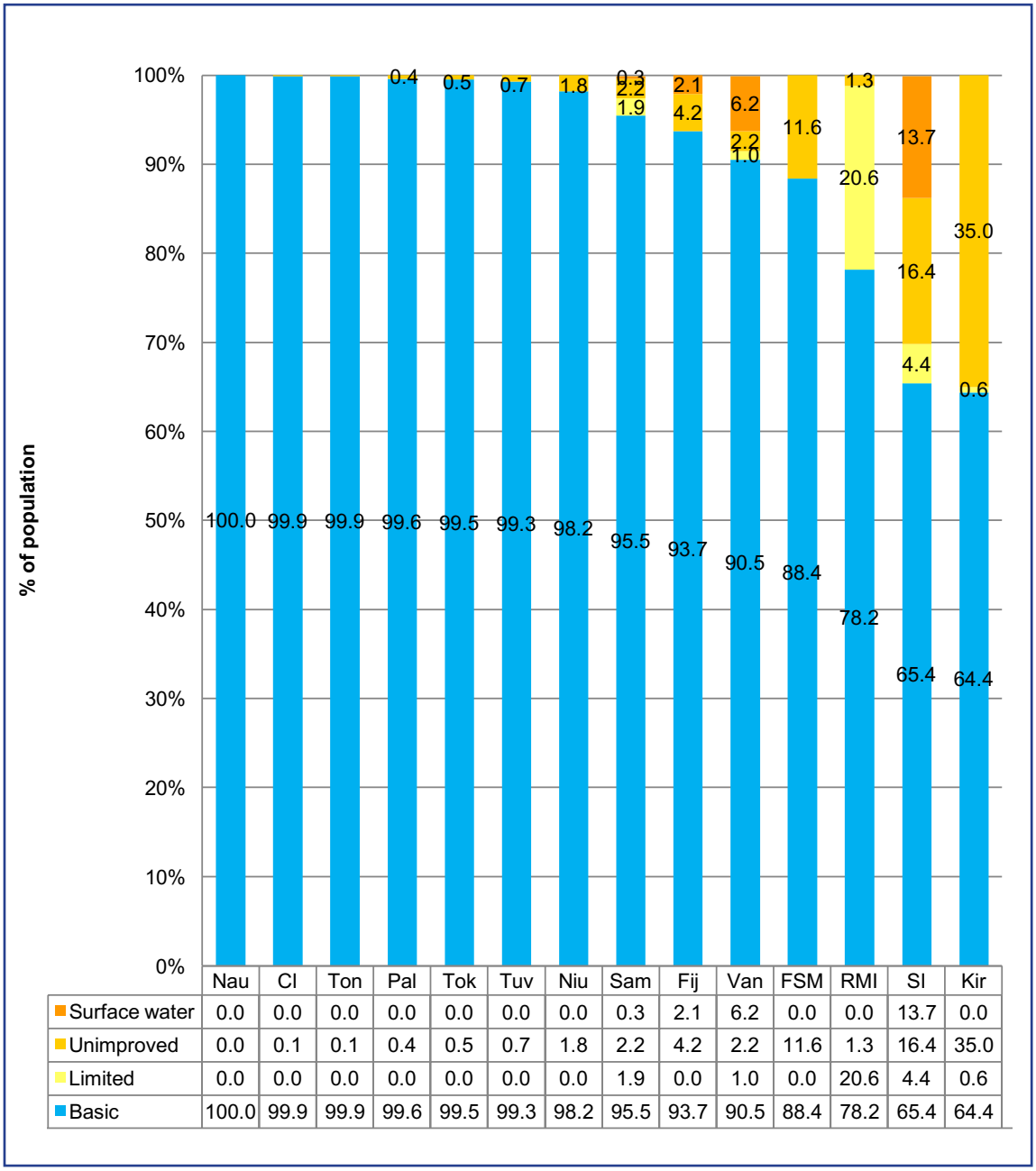
122 https://washdata.org/data#!/wsm [02.08.17].

123 Ibid.

124 Ibid.

125 Ibid.

Figure 4.2: Provision of drinking water services as per JMP service ladder, 2015 estimates

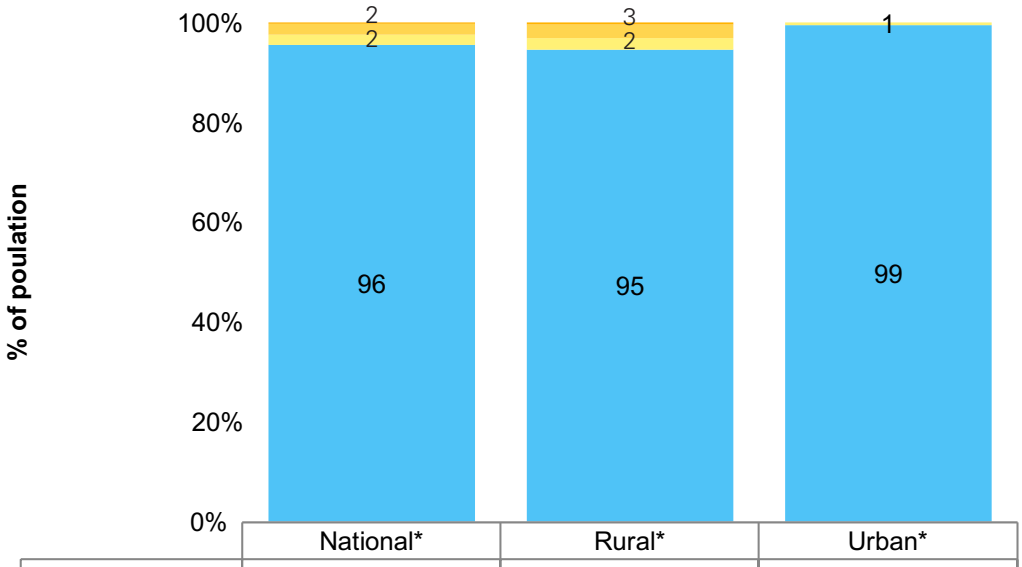


	Nau	Cl	Ton	Pal	Tok	Tuv	Niu	Sam	Fij	Van	FSM	RMI	SI	Kir
Surface water	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	2.1	6.2	0.0	0.0	13.7	0.0
Unimproved	0.0	0.1	0.1	0.4	0.5	0.7	1.8	2.2	4.2	2.2	11.6	1.3	16.4	35.0
Limited	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.9	0.0	1.0	0.0	20.6	4.4	0.6
Basic	100.0	99.9	99.9	99.6	99.5	99.3	98.2	95.5	93.7	90.5	88.4	78.2	65.4	64.4

Source: JMP data.[126]

126 https://washdata.org/data# [01.08.17].

Figure 4.3: Provision of drinking water services in Samoa, 2017 estimates



	National*	Rural*	Urban*
Surface water	0	0	0
Unimproved	2	3	0
Limited service	2	2	1
Basic service	96	95	99
Safely managed	0	0	0

Source: JMP data.[127]

Table 4.1 provides an indication of progress in relation to basic drinking water coverage in Samoa, showing that, according to JMP estimates, Samoa saw a steady increase between 2000 and 2015, with the proportion of the population only having access to unimproved sources decreasing from 4.9 per cent to 2.2 per cent.

Despite the good overall performance of Samoa in relation to access to improved water sources, some problems remain. For example, a 2011 EU report notes that water quality from all 'improved' water supply systems is generally not of a sufficient quality to qualify as 'safe to drink'.[128] It is unclear what improvements have been made in this area since then.

127 JMP data for Samoa available from https://washdata.org/data#!/wsm [02.08.17].

128 EU, 'Action Fiche for the Independent State of Samoa', Water and Sanitation Sector Policy Support Programme Phase II and MDG Initiative (FED/2011/023-477), 2011, https://ec.europa.eu/europeaid/sites/devco/files/aap-financing-samoa-af-20121219_en.pdf [13.04.2017].

Table 4.1: Provision of drinking water services, 2017 estimates

Year	Improved water	Improved within 30 mins	Improved more than 30 mins (limited)	Unimproved water	Surface water	Population using improved sources that are:				
						Piped	Non-piped	Accessible on premises	Available when needed	Free from contamination
2000	94.9	93.0	1.9	4.9	0.2	86.3	8.6	91.7	94.9	-
2005	95.2	93.3	1.9	4.5	0.3	86.4	8.8	92.0	95.2	-
2010	96.6	94.7	1.9	3.1	0.3	84.9	11.8	93.4	96.6	-
2015	97.5	95.5	1.9	2.2	0.3	82.5	15.0	94.3	97.5	-

Source: JMP data.[129]

4.2. Access to improved sanitation facilities

In order to meet SDG 6.2 in relation to safely managed sanitation services, Samoa's population should have access to improved sanitation facilities that are not shared with other households, and the excreta produced should be either treated and disposed of *in situ*, stored temporarily and then emptied, transported and treated off-site or transported through a sewer with wastewater and then treated off-site.[130] If excreta from improved sanitation facilities are not safely managed, people using those facilities will be classed as having access to a basic sanitation service (SDG 1.4); if they are using improved facilities that are shared with other households, this will be classified as a limited service.[131] Under SDG target 6.2, a specific focus is also put on ending the practice of open defecation. While this target aims to progressively raise standard sanitation services for all, the immediate priority for many countries will be to ensure universal access to at least a basic level of service.[132]

129 https://washdata.org/data#!/wsm [02.08.17].

130 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', p. 8.

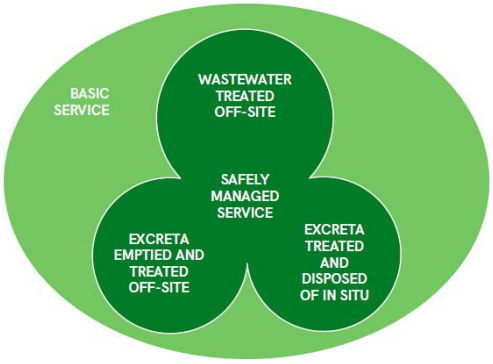
131 Ibid., pp. 8–9.

132 Ibid., p. 10.

Figure 4.4: JMP service ladder for improved sanitation facilities

SERVICE LEVEL	DEFINITION
SAFELY MANAGED	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite
BASIC	Use of improved facilities that are not shared with other households
LIMITED	Use of improved facilities shared between two or more households
UNIMPROVED	Use of pit latrines without a slab or platform, hanging latrines or bucket latrines
OPEN DEFECATION	Disposal of human faeces in fields, forests, bushes, open bodies of water, beaches or other open spaces, or with solid waste

Note: improved facilities include flush/pour flush to piped sewer systems, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.



Source: JMP Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines.

No estimates regarding access to safely managed sanitation services are available for Samoa, as data on excreta disposal are unavailable. However, as with drinking water, basic sanitation coverage in Samoa is reported to be close to universal, and, according to Figure 4.5, provision is fourth highest among the PICTs. JMP data estimates for 2015 suggest 95.5 per cent of the population in Samoa uses basic sanitation facilities (improved facilities that are not shared), with slightly better coverage in urban areas (99.5 per cent) compared to rural areas (94.6 per cent).[133]

Table 4.2 presents an overview of trends between 2000 and 2015 that suggest that basic sanitation coverage decreased slightly during this period. This trend should be monitored further, in order to establish if this is statistically significant and to ensure progress reached to date is not lost.

Table 4.2: Provision of sanitation facilities, 2017 estimates

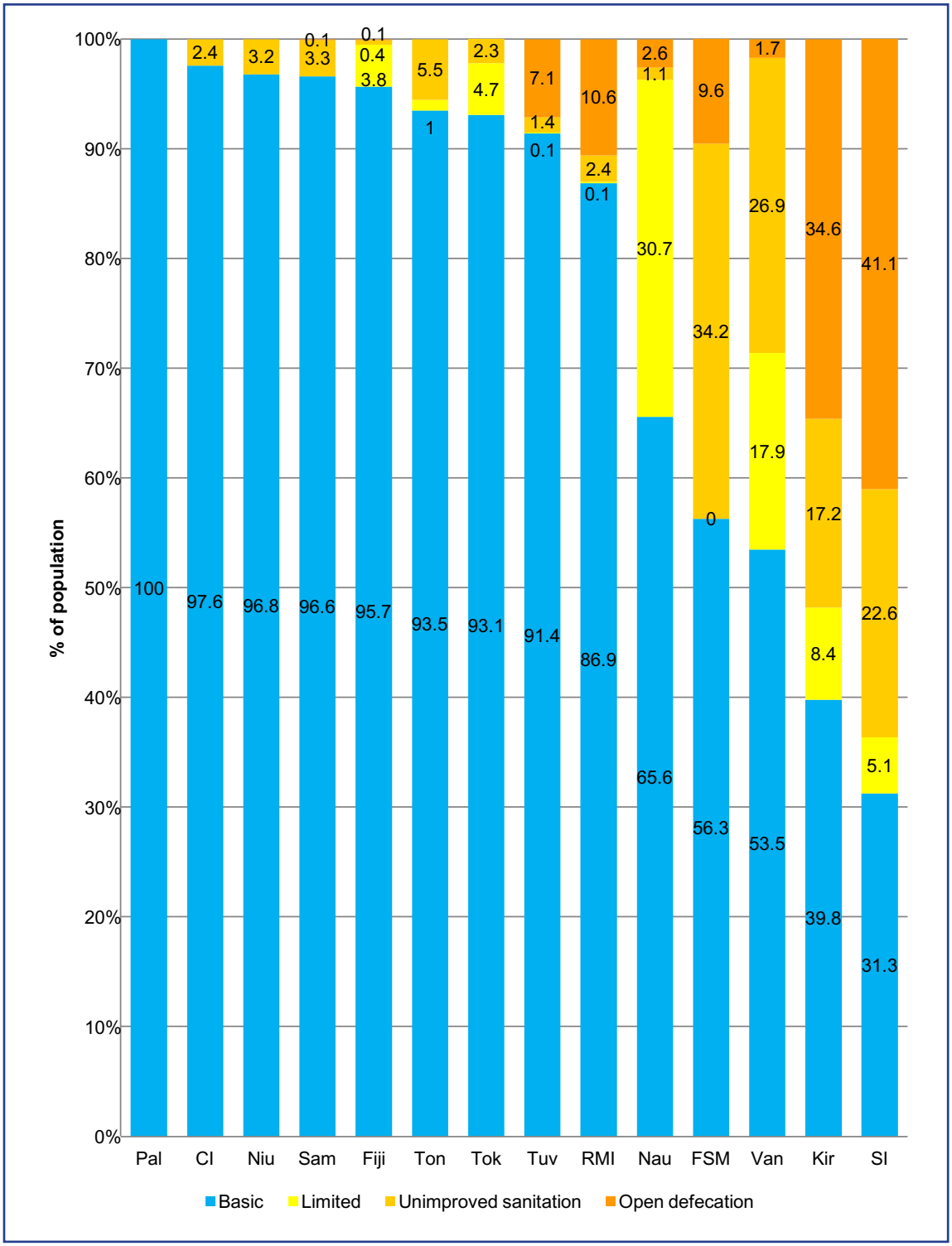
Year	Improved sanitation	Improved and not shared	Improved and shared (limited)	Unimproved sanitation	Open defecation	Population using an improved and not shared sanitation facility:					
						Latrines and other	Septic tank	Sewer connection	Disposed *in situ*	Emptied and treated	Wastewater treated
2000	98.7	98.7	0.0	1.3	0.1	14.9	83.5	0.2	-	-	-
2005	98.5	98.5	0.0	1.4	0.1	14.8	83.4	0.2	-	-	-
2010	97.6	97.6	0.0	2.4	0.1	12.7	84.6	0.2	-	-	-
2015	96.6	96.6	0.0	3.3	0.1	9.7	86.7	0.2	-	-	-

Source: JMP data.[134]

133 https://washdata.org/data#!/wsm [02.08.17].

134 Ibid.

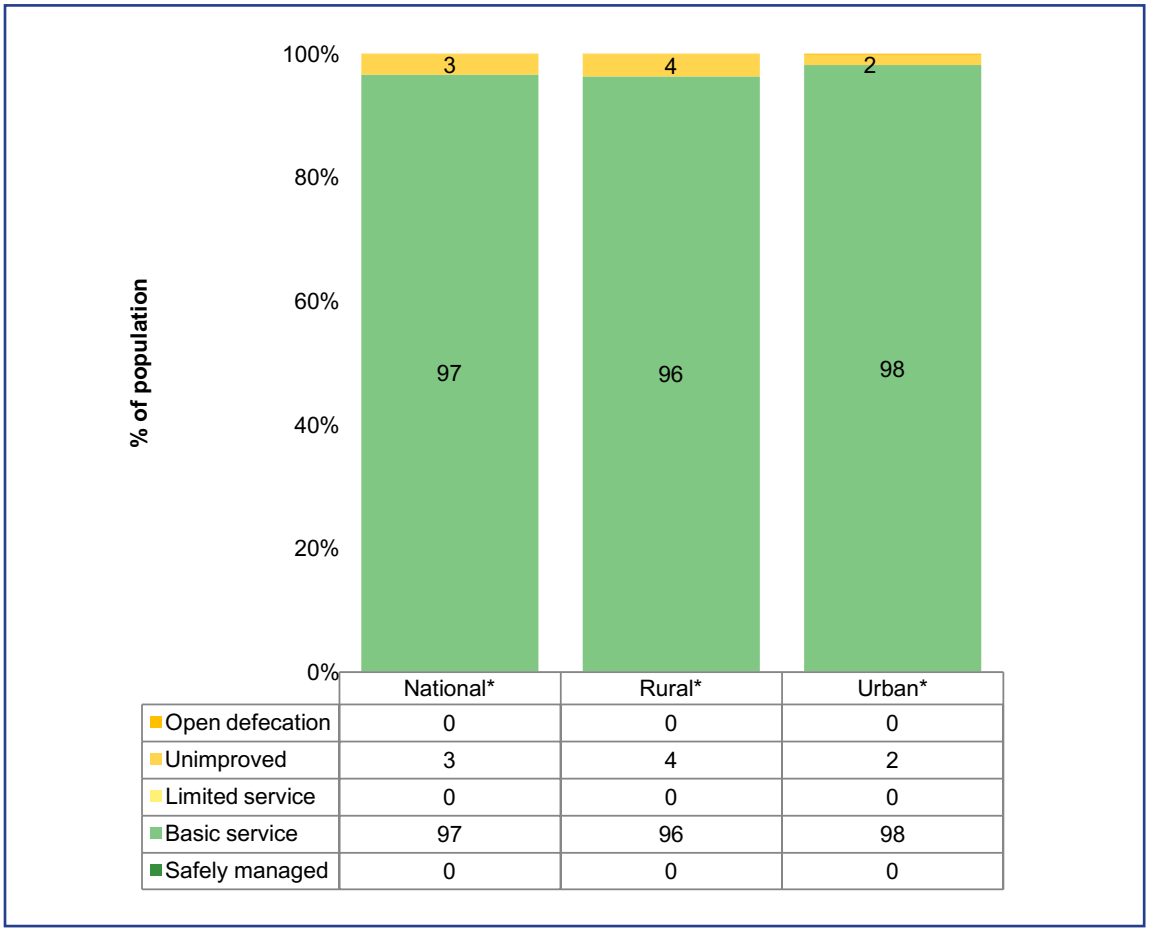
Figure 4.5: Provision of sanitation facilities as per JMP service ladder, 2015



Source: JMP data.[135]

135 https://washdata.org/data# [01.08.17].

Figure 4.6: Provision of sanitation facilities, 2017 estimates



	National*	Rural*	Urban*
Open defecation	0	0	0
Unimproved	3	4	2
Limited service	0	0	0
Basic service	97	96	98
Safely managed	0	0	0

Source: JMP data.[136]

According to SDG target 6.2, Samoa should aim to end any practice of open defecation by 2030. Most recent JMP estimates suggest open defecation is no longer practised in Samoa (see Table 4.2), which means that Samoa has already met this important WASH-related international development target.[137] However, alarmingly, the 2014 DHS suggests only a third of households in Samoa dispose of children's stools safely (by flushing them down the toilet or burying them), and roughly two thirds of households dispose of children's stools by simply throwing them into the garbage.[138]

4.3. Hygiene practices

According to SDG target 6.2, Samoa should, by 2030, also provide access to adequate and equitable hygiene for all, paying special attention to the needs of women and girls and those

136 https://washdata.org/data#!/wsm [02.08.17].

137 Ibid.

138 P. 176.

in vulnerable situations. Hygiene promotion that focuses on key practices in households and schools (washing hands with soap after defecation and before handling food, and the safe disposal of children's faeces) is an effective way to prevent diarrhoea (and other diseases). This in turn affects important development outcomes such as those related to child mortality or school attendance.[139]

The presence of a hand-washing facility with soap and water on premises has been identified as the priority indicator for the global monitoring of hygiene under the SDGs. Households that have a hand-washing facility with soap and water available on premises will meet the criteria for a **basic** hygiene facility (SDGs 1.4 and 6.2). Households that have a facility but lack water or soap will be classified as having a **limited** facility, and distinguished from households that have no facility at all.[140]

Figure 4.7: JMP service ladder for improved hygiene services

SERVICE LEVEL	DEFINITION
BASIC	Availability of a handwashing facility on premises with soap and water
LIMITED	Availability of a handwashing facility on premises without soap and water
NO FACILITY	No handwashing facility on premises

Note: Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.

Source: JMP Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines.

The recently published JMP study provides no data on hygiene practices in Samoa. The 2011 Global GSHS for Samoa therefore is the most important representative data source on hygiene practices among children in the country. According to this, around 17 per cent of surveyed pupils indicated that they had cleaned or brushed their teeth *less* than one time per day during the 30 days prior to the survey, with girls (13.6 per cent) somewhat less likely to report not brushing their teeth at least once a day compared with boys (21.5 per cent).[141]

139 See e.g. UN-Water Decade Programme on Advocacy and Communication, 'Implementing WASH', Information Brief, on http://www.un.org/waterforlifedecade/waterandsustainabledevelopment2015/images/wash_eng.pdf [27.03.17].

140 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', pp. 8–9.

141 Reported 95 per cent confidence intervals overlap, suggesting the difference is not statistically significant.

The GSHS data also suggest that almost **17 per cent of pupils never or rarely washed their hands after using the toilet** or latrine during the 30 days before the survey. Importantly, these data are self-reported, so they do not necessarily capture hygiene *practices,* and are likely to overestimate the proportion of pupils washing their hands after toilet use, owing to social desirability bias. The data do not reveal a statistically significant difference between boys and girls in relation to hand-washing practices.[142]

Unfortunately, the 2011 GSHS data capture reported hygiene behaviour only of school children aged 13–15, so very little is known about children in other age groups and children who do not attend school (i.e. out-of-school youth).

4.4. WASH in schools, MHM and disabilities

Besides the data obtained from the 2011 GSHS, no data on the situation of WASH in schools in Samoa appear to exist. There also appears to be no information on menstrual hygiene management (MHM) programmes in Samoa. Furthermore, data are lacking on access to WASH for persons living with disabilities and other disadvantaged groups in Samoa.

4.5. Barriers and bottlenecks

Even though data on WASH in Samoa are very limited, the existing evidence suggests there are several key structural barriers and bottlenecks that, if left unaddressed, could prevent Samoa from achieving further progress in the area of WASH.

4.5.1. Financing

Inadequate financing is likely to be a key barrier to more rapid progress in relation to improving access to WASH in the Samoa. A 2011 Institute for Sustainable Futures (ISF) WASH brief suggests that, out of the total financing needs of the WASH sector, the 'water use' sub-sector has the highest financing need, the highest recurrent costs and the highest investment needs. It also suggests that the water use sub-sector in Samoa has the largest shortfall in recurrent funding, which it estimates to stand at US$865,000 for 2011–2012.[143]

4.5.2. Service delivery

Samoa's WASH sector suffers from old and poorly maintained water and sanitation systems. For example, in rural areas, where the most common water supply is untreated groundwater and surface water sources, water supply systems are poorly maintained and degraded, and users

142 Reported 95 per cent confidence intervals overlap, suggesting the difference is not statistically significant.

143 ISF, 'Samoa Water, Sanitation and Hygiene Sector Brief', prepared for AusAID, October 2011.

are often reluctant to pay for the low levels of service they receive from the Samoan Water Authority.[144]

In Apia, Samoa's main urban area, about 75 per cent of households are connected to septic tanks, but many of these are overflowing and leaking black and grey water into groundwater or surface streams. The 2011 ISF WASH brief also notes that urban households frequently receive un-treated water and that water supply outages are quite common (and sometimes up to 12 days long).[145]

4.5.3. Climate and disaster risks

As mentioned in the previous chapter, natural disasters such as cyclones and rising sea levels are key risks facing Samoa (and the Pacific Islands in general). A recent WHO assessment report concluded that some of the key climate-sensitive health risks in Samoa were vector-, water- and food-borne diseases, many of which are affected by water safety.[146] Water safety therefore needs to be treated as a top priority in preventing and/or mitigating climate-sensitive health risks in Samoa.

The 2011 ISF WASH brief suggests climate change and sea level rise threaten bores with saltwater intrusion, although it also notes that, as of 2011, this was limited to the northern and eastern parts of Savaii.

144 Ibid, p. 4.

145 Ibid, p. 3.

146 WHO, 'Human Health and Climate Change in Pacific Island Countries'.

5.

Education

Key Education-related SDGs

SDG	Target	Indicators
4.1	By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes	Proportion of children and young people (a) in Grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex
4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex
		Participation rate in organized learning (one year before the official primary entry age), by sex
4.3	By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university	Participation rate of youth and adults in formal and non-formal education and training in the previous 12 months, by sex
4.4	By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship	Proportion of youth and adults with ICT skills, by type of skill

SDG	Target	Indicators
4.5	By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations	Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous peoples and conflict-affected, as data become available) for all education indicators on this list that can be disaggregated
4.6	By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy	Percentage of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex
4.7	By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development	Extent to which (a) global citizenship education and (b) education for sustainable development, including gender equality and human rights, are mainstreamed at all levels in (i) national education policies, (ii) curricula, (iii) teacher education and (iv) student assessment
4.A	Build and upgrade education facilities that are child-, disability- and gender-sensitive and provide safe, non-violent, inclusive and effective learning environments for all	Proportion of schools with access to (a) electricity; (b) the Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking water; (f) single-sex basic sanitation facilities; and (g) basic hand-washing facilities (as per the WASH indicator definitions)
4.B	By 2020, substantially expand globally the number of scholarships available to developing countries, in particular least developed countries, small island developing states and African countries, for enrolment in higher education, including vocational training and ICT, technical, engineering and scientific programmes, in developed countries and other developing countries	Volume of ODA flows for scholarships by sector and type of study

SDG	Target	Indicators
4.C	By 2030, substantially increase the supply of qualified teachers, including through international cooperation for teacher training in developing countries, especially least developed countries and small island developing states	Proportion of teachers in (a) pre-primary; (b) primary; (c) lower secondary; and (d) upper secondary education who have received at least the minimum organized teacher training (e.g. pedagogical training) pre-service or in-service required for teaching at the relevant level in a given country

The right to education is a fundamental human right, enshrined in Articles 28 and 29 of the CRC and Article 13 of the ICESCR. According to the United Nations Committee on Economic, Social and Cultural Rights, the right to education encompasses the following 'interrelated and essential features': availability; accessibility; acceptability; and adaptability.[147] The right to education is also contained in the SDGs, which recognize that, 'Quality education is the foundation to improving people's lives and sustainable development'. SDG 4 requires states to 'ensure inclusive and quality education for all and promote lifelong learning'. The SDGs build on the MDGs, including MDG 2 on universal primary education, and UNESCO's Education for All (EFA) goals, which this chapter references throughout where relevant.

In addition to these rights and targets, the United Nations International Strategy for Disaster Reduction (UNISDR) and the Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector (GADRRRES) Comprehensive School Safety Framework sets out three essential and interlinking pillars for effective disaster and risk management: safe learning facilities; school disaster management; and risk reduction and resilience education. These pillars should also guide the development of the education system in Samoa, which is vulnerable to disaster and risk.

The right to education in Samoa domestic law

The Compulsory Education Act, the Education Act 2009, the Strategy for the Development of Samoa 2016/17–2019/20 ('the Development Strategy') and the Samoa Education Sector Plan 2013–2018 are the principal documents governing education in Samoa. Education development has been a priority area for the government over recent years, as reflected in the Development Strategy, a key outcome of which is 'quality education and training improved'.[148] This key objective was also set out in the previous Development Strategy (2012–2016) and is elaborated in the Education Sector Plan, which sets out five goals for education reform: enhanced quality education at all levels; enhanced educational access and opportunities at all levels; enhanced

147 Committee on the Rights of the Child, General Comment No. 13, on the 'The Right to Education', 8 December 1999, para. 6.

148 P. 8; see also Development Strategy 2012–2016, p. 12.

relevance of education at all levels; improved sector coordination of research, policy and planning development; and established sustainable and efficient management of all education resources.

The education system in Samoa consists of three tiers: early childhood education (ECE); primary and secondary schooling; and post-school education and training (PSET). The Ministry of Education, Sports and Culture (MESC) is responsible for ECE and primary and secondary education. The Samoa Qualifications Authority (discussed in Part 5.3) is responsible for PSET.

Samoa has taken important steps to manage disaster and climate risks in the education sector in line with the Comprehensive School Safety Framework. Programme 5.4 of the Education Sector Plan focuses on strengthening disaster and climate change resilience at primary, secondary and PSET levels, with a view to achieving its broader goal of establishing sustainable and efficient management of all education resources.[149] According to the Plan, this programme involves coordination of the MESC, the Samoa Qualifications Authority and bilateral/multilateral agencies to better plan for future natural events, including by enforcing Minimum Service Standards of physical safety and well-being for children and young people, and increasing awareness of climate change effects and responses, including in school classrooms.[150] The Plan envisages that a sector strategy for disaster and climate change resilience will be developed and implemented by 2018. Data from 2011 suggest that natural disasters caused 11.2 million talas worth of damage to the education sector in that year and estimate 21.13 million talas in rebuilding and relocation costs.[151]

5.1. Early childhood education

5.1.1. Access

ECE, which is the first tier of education in Samoa, is not compulsory and officially targets children aged three and four.[152] However, in practice, children as young as 2.5 years of age are reportedly enrolling in ECE, as well as children above the official age, with a gross enrolment ratio (GER) in ECE of 39 per cent for 2.5 to five year olds in 2016 (37 per cent for males and 40 per cent for female) and a net enrolment ratio (NER) of 27 per cent for three to four year olds (26 per cent for males and 29 per cent for females).[153]

The MESC retains ultimate managerial responsibility for ECE. Under Part XI of the Education Act 2009, ECE centres must be registered with the MESC or an organization approved by the MESC,

149 P. 44.

150 P. 44.

151 UNESCAP, 'Economic Impact Assessment of Disasters: Samoa DALA and PDNA', on http://www.pacificdisaster.net/pdnadmin/data/original/EAD_WRKSHP_2011_ESCAP_samoa_dla.pdf [23.08.17].

152 Ministry of Education, Sports and Culture, 'Education Statistical Digest 2016', p. vii.

153 Ibid. pp. vii; p. 2.

and must meet several conditions before registration is permitted. Several requirements must be met before registration is approved, including whether a curriculum that meets the national ECE curriculum guidelines; an adequate building and appropriate facilities and equipment for young children as well as an appropriate outdoor play area, furniture, educational play equipment and materials in relation to the number of children to be enrolled; the employment of sufficient appropriately qualified and experienced staff; and an adequate management system (Section 68). The MESC also has powers of inspection of ECE centres (Part XII) and the power to establish an accreditation system for ECE teachers (Section 62), and sets the national curriculum and quality standards for ECE teaching (Section 58). For instance, in 2015 the MESC launched Minimum Service Standards for ECE to ensure ECE centres provide appropriate services for the safety and early education of young children.[154]

In practice, however, the National Council of Early Childhood Education ('the National Council of ECE'), an NGO to which the government has delegated its ECE coordination and management functions, oversees ECE provision in the country, including the setting of school standards and teacher training.[155]

The MESC reports that it collaborates with the National Council of ECE to monitor and enforce the ECE age requirement; provide pre- and in-service professional development for teaching staff; provide ECE training certificates to interested candidates; and monitor the effective implementation of curriculum guidelines and resource kits.[156] However, little further information can be found in reports on these initiatives.

According to the Education Statistical Digest 2016, the numbers of ECE centres in Samoa decreased between 2014 and 2016 from 107 to 102. Traditionally, ECE centres are established and operated by the local pastor and his wife or women's committees in the village.[157] Centres are still operated by the church, religious groups and private bodies.[158] In 2016, 33 per cent of ECE centres were privately run, compared with 29 per cent operated by the Methodist Church and 12 per cent by the Catholic Church and the Ekalesia Faapotopotoga Kerisiano Samoa or the Congregational Christian Church in Samoa management provider.[159] However, none was operated by women's committees (*Komiti Tumama*), which had been forced to close as a result of funding shortages.[160] According to the 2015 EFA National Review, most ECE centres are located in rural areas.[161]

Enrolment in ECE is very low, although the NER increased from 23 per cent to 27 per cent and the GER from 34 per cent to 39 per cent between 2012 and 2016.[162] The slightly higher GERs indicate

154 Government of Samoa, 'Minister of Education Launches Early Childhood Education Document', 17 June 2015, on http://www.samoagovt.ws/2015/06/minister-of-education-launches-early-childhood-education-document/ [17.04.17].

155 Education Statistical Digest 2016, p. 5; MESC, 'Education for All 2015 National Review', pp. 10 and 19.

156 EFA 2015 National Review, p. 19.

157 P. 1.

158 Pp. vii and 1.

159 P. 1.

160 P. 2.

161 P. 20.

162 Education Statistical Digest 2016, p. 2.

that notable proportions of the children enrolled in ECE fall outside the official age group of three to four years.

Disaggregated enrolment figures show that a higher percentage of girls than boys are enrolled in ECE centres, a pattern that remained fairly consistent between 2012 and 2016. In 2016, the GER was 37 per cent for boys and 40 per cent for girls, while the NER was 26 per cent for boys and 29 per cent for girls.[163]

5.1.2. Quality

Statistical data on the quality of ECE provision in Samoa are limited. The 2015 EFA National Review indicated that the quality of ECE varied considerably across the country.[164] ECE standards set by the National Council for ECE reportedly impose a minimum threshold of 15 students to one *trained* ECE teacher and a maximum of 30 students to a trained ECE teacher in-charge, with one assistant.[165] In 2015, the teacher–pupil ratio for ECE was 1:12,[166] which is below the minimum domestic threshold and recommended international standard of 1:15.[167] It is not clear whether this figure from 2015 refers to trained or other teachers.

Reports highlight cases of ECE centres being too small, having insufficient supplies of education resources to cater for enrolment numbers and not providing child-friendly environments conducive to learning.[168] Levels of qualification and experience of pre-school teachers also vary significantly, with few teachers reportedly being able to produce their teaching certification documents. The ECE curriculum is generally not implemented. Although the MESC has delivered workshops to strengthen ECE teaching practices, reports suggest these have not been successful, with teachers being slow to adopt new initiatives.[169] Teaching methods in many ECE centres also focus on rote learning and drilling.[170]

Access to ECE is limited for children with disabilities, and, where ECE is provided, it is generally untailored and inappropriate to the children's needs. The MESC states that children with special needs may enrol in ECE up until the age of eight,[171] suggesting that tailored ECE is not widely available, if at all. Buildings are not designed to facilitate access for children with physical needs.[172]

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163 Ibid.

164 EFA 2015 National Review, p. 19.

165 Ibid, p. 20.

166 Education Statistical Digest 2015, cited on the website of the Pacific Regional Information System, on https://www.spc.int/nmdi/education [12.06.17].

167 World Bank Group, 'SABER ECD Report for Solomon Islands 2013', p. 19.

168 EFA 2015 National Review, p. 19.

169 Ibid.

170 Ibid., p. 21.

171 Education Statistical Digest 2016, p. 1.

172 EFA 2015 National Review, p. 19.

5.1.3. Barriers and bottlenecks

The voluntary nature of ECE may be a contributing factor to low enrolment.[173] Low public provision of ECE may also be of concern. Funding shortages have forced ECE centres operated by women's committees to close,[174] suggesting that the non-availability of ECE may also be contributing to low enrolment rates.[175] Although the MESC provides ECE grants on a per capita basis,[176] with the rate remaining the same since 2010–2011 according to the 2015 EFA National Review, these are provided only to registered ECE centres (which not all are) and are insufficient to cover all ECE costs. This means ECE centres continue to rely on local community fundraising activities, donations from churches and community members, parents' fees and donor support.[177] This is likely to be particularly burdensome for ECE centres in poorer communities. The lack of funding is also likely to be a key barrier to the development of child-friendly, well-resourced ECE centres.

This lack of public or government provision of ECE and associated services, and the consequent dependence on parents' fees, community and donor funding to operate ECE centres, is a key barrier to the development of quality teaching practices and to encouraging professionalism in this sector. ECE centres employ their own staff and fund their salaries, with some teachers receiving no remuneration at all. This discourages quality teachers from joining or staying in the field, resulting in a limited supply of teachers and a dependence on voluntary, unskilled assistance.[178] The poor quality of ECE is also reportedly driving high absence rates.[179] The 2015 EFA National Review indicates that most ECE centres have not seen the curriculum booklet,[180] suggesting poor awareness-raising and training for teachers in curriculum delivery.

The absence of MESC oversight and the accountability gap created by the delegation of ECE management to the National Council of ECE are evident barriers to the achievement of universal, quality ECE provision.[181] The relationship between the MESC and the National Council of ECE is also reportedly weak. The National Council on ECE has reportedly not been rigorous in ensuring that ECE centres adhere to its standards prior to registration.[182] This has resulted in ECE centres establishing themselves according to their own standards, which are reportedly often inadequate. The MESC provides the National Council of ECE with grants to fund stationery and professional development within ECE centres,[183] although there is very little other information available on the amounts granted and how the National Council on ECE spends them.

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173 Education Statistical Digest 2016, p. 2.

174 Ibid., p. 1.

175 On the other hand, in some areas there is reportedly more than one ECE centre, which has resulted in low attendance numbers in some centres, raising questions related to the cost effectiveness and quality of teaching in these centres.

176 The 2015 EFA National Review states that the annual grant was US$375,000.00, i.e. 7.5 per cent of a US$5,000,000.00 grant to mission, private, ECE and special schools (pp. 19 and 21).

177 EFA National Review, pp. 19 and 50.

178 Ibid., pp. 21–2.

179 Education Statistical Digest 2016, p. 2.

180 EFA 2015 National Review, p. 19.

181 Ibid., p. 22.

182 Ibid., pp. 19 and 22.

183 Ibid., p. 19.

More broadly, a major barrier to the development of quality ECE and a driver of piecemeal developments is the absence of a sector-specific policy framework guiding the development and monitoring of ECE, that clarifies resourcing requirements and targets, sets minimum service standards and makes it possible to ensure providers are registered and are complying with quality standards.[184]

5.2. Primary and secondary education

According to Sections 4 and 6 of the 2009 Education Act, primary education in Samoa consists of eight school years (Grades 1–8) and is compulsory for children from ages five to 14 (if they have not completed primary education sooner). Secondary education consists of five years (Years 9–13) and is not compulsory under Samoan law. The official ages for secondary education are 13–17.[185] The 2015 EFA National Review indicates that the primary and secondary education budget declined from 7 per cent of gross national product (GNP)/GDP in 2007–2008 to 5 per cent in 2012–2013. Similarly, public expenditure on primary and secondary education decreased from 27 per cent to 19 per cent of total government expenditure during this period.[186]

5.2.1. Access to primary and secondary education

Samoa achieved a 100 per cent primary NER in 2015 and 2016,[187] which was a significant step towards the attainment of universal primary education under MDG 2. This is particularly encouraging in light of historical challenges in enforcing the Compulsory Education Act as a result of numerous factors, including limited human resources and weak coordination to ensure implementation.[188] The NER has been even for boys and girls over recent years,[189] indicating that there is universal enrolment in primary school between the genders.

However, on closer examination of the disaggregated figures, primary GER and age-specific enrolment rates highlight areas of concern, particularly regarding the participation of boys. The primary school GER decreased from 109 per cent in 2013 to 107 per cent in 2016,[190] suggesting a notable proportion of overage pupils are enrolled in primary school. The GER has varied slightly for boys and girls over recent years, reaching 108 per cent for boys and 106 per cent for girls in 2016,[191] indicating that a higher proportion of over-age pupils in primary school are boys. According to the MESC, over-age enrolment has occurred because of the Samoa School Fee Grant Scheme and the enforcement of compulsory education laws, which have led to more students being enrolled

184 Ibid., pp. 21–2.
185 Education Statistical Digest 2016, p. 46.
186 EFA 2015 National Review, p. 49.
187 Education Statistical Digest 2016, p. 7.
188 EFA 2015 National Review, p. 23.
189 Education Statistical Digest 2016, p. 7.
190 Ibid., p. 6.
191 Education Statistical Digest 2016, p. 6.

in some schools. However, age-specific enrolment figures indicate that children, particularly boys, are starting primary school at a later age than the compulsory minimum of five years, which may also be a contributing factor. In 2016, only 74 per cent of five year olds were enrolled in primary school, a significantly larger proportion of whom were girls (77 per cent girls compared with 72 per cent boys).[192] Although the enrolment of six year olds is higher (96 per cent for girls and 94 per cent for boys), it is still not universal.[193] This is supported by high gross intake rates, which were above 100 per cent between 2012 and 2016 (although they decreased from 115 per cent in 2014 to 103 per cent in 2016),[194] as well as net intake rates that were well below 100 per cent between 2012 and 2016[195] and higher for girls than boys.[196]

In 2016, age-specific enrolment for children between the ages of seven and 11 was above 100 per cent, after which it begins to decrease (99 per cent for 12 year olds; 85 per cent for 13 year olds; 87 per cent for 14 year olds). This indicates that enrolment rates are lower among older compulsory school-age children. In particular, disaggregated figures point to a significantly higher proportion of female 13 year olds (89 per cent girls compared with 82 per cent boys) and 14 year olds (88 per cent girls and 86 per cent boys) enrolled in primary school in 2016.[197] The reasons for this are not detailed in reports.

Primary school drop-out rates in 2016 fluctuate between grades, from a high of 5.9 per cent in Year 2 to -1.1 per cent in Year 6. However, drop-out rates were consistently higher for boys than girls across Grades 2–7, particularly in Grade 2 (7.6 per cent for boys compared with 3.9 per cent for girls).[198] In the same vein, primary completion rates were consistently higher for girls than boys between 2012 and 2015, although the gap narrowed to 80 per cent for boys and 81 per cent for girls in 2015.[199]

Encouragingly, the transition rate from primary to secondary education increased from 86.5 per cent in 2012 to 98.5 per cent in 2016, indicating that almost all children who complete primary school progress to secondary education. The transition rate was marginally higher for boys, at 99.1 per cent compared with 98.7 per cent for girls.[200] However, enrolment at secondary level is significantly lower than primary enrolment rates. Between 2012 and 2016, the secondary GER fluctuated between 75 per cent and 80 per cent, settling at 77 per cent in 2016.[201] The secondary NER remained between 68 per cent and 71 per cent during this period, ending at 68 per cent in 2016, indicating that a sizeable proportion of students enrolled in secondary education fell outside the official age group. While it might be assumed that most of these students are over-age, most

192 Ministry of Education, Sports and Culture, Education Statistical Digest 2016, p. 9.

193 Ibid., p. 9.

194 Ibid., p. 10.

195 70 per cent in 2012, 73 per cent in 2013, 79 per cent in 2014, 68 per cent in 2015 and 68 per cent in 2016; ibid., p. 11.

196 73 per cent girls and 67 per cent boys in 2012, 73 per cent girls and 72 per cent boys in 2013, 79 per cent girls and 78 per cent boys in 2014, 68 per cent girls and boys in 2015 and 69 per cent girls and 67 per cent boys in 2016; ibid., p. 11.

197 Education Statistical Digest 2016, p. 9.

198 Ibid., p. 18.

199 Ibid., p. 31.

200 Ibid., p. 50.

201 Ibid., p. 43.

likely a knock-on effect of late and over-age enrolment and repetition during primary education, MESC figures indicate that children as young as 11 are enrolled in secondary education.[202] According to the MESC, in 2016 the age-specific enrolment rate of 11 year olds in secondary education was 104 per cent,[203] although it is not clear how this can be the case as 11 year olds fall within primary school levels, assuming they start school at the age of five.

A significantly higher proportion of girls than boys enrol in secondary education. The secondary GER was 83 per cent for girls and 71 per cent for boys in 2016, compared with a secondary NER of 73 per cent for girls and 63 per cent for boys in the same year.[204] Secondary drop-out rates are also higher for boys than girls at all secondary levels. The MESC considers that this is because boys tend to prefer vocational training or leave education all together.[205]

The enrolment in secondary education also decreases significantly the higher the age of the pupil. In 2016, 99 per cent of 12-year olds were reportedly enrolled in secondary education according to the MESC, compared to 85 per cent of 13 year olds, 87 per cent of 14 year olds, 89 per cent of 15 year olds, 81 per cent of 16 year olds, 59 per cent of 17 year olds, 32 per cent of 18 year olds, 9 per cent of 19 year olds and 1 per cent of 20 year olds.[206] The MESC considers that students prefer to leave the school system and pursue PSET education instead or remain at home.[207]

Encouragingly, in 2016 the progression rates to Years 9, 10 and 12 were above 90 per cent. However, the progression rate to Year 11 was a low 74 per cent, reportedly because some schools do not have a Year 11, and some schools set internal exams at the end of Year 10 to determine which children can progress to the next level, resulting in the drop-out of students who do not pass.[208] Similarly, the progression level to Year 13 was a low 70 per cent, largely because of the drop-out of students who failed to pass the national Samoa School Certificate examination, which is used to determine progression to Year 13.[209] This is also reflected in the high drop-out rates for Years 11 and 13 (23.7 per cent and 29.0 per cent, respectively, compared with 9 per cent in Year 9, 7.4 per cent in Year 10, and 1.7 per cent in Year 12).[210]

Inclusive education for children with disabilities is a priority area for the MESC. This is reflected in its Inclusive Education Policy, which aims to improve 'educational opportunities for children living with disabilities in early childhood, school and post-school subsectors'.[211] There are few data on enrolment rates for children with disabilities. MESC figures show an increase in the number of enrolments of children with disabilities in government primary schools (from 133 in 2014 to 166 in 2015).[212] However, reports indicate that this comprises only a small proportion of children with

202 Ibid., p. 44.
203 Ibid., p. 45.
204 Ibid., p. 44.
205 Ibid., p. 50.
206 Ibid., p. 45.
207 Ibid., pp. 43–5.
208 Ibid., p. 47.
209 Ibid., pp. 47–8.
210 Ibid., p. 49.
211 Cited in ibid., p. 13.
212 Ibid., p. 13.

disabilities, the majority of whom do not attend mainstream schools.[213] In practice, children either attend programmes operated by NGOs (*Loto Taumafai*, *Fiamalamalama* and SENESE), private schools or mission bodies, or remain at home.[214]

5.2.2. Quality of primary and secondary education

As indicated above, repetition of primary schooling is an area of concern, particularly for boys, suggesting that the quality of education at primary level needs further improvement. In 2016, repetition rates were highest for children in Year 1 (4.3 per cent in 2016), particularly among boys (4.8 per cent for boys; 3.7 per cent for girls).[215] Further, a drop of 11 per cent in the net intake rate between 2014 and 2015 reportedly owes partly to the high repetition rate at Year 1.[216] Repetition in Year 1 most likely also owes to the unpreparedness of pupils entering school, stemming from lack of access to quality ECE (see above for details). Repetition rates in 2016 broadly decrease the higher the primary grade, from 1.2 per cent in Year 2 to 0.6 per cent in Year 8 (noting that the rate is 0.4 per cent for Years 5 and 7).[217]

In the same vein, the primary progression rate remained between 86 and 88 per cent between 2013 and 2016, indicating that, while the majority of children are progressing through primary education, 12-14 per cent of enrolled children are not. The primary progression rate in 2016 was lower for boys than for girls across most grades, reportedly because of the higher proportion of boys than girls repeating the school year.[218] The net intake rate for Year 8 has also decreased overall, from 45 per cent in 2012 to 35 per cent in 2016, indicating that the number of 12 year olds who reach the last year of primary education is extremely low.[219]

The MESC has introduced Minimum Service Standards to measure the progress and quality of primary education. The 2015 results of the country's assessment of schools against these standards indicate general under-performance. Only 7 per cent of primary school achieved clear and appropriate national competencies in literacy and numeracy at all levels; 17 per cent achieved clear and appropriate competencies in literacy and numeracy at school level; and 8 per cent achieved 20 per cent improved student performance levels according to Samoa Primary Education Literacy Levels (SPELL) results over a three-year period.[220]

The results of the national assessments conducted at primary level (Year 4 SPELL 1; Year 6 SPELL 2; and Year 8 Samoa Primary Education Certification Assessment (SPECA)) and secondary level (2015 Year 12 Samoa School Certificate and Year 13 Samoan School Leaving Certificate) indicate that the quality of education, particularly for boys and in literacy and numeracy more generally, requires significant improvement.

213 EFA 2015 National Review, p. 28.
214 Ibid.; Education Statistical Digest 2016, pp. 46–7.
215 Education Statistical Digest 2016, p. 17.
216 Ibid., p. 11.
217 Ibid., p. 17.
218 Ibid., pp. 14–15.
219 Ibid., p. 16.
220 Ibid., p. 42.

National data for SPELL 1 from 2015 indicate that seven out of 10 Year 4 students are yet to reach the 'proficient' level or higher in Gagana Samoa and English literacy. Further, more than half of Year 4 students have not reached proficiency in numeracy.[221] Females generally out-perform males in numeracy, with 49.3 per cent of females attaining proficiency level or higher compared with 40.8 per cent of males, and with 35.3 per cent of males being at beginner level compared with 27.6 per cent of females. However, males out-perform females in Gagana Samoa, with 49.0 per cent of males reaching proficiency or established levels compared with 36.2 per cent of females. Outcomes in English are low for boys and girls, with 32.2 per cent of girls attaining proficiency or established levels, compared with 22.3 per cent for boys, and 42.7 per cent of girls attaining beginner level, compared with 50.6 per cent for boys.[222]

The national data for SPELL 2 indicate that five out of 10 Year 6 students are yet to reach proficiency level or higher in Gagana Samoa, and eight out of 10 students are yet to reach this level in English literacy. Further, 49.4 per cent of students have yet to reach it in numeracy.[223] Similarly, 72 per cent and 69 per cent of students have attained beginner level in English and numeracy, respectively, in the Year 8 SPECA.[224] More encouragingly, 56 per cent of students are proficient in Gagana Samoa, while 23 per cent have achieved advanced level, indicating that literacy and numeracy are the areas of concern in Year 8.[225] Broadly, a higher proportion of girls than boys are proficient in literacy, numeracy and Gagana Samoa in the Year 8 SPECA.[226]

The results of the 2015 Year 12 Samoa School Certificate and Year 13 Samoan School Leaving Certificate similarly indicate poor educational outcomes for children at secondary level. With regard to the former, the majority of pupils achieved beginner level in English and mathematics (64 per cent and 89 per cent, respectively). A total of 52 per cent attained achievement level in Gagana Samoa, although the vast majority of the remainder (37 per cent) achieved beginner level. More girls than boys were proficient in Gagana Samoa and English, while no significant differences were found between boys and girls in mathematics.[227] With regard to Year 13 examinations, of significant concern are the 96 per cent and 53 per cent of pupils who attained beginner level in mathematics and English, respectively.[228]

Teachers are in short supply in primary schools, and this results in multi-grade classes at primary level, although teacher numbers increased very slightly from 1,374 in 2014 to 1,394 in 2016.[229] Teachers are reportedly overloaded, particularly in government schools, where the pupil–teacher ratio increased from 26.8:1 in 2012 to 31.7:1 in 2016. This is reportedly leading many teachers to resign from the profession or migrating in search of other opportunities.[230] Although

221 Ibid., p. 21.
222 Ibid., p. 22.
223 Ibid., p. 26.
224 Ibid., p. 29.
225 Ibid., pp. 29–30.
226 Ibid., p. 30.
227 Ibid., p. 53.
228 Ibid., p. 54.
229 Ibid., pp. 32 and 38.
230 Ibid., p. 38.

disaggregated data on classroom sizes are not available, reports suggest classes in urban areas are overcrowded.[231]

At secondary level, teacher resignations, retirements and migration are resulting in a declining workforce.[232] Although government, mission and private schools fell under the MESC target pupil–teacher ratio (20:1), the MESC highlights a 'longstanding issue' of teacher shortages and a need to attract quality candidates to the profession.[233]

The numbers of teachers with teaching certificates has declined over recent years, the primary reason being retirement.[234] Primary school teachers are under-qualified. The vast majority of teachers (82 per cent) in government primary schools in 2016 had a teacher's certificate, compared with a low 12 per cent of teachers in mission primary schools and 7 per cent in private primary schools. However, the MESC is shifting its emphasis to degree level as the minimum qualification for teachers. In 2016, just under half (49 per cent) of government primary school teachers had a degree, compared with 20 per cent of teachers in private primary schools and 3 per cent in mission primary schools.[235] In terms of performance standards, according to the 2014–2015 performance assessments, an average of 40 per cent of appraised teachers met performance standards, with no significant difference in the performance of male and female teachers or between teachers in Upolu or Savaii.[236]

At secondary level, the numbers of teachers with teaching certificates decreased from 794 in 2014 to 745 in 2016.[237] However, the numbers of teachers with degrees, the MESC qualification benchmark, increased from 333 to 347 during the same period.[238]

Primary schools are reportedly under-resourced for the numbers of students attending. The MESC reports that in 2016 all private schools had computers and photocopiers, but this compares with 91 per cent of government schools and 94 per cent of mission schools. Of concern is that only 1 per cent of primary government schools have science laboratories, compared with 33 per cent of mission schools and 67 per cent of private schools.[239] In 2016, secondary schools were generally equipped, although 9 per cent of government secondary schools and 33 per cent of private schools lacked science and computer laboratories and 4 per cent of government schools and 33 per cent of private schools lacked libraries.[240]

231 EFA 2015 National Review, p. 27.
232 Education Statistical Digest 2016, pp. 55–6.
233 Ibid., p. 60.
234 EFA 2015 National Review, p. 27.
235 Ibid., p. 35.
236 Ibid., p. 37.
237 Ibid., p. 56.
238 Ibid., p. 57.
239 Ibid., 39.
240 Ibid., p. 60.

5.2.3. Barriers and bottlenecks in primary and secondary education

The achievement of 100 per cent NER is significant, particularly considering historic challenges the government has faced in enforcing compulsory education laws in the country. The introduction of the School Fee Grants Scheme for primary level in 2010 has been an enabler for the attainment of the universal primary NER, by alleviating the burden of school fees on families that have hindered enrolment and providing financial support to schools to help them meet the Minimum Service Standards.[241] However, as indicated above, participation in primary education is not universal at the official school age, and drop-outs, particularly of boys, remain a concern. While factors such as migration may be contributing to drop-out rates,[242] reports indicate that the 'hidden costs of education' are still a barrier to the enrolment/survival of children from socio-economically deprived families and remote areas, together with a lack of parental support.[243]

The 2015 EFA National Review indicates that there are insufficient disaggregated data on the situation of children who do not enrol or who drop out of secondary school to enable a comprehensive causation analysis.[244] This is a significant gap, and is particularly important in light of the gender disparities in secondary school enrolment figures, drop-out rates and exam performance. While the 2015 EFA National Review highlights a need to develop appropriate teaching methods and relevant curriculum to motivate and engage boys in education, as well as to raise awareness of the importance of education in the wider community, it notes that limited pathways from secondary to PSET may also be a contributing factor to these gender disparities. Nevertheless, further research into underlying drivers is necessary.

Disaster and climate risks, such as the 2009 tsunami, are significant barriers to education, not only because they damage the physical infrastructure of schools, preventing attendance, but also because they reportedly affect the physical and psychological well-being of children, who prefer to remain at home rather than attending school during these events.[245]

There are significant barriers to access to quality education for children with disabilities. First, data on their participation in the education system are incomplete; this is an area in which the MESC acknowledges that further developments are needed in order to enable proper assessment of such children's educational situation.[246] Further, there are insufficient tailored resources and facilities for children with disabilities, particularly at secondary level and in rural areas, where 'special schools' are unavailable, resulting in children being kept at home.[247] Further, the MESC has identified a need to improve teacher skills with regard to children with special needs and disabilities.[248]

241 EFA 2015 National Review, p. 24.
242 Education Statistical Digest 2016, p. 18.
243 Education for All 2015 National Review, p. 29.
244 Ibid., p. 30.
245 Ibid., p. 26.
246 Education Statistical Digest 2016, pp. 13 and 46–7.
247 Ibid., pp. 46–7.
248 Ibid., pp. 13 and 47; EFA 2015 National Review, p. 29.

5.3. Tertiary and vocational education

Post-school education and training, or PSET, is the term used in Samoa to describe all formal and informal education and training activities adopting any structured form of delivery that take place outside of the ECE/school system.[249] PSET therefore includes university education; pre- and in-service professional education; technical and vocational education; theological colleges and religious instructions; apprenticeships; and on-the-job training.[250]

The Samoa Qualifications Authority is a public statutory body initially established under the Samoa Qualifications Authority Act 2006, and revived under the Samoa Qualifications Authority Act 2010, responsible for managing PSET in Samoa. Its functions include providing policy advice to the government on strategies and priorities for PSET; monitoring and reporting to the government and the PSET sector on the activities, resourcing and overall performance of the sector in relation to national strategic goals for economic, social and cultural development; regulating qualifications and quality standards for all PSET providers in Samoa; coordinating and strengthening PSET to better focus the sector on national development goals and to promote and develop coherence among programmes; promoting links and learning pathways between the school sector and the PSET sector; working with national stakeholder groups to ensure standards and training requirements are established, in particular for trade, technician and professional occupations; determining a national qualifications structure for Samoa; developing criteria and registration processes for all PSET providers; developing criteria and processes for the accreditation and quality audit of all PSET providers; promoting quality assurance in non-formal education and training programmes; coordinating and conducting registration and accreditation of providers, programmes, qualifications and quality audits of providers; and maintaining appropriate registers pertaining to its activities.[251]

In 2011, a total of 2,269 female and 2,011 male students enrolled in formal PSET courses with providers listed/registered with the Samoa Qualifications Authority. As at October 2013, there were a total of 30 PSET providers, the majority (16) of which were run by missions, compared with nine private, two government (including the National University of Samoa) and two regional (University of South Pacific Alafua Campus and Australian Pacific Technical College) PSET providers.[252] In addition to providing higher education degrees and programmes, the National University of Samoa is the country's main provider of technical and vocational education and training, delivered through its Institute of Technology.[253] The National University's Faculty of Education is the sole Samoan provider of pre-service training for teachers in primary and secondary education.[254]

249 Samoa Qualifications Authority Act 2010, Section 2.

250 Samoa Qualifications Authority, on http://www.sqa.gov.ws [17.04.17].

251 Samoa Qualifications Authority Act 2010, Section 4.

252 EFA 2015 National Review, p. 11.

253 Ibid., pp. 11 and 34.

254 Ibid., p. 11.

The PSET GER for adolescents increased significantly from 2.9 per cent in 2010 to 8.6 per cent in 2011, before decreasing to 7.9 per cent in 2012.[255] However, disaggregated drop-out and completion rates per PSET course/provider type and student age are not available.

According to the 2011 Population and Household Census, 98 percent of the population of 15–24 years old are literate, with females marginally more literate than males (98.7 per cent compared with 97.2 per cent). This suggests education in Samoa is of sufficient quality.[256] This represented a 7.4 per cent improvement to the literacy rate identified by the preceding census in 2006.[257] However, up-to-date disaggregated data on PSET outcomes for adolescents and young people are necessary to make it possible to conduct a more comprehensive situational analysis of the quality of education provision for this age group.

A lack of organizational capacity and limited budget are barriers to the delivery of quality PSET, particularly in terms of funding resources. The 2015 EFA National Review also highlights a need to strengthen the knowledge and skills of many PSET lecturers and trainers.[258]

255 Ibid., p. 35.

256 Cited in ibid., pp. 8 and 41.

257 Cited in ibid., p. 41.

258 EFA 2015 National Review, p. 47.

6.

Child Protection

The CRC, its two Optional Protocols and other key international human rights instruments outline the state's responsibility to protect children from all forms of violence, abuse, neglect and exploitation. While the CRC recognizes that parents have primary responsibility for the care and protection of their children, it also emphasizes the role of governments in keeping children safe and assisting parents in their child-rearing responsibilities. This includes obligations to support families to enable them to care for their children, to ensure appropriate alternative care for children who are without parental care, to provide for the physical and psychological recovery and social reintegration of children who have experience violence, abuse or exploitation, and to ensure access to justice for children in contact with the law.

The CRC recognizes the following rights that are the most relevant to this chapter:
Article 7 – The right to identity and to be registered at birth
Article 19 – The right to protection from all forms of physical or mental violence, abuse or neglect, or exploitation
Article 23 – The rights and special needs of children with disabilities
Article 32 – The right to protection from economic exploitation
Article 33 – The right to protection from illicit use of narcotic drugs
Article 34 – The right to protection from all forms of sexual exploitation and sexual abuse
Article 35 – The right to protection from the abduction, sale and traffic in children
Article 36 – The right to protection from all other forms of exploitation
Article 37 – The right to protection from torture, cruel or inhuman treatment, capital punishment and unlawful deprivation of liberty
Article 39 – The right to physical and psychological recovery and social integration
Article 40 – The rights of the child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity

State parties' obligations to protect children are further guided by: the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography; the Optional Protocol

on the Involvement of Children in Armed Conflict; the Convention on the Rights of People with Disabilities; ILO Convention 138 on the Minimum Age; ILO Convention 182 on the Worst Forms of Child Labour; the UN Guidelines for the Alternative Care of Children (2010); UN Standard Minimum Rules for the Administration of Juvenile Justice (1985); UN Guidelines for the Prevention of Juvenile Delinquency (1990); UN Rules for the Protection of Juveniles Deprived of Their Liberty (1990); and UN Guidelines for Justice on Child Victims and Witnesses in Criminal Proceedings (2005).

In addition to the CRC, the SDGs sets specific targets for child protection in relation to violence against women and girls (5.2), harmful traditional practices (5.3), child labour (8.7), provision of safe spaces (11.7), violence and violent deaths (16.1), abuse, exploitation, trafficking and all forms of violence against and torture of children (16.2) and birth registration (16.9). The SDGs also promote strengthened national institutions for violence prevention (16.a).

Key Child Protection-related SDGs

SDG	Target	Indicators
5.2	End all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
		Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18
		Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age
8.7	Take immediate and effective measures to secure the prohibition and elimination of the worst forms of child labour, eradicate forced labour and by 2025 end child labour in all its forms including recruitment and use of child soldiers	Proportion and number of children aged 5–17 years engaged in child labour, by sex and age
11.7	By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, particularly for women and children, older persons and persons with disabilities	Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months

SDG	Target	Indicators
16.1	By 2030, significantly reduce all forms of violence and related deaths everywhere	Number of victims of intentional homicide per 100,000 population, by sex and age
		Conflict-related deaths per 100,000 population, by sex, age and cause
		Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months
		Proportion of population that feels safe walking alone around the area they live in
16.2	End abuse, exploitation, trafficking and all forms of violence and torture against children	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by care-givers in the previous month
		Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation
		Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18
16.3	Promote the rule of law at the national and international levels and ensure equal access to justice for all	Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms
		Unsentenced detainees as a proportion of overall prison population
16.9	By 2030, provide legal identity for all, including birth registration	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age

UNICEF's global Child Protection Strategy calls for creating a protective environment 'where girls and boys are free from violence, exploitation and unnecessary separation from family; and where laws, services, behaviours and practices minimize children's vulnerability, address known risk factors, and strengthen children's own resilience'.[259] The UNICEF East Asia and Pacific Region Child Protection Programme Strategy 2007 similarly emphasizes that child protection requires a holistic approach, identifying and addressing community attitudes, practices, behaviours and other causes underpinning children's vulnerability, engaging those within children's immediate environment (children themselves, family and community) and ensuring an adequate system for delivery of holistic prevention, early intervention and response services.

259 UNICEF 20 May 2008, Child Protection Strategy, E/ICEF/2008/5// Rev. 1.

One of the key ways to strengthen the protective environment for children is through the establishment of a comprehensive child protection system. 'Child protection systems comprise the set of laws, policies, regulations and services needed across all social sectors — especially social welfare, education, health, security and justice — to support prevention and response to protection-related risks.'[260] The main elements of a child protection system are:

Main elements of a child protection system

Legal and policy framework	This includes laws, regulations, policies, national plans, SOPs and other standards compliant with the CRC and international standards and good practices.
Preventive and responsive services	A well-functioning system must have a range of preventive, early intervention and responsive services – social welfare, justice, health and education – for children and families.
Human and financial resources	Effective resource management must be in place, including adequate number of skilled workers in the right places and an adequate budget allocations for service delivery.
Effective collaboration and coordination	Mechanisms must be in place to ensure effective multi-agency coordination at the national and local levels.
Information management and accountability	The child protection system must have robust mechanisms to ensure accountability and evidence-based planning. This includes capacity for data collection, research, monitoring and evaluation.

Source: Adapted from UNICEF Child Protection Resource Pack 2015

6.1. Child protection risks and vulnerabilities

This section provides an overview of available information on the nature and extent of violence, abuse, neglect and exploitation of children in Samoa; community knowledge, attitudes and practices relating to child protection; and the drivers underlying protection risks.

6.1.1. Nature and extent of violence, abuse, neglect and exploitation of children

Samoa has limited quantitative data on child protection, and as a result it is not possible to present a clear picture of the nature and extent of violence, abuse, neglect and exploitation of children. Nonetheless, available information indicates that Samoan children experience various forms of violence, abuse, neglect and exploitation in several contexts, including within the home, in schools and in the community.

260 Ibid.

6.1.1.1. Violence in the home

Samoan children experience high rates of violence in their homes, with corporal punishment relatively widespread. A significant majority (77 per cent) of adult respondents who participated in a 2013 Child Protection Baseline Study reported that they had 'hit, smack, kick, pinch or dong children's heads or pull their ears,' and over half (51.4 per cent) of child respondents reported that, 'Within the past year, an adult at home has hit, smacked, kicked, pinched or donged their heads or pulled their ears.'[261] Of five PICTs for which comparable data are available, only Kiribati and Vanuatu reported higher rates of corporal punishment against children. The most common perpetrators of violence against children in the home were parents (75 per cent), and the most common reason adults gave was 'to discipline and educate the child' (60.6 per cent).[262]

A 2017 Family Safety Study similarly found high rates of violence experienced by both boys and girls. The study found that the life-time rate of violence against children was 89 per cent for girls and 90 per cent for boys, with a prevalence rate within the last 12 months of 69 per cent for girls and 63 per cent for boys. Reported physical abuse involved hitting with an object or hand, slapping, punching and throwing a heavy solid object such as timber. In addition, 43.5 per cent of children reported experiencing emotional abuse, including name-calling, telling off, being sworn at, teasing, not being spoken to child for a while and others/neighbours being told about child's wrong-doing. On the frequency of physical violence, 67 per cent of children indicated it was 'rarely experienced', 15 per cent reported 'frequently' experiencing violence, 13 per cent were 'occasionally affected' and 6 percent said they were 'usually' abused. As with the Child Protection Baseline Study, parents were the most common perpetrators of violence against children (48 per cent indicating father and 31 per cent mother), followed by older siblings and other children (19 per cent) and male relatives including uncles and cousins (2 per cent).[263]

Available data also suggest that a significant number of Samoan children are exposed to family violence in their homes. The 2017 Family Safety Study found that more than half (60 per cent) of the women who had ever been in a relationship had experienced some form of domestic abuse in the two years prior to the study, and 46 per cent experienced abuse in the last 12 months. This is higher than the average life-time prevalence rate of 48 per cent for the PICTs for which data are available.[264] The 2017 Family Safety Study also noted that there had been a significant increase in rates of domestic violence as compared with a similar Samoan Family Health and Safety Study conducted in 2000, where the rate of violence experienced in lifetime was 46 per cent and the rate of violence experienced in the last year was 24 per cent.[265]

6.1.1.2. Violence in schools

Despite the legal prohibition of corporal punishment in schools, 41 per cent of children who participated in the Child Protection Baseline Study reported being physically hurt by a teacher at

261 MWCPD and UNICEF, 'Child Protection Baseline Report for Samoa', 2013, p. 17.

262 Ibid., p. 18.

263 Ministry of Women and Social Development, 'Family Safety Study', 2017, pp. 45–47.

264 Cook Islands, FSM, Fiji, Kiribati, Marshall Islands, Nauru, Palau, Samoa, Solomon Islands, Tonga and Vanuatu.

265 P. 35.

school in the last year, with 55 per cent indicating that an implement such as a stick, ruler, duster or broom was used.[266] The National Policy for Children 2010–2015 notes that Samoa is in transition away from physical discipline, but teachers practising corporal punishment is still commonplace. The media regularly reports cases of students who have been severely physically punished by teachers, in some cases resulting in medical care being sought.[267]

A 2011 Global School Health Survey also suggests that Samoan children face significant levels of peer violence and bullying in schools. The proportion of Samoan students aged 13–15 who were engaged in physical fights in the last 12 months was higher than the regional average (for countries with data),[268] standing at 62.1 per cent (regional average of 49.5 per cent). The proportion of students aged 13–15 who had experienced bullying in the 30 days before the study (69.4 per cent) was the highest of all PICTs for which information was available (regional average of 45.4 per cent).[269]

Table 6.1: Violence and unintentional injury rates in 2011

	Male	Female	Total
% of students in a physical fight one or more times in past 12 months	67.7	73.3	62.1
% of students seriously injured one or more times in past 12 months	83.2	87.7	78.6
% of students bullied on one or more days in past 30 days	74.0	78.6	69.4

Source: GSHS 2011 data.

The Child Protection Baseline Study also raised concerns about sexual abuse and harassment of children in schools. Of the children surveyed, 9.5 per cent reported being touched inappropriately at school in the past 12 months, most of whom (74.3 per cent) had been touched by another child.[270]

6.1.1.3. Sexual abuse

Limited data are available on child sexual abuse in Samoa. According to the 2000 Family Health and Safety Study, 2 per cent of women surveyed reported that they had experienced sexual abuse

266 Family Safety Study, p.18.

267 National Policy for Children 2010–2015, pp. 8–9, on http://www.mwcsd.gov.ws/images/stories/PUBLICATIONS%20WEBSITE/New-update%202013/Ministry%20Policies/NATIONAL%20POLICY%20FOR%20CHILDREN%202010-2015.pdf [19.06.17].

268 Cook Islands, Fiji, Kiribati, Nauru, Niue, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu.

269 Ibid.

270 Child Protection Baseline, p. 20.

before the age of 15,[271] a figure that is considerably lower than the average of 17 per cent for the PICTs for which data are available.[272] Of this 2 per cent, 36 per cent reported that their father had perpetrated the sexual abuse; 4 per cent that it was a family male; 39 per cent that it was a family female; and 19 per cent that it was a teacher.[273] The 2017 Family Safety Study did not survey sexual abuse before the age of 15. However, 19.6 per cent of respondents aged 15–49 reported that they had experienced sexual abuse in their lifetime.[274]

Of the children who participated in the Child Protection Baseline Study, 15.9 per cent reported experiencing inappropriate touching at home, in the community or at school in the past 12 months. Of those who reported inappropriate touching, most (70.6 per cent) had been touched by another child and 25.8 per cent had been touched by an adult. These incidents most commonly involved touching of 'private parts', buttocks and chest/breasts. In total, 57 separate incidences of inappropriate touching were reported, involving 22 boys and 35 girls. [275]

Concern about child sexual abuse and incest was also noted in the Joint Submission to the UPR Process by the Samoan Umbrella for Non-Governmental Organisations and was reflected in the submission by the National Human Rights Institution (NHRI):

> *'Sexual abuse and incest is condemned by both national law and within the fa'asamoa. Despite this, the NHRI is concerned that sexual abuse and incest are prevalent and there is a lack of information and statistical data on its nature, extent and causes. The issue of broader family reputation plays a role in underreporting, silencing the child victim and protecting the adult perpetrator. Further, young children are not aware of where to report child abuse or incest.'*[276]

6.1.1.4. Child labour, trafficking and commercial sexual exploitation of children

Concern has been raised about the risks and vulnerabilities facing Samoan children engaged in child labour as street vendors, which interferes with child's education and social development.[277] Child street vendors reportedly begin at an early age, and often choose earning a living over continuing their education. This can have lasting ill effects on the children, including the development of poor lifestyle habits, staying up late, lack of sleep, eating junk food, picking up bad street habits and

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271 Samoa Family Health and Safety Study 2000, cited in UNICEF/UNFPA, 'Harmful Connections: Examining the Relationship between Violence against Women and Violence against Children in the South Pacific', 2015, p. 15.

272 Cook Islands, FSM, Fiji, Kiribati, Marshall Islands, Nauru, Palau, Samoa, Solomon Islands, Tonga and Vanuatu.

273 Samoa Family Health and Safety Study 2000, cited in UNICEF/UNFPA, 'Harmful Connections: Examining the Relationship between Violence against Women and Violence against Children in the South Pacific', 2015, p. 15.

274 Ibid.

275 Family Safety Study, p. 20–21.

276 NHRI, 'Samoa's Second UPR', 2015, para. 23, on https://www.upr-info.org/en/review/Samoa/Session-25---May-2016 [19.06.17].

277 US Department of Labor, 'Findings on the Worst Forms of Child Labour – Samoa', 2016, on https://www.dol.gov/agencies/ilab/resources/reports/child-labor/samoa; UPR, 'Summary of Stakeholders' Information: Samoa', 2016, para. 20, on https://www.upr-info.org/en/review/Samoa/Session-25---May-2016 [19.06.17].

poor personal hygiene and sanitation, as well as emotional trauma from the verbal abuse hurled at them on the streets.'[278]

In 2014, the International Labour Organization (ILO) commissioned a Rapid Assessment of Children Working on the Streets in Apia.[279] The assessment interviewed 106 children (75 male and 31 female) and found that children as young as 7 years old were working as street vendors in Apia. The study found children sometimes engaged in begging or selling drugs and were at risk of engaging in commercial sexual exploitation. The Rapid Assessment's key findings were as follows:

- At the time of the research more boys than girls were working.
- 41 working children were below the age of 15 years old (the minimum age of employment), with the two youngest 7-year-old girls.
- 21 children interviewed for the study were between 7 and 12 years old (below the age of light work).
- 97 children engaged in child labour had had to drop out of school and 9 had never attended school.
- 48 of the children had dropped out of school because their family could not afford school fees and expenses, while 20 of the children worked to pay their own school fees.
- 69 of the children had started work in order to provide an income for their family.
- 75 of the children worked for over 5 hours each day; 4 worked for more than 12 hours.
- Most children reported that they lived in rural villages and travelled in to Apia to work.

Children engaged in street vending labour face a number of hazards, including abuse, accidents, heat-related concerns or illnesses and the risk of harm from drunk people, other adults or other children.[280]

No information was available in relation to trafficking in or sexual exploitation of children in Samoa.

6.1.1.5. Child marriage

According to a joint report by the Inter-Parliamentary Union (IPU) and WHO, the practice of early and forced marriage does not appear to be widespread in Samoa.[281] The most recent data available from 2014 indicate that just 1 per cent of women 20–24 years old were first married or in union before they were 15 years old, and 11 per cent of women 20–24 years old were first married or in union before they were 18 years old.'[282]

278 National Policy for Children 2010–2015, pp. 8–9.

279 ILO, 'Report of the Rapid Assessment of Children Working on the Streets of Apia, Samoa: A Pilot Study', 2017, on http://www.ilo.org/suva/publications/WCMS_546199/lang--en/index.htm [19.06.17].

280 Ibid.

281 IPU and WHO, 2016, 'Child, Early and Forced Marriage Legislation in 37 Asia-Pacific Countries', 2016, p. 109, on http://www.ipu.org/pdf/publications/child-marriage-en.pdf [19.06.17].

282 DHS 2014, p. 112.

6.1.1.6. Children in conflict with the law

Samoa maintains data on 'young offenders' between the ages of 10 and 29 years, but does not disaggregate data for children under the age of 18. According to the Child Protection Baseline Study, offences are most commonly perpetrated by 20–29 year olds rather than under-18s. Of the total number of 10–29 year-olds on community-based sentencing between 2008 and 2010, only 16 per cent were aged 10–19, and on average there are approximately 20 cases of child offenders before the Youth Court each year.[283] This suggests that a relatively low number of children are being formally processed through the criminal justice system.

6.1.2. Community knowledge, attitudes and practices

Child-rearing in Samoa is strongly in influenced by cultural and Christian teachings and practices. Children are regarded as a blessing and a responsibility from God, and as a such families are highly protective of their children, as evidenced by Samoan proverb *O au o matua fanau* ('Children are parents' ultimate treasures'). Family is also very important in Samoan culture, and the concepts of *fassinomaga* (genealogical identity) and *aiga* (family) are pivotal cultural principles underpinning the protection of children. All Samoan children have an *aiga* to which they belong, and most *aiga* hold annual family reunions to maintain the importance of belonging to an *aiga*. It is normal practice for uncles, aunties, grandparents or other relatives to care for a child in the event of family breakdown, which acts as an important social safety net for children.[284]

Instilling children with respect for elders and discipline is considered a central part of a parent's responsibility to ensure that their children become respectful and well-mannered adults. Corporal punishment by caregivers is generally perceived as a preferred option for disciplining children.[285] While this falls primarily to parents, it is also generally accepted that other adults may also discipline younger persons, including teachers and pastors.[286]

Studies suggest that some progress has been made in promoting greater acceptance of non-violent parenting approaches and alternatives to corporal punishment. The Child Protection Baseline Study found that only 0.2 per cent of respondents supported the idea that 'Hitting and smacking children is one of the best ways to discipline children.'[287] However, those with traditional attitudes and older members of communities remain supportive of corporal punishment and other violence against women and children.[288]

283 Ibid., p. 27.

284 Child Protection Baseline, Op. Cit. p. 11; State Party Report, para 5.1.

285 State Party Report, para 4.19.

286 Family Safety Study, p. 55.

287 Child Protection Baseline Study, p. 18.

288 NHRI, Samoa's Second UPR Submission 2015, para. 23; National Policy for Children 2010–2015, pp. 8–9.

6.1.3. Drivers of violence, abuse, neglect and exploitation of children

Studies have highlighted a number of social norms and community practices that impact on child protection. In particular, the general acceptance of corporal punishment against children and the normalization of violence as a corrective and disciplining tool in the family, village and institutions has been identified as a key factor underpinning children's vulnerability to violence.[289] The Family Safety Study notes that, from an early age, both boys and girls are 'habituated to accept anger and assault as legitimate forms of discipline.'[290]

In addition, the culture of silence around violence against children and the perception that it is a private family matter perpetuates the cycle of violence and acts as a barrier to reporting and referral of cases. The Child Protection Baseline Study found that, while the vast majority of stakeholders surveyed said children knew who to talk to if somebody hurt them, in 79 per cent of cases where a child had been hurt or abused, the child had not told anyone.[291] The Family Safety Study similarly found that a large portion (48 per cent) of children who reported experiencing violence did not report their experience to anyone, with the most common reasons being that they still loved their parents and/or those who inflicted violence (39 per cent) or because they blamed themselves for causing it (30 per cent).[292] The Study notes that children's reluctance to talk about their experience or report abuse to relevant authorities indicates how their own perception of violence has been conditioned by broader societal acceptance of it as a form of discipline.[293] However, these attitudes are beginning to change, at least in relation to sexual abuse, with media and community outreach programmes contributing to greater willingness to report child abuse, particularly sexual offences, to the police.[294]

Children's limited bodily autonomy and lack of empowerment to protect themselves is also a contributing factor to violence and exploitation. Of the children interviewed as part of the Child Protection Baseline Study, 14 per cent indicated that they did not understand what kind of touching was acceptable or not; 27 per cent thought there was no need to tell someone if they were offered money, sweets, clothes or other things in exchange for that person touching their body; and 18 per cent agreed that there was no need to tell anyone if someone touched them in a way that made them feel uncomfortable.[295].

A key structural cause contributing to children's vulnerability to violence, abuse, neglect and exploitation are bottlenecks and barriers in the delivery of effective child and family welfare services, and in access to child-friendly justice (discussed below).

289 Child Protection Baseline, p. 10; Family Safety Study, Op. Cit, p. 16-17.
290 P. 17.
291 Ibid., p. 19.
292 Family Safety Study, p. 49.
293 Ibid., p. 55.
294 Child Protection Baseline, p. 10.
295 Ibid., p. 19.

6.2. The child protection system

The Samoan government has made significant progress in strengthening the national child protection system, but some gaps and challenges remain.

6.2.1. The legal and policy framework for child protection

Samoa does not have a current, over-arching child protection policy or plan of action. The National Policy and Plan of Action for Children 2010–2015 has expired and is in the process of being reviewed. Children's right to care and protection has been addressed under a variety of national laws:

Key child protection laws

Child care and protection	Infants Ordinance 1961; Family Safety Act 2013
Child custody and maintenance	Infants Ordinance 1961
Adoption	Infants Ordinance 1961; Infant Adoption Regulation 2006
Birth registration	Births, Deaths and Marriages Act 2002
Child labour	Labour and Employment Relations Act 2013
Penalisation of physical abuse, sexual abuse, and sexual exploitation	Crimes Act 2013
Child victims and witnesses in criminal proceedings	Evidence Act 2015
Violence in schools	Education Act 2009; Behaviour Management Guidelines; National Violence-Free Schools Policy
Children in conflict with the law	Young Offenders Act 2007; Community Justice Act 2008.
Children with disabilities	National Policy on Disability
Child protection in emergencies	Disaster and Emergency Management Act 2007; National Disaster Management Plan

A number of minimum age provisions have also been legislated to protect children from various forms of violence, abuse, neglect and exploitation:

Legal definition of the child under Samoan law

Definition of a child under child welfare law	16
Minimum age for marriage	18 for males, 16 for females[III]
Minimum age for employment	15
Minimum age for engaging in hazardous work	18
Age for consent to sexual activity under criminal laws	16
Minimum age of criminal responsibility	10
Maximum age for juvenile justice protections	17

6.2.1.1. Legal framework for child and family welfare services

Samoa lacks a comprehensive child protection law to provide a solid legal basis for the development of prevention, early intervention and response services for children and their families. A new Child Care and Protection Bill has been drafted and is pending approval. Currently, the primary legal basis for intervening to protect a child is the outdated Infants Ordinance 1961, which authorizes the court to place a child under the age of 16 into the care of a child welfare officer if the child is 'living in a place of ill repute or is a neglected, indigent or delinquent child, or is not under proper control, or is living in an environment detrimental to its physical or moral well-being.'[296] The Ordinance also regulates domestic and inter-country adoptions.

Under the Family Safety Act 2013, a child (or person acting on behalf of the child) who has experienced domestic violence may apply to the court for an interim protection order or protection order prohibiting further contact and communication by the perpetrator. The Act also requires police officers to make arrangements for the safety, security and counselling of a victim and the victim's family if needed, and to refer child victims to the Child Welfare Office.[297] This provides children with some protection from continued abuse, but is not an adequate substitute for a comprehensive child protection law.

6.2.1.2. Legal framework for justice for children

Samoa's Crimes Act 2013 penalizes a range of offences against children, including assault and causing injury; incest; sexual violation; sexual conduct with a dependent family member under the age of 21 (regardless of consent); sexual conduct with a child under 12 and with a young person under 16 (regardless of consent); possession, production and distribution of 'indecent material on a child;' 'dealing' with a child for the purposes of sexual exploitation or forced labour; and online solicitation (grooming) of children. These offences provide equal protection to boys and girls and generally carry penalties commensurate with the grave nature of violence against children. In addition, section 12 of the Infants Ordinance 1961 penalizes ill-treatment and neglect of children; however, section 14 grants parents, teachers or other person having 'lawful control and charge' of a child the right to administer 'reasonable punishment'.

296 Section 16.

297 Sections 8–15.

Samoa has also made provision for special procedural protections to facilitate children's testimony and reduce the trauma of participating in criminal proceedings. The Evidence Act 2015 gives the court discretion to allow a complainant to have a support person near them while giving evidence; allows the judge to disallow question that are improper or expressed in language that is too complicated for the witness to understand; prohibits the accused from directly cross-examining the complainant or any child witness in a sexual case or proceedings concerning domestic violence; and gives the judge discretion to allow a witness to testify via electronic link, video-taped testimony, or from behind a screen.[298]

The handling of children in conflict with the law is governed primarily by the Young Offenders Act 2007. The minimum age of criminal responsibility in Samoa is 10 years old, and there is a rebuttable presumption that children between the ages of 10 and under 12 are not criminally responsible unless the child knew 'that the act or omission was morally wrong, or that it was contrary to law.'[299] This is lower than the 'absolute minimum' age of 12 recommended by the UN Committee on the Rights of the Child, which has also been critical of the practice of having two different ages, subject to a subjective assessment of the child's culpability.[300] In addition, the special procedural protection for young offenders is only applicable to children under the age of 17, rather than 18.

The Young Offenders Act provides for pre-trial diversion of children by giving police discretion to issue a warning rather than formally charging the child.[301] However, it does not otherwise address child-sensitive arrest and investigation procedures. The Act creates a specialized Youth Court to handle cases involving children in conflict with the law and states that proceedings may be conducted in a manner consistent with Samoan custom and tradition, may be conducted informally, may (at the discretion of the judge) be closed to the media and the public and must be completed as soon as possible.[302] Provision is also made for the court to direct the Probation Service to arrange a pre-sentence meeting (*fa'aleleiga*), thus using traditional restorative justice practices to help inform the court's sentencing decision.[303] The Act includes a range of non-custodial sentencing options, states that imprisonment should be used only as a last resort and requires children in detention to be separate from adults.[304] However, offences for which the maximum penalty is life imprisonment are heard by the Supreme Court, and the Youth Court also has very broad discretion to transfer a child to the regular adult criminal court 'if the Youth Court is satisfied that the seriousness of the offence, or any other circumstances of the offence or the defendant make it appropriate' or the child is charged jointly with an adult, and to the Supreme Court if the offence is punishable by imprisonment for more than seven years.[305] This acts as a significant barrier to ensuring specialized treatment of all children in conflict with the law.

298 Sections 69, 73, 80, 86–90.

299 Young Offenders Act 2007, Section 3.

300 UN Committee on the Rights of the Child, General Comment No. 10, para 30.

301 Sections 17–21.

302 Sections 6–8.

303 Section 6.

304 Sections 16–17.

305 Criminal Procedure Act 2016, Section 12.

6.2.2. Child Protection structures, services and resourcing

At the core of any child protection system are the services that children and families receive to reduce vulnerability to violence, abuse, neglect and exploitation. These services should be designed to minimize the likelihood that children will suffer protection violations, help them survive and recover from violence and exploitation and ensure access to child-friendly justice.

6.2.2.1. Child and family welfare services

Responsibility for coordinating child protection services in Samoa lies with the Ministry of Women, Children and Social Development (MWCSD).[306] It has a Child Protection Unit (CPU) with one staff social worker at the national level. MWCSD staff have received training on basic child rights, psychosocial support (post-tsunami / working with children following disasters), basic counseling skills and social impact assessment.[307] The MWCSD also has paid government officers in all villages to coordinate community-based programmes related to child protection, and plans are in place to provide them with specialized training on child protection. In addition, the Samoa Victim Support Group (SVSG) has trained approximately 700 volunteer village representatives in child protection awareness and who report child safety/violence concerns directly and quickly to SVSG.[308]

The MWCSD has collaborated with government and non-government partners to conduct a number of community outreach programmes aimed at reducing violence against women and children, including a Men Against Violence Advocacy Group (MAVAG), a Children Mothers and Daughters Programme (aimed at improving communication between mothers and daughters in relation to sexual and reproductive health), a Young Couples programme, a Supporting Samoa's Children Initiative (addressing children involved in street vending) and a range of multi-media anti-violence campaigns.[309] A number of activities have also been implemented with women's committees and village councils of high chiefs on positive parenting and prevention of child abuse and neglect. The CPU conducts regular positive parenting workshops in communities, which focus on understanding of children's rights, identifying forms of violence and the use of six parenting principles which promote violence-free, positive discipline practices and encourage the development of safe and healthy families.[310] The CPU also conducts workshops for children on prevention of sexual violence which teach children how to keep themselves safe, who to call if they need help and how to distinguish between appropriate and inappropriate touch.[311]

Samoa has yet to develop comprehensive mechanisms for reporting, referral and case management of suspected cases of child maltreatment. An inter-agency referral system exists primarily between the Ministry of Police, the Courts, the National Health Service and SVSG, who refer to each other depending on the nature of children's needs (i.e. criminal investigations; legal interventions; medical and psychological attention; or shelter and psychological attention).

306 MWCSD, 'Annual Report 2014-15'.

307 Child Protection Baseline, p. 31.

308 Ibid., para 16.

309 Family Safety Study, p.57; State Party Report Op. Cit., paras 1.24 – 1.27.

310 Addendum to the State Party Report to the UN Committee on the Rights of the Child, para 16.

311 Ibid., para 20.

However, there is no government entity responsible for case management or for overseeing the care and protection of children. NGOs and government ministries working in the area of child protection reportedly have their own set standards and referral reporting formats and procedures, but they are not consistent or integrated and there are no standardized tools for reporting, referral and follow-up.[312] In its State Party Report to the UN Committee on the Rights of the Child, Samoa acknowledged that 'in some cases, the fragmented systems amongst the service providers, all with their own different reporting guidelines and protocols, have resulted in the system failing to always provide the best care and protection for children.'[313] It is anticipated that the inter-agency referral system will be actioned once the MWCSD is officially mandated as the lead agency for child protection under the Child Care and Protection Bill.[314]

Services for children who have experienced violence, abuse and neglect are primarily provided by NGOs and civil society groups, some of which receive annual grants from the Government. In particular, the SVSG operates four shelters to provide temporary care for children and also provides counselling services for child victims to assist in their psychological recovery.[315] The Social Services team at the National Hospital provides therapeutic counselling for children affected by violence, and there is small pool of social workers and counsellors working at community level for NGOs.[316] However, their capacity is limited.

Samoa lacks a formal foster care programme, and most children in need of alternative care are taken in by extended family or placed temporarily in SVSG shelters. In its 2015 State Party Report to the Committee on the Rights of the Child, Samoa noted an increase of 557 adoption cases between 2007 and 2009, the vast majority (90 per cent) of which were adoption applicants from New Zealand, followed by Australia, American Samoa and Hawaii (United States of America) and internal adoptions within Samoa. This suggests that domestic adoptions are not being given priority over inter-country placements. The report notes that most of these children are being adopted by their own relatives residing overseas, and that this is a normal part of the Samoan extended family care system.[317] Applications for adoption are submitted to the Office of the Attorney General and the MJCA for consideration by the courts, and are rarely referred to the MWCSD for further investigation, generally only in the case of an overseas applicant who wishes to adopt a child but has no blood relation to the child.[318] This does not adequately ensure that all adoption placements are in the best interest of the child.

The lack of a clearly mandated government agency with responsibility for coordination and oversight of child protection services acts as a barrier to the effective functioning of the child protection system. While NGOs and faith-based organizations provide some services to children and their families, there are no mechanisms to ensure accountability, quality control and sustainability of essential services.[319] In addition, human resources constraints and limited

312 Child Protection Baseline, p. 30.

313 Para. 8.8

314 Addendum to the State Party Report, para 4.

315 Ibid. para 13.

316 Child Protection Baseline p. 31.

317 Para. 5.13.

318 State Party Report, para 5.11.

319 Family Safety Study, p. 68.

budgetary commitment to social welfare services act as barriers to effective delivery of child protection services. The MWCSD is the 10th largest budget line ministry in Samoa,[320] and in recent years there have been modest increases in the percentage of the MWCSD budget that is allocated to child protection, up from 2.55 per cent of the MWCSD budget in 2012–2013 to 3.04 per cent in 2014–2015 and 3.57 per cent in 2015–2016.[321] Nevertheless, in its State Party Report to the UN Committee on the Rights of the Child, the government acknowledged that the MWCSD had limited technical, operational and financial resources to take on its new roles and responsibilities under the Child Care and Protection Bill once it is enacted.[322]

6.2.2.2. Access to child-friendly justice

Samoa has made some progress in promoting specialization in the handling of children involved in the criminal justice system as offenders, victims and witnesses. The police established a specialized Domestic Violence Unit in 2007 to handle investigations of domestic violence offences and submissions for protection orders.[323] Training on violence against women and children is provided to new police recruits, and in-service training has been provided on child-friendly procedures. However, the Child Protection Baseline notes that specialised training has tended to focus on youth offending rather than child victims/witnesses, and that further training and user-friendly standard operating procedures are needed to ensure that children are handled in an effective and child-sensitive manner. The report also notes that the Domestic Violence Unit is hampered in responding to cases due to lack of resources, particularly transport and personnel, and case management within the police is also weak, with information getting lost once the handling officer goes off duty and passes the case to someone else.[324]

At the court level, a specialist Family Violence Court was established in 2013 to deal with family violence and child protection cases. The court sits every Monday, and on an average sitting can hear up to 25 cases.[325] However, special measures to facilitate children's evidence in criminal cases (screens, video, etc.) are not routinely available, and there is no victim support programme to familiarize children with the court process and to provide support at all stages of the proceedings.[326]

Cases involving children in conflict with the law are heard by the Youth Court, a division of the District Court. The Child Protection Baseline Study found that, since the passing of the Young Offenders Act and the Community Justice Act, there had been an increase in community-based sentences of children, and an increased recognition of Samoan customs and processes through community mediation.[327] However, not all judges and other court officers have received specialized training, and while some personnel may apply child-friendly procedures based on their natural

320 State Party Report, Op. Cit., para. 1.2.

321 MWFCD Annual Report 2014-2015 and UNICEF Samoa response to internal questionnaire.

322 Para. 3.9.

323 Family Safety Study, p.58.

324 Pp. 24, 31.

325 Addendum to State Party Report, para. 21.

326 Child Protection Baseline, Op. Cit, p. 24.

327 Ibid. p. 27.

sensitivity, this depends on individual discretion and is not standardized procedure.[328] This acts as a barrier to ensuring that Youth Court proceedings are consistently conducted in a child-friendly manner, and that decisions are based on the best interest of the child.

Responsibility for supervision, rehabilitation and reintegration of children in conflict with the law rests with Community Justice Supervisors under the Ministry of Justice and Courts Administration. No statistics are available on court sentencing practices, but anecdotal information indicates that, on average, fewer than 10 young offenders (aged 10–16) per month undertake community-based service.[329] It is reported that the lack of multi-agency collaboration and working protocols to support inter-agency working means that practices such as diversion and alternative sentencing, which require effective joined-up working, are not used by the courts as frequently as they could be.[330] In general, there is a lack of integrated services aimed at reintegration of young offenders into the community.[331]

Samoa established the Olomanu rehabilitation centre for young offenders in 2006 to ensure that offenders under the age of 17 are not detained with adults in Tafaigata Prison. The centre provides educational programmes and training in agricultural skills, which is occasionally supplemented by support from NGOs and community-based projects aimed at building children's skills.[332] The Child Protection Baseline Study reported fewer than 10 young offenders in Olomanu Rehabilitation Centre.[333]

Informal justice mechanisms are commonly used in Samoa to resolve cases involving child offenders and child victims, without resorting to the formal justice system. According to a recent UNICEF report, an estimated 70 per cent of cases involving children in conflict with the law are handled through informal justice mechanisms such that only serious cases or those that cannot be settled at the local level, or those that local leaders do not want to settle, reach the formal justice system. Informal justice in Samoa usually involves victim–offender mediation, at which the child will be present unless under the age of 10 or 12 years.[334] This traditional mediation usually results in payment of a fine or other form of compensation, as well as an apology and some form of restitution such as cleaning the victim's house or engaging in community service.[335] Given the strong community-based structures and cultural preference for restorative justice in Samoa, these informal justice mechanisms have the potential to facilitate access to justice for children at the community level, provided proper safeguards and oversight is in place.

6.2.2.3. Child protection in the health, education, labour and other allied sectors

Samoa's education sector has taken significant steps to address violence in schools. The Education Act 2009 prohibits corporal punishment in schools, and in 2011 the MESC issued 'Behaviour

328 Ibid. pp. 24-25.
329 Ibid., p. 27.
330 Ibid., pp. 25–6.
331 Ibid., p. 26.
332 Ibid.
333 Ibid.
334 Van Welzenis, 'Country-Level Summaries', p. 127.
335 Ibid., p. 128.

Management Guidelines: A Guide for Schools - Improving Student Behaviour and Welfare' (BMG). The BMG highlights the importance of creating a learning environment that is safe, cooperative, caring and positive, reinforces the prohibition of corporal punishment and prohibits cruel and degrading treatment of students. It outlines procedures to follow when a member of staff or a student breaches the BMG, but does not address identification and reporting of suspected incidents of violence or abuse that take place outside the school environment.[336] This has been addressed in a new, more comprehensive National Violence-Free Schools Policy and supporting National Safe Schools Guidelines.

In response to a number of high-profile cases of corporal punishment resulting in serious injuries to students, the MESC established a multi-agency committee to address the use of violence in schools. The committee has undertaken research on the issue, has proposed legislative changes and is leading the development of policies and guidelines.[337] The MESC has reportedly taken steps to build the capacity of staff to use positive discipline techniques and create a safe and caring learning environment for students. However, research carried out by the Public Services Commission in 2013 found that 75 per cent of teachers were still of the view that corporal punishment should be allowed in schools, suggesting that more sensitization with teachers is needed.[338] The MESC, in collaboration with the police and SVSG, has also implemented a number of violence prevention activities with students. The Ministry of Police and Prisons carried out educational awareness programmes for children in schools on preventing alcohol and drug abuse, bullying, street fights and cybercrime.[339] In addition, SVSG provides awareness programmes in schools regarding anti-bullying and violence against children.[340]

Samoa has yet to develop a comprehensive child protection policy for the health sector. The Social Services team at the National Hospital together with the Mental Health Unit provide therapeutic counselling for children affected by violence, and they reportedly collaborate with the police and SVSG in responding to child victims.[341] However, there are no clear protocols for health professionals on identification, treatment and referral of child victims of violence, and child protection prevention and early intervention initiatives have not been integrated into maternal and community health services.

Samoa's labour sector has reportedly made 'moderate' advances in its efforts to eliminate the worst forms of child labour.[342] The Labour and Employment Relations Act 2013 prohibits the employment of a child under the age of 15, except in safe and light work suited to the child's capacity, and further prohibits the employment of a child under 18 years on dangerous machinery or in any other working place or condition injurious to the physical or moral health of the child.[343] The government has determined a list of hazardous work prohibited to children. The Ministry of

336 Child Protection Baseline, p. 32.

337 State Party Report, para 4.15; Addendum to State Party Report, para 8.

338 Addendum to State Party Report, para 8.

339 State Party Report, paras 4.15.

340 Addendum to State Party Report, para 16.

341 Addendum to State Party Report, para 15.

342 US Department of Labour.

343 Section 51.

Commerce, Industry and Labour Research has collaborated with the ILO through the TACKLE project to undertake research on the involvement of children in street vending, conduct awareness on child labour and produce an Employers Guide for Eliminating Child Labour. A Child Labour Taskforce has been established to coordinate implementation of strategies to address issues of children involved in street vending, including spot checks to enforce provisions under the Education Act 2009 prohibiting compulsory school-aged children from engaging in street trading or other work during school hours.[344]

6.2.3. Mechanisms for inter-agency coordination, information management and accountability

Samoa has established a National Council for the Convention for the Rights of the Child (NCCCRC), which, chaired by the MWCSD, plays a policy advisory and monitoring role in overseeing the implementation of CRC.[345] However, it does not have a sub-committee or specific mandate for strategic planning, policy development and coordination in relation to child protection.

Samoa developed a Child Protection Information System (CPIS) in 2007, using a centralized database managed by the MWCSD. The CPIS stores information in relation to 10 'risk indicators' and is, in theory, updated annually. The CPIS was reportedly used as a tool in the early stages of developing the National Policy for Children of Samoa and to support child protection programmes implemented by various government ministries. However, the Child Protection Baseline Study noted that training and awareness on the use of the CPIS was lacking, and, although it was initially envisioned that all partners would use the templates and upload data onto a common platform, the system is used only by MWCSD staff. It also noted that shortcomings owing to 'scarce resources and non-availability of trained staff' meant the MWCSD had switched to using DevInfo and Excel software to store current child protection data rather than CPIS.[346] Statistics collected by the justice sector are not clearly disaggregate by age, and therefore do not clearly distinguish cases involving victims or offenders under the age of 18.[347] Effective planning, policy development and monitoring of Samoa's child protection system is hampered by the lack of a fully-functioning, centralized child protection information management system.

6.3. Other child protection issues

6.3.1. Birth registration

Samoa's birth registration system is governed by the Births, Deaths and Marriages Act 2002 and managed by the Birth, Deaths and Marriages division of the Samoa Bureau of Statistics. A computerised registration system has been in place since 2002. Whether a child is born in a health

344 Addendum to State Party Report, paras. 58-62.

345 State Party Report, Op. Cit., para. 1.5.

346 Child Protection Baseline, p. 34.

347 Ibid.

facility or in the village, a birth notification must be made indicating the date of birth, place of birth, live/still birth, names of natural parents or mother if a one-parent child. Notifications from hospitals are done electronically, and at the village level a standard paper form is completed by either the village mayor or the appointed village women's representative. Birth notifications are sufficient proof for registration only up to three months from the date of birth, and registration after that time period requires supporting documents (e.g. baptismal certificate, child immunization card; confirmation letter from the church or an official hospital notification). Births can only be registered by the child's natural parents, but in practice grandparents of children born out of wedlock tend to register the child under their own name (to avoid stigmatizing the child, mother and family).[348]

Despite the legal framework and registration mechanisms in place, there are still children and in some instances young adults whose births have not been registered.[349] The latest DHS figures for Samoa show a birth registration rate of 59 per cent, with a 1:1.2 ratio of rural to urban registration and a 1:1.6 ratio of the poorest to wealthiest 20 per cent. This is an improvement since the previous DHS in 2009, when only 48 per cent of children under five had their birth registered.[350] However, inequity in access to birth registration continues to be a challenge for those in remote or rural areas and for those with the fewest financial resources. In its State Party Report to the UN Committee on the Rights of the Child, Samoa advised that the Birth, Deaths and Marriages division is working in partnership with the MWCSD to improve birth notifications and registration, including the possibility of encouraging more notifications within the three-month period by issuing birth certificate without charging the current fee of $WST 10.[351] The MWCSD noted in its 2014–2015 Annual Report that it had conducted eight birth registration trainings and 17 one-on-one sessions for village women representatives in Upolu and Savaii in order to improve birth registration. The Annual Report recorded a 60 per cent increase in registration from the previous year.[352]

6.3.2. Children with Disabilities

Samoa has ratified the Convention on the Rights of Persons with Disabilities and established a Disabilities Taskforce chaired by the Chief Executive Officer of Women, Community and Social Development.[353] In addition, the self-help advocacy group NOLA (Nuanua o le Alofa) has assisted in surveys and participated in numerous national and regional forums as key advisors to government on disability policy and concerns.[354] A National Policy on Disability and accompanying Implementation Plan 2011–2016 were developed but are now out of date. The Policy defined the nature of an inclusive and barrier-free society and designated roles, responsibilities and structures within government to address disability issues. It also provided a statement of vision, goals and a series of specific objectives, supported by identification of actions to be undertaken in order to achieve the overall goal of an inclusive society.

348 Child Protection Baseline Study, p. 35.
349 State Party Report, para. 4.4.
350 DHS 2014, p. 31.
351 Ibid., para 4.5.
352 MWCSD, 'Annual Report 2014-15'.
353 State Party Report, para. 6.13–6.15.
354 Ibid., para. 6–17.

A 2010 disability survey identified 1,371 Samoan children under the age of 18 with disabilities, 755 boys and 616 girls. The majority of children are affected by learning disabilities, epilepsy and deafness. Newborn babies and children detected by the Ministry of Health and the National Health Services as having a disability are referred to the Loto Taumafai Early Intervention programme or SENESE International Support Service, which are the only community-based programme available providing assistance and rehabilitation services for children with disabilities.[355] In its State Party Report to the UN Committee on the Rights of the Child, the government acknowledged that, while Samoa's commitment to incorporating disability issues into national and sector plans is clear, actions to move this commitment forward in the legislative, administrative, social and financial levels are currently limited.[356]

6.3.3. Climate change and natural disasters

Like most PICTs, Samoa is vulnerable to the impacts of climate change and natural disasters. In the event of a natural disaster, children are the most vulnerable population. Effects of climate change like drought and high tides also harm vulnerable children. Climate change and the risk of natural disasters can also act as a barrier or bottleneck to the child protection system in Samoa by disrupting infrastructure and services and placing children at additional risk. After Cyclone Evan in 2012, for example, the government of Samoa reported that 'The toilet/shower blocks for the hostel of a girls' college had safety and security issues, and did not provide adequate privacy for individual girls.'[357] This reflects an increased risk to children following natural disasters.

Samoa's Disaster and Emergency Management Act 2007 provides the legal and administrative framework for disaster risk management and emergency preparedness and response at all levels. The Ministry of Natural Resources and Environment has developed a National Policy of Combating Climate Change as well as a National Disaster Management Plan 2011–2016. The MWCSD works closely with the Disaster Management Office (DMO) and other relevant ministries to carry out and facilitate community preparedness for natural disasters, including the impact of climate change. This process is facilitated through the village council and Women's Committee, with active involvement of children and young people, to ensure increased awareness and improved family and community-level preparedness and how to cope and recover during and after the post-disaster period.[358] In addition, the Ministry of National Resources and Environment has collaborated with MESC to integrate disaster risk reduction and disaster risk management into the curriculum for school children of all ages, along with a Teachers' Resource Kit.[359] Training on child protection in emergencies has been provided for key stakeholders, including staff from the MWCSD, DMO and NGOs.[360]

355 Ibid., paras. 6.18-6.21

356 Ibid., para. 6.15.

357 Government of Samoa, 'Post-Disaster Needs Assessment, Cyclone Evan', 2012, on http://www.gfdrr.org/sites/gfdrr/files/SAMOA_PDNA_Cyclone_Evan_2012.pdf [19.06.17].

358 State Party Report, para. 6.67.

359 Addendum to the State Party Report, para. 47.

360 Interview with UNICEF Pacific staff [29.11.17.].

7.

Social Protection

A comprehensive social protection system is essential to reduce the vulnerability of the most deprived persons – including children – to social risks. Social protection systems can strengthen the capacity of families and carers to care for their children and help remove barriers to accessing essential services, such as health care and education, and thereby help close inequality gaps. Social protection measures can also help cushion families against livelihood shocks, including unemployment, loss of a family member or a disaster, and can build resilience and productivity among the population.

According to UNICEF, social protection is 'the set of public and private policies and programmes aimed at preventing, reducing and eliminating *economic* and *social* vulnerabilities[361] to poverty and deprivation, and mitigating their effects'.[362] Social protection systems are essential to ensuring realization of the rights of children to social security (CRC Article 26) and a standard of living adequate for their physical, mental, spiritual, moral and social development (CRC Article 27). According to Article 27(2) of the CRC, State Parties are required to 'take appropriate measures to assist parents and others responsible for the child to implement this right [to an adequate standard of living] and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing'.

In order to achieve this, SDG 1.3 requires the implementation of 'nationally appropriate social protection systems and measures for all, including [social protection] floors'. A social protection floors consist of two main elements: essential services (access to WASH, health, education and social welfare); and social transfers (a basic set of essential social transfers in cash or in kind, paid to the poor and vulnerable).[363]

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361 UNICEF distinguishes between the two as follows: 'Poverty reflects current assets or capabilities, while vulnerability is a more dynamic concept concerned with the factors that determine potential future poverty status. Vulnerability considers both an individual's current capabilities and the external factors that he/she faces, and how likely it is that this combination will lead to changes in his/her status.'

362 UNICEF Social Protection Strategic Framework, 2012, p. 24.

363 ILO and WHO, 'The Social Protection Floor: A Joint Crisis Initiative of the UN Chief Executive Board for Coordination on the Social Protection Floor', October 2009, on http://www.un.org/ga/second/64/socialprotection.pdf [14.08.17].

Key Social Protection-related SDGs

SDG	Target	Indicators
1.1a	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US$ 1.25 a day	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US$ 1.25 a day
1.2	By 2030, reduce at least by half the proportion of men, women and children living in poverty in all its dimensions according to national definitions	Proportion of population living below the national poverty line, by sex and age
		Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions
1.3	Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable	Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable
1.4	By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance	Proportion of population living in households with access to basic services
		Proportion of total adult population with secure tenure rights to land, with legally recognized documentation and who perceive their rights to land as secure, by sex and by type of tenure

Under UNICEF's Social Protection Strategic Framework, to achieve social protection it is necessary to develop an integrated and functional social protection system. This means developing **structures and mechanisms** to coordinate interventions and policies to effectively address multiple economic and social vulnerabilities across a range of sectors, such as education, health, nutrition, WASH and child protection.[364]

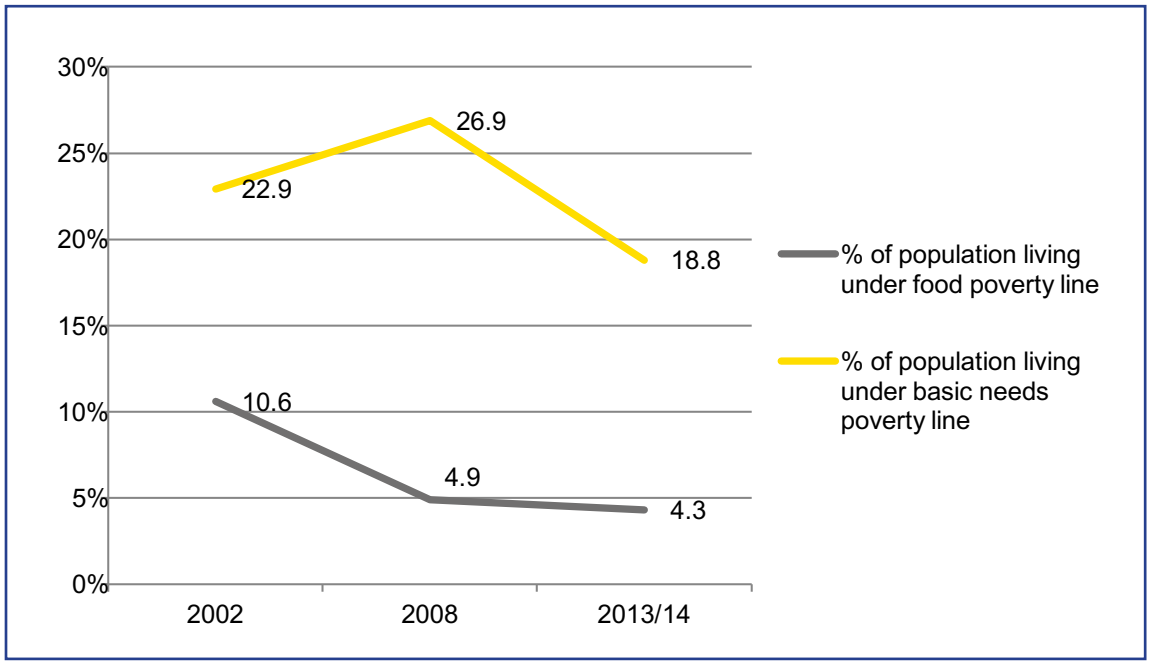
364 UNICEF Social Protection Strategic Framework, p. 31.

7.1. Profile of child and family poverty and vulnerability

As set out above, a significant proportion of Samoa's population is living in poverty, and rates of poverty appear to have declined since 2000. Incidence of food poverty remains very low, and has declined significantly since 2002. According to the country's HIESs, 10.6 per cent of the population in 2002 was living below the food poverty line, compared with only 4.3 per cent in 2013–2014.[365] The reduction in food poverty over this time period was accompanied by a significant increase in subsistence production as a percentage of household consumption.[366]

Incidence of basic needs poverty also appears to have declined since 2002. As Figure 7.1 illustrates, in 2002 22.9 per cent of the population lived below the basic needs poverty line. According to the 2012–2013 HIES, this proportion dropped to 18.8 per cent in 2013–2014, following a rise to 26.9 per cent reported in the 2008 HIES.[367] This rise has been attributed to the loss of jobs at Yazaki manufacturing firm and an increase in the prices of food, fuel and other items.

Figure 7.1: Percentage of population living under food poverty and basic needs poverty lines, 2002, 2008, 2013–2014



Source: Samoa Hardship and Poverty Report, 2016.

While there has been a significant decline in the rates of food and basic needs poverty, the proportion of the population vulnerable to poverty has increased. At the national level, the proportion of the population highly vulnerable to becoming poor (i.e. with expenditure only 20

365 UNESCAP, 'The State of Human Development in the Pacific', 2014, p. 14.

366 Ibid., p. 13.

367 Ibid., p. 14.

per cent above the basic needs poverty line) rose from 9.8 per cent in 2008 to 10.2 per cent of the population in 2013–2014. This suggests that the level of increase in real income of the poor was enough only to place a significant proportion of them just above the basic needs poverty line, but not enough 'to provide decent income and reduce vulnerability'. This leaves a significant number of people vulnerable to slipping back into poverty when faced by shocks and 'renders the remarkable progress achieved in terms of poverty reduction unsustainable and highly fragile'.[368]

Poverty has been found to particularly affect children and young people: the 2013–2014 HIES found that children were disproportionately more likely to be living in poor households. Around 22 per cent of children were living below the basic needs poverty line and around 25 per cent were living in households that were vulnerable to poverty.[369] The impacts of poverty are more significant for children, and there is growing evidence that children experience poverty more acutely than adults: the negative impacts of poverty on their development can have profound and irreversible effects into adulthood.

Youth (those aged 15–24 years) are also disproportionately affected by poverty. According to the 2013–2014 HIES, around 19.3 per cent of youth are living below the basic needs poverty line.[370]

Like most countries, in Samoa the national poverty averages mask inequalities within the country. Levels of inequality in Samoa are high compared with other countries in the Pacific, as measured by Gini coefficient.[371] The Gini coefficient in Samoa was 0.56, above the reasonable equality (with 0.30–0.35 generally accepted as 'reasonable'), according to the 2013–2014 HIES. The level of inequality has risen significantly 2002, when it was calculated to be 0.43.[372] The increase in inequality has been attributed to an undermining of traditional systems that promote equitable sharing of resources among community members and a trend towards increased monetization, resulting in the widening of 'the gaps between those operating in the cash economy and those depending on traditional subsistence activities'.[373]

The overall increase in inequality as measured by the Gini coefficient has been accompanied by growing inequality between urban and rural areas, and data from the 2014 DHS confirm this disparity, with 43.6 per cent of households in the highest wealth quintile located in urban areas against 14.3 per cent in rural areas.[374] This can be partially attributed to the lack of gains by workers in agriculture and fishing, who appear not to have benefited from overall economic growth during the 2000s.[375] Also, economic activity is concentrated in Apia, where around 70 per cent of Samoa's domestic activity occurs (2012) and which contains only around 40 per cent of the population. This has contributed to the growing disparity between urban and rural incomes.[376]

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368 UNDP, 'Samoa Hardship and Poverty Report: Analysis of the 2013/14 Household Income and Expenditure Survey', 2016, p. 48.

369 Ibid., p. 69.

370 Ibid., p. 70.

371 The Gini coefficient is a number between 0 and 1, where total equality is equal to 0 and total inequality (one person has everything) is equal to 1.

372 2008 HIES, p. 34

373 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific – Samoa Country Case Study', Pacific Social Protection Series, 2012.

374 2014 DHS.

375 UNESCAP, 'The State of Human Development in the Pacific', 2014.

376 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific'.

While poverty is associated with living in rural locations, it should be noted that urban poverty rates likely mask significant pockets of deprivation, particularly among persons living in informal 'squatter settlements'. Samoa has experienced growing unplanned urbanization, owing to high rates of migration of persons from rural to urban areas in recent years. From 1991 to 2001, for example, North-Western Upolu experienced a 35 per cent population increase, largely because of rural to urban migration. Migrants are often 'unemployed or earn low incomes, and may not be able to rely on subsistence agriculture'. As a result of this, and of lack of access to affordable, adequate housing, these persons often live in informal settlements.[377] Conditions in squatter settlements across the Pacific are generally very poor: they are characterized by poor-quality, overcrowded housing without access to improved water sources, sanitation and other basic services. Poor housing conditions have negative impacts for children, including poor health and, relatedly, poor educational attainment.[378] Adults are often working, if at all, in casual and uncertain work (though it has been noted that casual, informal work does not necessarily equate with poor income).[379] This likely perpetuates a cycle of poverty, exclusion and deprivation for children living in these settlements.

It is also noted that rates of basic needs and food poverty appear to be higher in Apia and North-West Upolu. The proportion of the population living under the food poverty line was highest in these regions (4.5 per cent in Apia Urban and 6.6 per cent in North-West Upolu, against the national proportion of 4.3 per cent), according to the 2013–2014 HIES. The proportion of persons living under the basic needs poverty line was also highest in Apia Urban (24 per cent) and North-West Upolu (23.7 per cent), against a national proportion of 18.8 per cent. According to the HIESs, progress made in reducing food and basic needs poverty has been uneven across Samoa, with rates of basic needs poverty decreasing only slightly from 2002 to 2013–2014 in Apia Urban Area and North-West Upolu, as Table 7.1 illustrates.

Table 7.1: Percentage of population under the food and basic needs poverty lines, by region, 2002, 2008, 2013–2014

	% of population below food poverty line			% of population below basic needs poverty line		
	2002	2008	2013/14	2002	2008	2013/14
National average	**10.6**	**4.9**	**4.3**	**22.9**	**26.9**	**18.8**
Apia Urban Area	7.6	3.5	4.5	25.9	24.4	24.0
North-West Upolu	16.2	3.3	3.6	29.5	26.8	23.7
Rest of Upolu	6.1	8.1	2.4	15.1	26.6	13.6
Savaii	10.3	5.1	2.9	19.1	28.8	12.5

Source: Samoa Hardship and Poverty Report, 2016.

377 Ibid.

378 World Bank, 'Hardship and Vulnerability in the Pacific Island Countries', 2014.

379 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific'.

The gender dimension of poverty in Samoa has recently been classified as 'rather subtle and mild'. Female-headed households are, at the national level, proportionally represented under the food poverty line (2.9 per cent of all female-headed households compared with 2.8 per cent of all male-headed households); and are only slightly over-represented below the basic needs poverty line (12.8 per cent of all female-headed households compared with o 10.1 per cent of all male-headed households).[380] However, data show a gender-based expenditure/income inequality. According to the 2013–2014 HIES, at the national level female-headed households were disproportionately represented in the lowest three income deciles, and male-headed households in the highest three income deciles.[381] This inequality is thought to be associated with disparities in access to formal jobs: in 2013, 60 per cent of the formal private sector workforce (which accounts for 60 per cent of employment) were male, and the number of females working at the minimum wage level was twice that of males.[382] Also, it has been noted that women are more vulnerable as Samoa moves to a cash-based economy, because they predominantly perform family and community work, where there is no cash income.[383]

Poverty is also associated with educational level, with a strong correlation between poverty and vulnerability and level of education, according to the 2013–2014 HIES. This association is particularly pronounced in Apia, in which around 28 per cent of females and 30 per cent of males with only primary education were below the basic needs poverty line, compared with 16.1 per cent and 16.5 per cent, respectively.[384]

Perhaps unsurprisingly, poverty rates are also significantly higher among unemployed individuals and those working in the informal sector. This is particularly pronounced in North-West Upolu. Fifty per cent of individuals below the basic needs poverty line and 31 per cent of the extremely vulnerable live in North-West Upolu and work primarily in subsistence agriculture.[385]

However, access to formal employment is not a guarantee against poverty. According to the 2013–2014 HIES, 17.4 per cent of the labour force (individuals aged 15–59 years) was below the basic needs poverty line, of whom 42.4 per cent lived in North-West Upolu, indicating a lack of formal employment opportunities and income-generating activities in this region.[386] According to a recent UNDP report, a significant proportion of the population in Samoa can be classed as 'working poor': they are typically engaged in small private enterprise businesses with low hourly pay rates, and an income that is insufficient to meet the needs of their family.[387]

Persons living with a disability appear to be particularly vulnerable to living in poverty. While there are no data available to test the association of disability with poverty (as disability is not included as a category in household surveys), persons with a disability are very likely to be vulnerable to

380 UNDP, 'Samoa Hardship and Poverty Report', p. 60.

381 Ibid., p. 62.

382 Ibid., p. 65.

383 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific'.

384 UNDP, 'Samoa Hardship and Poverty Report', p. 66.

385 Ibid.

386 Ibid.

387 UNDP, *State of Human Development in the Pacific, A Report on Vulnerability and Exclusion at at Time of Rapid Change*, 2014, p. 32.

poverty, given the lack of opportunities accessible to them. In Samoa, it has been found that only 1.2 per cent of disabled persons are able to earn an income.[388] Children with disabilities also do not have the same access to education as other children, as set out above.[389]

The causes of child and family poverty in Samoa are complex, interconnected and open to fluctuation. As a small island economy, Samoa faces many of the challenges confronting PICTs more generally. In particular, 'a narrow resource base, limited infrastructure in rural areas, small domestic markets, isolation from international markets and a heavy dependence on fuel imports' constrain economic development in Samoa. The economy remains heavily dependent on foreign aid and government borrowing overseas.[390]

Slow economic growth and exposure of the economy to shocks has led to a poverty of opportunity in PICTs, including Samoa, which has a high and growing unemployment rate, particularly among young people. Across the Pacific, economies are not able to generate sufficient jobs for the number of job-seekers. Also, the large number of young people with inadequate skills contributes to the high unemployment rate.[391] Job growth has declined since 2005, with the number of formal sector jobs growing between 2000 and 2007 (from 12,168 to 16,921), but declining since that time (to 12,711 in 2010).[392] The formal job sector was, in particular, negatively impacted by the closure of Yazaki (Samoa's largest manufacturing institution, which produced electrical wiring for cars).[393]

Youth unemployment is particularly high: 54 per cent of men and 64 per cent of women aged 15–24 years were unemployed in 2009.[394] Also, it has been observed that these figures may be an underestimate, owing to the large number of young people performing unpaid family work, which the data may not capture as unemployment. Lack of opportunities for youth perpetuates a cycle of socio-economic vulnerability, and is believed to be associated with high-risk behaviours, such as substance abuse, teenage pregnancy, crime and violence.[395] Urban drift, particularly among young people, has led to higher unemployment rates in urban areas and, as noted above, a growing number of people living in squatter settlements, characterized by poor living conditions and poor education attainment and health. Urban youth from rural areas are particularly vulnerable to high-risk behaviours: 'If they drop out of school, they are often too ashamed to return home, yet they lack a support system in the city.'[396]

388 Lane, 2002, in AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific', p. 22.

389 The 2011 census found a total of 4,061 persons with disabilities. The cast majority (80 per cent) were living in rural areas; however, most services and schools for persons with disabilities are located in urban areas.

390 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific', p. 7.

391 Ibid., p. 4

392 Samoa Bureau of Statistics, 2011, in Sasa'e Fualautoalasi Walter, 'A Review of Social Protection Programmes in Samoa since 2009', *Journal of Samoan Studies*, 2016, p. 57.

393 Sasa'e Fualautoalasi Walter, 'A Review of Social Protection Programmes in Samoa since 2009', p. 57.

394 ILO data, 2009.

395 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific'.

396 Ibid., p. 7.

Persons living below the poverty line are also more vulnerable to natural disasters. In particular, subsistence farmers who 'depend more on natural resources for their livelihoods' are particularly impacted by natural disasters.[397]

7.2. Bottlenecks and barriers to ensuring an effective social protection system

Social protection encompasses many different types of systems and programmes, including social insurance (e.g. contributory schemes to provide security against risk, such as unemployment, illness, disability, etc.); social assistance (non-contributory measures such as regular cash transfers targeting vulnerable groups, such as persons living in poverty, persons with disabilities, the elderly, children); and social care (child protection prevention and response services, detailed in Chapter 6). There has been a growing acceptance in recent times that social security, in particular the provision of regular cash transfers to families living in and vulnerable to poverty, should be a key component of a social protection system.[398] Cash transfers provide households with additional income that enables them to invest in children's well-being and human development.[399]

The comprehensiveness and impact of Samoa's 'formal' social protection system appears to be quite weak. ADB's Social Protection Indicator (formerly Index) (SPI) assesses social protection systems against a number of indicators to generate a ratio, which is expressed as a percentage of GDP per capita. The SPI for Samoa was, in 2016, 1.2. This is below the Pacific regional average (including PNG) of 1.9,[400] as Figure 7.2 shows.

The data also indicate that the vast majority of social protection expenditure is for social insurance measures (contributory schemes), as Figure 7.3 shows.

Table 7.2: Social Protection Indicator by type of programme, 2012

Programme	Social protection indicator (%)
Overall	1.0
Social Assistance	0.2
Labour Market Programmes	0.03
Social Insurance	-

Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 16.

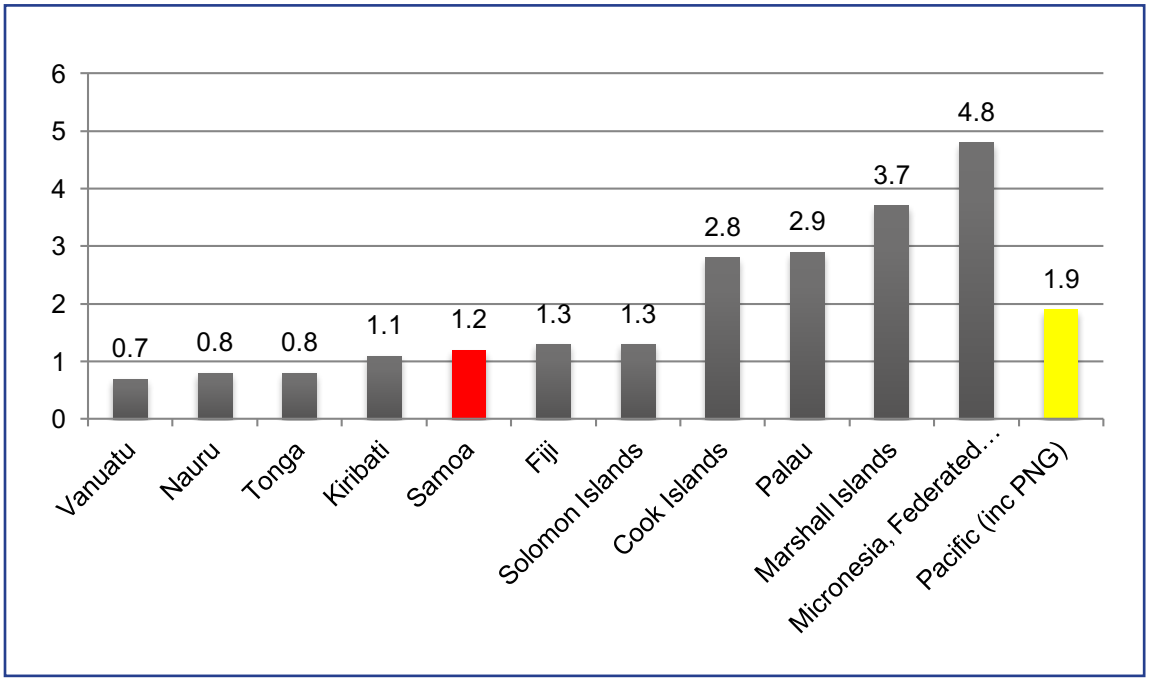
397 Ibid., p. 42.

398 UNICEF and MoWCPA, 'Child-Sensitive Social Protection in Fiji', 2015, p. 6.

399 UNICEF, Social Protection Strategic Framework, 2012.

400 ADB, *The Social Protection Indicator: Assessing Results for the Pacific*, 2016, p. 16.

Figure 7.2: Social Protection Indicator by country



Note: Please note that the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu. Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 16.

Social insurance is provided through a national provident fund and workers compensation scheme. However, this is limited to formal sector workers, and excludes the majority of workers who operate in the informal economy – it is therefore not targeted to the poorest members of society. Contributory schemes involving formal sector workers also tend to have a gender bias, as the majority of formal sector workers are men.[401] (Young) women in Samoa have limited access to employment, particularly in formal sectors (as set out above). According to ILO figures from 2012, young women's labour force participation is 32 per cent in Samoa, compared with 53.5 per cent for young men. (Young) women across the Pacific, including in Samoa, are disadvantaged in seeking employment owing to their 'low level of education and lack of employable skills as well as the cultural aspect of stereotyping women for domestic work'.[402]

In terms of social assistance measures, the government provides a universal pension scheme, which guarantees an income for all older persons in Samoa (at a cost of 1 per cent of GDP).[403] Benefits include cash transfers, free medicine and travel benefits. Consultations indicated universal awareness of the scheme among households in Samoa, and suggested the benefits were important in reducing vulnerability in old age.[404]

401 UNESCAP, 'The State of Human Development in the Pacific', 2014.

402 ILO, 'Pacific Island Countries', Youth employment brief, 2013, on www.youthmetro.org/uploads/4/7/6/5/47654969/youth_employment_policy_brief_pacific_islands_countries.pdf [24.08.17].

403 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific', p. 30. The scheme is administered through the National Provident Fund Amendment Act 1990.

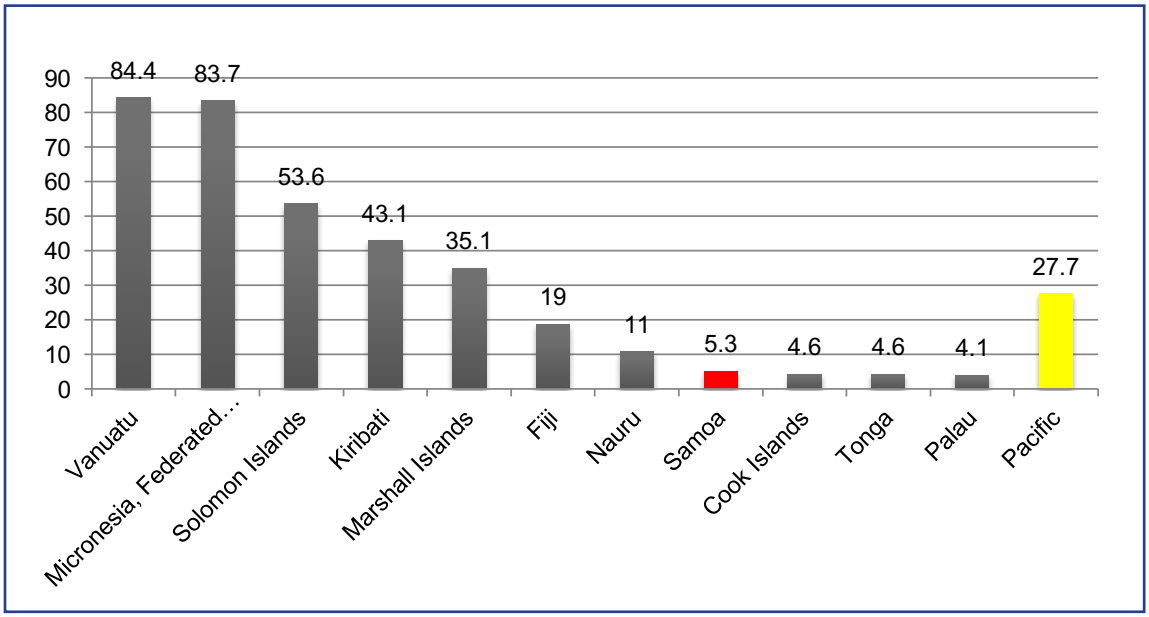
404 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific', p. 30.

However, social assistance measures targeted at other vulnerable populations are limited. Samoa has subsidized fee-free primary schools, but it does not have a system of cash transfers for vulnerable children or families. There are also no cash transfer programmes targeted at persons with a disability (though the government does provide assistance for children with disabilities in relation to accessing education and services).

Another component of social protection systems entails activities to generate and improve access to employment opportunities among young people. These activities have been limited in Samoa, and have focused on skills training rather than the provision of financial support, such as through subsidized wages and paid internship programmes, for example.

The data point to the limited impact of social protection programmes in Samoa, in terms of the level of benefits and the targeting of beneficiaries. The SPI for the depth of benefits in Samoa (the average benefits actual beneficiaries receive) is quite low, particularly in comparison with other PICTs, as Figure 7.3 illustrates.

Figure 7.3: Depth of Social Protection Indicator by country



Note: Please note that the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu. Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 16.

This indicates that benefits are quite low, and perhaps not enough to lift vulnerable individuals and families out of poverty. Moreover, the depth indicator is primarily driven by the high level of benefits received by a small group of persons: those in formal employment who have access to the social insurance scheme. The depth indicator is very low for social assistance schemes (which target more vulnerable persons).

Table 7.3: SPI depth indicator, by type of programme

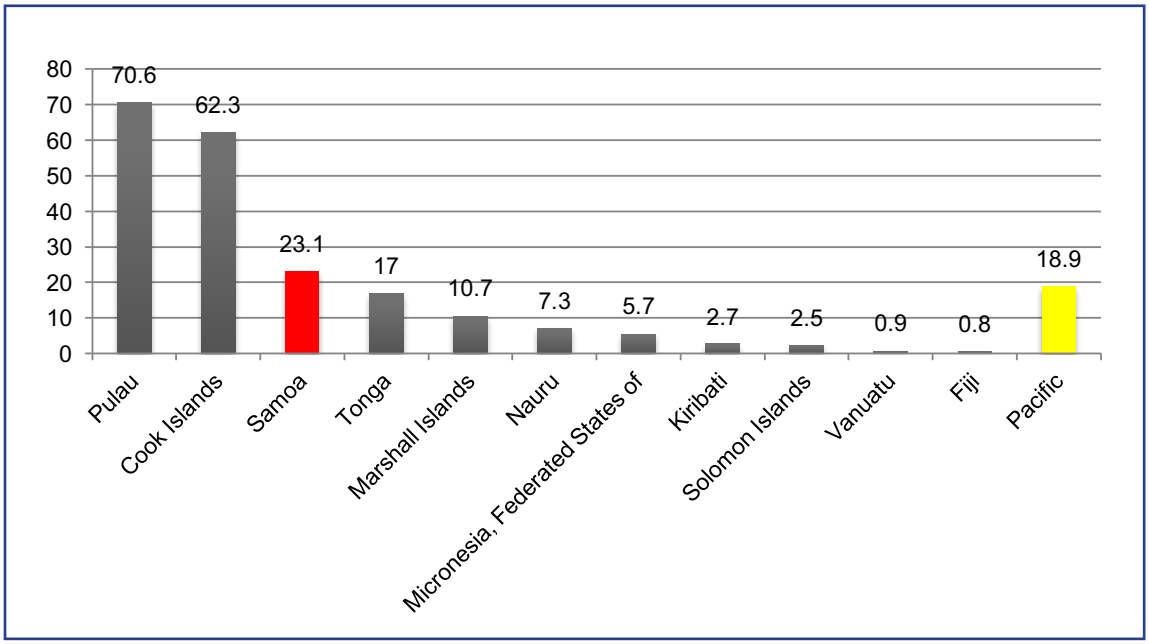
Programme	SPIC depth indicator (% of per-capita GDP)
Overall	5.3
Labour Market	55.1
Social Assistance	1.1
Social Insurance	21.2

Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 34.

Also, the relatively high indicator for labour market programmes (55.0) is related to persons who are/were employed in New Zealand, who receive relatively high levels of benefits under the Recognised Seasonal Employer scheme, which enables New Zealand employers to recruit short-term workers in horticulture.[405]

Breadth indicators represent the proportion of potential beneficiaries (those who could qualify for benefits) who actually receive social protection benefits. According to the ADB assessment, Samoa receives a relatively high breadth indicator, as Figure 7.4 illustrates.

Figure 7.4: Breadth of social protection indicator by country



Note: Please note that the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu. Source: ADB, 'The Social Protection Indicator: The Pacific', 2016.

405 Asian Development Bank, The social protection indicator: assessing results for the Pacific (2016).

The breadth indicator is highest for social assistance programmes (18.3), compared with social insurance (4.7) and labour market programmes (0.1). This indicates that only a very small proportion of the population benefits from the higher level of payments under social insurance and labour market schemes. A relatively high proportion of the population receives social assistance benefits, though the value of these benefits is small.

Data for the Pacific also indicate that social protection schemes are not well targeted. When the SPI is disaggregated between the poor and the non-poor, the non-poor are found to be the main beneficiaries of social protection programmes (the aggregate SPI for the poor in PICTs is only 0.2 per cent of GDP per capita, whereas the SPI for the non-poor is 1.7 per cent of GDP per capita). This owes to the dominance of social insurance programmes.

The targeting of social protection programmes also appears to have a gender dimension. Overall, the SPI for women in the Pacific is 0.8 per cent of GDP per capita, compared with 1.1 per cent of GDP per capita for men.[406] This is attributed to the differential access of women and men to social insurance measures. As noted above, social insurance measures have a gender bias, as access is generally restricted formal sector workers, who are predominantly male.

Other non-state forms of social protection exist in Samoa and should be taken into account in development policies and systems on social protection. Informal extended family and community systems represent important safety nets. However, 'The increasing monetization of Pacific economies, and of Samoa in particular with its high level of remittances and the need for cash gifts as part of *fa'alavelave*, together with increasing rural/urban and overseas migration, have begun to undermine these traditional systems.'[407]

Particularly in the context of diminishing traditional support systems, the absence of a comprehensive social protection system that effectively targets those who are most in need is a significant gap; lack of any social assistance programmes with wide coverage that provide cash transfers to those living in poverty and vulnerability impairs the ability of the country to lift its people out of poverty and create improved conditions for economic growth.

406 Please note that the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu.

407 UNDP, 'Samoa Hardship and Poverty Report', p. 66.

8. Conclusions

In addition to the specific bottlenecks and barriers identified under each chapter above, the following key findings can be drawn from the wider situation analysis of women and children in Samoa. Please note that these are not listed in any order of priority.

8.1. Climate change and disaster risks

Samoa is vulnerable to natural hazards such as tropical cyclones, floods and droughts.[408] Climate change and extreme weather can act as barriers in all sectors.

- In the **health sector**, climate and disaster risks increase the threat of both communicable and non-communicable diseases, and can exacerbate existing bottlenecks and create additional barriers for Samoans wanting to access health care.[409]
- The key climate-sensitive **health and WASH** risks in Samoa are vector-, water- and food-borne diseases, malnutrition, NCDs and mental health issues.[410]
- Children, older women and individuals living in coastal regions are particularly vulnerable to climate-sensitive-health risks.[411]
- Climate change and disaster risk have a strong impact on the child protection system by damaging infrastructure and by increasing risks of violence as a result of stress.

408 WHO, 'Human Health and Climate Change in Pacific Island Countries', 2015, p. 86, http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303_eng.pdf [13.03.17].

409 WHO Country Cooperation Strategy for Samoa 2013–2017.

410 WHO, 'Human Health and Climate Change in Pacific Island Countries'.

411 Ibid., p. 88.

8.2. Financial and human resources

Samoa is a lower-middle-income country, and financial constraints act as a barrier to the realization of rights in several sectors.

- The main barrier to progress for Samoa's health system is inadequate financing of health services. **Health services** are also likely to become more expensive as a result of the growing disease burden from NCDs.
- There are significant funding constraints in the **WASH sector**, and the country's WASH infrastructure is not well maintained.
- There are notable shortcomings in the **health workforce** that will affect Samoa's achievement of the SDGs. It is not clear what the causes of this are.
- Rapid urbanization in Samoa has placed urban service delivery centres such as hospitals under strain.
- Funding shortages affect the delivery of **education**, including ECE, as centres are reliant on parents' fees and community and donor funding.
- The quality of teaching/care in ECE is reported to be low as a result of poor training practices and lack of available training opportunities
- Inadequate staffing and training as well as budgetary constraints is a barrier to implementation of the legal and policy framework for **child protection** and **child justice**.

8.3. Equity

This SitAn made several important findings in relation to equity, but also noted a striking lack of disaggregated data to allow for a full equity analysis.

- In **education**, hidden costs are a barrier to the enrolment/survival of children from socio-economically deprived families and remote areas.[412] This is linked to **child labour** of street vendors, who engage in vending in order to fund schooling or as an alternative.
- There are notable data gaps in relation to **education**, including in terms of disaggregated data on the situation of children who do not enrol in or drop out of secondary school.
- Children with disabilities are not provided with sufficient access to education rights in Samoa: they lack adequate access to tailored resources and facilities, particularly at

412 EFA 2015 National Review, p. 29.

secondary level and in rural areas, where 'special schools' are unavailable, resulting in the children being kept in the home.[413]

- Social assistance measures targeted at vulnerable populations are limited (though the government does provide assistance for children with disability in relation to accessing education and services).

8.4. Gender

Socio-cultural norms and traditional perceptions around gender roles can act as barriers and bottlenecks to the realization of children and women's rights.

- Evidence on attitudes towards wife-beating indicate that girls and boys are permissive of wife-beating, suggesting social norms and actions support these views.

8.5. Impacts of poverty and vulnerability

The impacts of poverty are significant in Samoa, and children and families are highly exposed to risk and economic shocks, particularly those caused by natural disasters.

- Lack of social protection and other social welfare services represents a significant gap and limits the ability of the government to lift vulnerable persons out of poverty and support economic growth.

- Lack of opportunities for adolescents and young people perpetuates cycles of poverty and has led to unhealthy behaviours, such as drug and alcohol abuse and mental health issues.

8.6. Cultural norms and approaches

Cultural attitudes within Samoa are reported to be changing, with younger parents and the younger generation understanding that corporal punishment is not acceptable. However, this stands in contrast with attitudes towards violence against women in marriages, which have been shown to be permissive and accepting among children.

- Reliance on and preference for informal justice has led to the under-reporting of cases involving child sexual abuse, violence against children or other crimes against children, and to these cases being handled within villages. It is not clear whether child rights

413 *Education Statistical Digest 2016,* pp. 46–7.

safeguards are upheld in these proceedings, particularly in relation to children who are victims and witnesses.

- Informal justice practices in **child justice** may contribute to the realization of children's rights as they represent an informal 'diversion' option, and efforts should be made to explore the possibility of working with informal practices to support child-friendly justice.

- Traditional social support systems are diminishing as a result of monetization and increasing rural–urban and overseas migration in Samoa.

8.7. Legal and policy framework

The overall legal and policy framework in Samoa contains several important gaps, including specific legal provisions and broader governance documents.

- There is no sector-specific policy framework guiding the development and monitoring of ECE.

- The Child Care and Protection Bill 2015, if enacted, would fill some child protection and child justice gaps, including by setting out an authoritative definition of a child as a person below the age of 18 and by prohibiting child marriage, but this has not yet been passed.

Footnotes in tables

I UNISDR and GADRRRES, 'A Global Framework in Support of the Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector and the Worldwide Initiative for Safe Schools', January 2017, on http://gadrrres.net/uploads/images/pages/CSS_Booklet_2017-updated.pdf [24.01.17].

II Table reproduced from Ibid., p. 2.

III Under Section 9 of the Marriage Ordinance 1961, the minimum legal age of marriage is 18 for males and 16 for females (with parental consent) or 21 for males and 18 for females without, unless such consent is waived by a District Court judge (Section 10).

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