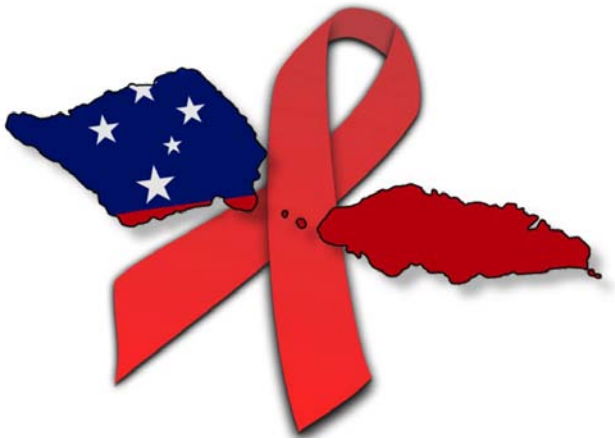
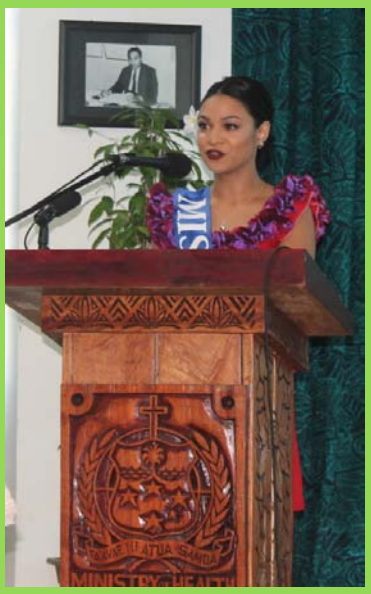
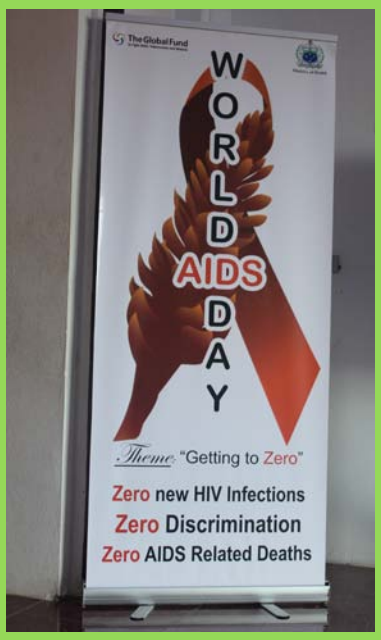
Ministry of Health



National HIV, AIDS, and STI Policy 2017-2022





FAAVAE I LE ATUA SAMOA

Government of Samoa

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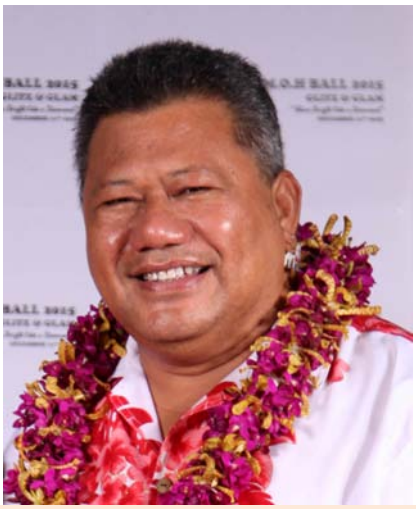

Leausa Toleafoa Dr. Take Naseri
Director General
Ministry of Health

The Ministry of Health is proud to present the latest version of the HIV, AIDS, and STI Policy for 2017 to 2022. Samoa's health sector is currently in the midst of several very important developments. This latest iteration of the HIV, AIDS, and STI Policy is a much welcomed and timely resource designed to guide multi-sectoral response to these diseases during this time of change.

The efforts to prevent, treat, and improve care for these diseases have been greatly up-scaled since the implementation of the previous policy in 2011. This draft of the policy seeks to build upon previous achievements of the health sector, address ongoing challenges, and expand prevention to a higher level in order to eliminate HIV and STI transmissions. As STI's increase globally, the efforts to prevent, treat, and improve population sexual health must intensify.

This version of the policy offers new approaches for addressing sexual health. Guidelines for services providers, stakeholders, and partners have been included to better coordinate the multi-sectoral response to HIV, AIDS, and STI's. The Ministry's commitment and strategies for reaching vulnerable populations are also detailed as part of ensuring a population based approach to sexual health prevention.

Finally this document represents the extensive partnership between the Ministry of Health, the health sector, all stakeholders, and all partners. We would like to thank all the people and organizations that contributed to the numerous consultations over the past 2 years to ensure this new policy would cover the evolving needs of the national response and the ever-changing context of HIV, AIDS, and STI's.

May this policy serve to strengthen our efforts to improve the health of our people, and reaffirm Samoa's commitment in the global fight to stop HIV, AIDS, and STI's.

Ma le fa'aaloalo lava.

Leausa Toleafoa Dr. Take Naseri
Director General/Chief Executive Officer (CEO)
Ministry of Health
Apia, Samoa

GOVERNMENT OF SAMOA

CABINET SECRETARIAT

APIA • • • • SAMOA

12 Iulai 2017

Mo le Faatinoina
Minisita o le Soifua Maloloina
Faatonusili Aoao o le Soifua Maloloina
Pule Sili Auaunaga Faa-Soifua Maloloina

Mo le silafia (ma nisi fuafuaga talafeagai)
Palemia
Minisita o Tupe

Faiga Faavae a Samoa mo le HIV/AIDS ma Faamai e Mafua mai i Feusuaiga 2017-2022

FK(17)25

I lana Fonotaga FK(17)25 o le Aso Lulu 05 Iulai 2017, na talanoaina ai e le Kapeneta le Pepa PK(17) 984 ma faamaonia ai le Faiga Faavae a Samoa mo le HIV/AIDS mo Faamai e Mafua mai i Feusuaiga 2017-2022 e pei ona vaevaeina ai i ona Vaega e 8:

Vaega 1:	Tulafono, Malupuipuia ma le Saogalemu o Faamaumauga ma le Aia Tatau a i latou ua maua i le HIV/AIDS
Vaega 2:	Puipuiga o le HIV/AIDS & STIs
Vaega 3:	Suesuega ma le Faamaoniga Faafomai
Vaega 4:	O le tausiga ma le Vaaia lelei o i latou ua Aafia
Vaega 5:	Puipuiga mai le Sauaina o Tina ma Tamaitai ma Isi Tagata e Mafua ona o Faamai Pipisi i Feusuaiga
Vaega 6:	Suesuega, Mataitu ma le Tulituliloa Galuega Faatino mo le HIVAIDS ma Faamai Pipisi e mafua mai i Feusuaiga
Vaega 7:	Nafa ma Matafaioi a le Vaega Maoti o le Soifua Maloloina ma Ana Paaga mo le Faatupeina o Galuega Faatino manaomia

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Thanks
Lita
21/7/17

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Vaega 8: Faavaa o Fuafuaga ma Galuega Fatino mo lo latou Faatupeina

(Agafili Shem Leo)
PULE SILI/FAILAUTUSI O LE KAPENETA

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Acknowledgements

It is with the greatest gratitude that the Ministry of Health would like to thank all those who have contributed to the development of this crucial policy document. Your endless support and valuable feedback have enabled the strategic planning process to come this far.

May we continue to work in sincere and genuine partnership to ensure that our people attain quality and healthy lives.

The Ministry of Health would like to recognize;

- All partners and stakeholders of the national response for numerous consultations and advice on the content of this policy.
    - Ministry of Police
    - Ministry of Women, Community and Social Development
    - Samoa Victims Support
    - Samoa AIDS Foundation
    - Samoa Nurses Association
    - Samoa Red Cross Society
    - Samoa Fa'afafine Association
    - Samoa Family Health Association
    - National Council of Churches
    - National Health Service
    - National Kidney Foundation of Samoa
    - UNDP
    - UNFPA
    - WHO
    - People living with HIV

- The SPPRD unit of MoH for collecting and reporting feedback for the redesign of the SRH and HIV/AIDS/STI policies.

- Delphina Kerslake and Deborah Porter of the Ministry of Health Legal Team for supplying legal reference content for the policy and technical advice.

Key Terms and Abbreviations

ART- anti-retroviral treatment given to those infected with HIV to reduce their viral load

ANC- antenatal care

DHS- Demographic Health Survey, 2014 is the most recent survey

DV- Domestic Violence

Key Populations- this term refers to the populations identified by UNAIDS and healthcare providers in Samoa as having high risk for HIV and STI's, or unique health needs with regards to prevention or treatment. This includes the following groups;

- MSM (men who have sex with men)
- Transgender men and women (fa'afafine and fa'atama)
- Sex workers
- Inmates
- Drug Users
- Pregnant women
- Youth
- People living with co infection of HIV with TB, Hepatitis, Syphilis, Diabetes, or Cancer
- People living with disability

M&E- monitoring and evaluation, a system of collecting data to evaluate the impact of programming on a disease

MoH- Samoa's Ministry of Health

MSM- men who have sex with men

MTC transmission- mother to child transmission of the HIV virus

NACC- National AIDS Coordinating Council

National response- the multi-sectoral mobilization of services and resources to address the HIV/AIDS and STI epidemic

NGO- non-governmental organization

NHS- National Health Service, national healthcare service delivery organization of Samoa

PEP- post exposure prophylaxis, a type of retroviral that is used to greatly minimize the chance of HIV infection after exposure

PLWHA- people living with HIV and AIDS

PMTCT- preventing mother to child transmission

STI- sexually transmitted infections, includes HIV and AIDS

TAC- Technical Advisory Committee for HIV and AIDS

TB- tuberculosis

UNAIDS- the United Nations Programme on HIV/AIDS

WHO- World Health Organization

Executive Summary

Objective 1 Safeguard the Rights of PLWHA
Safeguard the rights of people living with HIV/AIDS or other STI's to ultimately improve their health and quality of life, make health interventions for PLWHA more effective, and ensure a human rights approach to public health.
Key Strategic Actions for Objective 1
a) Minimize and manage stigma around HIV, AIDS, STI's and sexual health
b) ensure and promote health information privacy and confidentiality to establish social safety
c) Improve the legal and policy environment for PLWHA to prevent rights violations.
d) Advance the protection of PLWHA rights in legal, institutional and social domains.
Objective 2 Engage communities in behaviour change and improve access to prevention
2A. Engage communities in prevention through behaviour change programs that increase people's capacity to make well informed sexual health decisions to synergistically enhance the effectiveness of clinical and educational interventions.
2B. Improve access to testing, counselling, and prophylaxis by engaging community structures in service delivery and health promotion.
Key Strategic Actions for Objective 2:
a) Implement behaviour change programs to enhance health education outreach and reception of health messages aimed at increasing awareness and knowledge, with additional programmes for youth
b) Primary Health Care to incorporate comprehensive sexual health behaviour change, education, and clinical outreach to communities, using community structures to ensure sustainability
c) Increase testing rates by promoting testing resources, increasing lab capacity, and conducting screening outreach to rural areas
d) Increase prevention efforts with youth, antenatal mothers and key populations
e) Maintain 0% incidence of Mother to Child transmission of HIV
f) Implement national level health communication to increase knowledge and awareness of services
g) Needs assessment of condom programming (possible collaboration with UNFPA)
h) Promote Hepatitis B vaccination amongst tufuga
i) Community consultations with tufuga and their assistants to assess practices and establish ongoing dialogue around infection control with village committees
j) Conduct infection control trainings for tufuga for preventing blood borne pathogens (particularly HIV, Hepatitis, and extra pulmonary TB)
k) Establish a national register for tattooists and accreditation system
l) Implement infection control measures, policies and health guidelines for all methods of tattooing (traditional and non-traditional)
m) Partner the health sector with tufuga to promote infection control
n) Supply tufuga with infection control kits
Objective 3 Increase the coverage and access of HIV, STI and TB testing in all populations

Increase the coverage and access of HIV, STI, TB, and co-infection testing in the general and all key populations to expand surveillance and counseling services.

Key Strategic Actions for Objective 3:

a) Implement TB testing and screening in conjunction with all STI testing activities (and vice versa) to improve screening of co-infection.
b) Identify and eliminate barriers for all populations to get screened for HIV and STI's, particularly youth, fa'afafine, sex workers, inmates, and partners of ANC women
c) Create community linkages to HIV and STI testing and counseling services, or create community based testing options tailored to village community structures.
d) Expand the implementation of CD4 and viral load testing (includes training of providers).
e) Sustainable and cost-effective procurement and distribution of rapid diagnostic testing kits to support provider initiated counseling and testing
f) Sustainable and cost-effective procurement of rapid diagnostics that give same day results for untrained individuals and lay-providers
g) Conduct screening outreach visits to rural villages and vulnerable populations
h) Conduct screening outreach visits to rural villages and vulnerable populations.
i) Create friendly, safer and confidential environments to encourage turnout for all testing and counseling services for all populations, especially at risk youth.
j) Improve screening and surveillance by increasing the technical capacity of laboratory services to process larger quantities of specimens, reduce result-reporting processing time, and offer alternative testing/screening methods.
k) Increase testing rates by using Blood and Tissue Donation Screening as a mechanism to expand testing coverage

Objective 4 Expand treatment and care to address HIV, STI and TB social determinants and co-infection

Expand treatment and care activities to address social determinants of HIV, STI's, and TB, and take a broad horizontal sexual health approach in which programmes provide simultaneous care or linkages to care for other diseases

Key Areas of Action for Objective 4:

a) Expand and strengthen the Presumptive Treatment Program for ANC mothers and their partners to achieve equal and full implementation amongst women and their male partners
    a. Use village men's committees to assist in encouraging men to test for all STI's and comply with treatment
b) Develop capacity to offer STI, HIV and TB services in all sexual health settings
c) Conduct partnered outreach for HIV, STI, and TB treatment and care
d) Design and implement broad sexual health co-infection programmes for key population to ensure they are screened/treated for all STI's and can access TB treatment
e) Develop care programmes that support people living with HIV and STI's in terms of accessing reliable and discreet treatment and symptom alleviation
f) Develop programmes and interventions that target the social determinants and interrelated risk factors of co-infection
g) Training of service providers to offer case management of co-infections
h) Include HIV, STI, and TB co-infection prevention in all health education, health promotion, behaviour change and counselling offered by providers in healthcare settings

i) Create community counselling programmes for HIV and AIDS to assist village communities in supporting and accepting PLWHA who publicly disclose their status to advocate, in order to eliminate discrimination in the home environment of PLWHA public advocates. The purpose is to encourage PLWHA to publicly advocate for the PLWHA community, their healthcare needs, and for PLWHA to take ownership and participate in linking themselves to care.
j) Adherence to care, behaviour change and harm reduction programmes tailored to each key population developed and implemented.
k) Implement support services for PLWHA that address key social and financial challenges that relate to their healthcare, treatment adherence, and access to all health services
l) Improve procurement processes to prevent pharmaceutical stock outs and ensure national access to all HIV, STI and TB treatments
m) Build the capacity of youth friendly service initiatives to create safe treatment spaces for youth
Objective 5 Integrate sexual health with services targeting gender-based violence
Integrate sexual health testing, counselling, and treatment with services for survivors of violence in order to ensure gender equality of the national response and eliminate gender-based risk and morbidity regarding HIV and STI's.
Key Strategic Actions for Objective 5:
a) Implement health needs and STI risk assessments to formally assess the sexual health service needs of survivors of violence.
b) Target domestic violence as means of increase women's access to sexual reproductive health services, and therefore HIV care, and STI testing and treatment
c) Develop programs for ANC women experiencing domestic violence
d) Coordinate and enhance a violence services referral system within the health sector
e) Partner with village women's committees (Komiti Tumama) to discreetly deliver sexual health services to women and children impacted by violence.
f) Develop family counselling curriculum that is designed to support families of paediatric sexual assault cases in consenting to screen and treat the child.
g) Partner with the Ministry of Police to include offer voluntary STI screening, counselling and treatment as part of post sexual assault medical services for adult and paediatric cases.
h) Create access to safe abortion for survivors of rape and incest, PLWHIV, and people living with STI's preferably in-country or in partnership with the over-seas treatment program (ensure subsidized cost for these populations).
Objective 6 Expand health knowledge and information systems, while protecting confidentiality
Expand health knowledge and develop information systems regarding HIV, STI's and TB, while protecting confidentiality with the ultimate aim of improving services and building trust with key populations.
Key Strategic Actions for Objective 6
a) Develop pilot and baseline studies for key populations
b) Implement the M&E system outlined in the 2017 M&E Manual
c) Partner with Samoa Bureau of Statistics to expand population studies
d) Develop processes with MoH, the health sector, and all partners to improve and increase data collection and reporting
e) Develop human resource capacity in the health sector for health data, surveillance, monitoring and evaluation

f) Develop new memorandum of understanding (MOU) with key services providers across all sectors, as well as redrafting prior MOU's to meet the data collection, reporting and data sharing needs of the national response to HIV and STI's
Objective 7 Increase sector collaboration and expand partnership to communities
Increase collaboration within the health sector and expand roles in the national response to community structures in order to increase service delivery, effectiveness, and sustainability.
Key Strategic Actions for Objective 7:
a) Identify sustainable funding sources for HIV, STI's and TB after the close of the Global Fund in 2017
b) Formally establish role of village committees and other community structures in the health sector for HIV, STI's and TB prevention and care.
c) Capacity building for key partners and stakeholders in delivering interventions, coordinating service delivery and implementing M&E
d) Deliver better coordinated and well resourced multi-sectoral health forums in communities
e) Expand voluntary and provider-initiated HIV and STI screening of foreign visitors, contract workers, residents, and citizens who reside overseas through partnership with Port Health, Immigration and all organizations involved in the implementation of the International Health Regulations

Introduction

HIV, AIDS, and STI's all pose serious threats to Samoa's social and economic development. The first case of HIV was recorded in the Pacific region in 1984. Samoa had its first case of HIV recorded in 1990. Since then the government has coordinated a multi-sector, broad sexual health approach to address sexual health within general and key populations. Although low prevalence and incidence give the impression that the threat of HIV is insignificant, the low voluntary testing rates, the high prevalence of STI's and under-developed care and testing systems for TB and co-infection increase the risk for HIV transmission as well as indicate that sexual health may face larger challenges than what is currently recorded. Specific research and evaluation data for sexual health risks in key populations are largely unassessed which poses additional challenges for planning, policy and intervention.

The National HIV & AIDS Policy 2011-2016 was drafted then began consultation in 2008. It wasn't fully realized through parliament until 2011and was the first HIV/AIDS policy to be drafted by the Ministry of Health (MoH) since the Health Reforms in 2006 that divided the government health sector in MoH (regulating authority) and the National Health Service (the national healthcare delivery mechanism). This monumental achievement served as the foundation for better coordinating the national response to HIV, AIDS and STI's.

The previous period of the national policy 2011-2016 revealed challenges for the national response and alternative strategies for the way forward were raised by partners and stakeholders. This policy document seeks to address the specific challenges Samoa's national response faces in addressing HIV, AIDS and STI's. Each section contains objectives that form the National Strategy, with corresponding Key Strategic Actions that form the National Strategy. The last section (8) details that plan of action for mobilizing activities according to the strategy. The content of each section provides guidelines and reference materials for all organizations, communities and individuals involved in improving sexual health.

Vision

Samoa will be a place where HIV and STI infections are rare, and when they do occur, all sectors of government, NGO's, village councils, communities, community leaders and individuals will take ownership of linking people to care, preventing transmissions, eliminating discrimination and stigma, and improving health the Samoan way.

Purpose

The goal of this National Policy on HIV, AIDS, and STI's is to provide a framework for leadership and coordination of the National multi-sectoral response by MoH, the health sector, all partners and stakeholders, and relevant national coordination committees (such as the CDCC). This document serves the following purposes;

1. Provide information on policy issues related to HIV, AIDS and STI's in Samoa
2. Identify key areas of public health intervention for the next policy period 2017-2021 and provide objectives for each area
3. Serve as a reference document that provides national and international guidelines, standards, regulations and data for all partners and stakeholders to address HIV, AIDS and other STI's and implement programs.

As part of the Ministry of Health's role in providing strategic leadership, the 2017-2021 policy was developed to coordinate the implementation of the national, multi-sectoral response to HIV, AIDs, and STI's. It builds upon the previous policy by providing practical

guidelines and areas of action for partners and stakeholders. New sections have been added to the policy as new data has become available, changes to funding and implementation have occurred since the launch of the previous policy, and MoH's capacity to further develop policy has increased.

In order to serve as a living reference document, the policy is structured so that each policy area 1) outlines an objective, 2) presents key strategic actions, and 3) provides guidelines for each policy area.

Additionally, the policy areas outlined in this document are aligned with the national, regional and global goals for HIV, AIDS, and STI's.

Programme Goals

The primary source of funding for the HIV/AIDS/STI national programme is the Global Fund to Fight AIDS, Tuberculosis and Malaria. Additional funding for the national response and regional coordination is provided by UNAIDS, UNDP, UNFPA and WHO. These multilateral partners are involved in developing the global and regional goals for HIV, AIDS and sexual health programming. These global and regional goals as articulated through UNAIDS are provided below.

UNAIDS Goals
Reduce sexual transmission of HIV
Eliminate new infections among children and substantially reduce AIDS-related maternal deaths
Reduce TB related deaths
Reach people living with HIV with lifesaving ART treatment
Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms
Eliminate HIV-related restrictions on entry, stay and residence
Strengthen HIV integration- Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

In addition to these goals, Samoa's National Programme for HIV, AIDS, STI's and TB also has its own goals for the national response, which are taken from the Health Sector Plan, the Sustainable Development Goals (SDG's), specifically Goal 3- Improved health and wellbeing, with the target, "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases". The national response is also tasked with Outcome 3 of the Health Sector Plan "Improved prevention, control and management of communicable/infectious diseases" with a goal of reducing STI prevalence.

This policy serves to identify the areas that affect these impacts, outline key areas of action within each area, and provide the necessary guidelines to do so.

Principles to Guide the Implementation of the National Policy

The following principles should be integral to the planning, development and implementation of all HIV, AIDS and other STI activities for MoH, the healthcare sector, all

partners, and all stakeholders. They are also practical approaches that address the social contexts surrounding sexual health in Samoa.

- **HIV/AIDS/STI programming shall be informed by global standards.** The new emerging challenges from International Conferences i.e. 1994 International Conference on Population and Development(ICPD), 1995 the Beijing Conference and 1995 Copenhagen World Social Summit, and all human rights conventions which were signed and ratified by the government shall provide a framework for the formulation of HIV/AIDS policy and implementation.

- **Securing confidentiality** is essential to securing health. PLWHA will not report for care and all populations will not report for testing if their health information is not secure and protected by service providers. In a small island country like Samoa, protecting confidentiality and privacy is even more critical to controlling STI's and protecting individuals. Pre-and-post test counseling for HIV testing shall observe professional ethics, with emphasis on confidentiality and informed consent.

- **Gender equality** is integral to addressing sexual health and STI's. HIV/AIDS being a social, cultural and economic problem, women and girls need extra consideration to protect them from the increased vulnerability to HIV infection in the various social, cultural and economic environments.

- **Increasing clinical knowledge** of the epidemic is essential. Research, M&E and surveillance must be expanded in order to identify the scope of the impact STI's have on population health in Samoa. Research is an essential component of HIV/AIDS intervention, including prevention and control. Multi-sectoral and multidisciplinary research undertaken by various sectors shall abide by institutional sectoral research regulations.

- **Collaborate with community structures for interventions and build capacity from the community level**. Health education results in public cooperation with prevention as well as community ownership of prevention. This is key to creating sustainable changes in prevention. The objectives in the national response will be most effectively realized through community based comprehensive approach which includes prevention of HIV infection, care and support to those infected and affected by HIV/AIDS and in close cooperation with PLWHAs.

- **Eliminating disparities in access** to services, access to prophylactics, and prevention education, should be the foundation of all long term sexual health planning, legislation and intervention. Ensuring all Samoans have access to STI care and prevention will ensure the equity of public health.

- **Incorporate Culture (Fa'asamoa) and Religion (Lotu) in Addressing Sexual Health.** Public health in Samoa must overcome conflicts of sexual health with cultural and religious values, which has been an ongoing challenge. The national response should involve churches in sex education and prevention and observe village customs in public health delivery, while at the same time delivery the highest international standard of prevention, education, and care.

- **Country-wide Commitment.** All members of the community have individual and collective responsibility to actively participate in the prevention and control of the HIV/AIDS epidemic. National response shall be multi-sectoral and multidisciplinary. Strong Political and Government commitment and leadership at all levels is necessary for sustained and effective interventions against HIV/AIDS epidemic.

- **Behavior change builds capacity of people to engage in prevention**. HIV/AIDS is preventable. Transmission of infection is preventable through changes in individual behavior, hence education and information on HIV/AIDS, behavioral change communication as well as prevention strategies are necessary for people and communities to have the necessary awareness and courage to bring about changes in behavior at the community and individual levels.

- **Health communication is a public health duty**. The community has the right to information on how to protect its members from further transmission and spread of HIV/AIDS. The national response should target populations that have the least access to health education and promotion messages.

- **Combating stigma around HIV, STI's and sexual health** must be sustained by all sectors at all levels. Stigma remains a pervasive underlying issue behind low testing rates and low turnout for sexual health services.

- **All linked HIV testing must be voluntary**, with pre-and-post test counseling, and all testing for other health conditions must conform to medical ethics, i.e. informed consent.

- **PLWHAs have the right to comprehensive health care and other social services**, including legal protection against all forms of discrimination and human rights abuse. However, PLWHAs may be required to meet some of the cost of the Highly Active Anti Retroviral Therapy (HAART).

- **Assist key populations**. As high risk groups share a disproportionate burden of HIV, their needs must be formally identified through population research. In the context of Samoa, we need to assess 1) know what groups are at risk, 2) how to better serve the social and health needs of these groups, and ultimately 3) reduce the rates of STI's by addressing the health of key populations. High risk groups for TB also need to be identified. Appropriate strategies shall be developed to reduce the risk of HIV, STI and TB infection among specific high risk groups.

Background: HIV, AIDS, STI's, and TB in Samoa

The first case of HIV recorded in Samoa was in 1990. Since that time, the recorded prevalence of the virus has remained low in prevalence (0.005%) with 0 new cases being captured between 2012-2015. However, testing rates are low with around only 4 to 5% of the population being tested each year according to quarterly surveillance reports (see Table 1). Other STI's, particularly Chlamydia, are high in prevalence (26%) with low testing rates.

Table 1. HIV Testing Rates

Year	HIV Tests	Percent of Population
2012	9394	4.9%
2013	8443	4.4%
2014	7461	3.9%
2015	8870	4.6%
2016	7408	3.8%

Most of those tests come from routine antenatal blood panels in mothers having their first antenatal care visit. Voluntary testing, and testing in males are low. For these reasons, the full impact of HIV/AIDS on Samoa remains relatively unknown. However, Table 2 shows that a quarter of the documented HIV cases are mother to child transmissions, which suggests that HIV may be more prevalent than what current surveillance systems are detecting. All documented living cases are currently receiving ART treatment, which is free at all health centres.

Table 2. HIV/AIDS Summary

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

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

STI's generally have low voluntary testing rates (apart from ANC STI testing which is mandatory). Table 3 shows that Chlamydia, which has the highest prevalence, also has the low testing rate. This is a particular concern considering that a high prevalence of 26% is detected in only 1% of the population (See Table 3).

Table 3. STI Surveillance Data at a Glance

	2015 Prevalence	2015 Testing Rate	2016 Prevalence	2016 Testing Rate
Chlamydia	26%	1.0%	Not Tested	Not Tested
Hepatitis B	2%	4.6%	2.9%	3.90%
Syphilis	0.3%	4.4%	0.9%	3.60%
Hepatitis C	0.1%	2.0%	0.5%	1.90%
HIV	0%	4.6%	0%	3.80%
Gonorrhoea	Not tested	Not tested	Not Tested	Not Tested

HIV Knowledge and Condom Use

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

Table 4. Select DHS 2009 and 2014 Findings

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

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

Challenges in Addressing HIV, AIDS, and Other STI's

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

1. HIV has a low testing rate of 4.6% of the population being tested in hospitals and clinics in 2015. The Demographic Health Survey (2014) reveals that only 4% of women and 3% of men have ever been tested for HIV in their lifetime. So the true prevalence may be much higher, especially in rural areas where access to testing is lower.
2. Of women who have given birth in the past 2 years, only 23.9% have received HIV counselling in prenatal care visits, and only 4.1% percent received counselling, testing, and testing results, suggesting high risk for mother-to-child infections (DHS 2014)
3. Youth are also at risk with only 5% of women and 6% of men having comprehensive knowledge of HIV. Urban youth are also more likely to have sex before the age of 15 than rural youth (DHS 2014). Youth ages 15-19 are less likely to know where to access condoms (25.1 compared to 34.7 for all age groups). Youth ages 15-24 account for 26.3% of all Chlamydia infections in 2015, which has a syndemic relationship with HIV (Global Fund Progress report 2015).
4. Chlamydia, which has a high prevalence in Samoa, is also primarily transmitted sexually, and has been known to increase infectiousness in people with HIV via increase viral shedding in the cell walls of genitals. High Chlamydia rates increase HIV transmission.
5. Condom use is low. Only 1.5% of women have ever used a male condom and only 0.1% has used a female condom. For men only 14.4% have used a male condom during sex (DHS 2014)
6. Men in particular may be more vulnerable to HIV exposure than women, due to their lower age of first sexual intercourse, and higher rates have having first intercourse before the age of 15, both of which are risk factors for HIV (DHS 2014).
7. Increasing teenage pregnancy
8. Highly mobile population including seafarers, police engaged in UN operations, residents returning from overseas, and tourists.
9. Low access to prevention materials and condoms

Additionally, Samoa faces challenges in sexual health regarding Chlamydia, Gonorrhoea, Syphilis, and Hepatitis B&C.

As mentioned previously, Chlamydia is a major problem in Samoa, and the most prominent sexual health issue in terms of STI's. Though this rate is made up of predominantly antenatal women, Chlamydia is more prevalent in men (31% compared to 25% in females in 2014). Ages 15-24 represented 26.3% of all Chlamydia infections in 2015, which suggests youth are at particular risk. Chlamydia also has a low testing rate for the general population (only 1.0% in 2015). Chlamydia if left untreated can lead to sterility and blindness (for infants born to mothers with Chlamydia).

Syphilis, though lower in prevalence than Chlamydia, is increasing from 0.2% detected infections from NHS testing in 2013 to 0.3% in 2014 and 2015. Hepatitis B is the second highest STI prevalence to Chlamydia, and remains as such despite a slight decrease in cases

from 2013-2015 (2.5% to 2.0% respectively). Gonorrhoea has not been screened for between 2013 and 2015.

Multiple factors, including stigma around sexual health, low access to condoms, confidentiality concerns, and stigma around the prevention and treatment of STI's pose challenges to addressing STI prevalence and encouraging regular testing.

National Response

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

Ministry of Health's role has been to provide clear policy guidance and relevant, technical assistance, to ensure HIV/AIDS, and STI interventions are delivered in accordance within national policies and appropriate frameworks, and to minimize fragmentation and duplication of programs. Due to the relatively low prevalence of HIV, the Ministry of Health has taken a broad sexual health approach, addressing all STI's and sexual health threats in order to prevent HIV and safeguard the population from future epidemics. TB interventions have also been integrated into this programming.

Beyond the National AIDS Coordination Committee (NACC) and the Technical AIDS Committee (TAC) composition that included multi-sector partners from government ministries and non-government and civil society sectors, the donor partners i.e.: Global Fund to fight AIDS, TB and Malaria (GFATM) provided financial support to allow Health Sector partners from government ministries and non-governmental organizations (NGOs) to become more actively engaged in the HIV/AIDS and STI response in Samoa.

MoH's programme activities are mainly implemented through the National Health Service (NHS) and NGO stakeholders. NGOs such as the Samoa Fa'afafine Association (SFA), Samoa Family Health Association (SFHA), and Samoa Red Cross Society (SRCS) have been remarkable in strategizing ways to combat the spread of HIV/AIDS, including (i) addressing vulnerable groups such as men who have sex with men (MSM); (ii) mobile clinics promoting safer sex and distributing condoms; (iii) and ensuring safe blood is provided to the blood banks. Red Cross continues to advocate for safe blood donors thus contributing to a greater pool of voluntary blood donations (VNRBD). The majority of blood provided is from family replacement donors. Despite these efforts, an entity dedicated solely to the fight against HIV/AIDS does not exist after the programmes carried out by the Samoa AIDS Foundation and Samoa Plus ceased since 2012.

Mass media campaign and peer education programs that mobilizes young girls and women about their rights for their safety and health, inclusion of men in discussion of sexual reproductive health issues with emphasis on STIs/HIV and AIDS, the strong involvement of Samoa Fa'afafine Association in many other activities that targets fa'afafine populations is crucial, and many other programs carried out by the sector partners. A 2011 documentary "E te silafia", which described the status of the HIV/AIDS epidemic in Samoa, is regularly aired on World AIDS Day each year.

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

councils on issues of confidentiality. This poses a challenge to advocating for the rights of PLWHA.

1. Law, Confidentiality and the Rights of PLWHA

This section outlines the legal and policy objective with regards to legislation, confidentiality and the rights of PLWHA. A legal and policy infrastructure that protects and promotes the rights of PLWHA is critical for ensuring the effectiveness of public health and access to care. This also has implications for people dealing with any STI and more broadly sexual health. The activities of the national response dealing with law, confidentiality and human rights should address this objective and areas of action. This legislative component of public health in addressing HIV, AIDS, and STI's is as follows.

Objective 1 Safeguard the Rights of PLWHA

Safeguard the rights of people living with HIV/AIDS or other STI's to ultimately improve their health and quality of life, make health interventions for PLWHA more effective, and ensure a human rights approach to public health.

Key Strategic Actions for Objective 1

a) Minimize and manage stigma around HIV, AIDS, STI's and sexual health
b) ensure and promote health information privacy and confidentiality to establish social safety
c) Improve the legal and policy environment for PLWHA to prevent rights violations.
d) Advance the protection of PLWHA rights in legal, institutional and social domains.

1.1 Rights of PLWHA

This section defines the rights of PLWHA that the National Response must safeguard. The following statement of rights of PLWHA are summarized from international guidelines and articulated in the legislative and cultural context of Samoa. PLWHA include (but are not limited to) the following;

1. People living with HIV/AIDS are entitled to all basic needs and all civil, legal, and human rights without any discrimination based on gender differences of zero-status. These human rights include but are not limited to the following;
    A. The rights to, non-discrimination, equal protection and equality before the law.
    B. The right to seek and enjoy asylum;
    C. The right to liberty and security of person
        1) People with HIV or AIDS have the same rights to liberty and autonomy, security of the person and to freedom of movement as the rest of the population.
        2) No restrictions should be placed on the free movement of HIV-infected people and they may not be segregated, isolated or quarantined in prisons, schools, hospitals or elsewhere merely because of their HIV-positive status.

3) People with HIV infection or AIDS are entitled to maintain personal autonomy (i.e. the right to make their own decisions) about any matter that affects marriage and child-bearing - although counselling about the consequences of their decisions should be provided.

D. The right to highest attainable standard of physical and mental health
E. The right to privacy;
F. The right to freedom of association;
G. The right to freedom of opinion and expression and the right to freely receive and impart information.
H. The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

2. Persons seeking HIV/AIDS information or counselling, treatment and care are entitled to the same rights as any other individual seeking other health/social services

3. HIV infection shall not be grounds for discrimination in relation to education, employment, health and any other social services. Pre-employment HIV screening shall not be required. For persons already employed, HIV/AIDS screening, whether direct or indirect, shall not be required. HIV infection alone does not limit fitness to work or provide grounds for termination

4. HIV/AIDS information and education targeting the behavior and attitudes of employees and employers alike shall be part of HIV/AIDS intervention in the workplace.

5. Measures to protect the public from transmission of HIV/AIDS at work place shall be instituted by the respective organizations.

6. Adolescents have the same rights to confidentiality and privacy as well as informed consent, so they shall be involved in counseling

7. The public has the right of accountability on the part of PLWHAs with regard to prevention of HIV/AIDS.

8. Prison inmates have the right to basic HIV/AIDS information, voluntary counseling and testing, and care, including treatment of STIs.

9. Right to ethical HIV testing

   A. No person may be tested for HIV infection without his or her free and informed consent (except in the case of anonymous epidemiological screening programmes undertaken by authorised agencies such as the national, provincial or local health authorities or in the case of necessary population health measures under the legislative powers of the Ministry of Health Act 2006.)

   B. In all other cases – such as HIV testing for research purposes or when a person's blood will be screened because he or she is a blood donor – the informed consent of the individual should be required.

   C. Where an existing blood sample is available, and an emergency situation necessitates testing the source patient's blood (e.g. when a health care worker has

been put at risk because of an accident such as a needle stick injury), HIV testing may be undertaken without informed consent - but only after informing the source patient that the test will be performed and after assuring him or her that privacy and absolute confidentiality will be maintained.

D. If an existing blood sample is not available for testing in an emergency situation, the patient must give his or her informed consent for blood to be drawn for the HIV test to be done.

E. Routine testing of a person for HIV infection for the perceived purpose of protecting a health care professional from infection is impermissible - regardless of consent. Proxy consent for an HIV test may be given where an individual is unable to give consent. Proxy consent is consent by a person legally entitled to grant consent on the behalf of another individual. For example, a parent or guardian of a child below the age of consent to medical treatment may give proxy consent to HIV testing of the child.

10. Right to informed consent, pre and post HIV test counselling

A. Informed consent, which includes pre-HIV test counselling, is compulsory before HIV testing may be carried out.

B. *Informed consent* means that the person has been made aware of, and understands, the *implications* of the test.

C. The person should be free to make his or her own decision about whether to be tested or not, and may in no way be coerced or forced into being tested.

D. Pre-test counselling should occur before an HIV test is undertaken. It should take the form of a confidential dialogue between the client and a suitable, qualified person where relevant information is given and consent obtained.

E. Post-test HIV counselling should take place as part of the process of informing an individual of an HIV test result.

F. Anonymous and confidential HIV antibody testing with pre- and post-HIV test counselling should be available to all. Persons who test HIV positive should have access to continuing support and health services.

1.2 Building Legislative Capacity to Protect PLWHA

In order to support this policy to optimal implementation and support the goals of the national response the following areas of needed legislation and legal analysis have been identified:

Table 6. Areas of Legal Analysis

Legislation	Purpose and Relation to PLWHA
Law and case law affecting key populations	Criminalization of sex work, homosexual relations, and harsh punishment for drug abuse can affect the risk profile of key populations
Health Privacy and Confidentiality	Disclosure of HIV and STI status is widely perceived as socially dangerous. To ensure people trust the healthcare system, privacy and confidentiality are critical.

Legislation	Purpose and Relation to PLWHA
HIV Travel, Stay, and Residence Restrictions	Identify the legal situation regarding HIV status and travel, stay and residence. Restrictions to any are considered violation of PLWHA rights internationally.
Gender based violence	Violence impacts women's ability to protect themselves from HIV, access prevention services and treatment, and participate in PMTCT.
Legal incentives for voluntary testing	Create legal and policy measures than incentivize public attendance for voluntary testing
Gender Equality and Mandatory Testing	Since HIV and STI testing is mandatory for ANC visits of pregnant women, 1) the law needs to assessed if this is discriminatory since no laws require mandatory testing in adult males, 2) mandatory testing for males should be evaluated to see if such an option is lawful and ethical as well as what measures are feasible in Samoa, 3)all mandatory testing should be analysed to ensure no violation of international standards
HIV and Access to Reproductive Health Services and Abortion	Laws around abortion need to be amended to adequately address access to abortion for HIV positive women, and legal interventions for increasing access to SRH services need to be developed

1.3 Health Information Confidentiality and Privacy Guidelines for HIV, AIDS and other STI's

Samoa does not currently have legislation regarding the privacy and confidentiality of health information. This poses risks for individuals with HIV and STI's as unintentional disclosure of an individual's status is socially dangerous due to widespread stigma. In the absence of formal legislation, this section outlines policy measures for healthcare providers and other service providers in Samoa for ensuring general health information privacy and confidentiality for sexual health status and STI treatment. Based off of international hospital regulations, the guidelines in this section were drafted to comply with donor health information standards and the national health profession standards of Samoa.

A. Confidentiality- Professional Obligations

Though Health Information is not regulated by legislation, there are enforceable measures that professionally obligate healthcare workers to protect patient confidentiality within the Medical Practitioners of Samoa Code of Professional Standards 2007, National Standards for Nursing and Midwifery Practice 2007, and the Code of Professional Standards Samoa Allied Health Professionals 2010. These standards for care and practice detailed within those documents are enforceable through power granted in the Healthcare Professions Registration and Standards Act 2007, Part 3 Professional Standards and Part 5 Disciplinary Procedures, Nursing and Midwifery Act 2007, and the Pharmacy Act 2007.

HIV and STI care and treatment confidentiality fall under practice standards for healthcare professions. However, other service providers not governed by these standards are strongly recommended to follow the Health Information Confidentiality and Privacy Guidelines detailed in this section. Due to the sensitive nature of treatment, testing, and care for sexual health and STI's, it is strongly recommended that non-medical service providers follow these privacy and confidentiality guidelines with their clients.

B. Definitions

1. Privacy- means the individual right to control who has access to the individual's health information
2. Confidentiality- means the security measures and ethics undertaken by healthcare providers and healthcare institutions to ensure that health information is only accessible by other healthcare providers and institutions for lawful purposes.
3. Health Information- means any information, whether oral or recorded in any form or medium, that:

    a. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
    b. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.
    c. These privacy and confidentiality regulations apply to the following information or classes of information about an identifiable individual:
        (1) Information about the health, health status or treatment of that individual, including his or her medical history; or
        (2) Information about any disabilities that individual has, or has had; or
        (3) Information about any health services or disability services that are being provided, or have been provided, to that individual; or
        (4) information provided by that individual in connection with the donation, by that individual, of any body part or any bodily substance of that individual or derived from the testing or examination of any body part, or any bodily substance of that individual; or
        (5) Information about that individual which is collected before or in the course of, and incidental to, the provision of any health service or disability service to that individual

4. Lawful Purposes- means collection of health information is intrinsic or connected to the activity and/or function of an organization, institution, or individual profession.
5. Breach- means Breach: The acquisition, access, use or disclosure of protected health information in a manner which compromises the security or privacy of the protected health information. Breach excludes:

    a. Any unintentional acquisition, access or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure.
    b. Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized healthcare arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed.
    c. A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

C. Authorization of Health Information

Health Information shall not be collected, retained, or shared by any individual or institution unless the collection is done for lawful purposes or is necessary for the purpose of the organization or an individual's professional duties. This also means that healthcare providers and institutions are properly licensed to perform their activities and functions, and are legally empowered to do so by their respective professional standards and legislature. Lawful purposes (purposes connected with function or activity of organization) for healthcare providers includes the following;

1. Care and treatment
2. Administration
3. Training and education in patient care management
4. Monitoring and Evaluation
5. Research in which collected health data is de-identified (data in which all information that links health data to an individual's identity is removed i.e. name, ID number, and financial account numbers).

D. Collection of Health Data

1. Where a health agency collects health information directly from the individual concerned, or from the individual's representative, the health agency must take such steps as are, in the circumstances, reasonable to ensure that the individual concerned (and the representative if collection is from the representative) is aware of—

    a. the fact that the information is being collected; and
    b. the purpose for which the information is being collected; and
    c. the intended recipients of the information; and
    d. the name and address of—

        (1) The health agency that is collecting the information; and
        (2) The agency that will hold the information; and

    e. whether or not the supply of the information is voluntary or mandatory and if mandatory, the particular law under which it is required; and
    f. the consequences (if any) for that individual if all or any part of the requested information is not provided; and
    g. the rights of access to, and correction of, health information

2. The steps referred to in sub rule (1) must be taken before the information is collected or, if that is not practicable, as soon as practicable after it is collected.
3. A health agency is not required to take the steps referred to in sub rule (1) in relation to the collection of information from an individual, or the individual's representative, if that agency has taken those steps in relation to the collection,
    a. from that individual or that representative, of the same information or information of
    b. the same kind for the same or a related purpose, on a recent previous occasion.
4. It is not necessary for a health agency to comply with sub rule (1) if the agency believes on reasonable grounds, that;
    a. compliance would-
        (1) Prejudice the interests of the individual concerned; or
        (2) Prejudice the purposes of collection; or
    b. compliance is not reasonably practicable in the circumstances of the particular case; or

c. non-compliance is necessary to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences.

5. Health information must not be collected by a health agency—
   a. by unlawful means; or
   b. by means that, in the circumstances of the case,—
      (1) Are unfair; or
      (2) Intrude to an unreasonable extent upon the personal affairs of the individual concerned.

D. MOH Oversight

MOH has the right to mandate the collection of specific health information as dictated by national health priorities and population health events and trends. Collection of health information by MOH is considered lawful and necessary for MOH activity and function.

E. Privacy and Confidentiality Enforcement

MOH has the authority to enforce regulations relating to the privacy and confidentiality of health information. All healthcare facilities comply with MOH enforcement of privacy and confidentiality of health information.

F. Health Sector and Partner Organization Staff Compliance

1. All new employees shall be instructed on the patient information privacy and confidentiality policies in their orientation. Current employees shall be required to review patient information privacy and confidentiality policies on an annual basis.
2. Healthcare facility management and administration shall ensure employee competency to patient information privacy and confidentiality policies.
3. Medical Staff Compliance-All professional ethics, duties and standards of healthcare personnel relating to the protection of confidential health information apply to healthcare facility operation and administration. (See Code of Professional Standards for Allied Health Professionals 2008). Healthcare personnel are expected to practice confidentiality ethics that their professional licensure requires, in addition to measures outlined in this section.

G. Sharing Health Information

Healthcare Providers may share health information as necessary to providing treatment. Treatment includes;

1. Sharing information with other providers
2. Referring patients to other providers
3. Coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate healthcare services).
4. Sharing information with the patient. The healthcare provider must provide a private setting to discuss a patient's health information so as not to transmit the information to any other individuals not authorized by the patient.
5. All HIV Testing shall be confidential. Nevertheless, public health legislation shall authorize health care professionals to decide on the basis of each individual case and ethical considerations, to inform the sexual partners of the HIV status of their patients under the powers established in the MoH Act 2006 and Part 4 Section 37 of the Health Ordinance 1959 "Offences in regard to infectious diseases". Such a decision shall only be made in accordance with the following criteria:

- The HIV-positive person in question has been thoroughly counseled.
- Counseling of the HIV-positive person has failed to achieve appropriate behavioral changes.
- The HIV-positive person has refused to notify, or consent to the notification of his/her partner.
- A real risk of HIV transmission to the partner(s) exists.
- The HIV–positive person is given reasonable advance notice.
- Follow-up is provided to ensure support to those involved, as necessary.

H. Health Sector and Partner Org. Non-medical Staff Compliance

All staff employed by a healthcare facility who are not directly involved in patient care (including but not limited to administration, maintenance staff, contractors, and support personnel) shall also be responsible for complying with the measures for ensuring health information privacy and confidentiality outlined in this section.

I. Healthcare Facility Compliance

Measures outlined in this section shall apply to all personnel, services, procedures and patient care guidelines of all healthcare facilities, public and private.

J. Security of Health Information

1. Healthcare facility administrative authorities shall be responsible for creating procedures ensuring the security and confidentiality of health information collected and stored appropriately. These procedures must ensure that;

a. Patient information is only accessible to healthcare providers

b. Medical records are stored in a secure location accessible only by medical and administrative staff.

c. Medical records, electronic or otherwise are secure, accessible to pertinent personnel for data entry and management.

d. Any health agency that holds health information must ensure that-

(1) the information is protected, by such security safeguards as it is reasonable in the circumstances to take, against loss; or access, use, modification, or disclosure, except with the authority of the agency; or other misuse; and

(2) if it is necessary for the information to be given to a person in connection with the provision of a service to the health agency, including any storing, processing, or destruction of the information, everything reasonably within the power of the health agency is done to prevent unauthorised use or unauthorised disclosure of the information; and

(2) Where a document containing health information is not to be kept, the document is disposed of in a manner that preserves the privacy of the individual

2. Safeguards

a. Administrative Safeguards- Hospitals must have policies and procedures used to select security controls and govern behaviours relating to the protection of patient health information.

b. Physical Safeguards- Hospitals must have policies, procedures and physical controls used to protect health information housed within facilities, for example, establishing restricted, locked areas where health information is stored.

c. Technical Safeguards- Hospitals must have policies, procedures and technology controls used to protect health information contained within computer systems, for example, requiring a password to read computer files containing health information.

K. Health Information Quality Assurance

A health agency that holds health information must not use that information without taking such steps (if any) as are, in the circumstances, reasonable to ensure that, having regard to the purpose for which the information is proposed to be used, the information is accurate, up to date, complete, relevant, and not misleading.

L. Retention of Health Information

A health agency that holds health information must not keep that information for longer than is required for the purposes for which the information may lawfully be used.

M. Disclosure of Health Information

1. A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds, that—

a. the disclosure is to the individual concerned; or the individual's representative where the individual is dead or is unable to exercise his or her rights under these rules; or
b. the disclosure is authorised by the individual concerned; or the individual's representative where the individual is dead or is unable to give his or her authority under this rule; or
c. the disclosure of the information is one of the lawful purposes in connection with which the information was obtained; or
d. the source of the information is a publicly available publication; or
e. the information is information in general terms concerning the presence, location, and condition and progress of the patient in a hospital, on the day on which the information is disclosed, and the disclosure is not contrary to the express request of the individual or his or her representative; or
f. the information to be disclosed concerns only the fact of death and the disclosure is by a health practitioner or by a person authorised by a health agency, to a person nominated by the individual concerned, or the individual's representative, partner, spouse, principal caregiver, next of kin, close relative, or other person whom it is reasonable in the circumstances to inform; or
g. Compliance with sub rule (1) is not necessary if the health agency believes on reasonable grounds that it is either not desirable or not practicable to obtain authorisation from the individual concerned and that:
    1) the disclosure of the information is directly related to one of the lawful purposes in connection with which the information was obtained; or
    2) the information is disclosed by a health practitioner to a person nominated by the individual concerned or to the principal caregiver or a near relative of the individual concerned in accordance with recognised professional practice and the disclosure is not contrary to the express request of the individual or his or her representative; or

3) the information is to be used in a form in which the individual concerned is not identified; or is to be used for statistical purposes and will not be published in a form that could reasonably be expected to identify the individual concerned; or
4) (iii) is to be used for research purposes (for which approval by an ethics committee, if required, has been given) and will not be published in a form that could reasonably be expected to identify the individual concerned; or
5) the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to public health or public safety; or the life or health of the individual concerned or another individual; or
6) the disclosure of the information is essential to facilitate the sale or other disposition of a business as a going concern; or
7) the information to be disclosed briefly describes only the nature of injuries of an individual sustained in an accident and that individual's identity and the disclosure is by a person authorised by the person in charge of a hospital; or to a person authorised by the person in charge of a news medium for the purpose of publication or broadcast in connection with the news activities of that news medium and the disclosure is not contrary to the express request of the individual concerned or his or her representative; or
8) the disclosure of the information for a professionally recognised external quality assurance programme; or for risk management assessment and the disclosure is solely to a person engaged by the agency for the purpose of assessing the agency's risk and the information will not be published in a form which could reasonably be expected to identify any individual nor disclosed by the accreditation, quality assurance, or risk management organisation to third parties except as required by law; or
9) non-compliance is necessary to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation; or
10) the individual concerned is or is likely to become dependent upon a controlled drug, prescription medicine, or restricted medicine and the disclosure is by a health practitioner to an Officer of the Ministry of Health or National Health Service

N. Breach of Confidentiality Reporting

Any breach of privacy and confidentiality procedures of patient health information (occurring in staff, daily operations, or during events like theft or natural disasters) must be reported to MOH within 24 hours.

1.4. Criminalization of HIV Transmission

In some countries, criminal law is being applied to those who transmit or expose others to HIV infection. The Ministry of Health does not recommend nor endorse legislative measures to criminalize the transmission of HIV that is unintentional and views such measures as threats to public health. There are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights. Because of these concerns, UNAIDS urges governments to limit criminalization to cases of intentional transmission i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.

Willful spread of HIV has been so rarely documented worldwide that it is largely hypothetical. Since no cases have been processed in Samoa or Australia and New Zealand Commonwealth case law, legally it is urban myth and no legislation exists regarding the legal handling of such a case. Presently Samoan legal priorities regarding HIV, AIDS, and STI's are primarily concerned with protecting the individual rights and confidentiality of people as well as safeguarding public health.

Prosecuting a case of willful spread of HIV would necessarily involve addressing legal criteria in Sections 120-121 of the Crimes Act 2013. Supplying evidentiary support for a claim would entail 1) proving a person knew their HIV status prior to exposing other individual(s), 2) the individual did not disclose their HIV status to exposed person(s), 3) and the exposure resulted in HIV infection.

Any action taken against to quarantine and accuse a case of a willful spread of HIV would fall under the authoritative powers of MoH within Part 4 Section 36 of the Health Ordinance 1959 "Isolation of persons likely to spread infectious diseases" as well as Section 37 "Offenses in regards to infectious diseases".

It should be noted that all rights of PLWHA, national and international, must NOT be violated in the investigation, prosecution and sentencing of individuals involved in such a potential case.

2. Prevention

For the previous policy period 2011-2016, programming around prevention focused on raising awareness with regards to HIV, AIDS, STI's and sexual health. The DHS shows that awareness and knowledge are improving in women, but decreasing in men (see Table 7).

Table 7. HIV Awareness and Knowledge

Measure	**DHS 2009**		**DHS 2014**	
	Women	Men	Women	Men
Have heard of HIV/AIDS	85%	87%	91%	85%
Have Comprehensive knowledge of HIV/AIDs	4%	7%	6.5%	6.4%

MoH and stakeholders have asserted that to address this, the national response needs to go beyond dissemination of information, education, and clinical intervention towards community based behaviour change programs. By addressing behaviour and communities'

capacity for prevention, all clinical, educational and health promotion programs will have higher public participation and better outcomes. The main objective in the previous policy was to increase public awareness of the risk to change of behaviors. The 2017-2021 policy suggests that community education and behavior change will results in greater public awareness and capacity to receive health messages and participation in interventions.

Objective 2 Engage communities in behaviour change and improve access to prevention
2A. Engage communities in prevention through behaviour change programs that increase people's capacity to make well informed sexual health decisions to synergistically enhance the effectiveness of clinical and educational interventions.
2B. Improve access to testing, counselling, and prophylaxis by engaging community structures in service delivery and health promotion.
Key Strategic Actions for Objective 2:
a) Implement behaviour change programs to enhance health education outreach and reception of health messages aimed at increasing awareness and knowledge, with additional programmes for youth
b) Primary Health Care to incorporate comprehensive sexual health behaviour change, education, and clinical outreach to communities, using community structures to ensure sustainability
c) Increase testing rates by promoting testing resources, increasing lab capacity, and conducting screening outreach to rural areas
d) Increase prevention efforts with youth, antenatal mothers and key populations
e) Maintain 0% incidence of Mother to Child transmission of HIV
f) Implement national level health communication to increase knowledge and awareness of services
g) Needs assessment of condom programming (possible collaboration with UNFPA)
j) Promote Hepatitis B vaccination amongst tufuga
k) Community consultations with tufuga and their assistants to assess practices and establish ongoing dialogue around infection control with village committees
l) Conduct infection control trainings for tufuga for preventing blood borne pathogens (particularly HIV, Hepatitis, and extra pulmonary TB)
m) Establish a national register for tattooists and accreditation system
n) Implement infection control measures, policies and health guidelines for all methods of tattooing (traditional and non-traditional)
o) Partner the health sector with tufuga to promote infection control
p) Supply tufuga with infection control kits

To achieve this overarching goal for the 2017-2021, the following guidelines to organize the national response are articulated in this section.

2.1 Testing Rates

Voluntary testing rates for all STI's are low in Samoa (stats). Increasing the number of people screened is crucial to surveillance, assessing the full scope of the epidemic, and linking people to prevention and treatment services. Programmes and interventions aimed at addressing the low testing rates will be of high priority for the national response from

2017-2021. This includes increased screening of the general population and all identified key populations in Samoa.

Table 8. Testing Rates

	2015 Testing Rate	2016 Testing Rate
Chlamydia	1.0%	Not Tested
Hepatitis B	4.6%	3.9%
Syphilis	4.4%	3.6%
Hepatitis C	2.0%	1.9%
HIV	4.6%	3.8%
Gonorrhoea	Not tested	Not Tested

This will necessarily require changes to health sector data collection processes in order to identify cases that are from key population groups. Since Samoa's HIV incidence and prevalence among ANC is low, this indicates that HIV is most likely not in general populations, but in key population groups.

2.2 Increase General and Key Populations' Knowledge, awareness, and capacity to prevent STI's through Information, Education and Communication (IEC) Programmes and Behaviour Change

Sustainability of public health interventions in sexual health relies upon the population's capacity to engage in prevention through healthy behaviour and informed health decisions. This section details the health promotion and behaviour change programming directions and priorities for different populations.

For Youth in Schools and Institutions of Higher Learning

Youth are particularly vulnerable to HIV infection. It is important to reach youth in schools, to set a foundation or healthy behavior and sexual health awareness. The Ministry of Education, Sports and Culture and other public and private institutions of higher learning in collaboration with the National Aids Council, Ministry of Health shall develop appropriate intervention strategies to accelerate AIDS, STI, and sexual health information in schools. These include provision of non examinable HIV/AIDS information in primary and secondary schools. HIV/AIDS information should be introduced early enough so as to protect the children who are not yet sexually active before they are exposed to sexual practices so as to equip the youth with knowledge and skills to protect themselves and others from HIV transmission. Reproductive and sexual health should be incorporated in the school curricula at all levels.

For Out of School Youth

The Ministry of Women Community and Social Development, responsible for youth development affairs, in collaboration with the Ministry of Health, NGOs and Faith Groups shall develop participatory HIV/AIDS, STI, and sexual and reproductive health education programmes for the out of school youth. The youth should be given correct information including the prevention strategies including promotion of correct and consistent use of condoms, abstinence and fidelity, and voluntary counseling and testing. Girls should also be

encouraged to avoid unwanted pregnancies. Having been empowered with information, the youth should be encouraged and supported in developing their own strategies.

For Adults and People with Multiple Partners

IEC and behavior change programmes should be made available and accessible to promote safer sex practices including fidelity, abstinence, correct and consistent use of condoms according to well informed individual decision. Endorsement of family planning, STI prophylaxis, and other prevention methods shall be integral to all sites of service delivery. Sexual health strategies for healthy behavior and decision making should presumptively target all adults as having multiple partners. This allows counselors to deliver health information without having to address a client's fidelity/infidelity directly.

For Commercial Sex Workers

IEC and counseling services shall be made free of stigma and at no cost to commercial sex workers in order to enable them to adopt safer sexual practices. Outreach to this population is critical as their chances of exposure to HIV and STI's is high due to the fact that a lot of their clientele comes from international seafaring populations, sex work is illegal, and most are homeless lacking the income to access condoms and education. Additionally, their social needs should be addressed by IEC, counseling, and behavior change services in order to address the social determinants of their sexual health risks. Due to the fact that sex work is illegal, all service providers must ensure confidentiality and make sure their use prevention services does not expose them to legal risk.

The Pacific Multi-country Mapping and Behavioral Study 2016 found that there are an estimated 400 female sex workers in Samoa. Most women are doing sex work for economic reasons. Payment varies considerably from 50 to 200 tala. These women have a wide range of clients, including local and foreign men.58.3% had children and the majority had no other employment. The age at which women began sex work ranged from 13 to 21 years old. The mean numbers of partners in the last 12 months was 10, of whom nine were clients (most likely many regular clients). Only 33% of the participants used a condom on the last occasion of vaginal intercourse with a client; the majority were inconsistent condom users with clients in the last 12 months. Condom use with casual non-paying partners was low; 50% used a condom on the last occasion. A minority of the women (18.2%) drank alcohol in the last week. Their HIV knowledge was moderate. None of the women had accessed a sexual health service in the last 12 months, although 60% had been given condoms in that period. None had been tested for HIV in the previous 12 months.

There is therefore a need for extensive condom programming and health education outreach to this group. Interventions should also seek to provide female sex workers with housing, sanitation, and economic services to support their participation in prevention interventions.

For substance abusers

Government Ministries dealing with drug substance abuse in collaboration with NAC, TAC, and other NGOs and Faith groups shall strengthen their preventive activities and implement targeted IEC and counseling services for drug substance abusers. There is also a need to identify the size, demographics and health needs of this population through research studies. Since drug use is illegal, all service providers must ensure confidentiality and make sure their use prevention services does not expose them to legal risk.

Specifically, the development and delivery of harm reduction and opioid substitution therapy programs should be implemented at the community level to decrease morbidity and support this population in prevention and improving sexual health. These programs should be evaluated for cost-effectiveness once the population has been quantified.

For Fa'afafine (Transgender)

Historically, fa'afafine have been classified as a high risk group. Though traditionally valued within Samoan culture, fa'afafine face marginalization within their communities and there is anecdotal evidence that they face high rates of violence.

The Pacific Multi-country Mapping and Behavioral Study 2016 found that there are an estimated 25-30,000 fa'afafine and MSM in Samoa. 80 participants had sexual intercourse, and the mean age of sexual debut was close to 16 years. In the interviews, fa'afafine talked about the problems of relationships with men. They said that they had often had their hearts broken as men moved into relationships with women. The most common number of sexual partners in the 12 months prior to the survey was between one and three, with 49% reporting concurrent sexual partners in the six months prior to the survey. 32.4% had been paid for sex in the last 12 months.

Condom use was low, with 43.9% stating that they had never used a condom for sex with a regular partner in the last 12 months and 40% reported never using a condom with paying partners. In the interviews, many participants said that they did not use condoms because they felt safe from HIV. 41% of participants used a condom at last anal intercourse with a casual partner.10 people reported having sex with a female partner in the last 12 months.58.58% never used a condom for vaginal intercourse with a casual female partner in that period.

Knowledge about HIV was generally high. However, only 16.3% had an HIV test in the last 12 months. A small proportion of participants had experienced stigmatizing attitudes from family and community. Only 8.7% felt ashamed about their sexual identity, although the interviews indicate that this is complicated, particularly when young. 11.9% of participants had been sexually assaulted in the previous 12 months. 57.4% of participants knew of a local organization that provided access to information or services related to condoms, HIV and STIs, and sexual assault.32.7% had accessed these services in the past 12 months.

All health sector and partner organizations should partner with fa'afafine community leaders in order to deliver prevention, screening, health education, behavior change, and outreach. Organizations should strategize on how to reach fa'afafine in rural villages. Improving screening and surveillance of this group will also require revisions to the data collections systems and methods used by MoH and partners, as fa'afafine needs to be legally recognized and recorded as a valid gender in health records.

There should be needs assessments conducted to determine why fa'afafine don't feel they are at risk for HIV and don't utilize condoms. Interventions should also address the marginalization and abuse fa'afafine experience in their communities to fully enable them to participate in prevention and behavior change.

For Women

MoH views gender equality as integral to achieving equitable access to prevention, health education, and individual capacity building. Social contexts and community issues affecting women in Samoa shall directly inform prevention, health education and behavior change strategies for all organizations involved in the national response. These issues include, but are not limited to the following;

- Gender based violence
- Access to sexual and reproductive health services and family planning
- Disparity in education
- Representation in the political and business spheres
- Environmental health, climate change and gender
- Gender, Cultural Rights, and Human Rights

For Men

Men are also a high risk group for STI infection. Out of all men screened for Chlamydia in 2015, 38% tested positive for Chlamydia infection compared to 26% of women. Though both groups are higher, men have significantly higher rates. Men in Samoa also report for STI testing significantly less than women. Only 62 men were screened between July and December 2015 compared to 856 women during the same surveillance period. Clinically, men are also more reluctant to seek care and adhere to treatment. Providers need to develop strategies for delivering services to men in settings that promote access to them.

For PLWHA

Prevention should also involve those who are already living with the virus. PLWHA shall be encouraged to adopt healthy behavior which enables them to live positively, prevent transmission to their partners, and prevent the occurrence of health conditions related to their HIV status. This includes proper nutrition, healthy behavior, mental health, and social needs. Facilities and services shall be made available to make it easy for them to make healthy behavior changes.

For Inmates

Prison populations generally lack access to health services. Inmates are vulnerable to HIV, STI and TB infections in prison settings due to overcrowding, sanitation, and the high risk of interpersonal violence and sexual assault. Though Samoa Family Health Association has conducted outreach screening and treatment visits to prison facilities, consistent and complete health sector involvement needs to be achieved to improve health and health risk for this population. The following activity areas are key to developing a prison public health system;

- Routine HIV, STI, TB, and co-infection screening of inmates
- Testing counseling for HIV, STI, TB, and co-infection screenings
- Health delivery mechanisms for administering treatment to prisoners
- Health information, communication, education and behavior change for prison populations

For vulnerable co-infections

There are currently no routine clinical practices or protocols within the health sector to address the co-infection of HIV, STI's, and TB with each other and additional communicable diseases. Co-infection of these conditions leads to rapid progression of both illness and increases morbidity. Infection of HIV and TB means an individual's immunity and ability to fight off other illness is already reduced. This makes co-infected individuals more vulnerable to other infections and can quickly result in poorer health outcomes. For these reasons, improving the screening processes for co-infection is being identified as a high priority for the national response.

Media Institutions Involvement

Sustained public information and creation of awareness is paramount in the control of the epidemic. Therefore the role of the media is very important. The media including folk media, in collaboration with other relevant organizations shall play a leading role in educating the public on HIV/AIDS. The media should be actively involved in investigating the practical challenges in the control of HIV and the responses by different sectors in the society, including the private sector. Scientific publications regarding trends in epidemiological surveillance and research intervention activities to promote safe practices shall be disseminated in professional journals and through the mass media.

MoH and partners will establish processes, relationships, and agreements with media institutions in order to supply the technical information, funding and technical support required for public awareness and education. All organizations should develop accountability measures to ensure the accuracy and quality of circulated information of HIV, AIDS and STI's.

2.3 Preventing Mother to Child Transmission (PMTCT)

Since 2009, Samoa has maintained a 0% incidence of newly detected cases of mother to child transmission. The national response seeks to maintain this rate through the delivery of PMTCT programming at the community level. The chance for survival of the child who acquires HIV infection through mother–to-child transmission is poor, with most infants dying within the first year of infection. About 25 - 35% of HIV positive pregnant women will transmit the infection to their newborns. Also there is a 15 – 20% chance that infection will be transmitted to babies during breast-feeding. Testing is mandatory for pregnant women and testing and counseling for mothers and their husbands or partners is promoted by all partners. Since most of the intervention for PTMCT is clinical in nature, the Treatment section deals specifically with ART and prophylactic measures to prevent MTCT. This section deals with bringing counseling, screening and education services to mothers at the community level.

Prenatal Transmission

Education on the risks of mother-to-child transmission to all women of childbearing age and their partners should be delivered nationally at the community level. MoH and partners must establish programmes that utilize the village women's committees (Komiti Tumama) to distribute health information and link pregnant women and their partners for testing, counseling and care at district health centers.

Counseling and appropriate contraception for HIV infected women and their partners shall be provided at zero cost, funded by MoH and the health sector. The district health centers are currently the primary means of delivering these interventions, but MoH and health sector partners should also utilize community structure including but not limited to the Komiti Tumama. Community structures and community health workers will be the front line delivery mechanisms for information and education on alternative technological options including anti retroviral therapy for infected pregnant women.

Since estimates from the DHS 2014 indicate that only 29% of pregnant women access ANC services at health centers, part of PMTCT necessarily involves increasing ANC attendance nationally.

Intra-partum transmission

Health professionals shall apply current techniques, treatments and methods to manage pregnancy and deliveries. They shall choose methods that minimize the risk of HIV transmission to the baby. Healthcare standards and professional obligations shall be applied to all populations. These professional guidelines are articulated within the Medical Practitioners of Samoa Code of Professional Standards 2007, National Standards for Nursing and Midwifery Practice 2007, and the Code of Professional Standards Samoa Allied Health Professionals 2010. The standards for care and practice detailed within those documents are enforceable through power granted in the Healthcare Professions Registration and Standards Act 2007, Nursing and Midwifery Act 2007, and the Pharmacy Act 2007.

Breastfeeding and Preventing Post-natal Transmission

The decision to breastfeed is ultimately the decision of the mother; however MoH strongly endorses breastfeeding for all mothers as a means to improve infant and child nutrition. In the case of HIV+ mothers choosing to breastfeed, the MoH states that;

1. ART therapy is strongly recommended to be initiated before birth and before pregnancy or in early stages of pregnancy to protect gestational health.
2. ART regimen specific for reducing risk of MTC transmission during breastfeeding is strongly recommended (See *Treatment*)
3. The mother should remain on ART therapy after cessation of breastfeeding for her health
4. Breastfeeding generally is recommended for at least 12 months.

If an HIV+ mother chooses not to breastfeed, the MoH states that replacement feeding in place of breastfeeding should not be used unless it is acceptable, feasible, affordable, sustainable and safe according to WHO 2010 guidelines.

In order to prevent HIV transmission through breast-feeding the following services should be offered at the community level via the involvement of community structures in conjunction with MoH and its health sector partners;

- Individually tailored counseling on breast-feeding.
- Counseling of husbands, partners and other relatives on breast-feeding and HIV transmission, and to provide material and moral support to the mother and/or the family.
- Sensitize the community on the support needs of HIV positive mother in her own care and prevention of transmission of the infection to the child.
- Counseling on healthy baby feeding options or practices for infected mothers.
- Economic empowerment of women to enable mothers to provide nutrition supplements for their children.
- Breastfeeding ART training for providers
- Breastfeeding ART supply and national distribution plan
- Behavior change and capacity building around breast feeding and HIV/STI transmission

2.4 Co-infection testing

There should be a sector-wide clinical protocol linked with relevant legislation that mandates that providers test all patients that test positive for HIV, TB, and STI's for co-infection of each of these diseases. That is to say all HIV positive cases should be screened for TB and vice versa. To the fact that those with HIV, TB and STI's are susceptible to co-infection of these conditions, positive cases are therefore a clinically identified vulnerable group that needs to be monitored.

MoH and NHS will be responsible for drafting the protocol, healthcare providers will be responsible for implementing it and MoH with all health sector partners will jointly monitor the implementation.

2.5 Condoms

The distribution of condoms to the population is the foundation for creating individual capacity to participate in prevention. Access to condoms is a major issue in Samoa as the Apia Urban area is the only location that condoms can be easily accessed. Condoms are also available in district health centers, however there are un-assessed geographical, cultural and religious barriers in accessing condoms health centers.

Good quality condoms shall be procured and made easily available and affordable (offered free of cost through MoH and partners). The private sector shall be encouraged to procure and market good quality condoms so that they easily accessible in urban and rural areas.

Sustainable condom distribution plans need to be developed by all providers within the health sector to encourage condom use long term. This involves working with institutions or community spaces where condoms are distributed in order to ensure 1) people can access condoms, 2) the institution or community where condom dispensaries are placed are supportive of the distribution, and 3) stock is monitored regularly.

2.6 Provider Prevention and Management of STIs

Health care providers of all cadres shall be trained in order to acquire the necessary knowledge and skills for prevention, early diagnosis and case management of STIs. Counseling and partner notification shall be part of care in accordance with the guidelines for the management of STIs.

Healthcare facilities and staff shall adhere to the following components of Infection Control regarding prevention;

- universal precautions to prevent infection in healthcare settings
- Key Strategic Area 4: Infection Control Information, Education & Awareness of the Infection Control Policy 2011-2016
- relevant sections on prevention within the 2005 Infection Control Manual

2.7 Transmission through blood and blood products, donated organs, tissues and body fluids

Besides HIV/AIDS, other diseases like Hepatitis B and C, syphilis and other STIs can be transmitted through blood and blood products. Clear guidelines should be in place in the donation of blood to address and mitigate any possible transmission of HIV AIDS through blood transfusion. All blood transfusing services have to comply with these guidelines:

- Screening and donation of blood must comply with existing protocols
- Pre- and post test counseling should be offered services to all blood donors.
- Transfusion of unscreened blood by medical practitioners or other clinical professionals shall constitute a punishable offence
- Early treatment of infectious diseases and improved nutrition shall be encouraged to spare more mothers and children from the risk of blood transfusion.
- Screening measures of blood and tissue samples shall be compliant to WHO guidelines and reported to MoH
- All organizations working with blood and tissue products are subject to the Health Care Waste Policy 2006

2.8 Transmission through Invasive and non Invasive Skin Penetration Surgical, Dental and Cosmetic Procedures

The risk of HIV transmission through routine use of surgical, dental, tattoo and skin piercing instruments exists. Unsterilized dental surgical and cosmetic instruments and equipment pose a very definite risk, which can be reduced by proper sterilization.

A. Use of Sterile disposable re-usable Equipment and accidental injuries

- In order to minimize the risk of infection, disposable supplies included needles and syringes will be used in all health facilities. In the event disposable skin piercing equipment is not available, re-usable equipment will be used after thorough sterilization.

- The Government shall ensure that health-care providers have adequate training in the procedures for sterilization and its importance. They will have sterilization facilities and adequate supply of reusable equipment for sterilization.
- The government shall prepare guidelines to stipulate clearly steps to be taken when a health worker is accidentally injured and/or exposed to HIV infection using the WHO emergency post-exposure (PEP) approach.
- A mechanism for compensation and medical insurance for health workers whose HIV sero-status is known to have been negative shall be instituted to cover accidental exposure to HIV infection in the course of carrying out their duties.
- The plight of patients who may get infected accidentally with HIV in the course of receiving care shall be addressed in the same way as that of service providers.
- The guidelines on the management, handling of patients with infectious diseases and disposal of infectious materials shall be adhered to.

B. Education for users of cosmetic and health services

- Public education shall be provided to ensure that users or consumers of health services, home care and cosmetic services know about and demand use of sterile skin-piercing equipment and other materials like gloves. The public shall be informed about the structure of the reporting system for reporting their complaints and suggestions for improving the system.
- In case of transmission of HIV/STIs or other diseases to patients and clients of cosmetic services due to the negligence of service providers the patient or client shall take steps according to the existing laws.

C. Private sector compliance

- The private health sector and facilities shall be monitored for compliance to Infection Control, Healthcare Waste and National Healthcare Regulations.
- All health and health related business shall also be subject to compliance to Infection Control, Healthcare Waste and National Healthcare Regulations, and should be monitored.
- The capacity, protocols, and guidelines necessary to regulate the private health sector and health business should be developed in conjunction with stakeholders and partners of the MoH to prioritize areas of implementation

D. Best Practices for Tattooing and Body Modification

In 2016, a patient reporting an infection from a tattoo done with traditional Samoan tools was diagnosed with HIV. Though the tattoo was not the cause of HIV transmission, this highlighted the importance of regulating tattooing done with disposable needles or reusable traditional instruments. Hepatitis B and various bacterial infections of tattoos are common. No research has been done on the transmission risk of HIV and other blood-borne pathogens via traditional Samoan tattooing instruments. Since the instruments are reusable, clients are sometimes ceremonially tattooed in pairs, and the fact that Hepatitis virus can live outside the human body for 7 days on unsterilized surfaces; there is a serious potential risk of infection.

Summarized below are basic infection control principles for tattooing. However, all infections control laws, regulations or best practice guidelines by the Ministry of Health or National Health Service apply including Health Guidelines for Tattooing (MoH 2017).

1. Wash your hands with antibacterial soap and clean water
2. Wear disposable gloves

3. Follow these safe tattooing practices;

- For traditional tatau tools, the Ministry of Health strongly recommends ONE set of tools should be used for ONE person at a time. In the instance of a ceremony where multiple people are getting tattooed, each person should have a separate set of tools for the tattooing process. In the case there is only one set of tools, all tools must be cleaned and sterilized before being used on a different person to prevent the transmission of infections.
- For palagi tattoo machines with single use disposable needles, one needle should be used on one person then safely disposed of.
- Equipment must be thoroughly cleaned of blood then sterilized each time a different person is to be tattooed. Any equipment penetrating the skin must be sterile before use.
- Used and clean tools must not come in contact with one another.
- Clean tools are to be placed on clean, sterilized surfaces.
- Dirty linen, dressings, spatulas and disposable gloves are to be thrown away immediately and appropriately.
- Materials that people being tattooed come in contact with are clean and handled and used hygienically.
- The tattooist/tufuga observes personal hygiene standards at all times (for example, hand washing). Tattooists/tufuga must keep themselves and their clothing clean: any cuts, abrasions or wounds they have should be covered.
- The premises of tattooing, including any furniture or mats, are kept hygienically clean and in good repair.
- Any article that has penetrated the skin or is contaminated with blood must be disposed of immediately, as infectious or biological waste.
- There must be no smoking or alcohol use during the tattooing process.
- Animals should not be permitted on the premises where tattooing activities are carried out.
- Employers in the customary tattooing industry should provide adequate training for staff in all areas of hygiene, infection control and first aid.
- All tattooists/tufuga should be vaccinated against **Hepatitis B**.

Recommended chemicals or products for sterilization of tattooing tools include the following;

- Sodium hypochlorite (Clorox Bleach) 5.25%-6.25% with a dilution of 1:100
- Ethyl Alcohol 95%
- Parasafe (for tools that cannot be put in an autoclave)
- Mis Detergent or Getin Clean (used before an autoclave)

2.9 Involving Communities in Prevention Services

The involvement of community members, groups and village committees is key to improving the coverage of all prevention efforts. The following are guidelines to inform community inclusion by MoH and all partner organizations in prevention

- Each village community's demographic profiles need to be considered when designing outreach and involvement in prevention delivery. This includes assessment of the following factor:

1. The villages resources for implementing and sustaining a prevention programme
2. The mobility of the village population (i.e. how many people reside in the village regularly and long term?)
3. Income of individuals in the village
4. The employment status of people within the village and profession type
5. Village access to health centres or community health workers

- Initial consultations to determine village traditions and functions of committees should be the first step in prevention design
- Tasking village committees with roles in prevention should take into consideration target populations and which committee is most appropriate for acting as liaison for that population
- Political leadership and good public relations should be employed to ensure the support of village community and religious leaders to minimize conflict with implementation
- When possible, target populations should be given ownership of prevention roles for programmes addressing their needs

3. HIV and STI Testing

This section outlines the ethical conditions for HIV testing regarding surveillance of the epidemic, diagnosis, voluntary testing and research. Increasing the percentage of the population that has been screened for HIV and STI's is essential for improving surveillance. This reduces the estimated number of undetected cases and is the first step in linking more people to care. In addition to testing rates being low in Samoa (4.5% for HIV in 2015), testing for co-infection of all STI's and TB has not been implemented in previous years. The overall goal for HIV and TB testing for the next policy period 2017-2021 summarizes the key areas of action, which all involve expanding testing coverage and access.

Objective 3 Increase the coverage and access of HIV, STI and TB testing in all populations
Increase the coverage and access of HIV, STI, TB, and co-infection testing in the general and all key populations to expand surveillance and counseling services.
Key Strategic Actions for Objective 3:
a) Implement TB testing and screening in conjunction with all STI testing activities (and vice versa) to improve screening of co-infection.
b) Identify and eliminate barriers for all populations to get screened for HIV and STI's, particularly youth, fa'afafine, sex workers, inmates, and partners of ANC women
c) Create community linkages to HIV and STI testing and counseling services, or create community based testing options tailored to village community structures.
d) Expand the implementation of CD4 and viral load testing (includes training of providers).
e) Sustainable and cost-effective procurement and distribution of rapid diagnostic testing kits to support provider initiated counseling and testing
f) Sustainable and cost-effective procurement of rapid diagnostics that give same day results for untrained individuals and lay-providers

g)	Conduct screening outreach visits to rural villages and vulnerable populations
h)	Conduct screening outreach visits to rural villages and vulnerable populations.
i)	Create friendly, safer and confidential environments to encourage turnout for all testing and counseling services for all populations, especially at risk youth.
j)	Improve screening and surveillance by increasing the technical capacity of laboratory services to process larger quantities of specimens, reduce result-reporting processing time, and offer alternative testing/screening methods.
k)	Increase testing rates by using Blood and Tissue Donation Screening as a mechanism to expand testing coverage

3.1 Access

All HIV/STI/TB-Co-infection testing services, including pre and post-test counseling shall not only be made available but also accessible to all populations. This includes designing services and programs with special strategies for reaching key populations. Specific key populations that face challenges to accessing testing services include (but are not limited to):

- Youth
- Fa'afafine and fa'atama (transgender)
- MSM
- Rural populations
- People living with disability

Because testing rates are so low, barriers to access must be identified and addressed in both prevention and treatment delivery. It is not enough for prevention, healthcare, and testing services to be offered. They must also be relevant to and target key populations.

3.2 Testing for HIV, AIDS and STI's

Testing for HIV and STI's should be voluntary for all populations, however provider initiated counseling and testing (PICT) should be complimentarily implemented. PICT is often used to supplement low turnout for voluntary testing. It entails having health care or health service providers notifying the client of HIV testing and counseling services and encouraging clients to utilize these services. Testing is performed in the clients' best interest with informed consent and confidentiality, as with voluntary testing. Mandatory STI testing is required for all pregnant women reporting for ANC services. Similar measures should be expanded to their male partners as well. In absence of legislation, providers should perform targeted outreach to screen male partners of ANC women to fully safeguard the sexual health of the woman and child.

Individual pre-test counseling must precede all HIV testing. For PICT a lengthy counseling session is not required, but the medical practitioner should be guided by the client's knowledge, needs or requests.

The following are protocols for each model of HIV and STI testing:

For PICT…

PICT shall be made available to all populations including the following;

- All people attending health facilities
- All pregnant women attending
- All paediatric attending
- All people with presumed or diagnosed TB

- All people with presumed or diagnosed STI
- All people with hepatitis b/c
- All key populations
- All partners of HIV+
- All patients accessing immigration screenings and immigration health services
- Other populations, if any

PICT shall adhere to the following protocol;

1. Information on free HIV/STI testing is delivered to patients via group education or endorsed by a healthcare provider to a patient during a visit

2. If the patient agrees to testing, an individual consultation is scheduled to perform testing or PICT can be included as part of the patient's current visit if they consent.

3. During individual consultation, the patient is first undergoes pre-counseling which covers information on the following key points;

- assessing the client's understanding of information provided and reinforcing messages and concepts
- assisting the client to determine and assess their risk based on the information provided
- assessing the client's readiness for testing and possible results
- obtaining informed consent
- in the case of refusal, ascertaining reasons and responding to incorrect beliefs

4. The provider will then initiate informed consent procedures detailed within the following section in order to obtain the patients consent for testing and the risk assessment.

5. Following informed consent, the provider then should perform a risk assessment of the client, asking for information on the following risk factors for HIV and STI's;

- alcohol use
- drug use (especially intravenous drug use)
- domestic violence
- history of prison incarceration
- sexual history, including:
- number of previous and current partners
- history of unprotected high-risk sexual intercourse, anal and vaginal
- rape or sexual assault
- previous sexually transmitted infections

6. The testing of patient should then commence via collection of blood or urine samples. All STI's should be screened for in this panel of testing.

7. Post-test counseling shall be made available to all clients that are screened for HIV and STI's. The content will vary depending on the individual result. If positive, individuals will be immediately linked to care and treatment and their case information will be reported to the National STI Clinic and the MoH STI surveillance unit.

For voluntary HIV testing (or client initiated testing)…

Pre-and-post test counseling shall be done to enable test results to be communicated to the person tested or, in the case of minors, to parents or guardians. The main aim is to reassure and encourage the 85 - 90% of the population who are HIV negative to take definitive steps not to be infected, and those who are HIV positive to receive the necessary support in counseling and care to cope with their status, live healthy lives and take personal measures not to infect others. The protocol is as follows:

1. The patient requests an appointment to get screened for 1 or more STI's
2. Follow Steps 2-7 of the PICT protocol

For unlinked HIV testing…

No pre and post-test counseling shall be required. For blood donors who wish to know their test results, provision shall be made for follow up voluntary HIV testing with pre- and post test counseling. For donations that test positive, all cases shall be contacted and brought in for PICT visits with the nearest healthcare provider.

3.3 Informed Consent

Informed consent following adequate pre-counseling shall be obtained from the person before HIV and STI testing can be done. Hospitalized patients or ambulatory patients in semiconscious states and those deemed to be of unsound mind may not be able to give informed consent. Counseling shall involve a close relative or the next of kin in order to obtain the consent before proceeding with diagnostic testing, treatment, and clinical care.

Informed consent consists o the following elements according to international standards;

- an explanation in non-medical terms of the procedure that is about to be performed and the reason why
- a description of any foreseeable risks or discomfort to the patient
- a description of any benefits of the procedure
- disclosure of any alternative procedures if applicable
- a statement for the confidentiality protections of the patient and their results
- contact information on who to contact for care-related injury or malpractice, and who is administering the treatment (provider facility)
- a statement that testing is voluntary (if applicable)

3.4 Testing for TB and Co-infection

TB screening also needs to be expanded to cover more of the population. This should be done in accordance with the national strategy for TB. All HIV and STI testing should include at least one form of TB testing in order to assess vulnerable co-infection. TB testing comes in two forms 1) a tuberculin skin test, and 2) an antigen blood test.

The tuberculin skin test requires 2 visits with a healthcare provider, one to administer the injection, and a second for a healthcare provider to read the result within 72 hours of the first visit. Upon a detection of a positive tuberculin skin test, a blood test must be administered to confirm infection and type of TB.

TB and co-infection testing needs to be expanded within the prison system, as inmates are the most vulnerable group.

3.5 Confidentiality

All HIV Testing shall be confidential. Protections for all health information (verbal, written and electronic) are articulated in Section 1.3. Nevertheless, public health legislation shall be made to authorize health care professionals to decide on the basis of each individual case and ethical considerations, to inform their patients or sexual partners of the HIV status of their patients. Such a decision shall only be made in accordance with the following criteria:

- The HIV-positive person in question has been thoroughly counseled.
- Counseling of the HIV-positive person has failed to achieve appropriate behavioral changes.
- The HIV-positive person has refused to notify, or consent to the notification of his/her partner.
- A real risk of HIV transmission to the partner(s) exists.
- The HIV–positive person is given reasonable advance notice.
- Follow-up is provided to ensure support to those involved, as necessary.

3.6 Partner Notification

Physicians and other health workers are not allowed to notify or inform any person other than the individual tested of the test results without his or her consent. Counseling shall emphasize the duty to inform sexual partners and married couples will be encouraged to be tested together. In the event of refusal of the person tested to inform any other person, the decision to inform the third party shall adhere to the conditions laid down in Section 3.5**.** Partner's who cannot be involved in the same counseling session with the tested person, shall be persuaded to go for counseling before they can be notified of the tested person's HIV test results.

Notification of partners shall not under any circumstance reveal the name or any identifying information about the HIV positive person to their partners. Those who test positive will be asked to provide contact information of their partners and informed that their identity will remain confidential. Healthcare professionals will follow-up with contact information provided in order to bring individuals in for testing with sensitivity given to confidentiality concerns.

3.7 Pre-marital HIV Testing, and Testing for Couples and Partners (All Service Settings)

Pre-marital testing shall be promoted and made accessible and affordable. Like all other testing it should be voluntary or PICT with pre- and post–test counseling and patient education.

Major challenges have been cited by healthcare providers in getting partners of tested individuals to report for testing and presumptive treatment of STI's. This is especially so with male partners, who have lower turnout rates for testing services. HIV testing services and coordination needs to address 1) design strategies to ensure testing, counseling, treatment compliance, and follow-up with partners of those who report for testing services, 2) outreach and linkage to care mechanisms need to be designed by MoH and its partners to create sustainable effective processes of targeting partners of individuals who report for testing.

3.8 HIV testing during pregnancy

Mandatory STI testing is required for all pregnant women reporting for ANC services. Voluntary counseling and HIV testing services shall be promoted and made available to pregnant mothers for the purpose of prevention of mother to child transmission of HIV infection, and also encouraging higher ANC attendance.

3.9 HIV Testing with Children and Youth

The legal age of consent is 18 in Samoa. All children under this age will require consent of the parent except in the case of mandatory neonatal testing. Children of any age under 18 will require the consent of a parent to receive any testing (HIV, STI, TB or otherwise). Part of pre-test counseling in these cases should involve convincing both the parent and the child of the value of getting tested.

In special cases children living independently, who are not in contact with parents and who do not have a guardian, will be able to consent for HIV testing after they have been provided with age-sensitive information and counseling.

Table 9. Testing Protocols

Age Group	**Testing Protocol**
Birth to 18 months	Testing every 3 months or 6-8 weeks if born to positive parent(s) with RNA or DNA PCR methodology
18 months to 12 years	Children should be tested with antibody tests through voluntary counseling and testing (VCT) with confidential pre and post test counseling. The WHO adult testing algorithm should be followed.
12-18 years	Voluntary testing with parental consent via antibody tests
All children up to 12 years should be tested if parents became positive before the child was born or during breastfeeding, or if they do not know when they were infected. Family counseling should be conducted to achieve consent for testing the child. If parents still refuse testing, MoH can mandate the testing via powers of enforcement granted by the Health Ordinance of 1959, Samoa's Constitution and The Convention for the Rights of the Child (CRC).The same protocol should be followed for all at-risk minors 12-18.	
18-24 years	Voluntary testing via antibody tests with pre and post-test counseling delivering age-specific information for youth

In sensitive cases where a child is under 18, parental consent is required, and the child could face social stigma from parents or community for accessing testing, prophylaxis, counseling or treatment, HIV and STI testing services should be offered as part of a broad panel of services addressing the general health of the child. The aim is to make the sexual health component of the health services discreet.

3.10 Cost of HIV Testing

HIV testing shall be free to all people (both general and key populations) through all health sector providers, private providers and MoH service provider organizations fully funded by MoH in terms of stock and procurement. All those who seek testing at a healthcare

facility will receive it free of cost or referred to the next nearest facility in the case of testing kit stock-outs. Service delivery partners and private providers shall confer with MoH to establish processes for accessing resources to offer free testing, if not already doing so.

4. HIV and STI Treatment and Care

For HIV, the national response has achieved successful efforts in providing free treatment for reported HIV+ cases and retaining them on ART therapy. This has been sustainable due to the low case load. For STI's, Chlamydia stills remains a challenge with high prevalence. Presumptive treatment of ANC mothers and their partners was implemented in 2015 in order to address these rates, which revealed that there were challenges in getting male partners to comply with treatment and that turnout for ANC care is low. For TB, all treatment is offered free of cost and very few cases fail to comply with the treatment regimen, however detection remains an issue to due test kit supply and lack of human resources. To date, care has focused on vertical programmes to address STI, HIV, and TB care without horizontal partnerships in care and service delivery. This is perhaps why co-infection testing, treatment and care of STI's, HIV, and TB are a critical service gaps that have not yet been addressed.

For the next policy period, MoH and its partners should expand treatment and care activities to address social determinants of HIV, STI's, and TB, and take a broad horizontal sexual health approach. That is to say that MoH and all partners should design care/treatment programmes that provide simultaneous care or linkages to care for other diseases. For example, HIV services should be equipped to offer TB testing and treatment and vice versa. Programmes should also target the interrelated underlying causes of co-infection and low care attendance for STI's, HIV, and TB.

Objective 4 Expand treatment and care to address HIV, STI and TB social determinants and co infection
Expand treatment and care activities to address social determinants of HIV, STI's, and TB, and take a broad horizontal sexual health approach in which programmes provide simultaneous care or linkages to care for other diseases
Key Areas of Action for Objective 4:
a) Expand and strengthen the Presumptive Treatment Program for ANC mothers and their partners to achieve equal and full implementation amongst women and their male partners
1. Use village men's committees to assist in encouraging men to test for all STI's and comply with treatment
b) Develop capacity to offer STI, HIV and TB services in all sexual health settings
c) Conduct partnered outreach for HIV, STI, and TB treatment and care
d) Design and implement broad sexual health co-infection programmes for key population to ensure they are screened/treated for all STI's and can access TB treatment
e) Develop care programmes that support people living with HIV and STI's in terms of accessing reliable and discreet treatment and symptom alleviation
f) Develop programmes and interventions that target the social determinants and interrelated risk factors of co-infection
g) Training of service providers to offer case management of co-infections

h)	Include HIV, STI, and TB co-infection prevention in all health education, health promotion, behaviour change and counselling offered by providers in healthcare settings
i)	Create community counselling programmes for HIV and AIDS to assist village communities in supporting and accepting PLWHA who publicly disclose their status to advocate, in order to eliminate discrimination in the home environment of PLWHA public advocates. The purpose is to encourage PLWHA to publicly advocate for the PLWHA community, their healthcare needs, and for PLWHA to take ownership and participate in linking themselves to care.
j)	Adherence to care, behaviour change and harm reduction programmes tailored to each key population developed and implemented.
k)	Implement support services for PLWHA that address key social and financial challenges that relate to their healthcare, treatment adherence, and access to all health services
l)	Improve procurement processes to prevent pharmaceutical stock outs and ensure national access to all HIV, STI and TB treatments
m)	Build the capacity of youth friendly service initiatives to create safe treatment spaces for youth

4.1 Care

PLWHA, all individuals with STI's and TB are entitled to quality care in all health and social service settings. The community, NGOs, CBOs, private sector and faith groups are critical in facilitating this care, which should be governed by the following principles:

- PLWHAs shall have access to holistic health care. This includes clinical, medical care, counselling and social welfare services. Health care shall extend beyond the hospital precincts to include planned discharge and back up for home based care.
- PLWHAs shall have access to counselling as well as access to health information on how to live positively with HIV/AIDS while protecting themselves and others from further transmission.
- PLWHA and their allies shall have shall be encouraged and supported to advocate for the PLWHA, participating fully in the activities of health service delivery in the community. Both PLWHA, their allies, and communities shall receive community counselling, education, and stigma reducing support to ensure that there is no resulting discrimination when PLWHA disclose their status to advocate for sexual health care nor for their allies.
- Institutional and community care providers have a duty to care for people infected with HIV, other STI's or TB without discrimination on the basis of their HIV or sero-status. If care cannot be offered by a provider, the provider must refer the client to appropriate care.
- Home care and facility care must complement each other. There shall coordination between services providers in ensuring that all needs of the client are met with quality services.
- Service providers that serve PLWHA and people with STI's shall have access to information on best practices for working with both the general and key populations. Additionally training should be made available to increase competency and utilization of such best practices. Providing information and training to service provider staff shall be both the responsibility of the organization and MoH, given that these needs have been formally articulated to MoH.
- All organizations involved in HIV, AIDS, STI, and TB care have the ethical and legal responsibility to ensure that care;

- Is quality, meaning that it addresses all the needs of the client, medical and social in a timely manner
- Is cost effective, meaning it is affordable and sustainable for the client, as well as the organization
- Is accessible, meaning both that a client has minimal barriers in accessing a organization's services and that the organization has referral procedures to quality services in the circumstance that care cannot be offered at the organization
- Is confidential, meaning that all personal health information collected by a service provider is protected and not shared with any individual or community, rather only shared with individuals involved in a client's care (See Section 1.3)
- Is evidence based, meaning that care is informed by best practices in the field

4.2 Clinical Equivalence

All ART, drugs and related HIV, STI, and TB medications are procured in accordance with the most recent WHO guidelines. The recommended first and second line drugs are WHO recommended and approved, however wherein it is not possible for MoH to procure the recommended stock (or WHO alternative), MoH and its partners will utilize ART medications, dosage and regimens that are clinically equivalent to the WHO guidelines. That is to say that all ART medications, dosage and regimens will have the same biological effectiveness and cost effectiveness as the WHO recommended drugs. This will apply to treatment with all populations and service areas.

4.3 ART Treatment

ART treatment shall be made available to all populations with WHO specific drug and regimen guidelines for Adult, PMTCT, and Paediatric cases. The goal is to maintain that 100% of cases that are detected in both general and key populations receive ART therapy at no cost to them.

The MoH shall finance and supply all ART treatment to PLWHIV. All cases are treated regardless of CD4 threshold 500 and no prioritization given to those with <350 or advanced clinical diseases. MoH does not pay for private treatment overseas but does provide care coordination with no cost to the consumer.

All vulnerable populations in addition to the general population (who report for care) receive universal access to ART medication. This includes children born to HIV positive mother (initiate retroviral >1 year), confirmed TB cases, sero-discordant couples, and key populations (transgender, MSM, sex workers, inmates, and youth).

Below are the ART's recommended by WHO for particular populations. It should be noted that there has been a completed phase out of D4t for adults and youth and children.

Table 10. ART Regimens

Regimen Type	**Approved for…**
First Line	
TDF/3TC or (FTC)/EFV Fixed dose 3 drugs as 1 pill once a day	Adults, adolescents, and pregnant women
Second Line	
AZ/3TC or (FTC)/ATV/r or LPV/r	Adults and Adolescents
NRTI: LPV/r and AZT	children less than 3

Regimen Type	Approved for…
Third Line	
LPV/r based-regimens	all infants and children <36 months with HIV (regardless of NNRTI exposure)
NNRTI: Efavirenz (EFV)	treatment initiation in children aged three and older
AZT+3TC or FTC	recommended NRTI backbone for treatment initiation in children aged 3–10 years

4.4 Monitoring treatment response

Both CD4 and viral load testing are available for all populations nationwide free of charge in order to monitor response to ART treatment. Viral Load testing occurs every 3months for all populations and targeted cases of suspected non-response amongst the current HIV caseload.

Table 11. CD4 Availability

Population	CD4	Viral Load
Adolescents and Adults	STI Clinic, NHS Lab, National Health centres	STI Clinic, NHS Lab, National Health Centres
Children	STI Clinic, NHS Lab, National Health Centres	STI Clinic, NHS Lab, National Health Centres

4.5 TB and Co infection Care, Testing and Treatment

All treatment and testing for co infection of HIV with other targeted illnesses shall be provided free of cost to the consumer nationwide for ALL populations (adults adolescents and children) that are HIV positive. Testing for TB, Hepatitis B, and Hepatitis C in HIV positive cases is mandatory and vice versa.

For Hepatitis C positive cases, linkage to care processes are handled by the STI Clinic.

Table 12. Co infection Populations' Access to Services

Co infection	Access to treatment	Access to testing
Tuberculosis	Universal	Universal
Hepatitis B	Universal	Universal
Hepatitis C	Universal	Universal

Below are the standard treatment guidelines by type of TB for specific populations;

Table 13. TB Regimens by Population

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

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

4.6 PMTCT Treatment

The current mother-to-child transmission caseload includes 5 births with 6 HIV positive children. In 2015 there was 1 birth to an HIV positive mother; however the fetus was born premature and stillborn. In this case all ART regimens for pregnant women were adhered to.

Samoa's current goal for PMTCT is to maintain 0 new cases of newborns infected with HIV via the implementation of ART in pregnant women and NRTI or NNRTI for infants born to HIV positive mothers. The elimination of Chlamydia from the ANC population is also integrated with this goal.

HIV and STI screening is mandatory for all women who report for ANC care at national health centres. The tests used are RPR, HBsAg, HCV, and WHO recommended antibody and antigen tests for HIV and Chlamydia.

For pregnant women, Samoa has used WHO Option B+ (i.e. treat all ANC women free of cost) which has been implemented country-wide. Below are the recommended ART regimens for pregnant women in accordance with WHO guidelines.

Table 14. PMTCT ART Regimens

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

High risk is defined in Samoa as an infant born to HIV positive mother. Infants are tested every 3 months, with the final test at 18 months or 3 months after cessation of breastfeeding.

4.7 Treatment for Key Populations

Since detection of HIV positive cases in general population surveillance is low, the hypothesis is that there are higher numbers of undetected cases in key populations. There is also concern that key populations have specific unmet care needs with regards to STI's and TB as well. Consultations with stakeholders and partners in the health sector have identified the following key populations that face challenges related to HIV, STI and TB care;

- MSM
- Transgender (fa'afafine, and fa'atama)
- People who inject or use drugs
- Inmates
- Sex workers
- Adolescents who are sexually active

In order to improve service delivery to the above populations, the following areas of intervention within the care setting are needed;

- Training tailored to service providers on best practices for key populations
- Condom and lubricant programming
- Targeted information and communication
- Testing and treatment for HIV and all other STI's
- Adherence to care, Behaviour change and harm reduction programmes tailored to each key population developed and implemented
- Care coupled with services that address social determinants of disease

In addition to national level activities funded and implemented by MoH, all partner organizations and NGO's should develop organization level activities that address their ability to provide services to key populations.

4.8 Protecting Healthcare Workers and Traditional Birth Attendants

Health workers shall be given training in self-protection against, and prevention of HIV transmission occurring during handling of blood, body fluids, organs and tissues. Training on self-protection shall also be given to traditional birth attendants. All health care institutions shall provide protective gear to all health care providers in the health facilities as well as in home care and to traditional birth attendants. All national polices and legislation regarding personal protective equipment shall be adhered to. Counselling and support services necessary for managing affected cases shall be established for care providers.

PEP (post-exposure prophylaxis) shall be provided to all healthcare workers subsidized who have been exposed to HIV infected patient fluids. This includes supplying PEP to exposed traditional birth attendants. Considering the significant cost of PEP, the MoH should work to secure a sustainable supply with development partners. PEP is made available to all healthcare personnel working with HIV positive patients. It is the provider organization's responsibility to have well defined procedures for linking exposed staff to PEP and services offered by MOH. No organizations are authorized to charge exposed staff for the cost of PEP, as it is funded by the MoH.

4.9 Community Based Care and Support Services

Parallel to the national primary healthcare approach, care should also include create linkages between health centres and village, utilizing community structures to enhance service delivery. Community based testing, counselling and care services for HIV, STI's and TB have been shown to be effective at increasing access, adherence to care, and quality of life for PLWHA.

The government shall encourage village committees, NGO's, religious organizations, and other institutions across all sectors to collaborate in providing holistic care to those affected by HIV, STI's and TB. It should be noted that in the community setting, Samoa facing significant confidentiality challenges, which should be explicitly addressed by the design of community interventions to minimize risk to individuals.

5. Gender Based Violence and Sexual Reproductive Health Services

By compromising women's social safety, gender-based violence threatens women's capacity to protect their sexual and reproductive health and manage their risk for HIV and STI's. In Samoa, accessing sexual health services is a challenge due to cultural values around sex and sexuality. Gender-based violence compounds these challenges and creates disparity in risk for HIV and STI's.

Objective 5 Integrate sexual health with services targeting gender-based violence
Integrate sexual health testing, counselling, and treatment with services for survivors of violence in order to ensure gender equality of the national response and eliminate gender-based risk and morbidity regarding HIV and STI's.
Key Strategic Actions for Objective 5:
i) Implement health needs and STI risk assessments to formally assess the sexual health service needs of survivors of violence.
j) Target domestic violence as means of increase women's access to sexual reproductive health services, and therefore HIV care, and STI testing and treatment
k) Develop programs for ANC women experiencing domestic violence
l) Coordinate and enhance a violence services referral system within the health sector
m) Partner with village women's committees (Komiti Tumama) to discreetly deliver sexual health services to women and children impacted by violence.
n) Develop family counselling curriculum that is designed to support families of paediatric sexual assault cases in consenting to screen and treat the child.
o) Partner with the Ministry of Police to include offer voluntary STI screening, counselling and treatment as part of post sexual assault medical services for adult and paediatric cases.
p) Create access to safe abortion for survivors of rape and incest, PLWHIV, and people living with STI's preferably in-country or in partnership with the over-seas treatment program (ensure subsidized cost for these populations).

5.1 Domestic Violence

Gender violence may also play a role in exacerbating the health burden of STI's. Many women in Samoa feel domestic violence is justified with 70% stating it is permissible for a

husband to beat his wife if she is unfaithful to him, doesn't do housework, or disobeys him (State of Human Rights Report 2015). A multi-country study conducted by WHO from 2000-2003 found that in Samoa that 10% of all women who had ever been pregnant were beaten during at least one pregnancy. Among women that were ever physically abused in their lifetime, 24% reported the abuse occurred during pregnancy. In 96% of those cases, the perpetrator was the father of the child. In terms of the health of these women, abused women who had ever been pregnant were significantly more likely to have had stillborn children (16% versus 10%) and miscarriages (15% versus 8%).

STI's among antenatal women are very prevalent with 26% of ANC women testing positive for Chlamydia in 2015. There is likely related to the high prevalence of domestic violence, as women in abusive relationships are not able to demand condom use for fear of further violence. Accessing treatment is also met with stigma. Despite the high prevalence of Chlamydia, the actual figure is likely higher, as only 2,822 out of an estimated 9616 (29.3%) pregnant women reported for ANC visits and were screened for STI's in 2015.

Domestic violence has yet to be formally addressed by the health system. Several areas of action exist to address this gap;

- Develop DV screening mechanisms and competency among healthcare providers
- Research DV's impact on health outcomes in women's health, maternal and child health, and its co-morbidity and risk for HIV and STI's
- Referrals for survivors of violence across all sectors
- The leveraging of health services to intervene and address women's equality

5.2 Overview of Abortion Law in Samoa

Access to abortion services is critical to the health and wellbeing of PLWHIV, those dealing with a sexually transmitted infection, and survivors of rape and incest. In Samoa, Abortion is currently considered an OFFENCE under the Crimes Act 2013 Sections 111-116 in the following scenarios;

- Procuring an abortion or miscarriage for any person by any means (instrument or ingesting drugs or toxins)
- A person procuring their own miscarriage
- Supply the means for a person to procure an abortion

Abortion is NOT CONSIDERED AN OFFENCE in the following scenarios;

- The pregnancy is under 20 weeks gestational age
- The person performing the abortion is a registered medical practitioner
- The person doing the act believes the continuance of the pregnancy would result in serious danger to the life or mental health of the person
- The person is contemplating suicide, very young and/or was raped.

5.2.1 The Law- Crimes Act 2013

Section 111. "Miscarriage" defined
In this Division, ―miscarriage‖ means:
(a) The destruction or death of an embryo or foetus after implantation; or
(b) The premature expulsion or removal of an embryo or foetus after implantation, otherwise than for the purpose of inducing the birth of a foetus believed to be viable or removing a foetus that has died.

Section 112. Procuring abortion by any means

(1) A person is liable to imprisonment for a term not exceeding 7 years who, with intent to procure the miscarriage of any woman or girl, whether she is pregnant or not:
(a) Unlawfully administers to or causes to be taken by her any poison or any drug or any noxious thing; or
(b) Unlawfully uses on her any instrument; or
(c) Unlawfully uses on her any means other than any means referred to in paragraph (a) or (b).
(2) The woman or girl shall not be charged as a party to an offence against this section.

Section 113. Female procuring her own miscarriage – A woman or girl is liable to imprisonment for a term not exceeding 7 years who with intent to procure miscarriage, whether she is with child or not:
(a) Unlawfully administers to herself, or permits to be administered to her, any poison or any drug or any noxious thing; or
(b) Unlawfully uses on herself, or permits to be used on her, any instrument; or
(c) Unlawfully uses on herself, or permits to be used on her, any other means whatsoever.

Section 114. Supplying means of procuring abortion – A person is liable to imprisonment for a term not exceeding 7 years who unlawfully supplies or procures any poison or any drug or any noxious thing, or any instrument or other thing, whether of a like nature or not, believing that it is intended to be unlawfully used to procure miscarriage.

Section 115. Effectiveness of means used immaterial – Sections 112 to 114 apply whether or not the poison, drug, thing, instrument, or means administered, taken, used, supplied, or procured was in fact capable of procuring miscarriage.

Section 116. Meaning of "unlawfully" – In sections 112 to 114, any act specified in either of those sections is done unlawfully unless, in the case of a pregnancy of not more than 20 weeks' gestation, the person doing the act:
(a) Is a registered medical practitioner; and
(b) Believes that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl.

Case Law

Case law of all commonwealth countries applies to the Samoan legal system. As of December 2015, the abortion cases available on PacLII have all been brought under the Crimes Ordinance 1961; there are none that have been brought under the Crimes Act 2013.

In Police v Apelu [2004] WSSC 8 (10 August 2004) His Honour Sapolu CJ referred to the case of R v Bourne [1939] 1 KB 687 in relation to the meaning of 'unlawfully' as follow:

> 'The starting point must be the case of *R v Bourne [1939] 1 KB 687* which has been the leading English authority on the offence of procuring an abortion for many years. In that case, a doctor who was a consultant obstetrician of the highest skill performed an operation on a 14 year old girl to terminate her pregnancy which resulted from a shocking and violent rape. It was clear that if the pregnancy was allowed to continue the victim would become a physical and mental wreck.'[1]

His Honour Sapolu CJ considered the English case and stated:

[1] Police v Apelu [2004] WSSC 8 (10 August 2004) @ p3

> 'In terms of what was said by McNaughton J in *Bourne*, the two elements of the offence of procuring an abortion which the prosecution has to prove beyond reasonable doubt may be stated as: (a) that the accused intended to procure the miscarriage of the victim, and (b) that the accused did not procure the miscarriage of the victim in good faith for the purpose of preserving her life.'[2]

Ultimately His Honour Sapolu CJ applied the English case on the basis that:

> 'In view of the similarities in the English provisions and the Samoan provisions I have referred to, I am of the opinion that what was said in *Bourne* by Macnaghten J is relevant to a consideration of the interpretation to be given to the Samoan provisions and in particular the meaning of the word "unlawfully" used in s73A of the Crimes Ordinance 1961.'[3]

His Honour Sapolu CJ then noted further developments in this area of law as follows:

> 'In terms of the subsequent developments in *Bergmann and Ferguson* and more particularly in *Newton and Stungo*, the two elements of the offence of procuring an abortion which the prosecution has to prove beyond reasonable doubt are: (a) that the accused intended to procure the miscarriage of the victim, and (b) that the accused did not procure the miscarriage of the victim in good faith for the purpose of preserving her life or health. <u>The health of the victim means not only her physical health but also her mental health.</u>'[4] (Emphasis added)

His Honour Sapolu CJ then went on to consider the New Zealand case of <u>R v Woolnough [1977] 2 NZLR 508</u>. In this case the defendant was charged with procuring an abortion contrary to s183 (1)(b) of the Crimes Act 1961 (NZ). His Honour Sapolu CJ noted that the abortion provision of the New Zealand legislation was virtually identical to the Samoan legislation and, in considering the meaning of 'unlawfully' stated:

> 'It would appear from the way the test is formulated in *Woolnough* that for the prosecution to secure a conviction under s73A(1)(b) of the Crimes Ordinance 1961, it must prove beyond reasonable doubt that the use of an instrument was unlawful in the sense that it was not necessary to preserve the woman from serious danger to her life or to her health. This is essentially the same position as it was in England after *Newton and Stungo*. In the circumstances, I conclude that the two elements for the crime of procuring an abortion in the present case which the prosecution has to prove, beyond reasonable doubt are: (a) that the accused intended to procure the miscarriage of the victim, and (b) that the accused did not procure the miscarriage of the victim in good faith for the purpose of preserving her life or health.'[5]

This definition of 'unlawfully' was then applied successfully to the defence of the defendant in circumstances where the pregnant woman was contemplating suicide.[6]

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[2] Ibid @ p4
[3] Police v Apelu [2004] WSSC 8 (10 August 2004) @ p5
[4] Ibid @ p5, referring to Bergmann and Ferguson (1948) British Medical Journal (England) and R v Newton and Stungo [1958] Crim L Rev 469
[5] Ibid @ p8
[6] Ibid @ p25

The definition of 'unlawfully' in the s116 of the Crimes Act 2013 now explicitly provides it is not unlawful to procure an abortion where:

- the pregnancy is not more than 20 weeks' gestation
- the person doing the act is a registered medical practitioner; and
- The person doing the act believes that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl.

Analysis

The cases above demonstrate, given the definition of 'unlawfully', the abortion provisions do not apply where the pregnant woman was contemplating suicide or was raped. Presumably the provision regarding serious danger to the 'mental health' of the woman or girl would extend to further circumstances. For example, where pregnancy is the product of an incestuous relationship, where the pregnant girl is very young and arguably other circumstances that would create significant negative emotional consequences for the woman where it is believed this would lead to a serious danger to her mental health.

There is some support for a very broad interpretation of this provision. In the case of R v Woolnough, Dr Woolnough claimed the meaning of 'mental health was very broad:

> 'He pointed out that in his work he had sought out the meaning of 'mental health' and considered the World Health Organisation's definition to be a good one. "Health" is defined by the World Health Organisation as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."[7]

Further, in relation to this case it has been suggested that:

> 'The trial had shown doctors need not fear a prosecution for performing abortions as long as they claimed they believed it was necessary to avert a danger to mental health. Doctors claiming to interpret "health" within the framework of the World Health Organisations definition were on safe ground. For a prosecution to be successful it would require that all of the members of the jury be convinced, beyond reasonable doubt, that the doctor did not believe what he said he believed.'[8]

Summary

It is not an offence under the current Samoan abortion law to procure an abortion where:

- the pregnancy is not more than 20 weeks' gestation;
- the person doing the act is a registered medical practitioner; and
- The person doing the act believes that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl.

The cases demonstrate an abortion is not unlawful where the pregnant woman was contemplating suicide or was raped. It is also likely the circumstances extend beyond this to situations where pregnancy is the product of an incestuous relationship and where the

[7] R. v. Woolnough (1977) 2 NZLR 508.
[8] 'A New Zealand Resource for Life Related Issues' @ http://www.life.org.nz/abortion/aboutabortion/nzhistory18/ (retrieved 2/09/2015)

pregnant girl is very young. Arguably it extends even further to circumstances that would create significant negative emotional consequences for the woman where it is believed this would lead to a serious danger to the woman's mental health.

Although abortion is legal in the previous cases, access to safe abortion within the country is severely lacking, and most cases are referred overseas. There needs to be a legal analysis to assess the law, the interpretation, the inconsistency of case law, and ultimate population access to quality services. Once gaps between legality and access have been formally assessed the National HIV/AIDS and STI Policy will be updated to put forth guidelines that are first, compliant to national laws and secondly are aligned with donor regulations.

5.3 Sexual Assault and SRH Services

Emergency contraception shall be covered by the national healthcare system for all women to who report for care within 5 days. Sufficient pharmaceutical stock shall be ensured and stock-outs minimized.

First line psychological first aid support is available through NGO's but mostly inaccessible for those living in rural areas. MoH and NHS must strategize and collaborate with other ministries and service delivery organizations to expand the range of these services.

STI and HIV post exposure prophylaxis shall be covered by the national healthcare system for all women to who report for care within 5 days. Sufficient pharmaceutical stock shall be ensured and stock-outs minimized.

6. Research, Surveillance, Monitoring and Evaluation

Data are currently a priority need for HIV, STI's and TB. In addition to routine data collection through M&E and surveillance, the national response also requires research studies on vulnerable groups for planning purposes as well as human resources for data collection. Since the full scope of the impact of HIV, STI's and TB is largely unknown, obtaining information for providers, planners, and donors is crucial.

Objective 6 Expand health knowledge and information systems, while protecting confidentiality	
Expand health knowledge and develop information systems regarding HIV, STI's and TB, while protecting confidentiality with the ultimate aim of improving services and building trust with key populations.	
Key Strategic Actions for Objective 6	
g)	Develop pilot and baseline studies for key populations
h)	Implement the M&E system outlined in the 2017 M&E Manual
i)	Partner with Samoa Bureau of Statistics to expand population studies
j)	Develop processes with MoH, the health sector, and all partners to improve and increase data collection and reporting
k)	Develop human resource capacity in the health sector for health data, surveillance, monitoring and evaluation
l)	Develop new memorandum of understanding (MOU) with key services providers across all sectors, as well as redrafting prior MOU's to meet the data collection, reporting and data sharing needs of the national response to HIV and STI's

6.1 HIV, AIDS, STI and TB Research Ethics and Procedures

HIV, AIDS, STI and TB research proposals are all subject to the Screening and Approval of the Health Research Committee. Research in HIV/AIDS involving human subjects, shall conform to Research agreements and the necessary guidelines to do so. Psychosocial and social science research shall abide by stipulated ethical guidelines.

Protecting the confidentiality of the participants should be the key priority of all research projects, due to the sensitive nature of sexual health in Samoa. All research methods shall be redesigned accordingly to achieve this measure. Methods should be evidence based with the goal of obtaining data that are relevant, useful and utilizable by the communities affected. Research should be related to national research priorities in HIV, AIDS, STI's, and TB, which can be provided by officers of the National Programme for HIV/AIDS/STI's/TB.

Existing research structures shall be utilized for HIV/AIDS research to avoid duplication and unnecessary burden on the health system. Results of research must be shared amongst all those who have a direct role in facilitating work in HIV, AIDS, STI's and TB and must be retrievable and easily accessible.

All sectors shall maintain inventory of all on-going and completed research projects on HIV/AIDS and MOH shall compile and disseminate relevant research findings to respective stakeholders. The researchers shall translate research finding into easily understandable language for public consumption.

NACC and TAC in collaboration with the Ministry of Health shall mobilize funds for coordination and promotion of research activities, and dissemination of research findings. Research Institutions and individual researchers shall look for their own research grants and any other kind of research related support. Each sector shall strive to provide adequate funds for research activities on HIV/AIDS/STI's/TB.

6.2 Research Involving HIV Testing

All research involving HIV testing of individuals shall have a care plan in place as part of the research protocol for all participants. All research proposals shall seek ethical clearance from the Research and Ethics Committee of the hosting institution or sector. The ethics review should include staff of the HIV/AIDS/STI/TB National Programme for technical assistance or relevant sexual health workers. NAC and the Health Research Committee shall be informed of such research findings for the record and/or dissemination. Approved research proposals by the Health Research Committee shall be registered with NAC. Research involving international collaborators shall obtain ethical clearance from the Institutions from which the foreign collaborators are based and also from the relevant government Ministry such as Ministry of Prime Minister for License approval and the MOH for the proposal approval. All authors shall give consent, in writing, to the publication of the research report.

6.3 Surveillance

The current surveillance systems in place are foundational to the operation of the HIV/STI National Program. The TTM hospital in Apia houses the national reference lab that all specimens are referred to for processing. The quarterly reports comprise the core surveillance of HIV and STI's. To improve health information systems in Samoa, first the national reference lab at TTM Hospital in Apia must be further developed. Due to the lab's lack of capacity to process and report specimens and test results, improving the operational

capacity of the lab is being formally identified as priority area of health sector development in this policy.

6.4 Sentinel Surveillance

The MoH, NHS, and all of their partners currently lack the technical capacity, quality data information systems, and surveillance coordination to conduct sentinel surveillance. Once the M&E system for HIV and STI's, all sector organizations should formally assess the cost effectiveness of establishing sentinel surveillance units. With the current monitoring and evaluation infrastructure, Samoa's small number of healthcare facilities, and Samoa's low population density, it is currently unclear of how feasible and sustainable sentinel surveillance would be with key populations (transgender, ANC mothers, MSM, inmates, injection drug users, and sex workers). Both HIV drug resistance monitoring and toxicity monitoring should be evaluated in the same manner due to the low caseload of HIV positive cases.

6.5 M&E

The M&E manual for the national program should be reviewed annually by MoH and its stakeholders to ensure that indicators, M&E tools, and frameworks are still relevant to both donor and health sector reporting requirements. Data collection and indicator technical specifications should be formatted to the surveillance infrastructure currently in place to avoid duplication and ensure data availability.

The M&E Manual for HIV/AIDS and STI's is scheduled to be operational in 2017 after consultation with stakeholders and multi-sector partners. The framework and full list of indicators is available for reference in Appendix 1 and Appendix 2.

7. Sectoral Roles and Financing

The response to the HIV/AIDs crisis in Samoa has historically involved a partnership of agencies across sectors. This must be further built upon to enhance a coordinated and effective multi-sectoral approach towards curbing this epidemic, to mobilize adequate financial resources for HIV/AIDS activities, as well as incorporating community structures into the health sector to expand service delivery.

Objective 7 Increase sector collaboration and expand partnership to communities
Increase collaboration within the health sector and expand roles in the national response to community structures in order to increase service delivery, effectiveness, and sustainability.
Key Strategic Actions for Objective 7:
f) Identify sustainable funding sources for HIV, STI's and TB after the close of the Global Fund in 2017
g) Formally establish role of village committees and other community structures in the health sector for HIV, STI's and TB prevention and care.
h) Capacity building for key partners and stakeholders in delivering interventions, coordinating service delivery and implementing M&E
i) Deliver better coordinated and well resourced multi-sectoral health forums in communities

j) Expand voluntary and provider-initiated HIV and STI screening of foreign visitors, contract workers, residents, and citizens who reside overseas through partnership with Port Health, Immigration and all organizations involved in the implementation of the International Health Regulations

7.1 Government Roles

The Government of Samoa has the responsibility to provide management and financial leadership in the national response to the HIV AIDS epidemic. However, given the overwhelming high cost involved, it is beyond the capacity of the government to provide adequate funds for a national response. Therefore development partners and the private sector also share the responsibility and moral obligation to complement government efforts. These efforts can be realised under existing funding arrangements with the World Health Organisation, Sector Wide Approach Programme or any other funding arrangement that can assist in financing components of this HIV AIDS Policy and Plan of Action.

7.2 Regulatory Roles

NACC, TAC and the Ministry of Health shall play a leading role in the provision of multi-sectoral support in the design, implementation, and evaluation of prevention and control of HIV/AIDS and in mitigating its impact. The Ministry of Health shall assist in the mobilization of funds and it will be responsible for regular, evaluation to determine the impact of local and external donor funding on the HIV/AIDS prevention and control. In this role, MoH will require monitoring and evaluation data to be collected from partners and all organizations engaged in address HIV, STI's and TB. This is for the purposes of securing funding and directing the national response via the policy and plan of action.

7.3 Partner, NGO, and Private Sector Roles

The various partners in collaboration with the Ministry of Health shall draw up Plans for the control and prevention of HIV/AIDS within the framework of the National Policy and Plan of Action. NGO/CBO, Religious Organizations, and the Private Sector and Institutions shall design, and implement HIV/AIDS activities in their sectors. Within the framework of this policy and plan of action every sector shall identify, prioritize and implement HIV/AIDS prevention and control activities in line with its mandate and comparative advantage. For activities in which partner and non-partner institutions request funding from MoH, these activities will be reviewed by MoH to assess if the programmes meet the following criteria;

1. Alignment with the National Policy and the Plan of Action
2. Alignment with national regulations and care standards
3. The feasibility, safety, effectiveness, and sustainability of the proposed activities/programmes

All activities that do not request funding from MoH will be subject to regulations laid out within the Health Ordinance 1959 and any other relevant health or health related legislation. All legal requirements and penalties will apply, which MoH is responsible for enforcing. All partner and non-partner institutions will be able to consult MoH for compliance with relevant legislation, policies and standards.

Within the framework of this policy every partner organization shall budget, raise funds and mobilize material and human resources for its own HIV/AIDS prevention and control activities. MoH will fund key activities that align with the criteria discussed above. MoH and its partners can also partner on implementation of activities and programmes that meet mutual objectives, combining funding capacities. Additionally, funding for the activities of partner organizations that are NGO's are eligible to apply for donor NGO small grant schemes (particularly through UNDP). Partners will additionally be called upon for consultation on MoH's design and planning of the National Policy, the Plan of Action, the development of new initiatives, and any issues that may arise in the operations of the national response. All partners will have a Memorandum of Understanding that will detail the parameters of the relationship between the partner organization and MoH, the terms of which can be negotiated at the end of every fiscal year.

7.4 Community Roles

The MoH and its partners shall also initiate formal relationships with village committees or other community structures to deliver programmes and activities at the community level. MoH and all partners will ensure that;

- Programmes and activities do not create a financial burden on communities and are sustainable
- Relevant capacity building is provider to community structures organizations and individuals so that implementation is optimal, all national laws and regulations are observed, and all MoH policies and standards guide the process.
- Community structures do not violate any laws, policies, ethical standards, or human rights in all activities
- Community needs inform the activities and programmes. Assessment of these needs shall provide information detailed in Section 2.9 in order to tailor a program or activity to a specific community.

The communities will also establish their own processes for achieving programming objectives, complying with national and MoH law and policy, and ensuring activities are sustained long-term by the community. MoH will also consult communities for all national level regulatory activities, such as designing the national policy, plan of action, and work plan.

8. National Strategy and 2016-2017 Plan of Action

For the first 2 years f the new policy period, funding has been allotted to selected priority areas of the national policy. The table below shows the amount of funding per activity that falls under the Key Strategic Actions of the National Strategy, as well as the corresponding policy area.

Objective	Strategy	Action	Costing (SAT)
2016			
1. Safeguard the rights of people living with HIV/AIDS or other STI's to ultimately improve their health and quality of life, make health interventions for PLWHA more effective, and ensure a human rights approach to public health.	*c) Improve the legal and policy environment for PLWHA to prevent rights violations.*	Legal reviews on PLWHIV and key populations rights and services against stigma discrimination and violence	(included in cost below)
	d) Advance the protection of PLWHA rights in legal, institutional and social domains.	Legal review on PLWHIV and key populations workplace rights	$37,425.00
2A. Engage communities in prevention through behaviour change programs that increase people's capacity to make well informed sexual health decisions to synergistically enhance the effectiveness of clinical and educational interventions.	*a) Implement behaviour change programs to enhance health education outreach and reception of health messages aimed at increasing awareness and knowledge*	Behaviour change targeting youth and key populations	$50,000.00
2B. Improve access to testing, counselling, and prophylaxis by engaging community structures in service delivery and health promotion.	*d) Increase prevention efforts with key populations*	Support the National Fa'afafine Forum	$30,000.00
	e) Maintain 0% incidence of Mother to Child transmission of HIV	PMTCT training of healthcare workers	$25,000.00
	f) Implement national level health communication to increase knowledge and awareness of services	TV Radio Spots	$12,500.00
3. Increase the coverage and access of HIV, STI, TB, and co-infection testing in the general and all key populations to expand surveillance and counselling services.	*c) Create community linkages to HIV, STI and TB testing and counselling services, or create community based testing options tailored to village community*	Training Community Volunteers (TB)	$22,065.00

Objective	Strategy	Action	Costing (SAT)
	structures.		
4. Expand treatment and care activities to address social determinants of HIV, STI's, TB, and co infection	*b) Develop capacity to offer STI, HIV and TB in all sexual health settings*	TB Care and Prevention Salaries	$50,997.50
	c) Conduct partnered outreach for HIV, STI, and TB treatment and care	Community Outreach	$21,000.00
	f) Develop programmes and interventions that target the social determinants and interrelated risk factors of co-infection	TB/HIV Collaboration Workshops for Youth	$3,250.00
6. Expand health knowledge and develop information systems regarding HIV, STI's and TB, while protecting confidentiality	*a) Develop pilot and baseline studies for key populations*		(included in cost below
	d) Develop processes with MoH, the health sector, and all partners to improve and increase data collection and reporting	Sub national M&E visits to DOTS sites	$10,250.00
2017			
Objective 6 Expand health knowledge and information systems, while protecting confidentiality	b) Implement the M&E system outlined in the 2017 M&E Manual	Procurement of a Research and M&E Officer	$52,143.00
Objective 4 Expand treatment and care to address HIV, STI and TB social determinants and co infection	j) Adherence to care, behaviour change and harm reduction programmes tailored to each key population developed and implemented.	TB treatment and care adherence	$7,945.60
Objective 2 Engage communities in behaviour change and improve access to prevention	i) Train and resource TB community advocates for village level linkage to care and awareness	Training Community Volunteers (TB)	$22,347.00
Objective 3 Increase the coverage and access of HIV, STI and TB testing in all populations	Implement TB testing and screening in conjunction with all STI testing activities (and vice versa) to improve screening of co-infection.	Training of providers on TB/HIV co infection testing	$3,972.80
Objective 6 Expand health knowledge and information systems, while protecting confidentiality	b) Implement the M&E system outlined in the 2017 M&E Manual	Sub national M&E visits	$24,830.00
Objective 6 Expand health knowledge and information systems, while	d) Develop human resource capacity in the	M&E trainings for staff	$4,767.36

Objective	Strategy	Action	Costing (SAT)
protecting confidentiality	health sector for health data, surveillance, monitoring and evaluation		
Objective 2 Engage communities in behaviour change and improve access to prevention	l) Conduct infection control trainings for tufuga for preventing blood borne pathogens (particularly HIV, Hepatitis, and extra pulmonary TB)	Infection control trainings for tattooists	$13,904.80
Objective 2 Engage communities in behaviour change and improve access to prevention	a) Implement behaviour change programs to enhance health education outreach and reception of health messages aimed at increasing awareness and knowledge	Integrated Community Health Outreach Education Program (10 interventions)	$62,075.00
Objective 6 Expand health knowledge and information systems, while protecting confidentiality	b) Implement the M&E system outlined in the 2017 M&E Manual	Procurement of M&E Data Collection tablets	$16,387.80
Objective 6 Expand health knowledge and information systems, while protecting confidentiality	d) Develop human resource capacity in the health sector for health data, surveillance, monitoring and evaluation	Electronic reporting tool for NHS laboratory	$4,966.00
Objective 6 Expand health knowledge and information systems, while protecting confidentiality	b) Implement the M&E system outlined in the 2017 M&E Manual	DOTS TB data collection visits	$19,864.00
Objective 2 Engage communities in behaviour change and improve access to prevention	a) Increase prevention efforts with key populations	Focus groups with key populations	$9,932.00
Objective 6 Expand health knowledge and information systems, while protecting confidentiality	d) Develop human resource capacity in the health sector for health data, surveillance, monitoring and evaluation	Training for providers on rapid diagnostic saliva test kits	$7,449.00
Objective 4 Expand treatment and care to address HIV, STI and TB social determinants and co infection	f)Develop programmes and interventions that target the social determinants and interrelated risk factors of co-infection	Counselling trainings for clinicians on psychosocial issues surrounding health	$14,898.00
		Total	$527,969.86

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Appendix 1: Monitoring and Evaluation Framework for HIV, STI's and TB

Targets	**Target 1. Reduction of HIV, STI's and TB prevalence and transmission in general and key populations.**	**Target 2. Reduced morbidity and mortality related to HIV, STI's and TB**	**Target 3. Improve health information, surveillance, testing and M&E surrounding HIV, STI's, TB and sexual health**	**Target 4. Reduce Stigma and its effects on sexual health rights, HIV, STI's and TB**
Level	***Impact***			
Measurement	1.Prevalence of HIV, STI's and TB (case notification rate) in general and key populations*	1. Prevalence of conditions caused by untreated infections or treated in late stage (ex. PID, conjunctivitis, newborn blindness, genital ulcers)	1. Patient and provider notification time for HIV, STI, TB test results	1. Percent of people living with HIV, STI's or TB reporting rights violations in legal areas of discrimination sexual violence, sexual health and access to HIV, STI and TB services
	2. Incidence of HIV, STI's, TB, and Co-infection (includes HIV/TB, HIV/HBV and HIV/HCV)*	2. Number of AIDS related deaths	2. Estimated undetected prevalence STI's, HIV and TB*	
		3. Prevalence of congenital transmissions	3. Improved sensitivity and specificity for HIV, STI and TB testing	
		4. TB Mortality Rate per 1,000		

Targets	Target 1. Reduction of HIV, STI's and TB prevalence and transmission in general and key populations.	Target 2. Reduced morbidity and mortality related to HIV, STI's and TB	Target 3. Improve health information, surveillance, testing and M&E surrounding HIV, STI's, TB and sexual health	Target 4. Reduce Stigma and its effects on sexual health rights, HIV, STI's and TB
Level	***Outcome***			
Measurement	1. Condom use in general and key populations (youth, fa'afafine, inmates, sex workers etc.)	1. Percent of Late Diagnosis HIV cases	1. Relapse rate of TB per 100,000*	1. Knowledge of HIV, STI's, sexual health and TB transmission in all populations
	2. Knowledge of HIV, STI's, and TB transmission and prevention in general and key populations	2. Percent of detected HIV cases reporting suppressed viral load	2. Coverage of voluntary vs. routine and mandated screening	2. Number of gaps in legislation that given legal action (i.e. proposed amendment, legal analysis, redraft of legislation, or new law proposed) to address gaps or uncertainties in existing legislation for PLWHIV, key populations, women experiencing violence, sexual health and access to HIV, STI and TB services
	3. Mother to Child Transmission of HIV	3. Number of PLWHIV with an active TB infection	3. Estimated PLWHIV who know their status (including undetected and un-notified)	3. Percent of People Expressing Stigmatic Beliefs About PLWHIVA

Targets	Target 1. Reduction of HIV, STI's and TB prevalence and transmission in general and key populations.	Target 2. Reduced morbidity and mortality related to HIV, STI's and TB	Target 3. Improve health information, surveillance, testing and M&E surrounding HIV, STI's, TB and sexual health	Target 4. Reduce Stigma and its effects on sexual health rights, HIV, STI's and TB
	4. Young people having sex before age 15	4. Treatment success rates for STI's and TB*	4. Percent of laboratories showing adequate performance in external quality assurance	4. Percent of people expressing fear of confidentiality breaches or cultural barriers in accessing sexual health services
	5. Multiple sexual partnerships		5. Number of HMIS submitting timely reports	
	6. Treatment success rates for STI's and TB*			
Level	**Output**			
Measurement	1. Number of people and specific key populations groups reached by health education, communication, behaviour change, condom & lubricant distribution, or prevention programming	1. Percent of HIV exposed infants starting prophylaxis at birth	1. Percent of infants tested for HIV within 2 months of birth	1. Number of legal reviews and position papers advocating for legal advancements for PLWHIV

Targets	Target 1. Reduction of HIV, STI's and TB prevalence and transmission in general and key populations.	Target 2. Reduced morbidity and mortality related to HIV, STI's and TB	Target 3. Improve health information, surveillance, testing and M&E surrounding HIV, STI's, TB and sexual health	Target 4. Reduce Stigma and its effects on sexual health rights, HIV, STI's and TB
	2. People screened for HIV, STI's and TB 4. HIV positive pregnant women that received ART's to reduce risk of MTCT 5. People receiving treatment for STI's*	2. Percent of HIV exposed infants starting CTX within 2 months of birth 3. Percent of PLWHIV receiving ART treatment 4. Percent of cases of co-infection on effective combined therapy (includes HIV/TB, HIV/HBV and HIV/HCV) 5. Retention of ART treatment 16. MDR-TB treatment success rates 7. Percent of RR-TB cases that start treatment with 4 weeks of diagnosis 8. STI testing coverage in ANC women* (See People Screened for STI's)	2. Proportion of Previously treated TB patients receiving drug-sensitivity testing 3. Percent of PLWHIV tested for TB vs. Percent of TB cases tested for HIV 4. Number of external and internal QA audits with NHS participation	2. Community advocacy for legal issues regarding discrimination sexual violence, sexual health and access to HIV, STI and TB services 3. People reached by programming that addresses stigma and sexual health

Targets	Target 1. Reduction of HIV, STI's and TB prevalence and transmission in general and key populations.	Target 2. Reduced morbidity and mortality related to HIV, STI's and TB	Target 3. Improve health information, surveillance, testing and M&E surrounding HIV, STI's, TB and sexual health	Target 4. Reduce Stigma and its effects on sexual health rights, HIV, STI's and TB
		9. STI testing coverage in partners of ANC women*(See People Screened for STI's) 7. People receiving treatment for STI's*		

Appendix 2: HIV and STI Monitoring Indicator Glossary

***Yellow indicates data is not currently collected or reported to MoH**
***Orange indicates data is collected but no processes exist for reporting it to MoH**

Indicators	Numerator	Denominator	Source	Disaggregation
Impacts				
Prevalence of HIV, STI's and TB in general and Key populations				
HIV prevalence in all populations	Number of people who tested positive for HIV	Number of people screened for HIV	STI Surveillance Data and Screening Outreach records	Age and Sex
HIV prevalence in ANC Women	number of pregnant women who tested positive for HIV	number of women tested at ANC clinics	STI Surveillance Data and Screening Outreach records	Age and Sex
HIV and STI prevalence of pregnant women's partners	number of women attending ANC whose male partners were tested positive for HIV or any STI already knew they were positive	number of women attending ANC in past 12 months	STI Surveillance Data and Screening Outreach records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
HIV Prevalence in Fa'afafine (transgender)	Number of fa'afafine testing positive for HIV	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
HIV prevalence in female sex workers (FSW's)	Number of FSW's testing positive for HIV	Number of FSW screened or estimated population (400)	STI Surveillance Data and Screening Outreach records	Age and Sex
HIV prevalence in Men who have Sex with Men (MSM)	Number of MSM testing positive for HIV	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
HIV prevalence of inmates and detainees	number of detainees who test positive	number of detainees tested for HIV	STI Surveillance Data and Screening Outreach records	Age and Sex (including fa'afafine and FSW's)

Indicators	Numerator	Denominator	Source	Disaggregation
Hepatitis B prevalence in PLWHIV	number of people in HIV care who were tested for hepatitis B using HBsAg	number of people in HIV care during the reporting period	STI Surveillance Data and Screening Outreach records	Age and Sex
Hepatitis B prevalence in all populations	Number of people who tested positive for Hep. B	Number of people screened for Hep. B	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. B prevalence in ANC clinics	Number of pregnant women who tested positive for Hep. B	number of women tested at ANC clinics	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. B Prevalence in Fa'afafine (transgender)	Number of fa'afafine testing positive for Hep. B	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Hep. B prevalence in female sex workers (FSW's)	Number of FSW's testing positive for Hep. B	Number of FSW screened or estimated population (400)	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. B prevalence in Men who have Sex with Men (MSM)	Number of MSM testing positive for Hep. B	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. B prevalence of inmates and detainees	Number of detainees who test positive for Hep. B	Number of detainees tested for Hep. B	STI Surveillance Data and Screening Outreach records	Age and Sex (including fa'afafine and FSW's)
Hepatitis C prevalence in PLWHIV	number of adults and children enrolled in HIV care that were tested for Hepatitis C	number of adults and children enrolled in HIV care	STI Surveillance Data and Screening Outreach records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Hepatitis C prevalence in all populations	Number of people who tested positive for Hep. C	Number of people screened for Hep. C	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. C prevalence in ANC clinics	Number of pregnant women who tested positive for Hep. C	number of women tested at ANC clinics	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. C Prevalence in Fa'afafine (transgender)	Number of fa'afafine testing positive for Hep. C	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. C prevalence in female sex workers (FSW's)	Number of FSW's testing positive for Hep. C	Number of FSW screened or estimated population (400)	STI Surveillance Data and Screening Outreach records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Hep. C prevalence in Men who have Sex with Men (MSM)	Number of MSM testing positive for Hep. C	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
Hep. C prevalence of inmates and detainees	Number of detainees who test positive for Hep. C	Number of detainees tested for Hep. C	STI Surveillance Data and Screening Outreach records	Age and Sex (including fa'afafine and FSW's)
Syphilis prevalence in ANC Women	Number of pregnant women who tested positive for Syphilis	number of women tested for Syphilis at ANC care visits	STI Surveillance Data and Screening Outreach records	Age and Sex
Syphilis prevalence in all populations	Number of people who tested positive for Syphilis	Number of people screened for Syphilis	STI Surveillance Data and Screening Outreach records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Syphilis Prevalence in Fa'afafine (transgender)	Number of fa'afafine testing positive for Syphilis	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
Syphilis prevalence in female sex workers (FSW's)	Number of FSW's testing positive for Syphilis	Number of FSW screened or estimated population (400)	STI Surveillance Data and Screening Outreach records	Age and Sex
Syphilis prevalence in Men who have Sex with Men (MSM)	Number of MSM testing positive for Syphilis	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
Syphilis prevalence of inmates and detainees	Number of detainees who test positive for Syphilis	Number of detainees tested for Syphilis	STI Surveillance Data and Screening Outreach records	Age and Sex (including fa'afafine and FSW's)

Indicators	Numerator	Denominator	Source	Disaggregation
Chlamydia prevalence in all populations	Number of people who tested positive for Chlamydia	Number of people screened for Chlamydia	STI Surveillance Data and Screening Outreach records	Age and Sex
Chlamydia prevalence in ANC Women	number of pregnant women who tested positive for Chlamydia	number of women tested at ANC clinics	STI Surveillance Data and Screening Outreach records	Age and Sex
Chlamydia prevalence pregnant women's partners	number of male partners of ANC women who tested positive for Chlamydia or already knew they were positive	number of women and partners attending ANC in past 12 months	STI Surveillance Data and Screening Outreach records	Age and Sex
Chlamydia Prevalence in Fa'afafine (transgender)	Number of fa'afafine testing positive for Chlamydia	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Chlamydia prevalence in female sex workers (FSW's)	Number of FSW's testing positive for Chlamydia	Number of FSW screened or estimated population (400)	STI Surveillance Data and Screening Outreach records	Age and Sex
Chlamydia prevalence in Men who have Sex with Men (MSM)	Number of MSM testing positive for Chlamydia	Number of fa'afafine tested or estimated population of fa'afafine and MSM (25-30,000)	STI Surveillance Data and Screening Outreach records	Age and Sex
Chlamydia prevalence of inmates and detainees	number of detainees who test positive	number of detainees tested for Chlamydia	STI Surveillance Data and Screening Outreach records	Age and Sex (including fa'afafine and FSW's)
Case notification rate of *all forms* of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, new and relapse cases	N/A -Raw data, number of cases	N/A -Raw data, number of cases	STI Clinic, TB register	Age, Sex, HIV Status
Case notification rate per 100,000 population population- *bacteriologically confirmed* TB, new and relapse	N/A -Raw data, number of cases	N/A -Raw data, number of cases	STI Clinic, TB register	Age, Sex, HIV Status
Proportion of people living with HIV newly enrolled in HIV care with active TB	number of people who have active TB over the number of people newly enrolled in HIV care	number of those people newly enrolled in HIV care during the reporting period	STI Clinic, PLWHIV register	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Incidence of HIV, STI's, TB and Co infection (includes HIV/TB, HIV/HBV, and HIV/HCV)				
Incidence of HIV as a percent increase	Number of new cases within the past 12months	Number of currently detected cases	STI Clinic Registers	Age, Sex, Key population group
Incidence of Hepatitis B as a percent increase	Number of new cases within the past 12months	Number of currently detected cases	STI Clinic Registers	Age, Sex, Key population group
Incidence of Hepatitis C as a percent increase	Number of new cases within the past 12months	Number of currently detected cases	STI Clinic Registers	Age, Sex, Key population group
Incidence of Syphilis as a percent increase	Number of new cases within the past 12months	Number of currently detected cases	STI Clinic Registers	Age, Sex, Key population group
Incidence of Chlamydia as a percent increase	Number of new cases within the past 12months	Number of currently detected cases	STI Clinic Registers	Age, Sex, Key population group
Incidence of all types of co infection as a percent increase	Number of new cases within the past 12months	Number of currently detected cases	STI Clinic Registers	Age, Sex, Key population group
Prevalence of conditions that were caused by untreated infections or late stage infections (Cumulative prevalence of all indicators below)				
Pelvic Inflammatory Disease Hospitalizations Separations Rate	number of people hospitalized for Chlamydia related PID during reporting period	number of people hospitalized for PID during reporting period	NHS patient records	Age and Sex
Prevalence of Newborn Blindness due to Chlamydia	number of cases of newborn blindness due to Chlamydia in the reporting period	number of live births	NHS patient records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Prevalence of Chlamydia related conjunctivitis cases	number of cases of conjunctivitis due to Chlamydia	number of Chlamydia positive cases in the reporting period	NHS patient records	Age and Sex
Prevalence of Genital Ulcer disease in adults	Number of cases reporting genital ulcers in patient above age 15	Number of admissions within the past 12 months	NHS patient records	Age and Sex
Men with urethral discharge	number of males with urethral discharge during the reporting period	number of males 15 or older	NHS patient records and the DHS	Age
Number of AIDS related deaths	number who have died from AIDS related illness in the reporting year	n/a	STI Clinic, PLWHIV register	Age and Sex
Prevalence of congenital transmissions				
Prevalence of Congenital Syphilis	number of reported congenital syphilis cases (live and still births) in the past 12 months	number of live births	STI Clinic and NHS Hospital records	None
Prevalence of Newborn Blindness due to Chlamydia	number of cases of newborn blindness due to Chlamydia in the reporting period	number of live births	NHS patient records	Age and Sex
Mother to Child Transmission of HIV	number of children infected with HIV among children born in the past 12 months to HIV positive women	number of HIV positive pregnant women who delivered in past 12 months	STI Clinic and NHS Hospital records	Age and Sex
TB Mortality Rate per 1,000 (calculated from pop. estimates)	Number of deaths of patients registered in the TB Clinic register	Total number of cases in the TB register	TB Clinic records	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Patient and provider notification time for HIV, STI, TB test results	Average time between receipt of specimen and notification of results to physician	none	Lab Records	none
Estimated undetected prevalence STI's, HIV and TB*	Current prevalence	Estimated prevalence (based on SPECTRUM projections)	STI Clinic Reports	Age, Sex, and Key population group
Improved sensitivity and specificity for HIV, STI and TB testing	number of false positives and false negatives from internal and external QA exercises at NHS	Number of all specimens included in the QA exercise	Lab Records	Age and Sex
Percent of People Living with HIV, STI's or TB reporting rights violations in legal areas of discrimination, sexual violence, sexual health and access to HIV,STI's and TB services	Number of people reporting rights violations	Estimated population of each group	None, needs survey	Age, Sex, and population group
Outcomes				
Condom use in general and key populations				
Condom use at last sex among people with multiple sexual partnerships and key populations	number of people age 15-49 having sex with more than 1 person in the past 12 months who also reported that a condom was used the last time they had sex	number of people age 15-49 having more than 1 sexual partner in the past 12 months	None, needs survey	Age, Sex and Key population group
Condom use by type of sex (oral, vaginal, anal)	Number of people reporting condom use at last sex	Number of people surveyed or estimated population size	n/a	Age, Sex and key population group
Knowledge of HIV, STI's, and TB transmission and prevention in general and key populations				
Knowledge of Chlamydia in secondary school	Number of youth reporting correct methods of prevention and transmission for Chlamydia	Number of students in the survey sample	n/a	Age, Sex and key population group

Indicators	Numerator	Denominator	Source	Disaggregation
Comprehensive knowledge of HIV	Number of people with comprehensive knowledge of HIV: 1) knowing that using condoms and limiting sexual intercourse to 1 uninfected person are prevention methods, 2) being aware that a healthy looking person can have the virus, 3) and rejecting 2 most common local misconceptions about the virus.	Number of survey respondents	DHS 2014	Age and Sex (need key population group)
Knowledge of HIV prevention	Number of people that report using condoms and limiting sexual partners as prevention methods for HIV	Number of survey respondents	DHS 2014	Age and Sex (need key population group)
Young People (15-24) Knowledge about HIV prevention	Number of people that report using condoms and limiting sexual partners as prevention methods for HIV	Number of survey respondents	DHS 2014	Age and Sex (need key population group)
Knowledge of TB in all populations	Number of people reporting correct methods of transmission for TB	Number of respondents in the survey sample	n/a	Age, Sex and key population group
Young people having sex before age 15	people age 15-24 having sex before age 15	people ages 15-24	DHS 2014	Age
Treatment success rates for STI's and TB				
Treatment success rate for Chlamydia patients	Number of detected Chlamydia cases complying to anti-biotic treatment	Number of detected and suspect Chlamydia cases	None	Age, Sex and key population group

Indicators	Numerator	Denominator	Source	Disaggregation
Proportion of people living with HIV newly enrolled in HIV care started on TB preventative Therapy	Total number of people living with HIV newly enrolled in HIV care who started on treatment for latent TB infection during the reporting period	total number of people newly enrolled in HIV care	STI Clinic, PLWHIV register	Age, Sex, and key population group
HIV care coverage	number of people enrolled in HIV care	estimated number of adults and children living with HIV	STI Clinic, PLWHIV register	Age, Sex, key population group
Syphilis treatment coverage among syphilis positive antenatal care attendees	number of ANC attendees with a positive syphilis serology that received at least one dose of benzathene penicillin 2.4 mU IM	number of ANC attendees with positive syphilis serology	STI Clinic	Age, Sex and key population group
Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all TB cases registered for treatment during a specified period (ANNUAL)	Number of all cases of TB (all forms) cured in the current year and previous year	Number of all cases of TB (all forms) in the register for the previous year only	STI Clinic, TB register	Age, Sex, HIV Status
Treatment success rate - bacteriologically confirmed TB cases	Number of bacteriologically confirmed cases cured or completed treatment in the current and previous year	Number of all cases of TB (all forms) in the register for the previous year only	STI Clinic, TB register	Age, Sex, HIV Status
Treatment success rate of MDR-TB: Percentage of bacteriologically confirmed drug resistant TB cases (RR-TB and/or MDR-TB) successfully treated (ANNUAL)	Number of bacteriologically MDR TB confirmed cases treated in the current and previous year	Number of MDR TB cases in the register of the previous reporting year	STI Clinic, TB register	Age, Sex, HIV Status

Indicators	Numerator	Denominator	Source	Disaggregation
Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all TB cases registered for treatment during a specified period	Number of all cases of TB (all forms) cured in the current year and previous year	Number of all cases of TB (all forms) in the register for the previous year only	STI Clinic, TB register	Age, Sex, HIV Status
Late diagnosis of HIV cases	Number of HIV positive people with their first CD4 count <200 cells	number of people with first CD4 count in current year	STI Clinic, PLWHIV register	Age and Sex
Percent of detected HIV cases reporting suppressed viral load	number of adults and children with HIV receiving ART in the reporting period with a suppressed viral load <1000	estimated number of adults and children living with HIV	STI Clinic, PLWHIV register	Age and Sex
Number of PLWHIV with an active TB infection	Number of people in the HIV register that had any type of positive test result for TB	Number of PLWHIV in the HIV register	STI Clinic, PLWHIV register	Age and Sex
Prevalence of reported urethral discharge	Number of males reporting urethral discharge in the past 12 months	Number of male admissions	None	Age and key population group
Prevalence of genital ulcer disease in adults	number of adults with genital ulcer disease during the past 12 months	number of individuals 18 or older	None	Age, Sex and key population group
Prevalence of Newborn Blindness attributable to congenital Chlamydia	number of cases of newborn blindness due to Chlamydia in the reporting period	number of live births	None	None

Indicators	Numerator	Denominator	Source	Disaggregation
Prevalence of conjunctivitis attributable to Chlamydia	number of cases of conjunctivitis due to Chlamydia	number of Chlamydia positive cases in the reporting period	None	Age and Sex
Prevalence of Pelvic Inflammatory Disease	number of people hospitalized for Chlamydia related PID during reporting period	number of people hospitalized for PID during reporting period	None	Age and Sex
Relapse rate of TB per 100,000	Number of TB cases completing treatment but not cured in reporting year	Number of TB cases cured or completed treatment within reporting year	TB Register	Age and Sex
Coverage of voluntary vs. routine and mandatory screening	Ratio: percent of population screened from hospitals, private, and STI Clinics vs. percent screened at ANC and Immigration	n/a	STI surveillance	Age and Sex
Estimated PLWHIV who know their status	number of people who are alive and know their status (# of PLWHIV + # of AIDS related deaths)	estimated number of PLWHIV	STI Surveillance	Age and Sex
Percentage of laboratories showing adequate performance in external quality assurance for smear microscopy among the total number of laboratories that undertake smear microscopy during the reporting period	Number of labs that meet quality	Number of Targeted labs	NHS	N/A
Percentage of HMIS or other routine reporting units submitting timely reports according to national (or regional) guidelines	Number of HMIS reporting on time	Number of HMIS facilities	NHS	N/A

Indicators	Numerator	Denominator	Source	Disaggregation
Gaps in legislation	Number of gaps in legislation that given legal action (i.e. proposed amendment, legal analysis, redraft of legislation, or new law proposed) to address gaps or uncertainties in existing legislation for PLWHIV, key populations, women experiencing violence, sexual health and access to HIV, STI and TB services	Number of all identified gaps in legislation	n/a	n/a
Discriminatory Attitudes towards PLWHIV	Number of people expressing acceptance of PLWHIV in 4 categories	Number of people in survey sample	DHS 2014	Age and Sex
Percent of people expressing fear of confidentiality breaches or cultural barriers in accessing sexual health services	Number of people who report fear of their confidentiality being breached or express cultural beliefs against using SRH services	Number of people in survey sample	None	Age, Sex and Key population
Output				
People reached by health education, communication, behaviour change, condom and lubricant distribution, or prevention programming				
Percent of general population reached by HIV/STI prevention programs	Number of participants at the end of the fiscal year recorded attending education, health communication, behaviour change, or prevention programs	Estimated sexually active population based on most current Census	Multiple health sector partners	Age and Sex
Percent of fa'afafine reached by HIV/STI prevention programs	Number of participants at the end of the fiscal year recorded attending education, health communication, behaviour change, or prevention programs	20-30,000 (estimated fa'afafine and MSM population as of 2016)	Multiple health sector partners	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
Percent of MSM reached by HIV/STI prevention programs	Number of participants at the end of the fiscal year recorded attending education, health communication, behaviour change, or prevention programs	20-30,000 (estimated fa'afafine and MSM population as of 2016)	Multiple health sector partners	Age and Sex
Percent of female sex workers reached by HIV/STI prevention programs	Number of participants at the end of the fiscal year recorded attending education, health communication, behaviour change, or prevention programs	400 (estimated female sex worker population as of 2016)	Multiple health sector partners	Age and Sex
People screened for HIV, STI's, and TB				
General population screening coverage	Number of people screened for HIV, Chlamydia, Hepatitis B&C, and Syphilis at all national hospitals	Estimated population	STI Surveillance, Lab records	Age and Sex
PMTCT testing coverage	number of women who attended an ANC facility and/or had a facility based delivery and were tested for HIV during pregnancy or already knew they were HIV positive	number of women who attended ANC and had a delivery within the past 12 months	STI Surveillance, Lab records	Age
HIV and STI screening of ANC women's partners	number of women attending ANC whose male partners were tested for HIV or any STI already knew they were positive	number of women attending ANC in past 12 months	STI Surveillance Data and Screening Outreach records	Age and Sex
Syphilis testing in Pregnant Women	number of women accessing ANC services that were tested at any visit	Estimated population of pregnant women	STI Surveillance, Lab records	Age

Indicators	Numerator	Denominator	Source	Disaggregation
Hepatitis B Testing in pregnant women	number of women accessing ANC services that were tested at any visit	Estimated population of pregnant women	STI Surveillance, Lab records	Age
Hepatitis C testing in pregnant women	number of women accessing ANC services that were tested at any visit	Estimated population of pregnant women	STI Surveillance, Lab records	Age
Chlamydia testing in pregnant women	number of women accessing ANC services that were tested at any visit	Estimated population of pregnant women	STI Surveillance, Lab records	Age
STI testing coverage of pregnant women's partners	number of women attending ANC whose male partners were tested for any STI or already knew they were positive	number of women attending ANC in past 12 months	None	Age
Percent of fa'afafine that received an HIV test and know the results	Number of fa'afafine screened for HIV with result notification	20-30,000 (estimated fa'afafine and MSM population as of 2016)	Multiple health sector partners	Age
Percent of MSM that received an HIV test and know the results	Number of MSM screened for HIV with result notification	20-30,000 (estimated fa'afafine and MSM population as of 2016)	Multiple health sector partners	Age
Percent of female sex workers that received an HIV test and know the results	Number of female sex workers screened for HIV with result notification	400 (estimated female sex worker population as of 2016)	Multiple health sector partners	Age and Sex

Indicators	Numerator	Denominator	Source	Disaggregation
HIV positive pregnant women that received ART's to reduce the risk of MTC transmission	HIV positive women who delivered in past 12 months and received ART's to reduce risk of MTCT	number of HIV positive pregnant women who delivered in past 12 months	STI Surveillance, NHS	Specify WHO Option A, Option B, or Nevirapine
People Receiving treatment for STI's				
HIV and STI treatment of ANC women's partners	number of women attending ANC whose male partners were tested positive for HIV or any STI already knew they were positive, and received treatment	None	STI Surveillance Data and Screening Outreach records	Age and Sex
Consumption of stock of Azithromycin for Chlamydia infections	Number of doses of Azithromycin consumed by patients for Chlamydia (both presumptive treatment and physician ordered)	Amount of Azithromycin reported at the beginning of the reporting year	Pharmaceutical warehouse	None
Presumptive treatment for Chlamydia coverage	Number of ANC women and their partners registered as receiving presumptive treatment	Estimated ANC population	M&E audits of health centres	Age and Sex
Percent of infants starting prophylaxis at birth	number of HIV exposed infants born in the last 12 months who started ART prophylaxis at birth	number of HIV positive women who delivered in the past 12 months	NHS, STI clinic	None
Percent of HIV exposed infants starting CTX within 2 months of birth	number of HIV exposed infants born in the last 12 months who started CTX prophylaxis within 2 months of birth	number of HIV positive women who delivered in the past 12 months	NHS	None

Indicators	Numerator	Denominator	Source	Disaggregation
Percent of PLWHIV receiving ART treatment	number of adults and children receiving ART at the end of the reporting period	estimated number of adults and children living with HIV	STI Clinic, PLWHIV register	Age, Sex, key population group
Percent of cases of co-infection on effective combined therapy				
Proportion of HIV-TB infection persons currently on treatment	number of HIV/TB co infected people who receive treatment with ART's and antibiotic regimens for TB during reporting period	number of people diagnosed with HIV/TB co infection enrolled in HIV care during the reporting period	STI Clinic, PLWHIV register	Age, Sex, key population group
Proportion of HIV-HBV co infected persons currently on combined treatment	number of HIV/HBV co infected people who receive treatment with ART's effective for both viruses during reporting period	number of people diagnosed with HBV/HIV co infection enrolled in HIV care during the reporting period	STI Surveillance	Age and Sex
Proportion of persons diagnosed with HIV-HCV infection started on HCV treatment during past 12 months	number of people diagnosed with HIV/HCV started treatment for infection in the last 12 months	number of people diagnosed with HCV/HIV co infection in the last 12 months	STI Surveillance	Age, Sex and key population group

Indicators	Numerator	Denominator	Source	Disaggregation
Retention of ART Therapy	number of adults and children who are still alive and on ART after starting in the previous year	number of adults and children initiating ART in reporting year including those who have died since starting ART, those who have stopped, and those recorded as loss to follow up at month 12	STI Clinic, PLWHIV register	Age and Sex
Treatment success rate of MDR-TB: Percentage of bacteriologically confirmed drug resistant TB cases (RR-TB and/or MDR-TB) successfully treated	Number of bacteriologically MDR TB confirmed cases treated in the current and previous year	Number of MDR TB cases in the register of the previous reporting year	STI Clinic, TB register	Age, Sex, HIV Status
Proportion of detected rifampicin resistant TB cases (RR-TB) and MDR-TB cases that start treatment within four weeks of diagnosis	# of RR-TB or other MDR-TB commenced on treatment within four weeks of diagnosis	Total number of RR-TB or MDR TB in Tb Registering this reporting period	STI Clinic, TB register	None
Percent of infants tested for HIV within 2 months of birth	Number of infants who received an HIV test within two months of birth during reporting period	number of HIV positive pregnant women who delivered in past 12 months	STI Surveillance	None

Indicators	Numerator	Denominator	Source	Disaggregation
Proportion of previously treated TB patients receiving DST (bacteriologically positive cases only)	Number of previously treated TB cases with DST result for both isoniazid and rifampicin during the period of assessment	Total number of bacteriologically positive previously treated TB patients identified during the period of assessment.	STI Clinic, TB register	None
Percent of PLWHIV tested for TB vs. Percent of TB cases tested for HIV				
Co-management of HIV and TB treatment	number of people who are HIV positive and receiving ART that were tested for TB	Number of people receiving ART	STI Clinic, PLWHIV register	Age and Sex
Percentage of TB patients who had an HIV test result recorded in the TB register	Reported number of cases that had a TB test	Number of TB bases within the register	STI Clinic, TB register	Age and Sex
Number of external and internal QA audits with NHS participation	Number of QA exercises conducted within the reporting year	None	NHS Lab	Type of audit
Number of legal reviews and position papers advocating for legal advancements of PLWHIV	Number of review processes, consultations, position papers, or press briefings to advance the rights of PLWHIV	None	MoH Legal Advisor, NGO's, and HIV/STI programme staff	None

Indicators	Numerator	Denominator	Source	Disaggregation
Community advocacy for legal issues regarding discrimination sexual violence, sexual health and access to HIV, STI and TB services	Number of people attending community advocacy programming involving legal issues relating to sexual violence, discrimination, sexual health, and access to HIV, STI and TB services	None	Health sector partners, NGO's	None
People reached by programming that addresses stigma and sexual health	Number of people attending events aimed at addressing stigma surrounding sexual health issues	None	Health sector partners, NGO's	None