Gender and Disability Analysis COVID-19 Samoa

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Women in Business Development Inc.
SAMOA

NUANUA O LE ALOFA INCORPORATED
National Advocacy Organisation of People with disabilities

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Abbreviations

ADB	Asian Development Bank
BNPL	Basic Needs Poverty Lines
CEDAW	Committee on the Elimination of Discrimination against Women
COVID-19	Novel coronavirus 2019
DAS	Deaf Association of Samoa
DHS	Demographic and Health Survey
DPO	Disabled people organisations
FDI	Foreign direct investment
FPL	Food poverty line
GDP	Gross Domestic Product
HEOC	Health Emergency Operations Committee
ILO	International Labor Organization
IMF	International Monetary Fund
IWDA	International Women's Development Agency
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex and asexual
MAF	Ministry of Agriculture and Fisheries
MoH	Ministry of Health
MSME	Micro, small and medium-sized Enterprises
MWCSD	Ministry of Women, Community and Social Development
NCD	Non-communicable diseases
NOLA	Nuanua O Le Alofa
NUS	National University of Samoa
PDF	Pacific Disability Forum
PICT	Pacific Island Countries and Territories
PIFS	Pacific Islands Forum Secretariat
PSHEA	Prevention of sexual harassment exploitation and abuse
RA	Rapid Assessment
RCF	Rapid Credit Facility
SME	Small and medium-sized enterprises
SROS	Scientific Research Organisation of Samoa
SVSG	Samoa Victim Support Group
UN	United Nations
UNDP	United Nations Development Program
VAWG	Violence against women and girls
WASH	Water, sanitation and hygiene
WIBDI	Women in Business Development Inc
WHO	World Health Organisation

Executive Summary

Samoa, with a unique culture and language, is comprised of two main islands, Upolu and Savai'i, and ten smaller islands – Manono, Apolima, Nu'utele, Nu'usafe'e, Nu'ulopa, Namu'a, Nu'uala, Fanuatapu, Fatuanava and Lepuia'i. Only four of these islands, Upolu, Savai'i, Manono and Apolima, are inhabited.[i] Apia, the capital of Samoa, is situated on the main island of Upolu. The urban population is 19.1 percent of the total population. The rest of the population lives mainly in the rural and outer areas of Upolu and Savai'i.[ii] The majority of the population, 62.7 percent, are aged under 30 years old.[iii]

Novel coronavirus 2019 (COVID-19), declared a global pandemic on the 11th of March 2020, is having devastating impacts globally. On 20 March 2022, community transmission was identified, and subsequent set up of community testing sites found that COVID-19 was found throughout the communities of Upolu and Savaii islands. At the finalisation of this report, Samoa has reported 11,313 community cases and 24 COVID-19 related deaths[iv].

Samoa has had preventative measures in place to limit potential transmission with State of Emergency Orders in force.[v] Measures include travel restrictions for incoming travellers, limitations on public gatherings and public transport, reduced business operating hours, limitations on access to health facilities and requirements for social distancing.[vi] In March 2020, the National Emergency Operations Centre (NEOC) was activated for Coronavirus. A 24-hour call centre was established to support the public with COVID-19 related enquiries; however, it is noted that this call centre is not accessible to persons who are Deaf and hard of hearing. The absence of community transmission of COVID-19 in Samoa until early 2022 enabled the Ministry of Health (MoH) to build health system capacity and raise awareness about prevention measures.[vii]

The community outbreak of COVID-19 presents challenges in Samoa including health services being stretched, limited specialised services and intensive care and provision of services across multiple islands with limited resources.[viii] The measles outbreak in Samoa in late-2019 showed the need for strengthened preparedness of the health system to respond to an outbreak.[ix]

Key Findings

- COVID-19 has exacerbated the economic downturn resulting from the measles outbreak due to reductions in tourism and remittances.
- Persons with disabilities are particularly vulnerable to the economic impacts of COVID-19.
- Reduced access to public spaces and services will affect access to health services and social support. Restrictions can also be manipulated by controlling and violent partners to further isolate women experiencing domestic violence.
- There is a clear disparity in access to health care for rural and remote communities as compared to urban communities.
- Overloaded and under-resourced health systems will increase the risk of exposure to COVID-19 for the health workforce, who are predominantly women.
- People with disabilities will face increased vulnerability to COVID-19 exacerbated by challenges in lack of accessible information and communication.
- There are significant challenges for persons with disabilities in accessing services and facilities including WASH facilities.
- Women will have reduced access to all VAWG response services due to COVID-19 restrictions and it is expected that as restrictions are scaled back there will be an increased demand for VAWG services as well as a backlog of cases for the police and courts to respond to.

Gender as a concept is socially-constructed given certain cultural, historical, and environmental factors. As such, it is essential to understand some of the shifts in gender in Samoa over time to begin to appreciate the idiosyncratic nuances of gender and how it is constructed in contemporary Samoa. Specifically, gender as a concept must be decolonized to appreciate how it has been recently applied to Samoa. The intersectional complexity of gender in Samoa means that it is important to understand how Samoa's context constructs gender and where this context has changed or developed over time to begin to safely position current challenges and approaches related to gender. Further understanding of the context will support more meaningful, safe, and impactful empowerment of women and girls in Samoa.

The Government of Samoa recognizes that gender equality is intrinsic to achieving goals for sustainable social and economic development, and ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) in 1992: the first Pacific Island Country to do so. The National Policy on Gender Equality and Rights of Women and Girls recognizes that women and men are equal partners in the development of Samoa.

Pervasive cultural norms and attitudes which link social roles to gender apply to the traditional system of village government, in which leadership has traditionally been perceived to be a male role. Norms are changing, with increasing numbers of Samoan women becoming *matai* or chiefs (of different levels with the one being the main matai being identified by the title they are given by their families), often in recognition of their educational and career achievements; however, the National Policy on Gender Equality and Rights of Women and Girls suggests that education and training which promotes the shifting of norms is required for both men and women from a young age.

The family unit is central to Samoan social structure and culture and it is a fundamental part of one's designation or *faasinomaga*.[x] Generally, it is accepted that the man is the head of the family.[xi] There is a sacred covenant, *va tapuia*, that governs all social relationships in Samoa. The relationship between male and female relatives is governed by the *feagaiga*, or also known as the brother and sister covenant. The *feagaiga* emphasises that within the family the brother is given the privilege of leading the family while the role of *fautua* is taken by the sister who carries the *mamalu* or dignity of the family. [xii] Given this relationship, brothers will always serve and respect their sisters. Boys will often make sacrifices to ensure the safety and support of their female relatives. At the family level, some women define their decision-making experiences as mainly to do with decisions for domestic living such as; child-rearing, budgeting etc, and while decision-making for other matters including family 'obligations' or *fa'alavelave* are done by the men, women will provide advice to support this decision-making. [xiii]

Evidence regarding the roles and participation of people with disabilities in family and community **decision-making** is limited. In 2021, NOLA conducted consultations with more than fifty members with diverse disabilities. Only 11 percent reported attending village meetings and activities. This suggests that village-based discussion and decision-making are occurring without community members with disabilities. Their priorities and requirements may be excluded as a result.

Samoa's Parliament is based on a *fa'amatai* system, the way of life in Samoan culture (fa'a Samoa) and is basically a governance system looking after the welfare and wellbeing of the extended family or *aiga* and the protection of family property especially customary land, which requires Members of Parliament to hold a *matai* title. While this requirement applies to men and women, it has a disproportionate effect on women because they are not bestowed titles of *matai* in numbers equal to that of men.[xiv] In 2013, the Samoa Parliament unanimously passed the *Constitution Amendment Act (2013)*, which introduced a 10 percent quota of women representatives into the national legislative assembly. No other pacific country has introduced minimum gender quotas.[xv] In 2021, Samoa's first female Prime Minister was sworn in, along with four other female members of parliament. People with disabilities experience limited participation in public decision-making. This is likely underpinned by persons with disabilities being less likely to attend a school or have a paid job compared to people without disabilities, resulting in under-representation in many spheres of life.[xvi] The low representation of women in health and humanitarian response mechanisms means that decisions about COVID-19 preparedness and response may be made without adequate participation of women. To date, there are currently no persons with disabilities working within government health and humanitarian response management mechanisms.

Married women aged 15–49 have much lower participation in **economic work** than married men in the same age group. Only 28 percent of these women were employed at the time of the survey compared to 70 percent of the men[xvii] with 62 percent of unpaid work completed by women. Rural women continue to be especially disadvantaged compared to urban women.[xviii] The average wage and salary received per capita per week tend to be lower for female-headed households compared to male-headed households, which reflects a higher concentration of women in low paid jobs and junior positions. [xix] Women's economic empowerment is curtailed by social norms which limit women's control over economic resources and decision-making over financial resources in the household. The economic impacts of COVID-19 restrictions in Samoa are disproportionately affecting women and girls. The unequal division of labour between women and men in the household is exacerbated in the case of a COVID-19 outbreak in Samoa with women expected to undertake more unpaid domestic work including caring for sick relatives as health care systems become increasingly burdened.

Samoa's census (2016) found that only 15 percent of people with disabilities were engaged in the labour force, whereas 85 percent were non-economically active persons or not in the labour force. Five per cent of the population with disabilities were engaged in paid work, and a further 9 per cent were engaged

in unpaid work such as working in family plantations and businesses. Most employed persons with disabilities (60.9 percent) were working in skilled agriculture, livestock and/or forestry.[xx] Although less than half of the working population with disabilities were male, they dominated the paid work (6 percent) and unpaid work (16 per cent) of the employment spectrum. The lowest proportion of people with disabilities engaged in paid work were in Savaii.[xxi]

The economic impact of COVID-19 on persons with disabilities has not been explored at a national level and is not known. A business survey by the Samoa Chamber of Commerce and Industry reported that between January and May 2020, a total of 253 men and 186 women were made redundant, and a further 211 men and 212 women were forced to take leave without pay.[xxii] The most significant declines in employment were seen in the construction sector, accommodation, personal services and transport.[xxiii] Interviews with women engaged in microenterprises reveal that more households are now growing vegetables and/or producing items for sale in local markets to replace lost income leading to increased competition from new entrants seeking income opportunities to replace lost or reduced wages.[xxiv] Women engaged in microenterprises are likely to be disproportionately impacted by COVID-19 and this could have longer-term impacts on the confidence levels of women engaged in both informal and formal business activities.[xxv]

The measles outbreak in late 2019 resulted in a much larger economic contraction than that of past natural disasters. COVID-19 has exacerbated the economic downturn which heavily depends on now-closed inbound tourism and remittances.[xxvi]

Tourism is estimated to account for up to 20-30 percent of economic activity in countries like Samoa and is a prime source of employment and foreign exchange. Tourism may remain diminished after the COVID-19 crisis subsides due to factors such as the long-term impacts of prolonged loss of revenue for regional, national and domestic airlines and the impacts on global travel. [xxvii] The collapse of the tourism industry has had direct and indirect consequences for micro, small and medium-sized Enterprises' (MSMEs), with women involved in related supply and business activities and employment in the industry bearing the brunt of the economic downturn.[xxviii]

Remittances account for 16.4 percent of Gross Domestic Product (GDP) in Samoa[xxix] with globally shrinking employment and repatriation of guest workers expected to lead to a fall in remittances of around 20 percent. [xxx] Women in Samoa are traditionally the recipients of overseas remittances, with 48 percent compared to 39 percent of male recipients.[xxxi] Financial transfers from Samoans participating in seasonal work programs are not expected to be substantially affected by COVID-19 related disruptions, but those working in the hospitality sector are likely to suffer job losses, layoffs and/or repatriation, which will impact the steady income households previously received via remittance inflows.[xxxii]

In 2018, one person out of 20 was undernourished, one person in four did not have access to safe and nutritious food, and about one person in 40 was exposed to severe levels of **food insecurity**.[xxxiii] The agricultural sector in Samoa is integral for rural livelihoods and incomes, food security and healthy nutrition. Approximately 97 percent of all households in the country are engaged in some form of agriculture. Scarcity of food may not be an issue in rural areas but urban populations, who have lost employment and income and do not have access to gardens, may be more vulnerable to shortages of food and essential items. Fresh food availability in urban areas may also be affected by government directives on self-isolation and people choosing to protect themselves. In addition, the loss of jobs due to the closure of business is likely to cut incomes and affect purchasing power and the ability to procure food.[xxxiv] The reductions in remittances also impact food security with food being one of the main items purchased with remittances.[xxxv] In the UN Resident Coordinator Office survey, 46 percent of respondents reported that they are now eating cheaper, less nutritious food and 57 percent reported eating less food overall.[xxxvi]

Female-headed households are proportionately represented below the food poverty line (FPL) (2.9 percent of all female-headed households compared to 2.8 percent of all male-headed households) and slightly overrepresented below the Basic Needs Poverty Lines (BNPL), with 12.8 percent of all female-headed households compared to 10.1 percent of all male-headed households. As women are primarily responsible for ensuring food for the household, the workload demand on women may increase to secure food and essential items.

Samoans traditionally have rights to the use of customary land through both their paternal and maternal lineages. Women who move to live with their husband's family after marriage traditionally help their husband fulfil his role as *tama tane* in serving their *feagaiga* or sisters. Women have access to customary land, through their husbands. It is commonly recognised that women have customary property rights.[xxxvii]

When it is necessary to self-isolate or quarantine, women's and men's access to public spaces and services is affected.

A significant proportion of households report having adult members diagnosed with non-communicable diseases (NCDs), particularly diabetes and hypertension.[xxxviii] Smoking has also been identified as a possible risk factor for COVID-19 and given higher rates of smoking among men, men who smoke cigarettes are at a higher risk of complications should they contract COVID-19.[xxxix]

People with disabilities will face increased vulnerability to COVID-19 due to pre-existing medical conditions including respiratory or other health complications associated with their impairment, requiring high support from carers, personal assistants and family members, increased exposure due to the inability to adhere to all preventative measures and limited access to information on COVID-19 precautions, preparedness and response actions due to various attitudinal, communication and environmental barriers.[xl]

Many women and youth do not have **access to the information** and support that would enable them to protect their family and personal health.[xli] With a focus on responding to the COVID-19 pandemic, there is likely to be a considerable interruption to sexual and reproductive health services for women. Overloaded and under-resourced health systems will increase the risk of exposure to COVID-19 for the health workforce.[xlii] Women health care workers also face specific gendered challenges such as increased childcare responsibilities, menstrual hygiene management and, given their over-representation in low paid and casual roles, financial insecurity.[xliii]

LGBTQIA+ people suffer from higher rates of underlying health conditions than the general public, which has been shown to exacerbate the morbidity and mortality rate of those contracting COVID-19. These include, but are not limited to, diabetes and other NCDs, heart disease, cancer, respiratory problems associated with smoking, and compromised immune systems from chronic diseases like HIV. [xliv]

LGBTQIA+ people may face specific barriers to healthcare including stigma and discrimination in accessing healthcare and by healthcare workers.[xlv] LGBTQIA+ people also suffer from high rates of mental health issues, including depression and anxiety, high rates of suicidal ideation, attempts, and completions, which may be aggravated by situations of worry, stigma, family harassment, ill-health, and confinement.[xlvi] Lockdowns and isolation can have a greater impact on those identifying as LGBTQIA+ people with less access to shelter and housing, medicine and other healthcare, water and sanitation, social support services, and, in places where non-compliance to isolation policies is punishable, have less recourse against arrest, homophobic and transphobic violence, or harassment.[xlvii]

In terms of **communication and access to information**, when the COVID-19 Pandemic was announced in March 2020, State of Emergency regulations changed weekly with the quickly evolving situation. Consultations conducted by the Deaf Association of Samoa found that deaf members with low literacy were struggling to keep up with the press releases about new orders. In May 2020, NOLA and the Deaf Association of Samoa were able to successfully advocate with the Ministry of Prime Minister and Cabinet to include a Sign Language Interpreter for the Prime Minister's national address during the COVID-19 State of Emergency. This was the first time that Sign Language Interpreting was included at the national level during a humanitarian emergency.

During a focus group discussion that was hosted by Samoa Blind Persons Association in October 2020, persons who are blind and visually impaired identified that information specifically pertaining to persons with disabilities had not been disseminated from Samoa's Ministry of Health. Focus group participants spoke of the need for information on how to navigate social distancing for those who require a support person and information on how to extend sanitization protocols to mobility devices.

Throughout a research effort conducted by NOLA throughout Upolu, Savaii and Manono, 39 percent of over 1,000 members reported that they had never been taught to read and write, making the development of simple, easy-to-read resources on COVID-19 preparedness, prevention and response essential to ensuring no one is left behind during the Pandemic.

With COVID-19 posing additional stresses on **hygiene practice**, lack of mobility due to self-isolation and quarantine as well as the reduction in income, women and girls' ability to access menstrual hygiene management materials may be affected.[xlviii]

Challenges associated with **menstrual hygiene management** are exacerbated for women and girls with disabilities which will likely be further exacerbated by COVID-19. Women and girls with intellectual disabilities have been found to sometimes lack understanding or acceptance of menstrual hygiene management, while women and girls with physical disabilities experience difficulties related to

discomfort, positioning of the product, concerns about leakage due to sitting for an extended time, and the added difficulties of managing assistive products such as catheters.[xlix]

Sixty percent of women who have ever been in a relationship report experiencing some form of **domestic abuse** [l] and 64.7 percent of women reported having been abused by someone other than a partner. 53.7 percent of women who reported being physically abused had never told anyone about the abuse. Samoan children experience various forms of violence, abuse, neglect and exploitation in several contexts, including within the home, in schools and in the community.[li] Reductions in income and employment related to COVID-19 may provide opportunities to sexually exploit particular groups, such as women, children, single women, widows, adolescent girls, sex workers, lesbian, gay, bisexual, transgender, queer and intersex (LGBTQIA+) populations, and people with disabilities. With the imposition of the State of Emergency on 22 March 2020, case management data from Samoa Victim Support Group shows that between March and May, cases of domestic violence reported to the service increased by 48 per cent in comparison to the same months in 2019.[lii]

The Deaf Association of Samoa (DAS) reported in COVID-19 outreach efforts that persons who are deaf and hard of hearing reported experiencing severe violence and discrimination. In interviews conducted for this report, DAS reported that over 80 percent of COVID-19 program participants reported experiencing severe physical violence from a family member. A number of members throughout Upolu and Savaii were taken to hospital from injuries sustained from physical violence during the pandemic.

Key Recommendations

The following actions are recommended for stakeholders to inform humanitarian programming in Samoa to ensure it responds to the specific needs of women, men, girls, boys and persons with disabilities:

Recommendation 1. Increase engagement and investment in collaboration with local leaders to ensure response efforts are conducted in line with the *fa'a Samoa* and work in partnership with cultural mechanisms, particularly relating to understanding the concept of gender.

Recommendation 2. Ensure the meaningful engagement of women, including women with disabilities, in all COVID-19 decision-making on preparedness and response at the national, district and village levels.

Recommendation 3. Collect sex, age and disability disaggregated data, and if possible, data on people of diverse LGBTQIA+, on economic impacts, food security, care burden, accessibility of services/facilities and violence against women and girls (VAWG).

Recommendation 4. Ensure that any interventions relating to COVID-19 preparedness and response prioritise a mainstreamed approach to gender equality by working with both male and female heads of households and encouraging family-wide inclusion.

Recommendation 5. Continue COVID-19 preparedness communication and awareness ensuring:

- Engagement of women, men and persons with disabilities in the development, design and delivery of materials.
- Dissemination of information to male and female heads of household and persons with disabilities.
- Engagement with Organisations for Persons with Disabilities (OPDs in the development of materials to ensure accessibility and inclusivity of message.

Recommendation 6. Include men, women, people with disabilities and other marginalised groups as leaders in COVID-19 preparedness and response activities to ensure outreach to all members of the community.

Recommendation 7. Ensure that any intervention to increase income and employment is approached at an inclusive, household level in order to integrate the elimination of VAWG to mitigate the risks of VAWG.

Recommendation 8. Provide resources to support survivors of VAWG engaged in CARE activities to access VAWG services.

Recommendation 9. Work with VAWG services to be inclusive and accessible to persons with disabilities and prioritise a human rights-based approach.

Recommendation 10. Ensure child safeguarding and prevention of sexual harassment, exploitation and abuse (PSHEA) policies are in place with inductions provided for all implementing partners engaged in COVID-19 preparedness and response.

Introduction

COVID-19 and Samoa

First detected in China's Hubei Province in late December 2019, COVID-19 was declared a global pandemic on 11th March 2020. Globally, as of 13 May 2022, there have been 517,6481631 confirmed cases of COVID-19, including 6,261,708 deaths, reported to WHO. As of 13 May 2022, a total of 711,655,423 vaccine doses have been administered.[liii]

In Samoa, from January 2020 to December 2021, there had only been 1 confirmed case of COVID-19 with no deaths. However, in January 2022, 22 passengers from a repatriation flight from Australia tested positive for COVID-19 whilst in quarantine. An additional 5 nurses contracted the virus. On 20 March 2022, community transmission was identified, and subsequent set up of community testing sites found that COVID-19 was found throughout the communities of Upolu and Savaii islands. At the finalisation of this report, Samoa has reported 11,313 community cases and 24 COVID-19 related deaths[liv].

Samoa has had preventative measures in place to limit the potential transmission of COVID-19 since March 2020. State of Emergency Orders remain in force[lv] and include travel restrictions for incoming travellers, limitations on public gatherings and public transport, reduced business operating hours, limitations on access to health facilities unless seeking medical attention, and requirements for social distancing. In addition, people aged 60 and above are encouraged to remain at home, unless seeking medical attention.

In March 2020, the National Emergency Operations Centre (NEOC) was activated for Coronavirus. A 24-hour call centre was established to support the public with COVID-19 related enquiries; however, it is noted that this call centre is not accessible to persons who are Deaf and hard of hearing.

Schools reopened on the 4th of May 2020[lvi] after closing for six weeks.[lvii] This disruption affected an estimated 65,000 students (4,203 – early childhood education (ECE); 43546 – primary; 16,365 – secondary) and 2,885 teachers (423 – ECE; 1,427 – primary; 1035 – secondary).[lviii] Women teachers were further impacted by increased burden of domestic and unpaid care work. [lix] With the additional cases arriving to Samoa in January 2022, the start of the school year was again delayed[lx]. After three weeks of remote classes utilising national TV stations, school resumed on 14 February 2022 until community transmission was identified on 20 March 2022, after which schools went back into lockdown.[lxi]

COVID-19 presents a range of response challenges for Samoa's health sector. Health services are already limited due to a lack of infrastructure, equipment, qualified personnel, specialised services and intensive care, and these are easily stretched or overwhelmed, posing a problem of access to care when there is an outbreak.[lxii] Samoa also faces challenges related to service provision across multiple islands and vast distances, with limited resources.

The measles outbreak in Samoa in late-2019 identified key lessons in the case of a possible outbreak of COVID-19. Samoa was unprepared for the measles cases as a result of a staggeringly low vaccination rate.[lxiii] The measles outbreak placed enormous pressure on hospital staff and the health system.[lxiv] While there is a hospital located on Savai'i and six rural district hospitals and four health centres, most of the country's doctors were in the country's main hospital, *Tupua Tamasese Meaole*, in Apia, resulting in primary care largely being supplied by the main hospital.[lxv] In response to this, a multidisciplinary team consisting of a doctor, nurse manager, district or staff nurse, specialist public health nurse, dietitian, midwife, and environmental health inspector was sent to the district hospitals.[lxvi]

The prolonged absence of COVID-19 in Samoa enabled the Ministry of Health (MoH) to build capacity in the health system and raise awareness of prevention measures. The Health Emergency Operations Committee (HEOC) has sought to increase stock of health commodities and supplies, increase staff at community health facilities and build capacity of health surveillance needed for contact tracing, while promoting public health messaging and encouraging social distancing practices.[lxvii] The Government of Samoa has administered door-to-door vaccines as part of a mass vaccination drive, locking down the population for two days in September 2021 to maximise the delivery of first doses.[lxviii] A follow up lockdown was enforced in November 2021 to administer the second dose. After community transmission was detected in March 2022, a further push was made by the Government for vaccination roll out. In early May 2022, the Ministry of Health reported that 121,994 people 18 years and over had received the first dose of the AstraZeneca COVID-19 vaccine[lxix], with 113,010 people within the same age group also completing their second dose. 92.7 per cent[lxx] of the eligible population are double vaccinated against COVID-19 as of 4 May 2022. 70,439 booster doses have also been administered[lxxi].

In September 2021, the Government also began offering the Pfizer Vaccine for children aged 12 – 18 years of age. After community transmission was identified in March 2022, a greater push for child vaccinations was initiated. Vaccination sites were set up throughout Upolu and Savaii. For children aged 12 – 17 years, 87.2 per cent are double vaccinated[lxxii] and 61 per cent of children aged 5 – 11 have received their second dose[lxxiii].

Gender and Disability Analysis Objectives and Methodology

This Gender and Disability Analysis has the following objectives:

- To analyse and understand the different impacts that COVID-19 may have on women, men, girls and boys with and without disabilities, and other vulnerable groups in Samoa.
- To inform humanitarian programming in Samoa based on the different needs of women, men, boys and girls with and without disabilities, with a particular focus on women's economic empowerment and livelihoods.

Secondary data from existing gender and disability data analysis and the most recent COVID-19 data was used to develop this analysis.

Nuanua O Le Alofa (NOLA) conducted key informant interviews, focus groups and surveys with members of the disability community to further understand the impacts of COVID-19 on their lives. Further, members of leadership from NOLA and WIBDI were heavily involved for the entire development of this document.

Demographic Profile – Samoa

Samoa, with a unique culture and language, is comprised of two main islands, Upolu and Savai'i, and ten smaller islands – Manono, Apolima, Nu'utele, Nu'usafe'e, Nu'ulopa, Namu'a, Nu'uala, Fanuatapu, Fatuanava and Lepuia'i. Only four of these islands, Upolu, Savai'i, Manono and Apolima, are inhabited.[lxxiv] Apia, the capital of Samoa, is situated on the main island of Upolu. **The urban population is 19.1 percent of the total population.** The rest of the population lives mainly in the rural and outer areas of Upolu and Savai'i.[lxxv] **The majority of the population, 62.7 percent, are aged under 30 years old.[lxxvi]**

Sex and Age Disaggregated Data[lxxvii] [lxxviii]

Total population	195,979									
Total population with disability	3,370 (2%)									
Population by sex	Female				Male					
	95,087	49%			100,892	51%				
Population by sex and disability	2.2%				1.9%					
Population by age	0-14		15-29		30-64		65+		Not Stated	
	74,616	38.1%	48,203	24.6%	63,424	32.4%	9,592	4.9%	144	0.1%

Population by location	Location	Total		Female		Male		People with disability
	Apia Urban Area	37,391	19%	18,631	49.8%	18,760	50.2%	1.5%
	North West Upolu	69,376	35%	33,672	48.5%	35,704	51.5%	1.7%
	Rest of Upolu	45,652	23%	21,878	47.9%	23,774	52.1%	2.0%
	Savai'i	43,560	22%	20,906	48.0%	22,654	52.0%	3.0%

To establish disability prevalence, the *2016 Samoa Population and Housing Census* incorporated the Washington Group Short Set which assess six core domains of functioning: seeing, hearing, mobility, memory, communication and self-care. Using the recommendations from the Washington Group, "for international comparability, people with disabilities are classified as anyone with at least one domain coded as 'a lot of difficulty' or 'cannot do it at all'", **about 2 percent of the population of Samoa aged 5 years and older were classified as experiencing disability.**[lxxix] Of these:

- 2.2 percent of women have a disability compared to 1.9 percent of men.
- 2.2 percent of the rural population has a disability compared to 1.5 percent of the urban population.
- Savai'i has the largest prevalence with 3 percent of the population having some disability compared to Apia Urban Area with 1.5 percent.
- The prevalence of disability is highest among the age group 50 years and older (7.6 percent).

When the definition of disability is expanded to include those experiencing some difficulty, an estimated 7.1 percent of the population aged five and older in Samoa is categorised as having some disability.[64]

The average life expectancy in Samoa is 74.9 years with an average life expectancy of 76 years for women and 73.7 years for men.[lxxx]

The average household size is seven people[lxxxi] and 19.5 percent of households are female-headed, with no significant variation between rural and urban areas.[lxxxii]

In the *2016 Samoa Population and Housing Census*, 93 percent of those school-aged attended school (94 percent of girls and 93 percent of boys). School attendance was nearly equal in urban and rural areas (94 percent and 93 percent, respectively). Of the 7 percent of the population who were school age who were not in school, most were living in rural areas.[lxxxiii]

Age-disaggregation indicates that literacy levels decrease with higher age.[lxxxiv] However, literacy rates are significantly higher among persons without disabilities (68.5 percent) compared with persons with disabilities (38.1 percent). Analysis by region indicated that the reading literacy rate is higher in urban area dwellers and lower in rural areas, especially Savaii, for both persons with and without disabilities.[lxxxv]

Findings and Analysis

Gender in Context

Gender as a concept is socially-constructed given certain cultural, historical, and environmental factors. As such, it is essential to understand some of the shifts in gender in Samoa over time to begin to appreciate the idiosyncratic nuances of gender and how it is constructed in contemporary Samoa. Specifically, gender as a concept must be decolonized to appreciate how it has been recently applied to Samoa.

In pre-colonial Samoa, gender functioned mostly as a secondary principle when ascribing roles, rank, responsibilities and authority.[lxxxvi] Women often rose to high political status and used marriage to ascertain rank for their children. Notably, the last paramount chief of Samoa, the Tafa'ifa holder, was a woman by the name of Salamāsina. When gender was a source of demarcation, it was along the lines of connection with Samoan Atua (gods) where women often bridged heavens/earth divides through child-rearing of Alii (high chiefs) or aitu (half-human, half-spirit entities).

With the introduction of Christianity, and the accompanying Western, colonial ideologies in Samoa, came a modification of gender. Female status was redefined and reconstructed from the Victorian British Judaeo-Christian religious teaching in the 19th century and the later colonial education system of the 20th century.[lxxxvii] This influence, for example, impacted how roles were performed in the family sphere, seeing women take on more of the domestic duties like preparing food, which was traditionally a role that young men would perform and master.[lxxxviii] The role of women has shifted as pervasive binary distinctions present in colonially constructed notions of gender, however, much of the ancestral responsibilities or *mana* have remained until today.[lxxxix]

The intersectional complexity of gender in Samoa means that it is important to understand how Samoa's context constructs gender and where this context has changed or developed over time to begin to safely position current challenges and approaches related to gender. Further understanding of the context will support more meaningful, safe, and impactful empowerment of women and girls in Samoa.

Gender Roles and Responsibilities

The Government of Samoa recognizes that gender equality is intrinsic to achieving goals for sustainable social and economic development[xc], and ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) in 1992: the first Pacific Island Country to do so. The National Policy on Gender Equality and Rights of Women and Girls recognizes that women and men are equal partners in the development of Samoa.

Despite these commitments, inequalities exist. Many children – particularly boys – are starting primary school at a later age than the compulsory minimum of five years.[xci] A review of the first Education Sector Plan (2013 – 2018) indicated that boys are over-represented in dropout rates at both primary and secondary levels, and their literacy and numeracy achievements are generally lower than that of girls.[xcii]

Samoa's 2020 Demographic Survey indicates that married women aged 15–49 have much lower participation in economic work than married men in the same age group. Only 21.6 percent of these women were employed at the time of the survey compared to 53.7 percent of the men.[xciii] Further, the

2013–14 Household Income and Expenditure Survey found that female-headed households were disproportionately represented amongst households with the lowest incomes.[xciv]

Pervasive cultural norms and attitudes which link social roles to gender apply to the traditional system of village government, in which leadership has traditionally been perceived to be a male role.[xcv] Norms are changing, with increasing numbers of Samoan women becoming matai, often in recognition of their educational and career achievements; however, the National Policy on Gender Equality and Rights of Women and Girls (2021 – 2031) suggests that education and training which promotes the shifting of norms is required for both men and women from a young age[xcvi].

Division of (Domestic) Labour

The Committee on the Elimination of Discrimination against Women expressed concerns about the "*persistence of deep-rooted discriminatory stereotypes, harmful practices and patriarchal attitudes regarding the roles and responsibilities of women and men in the family and in society*".[xcvii]

While most Samoan women fulfil a wide and varied number of roles within their families, communities and churches, these are mostly confined to the domestic sphere, including responsibility for the care of children, the sick, and elderly relatives. A Woman's status is often connected with the status of her husband. Women are relied upon to perform a function known in the *fa'asamoa* as '*pae ma auli'*, literally 'to properly lay and iron things out'.[xcviii] This function means that women play an essential role in leading decision making and running of the household that often happens in quiet, more nuanced spaces.

NOLA and WIBDI noted from outreach efforts that in Samoan culture, men take on significant responsibility in household chores, especially raising children and preparing the food in the *umu.* This division of roles mitigates some of the challenges in the division of domestic labour.

Fa'afafine, which literally means *men who act in the manner of women*, have always existed in Samoa with Samoa more advanced on the acceptance of *fa'afafine* compared to many other Pacific nations. *Fa'afafine* are known for their hard work and dedication to the family in carrying out roles and responsibilities for men and women. [xcix]

The unequal division of labour between women and men in the household is exacerbated in the case of a COVID-19 outbreak in Samoa with women expected to undertake more unpaid domestic work including caring for sick relatives as health care systems become increasingly burdened. This was evident in the measles outbreak where there was an increased dependence on women's traditional roles as primary and secondary caregivers with increased expectations to provide the care.[c] Any school closures are also likely to increase women and girls' childcare responsibilities.[ci] **It will be important that any interventions relating to COVID-19 preparedness and response not increase women's work burden which will require men to increase their contribution to unpaid labour traditionally done by women.** This need to redistribute unpaid work between women and men was also identified during the measles outbreak.[cii]

Decision-Making

Decision-Making Within the Household and Community

The family unit is central to Samoan social structure and culture and it is a fundamental part of one's designation or *faasinomaga*.[ciii] Generally, it is accepted that the man is the head of the family.[civ] There is a sacred covenant, *va tapuia*, that governs all social relationships in Samoa. The relationship between male and female relatives is governed by the *feagaiga*, or also known as the brother and sister covenant.[cv] The *feagaiga* emphasises that within the family the brother is given the privilege of leading the family while the role of *fautua* is taken by the sister who carries the *mamalu* or dignity of the family.[cvi] Given this relationship, brothers will always serve and respect their sisters. Boys will often make sacrifices to ensure the safety and support of their female relatives.[cvii] At the family level, some women define their decision-making experiences as mainly to do with decisions for domestic living such as; child-rearing, budgeting and, while the decision-making for other matters including family 'obligations' or *fa'alavelave* done by the men, women will provide advice to support this decision-making. [cviii]

During the *Demographic and Health Survey (DHS)*, when women were asked about decision-making in the family:

- 93.2 percent reported making decisions about their own health care.
- 84.3 percent reported making decisions about major household purchases.

- 90.6 percent reported making decisions about purchases for daily household needs.
- 90.2 percent reported making decisions about visits to their family or relatives.
- 76 percent reported participating in making decisions in all four decisions.
- 2.9 percent reporting not participating in making decisions in all four decisions.

There was no difference between urban and rural women. [cix]

Families within village communities are often almost all related to each other and the larger the extended family, the greater their influence on village politics.[cx] Traditionally in the village, a married woman takes her status from her husband, irrespective of the traditional rank of her own family or her educational achievements.[cxi] Within the village, women play three distinct roles that reflect their status:[cxii]

- The *aualuma,* the highest status a woman can hold, are the unmarried, divorced and widowed daughters of the village.
- The *faletua* and *tausi* are the wives of the *matai*, the highest status for married women.
- The *ava a taulelea* are the wives of the untitled men, the lowest status. The wives of untitled men are part of the *faletua ma tausi* where they will serve and support the chief's wives

Traditionally, a wife's status is much less than that of a sister, and the status of a wife who marries and moves to her husband's family (*nofotane*) is much less than a wife who stays with her family. [cxiii] This practice is very dependent on the family and is becoming less common. Generally, once a woman marries, it is part of her responsibility to serve her husbands' family and her status is lower.

The extended family system consists of several *aiga* (family units),[cxiv] which typically has one main *matai* (chief) as the head of the family.[cxv] The main *matai* is usually appointed by the consensus of the *aiga*.[cxvi] **Hardly any village-based *matai* are women with a 2015 study revealing that of the total 16,583 *matai* identified by the *sui o nuu*, only 7 percent were women[cxvii] and very few of these were women with a disability. In addition, 10 percent of villages reported that they do not bestow *matai* titles to women.** When disaggregated by hierarchy, 7 percent of *matais* bestowed a high chief title were women and 3 percent of *matais* bestowed an orator title were women.[cxviii] It was also noted that for women, it is likely that they are bestowed high chief titles as a privilege and honour for the *feagaiga* of the family. Four key themes were identified for why villages do not allow women to become *matai*: [cxix]

1. Village taboo or family rule prohibiting women from becoming *matai (there is a very small percentage of villages who practice this rule).*
2. Gender roles and responsibilities whereby men are given the privilege to become *matais* while women play the role of the *fautua*, *va tapuia* or the sacred relationship between women and men makes it inappropriate for women and men to be seated together in the village council meetings.
3. Some women prioritise their male relatives to take the role of a *matai* because it is considered a man's role.
4. Women being married into the village.

Within the village social structure, there is the village council or *fono*, which is the governance forum within the village. [cxx] When some women are bestowed a *matai* title, they can still be restricted from being members of the *fono* and taking on a full decision-making role.[cxxi] In 22 percent of villages, women do not physically attend the *fono*.[cxxii] Of the villages which allow women to sit in the *fono* meetings, only 69 percent of villages surveyed reported to have women who sit and participate in *fono*.[cxxiii] Often both men and women in the family will hold a matai title, as such, some women will not attend fono, as their husbands would already be attending. Some other reasons for why some women do not sit and participate in *fono* included informal discrimination and women being socialised to adhere to norms that see men as the sole decision-makers and that it is disrespectful for women to sit in *fono* meetings.[cxxiv]

Evidence regarding the roles and participation of people with disabilities in family and community decision-making is limited. In 2021, NOLA conducted consultations with more than fifty members with diverse disabilities. Only 11 percent reported attending village meetings and activities. This suggests that village-based discussion and decision-making are occurring without community members with disabilities. Their priorities and requirements may be excluded as a result.

Participation in Public Decision-Making

Samoa's Parliament is based on a *faamatai* system which requires Members of Parliament to hold a *matai* title. While this requirement applies to men and women, it has a disproportionate effect on women because they are not bestowed titles of *matai* in numbers equal to that of men.[cxxv]

Samoa's national legislative assembly has 51 members.[cxxvi] Since Samoa's independence in 1962, women have remained below 10 percent of parliamentarians.[cxxvii] In 2013, the Samoa Parliament unanimously passed the *Constitution Amendment Act (2013)*, that introduced a 10 percent quota of women representatives into the national legislative assembly. The system uses a "floating" five reserved seats for women. If no woman is elected during the elections, the amendment is activated and five seats are added to the assembly. This will mean a Samoan Parliament with a total of 54 seats. If one woman is elected then four seats are added and Parliament has 53 seats, and so on. When extra seats are added, they are filled by women who have already run in open constituencies with the unsuccessful women candidates who receive the highest percentage of votes in the election filling the requisite number of reserved seats.[cxxviii] **Samoa is the only Pacific country to have adopted a parliamentary minimum gender quota, with ten percent of seats reserved for women**.[cxxix]

In 2021, Samoa's first female Prime Minister was sworn in, along with four other female members of parliament. Samoa is only the second country in the Pacific to elect a woman head of state.[cxxx] Of the 12-member cabinet, 25 percent are women, including for the first time, a female Minister of Finance.[cxxxi]

People with disabilities experience limited participation in public decision-making. This is likely underpinned by persons with disabilities being less likely to attend school or have a paid job compared to people without disabilities, resulting in under-representation in many spheres of life.[cxxxii]

Participation in Decision-Making About Humanitarian Services

Priority Area 7 of the Ministry of Women, Community and Social Development's *National Policy on Gender Equality and Rights of Women and Girls 2021 – 2031* is 'Increased visibility, contribution of women and girls in agriculture, climate change, natural resources management, and disaster preparedness and response, especially those facing multiple and intersecting barriers and forms of discrimination[cxxxiii]. A commitment to ensure the collection and analysis of disaggregated data to support evidence-based disaster response, and integrating a gender transformative approach is made in the Policy. Further, the Policy prioritises the participation of women and other marginalised groups, including persons with disabilities, are included in disaster preparedness and response decision making at the community level.

The 2015 stocktake of the gender mainstreaming capacity in Samoa identified that the Ministry for Women, Community and Social Development is stretched to address the division's core mandate, to mobilise, monitor and report on donor resources, and to support their civil society partners which reduces their capacity to promote, catalyse and monitor gender mainstreaming in collaboration with other ministries.[cxxxiv]

At the village level, the government appoints liaison officers from each of the villages whose role is to oversee all developments that take place at the village level. The government liaison officers are made up of the government representatives of the Women's Councils or the *sui o tamaitai* and the government representatives from the Village Councils, formerly known as the village *pulenuu* or village mayors.[cxxxv] The responsibilities of the government liaison officers include the coordination, implementation and monitoring of health-related programs as well as educational and environmental community development initiatives. [cxxxvi] Data on the number of liaison officers who are women could not be sourced.

The low representation of women in health and humanitarian response mechanisms means that decisions about COVID-19 preparedness and response may be made without adequate participation of women.

It is essential that there is meaningful engagement of women, including women with disabilities, in all COVID-19 decision-making on preparedness and response at the national, provincial and community levels. This improves consideration of their concerns and requirements.

To date, there are currently no persons with disabilities working within government health and humanitarian response management mechanisms.

In response to the COVID-19 Pandemic, NOLA with the support of CARE and other development partners launched a Disaster Risk Reduction Unit in July 2020[cxxxvii]. The Unit works to advocate for inclusive and accessible interventions for disaster preparedness and response mechanisms at the national and community level, to ensure no one is left behind. Further, the Unit prioritises the leadership and participation of persons with disabilities within multi-level mechanisms. Since its establishment, the

Unit has now extended to have three staff members and an additional 13 disability advocates who work with government and non-government stakeholders to ensure inclusive responses to humanitarian emergencies.

Economic Empowerment

Women's Access to Economic Work

In the second half of 2021, Pacific Private Sector Development Initiative (PSDI) published a report called *Leadership Matters: Benchmarking Women in Business Leadership in the Pacific.* The report noted 43 percent of working-age Samoans are in the formal labour force and most working-age Samoans participate in the informal workforce, including subsistence.[cxxxviii] Of the formal labour force, 42 percent are women. Within public services, 57 percent are women, compared to the private sector at 39 percent.[cxxxix]

According to the Samoa Bureau of Statistics (2021) women in formal employment have a higher average annual wage than men, despite lower labour force participation[cxl].

Almost 30 percent of chief executive officer (CEO) positions are held by women and female assistant CEO positions make up 70 percent. Further, women are estimated to lead over 40 percent of Samoa's microenterprises which constitute approximately 80 percent of all businesses in the country[cxli].

A business survey by the Samoa Chamber of Commerce and Industry reported that between January and May 2020, a total of 253 men and 186 women were made redundant, and a further 211 men and 212 women were forced to take leave without pay.[cxlii] The most significant declines in employment were seen in the construction sector (decline of 5.7 percent), accommodation (decline of 5.2 percent), personal services (decline of 4.9 percent) and transport (decline of 4.2 percent).[cxliii]

In an online survey conducted by the UN Resident Coordinator Office in June 2020 which reached 286 participants, two-thirds of the households reported that their main income had declined and close to 50 percent reported at least one job loss in the household due to the pandemic-related restrictions.[cxliv] Of these reported job losses, 52 percent were in formal wage employment, 24 percent were in informal employment, 16 percent were casual irregular wage earners and 8 percent reported as 'other' income sources. Thirty percent of respondents reported less income due to international travel restrictions. Other reasons for loss of income included that: [cxlv]

- The employer closed the business or reduced hours.
- The employer had terminated the job.
- There were fewer customers due to social distancing.
- The person had quit their job.

Only 20 percent of respondents reported that they had been able to supplement this income, with 66 percent reporting uncertainty that these job losses would be recovered. 71 percent of respondents reported having trouble servicing loans.[cxlvi] In the International Labour Organization (ILO) Rapid Assessment of the impact of COVID-19 in Samoa (2020), of 352 workers surveyed, 26 percent of workers, who worked for the surveyed business, had lost jobs. Of these, the majority - 64 percent - were women. The majority of those that were still in employment were part-time and 56 percent indicated reduction in income up to 50 per cent.[cxlvii] Of businesses surveyed (119), 86 percent reported decline in income and 55 percent reported difficulty in paying wages. 45 percent of businesses indicated they were operating partially and at risk of shutting down resulting in further job losses. 61 businesses had closed. [cxlviii]

While at the time of writing there is no available data, interviews with women already engaged in microenterprises reveal that more households are now growing vegetables and/or producing items for sale in local markets to replace lost income leading to increased competition from new entrants seeking income opportunities to replace lost or reduced wages.[cxlix]

Microenterprises producing handicrafts to sell to tourists from overseas or which supply agriculture inputs to exporters are likely to experience substantially reduced sales. Women engaged in small scale livelihood activities involving sales in local marketplaces have experienced serious declines in income as a result of many market closures. [cl] **Women engaged in microenterprises are likely to be disproportionately impacted by COVID-19 and this could have longer term impacts on the confidence levels of women engaged in both informal and formal business activities. [cli]**

Women with microcredit loans are facing repayment problems as a result of decreased demand for their products/services. [clii]

Small and medium-sized enterprises (SMEs), which account for approximately 75 percent of private-sector employment, have been significantly affected by the COVID-19 pandemic, with income losses and ongoing costs (such as rent, wages of key staff and loan repayments) depleting cash flow. Although many commercial banks are offering short-term loan interest rate repayment holidays, banks will be more risk-averse in the uncertain business environment.[cliii]

The Samoa Chamber of Commerce and Industry survey with responses from 218 enterprises, mostly SMEs, found that: [cliv]

- 19 percent of businesses were unable to continue operating.
- 66 percent of businesses had reduced opening hours to cut costs and keep some staff.
- 70 percent of businesses did not expect their business to survive if COVID-19 restrictions remained in place for another one or two months.

Persons With Disabilities' Access to Economic Work

Persons with disabilities participate significantly less in economic work, compared to people without disabilities. Samoa's census (2016) found that only 15 percent of people with disabilities were engaged in the labour force, whereas 85 percent were non-economically active persons or not in the labour force. Five per cent of the population with disabilities were engaged in paid work, and a further 9 per cent were engaged in unpaid work such as working in family plantations and businesses. Most employed persons with disabilities (60.9 percent) were working in skilled agriculture, livestock and/or forestry.[clv] Although less than half of the working population with disabilities were male, they dominated the paid work (6 percent) and unpaid work (16 per cent) of the employment spectrum. The lowest proportion of people with disabilities engaged in paid work were in Savaii.[138]

The economic impact of COVID-19 on persons with disabilities has not been explored at a national level and is not known.

Women's Control of Income

Women's economic empowerment is curtailed by social norms which limit women's control over economic resources and decision-making over financial resources in the household. In the *Samoa DHS,* nine percent of women, who were employed in the past 12 months, reported that their earnings were mainly controlled by their husband. The majority of women reported that either they controlled their earnings (40 percent) or their earnings were controlled jointly with her husband (47 percent).[clvi] 89 percent of the women claimed that they decided, either mainly (37 percent) or jointly with their husband (52 percent) how their husband's earnings were used. [clvii] **Any intervention to increase women's access to income and employment should include activities to increase women's control over their income that responds to the cultural context of Samoa.**

During focus group discussions conducted by Nuanua O Le Alofa in September – October 2020, of the 50+ members with diverse disabilities interviewed, 14 percent reported they were involved in the decision making of the family income.

Any interventions relating to increasing women's access to employment and income should integrate the elimination of VAWG to mitigate the risks of VAWG related to disruptions to unequal gender roles and norms. [clviii] WIBDI noted through their work that **a family-level intervention is essential to address the pre-existing responsibilities within the family and mitigate the risks of VAWG.**

Tourism

Tourism is estimated to account for up to 20-30 percent of economic activity in countries like Samoa and is a prime source of employment and foreign exchange. Tourism may remain diminished after the COVID-19 crisis subsides due to factors such as the long-term impacts of prolonged loss of revenue for regional, national and domestic airlines and the impacts on global travel.[clix] **The collapse of the tourism industry has had direct and indirect consequences for MSMEs, with women involved in related supply and business activities and employment in the industry bearing the brunt of the economic downturn.[clx]**

Remittances

Remittances account for 16.4 percent of GDP in Samoa[clxi] with globally, shrinking employment and repatriation of guest workers expected to lead to a fall in remittances of around 20 percent. [clxii] In March 2020, private remittances dropped by WST $8.3million to WST $46.3 million compared to WST $54.62 million in March 2019.[clxiii] In April 2020, remittance inflow was WST $36.74 million from WST $40.25 million in April 2019.[clxiv] Repatriation of migrant workers from Australia and New Zealand poses an additional burden on Samoa's labour market with the declining remittances severely affecting the local demand and crowding out small businesses.[clxv]

Women in Samoa are traditionally the recipients of overseas remittances, 48 percent compared to 39 percent of male recipients, including from family members undertaking contract work in countries such as New Zealand, Australia and the United States.[clxvi] Over a six-month employment period, the average Pacific seasonal worker is remitting approximately A$2,200 while in Australia and transferring A$6,650 in savings home at the end of their stay. [clxvii]

Proportionally, women's representation in the seasonal work programs remains low (14.4 percent). Female workers are earning slightly less than men, but remitting more and saving less. This is despite them having a higher mean level of education than male workers.[clxviii]

Control of and Access to Resources and Services

Food and Essential Items

In 2018, one person out of 20 was undernourished, one person in four did not have access to safe and nutritious food and about one person in 40 was exposed to severe levels of food insecurity.[clxix]

13 food products contribute to 80 percent of the total dietary energy consumed. Four of the products: coconut brown (18 percent), rice (11 percent), taro (9 percent) and chicken quarters (8 percent) contribute 46 percent of the total energy consumed.[clxx]

On average, a Samoan spends WST $5.4 a day to purchase food, which corresponds to 45 percent of their total expenditure. Purchases account for 62 percent of the dietary energy consumed, and 30 percent comes from their own production. More than 90 percent of the caloric intake comes from sweets, sugar, cereals, meat and fish that are purchased, while from their own production, three-quarters of the calories are from tubers, plantains, nuts and fruits. Cereals such as rice or flour, or foods such as oils and sugar are very cheap sources of dietary energy, as it costs less than WST $1 to get 1,000 kcal from these products. To get the same amount of dietary energy from fish, milk or other dairy products would cost more than WST $5. [clxxi] In Apia, 20 food products contribute to 80 percent of the dietary energy consumed. This number falls to ten products in Savai'i. Coconut, taro, pastry of all kinds and rice represent half of the calories consumed in Savai'i, while rice, chicken, coconut, pastry, sugar and bread represent 50 percent in Apia.[clxxii]

The Samoan diet is rich in fats that, on average, contribute 34 percent of the total amount of energy consumed, which is very close to the upper limit of the World Health Organisation (WHO) recommended norms for a balanced diet. Proteins, on average, contribute 11 percent and carbohydrates to 55 percent, both of which are close to the lower limit of the WHO recommended norms.[clxxiii] There are a high number of deaths caused by NCDs in Samoa. Access to enough dietary energy is not an issue in Samoa, as health problems are mainly the consequence of the quality of the dietary energy that is being consumed, rather than the quantity. [clxxiv]

Savai'i is the region with the highest prevalence of food insecurity in Samoa, with more than one in three households being food insecure in comparison to less than one in five households in Apia.

In the UN Resident Coordinator Office survey, of the 286 responses, 46 percent reported that they are eating cheaper, less nutritious food and 57 percent reported eating less food overall in the wake of the COVID-19 pandemic.[clxxv]

Female-headed households are proportionately represented below the food poverty line (FPL) (2.9 percent of all female-headed households compared to 2.8 percent of all male-headed households) and slightly overrepresented below the Basic Needs Poverty Lines (BNPL), with 12.8 percent of all female-headed households compared to 10.1 percent of all male-headed households.[clxxvi]

The agricultural sector in Samoa is integral for rural livelihoods and incomes, food security and healthy nutrition. Approximately 97 percent of all households in the country are engaged in some form of

agriculture. Of those, 19 percent have agriculture as their main source of income.[clxxvii] Scarcity of food may not be an issue in rural areas but urban populations, who have lost employment and income and do not have access to gardens, may be more vulnerable to shortages of food and essential items. Fresh food availability in urban areas may also be affected by government directives on self-isolation and people choosing to protect themselves. In addition, the loss of jobs due to the closure of business is likely to cut incomes and affect purchasing power and the ability to procure food.[clxxviii] The reductions in remittances also impact food security with food being one of the main items purchased with remittances.[clxxix] **As most women are primarily responsible for ensuring food for the household, the workload demand on women may increase to secure food and essential items.**

The severe decline in tourism in Samoa accompanied by the closure of restaurants and the restrictions imposed on public gatherings including weddings, church-related events and other community engagements significantly lowered the demand for food. Local farmers have faced challenges linking with markets due to limited market hours. Sunday closures and fishing boat restrictions have negatively affected the availability of fresh fish.[clxxx]

Women farmers face greater constraints than men in accessing productive resources, services, technologies, markets, financial assets and local institutions, which makes them more vulnerable to the socio-economic effects of COVID-19. **Policy responses should consider women's roles in agri-food systems and ensure that their multiple needs – as guardians of household food security, food producers, farm managers, processors, traders, wage workers and entrepreneurs – are adequately addressed. [clxxxi] Additionally, policy responses should consider organisations working directly with women and their families to support further economic development in agriculture, especially through value addition along the supply chain.**

To support food security and increase local food production. WST $3.5million has been allocated to the Ministry of Agriculture and Fisheries (MAF), under the COVID-19 economic stimulus package. WST $1million or was allocated to increase local food production. MAF had purchased seeds of fruits, vegetables and other short cycle crops and were distributed to farmers and families, including in town areas. MAF in partnerships with the Ministry of Women, Community and Social Development also distributed planting materials such as cassava, sweet potato and taro to increase food production in the local communities.[clxxxii] The government has also encouraged farmers to not overharvest, to reduce postharvest losses, and to avoid flooding local food markets. [clxxxiii]

Under the economic stimulus package, WST 2.5million were allocated to the SROS. With the allocated amount, equipment and consumables will be purchased. To substitute imports, SROS will produce and commercialise some local value-added agriculture products such as breadfruit flour, coconut oil, avocado margarine and others. [clxxxiv]

Approximately 97 percent of all households in the country are engaged in some form of agriculture with only 19 percent having agriculture as their main source of income.[clxxxv] However, the share of own food production in total per capita food expenditure, is gradually and steadily declining. In 2013-14 own food production averaged around 26 percent in total per capita food expenditure at the national level, down from 28 percent and 30 percent in 2008 and 2002, respectively.[clxxxvi]

In a Impact of COVID-19 Rapid Assessment (RA) in Fiji and Samoa conducted in 2020 by the International Labour Organization (ILO) in Samoa, of 210 households surveyed, the majority of the households reported that they would go back to farming and fishing. [clxxxvii]

Land/House Ownership

In the *2016 Samoa Population and Housing Census*, 64 percent of private households were reported to be living on customary land and 28 percent on their own freehold land, while the remainder living on other types of land tenure arrangements. The majority of the urban households lived on freehold land while the majority of rural households lived on customary land.[clxxxviii] **93.6 percent of households reported owning the house that they reside in,** 2.3 percent were renting, 1.9 percent were living in housing provided with their employment and 0.7 percent had a mortgage. [clxxxix] House ownership data is not disaggregated by female-headed households.

Samoans traditionally have rights to the use of customary land through both their paternal and maternal lineages. **Women who move to live with their husband's family after marriage traditionally help their husband fulfil his role as *tama tane* in serving their *feagaiga* or sisters. Women have access to customary land, through their husbands. It is commonly recognised that women have customary property rights**.[cxc]

Most people in Samoa do not have individual rights to property, which is generally shared by a family unit. While land has traditionally been in the custody of the highest-ranking *matai*, a number of factors related to modern life are contributing to a change including the decline in *matai* authority over land, the splitting of chiefly titles and the differing interests of Samoans living in villages and those living abroad. Today, portions of customary land that families live on and cultivate are recognised as their own family property. Customary land can be leased with the consent of all those who have rights to it and it is the responsibility of the *matai* who has authority over the land to obtain this consent. [cxci]

Mobility

When it is necessary to self-isolate or quarantine, women's and men's access to public spaces and services is affected. State of Emergency Orders include limitations on public gatherings and public transport, reduced business operating hours, limitations on access to health facilities unless seeking medical attention and requirements for social distancing.[cxcii] In addition, people aged 60 and above are being encouraged to remain at home, unless seeking medical attention at any health facility.[cxciii] **Reduced access to public spaces and services affect women and men in terms of access to health services and social support from friends and family.** Restrictions exacerbate any existing isolation for people with disabilities and the elderly.

Health Services

According to the *2014 Samoa DHS,* **a significant proportion of households surveyed reported having adult members diagnosed with NCDs, particularly diabetes (19 percent) and hypertension (23 percent).[cxciv]**

Smoking of cigarettes and pipes and the use of other tobacco products is relatively widespread, with men aged 25–49 years more likely to smoke cigarettes compared to women (36 percent and 12 percent, respectively).[cxcv] **Smoking has also been identified as a possible risk factor for COVID-19, men and women who smoke cigarettes are at a higher risk of complications should they contract COVID-19.**

Alcohol consumption is higher among men (44 percent) compared to women (9 percent). Alcohol consumption was higher for both women and men living in urban areas (19 percent and 58 percent, respectively) compared to rural women and men (5.5 percent and 40.4 percent, respectively).[cxcvi]

98 percent of pregnant urban women and 92.3 percent of pregnant rural women have received antenatal care during their last pregnancy from a skilled medical provider such as a doctor, nurse or midwife. Women from the lowest wealth quintiles are less likely to receive skilled antenatal care compared to women in the highest wealth quintile (89.1 percent compared to 98.2 percent). **The majority of urban and rural women deliver in a health facility (96.6 percent and 78.5 percent, respectively). The likelihood for a woman to deliver in a health facility decreases with her age, number of previous deliveries, lower education and lower wealth quintiles**.[cxcvii]

Both rural and urban women have indicated the same concerns in accessing health care when having serious health problems including that they are concerned that no drugs will be available (77 percent of both urban and rural women) and that no healthcare provider will be available (74.8 percent of urban and 73.5 percent of rural women). **About a quarter of both urban (24.9 percent) and rural (23.7 percent) women indicated that they need permission from a family member to go for a health treatment, and this was more pronounced for young women aged 15–19 years (31.5 percent).[cxcviii]**

The *State of Human Rights Report* reported that only 25 percent of respondents found health care affordable and 32 percent of respondents could access their nearest medical facility in less than 30 minutes, with the focus groups and village consultations in Savaii, Manono and Apolima indicating clear accessibility challenges, as many are required to travel for hours to receive medical attention. The lack of ambulatory care and emergency response was also highlighted. **There is also a clear disparity in access to health care for rural and remote communities compared to urban communities.[cxcix]**

The *State of Human Rights Report* also identified challenges around the quality of health services, such as complaints which are a direct result of the lack of doctors, lack of training for medical personnel, lack of proper equipment to treat and diagnose and the poor bedside manner of health personnel.[cc]

Many rural areas continue to heavily rely on traditional approaches to medicine,[cci] which may be because of issues in access to Western biomedical health services or due to varying levels of health literacy. This reliance was evident in the measles outbreak where some parents also first took their children to traditional healers.[ccii] **Trust in and reliance on traditional medicine may complicate**

timely access to health systems during the pandemic due to the practice of seeking traditional or alternative medicine prior to accessing the formal health system.[cciii]

Many women and youth do not have access to the information and support that would enable them to protect their family and personal health.[cciv]

With a focus on responding to the COVID-19 pandemic, there is likely to be a considerable interruption to sexual and reproductive health services for women. Evidence from past epidemics, such as Ebola and Zika, indicate that efforts to contain outbreaks often divert resources from routine health services including pre-and post-natal health care and contraceptives, and exacerbate often already limited access to sexual and reproductive health services.[ccv]

In the Western Pacific, 41 percent of physicians are women whereas 81 percent of nurses are women.[ccvi] **Overloaded and under-resourced health systems will increase the risk of exposure to COVID-19 for the health workforce.[ccvii] Women health care workers also face specific gendered challenges such as increased childcare responsibilities, menstrual hygiene management and, given their over-representation in low paid and casual roles, financial insecurity.[ccviii]** Additionally, in other countries, there have been reports of harassment, abuse and violence directed toward healthcare workers. Research before the pandemic found that most harassment, abuse and violence are targeted at women healthcare workers in emergency departments.[ccix]

People with disabilities face increased vulnerability to COVID-19. This is due to pre-existing medical conditions including respiratory or other health complications associated with their impairment requiring high support from carers, personal assistants and family members. Vulnerability is exacerbated by increased exposure due inability to adhere to all preventative measures, and limited access to information on COVID-19 precautions, preparedness and response actions due to various attitudinal, communication and environmental barriers.[ccx]

In addition, people with disabilities may: [ccxi]

- Experience increased social isolation as a result of preventative measures and restrictions.
- Experience increased barriers to access health services due to demands on the health services related to COVID-19.
- Experience discrimination and negligence by healthcare workers.
- Be discriminated against, isolated and abandoned by carers, personal assistants and family members when displaying signs of COVID-19 symptoms.

Globally, people with disabilities have been disproportionately affected by COVID-19 because of the increased risk of poor outcomes from the disease itself, and reduced access to routine health care and rehabilitation. People with disabilities face many barriers to inclusion in the COVID-19 response. Lockdown measures can result in exclusion, and limit access to regular health and rehabilitation services. When assistive technology is not prescribed, maintained or repaired, people with disabilities become dependent on those around them and are unable to move around independently.[ccxii]

In several countries around the world including the United States of America, people with disabilities experience barriers to receiving COVID-19 vaccines, including inaccessible vaccination sites, and are less likely to receive vaccines.[ccxiii] **Data regarding the vaccination rates of people with disabilities in Samoa is not publicly available, and particular efforts to deliver vaccines to people with disabilities have not been made.**

LGBTQIA+ Populations

LGBTQIA+ people suffer from higher rates of underlying health conditions than the general public, which has been shown to exacerbate the morbidity and mortality rate of those contracting COVID-19. These include, but are not limited to, diabetes and other NCDs, heart disease, cancer, respiratory problems associated with smoking, and compromised immune systems from chronic diseases like HIV.[ccxiv] **LGBTQIA+ people may face specific barriers to healthcare including stigma and discrimination in accessing healthcare and by healthcare workers.** [ccxv] LGBTQIA+ people also suffer from high rates of mental health issues, including depression and anxiety, high rates of suicidal ideation, attempts, and completions, which may be aggravated by situations of worry, stigma, family harassment, ill-health, and confinement.[ccxvi]

Lockdowns and isolation can have a greater impact on those identifying as **LGBTQIA+ people** with less access to shelter and housing, medicine and other healthcare, water and sanitation, social support

services, and, in places where non-compliance to isolation policies is punishable, have less recourse against arrest, homophobic and transphobic violence, or harassment. [ccxvii]

Access to Information

During Women in Business Development Inc's (WIBDI's) COVID-19 outreach efforts, they found that women are often well represented in training and discussions. The women then took this information home and shared it in family meetings that are commonplace in many Samoan households. This practice ensures that all members of the household receive essential information and communication. **It is important that COVID-19 preparedness communication and awareness:**

- Engages women in the development, design and delivery of materials.
- Reaches women directly in ways that are accessible to them.
- Engages with the OPD in the development of materials to ensure accessibility of messages for specific kinds of disabilities.
- Includes images and messages to promote men increasing non-traditional care and domestic roles.

Preparedness and response activities should include women, people with disabilities and other marginalised groups as facilitators in COVID-19 preparedness and response activities to ensure outreach to all members of the community.

In the *2016 Samoa Population and Housing Census*, 90 percent of households had Digicel mobile phones and 31 percent of households had Bluesky mobile phones but there are no further details about who had access and control of these phones.[ccxviii]

When the COVID-19 Pandemic was announced in March 2020, State of Emergency regulations changed weekly with the quickly evolving situation. **Consultations conducted by the Deaf Association of Samoa, found that deaf members with low literacy were struggling to keep up with the press releases about new orders.**

In May 2020, NOLA and the Deaf Association of Samoa were able to successfully advocate with the Ministry of Prime Minister and Cabinet to include a Sign Language Interpreter for the Prime Minister's national address during the COVID-19 State of Emergency. This was the first time that Sign Language Interpreting was included at the national level during a humanitarian emergency.

Ongoing negotiation has continued between government and non-government partners to ensure the continuation of the provision of sign language translation throughout the prolonged state of emergency. There is a continued need to advocate for the national level support of disability-led interventions. Deaf advocates from the Deaf Association of Samoa have raised concerns about the challenges still faced for national recognition of deaf ownership of Samoan Sign Language, and the inconsistent quality of sign language translation by providers who do not work under the guidance of the Deaf Association of Samoa and thus are self-regulated.

During a focus group discussion that was hosted by Samoa Blind Persons Association in October 2020, persons who are blind and visually impaired identified that information specifically pertaining to persons with disabilities had not been disseminated from Samoa's Ministry of Health. Focus group participants spoke of the need for information on how to navigate social distancing for those who require a support person and information on how to extend sanitization protocols to mobility devices.

Throughout a research effort conducted by NOLA throughout Upolu, Savaii and Manono, 39 percent of over 1,000 members reported that they had never been taught to read and write, making the development of simple, easy-to-read resources on COVID-19 preparedness, prevention and response essential to ensuring no one is left behind during the Pandemic.

Access to WASH Services

According to the *2014 Samoa DHS*, **95 percent of households obtain drinking water from an improved source.** 78 percent had access to piped water in their dwelling, yard, or plot, and only 1 percent accessed water from a public tap. 7 percent used rainwater for drinking while 9 percent took bottled water. About 1 percent of households used non-improved sources of drinking water such as an unprotected dug well, unprotected spring, or surface water.[ccxix]

Almost all households (97 percent) had water on their premises (98 percent in urban and 96 percent in rural areas). 2 percent of all households collected water elsewhere spending less than half an hour doing so and another 1 percent spent more than half an hour to do the same. Drinking water is collected more frequently by men (2 percent) than by other household members (less than 1 percent).[ccxx]

Overall, 95 percent of households used improved sanitation facilities that were not shared with another household. Nearly all sanitation facilities were flush type connected to either septic tank (87 percent) or pit latrine (7 percent). The proportion of rural households with improved sanitation facilities was slightly higher than that of urban households (96 percent compared to 94 percent); however, more of the rural households connect their toilet to a pit latrine rather than to a septic tank. [ccxxi]

In conducting assessments on access to water and sanitation throughout the COVID-19 distribution, **NOLA found that while only 2 percent of members did not have access to water, 25 percent of the 700+ persons with disabilities who were visited throughout Upolu and Manono were identified to have handwashing stations that were inaccessible to them.**

However, a recent water quality research undertaken jointly by the Ministry of Natural Resources and Environment and the National University of Samoa (NUS) in partnership with New York University and New York University of Abu Dhabi identified major problems in the quality of the freshwater streams, mangrove swamps and the seawater in Samoa, some caused by human activity such as poor waste management and inadequate fishing and diving practices.[ccxxii]

Menstrual Hygiene Management (MHM)

In the Pacific, adolescent girls and women face multiple challenges in managing menstruation effectively and with dignity. Challenges include non-functioning toilets and showers, poorly maintained facilities lacking in privacy, toilet paper, safe disposal options, soap and water. Inadequate WASH facilities contribute to unhygienic practices or extended delays in changing materials.[ccxxiii] **With COVID-19 posing additional stresses on hygiene practice, lack of mobility due to self-isolation and quarantine as well as the reduction in income, women and girls' ability to access menstrual hygiene management materials may be affected.[ccxxiv]**

Challenges associated with menstrual hygiene management are exacerbated for women and girls with disabilities which will likely be further exacerbated by COVID-19. Women and girls with intellectual disabilities have been found to sometimes lack understanding or acceptance of menstrual hygiene management, while women and girls with physical disabilities experience difficulties related to discomfort, positioning of the product, concerns about leakage due to sitting for an extended time, and the added difficulties of managing assistive products such as catheters.[ccxxv]

Brown Girl Woke, a local NGO, has worked to establish a social enterprise to make reusable menstrual hygiene products to alleviate period poverty exacerbated by the Pandemic. In partnership with NOLA, locally made products have been tested and amended to be accessible to women and girls with disabilities. These products have been included in NOLA's COVID-19 response distributions, to be distributed to women and girls with disabilities throughout Upolu, Savaii and Manono islands.

Protection

VAWG

The *Samoa Demographic and Health – Multiple Indicator Cluster Survey 2019-20* found that 50.5 percent of women aged between 15–49 years had experienced physical violence since the age of 15 by any perpetrator. Amongst women with disabilities, this number increased to 57.2 percent[ccxxvi]. 11.3 percent reported experiencing emotional violence since age 15[ccxxvii]. 51.5 percent never sought help and never told anyone about the abuse.[ccxxviii]

26.2 percent of ever-married women between the age of 15–49 reported ever experiencing physical violence from a partner, with 17.9 percent experienced physical violence from a partner in the 12 months preceding the survey[ccxxix]. 17.9 percent had ever experienced sexual violence, with 15.5 percent experiencing sexual violence from a partner in the 12 months preceding the survey[ccxxx].

With the imposition of the State of Emergency on 22 March 2020, case management data from Samoa Victim Support Group shows that between March and May, cases of domestic violence reported to the service increased by 48 per cent in comparison to the same months in 2019.[ccxxxi]

64.7 percent of women reported having been abused by someone other than a partner. 61.8 percent reported physically abused, 10.6 percent reported being forced to have sex and 1.9 percent reported being touched sexually or being made to do something sexual that they did not want to do.[ccxxxii] Where women reported being abused by someone other than a partner, the perpetrator was still identified as someone being known to them, such as a family member, teacher, friend or religious leader, in the majority of cases.[ccxxxiii]

The *National Public Inquiry into Family Violence in Samoa* reported that violence against specific groups such as people with disabilities, the elderly, ***fa'afafine*** and LGBTQIA+ people are poorly understood. Anecdotal evidence suggests that rates may be high. [ccxxxiv]

The *National Public Inquiry into Family Violence in Samoa* reported that the economic cost of family violence is likely to be at least ST $98-132m per year (6–7 percent of Samoa's GDP). [ccxxxv]

Studies show that women and girls with disabilities are two to three times more likely to be victims of physical and sexual abuse than women with no disabilities[ccxxxvi]. Women and girls with disabilities experience physical and sexual violence by partners, family members, caregivers and strangers or acquaintances. Women and girls with disabilities also experience different forms of violence from women without disabilities such as the denial of food or water, with-holding medication or assistance, and forced sterilisation and medical treatment[ccxxxvii]. Women with disabilities face additional barriers to access support services when they experience violence relating to discrimination, exclusion and isolation.[ccxxxviii]

Those who identify as LGBTQIA+ who are forced to isolate in hostile family homes, and who do not have the means to go elsewhere, are at particular risk. Situations are worse in countries where sexual orientation and expression are directly or indirectly criminalised, such as Samoa where sodomy is a crime,[ccxxxix] limiting the ability of those experiencing violence or harassment to access justice or support for fear of persecution.[ccxl]

The Deaf Association of Samoa (DAS) reported in COVID-19 outreach efforts that persons who are deaf and hard of hearing reported experiencing severe violence and discrimination. **In interviews conducted for this report, DAS reported that over 80 percent of COVID-19 program participants reported experiencing severe physical violence from a family member. A number of members throughout Upolu and Savaii were taken to hospital from injuries sustained from physical violence during the pandemic.**

Child Protection

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

The *National Public Inquiry into Family Violence in Samoa* found that physical, harsh verbal discipline / violence and sexual violence toward children has reached epidemic levels with:[ccxlii]

- 9 out of ten children experience violence in their lifetime.
- Physical discipline/violence often extreme in nature.
- Sexual abuse of children and incest levels have reached 'epidemic' proportions.

The *State of Human Rights Report* reported that 34 percent of respondents had witnessed domestic abuse against a child in the past year. The report also noted that the rate of abuse is likely higher as many village participants did not view the excessive discipline of children as a child abuse issue.[ccxliii] In the 2019-20 Demographic Health Survey, 82.2 percent of respondents between the ages of 1 – 14 reported experiencing psychological aggression, and 90.8 percent reported experiencing any violent discipline method in the last month. 19.9 percent reported experiencing severe physical punishment which was categorised as being hit or slapped on the face, head or ears or hit over and over as hard as one could.[ccxliv]

In the 2019-20 Demographic Health Survey, 79.2 percent of caretakers of children between the ages of 1 – 14 believe that a child needs to be physically punished.[ccxlv]

In the 2013 *Child Protection Baseline Report for Samoa,* 6.4 percent of child respondents reported experiencing inappropriate touching at home within the past 12 months and 9.5 percent of child respondents reported experiencing inappropriate touching at school within the past 12 months. Only

6.5 percent of children who had experienced inappropriate touching at home or school had reported it to an adult. More girls than boys reported experiencing inappropriate touching.[ccxlvi]

The Ministry of Women, Community and Social Development's recently launched *Samoa National Child Care and Protection Policy 2020 - 2030* makes particular mention of disaster preparedness and response with Outcome 6 'Child protection integrated into disaster risk management and response'.[ccxlvii]

In NOLA's COVID-19 response efforts, an increase in requests for support in response to protection issues was noted amongst program staff. Whilst specific statistics were not collected, NOLA and affiliates recorded that children were included in protection requests and referrals.

Sexual Harassment, Exploitation and Abuse (SHEA)

A recent survey with 84 frontline government, civil society and faith-based welfare workers directly managing cases that included children in seven Pacific countries, including Samoa, found an estimated 961 child victims (651 girls and 310 boys) of sexual exploitation. Perpetrators were overwhelmingly male relatives and community members. Frontline workers also shared observations about foreign companies exploiting local children.[ccxlviii] This also reflects risks of sexual harassment, exploitation and abuse by humanitarian worked in the response to COVID-19. **Reductions in income and employment related to COVID-19 may provide opportunities to sexually exploit particular groups, such as woman, children, single women, widows, adolescent girls, sex workers, LGBTQIA+ populations, and people with disabilities.**

Services

Samoa Victim Support Group (SVSG) is the most active civil society service for survivors of VAWG. Initially established to provide assistance to victims of violence, SVSG has expanded to provide a diverse range of services including counselling, shelter, support to the courts, and welfare work. In their 2017 study, 95 percent of respondents noted they were aware of the work of SVSG around family violence compared to only 56 percent who knew of the work of the police. [ccxlix]

The *National Public Inquiry into Family Violence in Samoa* found that police are not adequately trained to properly deal with cases of domestic violence and that there is no evidence to suggest that lessons were being learned from training to deal with victims of violence across the police force and that harmful attitudes and practices were still dominant preventing reporting of family violence. The Inquiry also heard from a number of serving officers who still counsel victims of violence to go back to their partner, placing them at further risk.[ccl] **While the Inquiry found that the justice system has made commendable progress in relation to family violence, issues remain around access to justice, community awareness and the use of customary practices in sentencing.[ccli]**

The Inquiry also found that the National Health Services is lacking the resources and knowledge to effectively screen for victims of family violence and there is no allied health system for victims to be referred to. Harmful attitudes and perpetrators among some health staff contribute to the lack of reporting and continuation of family violence.[cclii]

The *fono* was found in the Inquiry to not protect victims of family violence and in some cases prevent access to justice and increase the environment in which family violence thrives through ill-advised punishments and blocking the reporting of matters to the police. In addition, the churches were not offering protection to victims of family violence and often counsel them into returning to abusive relationships, placing them at risk of further harm.[ccliii]

Women have reduced access to all VAWG response services due to COVID-19 restrictions and it is expected that as restrictions are scaled back there will be an increased demand for VAWG services as well as a backlog of cases for the police and courts to respond to.

In interviews and focus groups conducted by NOLA and DAS, persons with disabilities reported hesitancy to access services due to attitudinal barriers and lack of accessibility of services. Women with disabilities particularly reported healthcare and support providers laughing and poking fun at their disability caused them to be less inclined to access services.

Capacity and Coping Mechanisms

Savings

A slightly higher proportion of women in Samoa (40 percent) have bank accounts than do men (38 percent). more men (39 percent) are excluded entirely from financial services than are women (30 percent). The Central Bank of Samoa hypotheses that the higher level of bank account ownership among women is likely driven by remittance income. A significantly higher proportion of women (48 percent) receive remittances than do men (39 percent), increasing their need for banking services.[ccliv]

Recommendations

The following actions are recommended for stakeholders to inform humanitarian programming in Samoa to ensure it responds to the specific needs of women, men, girls, boys and persons with disabilities:

Recommendation 1 Increase engagement and investment in collaboration with local leaders to ensure response efforts are conducted in line with the *fa'a Samoa* and work in partnership with cultural mechanisms, particularly relating to understanding the concept of gender.

Recommendation 2 Ensure the meaningful engagement of women, including women with disabilities, in all COVID-19 decision-making on preparedness and response at the national, district and village levels.

Recommendation 3 Collect sex, age and disability disaggregated data, and if possible data on people of diverse LGBTQIA+, on economic impacts, food security, care burden, accessibility of services / facilities and violence against women and girls (VAWG).

Recommendation 4 Ensure that any interventions relating to COVID-19 preparedness and response prioritise a mainstreamed approach to gender equality by working with both male and female heads of households and encouraging family-wide inclusion.

Recommendation 5 Continue COVID-19 preparedness communication and awareness ensuring:

- Engagement of women, men and persons with disabilities in the development, design and delivery of materials.
- Dissemination of information to male and female heads of household and persons with disabilities.
- Engagement with Organisations for Persons with Disabilities (OPDs in the development of materials to ensure accessibility and inclusivity of messages.

Recommendation 6 Include men, women, people with disabilities and other marginalised groups as leaders in COVID-19 preparedness and response activities to ensure outreach to all members of the community.

Recommendation 7 Ensure that any intervention to increase income and employment is approached at an inclusive, household level in order to integrate the elimination of VAWG to mitigate the risks of VAWG.

Recommendation 8 Provide resources to support survivors of VAWG engaged in CARE activities to access VAWG services.

Recommendation 9 Work with VAWG services to be inclusive and accessible to persons with disabilities and prioritise a human rights-based approach.

Recommendation 10 Ensure child safeguarding and prevention of sexual harassment, exploitation and abuse (PSHEA) policies are in place with inductions provided for all implementing partners engaged in COVID-19 preparedness and response.

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