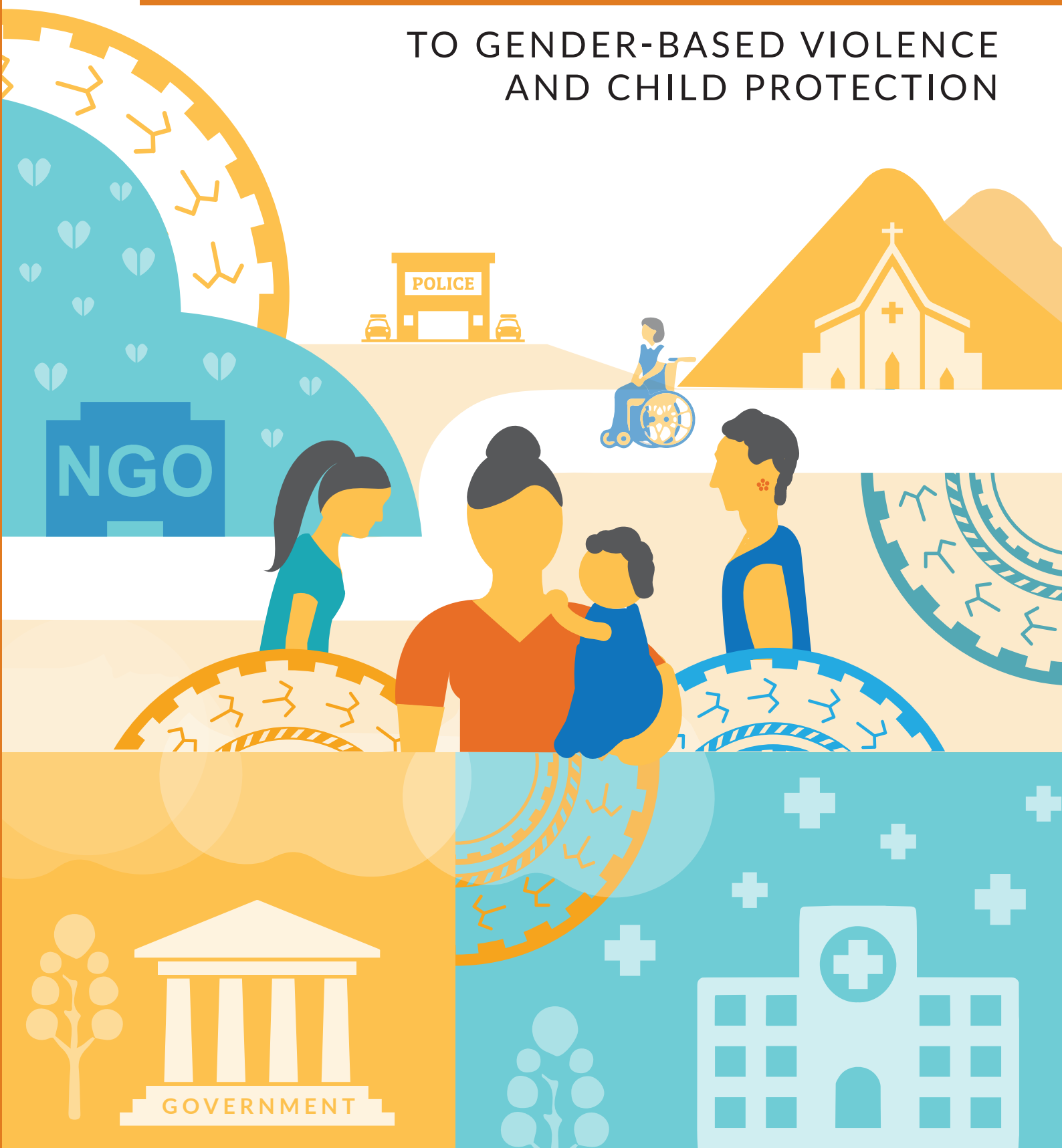


SAMOA INTER-AGENCY ESSENTIAL SERVICES

GUIDE FOR RESPONDING

TO GENDER-BASED VIOLENCE
AND CHILD PROTECTION



SAMOA INTER-AGENCY ESSENTIAL SERVICES
GUIDE FOR RESPONDING
TO GENDER-BASED VIOLENCE
AND CHILD PROTECTION

The Samoa Inter-agency Essential Services Guide for Responding to Gender-Based Violence and for Child Protection is developed by the Ministry of Women, Community & Social Development, with technical support from UN Women, UNICEF and UNFPA.

UN Women's support is through the Pacific Partnership to End Violence Against Women and Girls (Pacific Partnership). The Pacific Partnership brings together governments, civil society organisations, communities and other partners to promote gender equality, prevent violence against women and girls (VAWG), and increase access to quality response services for survivors. The Pacific Partnership is funded primarily by the European Union, and the Governments of Australia and New Zealand, and UN Women, and is led by the Pacific Community (SPC), UN Women and the Pacific Islands Forum Secretariat.

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Foreword

The Ministry of Women, Community and Social Development is pleased to present the Inter-Agency Essential Services Guide to respond to cases of Gender Based Violence and for Child Protection Services, a protocol to guide the referral pathway amongst all the service providers which all play a role within this space.

The two consultations conducted in the beginning of 2019 solicited the input of all the Social Sector partners, including government Ministries, NGOs and community representatives. These service providers whose role in the implementation of this referral guide is very vital all share the same goal of ensuring seamless flow of service delivery in response to gender based violence and for child protection.

Results and information gathered from these consultations informed the formulation of this guide with the assistance of the UN Women and UNICEF specialists. The validation workshop took place in October 2020.

In light of these processes leading on to the finalizing of this document, special acknowledgement is conveyed to all the stakeholders, the Social Sector partners – government, and non-government and civil society organizations, community representatives for their invaluable contribution in its formulation.

Lastly, the government through the MWCSO wishes to acknowledge the tremendous support provided by the UN Women, UNICEF and UNFPA both financially and technically.

We anticipate impactful and effective service delivery in response to gender based violence and for child protection through the use of this guide.

In all to be implemented and conducted, may God continue to be at the steering wheel.

Faafetai



Afamasaga Faauga Mulitalo
Chief Executive Officer
Ministry of Women, Community and Social Development



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Statement of Intent

This guide intends to be in consistence with the International Conventions ratified by the Government of Samoa, namely; the Convention on the Elimination of Violence Against Women (CEDAW), the Convention on the Rights of the Child (CRC) as well as the Convention on the Rights of Persons with Disabilities (CRPD). These international commitments are all a part of the government of Samoa's priority for its people to have quality of life. This is to ensure all people have access to equal opportunities and quality services as per their fundamental rights outlined in the Constitution of Samoa and translated through its National Plan, the Strategy for the Development of Samoa (SDS). The SDS provides direction to the priorities of each government Sector including the Community Sector in which MWCSD is the leading agency and the mandated administrator of the CEDAW, CRC and CRPD.

All in all, this guide purports to ensure that care and response services for survivors of violence are safe and meet quality standards. It reflects the provisions of the National Child Care and Protection Policy and National Policy for Gender Equality.



C H A P T E R O N E

SAMOA INTER-AGENCY ESSENTIAL SERVICES
GUIDE FOR RESPONDING TO

GENDER-BASED VIOLENCE



Introduction

Overview of the Samoan Context

Different forms of abuse against the most vulnerable members of the family constitute the diverse faces of domestic and family violence in Samoa. The victims are women, children, persons with disabilities (PWDs) and elderly people. Evidence shows that gender-based violence (GBV) against women and children continues to escalate, and abuse affecting PWDs and elders is an emerging issue of critical concern. The high prevalence of family violence is distressing and calls for a more aggressive and better coordinated effort to combat all forms of violence at the family, village and national levels.

Family violence is not a unique problem to Samoa. It is a major concern for almost every country worldwide and few countries would claim to have it under control. However, prevalence rates in the Pacific do appear to be higher and an understanding of why that is must be arrived at before proposed solutions can be implemented effectively.

In the first comprehensive Samoa Family Health and Safety Study 2000 (SFHSS 2000) carried out by the Secretariat of the Pacific Community and partners, it was found that 46 per cent of women had experienced domestic violence in their lifetime. When the study was carried out again by the Ministry of Women, Community and Social Development (MWCSD) in 2017 Samoa Family Safety Study (SFSS) this figure was found to be 60 per cent.

In the survey carried out by the National Human Rights Institute as part of this inquiry, 87 per cent of respondents within the family setting had experienced threats of violence and 86 per cent had been subject to kicking, punching or other assaults. A shocking 9.5 per cent of female respondents, almost 1 in 10, reported having been raped by a family member in their lifetime.



National Legislations and Policies

The Samoa Inter-agency Essential Services Guide for Responding to Gender-Based Violence and Child Protection

(hereafter referred to as the **Guide**) operates under the following legislation and policies:

National Legislations:

- Constitution of Samoa 1960, Article 15 (1)
- Family Safety Act 2013
- Crimes Act 2013
- Mental Health Act 2016
- Young Offenders Act 2007
- Community Justice Act 2008
- Ministry of Women Affairs Act 1990 and Amendment Act 1998;
- Ministry of Youth Sports and Cultural Affairs Act 1993 (provisions pertaining to youth)
- Internal Affairs Act 1995
- Village Fono Act 1990 and Amendment Act 2016
- Labour and Employment Relations Act 2013 & Regulation 2016
- Education Act 2009
- Infant Ordinance Act 1961
- Marriage Ordinance Act 1961
- Births, Deaths & Marriages Registration Act 2002

National Policies and Plans:

- National Safer Families, Strong Communities Policy (Draft)
- Child Care and Protection Policy (Draft)
- National Safe Schools Policy 2017
- National Policy for Gender Equality 2016–2021
- National Health Sector Plan
- Child and Adolescent Health Policy
- Sexual and Reproductive Health Rights Policy 2018–2023
- Non-Communicable Diseases Control Policy 2018–2023
- National Security Policy for Samoa 2018
- Strategy for the Development of Samoa (SDS) 2016–2021
- National Disability Policy (Draft)
- Samoa National Action Plan for Disaster Risk Management 2017–2021.¹

¹ <http://bsrp.gsd.spc.int/wp-content/uploads/2018/05/samoa-national-action-plan.pdf>

International Conventions and Declarations

This Guide operates under the following United Nations human rights conventions, ratified by Samoa:

- Convention on the Rights of the Child (1994);
- Convention on the Elimination of all Forms of Discrimination Against Women (1992)
- Convention on the Rights of Persons with Disabilities (2017)²
- Sendai Framework for Disaster Risk Reduction 2015–2030
- The Beijing+25 Platform for Action
- Small Island Developing States S.A.M.O.A. Pathway

² https://www.preventionweb.net/files/43291_sendai-frameworkfordrren.pdf

Purpose of the Guide

The Guide primarily focuses on the inter-agency aspects of the response process (i.e. how the agencies will work together to support the survivor). It serves as standard operating procedures that provide front-line workers with guidance on their roles and responsibilities in relation to supporting a survivor. This Guide may be used both in non-emergency and emergency settings, however, special considerations will need to be taken into account for each context to ensure the safety of survivors as well as the appropriateness, relevance and quality of interventions set out in Guide.

The evidence shows that GBV is a serious issue in Samoa and standard operating procedures for responding to cases across agencies and sectors is critical for a successful response. Currently, reporting of GBV to the police and health and social services remains low because of stigma, fear, shame, high levels of community tolerance of violence, inadequate responses from police and legal services, and lack of access to services in some rural areas and smaller communities, with limited options or support to escape the violence. A well-coordinated response across agencies in responding to individual cases will improve practice and encourage more women and girls to come forward.

This Guide provides guidance on key aspects of response management and service delivery, including:

- best practices on survivor-centred approach to service delivery;
- guiding principles and specific approaches for safely, ethically and adequately responding to cases of GBV;
- agreed national and community referral pathways for responding to GBV survivors;
- the key roles and responsibilities of multisectoral service providers, including health and social services, the police, the court system and legal aid – this includes the responsibility for service delivery coordination and governance;



This section introduces and elaborates the guiding principles that must be adhered to when responding to GBV cases.

Guiding Principles

Zero tolerance for violence

Zero tolerance for violence: Samoa does not tolerate violence in any form in the community, especially against women and children, persons living with disability, lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI)-identified persons including fa'afine and fa'atama, and the elderly, in any context or in any circumstance.

Survivor Centred Approach

Survivor Centred Approach: Agencies providing direct services to survivors of violence must make sure that frontline staff use a survivor-centred approach. This approach that prioritizes the survivor's needs, wishes, rights and diversity. Keeping the survivor as the focus and centre of support allows her/him to be empowered, feel cared for and feel of value. This will also allow the survivor to make her/his first steps towards healing and recovery. It also aids the survivor in rebuilding a sense of self, confidence and personal integrity in a timely manner. This approach requires professionals to keep to the following principles while working with individual survivors.

Safety

Safety: Ensuring the physical and emotional safety of the survivor is critically important during all parts of service delivery. All actions taken on behalf of the survivor must safeguard the survivor's physical and emotional well-being in both short and long term; during the process when support and help is being offered for the survivor. The following are some examples of actions that can help increase safety for a survivor:

- using a same-sex /age-appropriate service provider;
- using a same-sex/age-appropriate interpreter;
- allowing enough space between the service provider and the survivor, i.e. not sitting or standing too close together;
- avoiding any unnecessary physical contact with the survivor;
- speaking with your inside voice and holding interviews in a private place;
- contacting the police or emergency services when a survivor is in immediate or imminent danger during the intervention;
- ensuring emotional safety of the survivor (suicide, self-harm, depression and other mental health concerns);
- accompanying survivor to access support where necessary.

Respect

Respect: Respect the wishes, rights and dignity of the survivor in all actions taken. It involves understanding that the survivor is the main person and expert in the relationship of care. This means asking about and following the boundaries set by the survivor, asking the survivor how far she/he wants to take matters, and not putting pressure on the survivor to say or do something that she/he is not comfortable with (i.e. give her/his consent for information sharing). It also involves actively listening to what the survivor says, not interrupting or abruptly changing the conversation, not causing the

survivor to repeat her/his stories, and, most importantly, not making personal judgments about the survivor's decisions.

Confidentiality: This ethical principle requires that service providers involved in the care and treatment of a survivor must protect gathered information and agree to share only with the survivor's consent. This means guaranteeing:

- the confidential collection of information during interviews;
- that sharing information happens on a “need to know” basis with service providers and/or with the survivor's informed consent;
- that case information is stored securely.

Maintaining confidentiality also means that service providers never discuss case details with family and friends, or with colleagues who do not need to know about a case without the permission of the survivor.

Confidentiality

Non-discrimination: Survivors of violence should receive equal and fair treatment regardless of their sex, race, ethnicity, religion, age, disability, nationality, sexual orientation or gender identity or any other differentiating feature. For this, service providers must make sure that their personal beliefs, assumptions and attitudes do not interfere during interventions with survivors. This also means that a service provider who is known to a survivor must treat her/him fairly and equally and, if it is in the best interest of the survivor, refer her/him to a different person within the organization to assist. Service providers must ensure that caseworkers regularly perform self-reflection while keeping the focus on the survivor's human rights, in particular their right to the best possible service and assistance.

Non-discrimination

Empathy: Empathy is the ability to understand and share the feelings of another. When responding to GBV cases, service providers must show their ability to have and feel empathy with the survivor. Empathizing with a survivor is not the same as sympathy or pity, which can prevent the survivor from utilizing her/his own power to be able to heal. Empathy needs the provision of comfort, validation and encouragement to adult and child survivors of violence and abuse.

Empathy

Empowerment: The relationship between the service provider and the survivor must be about restoring power and control back to the survivor. Specifically, we seek to introduce or reconnect the survivor to her/his “power within” – the strength that arises from within herself/himself when she/he recognizes abuses of power and his/her own power to start a positive process of change for herself/himself. Service providers must emphasize choice rather than compliance, and strengths instead of deficits. For example, service providers (other than the police) should not start reporting to the police or any other service provider against the wishes of a survivor who is 18 years or older. Exceptions are made in cases where there is potential danger to that person or another person.

Empowerment

Rights based: To ensure that survivors have a clear voice throughout the referral process, service providers must:

- inform them of their rights and responsibilities;
- assist them to identify and express their needs;
- provide help and support with determining a course of action;

Rights based

Inclusive services

Inclusive services: Service providers should not discriminate based on sex, sexual orientation, gender identity, race, religion, age, disability, ethnicity or any other differentiating feature. Services should be offered equally, without judgement or bias, to ALL SURVIVORS, including persons with disabilities, the elderly, and persons with diverse sexual orientations and gender identities (SOGI). Service providers should be trained and knowledgeable on how to best support diverse survivors and on the many complex ways in which they can and do experience violence. This will enable service providers to be competent, ready and able to provide rights-based services and support.

No-drop policy

No-drop policy: The victim/survivor cannot withdraw or drop a complaint after it has been made to the police. This policy addresses the risk of unnecessary pressure placed on the victim/survivor by the perpetrator, or anyone else who may try and make the victim/survivor withdraw her/his statement or complaint.

Community strength-based approach

Community strength-based approach: This approach promotes the spirit and value of equal partnerships with members of the community. It recognizes the need to empower village/community groups with the necessary skills to be the positive social change. This approach involves coordinated collaboration and community leadership to empower people to take ownership of initiatives that strengthen protective environments for all members of the family as a primary solution of GBV. It recognizes the significant needs of all Samoan citizens and the equal contribution of community stakeholders towards the development and well-being of all Samoan citizens.

Declaration of conflicts of interest

Declaration of conflicts of interest: This is important for services to recognize and identify the best interests of the client and ensure that their personal biases/relationships do not interfere.

GBV in emergencies

GBV in emergencies: During emergencies such as natural disasters (e.g., cyclones, tsunamis, earthquakes) and public health concerns (e.g., measles outbreak, COVID-19 pandemic) the risk of violence, exploitation and abuse is intensified, particularly for women and girls. National systems and social support networks are overwhelmed as affected populations cope with the disruption in their lives. Pre-existing gender inequalities may become more evident. Women and adolescent girls are often at particular risk of sexual violence, exploitation and abuse, denial of resources and discriminating traditional practices. Men and boys may also be survivors and/or victims.

Often during emergencies, an environment of impunity prevails and perpetrators are not held accountable. GBV has significant and long-lasting impacts on the health and psychological, social and economic well-being of survivors and their families, thus it is essential to establish a functioning GBV response mechanism in disaster preparedness, response, and recovery plans.

Core Commitments for Gender-Based Violence

Advocacy and prevention: Service providers, as much as possible, will be involved in prevention and advocacy activities that challenge harmful gender norms and help people to better understand gender equality. This will advocate for power relations that respect the rights of women and girls and promote zero tolerance of violence.

Non-discrimination: Survivors of violence should receive equal and fair treatment regardless of their sex, race, ethnicity, religion, age, disability, nationality, SOGI or any other differentiating feature. For this, service providers must make sure that their personal beliefs, assumptions and attitudes do not interfere during interventions with survivors. This also means that a caseworker who is known to a survivor must treat her/him fairly and equally and, if it is in the best interest of the survivor, refer her/him to a different caseworker within the organization.

Service providers must also ensure that its' caseworkers regularly practice self-care so that they can better assist the survivors in their care.

Accountability and leadership: Service providers are accountable for and should provide leadership on gender inclusive budgeting, integration of GBV/child protection across sectors, human resources strategies and development of a skilled workforce. Mechanisms to receive feedback and respond to issues concerning the quality, safety, effectiveness, and appropriateness of services for survivors will be put in place.

Prioritize the safety/ best interests of the survivor: All actions taken on behalf of the survivor must safeguard the survivor's physical and emotional well-being in the short and long term by:

- identifying risk and danger;
- avoiding future danger through safety planning;
- protecting the survivor, her/his family and service providers.

It is crucial to ensure that the best interests of the survivor take priority over the interests of the organisation or community. It must remain as the main focus of every service provider that comes into contact with the survivor. Furthermore, in cases of conflict of interest and/or dual loyalty, priority should be given to the protection and well-being of the survivor.

Sharing Information and practising confidentiality: Service providers need to guarantee privacy during conversations with the survivor. To protect a survivor's rights and her/his integrity, the survivor should decide which information about her/him will be passed on to others. This also applies when passing information onto family members. Therefore, no information should be passed on to other service providers without the survivor's knowledge and informed consent. Exceptions are if the life and health of a survivor are at stake (i.e. in cases of suicide attempts, critical danger from a violent partner or abuse of a child).

All agencies and organisations involved in responding to GBV cases should agree to abide by the following core commitments:

Advocacy and prevention

Non-discrimination

Accountability and leadership:

Prioritize the safety/ best interests of the survivor

Sharing information and practising confidentiality

Skills and training

Skills and training: All parties identified in this Guide have a responsibility to ensure that, prior to handling any GBV cases, their personnel are well equipped with the core training and knowledge required to provide quality and effective services to women and girl survivors of GBV. It is strongly recommended that all service providers complete a standard training programme that equips them with the core fundamental knowledge and skills for responding to diverse cases of GBV in line with this Guide.

Timely response

Timely response: Service providers will offer timely support to survivors and will do their best to respond to cases of GBV as quickly as possible. For example, if a survivor reports to a hospital or police station, she/he should be seen immediately.

Zero tolerance for all forms of violence

Zero Tolerance for all forms of violence: There is ZERO tolerance for all forms of violence and this should be publicly condemned as a violation of a basic human right. This includes challenging, with sensitivity and respect, cultural and religious practices that are harmful and that take away the focus from holding the perpetrator accountable. This also means ensuring that perpetrators are held accountable for their actions in a timely manner by the police and those within the justice system.

Coordination and referral

Coordination and referral: In recognition of the multiple needs of survivors, service providers using this Guide will provide key support services across multiple sectors, including counselling, survivor advocacy and case management; medical care; shelter services; safety and security; and child protection. This Guide facilitates a coordinated, formal referral system that uses simple processes and procedures to support survivors' healing and recovery. A central aim of a well-coordinated and integrated service delivery system is to avoid re-victimizing the survivor through duplication and repetition (i.e. asking questions more than once).

Stakeholder accountability

Stakeholder accountability: All participating stakeholders must commit to ensuring that the appropriate agency systems are in place and that resources are made available to allow staff to respond to cases of GBV.

Perpetrators' accountability

Perpetrators' accountability: Perpetrators will be held accountable and challenged to take responsibility for their actions. Service providers will build on the current accountability mechanisms and criminal justice system responses to perpetrators by acting promptly. Service providers will fulfil their duties in evidence gathering for GBV cases to support the criminal justice system. Medical and social welfare reports and legal forms must be completed as soon as possible.

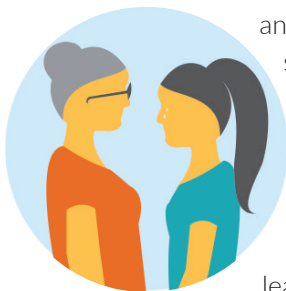
Duty of care

Duty of care: Agencies have the responsibility to provide adequate support to and promote the well-being of their staff handling cases of GBV. This may be in the form of supervision, coaching and mentoring, facilitating access to staff care services (e.g., counselling, peer support group), and promoting self-care (e.g., stress management, rest and recuperation).

These step-by-step procedures describe the process that service providers must follow when responding to reported or suspected cases of GBV.³

GBV Response Procedures

Reporting



A survivor of GBV has the right to report the violence to anyone she/he chooses, and anyone who is approached by a survivor of GBV for assistance should provide objective and comprehensive information to the survivor on services available in the community. In Samoa, the most common first point of referral for cases of GBV is the police. However, a survivor may report to anyone who she/he feels will be the most helpful, including religious and community leaders, teachers, parents, peers, friends, health-care providers and non-governmental organization (NGO) service providers.

Community and religious leaders, teachers or other key community members may receive direct reports of GBV and, if so, have a duty to provide objective and comprehensive information to survivors on the services available, as outlined in this Guide. Community leaders who receive a report of GBV should refer a survivor, with her/his permission, to health, police, counselling/advocacy and legal aid/court services that are available in the area. The person who the survivor reported to should escort the survivor to a service provider if she/he wishes.



Anyone who receives a report of GBV is obligated to keep the information related to the survivor and the incident confidential, unless the survivor consents to release such information to receive ethical and appropriate services.

An adult survivor has the right to choose to not formally report an incident (i.e. report to the police), but should still be supported in any way possible, as she/he chooses.



³ Note: All cases involving child survivors under the age of 18 should be handled using the Child Protection response standard operating procedures.

Confidentiality and Information-sharing Procedures

Confidentiality promotes safety, trust and empowerment. It means that information about a survivor's case will be shared only with individuals and/or organizations with the expressed consent of the survivor in all circumstances. Information must not be shared without consent.

Why is there a need for confidentiality?

Breaching confidentiality can put the survivor and others at risk of further harm. Confidentiality helps to avoid a survivor being ridiculed, any misinterpretation of the facts and/or distortion or malicious use of information. People do not hear things in the same way and they interpret things differently. If service providers do not respect confidentiality, others will be discouraged from coming forward for help. Non-confidentiality can put people's lives at risk and puts at extreme risk the ability of the service provider to support a survivor's healing and recovery.

The confidentiality of survivor(s), their families and affected persons must be respected at all times. In practice, this means that:

- Interviews will be conducted in a private setting.
- Information will be shared internally and externally on a "need to know" basis only, and only with individuals and/or organizations providing assistance and as requested and agreed by the survivor.
- People assisting with GBV cases cannot discuss any case information with family, friends or colleagues who are not involved with the cases.
- Only non-identifying data will be shared in public documents and reports. The exceptions are case management meetings when identifying information may be used, but only with the consent of the survivor and to support case actions.

Survivor consent is needed to share case information and must be indicated on the agency-specific consent forms.

- Staff must explain to survivors how information will be shared and stored in their agency and in each of the agencies being referred to.
- Staff must seek the survivors' consent to collect and store information.
- Survivors can decide what information they want to keep confidential. All written information with identifying details must be kept in a locked/secure space, such as a filing cabinet.

Informed Consent

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent to services and/or referrals, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give her/his consent.

When is informed consent needed?

To ensure that consent is “informed”, service providers must at the start of counselling/case management services obtain consent:

- to provide health services for every aspect/part of the treatment;
- to refer/share information with other service providers or anyone else;
- to take photographs.

To ensure that consent is “informed”, service providers must:

- provide the survivor with honest and accurate information about the services at the point of entry when the services start and the options available through referral so that she/he can make informed choices;
- clearly explain what can and cannot be provided or any limitations to services, to avoid creating false expectations;
- explain the benefits and risks of the service and ensure that the survivor understands;
- explain that the survivor has the right to decline or refuse any part of the services and the right to place limitations on the type(s) of information to be shared, and ensure that she/he understands;
- explain and discuss confidentiality and its limitations for the type(s) of information to be shared;
- clearly identify which organizations can and cannot be given information and ensure that the survivor understands the effects and consequences;
- decide what information will be shared and explain how the survivor’s information will be shared and stored among other agencies.

Survivor has the right to decline or refuse any part of the services and the right to place limitations on the type(s) of information to be shared

Making Referrals

Referrals are an essential part of this Guide. Victims and survivors of violence often require a range of services to heal and recover. The key services required include health care and treatment, case management services/counselling, shelter services, safety and security, and child protection. It is essential that designated service providers using this Guide follow the referral processes properly.

All service providers in the referral network must be aware of the services provided by other agencies to which they refer a survivor/victim and the processes involved.

The referral pathway outlines the broad framework of direct responses and referral among key actors responding to cases in Samoa. While survivors have the freedom and the right to disclose a violent incident to anyone, for example they may talk about their experiences to a trusted family member or friend, an organisation in the community or a health clinic, they might choose to seek help in the form of shelter, legal protection and/or redress by making an official “report” to the police. While there are a range of ways to seek help in the formal service-providing system, once in the system, all service providers should follow the national referral system shown below, which offers the following direct services for survivors of GBV:

- safety and security, including the Domestic Violence Interim Protection Order;
- medical care, including clinical care for physical and sexual assault;
- mental health and psychosocial support including counselling and survivor advocacy;
- shelter;
- child protection.

All agencies that fit into the referral pathway are able to provide a first immediate response. The immediate response actions identified in the referral pathway represent a common/integrated approach by agencies signed up to this Guide.

KEY STEPS IN MAKING REFERRAL



1

Obtain informed consent for referral and prepare the survivor

Informed consent is needed before referring survivors to other services. Once informed consent is obtained, contact the service provider to give advance notification of referral.

Make accompaniment plans for referral based on survivor wishes

All survivors being referred will be accompanied, on consent, to the next service. Accompaniment is mandatory for all high-risk cases. Accompaniment support strengthens safety in the GBV response.

2

3

Document the referral choice on the referral form

Once the service provider and the survivor have gone through the six immediate response actions in the referral pathway, the intake officer should document everything on the referral form.

4

Conduct any follow-up required

Service providers should have a follow-up form to enable survivor tracking.

Referral guidelines based on type of case for adults

Adult Sexual Violence (rape, sexual violence)	Adult Physical Violence (domestic violence)	Other types (Sexual harassment – non-physical, domestic violence that is non-physical or sexual, other)
Follow these steps for referral:		
STEP 1		
<p>Assess the immediate needs and obtain informed consent for referrals to health, counselling, police, shelter and/or legal aid services.</p> <p>***If this is a case of sexual violence within 5 days (of the assault), an immediate referral for health care is needed.</p> <p>***If a case is reported first to police, health or legal aid services, offer a referral to a GBV counselling agency.</p>	<p>Assess the immediate needs and obtain informed consent for referrals to health, counselling, police, shelter and/or legal aid services. If you do not know who to refer to call 911</p> <p>***If the survivor is injured, a medical referral should take priority.</p> <p>***If a case is reported first to police, health or legal aid services, make a referral to a GBV counselling agency.</p>	<p>Assess the immediate needs, with a focus on the need for referral to a GBV counselling agency.</p>
STEP 2		
<p>Make plans for referral and accompaniment based on survivor wishes.</p>	<p>Make plans for referral and accompaniment based on survivor wishes.</p>	<p>Obtain informed consent to make referrals or take any action needed to ensure the survivor's safety.</p>
STEP 3		
<p>Explain or plan for or deliver any services and actions that you are responsible for.</p>	<p>Explain or plan for or deliver any services and actions that you are responsible for (e.g. domestic violence restraining order).</p>	<p>Explain or plan for or deliver any services and actions that you are responsible for in terms of responding to the case.</p>
STEP 4		
<p>Conduct any follow-up required.</p>	<p>Conduct any follow-up required.</p>	<p>Give the survivor as much information as possible about what services are available and where she can get help.</p>

Police/Security and/or Legal Assistance Counsellors or Protection Officers

If the survivors want to pursue police/legal action - or - if there are immediate safety and security risks to others.

Refer and accompany survivor to police/security - or - to legal assistance/protection officers for information and assistance with referral to police



Mental health and psychosocial support service provider



Medical/health care service provider



Immediate Response

The service provider must provide a safe, caring environment and respect the confidentiality and wishes of the survivor; learn the immediate needs; give honest and clear information about services available. If agreed and requested by survivor, obtain informed consent and make referrals; accompany the survivor to assist her in accessing services



Telling someone and seeking help

Survivor tells family, friend, community member; that person accompanies survivor to the health or psychosocial "entry point"

Survivor self-reports to any service provider

Follow-up and other services

After Immediate Response, follow-up and other services Over time and based on survivor's choices can include any of the following:

Health care (e.g., clinical management of rape, treatment of injury, medico-legal examination)


Mental health and psychosocial services (e.g., psychological first aid, emotional support, trauma counselling, psychotherapy, peer support group)

Protection, security, and justice actors (e.g., family protection order, legal aid, victim/witness support, criminal case management)

Basic needs, such as shelter, ration card, children's services, safe shelter, or other



GENDER BASED VIOLENCE RESPONSE PATHWAY



In addition to the roles and responsibilities above, ministries, agencies and individuals have the following additional responsibilities when handling GBV cases.

GBV Response Roles and Responsibilities

Shared Principles for Collaboration and Inter-agency Respect

All Ministries/Organizations will respect the work of other Ministries/Organizations and interact to ensure the best interests of the survivor as the primary concern. They will also ensure to return telephone calls regarding GBV cases and provide necessary feedback in a timely manner.

Crucial to these considerations will be further shaping of an agreement on the shared principles of collaboration.

These key shared principles for organisations working together are as follows:

- Confidentiality.
- Commit to giving feedback to each other.
- Be courteous.
- Help each other to understand GBV.
- Facilitate collaboration.
- Respect the different scopes of agencies (i.e. one agency might only have domestic and family violence as its core function whereas for another agency it might be only one of their functions).
- Be non-judgmental in work with clients.
- Declare any conflicts of interest.
- Look for opportunities to collaborate (e.g. shared joint training or community outreach).
- Help each other to speak out within our organizations/communities.
- Prioritize risk management/safety planning for survivors.
- Collaborate in scheduling of activities that might require joint commitment.
- Help each other to do our duties, both generally with regard to GBV and specifically under the Family Protection Act.



Ministry of Women, Community and Social Development

MWCSD is the mandated government entity to develop a national strategy, policies, and mechanisms to prevent and respond to all forms of GBV in the communities both in emergency and non-emergency situations. As the custodian and lead agency for the implementation of this guide, MWCSD will be in charge of the following.

- Coordination of the Inter-agency Taskforce on Prevention of/Responding to GBV
- Policy/strategy development.
- Monitoring and Evaluation of the Guide.
- Prevention/Advocacy/Skills Training.
- Early Intervention and Case Management.
- Shared data management.
- National research.
- Resource mobilization.



Social Sector – NGOs

(e.g., *Samoan Victim Support Group, Fa'ataua le Ola, NOLA, Fa'afafine and Fa'atama Association, SUNGO, Wellbeing Community, Goshen Trust, Salvation Army, Tofa Sinasina*)

The Social Sector will work together to ensure safe, quality, and holistic services are afforded to the survivor. These services include but are not limited to 1) emotional support to assist with psychological and spiritual recovery and healing from trauma; 2) case management, support, and advocacy to assist survivors in accessing needed services; and 3) support and assistance with social re-integration. Below are some of the specific responsibilities of organizations within the social sector for a survivor.

- In-house policies governed by service standards;
- First-line support services (e.g., psychological first aid);
- Mental health and psychosocial support services including counselling;
- Free helpline;
- Shelters;
- Training, supervision, coaching and mentoring;
- Information sharing;
- Budget allocation.





Church and Faith Based Organizations and District/Village Groups

In general, church and faith-based organizations and district/community groups are engaged in GBV work in a variety of ways, including but not limited to:

- Prevention/early intervention activities.
- Impose village rules that comply.
- Reporting/sharing of information.
- Psychological first aid.
- Psychosocial/counselling support.



Health Sector

Ministry of Health
Samoa Family Health Association
Samoa AIDS Foundation

Health care providers will use standards and protocols and practices, in accordance with the minimum response interventions in the GBV Guidelines (IASC, 2005) and standards in the Clinical Management of Rape Guidelines (WHO/UNHCR, 2004). Medical providers ensure confidential, accessible, compassionate, and appropriate medical care for survivors of GBV. A range of responsibilities that include the following services should also be in place for survivors within the health sector.

- Policy role/health GBV service protocol.
- Medical care and treatment.
- Mental health and psychosocial support services and care.
- Sexual Reproductive Health services.
- Information sharing.
- Financial cost for GBV prevention and response.

Law and Justice Sector

Ministry of Justice and Courts Administration
Police
Samoa Prison and Correction Services

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- Shared data management.
- National research.
- Resource mobilization.



Education Sector

As a trusted adult, teachers and other school staff are often the first people who children will go to for help when they are being abused or neglected. Teachers and other school staff can play an important role in proactively identifying children who are experiencing abuse (on or off school grounds) and ensuring that they get the support and protection they need. This includes the following responsibilities:

- GBV and child protection service protocol for the education sector.
- Refer to service mapping.
- Accreditation.
- Mandatory reporting.
- Prevention programmes.
- Comprehensive sexuality education for in and out of school young people and linkages to services.
- Psychosocial support.





Data sharing and Information Management

Data starting and information management is key to the success of these Guidelines. The type, amount and style of data collected and then shared is critical to all agencies responding effectively to those in need. There will be a GBV information management system developed by a technical working group apportioned for this task. The system will be based on the needs and situation of the essential services agencies and their clients.

The framework serves as a tool for government and non-government service providers and agencies who collect administrative data in the context of GBV. A framework will help service providers and agencies standardize the collection of information to enable comparative analysis using common definitions such as definitions of violence, relationships, and risk indicators.

Collection and evaluation of GBV data

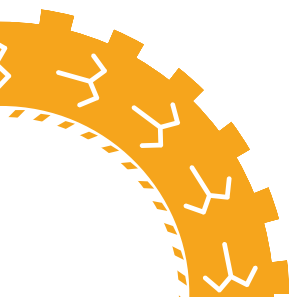
The MWCSO is responsible for maintaining an information management system on GBV. All key ministries/organizations will work together with the Ministry to improve the collection and sharing of data on GBV and children protection and the classification of cases. All key ministries/organizations will regularly share statistical information on GBV and child protection cases with the Ministry so that it can conduct periodic statistical analysis, to be presented to the Inter-Agency Task Force (this includes government ministries, NGOs, faith-based organizations and the private sector).

GBV data from community and service providers is important to support critical decision making, policy development, planning, research and evaluation activities.

Most GBV services, health systems, police and courts collect information about cases and clients. This information is referred to as administrative data (data typically collected by an agency or service provider as a by-product of providing services to clients or otherwise undertaking a core business activity).

When reviewing GBV data systems, there are several common data and knowledge gaps that are regularly identified:

- the demographic characteristics of priority communities, in particular, people with disabilities, minority and ethnically diverse communities, culturally and





linguistically diverse (CALD) communities, older people, and gender or sexually diverse people (lesbian, gay, bisexual, transgender and intersex (LGBTI));

- the number of unique clients and the extent to which individuals have multiple engagements with agencies and services related to GBV over time;
- a person's interactions with different system, which assists to link individuals across different data sets;
- the extent of and different forms of GBV beyond heterosexual intimate partner violence;

Analysis of administrative data is useful for organizations to understand their client needs and program planning. It is recommended that de-identified administrative data is shared and analyzed at a national or regional level to assist with understanding the impact of GBV policy development, programs and planning, it can inform other research and evaluation.

Improving multi-agency data collection practices and sharing de-identified data for analysis will subsequently advance the existing evidence base concerning GBV in Samoa.

Monitoring and Review of Guidelines

This Guideline document will be monitored and reviewed on a regular basis. MWCSD will develop a framework to measure and use and effectiveness of the guidelines based on monitoring visits and feedback from all partners and agencies involved.

As the lead organization for GBV prevention and child protection, the MWCSD is responsible for monitoring and assessing the implementation of these guidelines. Approved forms from the MWCSD should be used for monitoring and evaluating the services provided and referrals..

It is the responsibility of all agencies to ensure that their staff members are aware of the guidelines and have the appropriate knowledge, attitudes and skills to fulfil their responsibilities effectively and in a survivor-centred and child-sensitive manner. These guidelines should be included in training packages for staff, highlighting the importance of a multidisciplinary approach when managing GBV and child protection cases.

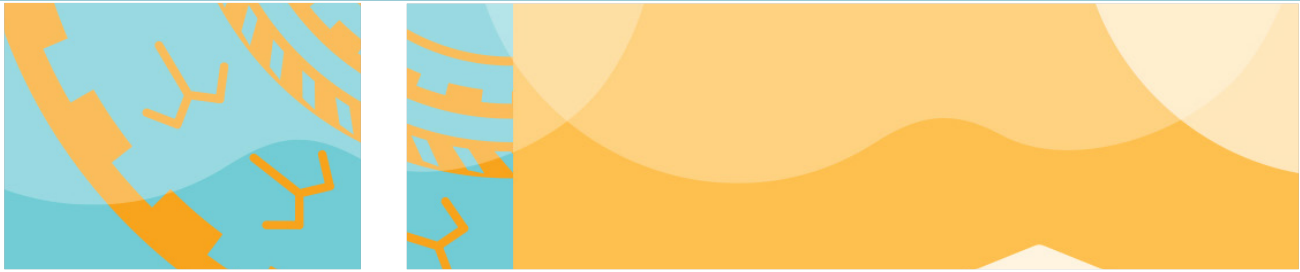




C H A P T E R T W O

SAMOA INTER-AGENCY ESSENTIAL SERVICES
GUIDE FOR RESPONDING TO

CHILD PROTECTION



Introduction

Violence against children remains a major issue in Samoa, with nine (9) in every 10 children experiencing violent discipline in their homes.⁴ This is perpetuated by caregivers (8 in every 10) thinking that physical punishment is necessary to raise or educate their children. Not surprisingly, more children with functional difficulty⁵ are punished physically.

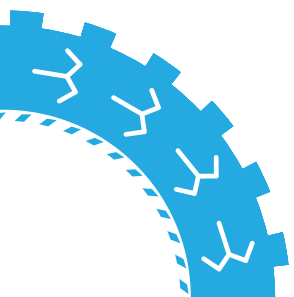
Samoa's Child Care and Protection Policy says that child protection is everyone's responsibility and emphasises the importance of all stakeholders working together to address concerns about a child's welfare or protection. It calls for a collaborative approach between government agencies, non-governmental organizations (NGOs), faith-based organizations (FBOs), community leaders and families in ensuring a timely and appropriate response to children experiencing all forms of violence, abuse, neglect and exploitation.

This Guide has been developed by the Ministry of Women, Community and Social Development (MWCSD) in accordance with its role as the state entity mandated to develop inter-agency procedures for responding to children in need of care and protection. The aim is to ensure a timely, effective and coordinated response to holistically address the needs of the child and his or her family.

Although many of the same service providers are involved in the referral network for both adult and child survivors, a child's "path" through the system is different. This is because children are especially vulnerable and are not always able to get the help and support they need on their own. While services for adult survivors are based on women's agency and independent choices, where children are concerned the government must be empowered to protect those who cannot protect themselves. This includes stepping in where necessary in the child's best interest, even if the parents or child do not want help.

⁴ National Human Rights Institute, 2017. *National Inquiry into Family Violence*

⁵ For this guide, *functional difficulty* refers to sensory impairments.





The MWCSO child protection officers (CPOs) must take a lead role in case management to ensure that children and their families get all the support that they need and that services are delivered in a coordinated way.

This Guide provides guidance on key aspects of response and service delivery, including:

- best practice for a child-centred approach to service delivery;
- guiding principles and core commitments for safely and ethically responding to cases of children in need of protection;
- agreed referral pathways for responding to children in need of protection;
- the key roles and responsibilities of multisectoral service providers, including the MWCSO and health, education, shelter, counselling, police, court and legal services;
- how to follow best practice in terms of confidentiality protocols, informed consent and mandatory reporting in children's cases;
- specific approaches required to adequately support children in need of protection and their families;
- ensuring an inclusive response for diverse populations, including boys and girls, children with disabilities, and lesbian, bisexual and trans children.

In addition the processes within this document are set up to ensure service providers follow the same steps when responding to reported or suspected cases of children in need of care and protection. Compliance with these procedures is essential to ensure firstly that children are protected from further harm, secondly that children and their families get the full range of support that they need and that response services are delivered in a coordinated and effective manner.



Guiding Principles

Zero tolerance for violence

Zero tolerance for violence: Samoa does not tolerate any form of violence, abuse, neglect or exploitation of children, in any context or in any circumstance.

Best interests of the child

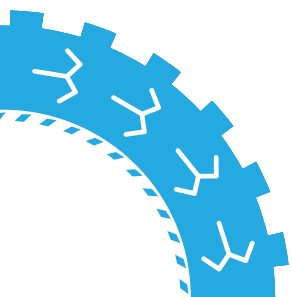
Best interests of the child: The safety, well-being and best interests of the child are always paramount. This means that, in responding to a child survivor, the primary duty is to protect the child and what is best for the child takes priority over the interests of others. It also means that sometimes actions may need to be taken to protect a child, even if that conflicts with the wishes of the child, their parents and their families. The primary duty is to protect the child.


Non-discrimination

Non-discrimination: Every child should receive equal and fair treatment regardless of their sex, race, ethnicity, religion, age, disability, nationality, SOGI or any other differentiating feature. For this, service providers must make sure that their personal beliefs, assumptions and attitudes do not interfere during interventions with children. This also means that service providers who are known to a child or her/his family must treat her/him fairly and equally and, if it is in the best interests of the child, refer her/him to a different person within the organization to assist. Service providers must ensure that case workers regularly perform self-reflection while keeping the focus on children's human rights, specifically their right to protection from harm and to the best possible service and assistance.

Inclusive services

Inclusive services: Services should be offered equally, without judgment or bias, to all children, including persons and children with disabilities and persons of diverse sexual orientation and gender identities. Service providers should not discriminate based on sex, sexual orientation, gender identity, race, religion, age, disability, ethnicity or any other differentiating feature. Service providers should be trained and knowledgeable on how to best support diverse boys and girls and the many complex ways in which they can and do experience violence. This will enable service providers to be competent, ready and able to provide rights-based services and support to diverse children who experience violence.





Child participation and consent: Children should be actively involved in all aspects of decision-making about their care and protection and should be empowered through the process. Service providers must always involve children in discussions about what is happening, give them an opportunity to express their opinions and wishes, and take these into consideration when making decisions, bearing in mind their age, evolving capacity and level of maturity. However, unlike adults, children's consent is not necessarily required to make a referral or to take action to protect them, and service providers may be required to report a case to a CPO or the police, even if the child and family do not agree. In cases where actions need to be taken that are not in line with a child's wishes, the reasons should be explained to the child.

Child participation and consent

No-drop policy: This means that the child or her/his family cannot withdraw or drop a complaint after it has been made to the police. This policy was made to address the risk of undue pressure being placed on victims/survivors by a perpetrator, the perpetrator's family or others acting on the perpetrator's behalf to try and make them withdraw their statement or complaint.

No-drop policy

Confidentiality: This ethical principle requires that service providers involved in the care and treatment of a child respect the child's privacy and protect information gathered about the child and her/his family. Maintaining confidentiality also means that service providers never discuss case details with family and friends, or with colleagues who do not need to know about a case.

Confidentiality

Protection of children in emergencies: When a natural disaster or other emergency strikes, children require special protection to ensure their safety and well-being. This is because, in times of crises, children face increased risks of violence, abuse, neglect, exploitation and being separated from their families. The safety and protection of children is a priority in disaster risk management planning and response management.

Protection of children in emergencies

In accordance with the Child Care and Protection Policy, all agencies and organizations involved in responding to child protection cases agree to abide by the following core commitments:

Centralised case management, led by CPOs

Written Care and Protection Plans

Confidentiality and information sharing

Core Commitments for Child Protection

Centralised case management, led by CPOs: The MWCSO and its CPOs will lead the assessment of and case management process for all high-risk cases of children in need of care and protection. They will act as the central case management hub for children's cases and where feasible should be present during interviews with other government ministries (e.g. police, justice and health services) for high-risk cases. From time to time "authorised child protection officers" will be trained and appointed to carry out child protection officer duties in the community.

Written Care and Protection Plans: All children must have a written care and protection plan, approved by the MWCSO. A Care and Protection Plan outlines what support and assistance is needed to ensure the well-being and protection of the child and assigns roles and responsibilities to each agency and individual who will be involved. This should include interventions targeting both the child and her/his family.

Confidentiality and information sharing: Children's privacy and dignity must be respected and protected at all times. Confidentiality is important because it promotes safety, trust and empowerment. Breaching confidentiality can put a child and others at risk of further harm and may expose the child to ridicule, misinterpretation of facts and/or distortion or malicious use of information. It can also cause significant emotional harm and undermine the child's healing and recovery. In practice, respecting confidentiality means that:

- interviews will be conducted in a private setting where conversations cannot be overheard by others;
- information will be shared internally and externally only on a "need to know" basis, and only with individuals and/or organizations providing assistance;
- case information must be stored securely, and access to and disclosure of personal information about a child will be limited to people directly involved in the case;
- service providers must never discuss case details with family or friends, or colleagues who are not involved with the case;
- any extended family and community members involved in the assessment or family group conference should also be reminded of the importance of protecting the child's privacy and not talking to others about what was discussed;
- only non-identifying data will be shared in public documents and reports – the exceptions are case management meetings when identifying information may be used, but only to support case actions.

When working with children, it is also important for service providers to be upfront about the limits of confidentiality. Before interviewing or taking information from a child, service providers must explain, in simple language, their obligation to report child abuse. Service providers must not make promises of secrecy that cannot be kept and should explain to the child that, if they are concerned about the child's well-being or safety, they have a duty to report to designated Child Protection Officers (CPO) so that the child gets the help she/he needs.

Minimise the number and duration of interviews with children: All agencies and service providers must be mindful of the importance of minimising the number of times a child is interviewed or asked detailed questions about an incident, as having to repeatedly provide details about embarrassing and painful events can further harm the child.

Timely response: Service providers will offer timely support to children and their families and will do their best to respond to a case of a child in need of care and protection as quickly as possible, as delay and indecision may place a child at further risk. For example, if a child reports to a hospital or a police station, she/he should be seen immediately with little delay.

Consensus-based decision-making: In responding to a child in need of care and protection, priority will be given to reaching agreement with the child, parents and extended family about what needs to be done to keep a child safe and to support the child's recovery. Where appropriate, family group conferencing will be used to actively engage the child's family and community members in case planning and decision-making. Protection orders from the court will generally be used only where agreement cannot be reached, or where a protection order is necessary in the interests of the child.

Family strengthening and family-based solutions: The best environment for the care and upbringing of children is their own family. Where feasible and appropriate, emphasis will be placed on providing support to a child's parents or caregivers to address underlying problems and strengthen their ability to appropriately care for their child, to minimize the removal of children from their families and communities. Removing children from their families and communities can be quite distressing, so this should be done only where necessary for their safety, protection or best interests. Wherever possible, the perpetrator should be removed, not the child.

Priority given to family-based forms of care: If a child must be removed from her/his home, priority must be given to placing the child in the care of a family member or other approved family-based care provider. Residential care (in the form of a shelter or children's home) will generally be used only on a temporary or emergency basis and as a last resort if family members and the community are unable to care for the child.

Minimise the number
and duration of
interviews with children

Timely response

Consensus-based
decision-making

Family strengthening and
family-based solutions

Priority given
to family-based
forms of care

Community care and support

Community care and support: Child protection interventions must respect the communal sense of belonging and living among Samoans and that child-rearing best practices are supported by the broader Samoan community.⁶ The response to a child in need of care and protection will seek to actively engage and mobilise the child's extended family, community and church network in supporting the child and family.

Declaration of conflicts of interest

Declaration of conflicts of interest: This is important for services to recognize and identify the best interests of the child and ensure that their personal biases/relationships do not interfere.

Stakeholder accountability

Stakeholder accountability: All participating stakeholders must commit to ensuring that the appropriate agency systems are set up and in place and that resources are made available to allow staff to respond to cases of children in need of care and protection.

Perpetrators' accountability

Perpetrators' accountability: Perpetrators will be held accountable and challenged to take responsibility for their actions. Service providers will build on the current accountability mechanisms and criminal justice system responses to perpetrators by acting promptly. Service providers will fulfil their duties in evidence gathering for child protection cases to support the criminal justice system. Medical and social welfare reports and legal forms must be completed as soon as practicable.

Specialised skills and training

Specialised skills and training: All service providers have a responsibility to ensure that, prior to handling any child protection cases, their personnel are well equipped with the core training and knowledge required to provide quality and effective services to children and their families. It is strongly recommended that all service providers complete a standard training programme that equips them with the core fundamental knowledge of and skills in the child protection response in line with this Guide. This is to ensure that providers have the essential knowledge and skills to handle children's cases effectively and in a child-sensitive manner.

Commitment to child safeguarding

Commitment to child safeguarding: All service providers must have a child safeguarding policy outlining their organisation's commitment to keeping children safe and the measures that the organisation will take to ensure the safety of children who use their services or otherwise come into contact with the organisation and its staff. This includes conducting background checks on all staff working with children and ensuring that all staff sign and abide by a child protection code of conduct.

Duty of Care

Duty of Care: Agencies have the responsibility to provide adequate support to and promote the well-being of their staff handling child protection cases. This may be in the form of supervision, coaching and mentoring, facilitating access to staff care services (e.g., counselling, peer support group), and promoting self-care (e.g., stress management, rest and recuperation).

⁶ See national Samoa Child Care and Protection Policy, p. 9.

These step-by-step procedures describe the process that service providers must follow when responding to reported or suspected cases of children in need of care and protection



Child Protection Response Procedures

These step-by-step procedures describe the process that service providers must follow when responding to reported or suspected cases of children in need of care and protection. Compliance with these procedures is essential to ensure that response actions are in line with the Child Care and Protection Policy and the guiding principles and core commitments of this document and that:

- children are protected from further harm;
- children and their families obtain the full range of support that they need; and
- services are delivered in a coordinated way.

STEP 1: Identification and immediate response

A child in need of care and protection may seek help from or be identified by many different actors, including the police, CPOs, health-care providers, teachers, religious and community leaders and NGO service providers.

All of these actors, as the first point of contact, should take the following five immediate actions:

1. Take the child to a private and safe environment.
2. Provide emotional support and listen attentively.

Before interviewing or taking information from a child, service providers must explain, in simple language, their obligation to report child abuse and must be upfront about the limitations of confidentiality. Service providers must not make promises of secrecy that cannot be kept and should explain to the child that if they are concerned about the child's well-being or safety they have a duty to report to a CPO so that the child gets the help she/he needs.

I'm here to help you and am willing to listen to whatever you want to share with me. Your confidentiality is one of the most important things to me. That generally means that what you share with me, I don't share with anyone unless you want me to. But there is one big exception. If I know about a child who is being abused, I am required to report it to a child protection officer. So, if I'm concerned about your well-being or safety, I may have to talk with someone from the Child Protection/Case Management Unit so they can make sure you are safe and get all the help that you need. But before I tell someone else, I will discuss it with you first. We will always talk about plans to help you. How do you feel about that? Do you have any questions?

Example of how to explain child abuse reporting requirements

3. Address any immediate medical needs the child may have, including accompanying the child to a health facility.

4. Provide the child with information, in language appropriate to her/his age and level of development, about the services available. Discuss options and what might happen next and give the child an opportunity to express her/his opinions and wishes. Service providers must respect the autonomy and wishes of the child (e.g. by not forcing her/him to give information or be examined) while balancing this with the need to protect her/his best interests. If action needs to be taken that is not in line with the child's wishes (e.g. reporting to a CPO), the reasons should be explained to the child.

5. If the child's safety is threatened, take action to keep the child safe (e.g. the child is too afraid to go home or is at risk of ongoing harm):

- immediately notify the police and/or CPO;
- ensure that the child is safe and accompanied by an adult at all times, until the CPO is able to take over;
- if necessary, arrange for the child to stay with a safe relative or Samoa Victim Support Group (SVSG).

In urgent cases or when an incident happens after hours or at the weekend, the case should be reported to the police so that they can step in immediately to protect the child. However, even if the case is reported to the police, the CPO should still be notified on the next working day so that she/he can conduct a risk assessment and follow-up to help the child.

For children under the age of 18, service providers must have consent from at least one parent or caregiver to treat a child and to take the child to a shelter. If the parents refuse to consent or cannot be contacted, the CPO or police should be contacted immediately by telephone so that they can take necessary legal action to protect the child (see step 3).

STEP 2: Reporting and referral to CPOs

After the immediate response, the child should be reported and referred to the Child Protection Officer. Where possible, a CPO should be notified verbally via telephone. The verbal notification should be followed up with a formal written referral using the Child Protection Reporting and Referral Form (see Annex 5).

Remember: Where children are concerned, the consent of the child and/or the non-abusing parent is NOT required for making a report or referral. All service providers have an obligation to take steps to protect a child who is at risk of harm, even if the child/parents do not want help. This reporting obligation, and the limits of confidentiality, should be clearly explained to the child and parents.

In some non-serious cases (such as minor physical abuse or concerns about neglect), teachers, health workers and other service providers may be able to resolve the concern by providing advice to the parents or enlisting help from the extended family, pastors/church leaders or other local support networks. However, if there is any concern that a child is at persistent or increased risk of harm, the case should be reported to the CPO for follow-up.

All high-risk cases must be reported to the MWCSD’s Child Protection Unit/ Case Management - Child Protection Officers for assessment and case management.

Cases that may be referred to the CPO
Any concerns about the well-being of a child, including:
Minor physical abuse or use of harsh discipline
Emotional abuse
Neglect
Teenage alcohol abuse
Child exposed to family violence

High-risk cases that MUST be referred to the CPO
Child found lost or abandoned
Physical abuse resulting in broken bones and/or multiple bruises
Child sexual abuse
Child who is pregnant or presents with a sexually transmitted infection if there are concerns that it is not from a consensual boyfriend/girlfriend relationship with someone of similar age
Child sexual exploitation (child involved in prostitution or pornography)
Child engaged in street trading at night or in a location that exposes them to risk
Child seeking help from or who is brought to a shelter (does not include children with their mothers)
Child who is being forced to get married, or whose parents are trying to arrange a marriage while the child is aged under 15
Child who has been trafficked
Mother has left home because of family violence and children have been left with the perpetrator, if there are concerns about the safety of the children
Mother wishes to return to an abusive partner with her children and there are significant concerns about the children’s safety

STEP 3: Preliminary risk assessment by the CPO

As soon as possible after receiving a report of a child in need of care and protection (within 24–72 hours), the CPO will conduct a preliminary risk assessment and respond to any immediate needs the child may have. The purpose of the preliminary risk assessment is to assess:

- the gravity of the child's situation;
- the immediate action that needs to be taken;
- the time frame over which action must be taken.

Depending on the case, the CPO may:

- Arrange a temporary safe place for the child to stay (with a relative or other approved family member or in a temporary shelter).
- Where necessary, take legal action to remove a child who is in immediate danger from her/his home, against the wishes of the parents if necessary. In these instances, the CPO may request to be accompanied by the police to assist in removal of the child.
- If not already done, organize for the child to receive medical treatment and counselling, as necessary.
- If the police are not already involved, report the case to the police and then coordinate with them in the response.

If the child's parents do not agree with the child being taken away, the police or the CPO will take necessary emergency legal action to remove the child to a safe place.⁷ When the police remove a child without a CPO being present, they must take the child to a temporary safe place (to a relative or SVSG) and immediately notify the CPO to make arrangements for the child's care. Children in temporary safe care are under the care of the Chief Executive Officer (CEO) of the MWCSO and it is the responsibility of the Ministry, not the police, to decide where the child will stay.

STEP 4a: Comprehensive assessment and care and protection planning

Once the child's immediate needs have been met, the CPO will conduct a more comprehensive assessment of the child's circumstances and her/his home environment. This may include:

- visiting the child's home;
- interviewing the child, the child's parents or caregiver, and any other person who knows the child;
- making inquiries about the child and her/his circumstances; and
- requesting information about the child and family from any person or agency.

The CPO will organize an inter-agency case conference or family group conference to discuss and decide on a care and protection plan for the child. This should be done as soon as possible, preferably within 1–2 weeks of the initial report.

⁷ Currently, CPOs can intervene to protect a child by making an application on behalf of the child for an Interim Protection Order under the Family Safety Act, or making an urgent application for custody under the Infants Ordinance. Once the Child Care and Protection Bill is enacted, CPOs and the police will have emergency powers to enter any home or place and remove a child (without a warrant) if there is reason to believe that the child is in immediate danger. The CPO must then, as soon as possible, obtain an interim care and protection order from the court.

The CPO will decide, in consultation with the child, who to invite to the inter-agency case conference or family group conference, bearing in mind the need to protect the child's privacy. This might include the child, the child's parent(s) or caregiver, other relatives, teachers, a pastor/priest or other church workers, community leaders and other service providers.

Through the family group conference, the CPO will work with the parents, extended family members and other service providers to develop an agreed care and protection plan that caters to the best interests of the child.

An agreed care and protection plan must:

- be in writing;
- be approved by the CEO;
- include provision for how progress and compliance with the plan will be monitored.

If the family cannot come to an agreement, or holding a family group conference is not in the best interests of the child, go to step 4B.

STEP 4b: Application for a care and protection order where necessary

The Child Care and Protection Policy puts priority on developing a care and protection plan in agreement with the child's family. However, CPOs also have the option of using more forceful action to protect a child by obtaining an order from the family court. These will be used where:

- no agreement can be reached on a care and protection plan for the child;
- the care and protection plan proposed during the family group conference is not, in the opinion of the CPO, adequate to keep the child safe;
- there was an agreed care and protection plan but the family did not follow it; or
- it is not in the best interests of the child, for whatever reason, to develop an agreed care and protection plan.

Applications for court orders will generally be made by a CPO, with the approval of the CEO, and must be accompanied by a detailed report and proposed plan for the child.

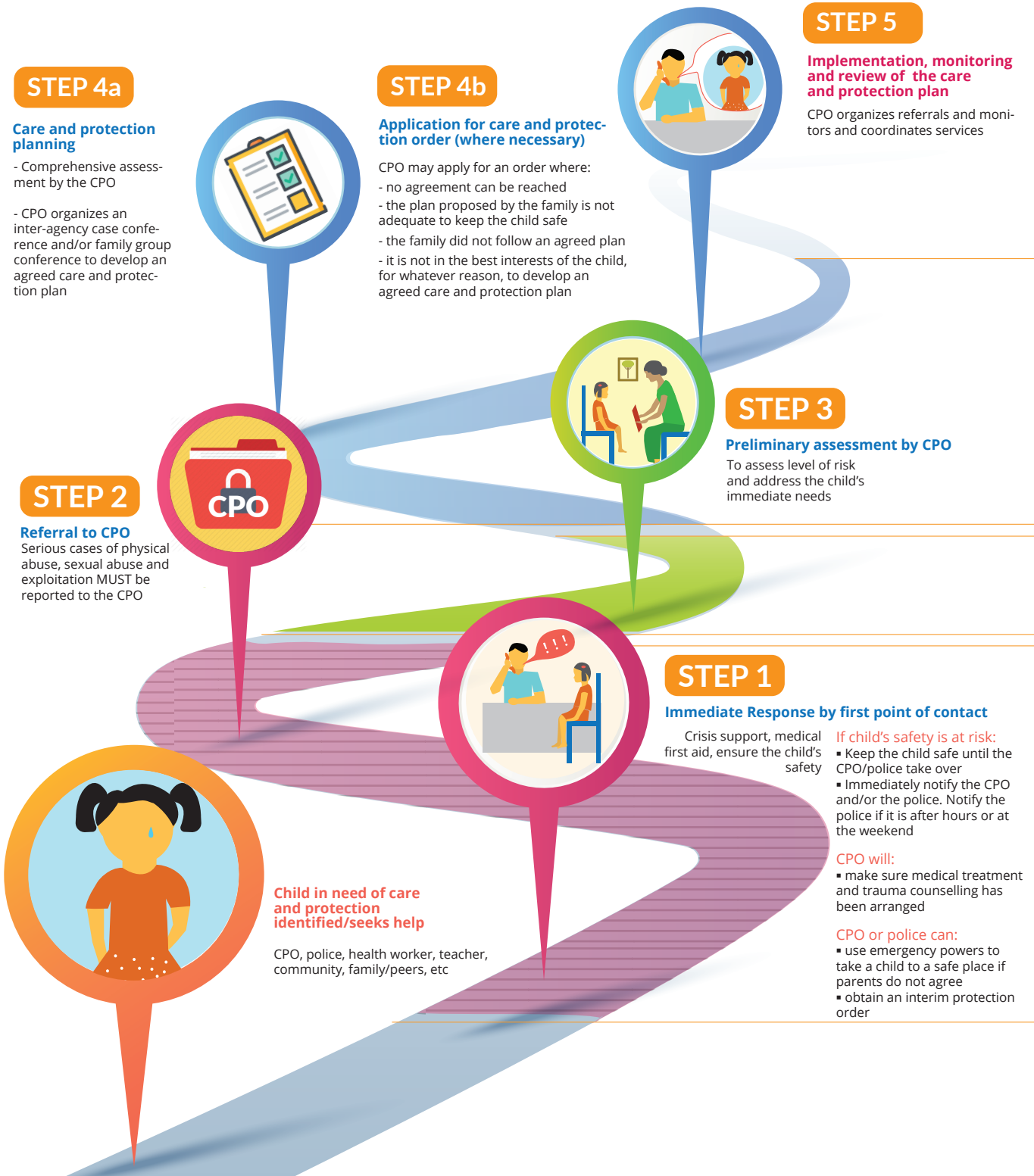
STEP 5: Implementation, monitoring and review of the care and protection plan

The CPO will organize referrals, accompany the child and parents (as needed) to service providers and ensure that all agencies and individuals are providing support to the child and family as agreed in the care and protection plan or order from the court.

All service providers will endeavour to cooperate fully in the implementation of the plan and will provide regular updates to the CPO on the child's and family's progress.

The CPO is responsible for regularly monitoring the implementation of the care and protection plan and/or the conditions stipulated by the court order, documenting the progress made and modifying the plan as necessary in consultation with inter-agency partners.

⁸ Under current legislation, CPOs can request a Protection Order on behalf of the child pursuant to the Family Safety Act, and/or a custody order pursuant to the Infants Ordinance. Once the Child Care and Protection Bill is passed, CPOs will have authority to apply to the court for a care and protection order, with conditions relating to supervision, contact, custody and maintenance of the child.



CHILD PROTECTION RESPONSE PATHWAY

In addition to the roles and responsibilities above, ministries, agencies and individuals have the following additional responsibilities with respect to children.



Child Protection Roles and Responsibilities

Community Development Sector

This sector includes Ministry of Women, Community and Social Development and all the community organisations and groups such as NGO's and church groups.

Ministry of Women, Community and Social Development

The MWCSO and CPOs have primary responsibility for leading and coordinating the response to any reported case of a child in need of care and protection. This includes the following key responsibilities:

- facilitate inter-agency collaboration in responding to children in need of care and protection;
- conduct community outreach to build linkages with community leaders, strengthen their capacity to deal with child protection cases and monitor how children's cases are being handled at the community level;
- receive reports of children suspected of being in need of care or protection and lead the case management process, including:
 - conducting risk and needs assessments;
 - taking emergency action to remove a child to a safe place (if necessary);
 - developing a care and protection plan for a child in coordination with family and other stakeholders;
 - where necessary, applying to the court for a protection order; and
 - monitoring implementation of the care and protection plan/court order;
- ensure that CPOs and other authorized officers are well trained in their responsibilities for managing children in need of care and protection;
- register, monitor and inspect all NGOs, societies and voluntary organizations providing care and protection services to children.





Extended Family, Communities and Churches

Extended family members, community leaders, church networks and other community helpers can provide invaluable support to children in need of care and protection and their families. Extended family members, community leaders and churches will be mobilised to:

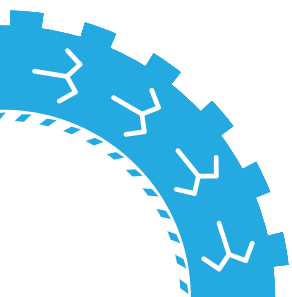
- Intervene early to provide support (social, spiritual, emotional) and financial assistance to children and their families facing difficulties.
- Report or seek help from the CPO and/or the police in suspected or confirmed cases of child abuse, neglect and exploitation. The police should be contacted in situations where urgent action is needed to protect a child.
- Participate in discussions or family group conferences with CPOs and help in developing care and protection plans.
- Provide follow-up support to children and their families, as agreed during family group conferences, including guidance and mentoring to the child; parenting advice or parenting support; family mediation; financial or in-kind support; and assisting with home visits and supervision of the child and family. In addition, relatives approved by the CPO may provide temporary or long-term care for children who cannot safely remain in or return to their homes.
- Ensure that conditions in the care and protection plan are followed and notify the CPO if any conditions are not being followed or a child continues to be at risk.
- Participate in the assessment process and provide CPOs with information about children and their family circumstances.



Shelter Providers

Currently there are a formal and informal 'shelters' or spaces used to provide care and protection for children in Samoa, who, for their own safety, are not able to remain in or return to their own homes. While the Child Care and Protection Policy and Legislation emphasises that family and extended family forms of care should be the priority, groups or agencies who are providing children with out-of-family residential shelter care must follow these safeguards to manage children's entry into and reintegration from residential care. Shelter providers will:

- provide temporary shelter to children on the guidance and direction of the CPO;
- notify the CPO immediately (next working day, by telephone) whenever a child is admitted and obtain approval from the CPO to keep the child (this does not apply to children accompanying their mothers);
- participate in inter-agency case conferences/family meetings, as requested by the CPO;
- consult with the CPO and obtain approval before a child is returned home;
- register with the MWCSO and comply with the minimum standards;
- have a child safeguarding policy and code of conduct in place and ensure that all personnel are trained on the policy and abide by it.



NGO Service Providers

In responding to children in need of care and protection, the MWCSO will work with a range of NGOs and FBOs providing counselling, mediation and other essential services for children and their families. The responsibilities of these organizations include:

- Mandatory reporting to the CPO of high-risk cases of suspected and confirmed cases of children in need of care and protection.
- Participation in inter-agency case conferences or family group conferences as requested and working with the CPO to develop care and protection plans for children.
- Providing follow-up support to the child and family, as agreed during the case conference or family group conference. This might include faith-based or pastoral counselling; guidance and mentoring for the child; parenting advice or parenting support; family mediation; financial or in-kind support; and home visits and supervision of the child and family.
- Having a child safeguarding policy and code of conduct in place and ensuring that all personnel are trained on the policy and abide by it.



Law and Justice Sector

This section outlines two areas within the Law and Justice Sector, the Police Services and the Courts Administration.

Police Service

In Samoa, the most common first point of referral for children in need of protection is the police. The police therefore have an essential role to play in keeping children safe, holding perpetrators accountable and ensuring that children receive follow-up support and assistance. In responding to children in need of care and protection, the police will:

- fully investigate all reports of violence against children, using child-sensitive interview techniques;
- take immediate action, if necessary, to ensure the safety and well-being of a child;
- notify a CPO as soon as possible of any case involving violence, abuse, neglect or exploitation of a child, whether or not criminal charges are being pursued;
- where feasible, conduct joint interviews of child victims with a CPO to reduce the need for the child to repeat what has happened;
- make sure that a supportive adult of the child's choice is present when interviewing the child;
- assist the CPO in the removal of a child at immediate risk of harm and seek assistance from a CPO whenever the police remove a child;
- where necessary, assist a child to access medical treatment and a forensic medical examination, including accompanying the child to a health facility;
- keep the child, the child's parents/guardians and the CPO updated on the



progress of criminal cases, including notifying them immediately if an alleged perpetrator is arrested or released on bail;

- ensure that officers handling child victims and witnesses always act in the best interests of the child, follow child-sensitive procedures and do not expose the child to any further harm;
- participate in the child protection case conference and support the child and family as requested by the CEO or CPOs of the MWCSO.



Courts Administrations

Holding perpetrators accountable and ending the impunity of child abusers requires commitment across the justice sector to improving access to justice for child survivors. This includes:

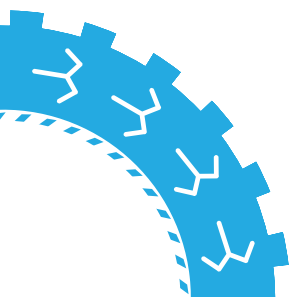
- ensuring that officers handling cases involving child victims/witnesses always act in the best interests of the child, follow child-sensitive procedures and do not expose the child to any further harm;
- ensuring that all child victims/witnesses receive pre-trial familiarization and are supported and accompanied throughout any criminal proceedings brought against a perpetrator of abuse;
- providing legal advice and assistance to the child and her/his caregiver about their options in relation to filing a case with the police and other related legal matters (e.g. custody, maintenance, access);
- using child-sensitive questioning techniques and special measures to facilitate children's testimony at trial, to reduce contact with the accused and to prevent secondary victimization;
- keeping the child, parent/guardian and CPOs updated on the progress of cases/reports.



Health Sector

Many children in need of care and protection first seek help from a health centre. Health workers have an essential role to play in identifying children experiencing abuse and neglect, providing quality, child-sensitive clinical care, and ensuring that children receive follow-up support. This includes the following key responsibilities:

- identify children showing signs of abuse or neglect;
- provide child-sensitive treatment to children who require care for injuries from physical or sexual abuse, including sexually transmitted infections (STIs)/HIV, and immediate access to post-exposure prophylaxis/rape kits and emergency contraceptives;



- ask children if they would like a supportive adult present during any examinations;
- obtain legal consent from a parent or guardian for any medical examination or contact the CPO when parental consent is being unreasonably withheld;
- although children cannot give legal consent to medical treatment, health workers should explain any procedures to them and seek their “assent” before proceeding;
- prepare forensic medical reports and testify in court as needed;
- provide psychological first aid/first-line emotional support;
- referral to specialized mental health and psychosocial support services and care;
- mandatory reporting to a CPO of high-risk cases of suspected and confirmed cases of children in need of care and protection;
- participate in the child protection family conference/case conference and provide any follow-up medical care needed, as agreed during the case conference;
- waive medical fees for child survivors.

Education Sector

As a trusted adult, teachers and other school staff are often the first people who children will go to for help when they are being abused or neglected. Teachers and other school staff can play an important role in proactively identifying children who are experiencing abuse (on or off school grounds) and ensuring that they get the support and protection they need. This includes the following responsibilities:

- ensure that teachers are aware of all policies, procedures and legislation relating to the protection of children and are able to identify children who are facing abuse, neglect and exploitation at home;
- identify and respond appropriately to cases of violence and abuse perpetrated against children in school, whether by school staff or by other children;
- mandatory reporting to a CPO of suspected high-risk cases of children in need of care and protection, whether the abuse occurs within or outside the school or educational establishment;
- participate in child protection case conferences and provide follow-up support as agreed in a child’s care and protection plan (e.g. assistance to go back to school or to transfer to another school, catch-up tutoring);
- waive school contributions and other expenses for children in need of protection who have been placed by the MWCSO in alternative care.

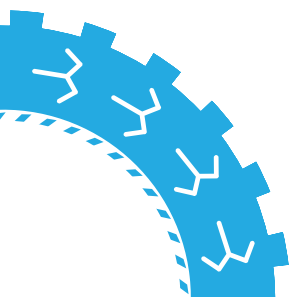




Child Protection in Emergencies

Children are particularly vulnerable to abuse, neglect and exploitation in times of emergency or in the aftermath of a disaster. Stress and displacement contribute to family stress and can lead to an increased incidence of family violence, and natural disasters can result in children being orphaned or separated from their families. The disaster risk management sector must therefore ensure that child protection is fully integrated into emergency preparedness and response mechanisms, including:

- identifying child protection risks that emergencies pose to children and integrating child protection in emergencies (CPiE) into disaster preparedness planning;
- training disaster risk management personnel on child protection;
- discussing CPiE in disaster risk management planning with communities and schools;
- ensuring that the emergency response includes measures to assess and respond to child protection issues;
- creating safe community spaces for children and ensuring that evacuation centres are child safe;
- ensuring that mechanisms are in place for reporting, referral and support services for children who have experienced violence, abuse or exploitation in times of emergency;
- providing child-sensitive mental health and psychosocial support.





Data Sharing and Information Management

Data starting and information management is key to the success of these Guidelines. The type, amount and style of data collected and then shared is critical to all agencies responding effectively to those in need. There will be a child protection information management system developed by a technical working group apportioned for this task. The system will be based on the needs and situation of the essential services agencies and their clients based on the National Child Care and Protection Policy and these guidelines.

The framework serves as a tool for government and non-government service providers and agencies who collect administrative data in the context of CP. A framework will help service providers and agencies standardize the collection of information to enable comparative analysis using common definitions such as definitions of violence, relationships, and risk indicators.

Collection and evaluation of CP data

The MWCSO is responsible for maintaining an information management system on Child protection. All key ministries/organizations will work together with the Ministry to improve the collection and sharing of data on GBV and children protection and the classification of cases. All key ministries/organizations will regularly share statistical information on child protection cases with the Ministry so that it can conduct periodic statistical analysis, to be presented to the Inter-Agency Task Force (this includes government ministries, NGOs, faith-based organizations and the private sector).

CP data from community and service providers is important to support critical decision making, policy development, planning, research and evaluation activities.

All CP services, health systems, police and courts collect information about cases and clients. This information is referred to as administrative data (data typically collected by an agency or service provider as a by-product of providing services to clients or otherwise undertaking a core business activity).

When reviewing CP data systems, there are several common data and knowledge gaps that are regularly identified:

- the demographic characteristics of priority communities, in particular, people with disabilities, minority and ethnically diverse communities, culturally and linguistically diverse
- the number of unique clients and the extent to which individuals have multiple engagements with agencies and services related to CP over time
- a person's interactions with different system, which assists to link individuals across different data sets

Analysis of administrative data is useful for organizations to understand their client needs and program planning. It is recommended that de-identified administrative data is shared and analyzed at a national or regional level to assist with understanding the impact of CP policy development, programs and planning, it can inform other research and evaluation.

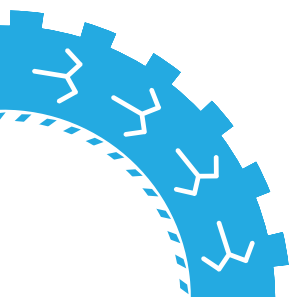
Improving multi-agency data collection practices and sharing de-identified data for analysis will subsequently advance the existing evidence base concerning GBV in Samoa.

Monitoring and Review of Guidelines

This Guideline document will be monitored and reviewed on a regular basis. MWCSO will develop a framework to measure and use and effectiveness of the guidelines based on monitoring visits and feedback from all partners and agencies involved.

As the lead organization for child protection, the MWCSO is responsible for monitoring and assessing the implementation of these guidelines. Approved forms from the MWCSO should be used for monitoring and evaluating the services provided and referrals..

It is the responsibility of all agencies to ensure that their staff members are aware of the guidelines and have the appropriate knowledge, attitudes and skills to fulfil their responsibilities effectively and in a survivor-centred and child-sensitive manner. These guidelines should be included in training packages for staff, highlighting the importance of a multidisciplinary approach when managing GBV and child protection cases.



The background features a complex, repeating pattern of interlocking gears and chemical structures, rendered in a lighter shade of orange against a darker orange gradient. The gears are of various sizes and orientations, creating a sense of mechanical complexity. Interspersed among the gears are several chemical structures, specifically branched hydrocarbon chains, which appear to be repeating units of a polymer or a specific class of organic molecules. The overall aesthetic is technical and scientific.

ANNEXES

Note about language

Certain terms will be used interchangeably throughout this text. For example, the terms **“victim”** and **“survivor”** are both used, although where possible the word “survivor” is used. Both terms refer to a person who has experienced GBV.

The terms **“patient”** and **“client”** will also be used interchangeably. Different people use these words to describe the same thing: a person in their care who is receiving services to help them after they have suffered violence. “Patient” is often used in the health sector while “client” is used in counselling and social service sectors.

Because it is almost always women and girls who experience acts of GBV, **“her”** or **“she”** is used throughout this document. However, it is recognized that men and boys also sometimes experience violence and the guidance given in this Guide can also be used for male survivors.

The term **“emergency”** is sometimes used interchangeably with the term **“disaster”**, for example in the context of biological and technological hazards or health emergencies, which, however, can also relate to hazardous events that do not result in the serious disruption of the functioning of a community or society.

Annex 1: Definitions

Gender-based violence (GBV): GBV is any act of violence that is directed against a woman because she is a woman or that affects women disproportionately. GBV involves the use and abuse of power and control over another person. Types of GBV include intimate partner violence, sexual violence against girls, violence against women, girls and children, and domestic violence (Safer Families, Stronger Communities Policy, 2018). It includes acts that inflict physical, sexual or mental harm or suffering, threats of such actions, coercion and deprivations of liberty.

The United Nations Declaration on the Elimination of Violence against Women (1993) defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women”.

Gender discrimination is not only a cause of many forms of violence against women and girls but also contributes to the widespread acceptance and invisibility of such violence, so that perpetrators are not held accountable and survivors are discouraged from speaking out and accessing support.

In all types of GBV, violence is used mostly by males against females to subordinate, disempower, punish or control. Whereas violence against men is more likely to be committed by an acquaintance or stranger, women more often experience violence at the hands of those who are well known to them: intimate partners and family members.

When violence occurs, it is because a person (the perpetrator) is exerting power over another (the victim) to obtain control over that person. While this control can take on many different forms, the common thread to all types of violence is that it is founded on the dynamic of exerting power to gain control.

Similarly, in the case of violence perpetrated against a woman or girl, the perpetrator’s power is specifically aimed at controlling her because of her gender, because she is a woman or girl, and for this reason is considered to belong to the “less powerful and less valuable” gender.

Acts of GBV addressed in this Guide shall be understood to encompass, but not be limited to, the following:

- physical, sexual and psychological violence occurring in the family, including battering, sexual exploitation, sexual abuse of children in the household and marital rape;
- physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in education institutions and elsewhere, trafficking in women and forced prostitution.

Intimate partner violence (IPV): IPV is behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behaviours. IPV includes violence by both current and former spouses and violence in other intimate partnerships, such as dating. Dating violence is included in IPV as dating refers to an inti-

mate relationship between two people of varying duration and intensity and that does not necessarily involve cohabitation. IPV is often referred to as “domestic violence”.

‘The pattern of behaviour of the perpetrator is similar in both domestic violence and IPV; in fact, while exerting power over his victim, the abuser uses the bonds of closeness and intimacy that have been built over time in the relationship to gain control over the victim. Bonds of intimacy are defined as bonds of love, friendship, confidence and attachment between two people.

Economic/financial abuse: Economic abuse is behaviour that is coercive or deceptive or that unreasonably controls another without their consent and in a way that denies them economic or financial autonomy. It also includes situations where one person withholds or threatens to withhold financial support necessary to meet reasonable living expenses such as for food, water and medical treatment. Acts of financial abuse include:

- preventing a woman from finding or keeping employment;
- forcing a woman to quit her job;
- controlling a woman’s finances;
- forcing a woman to work to pay back “debt”.

Equity: This refers to the concept of fairness and involves access to equal opportunities and the development of basic capacities. To ensure equity, it is necessary to recognize that some groups have been disadvantaged and that, even though the rules do not specifically discriminate against some people, they could, in fact, induce some forms of discrimination when social inequalities are overlooked. Therefore, equity could necessitate special measures to compensate for such disadvantages. Equity is an essential element of equality (Safer Families, Stronger Communities Policy, 2018).

Incest (see the Crimes Act 2013, section 55):

- Sexual connection is incest if (a) it is between two persons whose relationship is that of parent and child, siblings, half-siblings, or grandparents and grandchild and (b) the person charged knows of the relationship.
- In this section, “child” includes an illegitimate child or an adopted child, and “grandchild” has a corresponding meaning.
- A person who is or over the age of 16 years who commits incest is liable to imprisonment for a term not exceeding 20 years.

Sexual exploitation (see the Crimes Act 2013): Committed by a person in a position of power, influence or control over another more vulnerable person, sexual exploitation is the abuse of that power and the vulnerable person’s trust for sexual purposes; this includes profiting monetarily, socially or politically from the sexual exploitation of another. Acts of sexual exploitation include trafficking, forced prostitution, forced pregnancy or sexual slavery/servitude.

Trafficking (see Crimes Act 2013, section 153): Trafficking is an act of coercion against a person and includes:

- abducting the person;
- using force against the person;
- harming the person; or threatening the person (expressly or by implication) with the use of force in respect of, or the harming of, the person or some other person.

Coordination: Coordination of services and referrals is critical for the safety of women and children. The following are key areas that services need to be clear on, both internally and across agencies:

- Who the focal point is for GBV within each agency.
- There needs to be an inter-agency taskforce in charge of coordination. Inter-agency accountability covers full budgeting and resources (standard operating procedures), etc.
- The MWCSO is the focal point for GBV and the secretariat for the taskforce.

Referral pathway: Referral is the act of referring someone or something for consultation, review or further action. For the purpose of these guidelines, a referral pathway is the flow and order of services that should be followed to ensure that survivors access the appropriate support at the time of need.

Case management: This refers to a collaborative process of managing the assessment, planning, facilitation, care coordination, evaluation, accompaniment and advocacy for options and services to meet an individual's and family's needs.

Family/domestic violence: Family/domestic violence or IPV involves violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence causes fear and physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman. Living with domestic violence has a profound effect on children and young people and may constitute a form of child abuse (national Samoa Child Care and Protection Policy and National Action Plan 2019–2024) – family violence more commonly refers to domestic violence.

Child: Any person under the age of 18.

Child in need of care and protection: A child is in need of care or protection if:

- the child has been orphaned or abandoned and appropriate arrangements have not been made for her/his care;
- the child's parents are unwilling or unable to care for the child;
- the child has been displaced, traumatized or separated from her/his family as a result of an emergency, natural disaster or conflict;
- the physical development or health of the child has been, or is likely to be, significantly harmed and the child's parents have not provided or allowed the provision of medical, surgical or other remedial care;
- the child is being, or is likely to be, harmed because of physical abuse, emotional abuse, neglect, sexual abuse, sexual exploitation, or hazardous or exploitative labour.

Child physical abuse: This means any act of violence or maltreatment that results in physical wounds or bodily injury to the child. It may consist of a single incident or repeated incidents. Examples are kicking, punching, shoving, shaking, throwing, strapping, slapping causing injury, pinching leaving bruises, or choosing not to assist a child when a situation is causing them physical pain. Indicators of child physical abuse include broken bones, multiple bruising and cuts.

Child sexual abuse: This means engaging in sexual activity with a child who has not reached the legal age of consent or that is in violation of the laws of Samoa. This includes engaging in sexual activities with a child under the age of 16 (the legal age for consent); using coercion, force or threats; abusing a position of trust/authority or influence over the child; or taking advantage of the particularly vulnerable situation of a child, such as when a child has a mental/physical disability or is dependent. Child sexual abuse can take the form of contact acts such as kissing, touching a child in a sexual manner (fondling or masturbation), penetration of the vagina or anus either by fingers, penis or any other object, or making a child perform these acts on themselves or anyone else. Non-contact acts of sexual abuse can include sexual harassment or unwanted sexual comments, flashing, exposure to pornography, having a child pose or perform in a sexual manner, grooming and communication of graphic sexual matters using technology, including but not limited to instant messenger, text messages and emails. Indicators of child sexual abuse include:

- child has a STI and is pregnant underage;
- change in behaviour: withdraw, act out;
- fear of the same or opposite sex in general;
- bedwetting or other regressive behaviour;
- depression, aggression;
- running away from home.

Child emotional abuse: This means a single act or omission or series of acts causing or likely to cause mental or emotional suffering, including patterns of belittling, denigrating, threatening, scaring, ridiculing or other non-physical forms of degrading or rejecting treatment. Examples include cursing; making a child feel unloved, unworthy, inadequate or frightened; blaming, ridiculing or humiliating a child; discrimination; exclusion of a particular child; unrealistic expectations of a child; and threatening or corrupting a child. Indicators of child emotional abuse include:

- being withdrawn, afraid or untrusting;
- having low self-esteem;
- suicidal ideation.

Child neglect: Failure by a parent/caregiver to provide for a child's basic physical, intellectual, emotional or social needs, including any special needs in relation to disability, such that it is likely to cause harm to the child's development. This includes an inability to respond emotionally to a child, child abandonment, depriving or withholding physical contact, the failure to provide psychological nurturing and treating one child differently from another (national Samoa Child Care and Protection Policy and Plan of Action 2019-2024). Indicators of child neglect include:

- showing signs of malnourishment;
- being unclothed, dirty and often sick;
- having no primary caregiver and being unsupervised;
- not attending school;

- doing small jobs such as vending;
- begging;
- using drugs.

Hazardous or exploitative child labour: This means any work that is inappropriate for a child's age, that is hazardous to a child's physical or mental health and that interferes with a child's education and moral development. This includes any work that is defined as hazardous work or a hazardous occupation under Samoan law. Examples are selling goods close to places such as bars, hotels, cinemas or wharfs at night-time, sea walls (school nights at late hours).

Child sexual exploitation: Two types of child sexual exploitation have been identified:

1. child prostitution: engaging a child in sexual activity in exchange for cash, gifts, favours or any other form of payment;
2. child pornography: any depiction of a child engaged in sexually explicit conduct or depiction of the sexual parts of a child for sexual purposes.

Indicators of child sexual exploitation include:

- children being found in places that are inappropriate for their age;
- children out late at night or in entertainment places such as bars and hotel;
- children taking inappropriate pictures of themselves and sharing them;
- children communicating with adults/people they do not know.

Disaster: A serious disruption of the functioning of a community or a society at any scale as a result of hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts.

- The effects of the disaster can be immediate and localized, but are often widespread and could last for a long period of time. The effects may test or exceed the capacity of a community or society to cope using its own resources and therefore assistance may be required from external sources, which could include neighbouring jurisdictions or jurisdictions at national or international levels.

Disaster damage occurs during and immediately after the disaster. This is usually measured in physical units (e.g. square meters of housing damaged, kilometres of roads damaged) and describes the total or partial destruction of physical assets, the disruption to basic services and damage to sources of livelihood in the affected area.

Disaster impact is the total effect, including negative effects (e.g. economic losses) and positive effects (e.g. economic gains), of a hazardous event or disaster. The term includes economic, human and environmental impacts and may include death, injuries, disease and other negative effects on human physical, mental and social well-being.

For the purpose of the scope of the Sendai Framework for Disaster Risk Reduction 2015–2030 (paragraph 15), the following terms are also considered:

- **Small-scale disaster:** a type of disaster affecting only local communities, which require assistance beyond the affected community.
- **Large-scale disaster:** a type of disaster affecting a society, which requires national or international assistance.

- **Frequent and infrequent disasters:** these depend on the probability of occurrence and the return period of a given hazard and its impacts. The impact of frequent disasters could be cumulative or frequent disasters could become chronic for a community or a society.
- **A slow-onset disaster** is defined as one that emerges gradually over time. Slow-onset disasters could be associated with drought, desertification, sea level rise and epidemic disease, for example.
- **A sudden-onset disaster** is one triggered by a hazardous event that emerges quickly or unexpectedly. Sudden-onset disasters could be associated with earthquakes, volcanic eruptions, flash floods, chemical explosions, critical infrastructure failures and transport accidents, for example.⁹

Disaster risk reduction:

- Disaster risk reduction is aimed at preventing new and reducing existing disaster risks and managing residual risks, all of which contribute to strengthening resilience and therefore to the achievement of sustainable development.
- Disaster risk reduction is the policy objective of disaster risk management and its goals and objectives are defined in disaster risk reduction strategies and plans.
- Disaster risk reduction strategies and policies define goals and objectives across different timescales and with concrete targets, indicators and time frames. In line with the United Nations-endorsed Sendai Framework for Disaster Risk Reduction 2015–2030, adopted in March 2015, these should be aimed at preventing the creation of disaster risk, the reduction of existing risk and the strengthening of economic, social, health and environmental resilience.
- A globally agreed policy of disaster risk reduction is set out in the Sendai Framework for Disaster Risk Reduction 2015–2030, whose expected outcome over the next 15 years is “The substantial reduction of disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries”.¹⁰

Matai: A person of chiefly title.

Tulafale: A chief who performs the role of spokesperson, also known as an orator.

Pulenu'u (Sui o le Nu'u): Government representative of a village (village mayor).

Fono a le Nu'u: Village council or meeting of village chiefs.

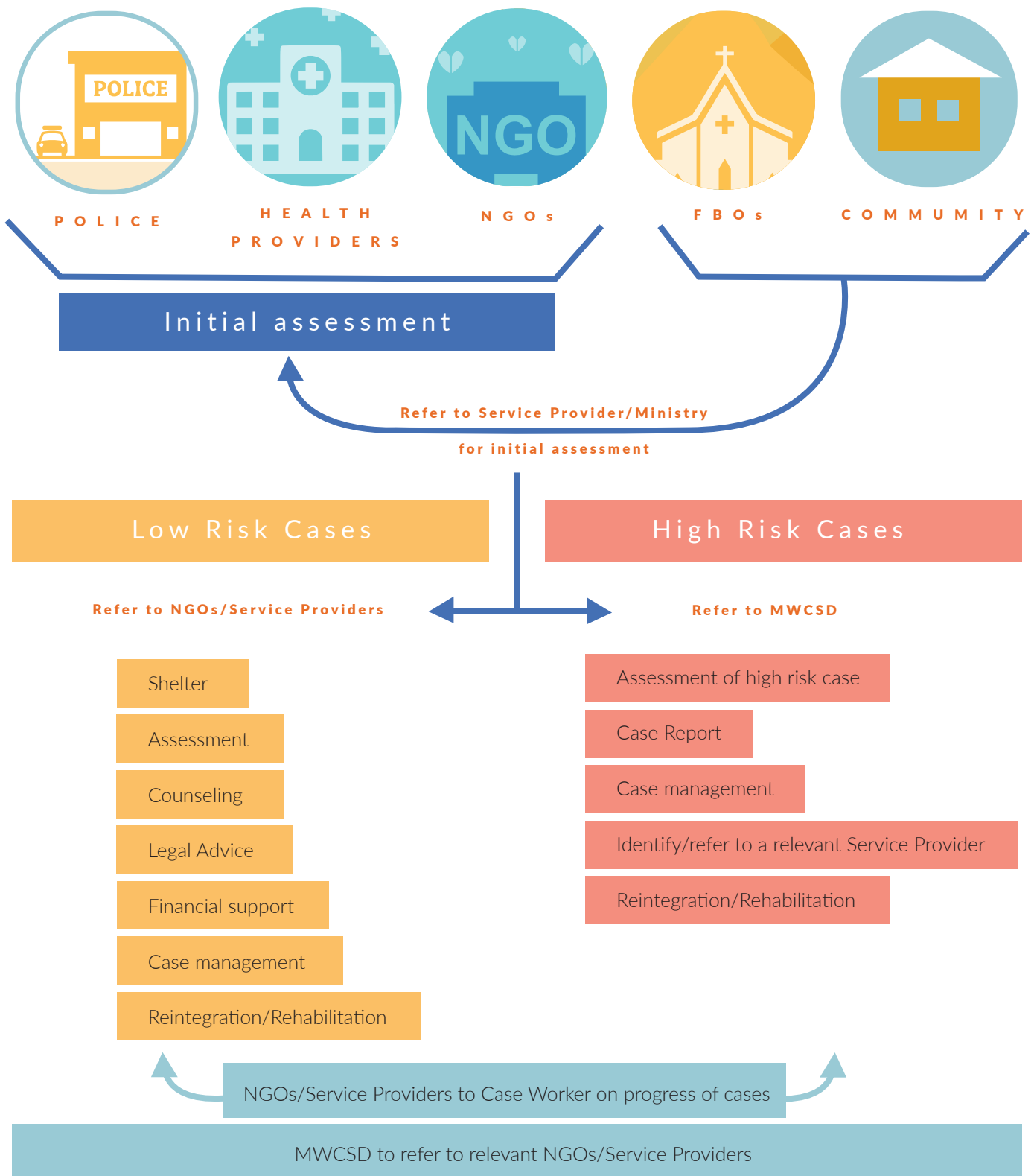
Sui Tama'ita'i o le Nuu (STN): Female representative of the government in a village.

Sui o Ekalesia So'ofa'atasi: Representative of the Council of Churches, Samoa.

Sui o Komiti o le Fale'ula: Representative of the Fale'ula Committee.

⁹ <https://www.unisdr.org/we/inform/terminology>
¹⁰ <https://www.unisdr.org/we/inform/terminology>

Annex 2: Entry Point/First Point of Contact Diagram



Community, village representative, extended family, community nurses, youth network, churches, charities

Annex 3:

Form 1 GBV Referral to MWCSO



Malo o Samoa
Matagaluega o Tina ma Tamaitai, Atinae o Nuu,
Afioga ma Agafesootai

MWCSO Case File Number: _____
Numera o le Faila: _____

PEPA FESILI 1: FAAMATUU I LE MWCSO GBV REFERRAL TO MWCSO

O iai se tasi o loo I setulaga e ono lamatiaai le soifua? Ioe Leai

(Is there anyone in IMMEDIATE danger?)

Afai e Ioe, valaau Leoleo I le - Tel:995

(If Yes, DO NOT wait, call the Police - Tel: 995)

Suafa o le Tamaitai/AliiOfisa o Leoleo/MWCSO safaatalanoaina

(Please provide the name & office of Police Officer/MWCSO staff spoken to)

Taimi:

Aso:

Igoa:

Vaega:

Vaega 1: Faamatalaga Taua (Section 1: Core Details)

(1.1) Faamatalaga o le natuuinaatu le mataupu (Referrer Information)

Suafa (Name):			
Galuega (Work)			
Faamaumauga o Feso'otaiga (Contact Details)	Nu'u (Village):	Telefoni (Number):	Imeli (Email):
O se matauputuunamai?	Ioe <input type="checkbox"/> Leai <input type="checkbox"/>		

(1.2) Igoa atoa o le o loo e aveia i lau faamamafa (Full name(s) of the person(s) you are concerned about)	Nu'u / Telefoni	Aso Fanau	Tausaga	Kenera	E iai se aafiagatum au?	Tusi le igoa o le A'oga (laloifo o le 18 tausaga)
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

(1.3) Igoa atoa o le o loo masalomiasafaaoolima, leaga le tausiga ma tuulafoaiina se tagata (Name(s) of the person(s) you suspect to have caused abuse / maltreatment / neglect)	Nu'u/Telefoni	Aso Fanau	Tausaga	Kenera	E iai se aafiagatu ma?	Tusi le igoa o le A'oga (laloifo o le 18 tausaga)
					<input type="checkbox"/>	
					<input type="checkbox"/>	
(1.4) Igoa atoa o isi tamaiti o loo itotonu o le aiga (Names of other children in the household)	Aso Fanau	Tausaga	Kenera	E iai se aafiagatu mau?	Faiai le tamaititi o loo aafia (Relationship to child)	
				<input type="checkbox"/>		
				<input type="checkbox"/>		
(1.5) Nisi tagata e pei o le Pulenuu, Matai ma isi (Other key supportive people)	Aso fanau	Tausaga	Kenera	E iai se aafiagatu mau?	Faiāi le o loo aafia (Relationship to client)	
				<input type="checkbox"/>		
				<input type="checkbox"/>		

Vaega 2: Mafuaaga o le Mataupi (Section 2: Reason for Referral)

(2.1) Faamolemole faamatala mai le mafuaaga ua oo mai ai lenei mataupu

(Please tell us the reason for this referral)

2.2) E fesoota'i lenei mataupu ma niuiga tau faamata'u ma le amanaia le tagata soifua?

(Does this relate to any abuse or neglect of an individual?)

(2.2.1) Sauaina o le tino (Physical Abuse) Sauaga tau feusuaiga (Sexual Abuse)

Sauaina o lagona ona o upu lafo (Verbal/Emotional Abuse) Le amanaia (Neglect)

(2.2.2) Faamolemole faamatalamai (Please explain)

(2.2.3) Na faapefea ona e silafiaina o le mataupu lenei e tatau ona matuasuesueina ma faamamafaina?

(How were you made aware of the issue that has given you cause for concern?)

(2.2.4) O anafea na tupuai lenei faafitauli/poo nei faafitauli?

(When did these event(s) occur?)

Aso :

Taimi:

(2.3) Sa iai nisi vaega na aafiai lenei mataupu? (Are there any other concerns?)	
(2.3.1) Na aafiai nisi o vaega o loo ilalo?(Faasa'o le pusatalafeagai) Does it involve any of the following (tick all that apply)	
Faaogaina Ava malosi (Alcohol Misuse) <input type="checkbox"/>	Faaogaina o fualaaufaasaina (Drug Misuse) <input type="checkbox"/>
Aafiaga o le mafau (Mental Health Issues) <input type="checkbox"/>	E amioaa'i le sau (History of Violence) <input type="checkbox"/>
Tamaiti e le o aoga (Children not in School) <input type="checkbox"/>	E masaniai le tiga o lagona (History of Offending) <input type="checkbox"/>
Isi (Other) <input type="checkbox"/> : _____	
(2.3.2) Faamolemole faamatalamai (Please explain):	
(2.4) Faailoamaini faamatalaga poo se galuega safaatinoina e nisi e uigai lenei lava mataupu (Any discussions and/or actions that have already taken place regarding this concern/any action taken?)	
(2.5) E iai ma nisi faamatalaga e tatauona e faailoamaia e taua ma aogai le faatalanoaina o leneimataupu? (Is there any other information that you believe would be helpful to know?)	

(3.0) Faasoa'a'i o Faamatalaga (Information sharing (do not complete for self-referred))	
O iloaie le tagata aafia uamaea ona fefaasoaiina faamatalaga nei (Is the person concerned aware that you have shared this information?)	
	loe <input type="checkbox"/> Leai <input type="checkbox"/>
E temanao e faailoa nei faamatalaga I niaualafaalilolilo (pe a manaomia) Do you wish to share this information confidentially (if possible)?	
	loe <input type="checkbox"/> Leai <input type="checkbox"/>
(4.0) Mo le Faaogainana o Faalapotopotoga e tauaao I aimataupu (For receiving agency purposes only)	
Taulimaina e (Referral received by)	
Tuinaatuia (Delegated to)	
Numera o le Faili (Case File Number)	
Iuga toe faafoi I lēnafaamatuuinamai le mataupu (Outcome fed back to referrer)	Aso: E ai:

Annex 4:

GBV Referral to External Agency



Malo o Samoa
Matagaluega o Tina ma Tamaitai, Atinae o Nuu,
Afioga ma Agafesootai

MWCSD Case File Number: _____

PEPA FESILI 4A: FAAMATUU I ISI FAALAPOTOPOTOGA

GBV REFERAL TO EXTERNAL AGENCY

ASO FAAMATUU ATU AI
(DATE OF REFERRAL): __/__/__
TAIMI (TIME): __:__

Vaega 1: (Section 1: Client Information)

Vaega 2: Faalapotopotoga taulima faamatalaga tuuina atu (Section 2: Organisation Receiving Referral)

(1.1) Igoa Atoa o le o loo tuuina atu	Nu'u / Telefoni	Aso Fanau	Tausaga	Kenera	E iai se aafiagatuma?	Tusi le igoa o le A'oga (laloifo o le 18 tausaga)
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Faamolemole faamatala mai le mafuaaga ua oo mai ai lenei mataupu (Please tell us the reason for this referral)						
(2.1) Faalapotopotoga (Organisation)						
(2.2) Suafa o le Tagata Faigaluega ma Iona Tulaga (Name of Staff / Designation)						
(2.3) Faamaumaugafesootaiga (Contact Detail)	Tuatusi (Address):			Imeli:		
(2.4) Mafuaagauatuinaatuai (Reason for Referral)						

(3.1) Ofaamatalagatuuina o aafiaivaega o loo tauailalo? (Is this case being referred for any of the following reasons?)	
Sauaina ole Tino (Physical Abuse) <input type="checkbox"/> SauagaTaufeusaiga (Sexual Abuse) <input type="checkbox"/> Sauaina o lagona maupusoonalafo (Verbal/Emotional Abuse) <input type="checkbox"/> Le amanaiaina (Neglect) <input type="checkbox"/>	
Faamatalaga (Explanation) Pe a faamautinoaina le tupu o leneimataupu/poo neimataupu? When these event (or these events) are believed to have occurred Aso: _____ Taimi: _____	
Vaega 4: Sa faatalanoaina pe o loo faatalanoaina (Section 4: Previous or ongoing interventions)	
Vaega 5: MWCS D Faamauga a le na tuulimaina atu le mataupu (Section 5: MWCS D Referrer Information)	
(5.1) Suafa & Tulaga (Name & Designation)	
(5.2) Vaega o le Matagaluega (MWCS D Division)	
(5.3) Auala o Fesootaiga (Contact Details)	Tuatusi: Telefoni: _____ Imeli: _____

PROFESSIONAL WHO RECIEVED THIS REFERRAL/TAGATA NA FAAMAUINA LE MATAUPU	
Faapeanafaao lea galuega? (How was this referral made?)	<input type="checkbox"/> Talanoa (Verbal): Aso: __/__/__ Taimi __: __ <input type="checkbox"/> Tusitusia (Written) Aso: __/__/__ Taimi __: __
Tagata na taulimaina (Referral received by)	
Tulaga (Designation)	

Annex 5: Child Protection Reporting and Referral Form

FORM 4A: REFERRAL TO EXTERNAL AGENCY // Ministry of Women Community and Social Development (Edition JUL17)



Malo o Samoa
Matagaluega o Tina ma Tamaitai, Atinae o Nuu,
Afioga ma Agafesootai

MWCSD Case File Number: _____

Child Protection Reporting and Referral Form

Fa'ata'ita'iga o le Ripoti ma le Pepa Fa'amatu'u
mo le Puipuiga o Tamaiti

REPORT OF A CHILD IN NEED OF CARE AND PROTECTION (LIPOTI MO SE TAMAITITI O LOO MANAOMIA LE FESOASOANI)		
CHILD'S INFORMATION (FA'AMATALAGA O LE TAMAITITI)		
Name (Igoa):	D.O.B or approximate age: Aso Fanau poo Tausaga:	
Place where the child is living: (Nu'u)	Male (Tama)	Female (Teine)
PARENT / CAREGIVER INFORMATION (FA'AMATALAGA O LE MATUA PO'O LE TAGATA O LOO VAAIA LE TAMAITITI)		
Mother's name: (Igoa o le Tina)	Phone number: (Telefoni)	Address: (Nu'u)
Father's name: Igoa o le Tama:	Phone number: (Telefoni)	Address: (Nu'u)
Other Caregiver: name / relationship to the child: (Igoa o le tagata o loo vaaia le tamaititi/Faiā I le tamaititi)	Phone number: (Telefoni)	Address: (Nu'u)
REASON FOR REPORTING (MAFUA'AGA O LE MATAUPU)		
Description of reason for concern about the child: (Mafua'aga o le popolega I le tamaititi)		
Description of any action taken in relation to the child: (Fa'amatalaga o se galuega sa faatinoina e nisi e uiga i lea lava mataupu)		
REPORTER'S DETAILS (Fa'amatalaga o le na tu'uina mai le mataupu)		
Name: (Igoa)	Agency / Organisation: (Fa'alapotopotoga)	
Phone: (Telefoni o le Ofisa)	Title / position: (Tulaga I le galuega)	
Mobile: (Telefoni Feavea'i)		
Date: (Aso)	Signature: (Saini)	