

**When we stand together as one. Improving health outcomes in Samoa.  
A study of New Zealand Health Aid in Samoa 2002 – 2012**

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## Abstract

Despite more than \$1 billion disbursed in health aid regionally over the last decade, the poor health of people in Pacific Island Countries and Territories (PICTs) remains deeply concerning. This has included significant investment in infrastructure supporting quality health services. However, there has been less attention on the context of health aid delivery, such as social, economic and cultural factors or “modern/western” lifestyle transitions that lie outside the health sector but not addressing a variety of behavioural, social, cultural, traditions and more particularly.

Given the stark disparity between people’s health outcomes and investment levels, there is an urgent need to examine the factors influencing aid delivery processes in small Pacific nation states. These factors are the focus of this study. This research explores how health aid can be more effectively delivered in Samoa utilising the Paris, Busan and Accra aid agreements, and considers the applicability of such international aid models. More particularly, my focus was on principles of participatory decision-making, and how aid donors and recipients perceived their role and rationale in this process. The study focus years were 2002-2012, and fieldwork carried out between December 2012 and January 2013. Fieldwork comprised interviews with aid personnel, practitioners and NGOs, with the aim of gaining three perspectives of health aid decision-making, including participants’ views of what constitutes good aid, how this worked, challenges to good aid and ways to improve health delivery. Unfortunately, Samoa was hit by Cyclone Evan as fieldwork began and this naturally impacted data collection, as all national resources were directed to cyclone recovery. At the same time, this situation clearly highlighted the vulnerability all PICTs to natural disasters, and how this directly affects all planning, particularly in the area of health.

The major finding of this research was that while agreeing to international mandates such as Paris, Accra and Busan Agreements as well as the Pacific aid principles, Samoa experienced major constraints in implementation. This was largely due to limited human resource capacity and economic constraints, with emigration also playing a role. Limited budgets impacted negatively on training, the establishment and maintaining of robust data collection systems by which to inform planning, and even the release of medical staff to allow the opportunity for participation in decision- making. In a similar vein, NGO participation in health decision-making was minimal. In sum, while participatory planning and donor harmony was espoused by all, this was practised in a limited way. In fact, there are questions as to how a participatory model is fully achieved in small nation states such as Samoa.

For Samoa, this research on perceptions of health aid decision-making highlights the need for a rethink of planning and policymaking, including linkages to cross-sector development strategy. It is likely that this will resonate with the experience of other PICTs. Findings will also add to global understanding of factors influencing the application of the Paris principles, and subsequent agreements in small nation states.

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## List of Abbreviations

CSASP – Civil Society Support Programme

GoS – Government of Samoa

GDP – Gross Domestic Product

HSP – Health Sector Plan

LDC – Least Developed Country

MOH – Ministry of Health

MDG – Millennium Development Goal

MTEF - Medium Term Expenditure Framework

NCD – Non-Communicable Disease

OECD – Organisation for Economic Cooperation and Development

PICTS – Pacific Island Countries and Territories

SPC – Secretariat for the Pacific Community

StEPS – Stepwise Approach to Surveillance

SUNGO – Samoa Umbrella for Non-Government Organisations

SWAp – Sector Wide Approach

WHO – World Health Organisation

## Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

A handwritten signature in blue ink, appearing to be 'D. Frost', written in a cursive style.

Signature

Date 27 June 2018

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I can do all things through Christ who strengthens me.

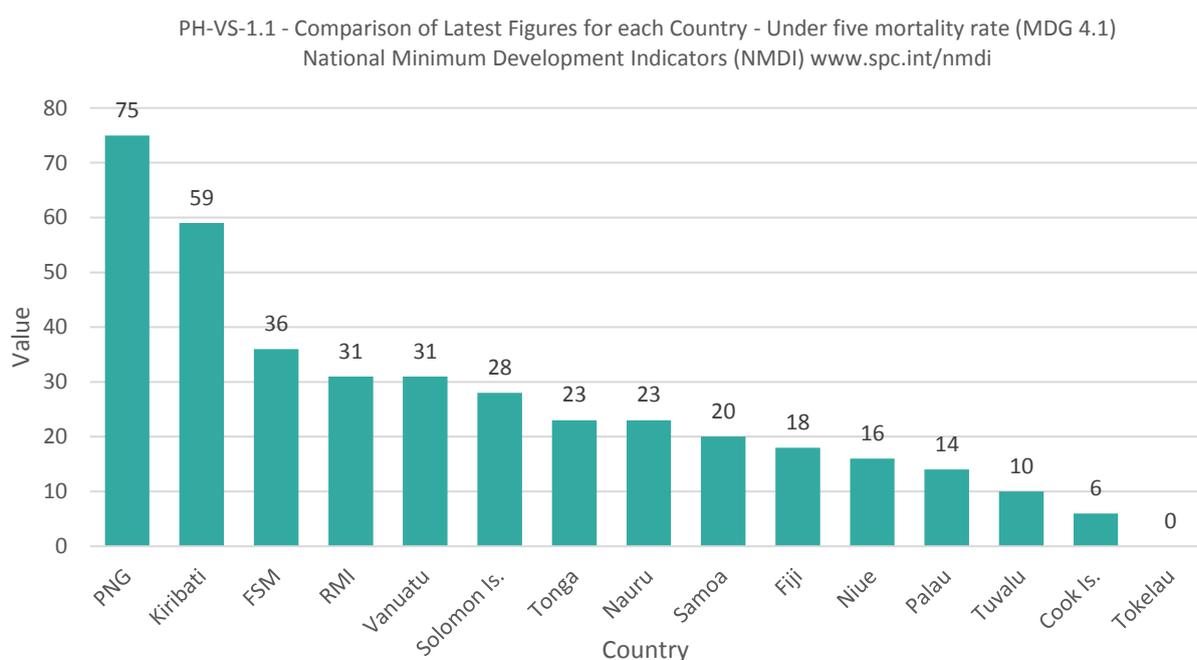
Philippians 4:13

# CHAPTER ONE: INTRODUCTION

The poor health of the peoples/populations of Pacific Island Countries and Territories (PICTs) is deeply concerning. This is despite more than USD\$1 billion disbursed in health aid regionally over the last decade (WHO, 2012). This includes significant investment in infrastructure, supporting quality health services. However, there has been less attention on the context of health aid delivery, such as social, economic and cultural factors or “modern/western” lifestyle transitions that lie outside the health sector but not addressing a variety of behavioural, social, cultural, traditions and more particularly.

For example, the under-five mortality rate is commonly used as a significant marker of national health status. Taking the Millennium Development Goals (MDGs), Goal 4 aimed to reduce the under-five mortality rate by two thirds between 1990 and 2015 (United Nations, 2016). The Pacific Under-Five Mortality Rate shown in figure 1 below shows wide ranging data by country from a high rate of 75 per 1000 in PNG to 6 per 1000 in the Cooks, a rate which is comparable with many developed countries such as New Zealand and Australia. The (SPC 2015a) report also detailed problematic system issues around health status data in the Pacific more specifically. Reliability and collection constraints and other factors likely to influence data. For example some countries may have much better access to out of country health evacuation opportunities for serious cases and as a result some deaths may not appear in their country data.

**Figure 1: PICTS Health Statistics - Under-five mortality rate**



Source: SPC, 2015a.

However, the under-five mortality rate is a small portion of an extremely poor health picture. Data shows that Pacific people face a range of negative health outcomes across health indicators, particularly those related to child and maternal health and those associated with the increasing burden of non-communicable diseases. For example, the PICTs comprise eight of the ten most overweight populations in the world (World Health Organisation [WHO], 2007). Seventy percent of people in Tonga and more than half of people (56 percent) in Samoa are classified as obese (Secretariat for the Pacific Community, 2015a).

The emergence of a 'double health burden' (Lewis & MacPherson, 2008) also provides a challenge as the re-emergence and increasing severity of traditional diseases such as dengue fever must be dealt with alongside the increasing burden of non-communicable diseases (NCDs). Further, new attention focuses on the effects of climate change and natural disasters on health, e.g. the impact of extreme weather and climate events on climate-sensitive diseases, such as malaria, dengue fever, and diarrheal diseases (Ebi, Lewis and Corvalen (2005).

Given the stark disparity between people's health outcomes and investment levels (WHO, 2012) there is urgency for a deeper examination of factors influencing the aid delivery process. Looking more closely at the impact of newer models of participatory development and stakeholder engagement on health planning and implementation is critical to assess whether these have led to better health delivery and outcomes than the government aid planning and delivery processes.

As is well documented, participatory processes and stakeholder engagement has a central place in the raft of public sector reforms introduced from the 1990s onwards, including the good governance agenda. These participatory models run counter to the top-down models of government which PICTS had been familiar with and expected. In contemporary terms, governance is defined as:

'... characterised by people's participation, networks, alliances, alignments and cohesion across and between institutions and processes in the planning of national affairs' (Polit & Beck 2008; UN, 2006)

'... comprising the traditions, institutions and processes that determine how power is exercised, how citizens are given a voice and how decisions are made on issues of public concern' (Graham, Amos and Plumptre, 2003)

'...the means to sustainable outcomes' (Jon Pierre, 2000)

'... as the means by which an activity or ensemble of activities is controlled or directed, such that it delivers an acceptable range of outcomes according to some established standard.' (Hirst, 2000)

'The concept of governance encompasses the actions of stakeholders within sovereign states as well as those at the international level.' (Lee & Scott, 2003)

The philosophical underpinnings of the governance agenda evidenced in these definitions have become the model for aid planning and delivery from the 2000s onwards as seen in the aid effectiveness discussions. The 2005 Paris Declaration and subsequent Accra and Busan agreements (OECD 2015) draw on the governance agenda and enshrine a set of principles aimed at transforming roles, relationships and decision-making processes. It is proposed that these changes will ensure aid effectiveness by improving the alignment between national and international development planning efforts, while the same time addressing a lack of harmonisation between donors in aid planning and delivery (Harmer and Ray, 2009). Globally most nations and all Pacific countries are signatories to the Paris Declaration and the subsequent Accra and Busan agreements (OECD, 2015); and Pacific countries prepare their own aid effectiveness principles.

Global efforts to enhance aid delivery have resulted in evolving aid models which reflect ongoing critique about aid delivery and impact, as will be discussed in chapter two (Lancaster, 2007). The partnership model was an important influence on the 2005 Paris Declaration. Briefly, the aims of the Paris Declaration were to improve alignment between national and international development efforts and decision-making and address the perception of a lack of harmonisation between donors (Harmer and Ray, 2009). The Declaration and subsequent Agreement's principles each have specific impacts for decision-making. These are ownership, advocating developing countries leadership over their development policies and plans; alignment, assistance using countries' own development strategies and systems; and harmonisation, coordination, simplification and information sharing to avoid duplication. The *results* principle involves organisation of activities to achieve the specified results; and the *mutual accountability* principle involves both donors and partners being accountable for development results (Fairbairn-Dunlop, et al., 2009; OECD, 2012). Progress in implementing Declaration principles has been mixed (OECD, 2011, Overton, 2011). While advances in collaboration and coordination are reported and new partnerships in decision-making developed, systems to support these partnership relationships are slow in progressing. In addition, while the Paris Declaration has enshrined principles, different donors still have different models for aid delivery. This I will elaborate on throughout my research.

I define research aid as the provision of foreign exchange, or goods and services, from a developed country to one deemed to be developing, and where there is no obligation to repay (Liuvaie, 2009).

## **Research gap**

While the principles underlying the Paris Declaration and other aid agreements are extensively documented; somewhat surprisingly, there is less effort devoted to investigating the effects of or the process of implementing the Paris principles (Sjöstedt, 2013), nor the nature of the decision-making involved. International organisations such as the OECD evaluate the implementation of the aid effectiveness principles within recipient partner countries (OECD, 2010a), and there are myriad monitoring and evaluation reports on aid projects. Pacific health research focuses on particular elements of aid decision-making such as the implementation of Sector Wide Approaches (SWAp) (Negin, 2011a, 2011b) or the impact of single projects, such as rheumatic fever screening (Department of Health, 2002). However, I find little research undertaken to explore and document the actual aid delivery process signaled in the aid effectiveness principles including, for example, the experiences of the national planners, the practitioners, and the people or communities who were recipients of aid.

For example, do they as stakeholders, have a place at the decision-making tables on health priorities and spending, effective delivery mechanisms, and, as users? Also of interest is whether the roles and relationships between different stakeholder's impact on the decision-making processes and in the health outcomes being achieved.

Community and NGO voices are missing in the aid debate generally (Paton and Fairbairn- Dunlop,

2010), evidenced in the climate change debate as well as in the health aid debate. With this in mind my study will explore the question: How can small nation states make health aid decisions, which will lead to better health outcomes incorporating participation by all? While I explore this from the perspective of the participatory ethos underpinning the aid effectiveness principle, I also strongly believe that people have a right to be involved, or at least informed, in the decisions that affect them (International Association for Public Participation Association Australasia, 2016), but also that more effective decision-making is achieved when knowledge and information is shared.

As has been well reported, stakeholder engagement is associated with more successful outcomes as all work together to achieve the agreed goals (Goss, 2007). The International Association for Public Participation Australasia's (IAP) values highlight seeking out and facilitating the involvement of those potentially affected by or interested in a decision, and recognising and communicating the needs and interests of all participants, including decision makers for sustainability (International Association for Public Participation Australasia, 2016). Despite the importance of stakeholder engagement and participation, little research investigates whether and how this plays out in health services in the Pacific.

To address this gap, and using Samoa as a single in-depth case study of health, my research seeks to answer questions such as: who are the stakeholders involved (or invited to participate) in health planning in small Pacific nations, what are their perceptions of good aid and how should this be implemented at ground level? This will be explored through questions about stakeholder roles and capacity, the systems in place to enable and ensure stakeholder engagement, and working together, including a consideration of equity and emerging challenges and potential solutions. Encompassing this, my study focuses on whether the good governance model of democratic participation and the Paris aid effectiveness model are realistic, doable, and a relevant model in PICTs which, as was well documented, faces issues of capacity including, as in the case of Samoa, significantly high levels of out-migration of highly qualified health and technical staff.

Finally, my personal and working experience in Samoa, as well as previous research incorporating Samoa, provides further impetus for this choice. My perspective, writing as a Samoan citizen and potential aid user, is also uncommon. Other research explores Samoan policy, its evolution and

characteristics (Kerslake, 2010; Ulu, 2012); however, studies have not examined a sector specific case study of how collaborative decision-making impacts outcomes.

## **Research aims and questions**

My research aims to explore people's perceptions of health planning and decision-making practices with a view to identifying how planning can be enhanced to ensure more robust health outcomes and to gain the views of local stakeholders engaged in aid decision-making, more particularly, in querying who participated in aid decision-making, how decisions are made (including information used, priorities, capacity, and collaboration levels), and how aid is delivered.

To achieve these aims I employ the following questions:

1. What is good aid?
2. How does good aid work?
3. What are the challenges to good aid and what can be done?

For this exploratory study, I utilise an in-depth national case study of Samoa, rather than a Pacific-wide approach, so as to contextualise and understand health decision-making drawing on the perceptions of those who engage in the activity of health provision and the structural, economic, and political contexts in which they work. Samoa is a long-standing recipient of aid through bilateral and multilateral aid channels and is a member of many groupings including the Secretariat of the Pacific Community; also I explore Samoa's relationship with New Zealand..

I explore these aims through a qualitative study comprising interviews to gain people's perceptions of health aid delivery processes generally and their place within the national health systems. A strengths-based approach identifies opportunities for action and enablers are used (Institute for Research and Innovation in Social Services [IRISS], 2012).

This belief aligns with the Samoan saying that to understand an issue it is wise to get the views of those at the top of the tree (e.g., the policy makers) those at the middle of the tree (the practitioners or the actioners) and those at the shoreline – the people affected by or impacted by the decision. This view aligns also with the strategy of consensus decision-making which is embedded in the Fa'a Samoa (Meleisea, 1987).

I use the Paris Declaration on Aid Effectiveness as the starting point for discussions. My study explores how the partnership model plays out in Samoa, with particular consideration to aid delivery funded by donors such as New Zealand. China is a secondary focus, selected due to its on-the-ground delivery of aid using a model different to other countries. Documentation, plus discussions with aid personnel, provides some insight into Chinese aid.

The Paris Declaration represents a major evolution in aid delivery giving central importance to the partnership approach and supporting participatory processes. New Zealand and PICTs support the Paris Declaration and give further specificity to this by developing the Pacific Principles of Aid Effectiveness, as will be discussed. As appropriate, I also refer to the Sector Wide Approach (SWAp) as my baseline.

It is critical to note that China is a signatory to all three aid agreements, but as an aid recipient rather than a donor (Oxfam America, 2012) China's leaders believe its model is different from Western countries and are non-committal about accepting a multilateral coordination mechanism (Callick, 2009).

The years 2002 to 2012 are the focus of this study being that they are the years immediately before and after the Paris Declaration. The Paris principles are explored from different perspectives, comparing and contrasting literature, and participant perspectives.

## **My place in this research**

As a Samoan, the poor health status of Pacific people is both academically and personally concerning to me as this involves the health and wellbeing of my family, friends and community, and national development. In addition, working as I did in a policy role I am keenly aware of the concepts and processes emphasised in development and implementation of health aid policy, as well as the complexities which arise when inputs do not produce the policy outcomes sought, for a range of reasons. Knowing how health decision-making and practices work on the ground is crucial to assessing (their) impact, effectiveness, and understanding the challenges and enablers which contribute to building more robust aid delivery processes. Furthermore, and less considered in the aid effectiveness debate, is that contextualising and understanding health decision-making requires not only the structural, economic, and political contexts in which health aid is delivered but also taking account of the viewpoint of those engaging in the activity of health provision, i.e., the stakeholders engaging in the activity of health planning and delivery such as a) aid donors, b) practitioners, and c) NGOs. These perspectives, regarding government health practices and civil society, are given prominence, drawing on literature and participant views from the government and the people including NGOs (Action for Global Health, 2011; Davies, 2013; Feachem, 2011; Government of Samoa, 2013; Vaillancourt, 2012).

I also understand and value the place of culture in Pacific people's lives and see the potential for cultural values, and practices to influence the aid process. I see that it is paramount to explore the impact of culture on health decision-making and to explore the dynamics surrounding local engagement. Gathering this knowledge is crucial for PICTs where, as is well reported, cultural practices are integral to daily life, and where health aid programmes impact on most PICT citizens. Exploration of culture's impact has potential benefit in identifying how service delivery aligns with traditional understandings of health, and improved healthcare access. In my reading, I find little prominence given to the impact of culture (positive and negative) on health aid delivery, which is at odds with Lasry, Carter & Zaric (2011) who proposed that culture played a role in the decision-making process.

## Study context

### New Zealand and Samoa

Assuming mandate over Samoa after seizure of control from Germany at the outbreak of World War One in 1914, New Zealand administrators governed Samoa with the support of the New Zealand Department of Island Territories. During these years, decisions were made by the New Zealand Parliament regarding funding and services in Samoa and periodically New Zealand officials visited Samoa to witness the programmes implemented (Meleisea, 1987). Led by Samoan chiefs, citizens expressed opposition to New Zealand policy and the exclusion of their perspectives in decision-making, which resulted in the tragic death of one Samoan leader on Black Saturday, 1929 (Field, 1991). Following the Samoan people's vote for independence in a United Nations Plebiscite, Samoa was the first Pacific Island Country to become independent in 1962. Following Samoa's independence, a traditional bilateral relationship with the New Zealand government was maintained, reinforced by policy instruments such as the 1962 Treaty of friendship which set out assistance. New Zealand assistance was also adapted to recent aid effectiveness work as a signatory to the Paris Declaration enshrining new partnerships.

Additionally, the Treaty of Friendship is one mechanism which supports the migration of thousands of Samoan people to New Zealand and supports the growth of Auckland as the city with the largest number of Pacific people in the world.

While New Zealand aid support is largely bilateral, it is also delivered to regional organisations and donors such as the Secretariat for the Pacific Community. Multilateral aid is also provided by a group of countries, or an institution which represents a group of countries, to one or more recipient countries (Liuvaie, 2009).

By contrast, Chinese aid is a recent development which stands alone without contribution to multilateral aid. One of the six largest donors in the Pacific, China's aid includes complete projects, technical cooperation, humanitarian aid and debt relief.

### Aid delivery to the Pacific

Aid comprised funds, technical assistance, and infrastructure. Main strategies for aid delivery are through government and regional organisations notably:

- as bilateral aid originating from a single donor country to a single recipient country;
- or as multilateral aid provided by a group of countries, or an institution representing a group of countries, to one or more recipient countries. (Liuvaie, 2009)

## *Main regional and multilateral programmes for health aid and delivery*

### SPC

Founded in 1947 by metropolitan powers drawing on a colonial aid model, the South Pacific Commission (SPC) includes external and former colonial powers within its membership of 26 countries, comprising 22 Pacific Island Countries, Australia, France, New Zealand and the United States of America. Global influences are also evident in SPC's relationships with other organisations. The organisation funds itself from member contributions and global bodies such as the Global Fund (South Pacific Commission, 2014), which funds interventions, often through domestic Ministries, to halt HIV, tuberculosis, and malaria, as well as work in areas such as adolescent health, with schools to develop life skills programmes, and with health centres to make services more youth friendly (Government of Samoa, 2011).

### WHO

The World Health Organisation (WHO) is a specialised agency within the United Nations (UN). Established in 1948, it represents the internationalisation of public health policy (Lewis & MacPherson, 2008). Funded through member state contributions, this multilateral organisation works with Government Health Ministries setting standards, and providing technical support (World Health Organisation, 2012) in areas such as health promotion, tobacco prevention, and surveillance systems for AIDS, TB and STIs (Government of Samoa, 2011).

The 1978 International Conference on Primary Healthcare produced the Alma-Ata Declaration which heralded a new public health strategy including the connection of health to issues of equity, social and economic reform, and capacity building (Lewis & MacPherson, 2008). Consistent with the basic needs model of aid delivery, designed to meet people's basic needs, it includes presence and participation at national, regional and global levels; with work planning set out in regional strategies. A well-established governance and representation system was established, which includes Pacific Island Country Representatives or Liaison Officers as key stakeholders for national Ministry engagement, particularly those who support the translation of clinical standards in a meaningful way at the country level (World Health Organisation, 2012). National decisions are made in alignment with the WHO's Multi-Country Cooperation Strategy for the Pacific and through discussions at the biennial Meeting of Ministers of Health for the Pacific Island Countries sponsored by the WHO and SPC (World Health Organisation, 2012).

Both the SPC and WHO were involved in the first meeting of the Ministers of Health for the Pacific Island Countries where the 'healthy islands' concept was developed and maintained to drive an integrated, holistic approach to health protection and promotion in the region (WHO, 2015a). Focusing on health protection and health promotion, but without funding attached, the Ministers issue a biannual

communicate with regional focus areas following these meetings. In 2013, these included but were not limited to NCDs, revitalization of the healthy islands concept, improved performance through strengthening national health planning, monitoring and evaluation, strengthened food security and achievement of Millennium Development Goals (MDGs).

Established to guide global development, United Nations MDGs have significant influence on Pacific decision makers, and their agencies also provide health assistance in specific areas such as sexual and reproductive health, health worker training and development of materials for community awareness. However, their financial support to the health sector is limited.

These bilateral, regional and multilateral donor partners comprise a significant proportion of PICT's health budgets, while the proportion of gross domestic product (GDP) spent on health remain below the global average. For example health spending proportions relating to government expenditure on health as a percentage of total government expenditure vary by Pacific country and range between 6.9 percent in Nauru to 20.6 percent in the Federated States of Micronesia. (Secretariat for the Pacific Community, 2015c) By way of contrast health related government expenditure in South East Asian countries is 34 percent of total government expenditure compared to 76 percent of total government expenditure in European countries. Worldwide, on average Governments spend on average USD\$971 on health annually per capita, while in the Pacific region Papua New Guinea spend USD \$32.30 per capita (and receive USD\$61.2 million in health aid) while Palau (who have a Compact of Free Association with the United States) spend USD\$912 per capita. Samoa ranks 9<sup>th</sup> and spend USD\$190.60 per capita on health (and receive USD \$11.43 million in health aid) (SPC, 2015b). External resources and user payments are an important part of Samoa's health spend (WHO, 2009) as PICT's health spending is both lower than the global average and comprises a smaller proportion of total government spending when compared with global spending proportions (World Health Organisation, 2009).

## **Factors impacting health planning and delivery**

Most PICTs share similar sustainable development challenges including: vulnerability to natural disasters, climate change, and economic shocks (Schmidt, 2005); isolation; and resource and capacity constraints (Clark, 2014; Liuvaie, 2010); each of which potentially impact access to, and spread of, health aid.

Health planning and policy making is impacted by people's health and quality of life including factors such as very high fertility rates in PICTs (United Nations Population Fund [UNFPA], 2014), and the high costs (financial and human capacity) relating to the provision of maternal and child health care, which are significant considerations in health planning (UNFPA, 2014). The relatively small number of NGOs in many Pacific nations is another significant impacting on health planning and delivery. Additionally, in the Samoan context the small population numbers mean that many people who work in the government health sector also play lead roles in the health-related NGOs.

The location and spread of population for which health care must be provided is another factor. For example, Vanuatu comprises over 65 inhabited islands spread across 1300 kilometres from north to south. The majority (75 percent) of the population lives in isolated rural areas, far from urban centres (Vanuatu National Statistics Office, 2009). At the same time, all PICTs are experiencing rapid urban drift which is drawing more attention to poorly developed infrastructure, limited financial and human resources, and out-migration. Reliance on aid is also highlighted through urbanisation (Nurse, et al., 2001). Physical factors also impact health delivery including geological type, size, elevation, soil composition, drainage characteristics, and natural resources, along with social, economic and cultural settings (Ebi, Lewis & Corvalen, 2005). Factors such as these can impact, for example, on the method and location of services, as well as cross-sector factors such as the effects of available housing and housing type on health. Finally, high rates of out-migration compound health planning challenges such as loss of human resource capacity which negatively impacts the health system from planning to community health service delivery.

### *Health planning*

Looking specifically at health planning in small island nations, which is the focus of this study, Hotchkiss (1994) identifies shared issues of isolation and size which impacts in distinct ways, such as creating the need to balance sending residents away for medical care with bringing specialists in.

Despite emerging challenges, methods of recording and storing health information many PICTs are largely paper based (Samoa Ministry of Health [MOH], 2013). Where modernised processes for information are introduced, inequities arise where urban areas adopt these systems while rural areas are slower to adopt based on available capacity. This has been facilitated by the introduction of information technology in recent years; however, many activities remain carried out by hand and the use of paper, with variable access to technology and/or knowledge of technology.

Limited human resource capacity and systems building capacity are another huge constraint to planning in most PICTs. Education of sufficient numbers of health practitioners is also a focus for many PICTs; however, the financial resource for this is significant and where the investment is made, significant numbers of practitioners later migrate away from PICTs and human capacity is lost (Connell, 2004).

Finally, planning is very personal in small nation states where everybody knows each other and many could be related. On this point, I recalled a casual remark made by a group of Pacific health workers some time ago, when they were discussing the recent appointment to a senior government post. Briefly, the post was advertised and people had applied in what looked to be a very robust and transparent process. Not so. Everyone had been totally surprised at the appointment of someone who had little experience in the field at all; thus raising questions about the role of personal relationships within decision-making and the transparency of decision-making processes within a smaller health system. Therefore, the interplay of cultural mores and personal relationships are also considered.

### *Civil society as partners*

The World Bank defines Civil Society Organisations (CSOs) as ‘the wide array of non-governmental and not-for-profit organizations that had a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. Civil Society Organizations (CSOs) therefore referred to a wide of array of organizations: community groups, non-governmental organizations (NGOs), labour unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations’ (World Bank, 2013b); and I use this definition in my study. The definition of Non-Government Organisations is narrower, being defined as: ‘private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development’ (World Bank, 1989).

### *Changing global aid architecture*

Gilson and Raphaely (2008) argue that politics, process and power must be integrated into the study of health policies and health system development in such settings. While there are many factors which contribute to good health, and health systems, this research aligns with Gilson and Raphaely’s argument asking whether these external principles are viable in the Samoan health sector context, in terms of, for example, whether the application of partnership principles and participatory processes lead to better decisions and better outcomes.

Changing global health paradigms also impact aid planning and delivery. Lewis and Macpherson (2008), for example, refer to three ‘revolutions in public health strategies’. Briefly, they describe the 19th century sanitary and hygiene movement (fundamentally environmental in perspective, including the provision of pure water supplies, and the development of science and technology to a level in which there is an understanding of the aetiology of infectious disease control). Secondly, they discuss the 20th century, where the definition of public health expanded from environment concerns and scientific advantages to support for the role of individual behaviours and societal (and political) responsibility for health. The third revolution, and the one taken for the focus of this research, was the internationalisation of public health policies which followed the founding of the WHO in 1948 and the ‘new public health’ strategy in the 1980s (Kickbusch, 2003, p. 383). Lewis and Macpherson (2008) propose that in this third revolution:

‘Essentially, the goals and objectives of the new public health strategies target issues of equity tied to social and economic reform, government and capacity building, a shift in perspective from input to outcomes where governments were to be held accountable for the health of their populations, not just for the health services they provided’.

### *Questions of national sovereignty*

This last point raises issues of local sovereignty with regards to global donor driven projects, but also the interplay between regional and local objectives in aid delivery, and role of national governments and health ministries in aid decision-making and resource allocation. While an autonomous health system exists, the numerous interplays which exist raise important questions about complexity in a crowded space. Questions are also raised regarding the autonomous nature of decision-making, and whether and the extent to which, decisions were subject to the wills/desires and programmes of others.

## **Research significance**

This research on how health decisions are made has significance on a number of levels.

### *Global*

This research contributes to increasing global understanding of how decisions are made regarding aid delivery to small nation states. Much research focuses on health outputs such as indicators of progress against MDGs, but there is little research about how global aid effectiveness principles (and resulting outputs) are being practiced at a nation domestic level in the Pacific and, more particularly, how the concept of shared decision-making and harmonisation is being carried out.

### *PICTs*

This Samoa case study is likely to resonate with other PICTs given PICTs similar social, economic and environmental conditions and shared need for aid. Identifying how aid 'works' in Samoa will better inform policymaking regarding Samoa and enable other PICTs to compare their own systems and consider how a rethink may benefit domestic health outcomes.

### *Samoa*

My case study which explores decision-making from planning, partners and system perspectives has significance for Samoa. Within the implementation of its development cooperation policy framework, opportunity exists to improve processes, relationships and systems, and capacity in a number of sectors. Identifying challenges and opportunities within aid decision-making will ensure that processes support the Samoa Development Strategy, which includes improvement in health outcomes (Government of Samoa, 2012a).

While evolving aid models produce improvements in collaboration and coordination, it is critical to understand how models are being applied to further accelerate improvements in Samoan health outcomes. In going further, and rethinking aid delivery, difficult questions regarding relationships and

collaboration require consideration: about which partners should be involved, how much integration of partners is practical or desirable, and how to communicate in a meaningful and sustainable way with diverse groups. Rethinking aid delivery also potentially requires difficult trade off or prioritising decisions about, for example, increases to capacity across the aid process while still being able to respond to emerging issues, or a focus on particular health concerns versus maintaining capacity across a range of areas.

This research examines whether and how international aid declarations and the partnership model are workable in small nation states.

## **Limitations and risks**

Firstly, my review of literature determined that there has been little research in this field, which is a limitation. However, existing international and sector work is referred to as appropriate.

The availability of data was another limitation. Simply put, archival record keeping was not easily accessed with the exception of donor led evaluations. Table one overleaf shows that of the 21 health documents sought, about one third of this information (including only one of three Health Sector Plans) was available to me following repeated requests. The absence of an Official Information Act in Samoa was a further barrier to requesting material.

The availability of aid personnel for interview was another limitation. For example, this field work began at the same time as cyclone Evan hit Samoa with devastating force; aid personnel, practitioners and civil society were heavily involved in disaster recovery work.

**Table 1: Ministry of Health information availability**

Information	Availability
Annual Programme of Work 2008	-
Annual Programme of Work 2009	-
Annual Programme of Work 2010	-
Annual Programme of Work 2011	-
Annual Programme of Work 2012	-
Corporate Plan 2012-2015	✓
Health Sector Medium Term Expenditure Framework	-
Health Sector Plan 1998-2003	-
Health Sector Plan 2004-2007	-
Health Sector Plan 2008-2018	✓
Health Sector Plan 2008-2018 Work Plan	✓
Health Sector Plan Annual Report 2008	-
Health Sector Plan Annual Report 2009	-
Health Sector Plan Annual Report 2010	-
Health Sector Plan Annual Report 2011	-
Health Sector Plan Annual Report 2012	-
Samoa Demographic and Health Survey	✓
SWAp monitoring and Evaluation Framework	-
SWAp Programme of Work 2011-2012	✓
SWAp Programme Operational Manual	✓
Work Programme and Strategies 2008-2018 (within HSP)	✓

## Thesis structure

My thesis is structured in eight chapters. This chapter sets out the introduction and chapter two presents the literature about aid, more particularly from developing countries, and from a planning and decision-making perspective. Chapter two also outlines some key components in good aid.

Chapter three sets out the design, approach and method I employ for the qualitative study, which applies an interdisciplinary and multi-level lens. It is in three parts, firstly the research design, secondly the research method and finally fieldwork reflections.

Chapter four sets out the Samoa research context looking at the country's changing economic and social situation, development assistance provided, and New Zealand and China's aid influence in Samoa. In addition, this chapter will focus on Samoan perspectives of health and the influence of both external partners and conditions on people's health today. Finally, this chapter will also include a survey of Samoan health policy and planning, to improve people's health over the research period.

Findings are presented in chapters five and six. In chapter five, the perceptions of the three participant groups (aid personnel, practitioners and NGO representatives) are outlined with respect to the health and decision-making process, aid implementation and challenges. In Chapter six I present an embedded case study of the Samoa health SWAp WHICH gives further insights into the process of implementing the Paris principles.

In chapter seven I discuss research findings more broadly and examine the implications for practice and research. Finally, in the concluding chapter, eight, I draw together conclusions and recommendations.

# CHAPTER TWO: A REVIEW OF THE LITERATURE

## Introduction

This chapter establishes a background for exploring my research questions concerning how decisions are made regarding aid in Samoa and how this impacts health outcomes. Aid models are complex, contested and often overlapping in intent. From the neoliberal model of economic growth, to basic needs and people-centred aid approaches, evolving models have prioritised different aspects of policy and different roles in decision-making. Highlighted also is the interdisciplinary and interconnected nature of aid, bringing together the political, economic, and social factors at play within my case study (Cresswell, 2007; Stake, 1995). Because my standpoint for this research will be the Paris Declaration on Aid Effectiveness and the Accra and Busan principles, I will focus more attention on the principles of ownership, alignment, harmonisation, managing for results, mutual accountability and inclusive partnerships in this review. I will also highlight the transition from top down government led models to the governance agenda of partnerships and the incorporation of civil society these principles imply.

For this review, I will draw on multi-level global, regional and national literature on health aid disbursement (Negin, 2010; Thurab-Nkhosi, 2000) to illuminate trends, emergent issues and demonstrate the varied decision-making processes and perspectives by donors with special attention on health planning and health policy development (Hotchkiss, 1994; Thurab-Nkhosi, 2000). I present a small amount of international and regional work. Notably, much of the available literature on Pacific health aid planning is found in regional reports. For Samoa, a paucity of research data on health aid and planning, causes difficulties in accessing this. Much of the body of work I access by internet, library and interaction with Samoan officials; much of these materials are donor partner evaluation reports. I will consider these pieces of work in this chapter as well as trace their impact on participant perspectives and future work throughout my research. Because culture is central to the way decisions are made in Pacific nation states generally (Meleisea, 1987), I try to find documentation where this occurs, with less success; however, this study will address this gap. The main points I highlight in this literature review include:

Development assistance is integral to the sustainable development of 150 countries (OECD, 2015a, 2015b), nearly one third (39) of which are Small Island Developing States (SIDS) and almost half of which are in the Pacific (UN, 2015).

There is an increasing proliferation of donors. Estimates are that currently there are over 230 international organisations, funds, and programmes. Donor proliferation is pronounced in the health sector, where more than 100 major organisations are involved (World Bank, 2008). The average number of donors per country rose from about 3 in 1960 to 30 in 2006. New donors are also becoming increasingly prominent. Today, 'emerging' donors such as China are represented within the expanding aid channels. The increase of new donors creates challenges for harmonisation and alignment.

The growing interconnectedness and alignment of the many international efforts to improve the effectiveness and efficiency of aid delivery is also significant. For example, the platform, challenges, and enablers of the Paris Declaration build on and align with the Governance and Sector Wide Approaches (SWAp) the Millennium Development Goals (MDGs) and the recently released Sustainable Development Goals<sup>1</sup> (United Nations Department of Economic and Social Affairs, 2015).

Partnership models are growing in importance. Estimates are, that one third of official development assistance now flows through partnership-based global and regional programmes, whose goals are set and agreed to by partners at international and regional forums, as in the Pacific Principles of Aid Effectiveness (PIFs, 2007).

Nyatoro (2013) suggests that the partnership model and focus on national level collaboration and capacity building would counter the risks of aid dependency underpinning previous models.

The millennium development goals (MDGs) have added complexity to the aid architecture, making it difficult to get a general overview of the different roles and contributions by aid partners (OECD, 2009a).

The chapter is presented in six sections and from two perspectives – the views of donor governments and researchers and those of recipient governments, CSOs and NGOs and aid users. The sections are:

1. Changing aid models
2. The evolution of partnership as a model
3. Aid effectiveness and the Paris Declaration
4. The people's perspective – partnerships
5. Aid to Small Island Developing States(SIDS)
6. Aid to Pacific health

## **Changing aid models**

The delivery of aid has grown in monetary value and in the number of donors and recipients since the launch of the 1947 Marshall Plan, described as America's drive to improve the economic health of the

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<sup>1</sup> The Sustainable Development Goals are formally known as the Transforming our World; 2030 Agenda for Sustainable Development. They include a set of seventeen aspirational Global Goals with 169 targets between them

world (Marshall, 1947). Estimates are that more than USD\$1 trillion has been given in aid over 60 years and, in 2006 alone, USD\$16.7 billion was invested in health assistance (World Bank, World Health Organisation, 2008). Multiple and contested meanings of aid exist beyond its broad definition as a tangible means of assistance (Merriam-Webster, 2012). The OECD considers aid to be grants and concessional loans (Easterly, 2003); others, such as Poirine (1999), describe aid as a public good supplied by government to satisfy altruists; while some describe aid in terms of foreign exchange and resource needs (Gounder, 2001). The different ways in which aid is defined is in turn reflected in its application in different categories and project contexts. Foster and Leavy (2001), in their study of aid types, point to the use of project aid for discrete projects or activities appropriate to country circumstance. On the other hand, an OECD (2006) study highlights the value and use of aid as budget support given directly to partner government's national treasury or as sector wide assistance to a specific sector. The use, especially by new donors, of grant aid – a donation with no material return – has been noted by those working in the Pacific region (Government of Samoa, 2013; Hanson, 2011; Hoadley, 1980; Vaillancourt, 2012), including loan assistance for infrastructure development (Bangkok Post, 2011; Crocombe, 2007; Hanson, 2011; Tavita, 2010; Yang, 2011). This is in addition to bilateral aid (government to government) and multilateral aid (provided by a group of countries or an agency representing them such as the United Nations or World Bank, to one or more recipient countries). (InvestorWords, 2017)

#### *Aid models*

Donor goals and motivation are a major factor in aid decision-making. For example, some support the prioritising of aid to specific sectors such as trade (Naidu, 2006) while others favour political diplomacy (Bangkok Post, 2011; Department of Prime Minister and Cabinet, 2013; Hanson, 2011). That said, evolving aid models reflect a consideration for the economic and political concerns of the day coupled with global thinking about the best methods for aid delivery, roles and partner responsibilities. While recent years have seen the emergence of aid models such as modernisation, basic needs, neoliberal, human development, and partnership theories, Lancaster (2007) proposes that the multiple rationale, actors and contexts underpinning aid provision means simplistic comparisons about aid effectiveness cannot be made.

The aid models discussed in this section are consistent with categories outlined by Lancaster (2007) in her qualitative study of the evolution of aid.

The colonial aid model, which is characterised by the desire of conquering colonisers to assist the countries they have claimed, is underpinned by modernisation theory (Lancaster, 2007) and exemplified in the provision of infrastructure and support to basic services. In noting the continuing existence of this model in newly independent nations, Eigenraam, Hochstetler and Yebari, (2005) criticise the asymmetrical power relationship this approach implies and the dependence on donor driven aid choices which implies beneficiaries are unable to make robust choices themselves.

The end of World War Two and the establishment of the United Nations (UN) heralded the introduction of the basic needs model which calls for a focus on better living standards including questions about poverty and the impact of poverty on people's everyday lives, as well as the possibility of equitable economic growth. Agencies such as the World Bank apply the basic needs model to address social issues such as health, education, and sanitation.

Ongoing concerns about aid dependency help spark the debate about how aid can be used to enhance national self-sufficiency. The focus on independence through economic growth is central to the neoliberal model by which recipient Governments agree to instigate free market reforms focusing on expanding available export goods, encouraging import substitution, decreasing state economic involvement and decreasing the number of people employed in the public service. This model's emphasis on economic growth as a way of spurring human and social development is described by Reid-Henry (2013) as a strategy to get market conditions right, and minimise state involvement. Reid-Henry also draws attention to the centrality of donor directed reform to decision-making and relationships within the neoliberal model.

Drawing on human development theory, human development models signal a broader and more people-centred focus to development (United Nations Development Programme [UNDP], 2015). Sen (1999) stressed the multifaceted benefits of the human development model, including peoples' access to knowledge and information, their participation in decision-making, better quality of life and longer life expectancy.

The partnership model incorporates and extends the focus on quality of life, including peoples' rights to be engaged in the decisions which affect them. Partnership models challenge prevailing top down aid models highlighting instead the importance of donor/recipient relationships and of developing country leadership over their policies, strategies and systems (Fairbairn-Dunlop, Mason, Reid & Waring, 2009; OECD, 2012). In the view of Reid-Henry (2013), previous aid models failed to respond to the challenge facing developing countries and in doing so contributed to aid fragmentation, so placing additional pressure on developing country processes. In summary, partnership models encourage greater national responsibility in planning, lower compliance costs, have the potential to end siloed ways of working (Goss 2007) and broaden national understanding and commitment to policy solutions, so leading to improved outcomes. Mulley and Menocal (2005) and Quirk (2007) also see the potential of the partnership model to combine resources and adopt shared solutions across sectors. The organisational breadth of partnerships also offer opportunities for multinational organisations, such as the United Nations, regional partners, such as the Secretariat for the Pacific community, and new and old country partners to collaborate. (Secretariat of the Pacific Community (SPC), United Nations Department for Economic and Social Affairs, 2015)

### *Sector Wide Approaches (SWAs)*

SWAs have become an important application within the partnership model. In action, donors contribute directly to a sector-specific funding pool which is tied to a defined sector policy under a government authority (World Health Organisation, 1990). Funding is contingent upon the preparation of standardised planning, implementation and monitoring tools, which ensure accountability by all partners. These include, for example, medium-term expenditure programmes, harmonised implementation systems and performance monitoring systems. Collaborative relationships for SWAs are developed and maintained through consultation mechanisms; a formalised government-led process for aid co-ordination and dialogue at the sector level (Peters & Chao, 1998). Cassels (1997) describes the benefits of SWAs as significant decreases in compliance costs, while Hutton and Tanner (2004) draw attention to the positive impact of greater clarity and predictability that SWAs provide on which to base policy development and implementation decisions for developing partners (Hutton and Tanner, 2004). Peters, Paina, Schleimann (2012) stress the significance of SWAs in integrating donor partners and processes into national health planning strategies. In Negin's view (2010), the evolution and definition of SWAs in the Pacific has focused more on the development of SWAp as a process, rather than as a tool.

### **The evolution of the partnership model**

The concept of participation is central to the partnership model, Blacher and Adams (2007) connect participation with multiple relationships and complex networks of multi-organisation, multi-governmental and multi-sectorial collaboration. The concept of peoples' participation also has a broader context harking back to the Arusha Declaration or the 1990 African Charter for Popular Participation in Development and Transformation (Arusha, 1990). Enshrining participation in economic and human development, the charter formally recognises the role of people's participation in African recovery and development efforts.

Participation is said to be influenced by the five critical factors detailed below, each of which relates back to ownership, decision-making and sustainability.

**Table 2: Critical factors in determining participation**

AGENCY	TENURE	PARTICIPANT NATURE	TASK	DURATION
Which party carries the initiative in such processes	The nature of the respective parties' control over the resources (including shared or unclear responsibilities)	The nature of the participants: <ul style="list-style-type: none"> <li>• Are there many or few parties?</li> <li>• Are they included because of their resource ownership or stakeholder role, or voluntary and self-selected?</li> <li>• Is the 'public' party an organised group (that is easily contacted) or otherwise?</li> </ul>	Is the need for policy making, planning or on-going management; strategic decisions or on-ground works?	Is the task for a fixed period of time, or intended to continue? Therefore are long or short-term processes needed?

Source: Ross, Powell and Hoverman (2008)

Planning to ensure robust participation includes attention to questions such as: do people have adequate information, so that they are in a position to engage in and contribute to decision-making (Maher 2007) and are structural measures in place to facilitate participation, especially by minority groups (Blacher and Adams (2007)? Ross, Buchy & Proctor (2002) argue that people's tasks and duration are critical factors to be taken into account when designing participatory processes including making sure peoples' roles are clearly set out.

**Table 3: Citizen Influence and Government Support**

	PRESENT			FUTURE
Government support (IAP2 Spectrum of Public Participation)	We will keep you informed	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible
	Participation methods <ul style="list-style-type: none"> <li>• Fact sheets</li> <li>• Websites</li> <li>• Open houses</li> </ul>	<ul style="list-style-type: none"> <li>• Public comment</li> <li>• Focus groups</li> <li>• Surveys</li> <li>• Public meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Workshops</li> <li>• Deliberate polling</li> </ul>	<ul style="list-style-type: none"> <li>• Citizens advisory committees</li> <li>• Consensus building</li> </ul>

Source: Bate & Robert, 2006; International Association for Public Participation [IAP], 2006.

Studies show that Pacific peoples value the participation model because this aligns with Pacific ways of consensus decision-making, as in the fono. For example, Makisi (2010) uses the International Association for Public Participation model in his study of Government collaboration with Pacific communities in New Zealand. He finds that blending Government decision-making structures with Pacific preferred ways of decision-making leads to greater participation by Pacific peoples and served to validate the Pacific voice. Research in the Pacific region on public participation in project decision-making also indicates a preference for participation. For example, the use of participatory decision-

making in a water project resulted in better resource management and the minimisation of future negative impacts. Positive spinoffs also occurred such as alleviating community poverty, the development of shared water management arrangements, and public/private infrastructure development (Ross, Powell and Hovermann, 2008).

Despite encouraging outcomes gained through participation strategies, questions of impact remain, including significant challenges in measuring and quantifying the impact of participation, as seen in Hanlon's (2007) comment 'how do you measure four members of a council chatting over coffee?'

## **Aid Effectiveness and the Paris Declaration**

### *What is effective aid?*

There is extensive debate on what effective aid comprises. Feachem (2011) highlights the spectrum of opinion from those arguing aid is an ineffective political, economic and humanitarian disaster to those arguing aid is good and more aid would be better. A number of studies also note that despite the significant financial and human resources spent on the review of aid outcomes (McDonald, 1998; Phillips, K., 2013) it is a prohibitively complex process to assess whether and how aid inputs can be attributed to outcomes (Action for Global Health, 2011; Davies, 2013; Feachem, 2011; Government of Samoa, 2013; Vaillancourt, 2012).

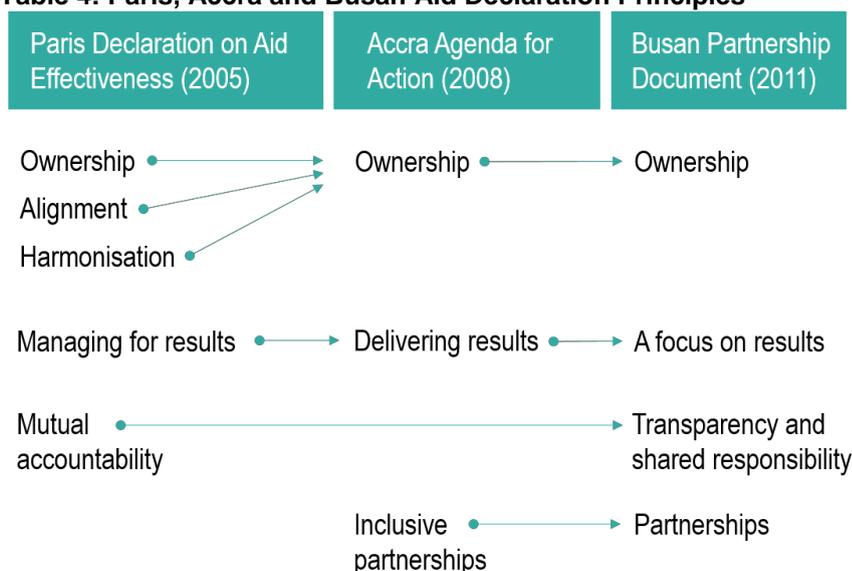
While researchers and donor partners write extensively about aid outcomes, less is written from the people's perspectives of aid. The International Development Institute (2006) reports there exists no holistic discussion on whether international aid architecture is 'fit for purpose' or whether the people's perspectives (recipient partner officials, recipient NGOs and aid users themselves) are wholly being heard.

### *The Paris Declaration (2005)*

The Paris Declaration emerged as a first major global agreement on effective aid. Samoa and other Pacific countries are signatories to the Paris Declaration. The Paris Declaration addresses what was seen to be a disjunction between national and international development efforts and the lack of harmonisation amongst international donors, compounded by little focus on the countries' own development aspirations and strategies (Harmer and Ray, 2009).

Table 4 outlines the principles of the Paris Declaration on Aid Effectiveness and its subsequent refining in the Accra Agenda for Action (2008) and the Busan Partnership (2011). After considerable discussions, I opt to employ the Paris principles of effective aid as a focus in this study with the addition of civil society partnerships as added in the Accra Agenda (2008) and the Busan Partnership Document (2011).

**Table 4: Paris, Accra and Busan Aid Declaration Principles**



Source: OECD, 2005; Government of Samoa, 2010; OECD, 2011.

The Paris Declaration principle of ownership gave national governments leadership over their development policies, the responsibility to improve their institutional processes and tackle corruption, to align and harmonise development initiatives, and to manage for results. The mutual accountability principle involved both donor and national partners as accountable for results (OECD, 2012).

The Accra Agenda broadens participation to include Civil Society Organisations (CSOs) and the Private Sector. As also seen in table four, the Accra Agenda combines the five Paris principles into three principles of ownership, delivering results, and inclusive partnerships (OECD, 2015). The Busan partnership document reinforces the principal of partnerships as outlined in the Accra Agenda and adds transparency and shared responsibility for outcomes to the delivering for results principle.

### *Responses to the Paris Declaration*

Not unexpectedly there has been considerable debate on the viable application of the Paris principles, the Accra and Busan Statements. I discuss these by principle, for example, Balogun (2005) proposes that where ownership exists, harmonisation and alignment also flow on in a positive way. He suggests that the more ownership countries exercise over development agendas, the easier it is for development partners to harmonise their aid and come into alignment with the goals established by the recipient countries. Winters (2002) highlights the longer-term benefits of interdependence. She suggests that the more that aid is owned by recipient countries, aligned with national systems and harmonised among development partners, the more effective it is expected to be. This is in terms of delivering goods and services to citizens and facilitating national policy changes with the goals of catalysing poverty alleviation and economic growth. On the other hand, Sjöstedt's (2013) case study demonstrates that there can be a negative relationship between alignment and harmonisation principles. His research

highlights that where Swedish aid to Africa was not aligned to country systems the resulting burden of compliance falls on Tanzanian officials. In addition, the act of donor alignment reduces Sweden's ability to harmonise with other donors and agree on a division of labour in the donor collective.

In the following section I will discuss and review each of the principles and comment on their progress. To do this, I draw on the 2005 Paris Declaration principles and the Accra and Busan inclusive partnership principles.

## Ownership

The ownership principle is said to be key in ensuring commitment across Declaration objectives (Wood, Kabell, Muwanga et al., 2008), consistent with the interdependence noted by Balogun (2005) and Winters (2002). The concerted development of local ownership and management over the aid process by recipient partners is noted by many (Booth, 2011; OECD, 2008; Harold, 1995). Cassels and Janovsky (1997) describe this as an explicit decision-making power shift as recipients direct and manage donor inputs.

The OECD review (2011) highlights the visibility of ownership and translation into prioritised results-oriented operational programmes as expressed in medium-term expenditure frameworks and annual budgets. The review also highlights the participatory nature of ownership and leadership at all levels. Within governments, individual ministries with expanded mandates have been accorded greater decision-making roles and leadership through SWAps (Davies, 2013; Hutton and Tanner 2004; Walt, Pavignani et al 1999). Ownership also supports more participatory relationships incorporating dialogue with donors and civil society, and private sector participation (OECD, 2011).

Others suggest however that growing ownership also creates negative impacts and ambiguity. In addition to issues of alignment and harmonisation, Sjöstedt (2013) argues that the emergence of the ownership principle has unintended effects, placing severe and competing demands on development practitioners. He states that donor's responsibility to promote ownership; harmonize with other donors; align to partner country priorities; and implement results-based management, results in decreased ownership by development partners. This is said to occur when development partners are continuously measuring and reporting results while being subject to stricter hierarchies of priority on behalf of donor governments due to the broadened requirements listed above (Sjöstedt, 2013). Dissanyake (2009) notes the impact of donor prioritisation specifically as a challenge to ownership. He argues that if the priority is externally imposed and driven, even if implemented by a development partner and attributed to their leadership, ownership has been co-opted into an activity, and does not actually exist. This study will assess whether the principle of ownership is compromised within the Samoa context.

## Alignment

Alignment is described as aligning policies and strategies as well as systems and procedures (OECD, 2006). Buse and Walt (1996) highlight its emergence in the late 1980s, particularly within the health sector where donor volume and diversity increased, escalating complexity, confusion, and the potential for conflict. Even prior to the emergence of global aid effectiveness agreements, effective health system development was perceived as synonymous with the coordination of multiple external resources within country systems (Buse and Walt 1997, p. 461). Aid Declarations highlight the significance of national government systems for financial management, procurement and fund channeling. Literature also highlights partner's specific roles in the implementation of this principle. Donor partner's roles in committing to country policies and systems is considered central. While the need for developing country partners to build capacity to use these systems is also identified (OECD, 2006).

Despite the clearly articulated goal of aligning donor partners under the developing partner's systems and processes, OECD evaluations (2010; 2011) reveal progress towards alignment is mixed globally. Contrast in the rate of progress is particularly distinct when comparing alignment at a strategic level versus the operational level. While progress was observed in aligning aid flows with national priorities, less development took place in building country systems and eliminating parallel project implementation units. In contrast, OECD (2010) highlights that support to build strong and workable in country systems is apparent. The report emphasises the existence of dedicated teams to strengthen the capacity of country systems in procurement, project management, human resource management and financial management.

Consistent with Balogan (2002) and Wood, Kabell, Muwanga et al.'s (2008) arguments about ownership's broad impact, successful strategic alignment is associated with the effective exercise of ownership by developing country partners. Initiating alignment at a strategic level first is described as approaching the 'straightforward', first linking familiar priorities together with aid flows (OECD, 2011). Within the Samoa environment I will trace whether and how strategic and operational alignment has taken place.

## Harmonisation

Harmonisation is defined in four major areas including the development of common arrangements for planning, managing and delivering aid and the reduction of agency-specific procedures and requirements for reporting, as well as procurement and financial management. Harmonisation also focuses on donors' comparative advantage as a basis for complementarity and sharing of information to promote transparency and improve co-ordination (African Forum and Network on Debt and Development, 2011; PIFS, 2015).

Like the ownership principle, harmonisation underpins the achievement of other Paris Declaration principles. It provides the rationale for donors to work together within the aid process, incorporating common frameworks with shared arrangements, aligned priorities and systems (OECD, 2011). Best practice harmonisation applies approaches such as the direct budget support, Sector Wide Approach and other arrangements with joint planning and harmonisation of procedures (OECD, 2011). Harmonisation also has well defined connections to good governance with an emphasis on building institutions and establishing governance structures as the basis for decision-making (Liuvaie, 2009; Ministerial Review Team, 2001; OECD, 2003).

Prioritisation is central in achieving harmonisation. This involves decisions about the number and ranking of priorities, as well as procedures, arrangements and incentives for donors to behave collaboratively. Like alignment, literature suggests that challenges to harmonisation occur particularly at an operational level and are closely connected to relationships as partners seek to agree on priorities to be addressed; conceptual frameworks and methods to be employed; and the sequencing of activities (Davies, 2013; Dissanyanke, 2009; OECD, 2011).

Difficulties also occur where there is only partial support for harmonisation. The World Health Organisation (2007) report highlights difficulties where donor partners choose to support only one or some priorities. An extreme example of this scenario occurred in Rwanda where the Government identified seven health objectives and donor funding was only earmarked to one goal (WHO, 2007). Dissanyanke (2009) and Overton (2011) argue that at its most extreme, where only externally driven priorities are supported, ownership is diminished.

### Managing for Results

Results-based management is increasingly being applied to international development policy (OECD, 2008; Sjöstedt, 2013) encouraging recipient partners to improve the links between planning and outcomes. This includes the implementation of assessment frameworks and information systems to track results-based indicators. Supporting alignment and harmonisation, donors are expected to align with recipient countries' monitoring and evaluation systems, avoiding additional parallel reporting, and focus on strengthening capacity for results-based management. Countering aid dependency risks, the need for development partners to build their own capacity rather than donor substitutes leading management for results activities is stressed by both organisations and researchers (Nyatoro, 2013; OECD, 2005). Both organisations and partners also note where donor partners might build capacity here (OECD, 2011; Rwangombwa, 2011).

Planning within a management for results system has proved challenging, in part due to poor harmonisation. Efforts to define measures, standards of performance and accountability systems are difficult due to partner's prerequisites and the planning capacity required (European Commission, 2013; Wood, Betts, Etta, et al., 2011). Knock-on effects impact the rate of progress in

implementing operational frameworks such as sector strategies, despite having the high level national development strategic frameworks in place (Wood, Betts, Etta, et al., 2011).

The need for human capacity to manage for results throughout the process has been highlighted by Nyatoro. (2013). The existence of and capacity to managing for results tools are examined in global reviews by OECD (2008) and Ortiz, Gorita, Kuyama, Munch, Tang, & Vislych (2004) who emphasise the potential of, and barriers presented by, systems when managing for results. Information systems are crucial to monitoring results (Information Training and Agricultural Development [ITAD], 2012) however where systems are still developing, moving forward to actually using statistical data as a basis for better decisions is difficult (OECD, 2008). Encouraging progress is noted in the flexibility of some donor systems (European Commission, 2012). It is suggested that progress here is a question of maturation (OECD, 2008) and I will look at the existence and development of information systems in my research. Additionally, OECD (2008) emphasises the importance of integrating capacity building efforts into projects including information on how pilot projects may assist in building capacity.

Development partners have also worked to analyse their own capacity to manage for results. Rwangombwa (2011) defines three types of capacity issues faced by his country – institutional capacity, human capacity, as well as economic capacity – highlighting the necessity of all three in decision-making.

Broader debate about managing for results also exists particularly with regard to assessing whether aid can be attributed to outcomes (Action for Global Health, 2011; Davies, 2013; Feachem, 2011; Government of Samoa, 2013; Vaillancourt, 2012). I will consider how results might be defined including 'hard' data only or whether other information might be taken into account. I will also give attention to the argument that fixating on data negatively impacts dialogue regarding, and monitoring of, genuine policy priorities (OECD, 2008).

Donor partner literature stresses the importance of evidence in managing for results. Sutcliffe & Court (2005) describe evidence-based policy as a discourse which informs the policy decision-making process and includes rational analysis. With consistent use, its potential to improve development performance is also highlighted. Selective evidence use is described as challenging by one international organisation (World Bank, 2006) and the lack of the people's perspectives in evidence labelled concerning. In my research, I will look at whether evidence is used and how evidence is used.

Good governance is also closely connected to managing for results. The extensive body of literature defining this concept is exemplified by OECD (1994) and Neumeyer's (2003) description of good governance as respecting the political, civil and human rights of citizens, consistent with the rule of law. The United Nations Economic and Social Commission for Asia and the Pacific (2012) emphasises good governance as having a focus on participation by the people.

The entrenchment of good governance within the managing for results principle is pointed out by Fielding (2008), who notes that many donors now assume that bad governance leads to a low return on their aid dollars and develop policy redirecting aid towards recipients with good governance.

#### Mutual Accountability

The Mutual Accountability principle states that aid relationships embedded in accountability mechanisms which monitor reciprocal commitments are central (Agulhas, 2006). This also aligns with Public Participation frameworks set out by the International Association for Public Participation (2006). Despite this centrality of accountable relations, and significance for public participation, OECD review (2008) highlights slow progress due to ambiguous processes and responsibility definitions.

The development of singular collaborative decision-making processes through SWAPs is said to exclude consideration of how agencies are accountable to government and citizens Agulhas (2006). De Renzio, Foresti, & O'Neil (2006) go on to suggest that particular difficulty exists in making donors accountable to partner countries and their citizens. The case study will look particularly at whether and how donors provide accountability both for the Samoan Government and its citizens.

#### Inclusive Partnerships

The inclusive partnerships principle was introduced within the Accra Agenda for Action to accelerate progress towards Paris targets and enshrines relationships and partnerships for collaboration and dialogue (OECD, 2012). Again, this principle has a particularly strong connection to public participation as set out by those such as Maher (2007). These partnerships are said to incorporate openness, trust, mutual respect and learning throughout decision-making and recognise the different and complementary roles of all actors, including donors and civil society organisations (OECD, 2011), though civil society is not referred to specifically.

Inclusive partnership models have been identified as particularly effective, responding to natural disasters and bringing together a range of groups to provide humanitarian aid. (Development Policy Blog)

### **The peoples' perspective – partnerships**

As noted, the Accra and the Busan agreements emphasise the fundamental importance of the civil society voice and engagement in aid decision-making, so as to ensure effective, relevant and appropriate aid delivery. However, this is no easy task; to establish and abide by agreed strategies to ensure civil society participation prove difficult over time, context and environment.

## Ownership

In its report on the WHO and Civil Society (2002), the WHO emphasises that health focused Civil Society Organisations play a valuable role at every point of the decision-making process in:

- Ensuring that public needs are not overshadowed by private sector concerns in programme design;
- Collaborating with marginalised populations and remote areas, ensuring community participation and consultation, and service delivery to these groups;
- Service establishment and emergency service provision;
- Strengthening national and local health systems where Governments and health systems have to balance competing health demands with limited resources.

The growing recognition of the importance of people's participation today has its genesis in what Lewis and MacPherson (2008) term the new public health strategy. The 1978 Alma Ata Declaration (the international agreement which conjoined public policy and public health) was described as timely by the WHO (2001), which highlighted the importance of CSOs in determining public health direction especially in an era which saw a decline in state service provision. More recently the strategy of SWAps also recognises and requires governments to establish mechanisms to listen and respond to the views of civil society. The CSO's role has also been positioned among increased promotion of, and 'transnational' support for, issues such as human rights, environment, debt, development and health (World Health Organisation, 2002).

At the same time, there has been considerable debate among civil society agencies as to whether or not they should be so closely aligned with government. Association for Women's Rights in Development, (2010) suggested that CSOs/NGOs no longer play the traditional watchdog role to government. Additionally for example, a study of Pacific gender and aid effectiveness found that the National Council of Women (NCW) did not join the initial coalition of NGOs established by NZAID in New Zealand but, later, and under different leadership the NCW did join (Fairbairn-Dunlop, 2000).

By way of contrast, Rauh (2010) stresses that NGOs are in fact strategic actors who move beyond government, actively negotiating and resisting donor agendas. I will examine whether this holds true in my case study and whether Samoan CSOs engage directly with donors, bypassing government.

## Alignment

Predictable health aid and the CSOs use of national government systems for financial management is identified as central to alignment given recurrent costs such as staff salaries and long-term drug therapies for chronic illnesses (Action for Global Health, 2011; WB & WHO, 2008). Literature also highlights the need for some short-term flexibility in decisions and systems, particularly in response to humanitarian disaster (European Commission, 2012). Research highlights that some

progress has been achieved in addressing this. The European Commission has designed flexibility instruments as emergency aid reserve measures to counter immediate health risks at such times (European Commission, 2010, 2012). However, NGOs continue to raise concerns about participation in alignment efforts. African research proposes there is a vertical relationship whereby policy makers and donors push projects from the top down through national agreements which do not have CSO input at all (Collaborative for Development Action, 2010).

#### Harmonisation

Overton (2011) highlights the cost of coordination and harmonisation between donors, partner governments and civil society which is consistent with Sjöstedt's (2013) and Alpizar, Hopenhaym, Knab, et al's., (2008) discussion. Most of the literature suggests the transition from programme-based aid to SWAps has impacted negatively on NGO inclusion, and resulted in decreased funding channeled through NGOs and CSOs (Agha, Foresti, & O'Neil, 2006) and this will be considered in this study.

#### Managing for results

Helleiner (2000) argues that from some NGO and CSO perspectives, coordinated and collaborative systems do not result in more streamlined management of development assistance but actually increase their responsibilities and duties. Despite efforts at alignment and harmonisation, compliance challenges remain, and little has changed in the degree of reporting aid recipients must complete or the intensity of monitoring of their performance by the IMF, World Bank and individual bilateral donors.

Some CSOs highlight that they lack access to the information they need to hold their government and aid agencies accountable (Collaborative for Development Action, 2011). While it is unclear whether these questions concern transparency, systems, maturation, or other factors, these will be an important and ongoing point to consider.

Kaufman (2007), the Collaborative for Development Action (2011), and Kittani & Moulin (2014) are unified in presenting development partner's perspectives, stressing the importance of good governance for effective aid. This was further reinforced by development partners surveyed by the World Bank and Gallup (OECD, 2008). In this report, countries state that quality of governance should be a determinant in donor disbursement and a factor in deciding whether government or a stakeholder outside government should receive funds direct. In contrast to historical concerns about aid dependency only eight percent of states agreed funding should be provided regardless (World Bank and Gallup, 2008).

## Inclusive partnerships

Integrating civil society stakeholders into decision-making within inclusive partnerships is a work in progress. An OECD (2008) evaluation shows that consultation and dialogue with civil society is taking place, however there are significant emerging challenges regarding levels of engagement and more in-depth study of this is needed. In addition, while there is high-level consultation on national development strategies, there is almost no consultation with beneficiaries and other stakeholders at project level (OECD, 2011).

## **Aid to Small Island Developing States (SIDs)**

Thirty-nine small islands with specific characteristics of small size, remoteness, vulnerability to demand and supply side shocks, a narrow resource base and exposure to global environmental challenges are termed by the United Nations as Small Island Developing States (SIDS) (United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and the Small Island Developing States [UN-OHRLLS], 2015). Of these states, almost half are in the Pacific (UN, 2015) making discussion of aid both in the context of Small Island Developing States and Pacific states significant to understanding aid in multiple contexts. Small Island Developing States, such as Samoa, share a number of characteristics which influence policy planning and decision-making, and specifically, aid-related decision-making.

In this section I present research on aid delivery to SIDS; I frame these according to the Paris principles and link materials back to the earlier section on aid effectiveness.

## Harmonisation

The importance of harmonisation and prioritisation in small and remote island states is highlighted by Gish (1992) who concludes that ill-defined priorities result in knock-on effects including reduced public health care access. Unger, De Paepe, Sen and Soors (2010) also highlight prioritisation, again arguing that failure to do so has a relationship impact, discouraging aid users from using crucial facilities. Prioritisation also implies trade-offs are likely; for example, Unger et al.'s (2010) research finds that decisions in some small developing nation's services and systems development takes place at the expense of disease control conditions.

## Managing for Results

SIDS face significant challenges relating to financial management, capacity, and centralisation. Financial planning and management requires accounting for both government and externally received resources and utilising both domestic and international accountability systems. Strong financial management of these resources is crucial for effective and sustainable economic management and

public service delivery (OECD, 2014). In addition, while government expenditure of internal resources may be agreed to through existing domestic processes, external resources are subject to both internal and external management systems, through tools such as the Medium Term Expenditure Framework (MTEF). Added complexity is said to emerge where SIDS face accelerating costs due to a rapid increase in non-communicable diseases (Council for International Development, 2012), or, in times of national disaster. Growing costs are a significant challenge to financial management in SIDS (Clark, 2014; CARICOM, 2007); for example, in the Caribbean, the economic burden of four major NCDs reached \$27 million, which was 2.8 percent of the island's GDP in 2006 (Council for International Development, 2012). Pacific NCD healthcare spending is significant: a diabetes patient costs in Samoa those with diabetes related kidney failure cost USD\$38,686 a year, more than 12 times the Gross National Income of Samoa. (Council for International Development, 2012). Growing health costs increase the importance of financial management and decisions about how funds will be allocated.

Service delivery costs are another consideration in financial management; as a result of SIDS' small populations and the remoteness of many communities there are no economies of scale (Hotchkiss, 1994; Singleton, 1990). Hotchkiss (1994) notes that to maintain basic services SIDS often need to spend more to achieve the same provision of services which developed nations enjoy. Human resource capacity is another factor in effective service delivery and planning. Planning capacity in SIDS has historically been stretched through ongoing aid fragmentation. More recently, the economic impacts of reduced capacity have been noted (World Bank, 2012).

Planning for, maintaining and building human resource capacity is critical to the sustainability of tertiary healthcare within SIDS. In the first instance, ensuring robust planning units and systems which in turn recruit, retain and ensure professional development for staff is crucial (Connell, 2004; Hotchkiss, 1994; Singleton, 1990). Key findings from Hotchkiss' (1994) Caribbean study were that SIDS with populations of 12,000 to 50,000 shares three main problems for the delivery of hospital services, each of which was capacity related. These were the provision of adequate cover in the main disciplines; in the more specialist areas such as Ear, Nose and Throat, and Ophthalmology; and providing reasonable diagnostic facilities. Connell's (2004) research on the Pacific health workforce goes even further, illuminating significant capacity challenges in all areas of the health workforce. Capacity solutions for health delivery in SIDS include regional service hubs, visiting outside specialists, distance education and redefined planning roles (Hotchkiss, 1994; Singleton, 1990; Thurab-Nkhosi, 2000). Furthermore, Connell (2004) proposes the recruitment of health professionals to SIDS through attractive salary packages as an important consideration generally.

The move towards predictable health funding directly impacts on forward planning, service delivery and capacity building given that the bulk of health costs are recurrent and the success of many interventions requires sustained and multi-year support (Dodds & Lane, 2009).

Decentralisation is identified as a solution to a number of SIDS' financial management concerns, although it is not a significant theme within my review of global aid effectiveness material. A recent World Bank (2014) report emphasises the efficiency benefits of decentralisation and suggests that giving locals a decision-making role leads to improved information and in turn leads to greater allocative efficiency. Decentralisation also increases participatory processes and local stakeholder responsibility for actions taken (Pederson, 2002). Despite these benefits, literature also outlines that in SIDS, having multiple people and groups involved in decision-making adds complexity if local governments or agencies pursue their own agendas and the Ministry of Health is not well informed about these activities (Pedersen, 2002).

A Bossert and Beauvais (2002) study indicates the mixed impacts of decentralisation in SIDS. Findings from their survey of four developing countries, which has a partial user pays system, are that while most are able to reduce policy cost and spending at a central level, similar gains are not made at a local level. In addition, there are differences in prioritisation that emerge between national and local levels. Roles and responsibilities are contentious, with control of human resources and particularly the hiring and firing of staff becoming problematic and impacting relationships between the sector groups. A major benefit of decentralising is the emergence of innovative policy tools, particularly in Africa.

#### Inclusive partnerships

The changing global aid architecture has seen SIDS engaging with new donor partners (Lancaster, 2007; Nissanke, 2010). Nissanke (2010) focuses specifically on south/south Cooperation where aid recipients may also be donors, and its contribution to entirely new forms of collaboration are characterised by 'coalition' engagement and shared solutions.

## **Aid to Pacific health**

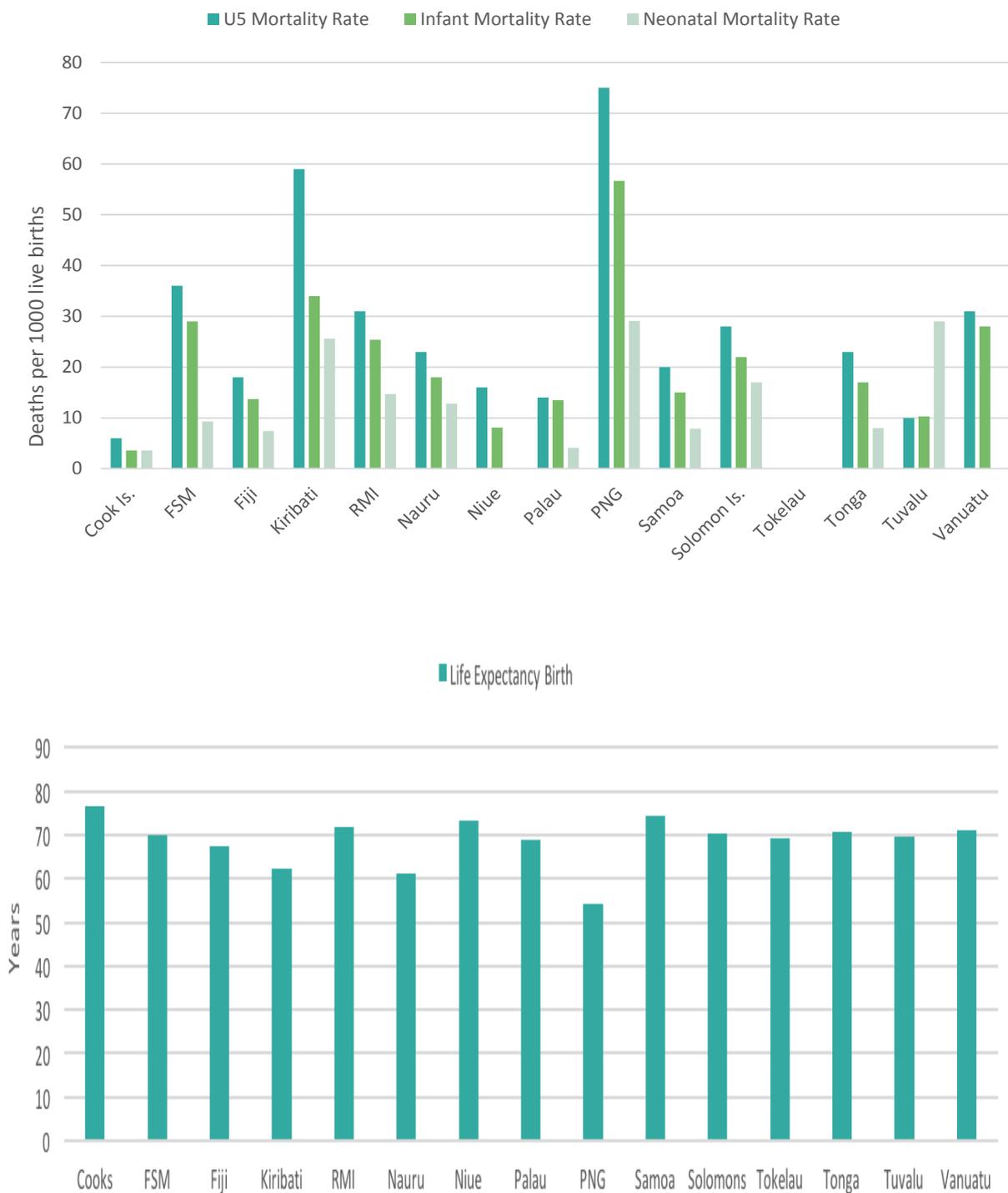
As outlined in chapter one, aid to Pacific states generally is a priority and the Pacific have developed their own set of aid effectiveness principles as will be discussed.

#### *The Pacific health situation*

Figure two (overleaf) highlights the critical situation of Pacific health across several key indicators: mortality rates for under-fives range from 0 to 74.7 deaths per 1000 children born, with no under-five deaths in Tokelau compared with nearly 75 per 1000 live births in Papua New Guinea (PNG). Life expectancy at birth, ranges across the region from 55 years in PNG, to almost 80 years in the Cook Islands.

In Samoa, nearly 20 under-fives die per 1000 live births and, at birth, a Samoan person can expect to live for 74 years on average.

**Figure 2: Pacific Health Statistics**



Source: Secretariat for the Pacific Community, 2015c

Chronic diseases such as heart disease, stroke and diabetes, termed diseases of affluence due to their prevalence in wealthy, high income countries (Danaei et al., 2013), are also evident in PICTs. The success developing countries have achieved in reducing blood pressure can be achieved in PICTs through improved primary health care services, lowering salt intake and increasing the availability of fresh fruit and vegetables, for example (Danaei et al., 2013).

The Pacific is described as experiencing a 'double health burden' (Lewis & MacPherson, 2008), whereby the treatment of new diseases (e.g. diabetes) must be dealt with alongside the re-emergence and increasing severity of traditional diseases such as dengue fever. Epidemics of dengue are becoming larger and more frequent: an estimated 50 to 100 million people contract dengue each year in over 100 countries (National Institute of Allergy and Infectious Diseases, 2013). In the Pacific region, Fiji recorded more than 10,000 cases of dengue fever, with 11 deaths, between October and March 2014 (New Zealand Herald, 17 March 2014). In March 2014, Samoa also issued a dengue fever alert following a new case (Islands Business, 2014). Dengue was also at high levels in 2008 when Samoa reported an unusually high number of cases and American Samoa recorded over 200 cases (New Zealand Herald, 20 October 2008).

Economic limitations faced by Pacific small island nations make aid essential to delivering basic health services and for achieving international objectives such as MDGs. Literature charts both the longevity of aid and growing complexity in the region (Lancaster, 2007; Liuvaie, 2010; Overton, 2011). Furthermore, while aid was once delivered by single colonial powers, today health aid to the Pacific is dispersed through a number of bilateral donors, regional and multilateral organisations and NGOs, to the tune of more than USD\$1 billion over the last decade (WHO, 2012). Donor organisations include the Secretariat of the South Pacific Community (SPC), the World Health Organisation (WHO) and United Nations organisations such as the United Nations Population Fund and the United Nations Development Programme. Regional aid effectiveness efforts are also multi-level, based around multiple regional and international agreements (through the Pacific principles, Paris and subsequent declarations).

Twelve PICTs have health plans (Secretariat for the Pacific Community, 2015c). This reflects the specific efforts to support health planning and decision-making resulting from the Paris principles. These measures include training and scholarships, expatriate consulting presence, academic collaboration and funding to attend overseas policy relevant events (Prinsen, 2013).

## **Pacific principles of aid effectiveness**

Following extensive regional and national consultations, PICTs agreed in 2007 to a set of Pacific Principles of Aid Effectiveness (PIFS, 2007) fitted to the Pacific context, each of which has relevance to Pacific health sector planning. The Pacific Island Forum (PIFs), which all PICTs are members of, has leadership over the regional model within a framework of forum leader-endorsed regional development

priorities. The expectation is that donor assistance aligns with PICTs common national development needs so enhancing the effectiveness and efficiency of aid delivery (figure 3).

**Figure 3: Pacific Principles of Aid Effectiveness**



Source: PIFs, 2007.

Major differences between the Pacific Principles of Aid Effectiveness and the Paris principles are the principles of country leadership and ownership, multiyear commitment of aid, and Pacific ownership of leadership development. The focus of the remaining principles is on strengthening institutional capacity, coordinated approaches and monitoring and evaluation. The Pacific principles signal greater Pacific ownership of regional development and the use of the Pacific Plan (PIFs, 2007) as the focus and driver of Pacific Regional Strategies. Notably, Pacific donors and development partners are committed to pursuing a coordinated approach in the delivery of assistance. Strategies to evaluate the effectiveness of the Pacific principles were formalised through the 2009 Cairns Compact.

Reflecting on Country Leadership and Ownership, views are that national priorities are not always reflected in planning but are being traded off for donor priorities (Liuvaie, 2010). The World Health Organisation (2012) also notes instances where its prioritisation efforts are inappropriate. Adding to this, Overton (2011) voices a concern that the implementing mechanisms contradicted the Pacific principle of country leadership and ownership. There is little research on the application of the Pacific

principles. I comment briefly on the four new principles listed and follow this with a more in-depth review of the literature relating to the application of the inclusion principle by NGOs and civil society.

The multiyear commitments principle is associated with predictability in planning. In the region, donor partners have begun to commit to multiyear planning. For example, New Zealand now uses a process of agreed Joint Commitments for Development with many Pacific Island Countries thereby committing aid support over a three to four year period (Ministry of Foreign Affairs and Trade, 2015a). On the global scene, this practice has been identified as crucial but rare, as noted by OECD (2008, p. 28): ‘with the notable exception of the New Zealand practice, development and country partner reports register little information on progress toward providing more predictable aid – except by the multilateral agencies’. I will consider how this relatively rare agreement regarding aid predictability has impacted all partners’ aid conceptualisation in my research.

Strengthening Institutional Mechanisms and Capacity is a crucial goal given PICTS usually have a small number of ministry staff compared with the heavy workload required (Connell, 2011), including the challenges of managing large scale technical assistance (Vaillancourt, 2011). The interplay of bilateral, regional and global existence partnerships, structures and programmes also stretches local capacity (Danaei et al., 2013).

Technical Assistance that builds capacity and the provision of technical assistance that is carried out in a manner which supports national ownership is also essential; for example, Samoa’s clinical labour force is likely to come under pressure, given projections that an additional 3000 working age Samoans will have diabetes by 2030 (International Diabetes Foundation, 2011). The increasing impact of non-communicable diseases on this group will also affect productivity and income at national and household level.

Despite the increasing prominence given to the importance of inclusive partnerships to effective aid, there has been less research on the role of civil society within the inclusive partnership model (Frost, 2002). More literature exists on collaboration and partnering from a cultural perspective which is labelled the ‘Pacific Way’. Described as the search for Pacific solutions to Pacific problems and an unlearning of Western modes of conflict resolution by Haas (1989), collaboration is played out in contrasting ways. For example, the establishment of the ‘Pacific Islands Development Forum’ is termed a “Pacific Way” of consultation, whereby business, church and civil society leaders have dialogue with political leaders (Seneviratne, 2013). In comparison, however, regional trade meetings with multiple aid partners involved are often restricted to political delegates only (Samoa Observer, 5 September 2013).

Less research was found on the impact of culture on health planning. Overton (2011) and Slatter (2006) propose that aid effectiveness is enhanced by connecting aid with culture. The WHO (2007) claims its programmes align with and incorporate Pacific holistic perspectives of health and wellbeing at the

development and planning stages. But importantly, WHO does not indicate how culture should be incorporated in aid planning processes.

### *Responses by Pacific civil society*

Regional NGOs such as the Pacific Islands Association of Non-Governmental Organisations (PIANGO) have call for greater participation in regional decision-making. PIANGO, established in 1991, coordinated Pacific CSO input from its twenty-three member countries to the 2008 Accra and 2011 Busan Declarations. Drawing on the Cairns Compact, PIANGO calls for an expanded role, proposing that the umbrella national non-government and private sector organisations lead policy engagement.

## **Summary**

There is extensive ongoing debate about how to best invest health aid to improve health outcomes in developing countries. How to best spend health related aid to save lives is an area of specific discussion. The literature highlights some of the considerable debate on how to ensure the vision and delivery of health aid to ensure effective and efficient aid which addresses priority national concerns.

The Paris Declaration is heralded as a critical turning point in aid effectiveness efforts, entrenching a partnership model, and gaining unprecedented global agreement on aid delivery as is the addition of the inclusion and partnerships principle in the Accra and Busan declarations. The Paris Declaration and the Accra principles of inclusion and participation with civil society are the focus of this study of health decision-making and practice. The increasing proliferation of donors including regional and multilateral donors is noted as are some of the challenges this presents to the principles of ownership, etc. The Paris principles also have the potential to impact on factors such as transaction costs, human resource capacity, research, and data systems management, of small nation states. The increasingly negative health statistics show that implementing effective aid is an urgent priority. While there are multiple aid donors and partners in the Pacific region, it is unclear how these stakeholders participate in decision-making and planning. Finally, and as noted before, much of the health aid literature is largely from the donor's perspective and grounded in other parts of the developing world such as Africa. This confirms the importance of this Pacific study – and from the voices of people.

In the following chapters I will examine peoples' perceptions of what makes for good aid in Samoa and how planning and decision-making functions toward this end, before concluding with considering how challenges and successes might contribute to improvement in outcomes.

# CHAPTER THREE: METHODOLOGY

## Introduction

This chapter has three parts; part one describes the way I designed my research, in part two I outline the methods I employ, and I conclude with my reflections on my fieldwork. The aims of my research are to explore people's perceptions of decision-making practices with a view to identifying their perceptions of whether and how they are involved in health decision-making in line with the principles outlined in the Paris Declaration. The key questions were:

1. What is good aid?
2. How does good aid work?
3. What are the challenges to good aid and what can be done?

Because my aim is to get the people's views of their experiences, I utilise a qualitative study and more specifically a phenomenological approach. In doing so I see the value of using the talanoa research method (Manu'atu, 1999), which fits Samoan values, communication patterns, and ideals and which assists in building rapport with the participants. Samoan researcher Tamasese (2008) refers to the value of people-centred approaches, such as the talanoa, to cut through the clutter and declutter, and to understand people's perspectives on their own terms. Hand in hand with the individual interviews, I understand a document review will be carried out to add to the literature and assist in setting out the context for this study.

This chapter is in three sections: research design; research approach; and fieldwork reflections. Selected methods will be outlined in this section consistent with the Punch (2005) recommendation that methods must follow from questions and objectives so providing in-depth and detailed empirical information about the world, not in the form of numbers (Punch, 2005).

## Research design

### *Qualitative*

My research is qualitative in design as I want to ensure that the people's voice is captured. Latu (2009) describes qualitative research as being multi-method in focus, involving an interpretive naturalistic approach to its subject matter. Though Stake (1995) suggests that a weakness of qualitative research includes the frequent production of new puzzles rather than solutions to old ones, I see that as a strength – that this exploratory research will generate further questions that add depth to existing research on health aid in the Pacific and help inform better solutions and address critical health statistics now.

Miles and Huberman's (1994) research provides a valuable summary of the role, objectives and process of qualitative research. They propose that the researcher's role is to gain a 'holistic overview of the context under study: its logic, its arrangements, and its explicit and implicit rules'. They state that qualitative research is conducted through an intense and/or prolonged contact with a 'field' or life situation. These situations are typically 'banal' or normal ones, reflective of the everyday life of individuals, groups, societies, and organisations. A main task for qualitative research is to explicate the ways people in particular settings come to understand, account for, take action, and otherwise manage their day to day situations. Capturing peoples' perceptions 'from the inside' is said to involve a process of deep attentiveness, of empathetic understanding, and of suspending or 'bracketing' preconceptions about the topics under discussion (Miles & Huberman, 1994). Reading through these materials, data analysis is said to take place when the researcher isolates certain themes and expressions. These can be reviewed with informants, but they should be maintained in their original forms throughout the study (Miles & Huberman, 1994).

I see the qualitative method as highly relevant for my research as my questions and objectives explore a process (Punch, 2005) and examine explicit and implicit rules (Miles and Huberman, 1994). Punch (2005) emphasises that qualitative research focuses on things that happen in the world and Wollcott (1992) expands and suggests that qualitative data is sourced from the research actions of watching, asking or examining, and reflecting on these experiences. I capture the perceptions of participants from the inside, highlighted by Miles and Huberman (1994) and, in my study, this refers to the experiences of personnel, practitioners and NGOs involved in aid decision-making.

### *Phenomenology*

I choose a phenomenological approach described by Moustakas (1994) as the search for meanings and essences of experience rather than measurements and explanations to 'illuminate the specific, to identify phenomena through how they are perceived by the actors in a situation' (Lester, 1999). Additionally, phenomenology is particularly relevant when questions of policy are explored (Cresswell, 2007). The phenomenological approach enables me to utilise people's experiences to define policy problems and as a basis for broader discussion on improving health outcomes through policy decision-making.

This approach allowed for the centralisation of aid personnel experiences described by Lester (1999), who identifies challenges and opportunities within the aid system and challenges structural and/or normative assumptions. Stake (1995) proposes that phenomenology's potential to uncover patterns of unanticipated experiences and to illuminate the unexpected is important in determining firstly if and where unexpected relationships play a role in aid policy. The use of the phenomenological approach sheds light on how unexpected elements might have a role in future health aid delivery. Phenomenology has the particular strength of focusing on the wholeness of experience rather than solely on its objects or parts, according to Moustakas (1994).

Phenomenology also has strong links to particular qualitative data collection methods, gathering 'deep' information and perceptions through inductive, qualitative methods and representing it from the perspective of the research participant(s) (Lester, 1999). For example, the talanoa method, discussed in a following section, is positioned as belonging to the phenomenological research family which focusses on meaning that events have for participants.

### *Case Study*

I decided to use Robert Yin's (1989) definition of case study in my research. Yin describes the case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context. I saw this as relevant to my focus on the here and now of researching aid to Samoa. Yin's explanation of the case study as blurring the boundaries between phenomenon and context is also consistent with my study's concentration on, for example, health spending and delivery. Finally, Yin's emphasis on the multiple sources of evidence used in the case study was well aligned to my document review and interview methods.

My single in-depth case study on Samoa would comprise a document review and, interview materials underlining the importance of reviewing health decision-making, not only from a health context but also from a cultural, economic, and policy perspective. A single case study was chosen as health aid delivery was an area where very little or no complementary research already existed. I sought to do this as a starting point for future research. In addition, I decided the value of using an embedded case study to show how decision-making worked in more detail. This would assist in telling the broader decision-making story.

Additionally, the choice of a case study approach enables me to focus attention on the experiences of what Miles and Huberman (1994) describe as an individual, small group, organisation, community or nation and decision, policy, process, incident or event. Yin (2004) highlights the in-depth nature of case study as enabling a detailed contextual analysis of a limited number of events or conditions and their relationships. Both Yin's (2004) research and Punch (2005) draw attention to the interconnectedness of the case study as enabling a response to questions about real life events using a broad range of empirical tools.

Stake (1995) expands on the in-depth nature of case study emphasising its significance in understanding important aspects of a new or persistently problematic research area. The use of the case study method adds further weight to and complements a phenomenological approach and provides alternate methods by which to explore information about aid personnel experiences, illuminating what is different or unique within the Samoan context or case. Stake's earlier (1994) work on case study types categorises my research as an instrumental case study where a particular case is examined to give insight into an issue, or to refine a theory. This type of case study is said to help us understand phenomena or relationships within it, particularly significant given the emphasis of my study on relationships and decision-making.

Yin (2004) provides excellent rationale for my use of a case study approach, stressing its applicability firstly when 'how' questions are being asked and secondly when conducting contemporary policy research. Stake (1995) also draws attention to the applicability of case study for policy questions which emphasises the need for programme report readers who are also impacted by programmes to understand both problems and programmes. Applying this to my research, it is crucial for those who are impacted by health services to understand problems and programmes in health aid delivery.

While the case study is sometimes criticised due to difficulties in generalising from a single case, Punch (2005) argued that studying a particular case in its own right, which is unusual, unique, or not yet understood, builds a valuable in-depth understanding of the case; and provides understanding of the important aspects of a new or persistently problematic research area. Within my research the case study method has the potential to uncover in-depth information about an area where little material exists currently on aid decision-making processes. Case study also provides a new perspective on the research area of aid effectiveness where the impact of aid and increasing aid effectiveness is studied worldwide.

### *Talanoa*

New perspectives will also be gained through the use of the talanoa method defined as a Pacific approach to gathering deep and meaningful knowledge about the reality of Pacific people's world as understood by them (Manu'atu, 1999). While talanoa is said to have multiple connected meanings (Morrison, Vaioleti & Vermeulen, 2002), for this research talanoa is more specifically defined as engaging in meaningful dialogue with participants in the Samoan context. According to Otsuka (2006), culturally appropriate methodology is more reliable and valued and will support knowledge-sharing and the bringing together of the perspectives of those engaged in decision-making in Samoa, creating the space and conditions for critical discussion.

As discussed earlier, talking things over rather than taking rigid stands are integral to Pacific cultures confirming the value of the talanoa method (Halapua, 2005). Tongan academic Timote Vaioleti (2006) suggests that talanoa emphasises the relationship between talanoa and culture, incorporating the values and beliefs underpinning the unique epistemologies of Pacific people, which create the space and conditions for critical discussion.

Talanoa is also described as a way of filling 'the gap on self-theorising by Pacific academics' or others (Ferguson, Gorinski, Wendt-Samu & Mara, 2008). Halapua (2005) explains that the way of the people of the Pacific nations is spoken rather than written and my use of a qualitative approach and interviews using a talanoa method will support this.

I incorporate culture in this research both as a methodology and as a research focus. I will ask what role culture plays in the decision-making process and in a broader context my research will be

conducted in a manner which centralises custom and culture. A significant aspect of talanoa is synthesis of the knowledge (Thaman, 1993); and I aim to produce research which Tupuola (1993) describes as being processed and written in a Samoan context.

The talanoa process also addresses the need for an interdisciplinary approach, e.g. knowledge views and modes of thinking from two or more disciplines, for example, politics, economics and sociology (Klein, 2006). Mansilla, Dillon, & Middlebrooks (2000) claim that the interdisciplinary approach 'advances knowledge and understanding in ways which would not have been possible through a single discipline'. Within Pacific studies this 'allows for and emphasises connections between political, cultural, economic, social, or spiritual phenomena, rather than emphasising their separateness' (Wesley-Smith, 1995, p. 310). This was useful in my study given the relationship between socio-cultural values and health for example.

Other work on health planning in small island nations such as the World Health Organisation's *Healthcare on Small Islands: A Review of the Literature* draws on economics, geography and public policy to identify major issues impacting on health service delivery. An emphasis on integrating knowledge and connection development between fields of knowledge is important in my study with the aim of exploring and examining decision-making about health aid identifying and linking the political, economic and social factors at play.

This research is also multi-levelled in its incorporation of the local, regional and global context in which health aid takes place. The studies I review on health planning identifies examples from around the world of health policy development (Hotchkiss, 1994; Singleton, 1990; Thurab-Nkhosi, 2000) and much of the quantitative data I utilise is from regional reports (Secretariat for the Pacific Community, 2012).

However, my primary focus is on the Samoan local context and the multiple perspectives of local actors. These participants were chosen from a wide range of employment levels to ensure a diverse range of perspectives. The study presents perspectives which are past, present and future looking.

## **Research methods**

Two main research methods are used. A document review and the participant interviews which I classify as the primary study.

### *Document review*

When I carried out my literature review prior to going into the field it became extremely clear that there were significant gaps in the Samoan health planning and documentation literature.

So while carrying out my fieldwork I gave priority to personally accessing as much documentation and as many reports as I could ( from Samoan officials in person) for review. Doing so builds on my literature and helps inform my interview guidelines. Gathering these materials together also confirms the

importance of this study, added support, and the necessary context to findings chapters. Punch (2005) emphasises the value of document review as a rich source of data for social research. Reviewing provides a set of baseline information to compare with information gained through other methods as well as informing data collection and strengthening my findings (Yin, 2004).

Records reviewed include Samoan Work Programmes, Annual Reports, and Development Strategies in New Zealand and Samoa. This information is the basis for identifying partner's roles and policies, and aid trends. Accessing government strategies and plans provides a crucial backdrop component in my analysis and complements the comments of aid officials. During my document review I consider the important questions raised by Finnegan (2006); asking for examples of whether all existing sources are relevant and appropriate for the research topic are utilized, and whether the source is concerned with recommendations, ideals, or what ought to be done.

While my document review uncovers a very useful body of work, a large number of additional relevant documentation is also identified and many of these reports are not available to me despite repeated requests to government officials.

## **Primary research**

My primary data collection method was semi structured interviews.

### *Preparation of interview guidelines and piloting*

Prior to ethics approval and fieldwork I piloted my interview schedule with three groups of people. The first pilot group were four colleagues at the time who had some experience in policy and research but no specialist knowledge in this field. This group's purpose was to advise on whether questions were appropriate for purpose. Secondly I piloted this schedule with a group of four friends who had no background in the topic or in research. I asked them whether they could particularly consider if questions made sense and whether they were repetitive. This group's feedback was particularly useful in highlighting where questions in different sections were in fact repeating themselves. Thirdly, due to my pre-existing relationships with key stakeholders in Samoa I was able to ask two people to provide advice on the interview schedule particularly about whether this made sense in a Samoan context, specifically was the right terminology being used and whether questions were accurate for Samoa?

### *Individual interviews*

Given that I want to explore the voices of the people and their experiences, individual interviews are selected as the main data collection tool. Interview is one of the most powerful ways we have of understanding others (Punch, 2005), and other people's constructions of reality in their own terms (Jones, 1985). Interviewing also has the benefit of not imposing restricted theoretical constructs on participants, but instead allowing the full meaning and richness of their experiences to emerge (Van

Kaam, 1966 p. 14).

My aim here is to interview an even spread of participants across the aid personnel, practitioner and NGO groups of up to 20 people. Interviews will be individually conducted rather than in a group, due to the sensitive nature of this issue and the possible impact on participants' employment security. Individual interviews will illicit responses which are defined by personal experience of the lived reality (Denscombe, 2003).

#### *Interview schedule*

My interview schedule was developed, informed by both my research objectives and the specific research questions I sought to answer, the literature on this topic that I read, and by talking to people in the aid field. (see annex one)

I designed my interview schedule to gather background information, first about participant's employment and their organisation. I also decided to ask these questions initially to develop a rapport with the participant following initial talanoa prior to the interview about shared acquaintances and family connections. Sections two and three of my schedule were aimed at understanding what the participant perceived as good aid and the ideal, as well as some realities of existing aid processes. In these sections I worked to explore what the process of developing, implementing and monitoring aid projects currently was.

The following sections looked at how aid effectiveness is defined in a Samoan context, what if any role culture played and specifically whether and what role partnerships play in effective aid.

Questions were open ended to allow understanding of the world as seen by participants (Patton, 2002). In the nature of the talanoa questions might appear closed but these were mainly used as discussion starters. As talanoa developed and trust and rapport was built. This encouraged participants to share other information and personal insights in an environment that felt safe. Confidentiality was a key feature of interviews Participants were provided with a written transcript of their interview for approval after the interview and to add any other comments they wished to add to the study.

## Sample

A purposive sampling approach was adopted as it was important to deliberately and carefully select participants who have experienced the phenomenon of working in health and specifically areas impacted by health aid. As the aid decision-making process is a long and complex one (from planning to implementation, monitoring and evaluation) I wanted to talk with people who had worked in the health aid sector for more than two years. Adequate representation by both male and female participants was another aim, as appropriate. As elaborated on the previous page, I intended to also identify one specific aid area for a detailed case study. I followed this issue from conceptualisation to implementation asking people on the ground how these project(s) impacted their lives.

Because I saw it as essential to gain three perspectives of the decision-making processes – consistent with the focus placed on Civil Society through the Accra and Busan Declarations - my aims were to interview three groups – aid personnel (from both Samoa and New Zealand), health practitioners and NGOs. I saw these multi-level interviews as capturing what Tamasese (1997) refers to as ‘the perspectives of the person at the top of the mountain, the person at the top of the tree, and the person in the canoe who is close to the school of fish’. Drawing on this multi-level approach, I sought to capture the views of a range of aid personnel including managers and administrators, to provide equally necessary perspectives. While it would have been valuable to gain the views of grass roots people using health services, I did not interview aid users, due to time constraints and also the difficulties, following Cyclone Evan, with locating the appropriate people with the capacity to approach aid user groups. I have however identified and followed one specific non-communicable disease as a detailed case study from conceptualisation to implementation.

I saw this research as an opportunity for those engaged in aid delivery to reflect on and present their views on how aid is (and has) been conceptualised, delivered, monitored and evaluated in Samoa. Participation gave the opportunity to reflect on the value of health and enable a comparison with the changing contexts and times – and also an ‘if we had done that then’ type of analysis. For donors, participating in this research offered the chance to put forward their views and evaluate their processes against the data showing the national health status today.

### *Recruitment*

Actual recruitment was difficult with timing and Cyclone Evan, and I was fortunate to interview 14 participants across the three groups. Following an initial visit to introduce this research six months previously, my eventual recruitment included asking key contacts within government ministries to confirm their organisation’s willingness to be involved and to identify the relevant teams and their members. I sent a blind copy email to all relevant staff and followed it up with phone calls. Some participants were unavailable as they declined due to their involvement in urgent cyclone related work or did not respond to my three attempts to make contact. Of all participants, six were at management or governance level, four were planners and four were in implementation roles.

Interviews were carried out between December 2012 and January 2013 in Apia, Samoa. The location of these interviews was determined by participants and was either at their place of work if preferred or at a booked meeting room off site. Interviews were audio recorded and transcribed later by myself and a third person.

Table six shows participant roles, the number within participant groups, gender, classification, and the years in each job. Participants were assigned a code to differentiate them from each other, and groups while ensuring confidentially so employers did not know for certain which employees participated. Interviews were also held at a time and a place preferred by the participants. Those interviewed were offered the opportunity to be sent a summary of the research findings and participant acknowledgement was placed in the text of all publications relating to the research.

**Table 6: Participants by these groups**

Participant role	Number	Gender	Coding	Years in job	
Aid Personnel	8	3 Males	NZAP1m	3	
			5 Females	NZAP2f	3
				SAAP1m	2.5
			SAAP2m	5	
			SAAP1f	7	
			SAAP2f	3	
			SAAP3f	4	
			SAAP4f	8	
		Practitioners	3	2 Males	PR1m
1 Female	PR2m				20
	PR1f			6	
	2 Males			NGO1m	5
				1 Female	NGO2m
NGO1f	7				

## Ethics

Ethics approval was gained through the Auckland University of Technology's Ethics Committee and a copy of this approval can be found in appendix two. A copy of the consent form and information sheet can be found in appendices three and four.

## Data interpretation

A central concern in a qualitative study is to 'analyse the data in a rigorous and scholarly way – in order to capture the complexities of the social worlds we seek to explain' Coffey and Atkinson (1996, p. 211).

Patton (2002, p. 432) also highlighted the challenge following interviewing of 'making sense of massive amounts of data'. For this study, data was analysed using Giorgi and Patton's approach below. Cooper (1989) was supportive of this approach, he suggested this process facilitated a fuller understanding of the phenomenon, context or culture being explored and I believe this elicited data from phenomenological and talanoa approaches particularly successfully. The works of Giorgi (1985) regarding a phenomenological approach to analysis provided further detail about how the pulling apart and putting back together process of data interpretation occurs.

**Table 5: A phenomenological approach to analysis**

<b>1</b>	<p><b>Horizontalisation</b></p> <p>Transcription and review of data highlighting emerging themes (how participants have experienced the phenomenon).</p>
<b>2</b>	<p><b>Textual description</b></p> <p>Second review and collation of data into emerging themes bearing in mind the questions of What is good aid, how does good aid work, what are the challenges and what can be done?</p>
<b>3</b>	<p><b>Nvivo</b></p> <p>This qualitative data collation tool was used as a support tool to review my manual collation and analysis of emerging themes undertaken in steps one and two previously.</p>
<b>4</b>	<p><b>Composite description</b></p> <p>This featured the development of descriptive statements and themes under each question and summary of these together into a one page summary for consideration and amendment as writing progressed.</p>

Source: Giorgi, 1985; Patton, 2002

As Lester (1999, p. 2) noted, 'analysis is also necessarily messy, as data doesn't tend to fall into neat categories and there can be many ways of linking between different parts of discussions or observations'. Triangulating and validating the data was crucial to sort and confirm sense among the messiness. Triangulation was carried out in a number of ways drawing on methods identified by Denzin (1978), Patton (1990) and Yin (2003).

Firstly, I triangulated responses across the three participant groups to identify any emerging patterns in multi-level interviews with 'the perspectives of the person at the top of the mountain, the person at the top of the tree, and the person in the canoe who is close to the school of fish. (Tamasese, 1997) Theoretical triangulation, (using multiple theoretical perspectives in interpreting a set of data) was also employed, for example analysing interviews to see how these fit against literature. Finally, I had both

my supervisors discuss at length my emerging themes as part of a validating procedure. (Yin, 2003)

In this study, the major themes emerging from the data analysis process are; participation, ownership, access, (because this is multifaceted) collaboration and consultation, capacity building, monitoring and evaluation. Minor themes are predictability, sustainability, (probably because these also fall under the more major theme of access) prioritisation.

## **Fieldwork reflections**

Overall my fieldwork was a hugely enjoyable process and was informative, yielding rich information. Despite the fact that a cyclone caused some disruption I found that participants were eager to share their views and some in fact said no one had ever asked them before. They had not considered their participation and some did not see the place they might have in decision-making

### *Entry into the field*

Getting ethics approval in Samoa was quite problematic and a lengthy process. For example, when I arrived in Samoa in October 2012 I made a series of visits to pre-existing contacts at the Ministry of Health and the National University of Samoa to clarify the process of gaining research approval. No documented process existed but officials were willing to suggest a possible course of action. From my arrival in Samoa it took seven weeks to ascertain whether research approval was needed; identify the appropriate research body; submit my research with letters of support; and have approval granted from the National Research Committee within the Ministry of Health and the Chief Executive.

Building relationships were a key element during this research approval phase and I made a number of visits to staff across the Ministry of Health to introduce and reintroduce myself and seek advice. Building relationships in this context required both email and personal contact and the flexibility to adapt to changes in contacts and direction rapidly. Persistence and patience was another crucial factor during my research approval phase and it was important to know when to press for an answer and when to wait for a response to be given.

### *Timing and cyclones*

I organised some interviews with the people I had met prior to my fieldwork and during the approval process. After piloting my interview questions, some questions were amended and I conducted my first interview on 12 December 2012. Cyclone Evan hit Samoa on 13 December 2012. The Cyclone and subsequent flood impacted my village particularly badly – my home was only 200 metres from where houses were completely destroyed. Water was waist high throughout my house which sustained damage to floors, walls and appliances, though my computer and research material were secure. Most of my village was evacuated and many people stayed away from their houses for days and weeks while we began to clean up. In seriously damaged areas health was a major concern and health workers and other aid partners visited our village and home to ascertain what condition our home was in and what was needed,

as well as providing support to families whose homes were destroyed and who had been evacuated to disaster centres.

Given my personal situation and the cyclone clean-up work health sector participants were undertaking, it was very clear that I should delay my interviews until the immediate disaster recovery work was complete. I delayed meeting potential research participants until the beginning of January.

The challenges of gaining ethics approval, and the cyclone, both reinforced that in the field it was crucial to be prepared for the unexpected.

### *Participants*

Those invited to participate were pleased to be involved and some expressed pleasure in having their perspectives recorded, where other contemporary reviews had excluded them. They noted that they had not had the privilege of being included in other health sector reviews.

The snowball sampling method was effective and I was fortunate that participants were open to proposing other potential participants. This was despite arguments presented previously that Pacific people are tired of research (Vaiotei, 2006). In addition, participants were pleased to see a Samoan studying what they perceived to be a highly important issue and my knowledge of protocols and language was of assistance.

### *Participant constraints*

The small human resource base within the Samoan health sector as a whole meant that some participants held multiple roles working as a practitioner within the hospital as well as being an office holder within an NGO for example. Those playing multiple roles were consistent with small nation states where skills and capacity exists within a small group (Commonwealth People's Forum, 2013).

Participant's workloads, and the reactive nature of their work, meant that in most cases a number of attempts were made to meet before interviews took place and some interviews had to take place over a number of sessions. One senior aid personnel did not respond to my requests for an interview and there were fewer eligible and available practitioners and NGOs than I had envisaged. However, I was able to accommodate timing changes, and other changes in circumstance. Two participants also asked to be interviewed together and further value was gained from long time colleagues reflecting together over shared experiences. Other participants sought to verify my relationship with the participant who had identified them before an introductory visit was agreed to. In some instances, this was connected to seeking permission from their employer to be interviewed. In this instance, the time I spent building relationships while awaiting research approval was advantageous. At the conclusion of my fieldwork I

had interviewed 14 people within the aid personnel, practitioner and NGO categories. Interviews were conducted in English in accordance with participant's preferences, so no translation was required.

Interviews were semi-structured and as in the talanoa I adapted my questions. Punch (2005) commented that interview data is never simply raw but always situated and textual and I observed this to be true when participants made reference to current events such as the cyclone and issues in health planning which have been identified across small island nations. These included workforce challenges and access to services (Hotchkiss, 1994; Singleton, 1990; Thurab-Nkhosi, 2000).

### *Summary*

This chapter presented my research design and methods for the study and my reflections on my research objectives and questions. Research was designed selecting those approaches which gave prominence to the participant's perspectives in a detailed and culturally appropriate manner. Throughout this research, people's experiences and document reviews have informed content. Interviews have provided a way to understand people's experiences first hand and the data collation and analysis methods selected contributed to a fuller and more robust understanding of the phenomenon. Participants interviewed represented a cross section and gender mix of those involved in aid decision- making and they valued the opportunity to share their experiences despite competing demands during the post disaster recovery phase.

# CHAPTER FOUR: SAMOA

## Introduction

This chapter presents Samoa's social, economic and political conditions which are the context for health aid decision-making in my study. It is divided into the following areas.

1. Land and peoples
2. Aid to Samoa
3. Health profile and planning
4. The state of Samoan health
5. Health planning for a healthy Samoa

## Land and peoples

Samoa is a small island state with a land area of 2,935 km<sup>2</sup> and an exclusive economic zone of 120,000 km<sup>2</sup>, which is the smallest in the South Pacific (Lee, 2013). With 188,900 inhabitants across two islands, Samoa's main island Upolu is actually the smaller of the two with a land area of 1100 km<sup>2</sup>. Apia, the administrative capital and the seat of government, is on Upolu. However, it is notable that 80 percent of the population continue to live in rural areas.

While modern systems of government are in place, the endurance of the customary family-based systems of living and decision-making – or the Fa'a Samoa remain. Fa'a Samoa or the Samoan culture characterises the Samoan way of life including the importance of spirituality. Fa'a Samoa is family-based involving the large extended *aiga* or family with a *matai* or chief at its head. The word *matai* comes from '*mata i ai*' which has the connotation of 'being set apart' or 'consecrated' (Meleisea, 1987). Both in traditional times and today the family, headed by the matai, is the main social organisation. Land is held in customary tenure for family use – and over 90% of the land is customary land and is the foundation of the semi-subsistence agricultural system practiced today.

The *matai* is selected by their family and have responsibility for leading decision-making about the *aiga*'s land assets and distribution as a trustee of land and property, while also overseeing the welfare of the family and settling disputes (Fairbairn-Dunlop, 1991). *Matai* suffrage also dictates that only those who hold a chiefly or matai title may become a decision-maker at parliamentary level (Meleisea, 1987).

The customary (Fa'a Samoa) decision-making model is consensus with the involvement of all families in goal setting (Meleisea, 1987). The *fono o matai* (meeting of the chiefs) is the main decision-making institution in the village and is responsible for village administration. In the *faamatai*, clearly distinguished roles exist, for example, chiefs responsible for decision-making, young males for

agriculture, and women for reproductive health. Within this system, the existence and role of traditional midwives and medicine will be discussed below. The arrival of foreign powers, and specifically the New Zealand administration, brought with it a partnership between government and community in addressing development needs such as the introduction of health committees using the village structure (Fairbairn-Dunlop 1991; 2006 Schoeffel, 1984; Thomas, 2014). Villages sought to contribute to this new system of healthcare, giving or donating land for hospitals (Fairbairn-Dunlop 1991; 2006 Schoeffel, 1984; Thomas, 2014).

*Current demographic, social and economic status*

As seen in table eight, Samoa's population is extremely youthful, which impacts on the planning and delivery of basic services such as health and education. Life expectancy rates are also increasing, with Samoa's elderly living amongst the longest in the region at 74 years in 2012 (World Bank, 2013). High fertility rates are balanced by out-migration (Samoa Bureau of Statistics, 2015b; UN Data, 2014). Growth in the numbers of people outside the labour force suggests that dependency ratios (those economically dependent on others) are likely to be high (and increasing).

**Table 7: Samoa key demographic, social and economic indicators**

Indicator	Result
Total population 2012 (Samoa Bureau of Statistics, [SBS] 2015a)	189,236
Population 0-14 Years (World Bank, 2013)	38%
Population 15-64 Years (World Bank, 2013)	57%
Population 65 Years Plus (World Bank, 2013)	5%
Population Median Age (World Bank, 2013)	21 Years
Life expectancy (Secretariat of the Pacific Community, 2015)	74.2 Years
Total fertility rate per woman 2011 (SBS, 2015b)	4.7
Population growth rate from 2006 – 2011 (SBS, 2015c)	3.9%
Population in urban setting (SBS, 2015c))	19.5%
Mean household size (SDHS, 2009)	7.4
Net migration (UN Data, 2014)	-12690

As seen before, almost 20 percent now live in urban settings, which has an influence on health planning and services and also raises other issues in those areas such as employment, pressure on land and housing, overcrowding and sanitation concerns as well as the growing likelihood of contracting infectious diseases (Ministry of Health, 2009).

Issues associated with internal migration and urbanisation are likely to loom even larger in the future because unprecedented numbers of young people are moving to cities in search of work, placing

increased demands on urban infrastructure services. For example, 99 percent of urban areas had water supply coverage in 1990, whereas only 76 percent are projected to have coverage in 2015, and sanitation is projected to drop to 91 percent (Asian Development Bank, 2012). Current and future decisions must take into account the changing shape of cities like Apia.

### *Economy*

During the study period, Samoa's Least Developed Country (LDC) status was an important influence on planning and decision-making due to the entitlements available as a country facing multiple development challenges. While graduation from this group in January 2014 was an achievement, this also means that Samoa will be less eligible for aid or international concessions (SIDS Policy and Practice, 2012). Some suggest this change in status will negatively impact the assistance received (Lesa, 2013) fueling public debate over whether to acknowledge Samoa's growth and accept less assistance or downplay Samoa's growth and continue receiving current levels of assistance (Huch, 2014).

Samoa is categorised in the lower middle-income country bracket according to the World Bank (2013). Samoa's USD\$677 million GDP (including traditional dependence on semi-subsistence agricultural production, development assistance, and remittances) is calculated producing economic classifications which are reviewed annually (World Bank, 2015).

Despite some economic growth, aid as development assistance continues to be required. Low rates of employment and minimal national income indicate that many people in Samoa are living with significant cash constraints. These financial limitations have both lifestyle and health impacts concerning the affordability of healthy food and the available resource to access a doctor. Policy design which addresses the impact of people's limited financial resources on service access will be explored within this research.

### *Vulnerability to natural disasters*

Samoa is vulnerable to natural disasters (UN-OHRLLS, 2014) and, as noted during the study period, faced significant impact from tsunamis, cyclones and floods during the study period

Dayton Johnson (2006) also highlights the significance of factors such as health and education to inform decision-making and the impact on the country's resilience to natural disaster. This draws on the rationale that people with higher levels of education and better health status are better able to weather shocks, better prepared to heed disaster warnings by governments and seek alternative means of generating income. In addition, if they are in better health, they are better able to withstand reduced food or housing unavailability.

At a national level, policy decisions must consider the projected financial impact of national disasters on the economy. The World Bank has also quantified the fiscal impact of a natural disaster in Samoa with the aim of informing their work and strengthening resiliency-based and structural indicators. Highlighting the scale of risk, projections indicate Samoa is expected to incur, on average, USD\$10 million per year in losses due to earthquakes and tropical cyclones (World Bank, 2011). In the next 50 years, Samoa has a 50 percent chance of experiencing a loss exceeding USD\$130 million and casualties of over 325 people. Additionally, there is a 10 percent chance of experiencing a loss exceeding USD\$350 million and casualties of more than 560 people. Significantly this assessment has also estimated that the replacement value of all the assets in Samoa is USD\$2.6 billion (World Bank, 2011). It is unclear whether the Samoan Government's financial planning considers these future costs and how to save now for such a situation. However, saving for future risk does have an opportunity cost, potentially negatively impacting on expenditure available for health services now and increasing the possibility of trade-offs.

### *Samoa health practices*

Samoa has always had its own health practices drawing on Fa'a Samoa cultural belief and interaction with the outside world. MacPherson (1990) suggests that prior to European contact, ill health was said to be associated with the displeasure of the Gods. It was said that the offending God was identified and prayers were offered, while Samoan healers also practiced herbal medicine (MacPherson, 1990). Traditional medicine has at its heart – Fa'a Samoa ideals about self, community and wellbeing. This includes the Samoan self-defined in relationship with other people, not as an individual (Tamasese et al., 2005). This emphasises a broad, interconnected and collective understanding of health, group wellbeing and of the ways this is achieved (Fana'afi, 1986), aligning with Tamasese et al.'s (2005) definition of the Samoan self as '*itu lua*', incorporating physical, mental and spiritual aspects that cannot be divided up

During the European contact period influenza, syphilis and whooping cough all emerged influencing what and how health care was provided, including the introduction of medicines. Only limited medical treatment was available at that time and much of this was administered by missionaries with limited or no medical training (Macpherson, 1990). While missionaries and doctors brought European medicine, they also observed that Samoans continued to use their own medicines alongside these, a practice which continues today (MacPherson, 1990).

Beginning in the 1920s, island administrators established formalised health programmes extending treatment and public health programmes, which were said to build on existing indigenous practices (MacPherson, 1990). The provision of health care by women's committees encompassed a holistic approach to health incorporating environmental health, mosquito nets, bathing, as well as medical supplies. Healthcare at a village level was also emphasised by early publications such as *Health for Samoa* (1937) accentuating cooperation between health professionals and non-professionals. There

were also accounts of Native Medical Practitioners and Samoan healers, or Taulasea, who cooperated in patient treatment (MacPherson, 1990). Nurses were also attached to Women's Committees and the removal of this support in the 1990s has seen a decline of healthcare within these committees (Thomas, 2015). Developments in maternity care have further united Western and traditional medicine and philosophies with Fa'atosaga or traditional birth attendants. The Samoan government has begun work bringing spiritual and physical dimensions of health together formally with the registration of Samoa's Traditional Birth Attendants (TBA), or Fa'atosaga, as one of the few traditional healers granted registration (Pacific Human Resources for Health Alliance, 2012).

Building on the increasing interplay between Western and traditional medicine, effort has been made to translate this into a platform for health decision-making. For example, the Fonofale Samoan health model incorporates a holistic approach considering physical with spiritual, mental and social dimensions of health and the family, to treatment within primary and secondary health systems, which will be considered in my study (Pulotu-Endemann et al., 2007).

Globally, the applicability and importance of traditional knowledge and culture in development has been recognised. For example, Phillips' (1995) study of Nigerian traditional knowledge in development illuminates three factors consistent with the partnership model: participatory decision-making; as a practical concept to facilitate communication; and in ensuring that end users of projects are involved in developing technology appropriate to their needs.

Research from elsewhere in the Pacific also highlights the successful coexistence of culture and development. In Chuuk, a Western savings system was established for villages and saving meetings successfully incorporated cultural practices and values to enhance popularity resulting in funding of small scale commercial projects. This savings system exhibited people's appropriation of a foreign practice in ways which were indigenously defined and directed (Hanlon, 1998).

The ongoing use of traditional medicine and approaches, alongside increasing education levels in Samoa, offers an opportunity to improve health literacy and health outcomes, while decreasing costs to the Samoan Government. As indicated in OECD (2006), the collaboration between Western and traditional medicine, together with research outlining the connection between improved education and better health, should be capitalised on further. High levels of literacy should be translated into work to improve health literacy or the capacity to obtain process and understand basic health information and services, in order to make informed and appropriate health decisions (Kickbusch et al., 2005). A multi-pronged approach continuing to incorporate both traditional and Western notions of health and wellbeing, integrated into prioritised areas of the health system, to an increasingly health literate population will be returned to in a later chapter. This may also imply cross-sector collaboration with education as proposed in OECD (2006).

## Aid to Samoa

In a coincidence of timing, and as the Paris Declaration sought to embed the partnership model, research emerged highlighting Samoa's strong track record in engaging with multiple aid models over the previous century (Delay, 2002, 2005). More specifically, Samoa's aid management was described as exemplary in the region including high level champions of aid coordination, supported by high calibre teams, strong links with planning functions, and ownership over the aid process. Despite this, the current Health Sector Plan (HSP) raises questions about the Ministry of Health's capacity to manage the sector and aid relationships, and this will be considered through this work. Both assessments will be considered.

Samoa's century of aid engagement began with support from New Zealand as an island territory prior to its independence in 1962. Some commentators suggested this was conscious or unconscious atonement for the influenza epidemic which killed almost 20% of Samoans in 1918 (Hoadley, 1980). Decision-making during the pre-independence period 1920 – 1961 was centred on service and infrastructure establishment and developing Samoan health professionals. Aid to Samoa in the 1920s reflected political concerns, focusing on primary health care consistent with New Zealand's domestic focus (Schoeffel, 1984). Women's health committees were central to early primary health care, working to improve village sanitation, assist in rural health centres and provide mother and child health services with public health nurses (Schoeffel, 1984).

In the pre-independence period, shared service development and delivery was an important feature of healthcare. Involving other island administrators, the South Pacific Health Service was established in 1946, formalising a joint Health Service in New Zealand and United Kingdom island territories, with a New Zealand contribution of £1,504 (Department of Island Territories, 1947).

Shared service development grew to emphasise collaborative research and in 1948 – 1949 New Zealand funding (£986) supported the establishment of a second body, the South Pacific Medical Board of Health (Department of Island Territories, 1950). This organisation collected and distributed epidemiological information, drew up quarantine procedures, assisted administrations to maintain adequate staff, encouraged and coordinated medical research in the area, and advised on training local people as assistant medical practitioners and allied callings.

Capacity requirements were also addressed from early in New Zealand's relationship with Samoa, originally as a military administrator taking over from German authorities at the outbreak of World War One and later under a League of Nations mandate (Meleisea, 1987). In 1946 – 47, assistance was also given to the education sector, with an additional £9,500 provided for the Island Scholarship Scheme selecting students from island territories for higher education in New Zealand (Department of Island Territories, 1947). Samoan health workforce development was also invested in, with young people trained at what is today the Fiji School of Medicine as assistant medical inspectors. Over time, training

areas expanded to include filariasis inspectors, assistant sanitary inspectors, lab assistants, and assistant pharmacist's courses. Funding for initiatives not only came from external funding sources, but also from other sources including a Samoan corporation which made a profit of \$359,915 that year and provided funding towards a TB sanatorium (Department of Island Territories, 1950).

Post-independence, reports suggest that Samoan and New Zealand priorities began to differ. Schroff (1980) argues that New Zealand's focus on transport infrastructure, agricultural exports, small scale industrial development, and teachers and scholarships, did not reflect Samoa's external relations priorities. Samoa furthered its international profile joining the United Nations in 1976 (United Nations, 1976) and engaging with institutions such as the World Bank. Influenced by neoliberal aid models, Samoa was one of six Pacific countries which adopted structural adjustment policies (SAP) involving prudent fiscal and monetary policies, as well as public sector reforms. These were designed by the World Bank to assist PICTs achieve the same growth rates as Caribbean and Asian countries. Under these policies, health sector priorities and work was focused on asset management and institutional reforms to create a sound economic and social infrastructural network (World Bank, 1991).

Kerslake (2007) argues that SAP failed more broadly because they lacked connection, as economic policies did not support other, for example, trade-related policies and subsequently a new wave of reform policies were introduced in the late 1990s including poverty reduction. During this period decision-making became more coordinated as donors and government came together in roundtable meetings to organise Samoa's development agenda and agreement was made to support each other and agree on both the development philosophy and on the projects each one would support. In the 1990s, Samoa's evolving policy approach also included realignment of government structures and functions. By 1995, the aid planning function had been shifted to the Ministry of Finance from the Ministry of Foreign Affairs and Trade and the first two-year *Statement of Economic Strategy of Samoa* was launched to cover the period 1996-1997. Over time, the Statement of Economic Strategy evolved into the four-year *Strategy for the Development of Samoa (SDS)* 2002-2004, 2005-2007, 2008-2012 and 2013-2016.

While there are many donors here I present a brief account of New Zealand aid and Chinese aid in the following sections.

#### *New Zealand aid*

New Zealand is one of Samoa's major donors, supported by the 1962 Treaty of Friendship which promised ongoing assistance when Samoa became independent. The New Zealand Aid Programme (NZ Aid) describes its objective as supporting sustainable development in developing countries to reduce poverty and contribute to a more secure, equitable and prosperous world with a focus on sustainable economic development in the Pacific region (Ministry of Foreign Affairs and Trade, 2011). Arguably, an economic focused review (Reid-Henry, 2013) has also located education and health

initiatives alongside measures to drive private sector growth (Government of New Zealand and Government of Samoa, 2011).

New Zealand has devoted considerable effort to building collaboration and participation following significant concerns raised in 2001 about aid fragmentation and the need for improved alignment and training (State Services Commission, 2002). New Zealand formally adopted a more coordinated approach following its agreement to the Paris Declaration, but recent debate has centred on the government's adoption of neoliberal approaches to aid (Ministerial Review Team, 2001). Labour Governments from 2000 to 2008 are said to have favoured a basic needs and human development approach focusing on healthcare and education with a prosperity focused outcome (Ministry of Foreign Affairs and Trade, 2005). In contrast, the National Government from 2008 has adopted a more neoliberal focus transitioning from poverty alleviation to a focus on a more competitive and internationally focused economy (Ministry of Foreign Affairs and Trade, 2012).

A recent OECD (2010) assessment of New Zealand's aid was favourable suggesting that its assistance was both flexible and predictable, though internal decision-making was still fairly centralised with limited field capacity. Furthermore, New Zealand's Public Finance legislation applies accountability and compliance requirements across the public sector supporting good governance (Liuvaie, 2009). Aid programmes have been developed, implemented and reported on publicly and the NZAID's public reporting responsibilities are an important contrast to Chinese aid reporting, where aid spending is said to be a state secret (Hanson, 2009).

New Zealand continues to broaden its aid outlook and expand partnerships, joining the Chinese and Cook Islands' governments in a water upgrade project for the Cook Islands in 2012. This project represents the first cooperative development between China and any other developed country and is the first time China has partnered in this way to deliver a development project (Ministry of Foreign Affairs, 2013). New Zealand contributed up to NZ\$15 million as a grant while China funded other parts of infrastructure development and supplied a Chinese construction company to develop the new water reticulation system (Ministry of Foreign Affairs, 2013). Government documents omit the rationale for each partner's involvement in this project, though the Cook Islands are within the realm of New Zealand and receive ongoing budgetary assistance (Fraenkel, 2012). Though it is unclear to what extent this initiative represents a partnership aid model and draws on aid principles, it is apparent that this initiative is consistent with outcomes sought by the New Zealand Foreign Ministry and the Cook Island government (Ministry of Foreign Affairs and Trade, 2013).

New Zealand and Samoan priorities are reflected, but not sequenced, in various shared strategic agreements and domestic documents. Flexibility is a consideration within the New Zealand aid programme specifically economic and market circumstances. Its partnership work stream is described as involving a flexible approach, adapting and responding to new partnership opportunities and market and commercial imperatives (New Zealand Aid Programme, 2011). New Zealand aid to Samoa during

the study period is outlined in appendix five. A wide range of sector and activities were funded during this period including general budget support, government and civil society and health.

The New Zealand Aid Programme has recently prioritised a flexible approach including improving resiliency and recovery from emergencies. This particularly refers to 'respecting local communities and promoting local participation and ownership', suggesting flexibility to local conditions and circumstances (Ministry of Foreign Affairs and Trade, 2015a).

Building New Zealand capacity offshore is noted in recent publications (New Zealand Aid Programme, 2012). New Zealand also supports capacity building evidenced by the New Zealand and Samoan Government's commitment to build capacity within Samoa's National Health Service (Ministry of Foreign Affairs and Trade, 2011).

### *Chinese aid*

China is a recent donor partner to Samoa and a significant donor in dollar terms. Brant (2015) suggests China is the third largest regional donor behind New Zealand's USD\$1.096 billion and Australia's USD\$6.831 billion. In Samoa, China's contribution is said to be even more significant (Brant, 2015) as the second largest donor in the country totaling USD\$207.99 million across 28 projects from 2006 – 2011 (Brant, 2015).

Commerce has linked China and Samoa for over a century. Almost 7,000 Chinese indentured labourers arrived in Samoa between 1903 and 1934 and have paved the way for Chinese entrepreneurship today (Noa Siaoisi, 2010). Descendants have intermarried with Samoans and have a hugely visible influence today (Aiovao, 1993).

Forty years after China and Samoa established diplomatic relations (Iati, 2010), two Chinese White Papers on Foreign Aid (Information Office of the State Council People's Republic of China, 2011; 2014) outlined Chinese aid evolution, aid forms and relationships with regional and international organisations. Globally, Chinese assistance has supported 121 countries (including 9 in Oceania) on 580 complete projects (Information Office of the State Council People's Republic of China, 2014).

Chinese assistance to Samoa (see appendix six) is extensive and varied, spanning schools, to a demonstration farm, and a CT scanner totaling \$207.99 million from 2006-2014. Detailed country level information and decision-making details (especially planning) however are absent. Aid monitoring and evaluating is also outlined but specific frameworks are excluded.

Yang (2011) argues that Chinese aid is motivated by its Grand Strategy (incorporating National Security, Development and Unification Strategies) and objectives of independence, sovereignty, territorial integrity, common development and non-interference in other nation's affairs (Foreign Ministry

of the People's Republic of China, 2003) constitute an assistance model separate to aid effectiveness agreements. Chinese aid rationale has been linked to political need for resources and votes (Crocombe, 2007), diplomatic recognition (Biddick, 1989; Henderson, 2001), and military ambitions (Henderson, 2001).

China's eight aid forms have proven very popular with Samoan Prime Minister Tuilaepa Lufesoili Satai who stated 'China is more flexible in its aid and it is the sort of help we can't get from its traditional partners' (Radio Australia, 2012), while a Chinese official stated 'we believe if projects are welcome by local people and governments they must be good projects' (Callick, 2009).

Prior to the Chinese White Papers, there was said to be no systematic approach and plan to Chinese aid provision with officials unaware of aid spend or impact (Lancaster, 2005). Aid monitoring and evaluating is also outlined but specific frameworks are excluded also.

Unpublished material from a local aid consultant suggests that quite separate from formal process, a specific and unique aid agreement exists between China and Samoa, which is separate from existing developing cooperation policy (personal communication, July 9, 2011).

Calls are emerging for engagement and agreement between China and other donors on issues of shared interest (Hanson, 2008, 2009, 2011). This is of growing importance as non-OECD Development Assistance Cooperation (DAC) donors such as China now disburse up to a quarter of the aid disbursed by DAC donors. Aid recipients also seek to understand and analyse Chinese aid and how it works for regional aid policy benefit (Callick, 2011).

China's OECD involvement is expanding and they are collaborating with a range of multilateral organisations on training and workshops (Information Office of the State Council People's Republic of China, 2014). The Bangkok Post (2011) proposed the Pacific as a laboratory to test Chinese engagement strategies and this may already be initialised through the joint New Zealand China project in the Cook Islands, which is underway (Ministry of Foreign Affairs and Trade, 2013). A programme of dialogue and co-operation between the OECD and China was established in the 1990s (OECD, 2009) and the participants in a 2005 joint study group recognised the importance of ownership, capacity development and mutual learning as shared concepts for complementary efforts by widening the range of development partners (China DAC Study Group, 2009).

## **The state of Samoan health**

The State of Samoan health is outlined in the following table detailing Samoa's performance against a range of indicators presented in Samoa's cross government strategic planning document, measured against Millennium Development Goals, SWAp and HSP objectives. Health improvements are denoted by a green dot, declines in health are denoted by a red dot and where no change has occurred an

orange dot is used. Gaining reliable data to measure the impact of the Health Sector Plan and SWAp interventions is described as an ongoing challenge (Davies, 2013; Vaillancourt, 2012) and one which I argue impacts future decision-making. Process monitoring indicators such as those reported on within SWAp was not included. Data held by the World Health Organisation's Global Health Observatory collected from member states on an annual basis is also shown.

**Table 8: Progress against health indicators 2007 – 2012**

Indicator	2007 - 2012	Total change	RAG
<b>Infant mortality rate (per 1000 live births)</b>			
SDS (Government of Samoa, 2012)	12.5 - 13.9	+1.4	●
SPC (2017a)	24.7 - 22	-2.7	●
World Health Organisation (2015a)	16.2 – 15.8	-0.4	●
<b>1 Year Olds immunised against measles</b>			
SDS (Government of Samoa, 2012)	63%	0%	●
SPC (2017b)	55.7% – 60.6%	+4.9%	●
World Health Organisation (2015b)	63% - 67%	+4%	●
<b>Under-5 mortality rate (probability of dying before age 5 per 1000 live births)</b>			
SDS (Government of Samoa, 2012)	17.5 – 18.0	+0.5	●
SPC	24.7 - 22	-2.7	●
World Health Organisation (2015c)	18.9 – 18.5	-1	●
<b>Maternal mortality ratio (ratio per 100 000 live births)</b>			
SDS (Government of Samoa, 2012)	2.8% - 2.0%	-0.8%	●
SPC <sup>4</sup> (2017d)	46	0%	●
World Health Organisation (2015d)	93 - 51	-0.04%	●
<b>Percentage of births attended by skilled health personnel staff</b>			
SDS (Government of Samoa, 2012)	100% - 96%	-4%	●
SPC (2017e)	80.8% - 82.5%	+1.7%	●
World Health Organisation (2015f)	82.5%	0%	●
<b>Prevalence of diabetes per 1000 people, hypertension and obesity</b>			
SDS (Government of Samoa, 2012)	Diabetes: 21.5% Hypertension: 21.2% Obesity: 54.8% - 85.2%	+/-0% +/-0%	● ● ●
SPC (2017f; 2017g)	Diabetes 22.1 – 45.8 Hypertension not available Obesity 54.7% - 55.8%		● ● ●
World Health Organisation (2015f; 2015g; 2015h)	Diabetes: 22.3% Raised blood pressure: 42.7% <sup>5</sup> Obesity: 41.8%		● ● ●
<b>Prevalence and death rates of Tuberculosis (TB) decrease</b>			
SDS (Government of Samoa, 2012)	Prevalence TB: 1.4% - 0.8% TB death rate: 0.07% - 0.2%	-0.6%  +0.13%	● ●
SPC (2017h; 2017i)	Prevalence TB: 0.016% - 0.03% TB death rate: 0.0013% - 0.032%	+0.014%  +0.0019%	● ●
World Health Organisation (WHOj)	Prevalence TB: 49 - 55 TB death rate: 5.2 - 6.4	+6  +1.2	● ●

Comparing 2007/08 figures against 2011/12, a mixed picture emerges. Results show that maternal mortality rates have decreased along with TB prevalence. No change has been recorded in immunisation rates according to SDS figures, while SPC and WHO figures record encouraging increases. Differing pictures also emerge of progress on the proportion of births attended by health personnel and under-5 mortality. For maternal mortality all data sources agree that improvements have been made. A caveat to this assessment is in noting that the majority of these indicators have increased by less than one percent while acknowledging the exception to this in obesity rates which have climbed steeply by 30 and 50 percent respectively. Year after year analysis of immunisation for example, shows fluctuations with both sharp increases and decreases over the period while registering no change at the end. Understanding the impact initiatives on this pattern would be valuable.

Comparing the three datasets it is apparent that there are some data differences and it is important to note that both WHO and SPC data provide a more positive picture of Samoa's health outcome achievements than Samoa's own results. Another significant factor is the impact of health promotion within the HSP and SWAp on reporting rates. It will be important to consider whether and how these different trends illustrate impacts on decisions at multiple levels, local, regional and international. Of particular importance will be tracing these impacts where differences are stark.

Looking beyond assessment of trends and progress, critical questions are raised about how robust this data is. These impact on the foundation and ongoing rationale for decision-making.

The accuracy of data presented here is unclear given the inconsistency of data presented across data sets. Relevant to small differences in reported data, WHO (2015b) reports that 'datasets represent the best estimates of WHO using methodologies for specific indicators that aim for comparability across countries and time; they are updated as more recent or revised data become available, or when there are changes to the methodology being used. Therefore, they are not always the same as official national estimates, although WHO whenever possible will provide Member States the opportunity to review and comment on data and estimates as part of country consultations'. While data collected by the Secretariat for the Pacific Community notes that for example: 'SPC under 5 mortality Sample survey - birth history may be under reported as this is inconsistent with 2002-2006 Census results. SDHS childhood mortality rates are very likely underestimates and must therefore be treated with great care'.

Firstly, the SDS omits a discussion of data origin, usage rationale and calculation method, for example, assessment of progress produces a different picture if a discrete start and finish is used compared with data analysis year on year over the entire period. Discrete analysis of 2007 rates against 2012 figures shows that over the five-year period most indicators stayed the same or were impacted negatively. However, year after year analysis available in external datasets presents greater variance. Secondly, any narrative regarding trends is omitted (though overview of activity is included) and thirdly, there is no note of any statistical limitations or caveats. Where datasets demonstrate contrasting trends, there

is particular need for further analysis of data, its collection and systems to best understand the state of Samoan health.

The inconsistency and lack of information accompanying key health statistics make it very difficult to tell whether and how progress has been achieved in improving the health of Samoan people.

## **Factors impacting health status**

### *Access to healthcare*

The Samoan Government's strategic commitment to measure performance around improving access is evident within the 2008-2016 HSP incorporating monitoring of emergency, triaging and outpatients waiting time. However, the absence of targets or trend data makes it difficult to assess government performance on access over time. However, from 2012 data it is known that more than half of patients (57 percent) had to wait more than two hours to see a doctor (Government of Samoa, 2013).

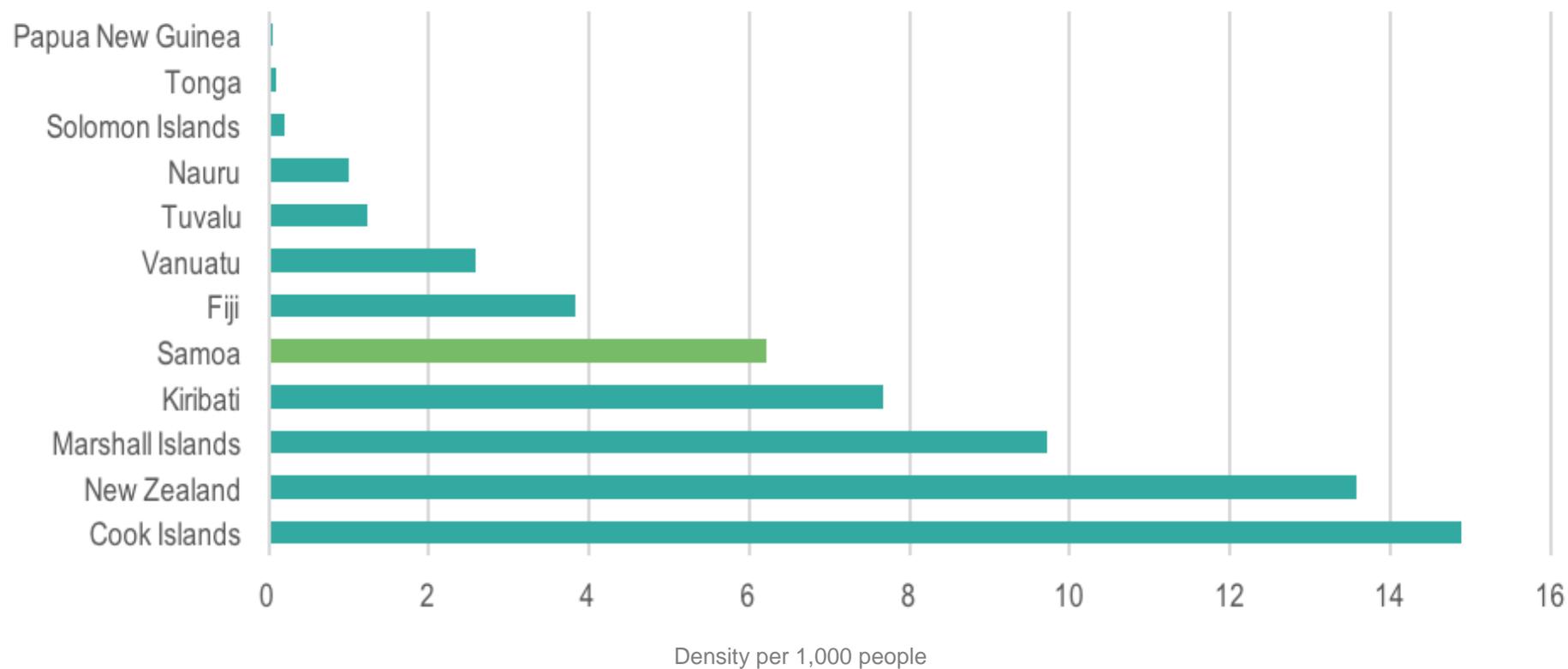
Access to primary healthcare is straightforward with village-based rural health centres or district hospitals. However, there are differences in access to tertiary care with 'big cases' required to be treated at the national hospital in Apia, up to one and a half hours away from rural villages. Davies (2013) evaluation of the Health Sector Management Programme claimed that operational efforts to improve access, especially construction of new facilities, diverted funding from specific health concerns. Investment in infrastructure projects is said to distort spending priorities, weaken primary care focus and divert attention from challenges in NCD and prevention within the Health Sector Plan (Davies, 2013). In contrast, the importance of access to basic services is highlighted by many including the World Bank (2009) and Peters et al. (2008). Ongoing debate and recent events do however make it apparent that investment decisions, and particularly infrastructure investment, need a clear rationale and demonstrable short, medium and long-term outcomes to address the issues raised by both sides of the argument. How decisions are made about infrastructure and other priorities will be considered in future chapters.

### *Economic and Human Resources*

From planning to service delivery in Samoa, capacity is a critical consideration with human resource capacity shortfalls in most areas. Table 9 illustrates health worker shortages across the region showing, for example, that while Samoa has significantly less than one doctor per 1000 people, it falls in the middle of the region for doctor numbers. There are slightly more nurses and midwives proportionately (1.85 per 1000 people) but nurse numbers are still amongst the lowest in the region (World Health Organisation, 2012b).

**Table 9: Pacific Health Workforce**

## Density of Health Workers



Source: World Health Organisation 2012

While capacity is a concern now, these issues may loom even larger in future decision-making. Connell and Negin's (2009) study of the Pacific health workforce notes Samoa's ongoing downturn in capacity and points to the significant number of Samoan health workers now in New Zealand. For example, at the time of writing there were 42 Samoan doctors in New Zealand compared with 50 doctors in Samoa. A comparable situation exists for Samoan nurses in New Zealand who outnumber nurses in Samoa with 469 working in New Zealand compared with 310 in Samoa. Connell suggests that low incomes, the working environment and 'politics', are all pull factors driving outward migration.

As noted, capacity impacts significantly on health planning across all small island nations and specifically in terms of training and retaining staff (Hotchkiss, 1994; Singleton, 1990; Thurab-Nkhosi, 2000). Despite this, progress has been made with Samoan efforts to professionalise the health sector with the registration and accreditation of existing health professionals, accredited through annual practicing certificates (Government of Samoa, 2013). Nursing training is also offered domestically through the National University of Samoa (National University of Samoa, 2014).

The health worker data in Table 10 excludes health planning staff. Using a broad definition of the health workforce to include policy and planning staff will be important to understanding capacity required across the health decision-making process. For example, those working in health policy are not currently counted in World Health Organisation Statistics and efforts to access numbers from the regional health worker body went unanswered. The paucity of work documenting and describing the impact of health policy personnel and other non-clinical staff involved in aid decision-making is an area for future consideration when looking at health aid effectiveness. For now, how staffing issues are taken into account in decision-making is an important consideration.

## **Health planning – for a healthy Samoa**

### *National Development Objectives – Strategy for the Development of Samoa (SDS)*

This strategic document sets out the Government's intentions over the medium term. During this study period, all the SDS focused jointly on health and education to provide opportunities for all and improved quality of life alongside private sector development to drive economic growth (Government of Samoa, 2002, 2005, 2008, 2013). The SDS, prior to 2008, prioritised improving health services in specific areas such as primary care, and child and maternal health. This was alongside work to strengthen monitoring and evaluation mechanisms, health facilities, workforce capacity, and private sector partnerships, which is said to also be consistent with earlier Health Plans. Changes in the global health environment were also reflected in these national documents with the use of media for health prevention work and exploration of ways to finance the health sector emerging from 2005. The 2008-2012 SDS health section contained a major change in policy approach with the Health Sector Plan 2008-2018 and specific indicators to measure progress on the plan, including infant mortality falling and immunisation rate increases.

### *Health Sector Planning 1998-2003 & 2004-2007*

As with all government agencies, the health sector is required to produce multiple planning documents setting out work at a range of levels. Three Health Sector Plans covering, 1998-2003, 2004-2007 and 2008-2018 were at least partially implemented during the study period. All plans have set out to achieve the vision of 'A Healthy Samoa'.

Despite these document's publication, gathering briefing, strategy and work plans outlining Samoa's decision-making process has been problematic, largely related to both historical and contemporary information gaps. There were difficulties accessing these plans; for example, publication delays have been one factor with government ministries making available the most recent annual reports which are up to ten years old. In contrast, the availability of historical planning documents has been challenging with officials providing electronic copies of current strategies but unable to locate historical Health Sector Plans from 1998-2007 within the Ministry library or online filing systems. In addition to current strategy, planning documents such as the Ministry of Health SWAp Programme of Work, Corporate Plan and Mid-Term Review were also made available, however other contemporary documents such as the Monitoring and Evaluation Framework and Medium-Term Expenditure Framework were not accessible.

### *Health Sector Plan 2008-2018*

This Health Sector Plan will receive the most attention due to its publication following the Paris Declaration and its relationship with the current partnership model and SWAp. The 2008 plan was informed by a 2006 situation analysis prioritising NCDs, child and maternal health, infectious diseases and injury prevention. In addition to links with WHO, MDG and regional planning work, it was also influenced by analysis highlighting the importance of the government's institutional reform processes and realignment of roles and functions (Government of Samoa, 2012). Priorities also reflected Samoa's demographic, economic and social context alluded to earlier in this chapter. The Plan identified four challenges of:

- NCDs;
- reproductive, maternal and child health;
- infectious diseases and;
- injury causing disability and death.

The plan then went on to identify six strategic work plans to meet these challenges:

- health promotion and primordial prevention;
- quality health care service delivery;

- governance and human resources for health and health systems;
- partnership commitment;
- financing health and;
- donor assistance.

The Health Sector Plan's work programme identifies indicators and the means of delivery for each of the six objectives (see appendix six). The 2009 Demographic Health Survey also supports the plan, providing the baseline data for monitoring and evaluating progress.

### *Implementation*

Financial planning for this work has been undertaken through the Medium-Term Expenditure Framework, which provides an overall picture of the funds committed as well as financial projections for the next three years based on anticipated resources. Vaillancourt (2012) highlights the significance of the omission of costs from the framework, information which would be central in annual financial planning. The importance of this omission will be considered in conjunction with stakeholder perspectives.

The Health Sector Plan states that assessment will be undertaken through reporting to parliament, monitoring groups and evaluation. Minimal reporting and monitoring information was available; however, four recent reviews have analysed the Plan's impact to date, looking variously at progress and effectiveness against objectives (Davies, 2012; McFarlane, 2013; Negin, 2010; Vaillancourt, 2012). These will be discussed later in this chapter.

**Figure 4: Health Sector Plan 2008-2018**



Source: Ministry of Health, 2008

## Health aid

In Samoa funding to implement health policy comes from both government expenditure and external support as aid. This collaborative Samoan Government aid approach can be seen within nursing training, for example, through government support of the National University of Samoa nursing qualifications where student co-pay also exists (National University of Samoa, 2014) alongside NZAID funding of specific post graduate nursing qualifications and professional development in New Zealand Universities and hospitals (Ministry of Foreign Affairs and Trade, 2014).

Table 10 shows the growth in health funding in the years 2002-2012. Government spending per capita has more than doubled, while health funding from all sources has also grown. Global health aid spend has also ballooned, accelerating between 2008 and 2009, from USD\$368.46 billion to USD\$410.50 billion (Institute for Health Metrics and Evaluation, 2011).

**Table 10: Samoa health expenditure**

Samoa Health Expenditure	2002-2012
Growth in overall health expenditure per capita	45.8%
Growth in Government health expenditure per capita	228%
External resources for health as a percentage of total expenditure on health	+0.3%
Private expenditure on health as a percentage of total expenditure on health	-1.2%

Source: Secretariat for the Pacific Community, 2015; World Health Organisation, 2014

### *Samoa's aid partners*

Like other PICTs, Samoa has a range of bilateral and multilateral aid relationships which differ in breadth and focus. The relationship between Samoa and New Zealand has a strong emphasis on collaboration and coordination reflected in documents such as New Zealand and Samoa Joint Partnership Agreement Joint Commitment for Development (Government of New Zealand and Government of Samoa, 2011). Conversely, the aid relationship between China and Samoa is representative of the Asian country's own distinct model with specific characteristics (Brant, 2011).

Other bilateral donors include Australia, who are the largest donor to the region providing 65 percent of all aid. Australia's contribution in Samoa is also significant with USD\$99 million given in 2011 (Pryke, 2011) and adheres to the partnership model through agreement to both global and regional aid effectiveness agreements and contributing to the Samoan health SWAp.

While the United States of America has a number of Pacific territories, and significant aid arrangements with them, health aid is not a significant feature of its bilateral assistance to other PICTs. Aid is dispersed through climate change initiatives broadly impacting health with \$21 million from 2010-2012 for climate adaptation projects and related programmes in PICTs. Amongst these initiatives has been the establishment of new rainwater catchment infrastructure in four villages in Savaii designed to mitigate shortages of fresh water during drought (Embassy of the United States in Samoa, 2014).

Multilateral relationships have included partners such as the World Health Organisation and the Secretariat for the Pacific Community working with the Samoan Ministry of Health. One example of this is the Secretariat of the Pacific Community funded initiative, the '2-1-22' programme providing grants and infrastructure for coordination of the campaigns on NCDs with the aim of developing national strategies and supporting their implementation with capacity building and funding mechanisms (Secretariat of the Pacific Community, 2008).

Though less detail exists about these relationships, international Civil Society organisations also have relationships with the Samoan Health Ministry. Support to Samoa is provided through medical aid such

as pharmaceutical and surgical supplies provided to the National Health Service by organisations like Medical Aid Abroad (Medical Aid Abroad, 2011). Humanitarian aid was provided through the Red Cross who supplied personnel and emergency supplies in response to the 2009 Samoan tsunami (Red Cross, 2009).

## **Factors impacting aid delivery**

### *Evidence-based planning*

While available documentation demonstrates that evidence has been used in the development of Samoan health programmes (Ministry of Health 2006, 2007), its influence on other programme implementation, monitoring and evaluation is unclear, echoing concerns raised by Sutcliffe and Court (2005) about evidence visibility throughout the process. For example, rheumatic fever initiative planning employed clinical presentations and admission data, as well as an assumed prevalence rate informing the prioritisation of this project; however an evidence base supporting the selected approach was absent.

### *Collaboration and consultation*

Kerslake's (2005) research highlighted that the Samoan government's efforts at stakeholder collaboration and coordination on the ground has been problematic (Lancaster, 2007; Negin, 2010b; and Waring, 2005).

### *Prioritisation and flexibility*

Aid that is unaligned to partner government priorities was said to be an impediment to effectiveness. (WHO, 2007). Samoan priorities were strongly reflected in strategic documents.

### *Monitoring and evaluation*

The international and national evaluations accessed during this research have underlined monitoring and evaluation challenges (Ministry of Foreign Affairs and Trade, 2002; OECD, 2010). The European Commission (2013) and Wood, Betts, Etta, et al., (2011) and Samoan documentation all point to the importance of establishing baseline data. Infrastructure support provides a particular challenge in terms of measuring its contribution to better health (Government of Samoa, 2011). This is demonstrated by the below table showing that the impact of improved infrastructure will be attributed to imprecise clinical measurements whose relationship lacks clarity. Indicators such as these are measured through the Samoan Ministry of Health's monitoring and evaluation framework and the results are presented through the parliamentary reporting system.

**Table 11: Programme Operational Manual – infrastructure indicators**

Programme development objective	Impact indicators	Use of the information
Quality Health Services Improving the quality of health services through strengthened human resources, standards, supplies, equipment and infrastructure	<ul style="list-style-type: none"> <li>• Primary care utilisation by gender, age, domicile</li> <li>• Antenatal care coverage for at least one visit</li> <li>• Proportion of Rheumatic Heart Disease patients complying with treatment</li> </ul>	These are proxy indicators for improvement in quality of health delivery

Source: Samoan Ministry of Health, 2008.

### Summary

Samoa’s demographic profile (including health statistics) and history are important factors in contemporary development assistance. Samoan, New Zealand and Chinese policies, for example, as well as international aid architecture, have underpinned significant relationship changes which have occurred between developing countries and donor partners; developing a partnership in which donor government and development agency partners transition their relationships to clearer recipient partner ownership and leadership. Planning processes are also a focus in the formulation of policy, but there is less on the details of its implementation. (World Health Organisation, 2013).

New Zealand and Chinese models of health aid policy development and delivery represent largely contrasting models, which to differing extents support Samoan health policy. Factors such as ambiguity about how decisions are implemented are significant. Despite a range of strategic documents setting out intention, current planning, and delivery; monitoring frameworks make it unclear whether and how aid impacts health outcome change.

Government and health sector specific plans set out priorities to achieve *a healthy Samoa*. However, while some progress in Samoan peoples’ health is recorded, it is difficult to assess health system performance due to inconsistent data which contains minimal information about collection and trends.

# CHAPTER FIVE: FINDINGS - PRINCIPLES OF HEALTH AID

## Introduction

The research findings are presented in three sections and in response to the following questions:

1. What is good aid?
2. How does good aid work?
3. What are the challenges to good aid and what can be done?

In the first section, I outline participants' perceptions of good aid, which sets the background for section two on their views how good aid works, while section 3 focuses on the challenges to good aid.

In all three sections, the findings are presented by the three participant groups – aid personnel, practitioners, and NGOs – emphasising the different and distinct involvement of each group within the aid process. Within these groups it is also important to note that differences exist, particularly for the aid personnel group, where there are both New Zealand and Samoan aid personnel, and within the Samoan personnel there are both health planners and general planners. They will be differentiated by using the terms 'aid personnel Samoa health', and 'aid personnel Samoa general'.

The responses showed all participants had reflected quite deeply on the changing aid models they had experienced, more specifically the shift from the top down models of earlier years to the more collaborative ideals underpinning the Paris and subsequent aid agreements.

## What is good aid?

Answers to research question one are grouped into two categories: a) those relating to partnerships in planning, and b) those relating to on the ground delivery, e.g. access, predictability and sustainability. Notably, participant's views were very much in line with the Paris principles of ownership, alignment, harmonisation, managing for results and inclusive partnerships and so are arranged in this way in this discussion.

### *Participatory*

Participation was the term mentioned often and strongly by all participants, backed by the view that all aid should involve all stakeholders, which reinforces the significance of ownership, leadership and predictability discussed later in this chapter. Not surprisingly they referenced participation in terms of their own roles and responsibilities and through categories of ownership and leadership, accessibility, predictability and sustainability. Despite this wish for participatory aid, NGO participation differed from

that of other groups and will be discussed in more detail going forward. This support for participatory processes was contrary to the traditional top down decision-making process with Fa'a Samoa where decision-making was significant, involving its own hierarchy of leaders and traditions (Meleisea, 1987).

### *Decision-making*

Participant's experiences of decision-making influenced their perceptions of what good aid is and how this works. Participant's views about the nature and scope of their participation and role in decision-making varied from those who could look across sectors to decision-making across the Samoan government, to those who were involved in Samoan and New Zealand processes, to those who were focused on achieving organisational objectives within their own sector plans.

For example, Samoan aid personnel working in health discussed their roles in terms of fulfilling Samoa's health objectives as outlined in the Health Sector Plan 2008-2018, which is also included within the literature review. We facilitate and co-ordinate stakeholder and partner consultations for policy development. We deal with strategic planning, we develop the Health Sector Plan and we are also responsible for the Ministry of Health Corporate Plan, which is derived from the Sector Plan and other Corporate Plans. (SAAP1f)

One of the New Zealand aid personnel focused on the importance of a 'good process'.

The other thing that probably I personally would say is very important is a good process. There are plenty of other things I could raise around human rights which should be incorporated and it should be value for money. (NZAP1m)

Additionally, and in contrast to Samoan counterparts, New Zealand aid personnel described their decision-making as very much aligned with MFAT foreign policy objectives and operational aims.

New Zealand has an over-arching objective, which is sustainable economic development in order to reduce poverty. So from that you can see what our objectives are I guess, in that we wish to help, particularly the Pacific, to address poverty and we feel that one of the key strategies to do that is to achieve a stronger record of sustainable economic development. We engage in the economic sphere to try and support that work but also in key social development spheres such as education and health because those are also critical to people's well-being, to addressing poverty and to strengthening economic development. (NZAP1m)

One of the Samoan aid personnel with responsibility for aid across government shared a similarly broad outlook, with this official describing their aid partner role as involving co-ordinated relationships across sectors and resource equity:

Leading the co-ordination of development partners, so that there is no competition as to who would get what and it also means for us that there is no sector that would be without support externally. (SAAP5f)

New Zealand aid personnel added specificity; describing their role as implementing New Zealand Ministry of Foreign Affairs and Trade policy priorities and New Zealand strategic roles mentioning key New Zealand Strategic documents such as the Ministry of Foreign Affairs and Trade's Statement of

Intent 2011-2014. New Zealand aid personnel also discussed high-level priorities such as sustainable economic development and engagement in the education and health spheres. On an operational level, one aid staff member referred to supporting Samoan implementation in a day-to-day relationship involving ongoing and deep discussion (NZAP1m). New Zealand staff were unable to comment on changes to their role over longer periods due to the short-term and fixed tenure of aid personnel's offshore secondment.

Health practitioners had different views, which reflected a different type of scope in decision-making. Most, it seemed, held multiple roles within the sector, involving different relationships and differing levels of interaction in the aid process. Practitioners saw their roles as directly related to health improvements. Clinicians described their clinical roles and provided a rationale for their work in terms of health improvements. One of the three clinicians had not been involved in decision-making but other clinicians had a role in the aid process and policy development as representatives of other organisations such as the Oceania University of Medicine (OUM). It is also important to note there were capacity shortages faced by the practitioners.

NGO participants described their roles in varying ways associated with achieving organisational objectives. Roles in the aid process were diverse; with one NGO staff member providing their perspective to the Chief Executive who, in turn, represented those views at a high-level meeting to another participant who engaged in dialogue with the Ministry of Health Director General directly.

### *Ownership and Leadership*

Good aid was very much tied to ideas of ownership and leadership. For example, all aid personnel stressed the ideals of national ownership as fundamental to good aid and that the ownership role rested with Samoa. This is in contrast with concerns about any potential infringement on sovereignty, connecting ownership and leadership raised in the literature and by one of the New Zealand aid personnel.

Samoan aid personnel were more likely to express their views in negotiations with donors.

We are very fortunate that we are strong enough to fight for our cases ... fortunately we have strong members ... We don't want to be donor-driven, that's the last thing we would want, but we would want to balance it. This is not in our sector plan, so that means this is not what our communities agreed on. This is what we are saying because we understand our communities better than you and if you want your money to be worthwhile and spent wisely you would listen to us and we would say this is appropriate. (SAAP3f)

New Zealand aid personnel supported Samoa's ownership role, and saw ownership as being engendered by previous work and relationships on the ground as well as being opened up through current models:

They should direct that support, rather than being a team responsible to us, let them help bring in the design team. (NZAP1m)

Very importantly, ownership was often linked with leadership and, in turn, sustainability and policy planning processes as central factors in success. New Zealand aid personnel were quick to highlight examples where project success had been blighted by lack of ownership.

I often think of a justice sector example to highlight projects where I have seen that there has been lack of ownership and lack of leadership. The Ministry, or agency or organisation that the project is meant to benefit – a lot of the lack progress or lack of achievements is seen to lead up to lack of leadership or ownership, really, by the organisation as a whole. (NZAP1f)

NZAP1m discussed capacity building in their relationships with the Samoan government, suggesting that the Samoan ownership and leadership role presented capacity challenges at that level. This was a point reinforced by external review, also in the context of higher initial transaction costs (Davies, 2013; Vaillancourt, 2012).

The thrust has been to put Samoan institutions more at the centre of designing their own programmes ... So historically, we've taken some ownership over developing the programme logic for that. We are handing it over to a system that hasn't always had to do that level of planning and doesn't always have the tools or the formats or the frameworks. (NZAP1m)

NZAP1f stated that sometimes due to capacity issues, New Zealand counterparts assisted with tasks such as drafting. She questioned how this impacted on Samoan ownership (NZAP1f), echoing the concerns of Overton (2011) and Sjöstedt (2013) regarding compromises over ownership in aid implementation.

Now, the shift has been to say “well look, they are all very well, those processes, and you can deliver a really fine-looking document, but the question is: have you, by the very process, undermined the ownership?” Because people haven't done it themselves and it can be too easy and also you are never quite sure whether people really have the buy-in to that. So, the thrust has been to put Samoan institutions more at the centre of designing their own programmes. (NZAP1f)

NZAP1m noted that strong ownership was not always linked to sustainability with these words:

So, an initiative that might have strong ownership just by a few people at the centre, but not more broadly, can mean that it's just not going to be sustainable and if the programme logic is not right then you are unlikely to achieve your outcomes at the start. (NZAP1m)

By way of contrast, an NGO participant expressed a high-level of ownership in determining priorities for their own organisation and defining their role.

Actually, we own the projects, but we report to donors at the conclusion of the project. (NGO1f)

However, NGOs knew very well, and were able to give examples of the fact that they had little control over their place in the sector, and that, in fact, they were distant from high-level decision-making. Their

views indicated that the Paris principles were not always followed and that NGOs must be further integrated into decision-making for this group to assume autonomy over its place and role in decision-making.

### *Good aid on the ground - access, predictability and sustainability*

#### Access

All groups agreed that universal and equitable access to healthcare were critical to good aid, though this conceptualised in varying ways related to physical access to a hospital, rural and urban equity and staffing equity.

One NGO emphasised, very compellingly, accessible medical care throughout the country and the importance of access to primary, secondary and tertiary health care for all people.

What we have is easy to access by people. How they do it should be fair to everyone, equality and equity, which is something which is very difficult to achieve in every country, particularly developing countries, because of the gap between the rich and the poor – it changes the mind-set of those making decisions. Most of our people don't have access to a doctor, like out in the villages. And then, if they are referred to hospitals, they should have the capability of doing that. Manage those highly sick people, especially with chronic things, heart problems. (NGO2m)

At the time, a new National Hospital was being built by Chinese donors and in the view of two practitioners this had the potential to address service access issues.

Hopefully in this new hospital there will be different additional services than are in place in this hospital. That was one of our other functions; for instance, we are going to put in place a good disability assistance service, orthotics, and mental health. We don't have much in the way of services for the disabled but we would like to offer more of those kinds of services. (PR1m)

SAAP4f talked about the importance of access to services in rural areas as well as urban and how this is addressed:

We also don't have difficulties in terms of access because it's a small place, very good transportation, so that you can have access to the referral centre up at Motootua at any time ... What they've done is that they've engaged the private sector to visit the rural areas where the staff up at the hospital aren't able to have medics located in the rural areas so we are now using the private sector. (SAAP4f)

For New Zealand aid personnel, there was an expectation that good aid must include access to a clinician. NZAP1m drew on data regarding the number of doctors per 100 people as a way to support this claim. This also aligns with existing health workforce support within aid policy (Ministry of Foreign Affairs and Trade, 2014). Access to robust health information was also identified as critical to ensuring a connection between aid and health outcomes. For Samoan aid personnel, access to information could impact the budget allocation, a view which a New Zealand aid staff member was in agreement with:

I do think that having good information and having that accessible and available to the population starts to build domestic pressure for strengthening of the health services and that is vastly more effective than any kind of policy dialogue that we might have at a central level. (NZAP1m)

*Predictable and sustainable – human resource elements*

Good aid was also described in terms of predictability and sustainability. SAAP5f explained that sustainability is crucial and connected to capacity:

So, when those programmes come we look at cost-efficiency, effectiveness, and also whether they are tailored to capacities we have, because we don't want ambitious programmes which we don't have the capacity to deliver. Because, while there can be technical assistance available through the programmes, we should never be reliant on external resources because at some point they will run out and then we are left to deal with the situation. (SAAP5f)

A practitioner in a service delivery role highlighted the need for sustainable services and predictable financing to meet workforce challenges.

There's been many projects in the past that were not successful. One of the biggest things why it's not sustainable is personnel. You train people for this thing and then they migrate, it becomes a failure, an ongoing sort of thing. Because people move from position to position or move from where they used to work to another area, mass migration both internally and overseas. One of the things that affected the continuation of programme, but one of the biggest things, is funding because once the funding is cut usually that programme will wind up because it may not have enough funding from the government to sustain that sort of thing. (PR2m)

Despite the importance of sustainable human resource, according to PR1m, other budget items such as tertiary care continue to occupy significant proportions of the budget.

Getting a very clear conceptual direction for the model of health in Samoa – I think that's still a bit contested. It is in most health sectors, and it certainly is not currently reflected in the health budget. On one level, the Ministry and the NHS will say "our focus is primary health care" but that is not the way the budget is allocated. The budget is allocated towards: about 10-20% goes to overseas medical treatment for a very small number of people in a very advanced tertiary capacity. There is a lot of money put into dialysis which again is not primary health. There is currently a big investment in the secondary/tertiary infrastructure here. (PR1m)

NGOs also stressed the importance of predictable aid including forward planning and financing. To them planning and service delivery relationships were central to sustainable service delivery, consistent with practitioner's emphasis on sustainable services.

You never know when the funds will dry up. There is not much funding for NGOs like us and the problem I see is that NGOs like us, with very little funding, actually do a lot of work and do make a difference in the lives of people. (NGO1m)

One NGO saw partnerships as essential to sustainable aid, highlighting the fine balance between their ownership and leadership, with donor money and decisions over predictability and sustainability.

Partnership is very important in terms of sustainability and strengthening services with partnerships. So, it is important. Ownership: the projects are ours but it is always the donors that we report to afterwards, because it is their money and we are implementing it. (NGO1f)

While, as noted, literature emphasised Fa'a Samoa's top down decision-making processes, this was not widely referred to by participants in planning, however it did feature in implementation. NZAP1m stated:

Decision-making on the Samoan side is very much within the Samoan system and that doesn't involve us and nor should it. (NZAP1m)

It was practitioners in service delivery who noted the place of cultural expectations including local engagement and service delivery. They drew on their own experiences:

When we try to educate the masses in the villages we have to go through the protocols that need to be done in order to be accepted by the people in the villages. It's a different way of life there, we can use that, and the different culture, to improve delivery of our services. (PRA2m)

This was acknowledged and understood by SAAP2m:

Some of the projects that involve the villages – you really have to be culturally sensitive in your approach and in what you do. (SAAP2m)

These views about what good aid is provided important insights to the responses on how good aid works which follows below.

## **How does good aid work?**

In line with the Pacific principles, collaboration and consultation, prioritisation, and monitoring and evaluation are crucial functions within a decision-making process that produces good aid.

### *Collaboration and consultation*

All three groups agreed strongly that collaboration and consultation was essential to good aid and its functioning, as well as a crucial element, especially in ensuring 'buy-in' or ownership, throughout the aid process. Experiences of collaboration and consultation differed from those who were collaborated and consulted with on a case by case basis to those who collaborated regularly as a part of formal grouping. Within the NGO group there was marked variation in collaboration and consultation experience, particularly in terms of collaboration partners and mechanisms for collaboration, so I start this section with the NGO views:

We go about doing our own thing and we do engage with them from time to time to make sure we are not stepping on toes.... They've always been supportive, there's no question about

that, but the engagement has generally had to be prompted by us and it would be nice if the interaction was prompted from the other side. We do get requested to be on panels and that's been Christine, so it's improved over the last few years, but Palanitina's excellent – she is always supportive. Every time I talk to her she always says “give us what you want” and she pushes it and gets it for us so she has been a great supporter and she sees the work that we are doing and supports it for that reason. (NGO1m)

NGO1f said their organisation collaborated with a number of Government Ministries and also other NGOs in their work.

Government Ministries, like the Ministry of Health, in terms of planning and implementation we collaborate with them. We collaborate and work with the Ministry of Women, Culture and Social Development; the Ministry of Education, Sport and Culture; the Ministry of Police; Church/Faith organisations; Samoa Red Cross; and SUNGO (Samoa Umbrella for Non-Governmental Organisations). We also had an alliance with Samoa Red Cross and Samoa Aids Foundation ... We have regular meetings, especially with MOH We are involved with the National Aids Co-ordinating Committee. We have monthly meetings. We are involved in the Nurses Leader's group meetings every month and we work collaboratively with the Sexual Reproductive Health and Adolescent Health Division in the MOH. We are also a Board Member of the Samoa Red Cross and the national secretary for the Samoa Umbrella Organisation and that is how we work with them. So, we have regular meetings – but it is up to them because they call meetings every month or every two months. (NGO1f)

NGO1m stressed the need for strategies to enable NGOs to collaborate directly with overseas funders in future, suggesting that the existing organisational infrastructure was equipped to deal directly with overseas funders:

One of the great things about CSSP (Civil Society Support Programme) is that the funding comes straight to us – we don't have to go through the Ministry and that is one part of the CSSP we really like. They give us the money and we report directly back to CSSP rather than having to go through a middle organisation like the Ministry. (NGO1m)

Samoa aid personnel had a lot to say about the collaboration mechanism. They were more likely to describe how the collaboration process worked, while New Zealand aid personnel gave more attention to the process. Samoa aid personnel described their experience within the existing coordination arrangements and displayed an in-depth understanding of how high-level collaboration occurred between SWAp partners in particular, as well as the monitoring and evaluation processes in place. Two aid personnel believed that regular consultation meetings with smaller groups of senior officials involved in aid planning were central to the aid process, though it is unclear where this collaboration occurred. For example:

High quality aid, on the other hand, really the development partners and donors would tend to listen to us and agree on the strategy, plans, and objectives that we've set for our people, and then for us to balance it up, and then we get a combined approach (SAAP1f)

We have a quarterly dialogue with our development partners, so every three months we hold consultations with them on issues that emanate from the implementation of programmes, or on issues that they would also like discussed at the higher level, at sector level, and at programme level. So, there is a very robust system in place that we apply and, so far, we haven't come across any difficulties as far as this is concerned. (SAAP5f)

SAAP5 focused on collaboration arrangements between SWAp and non-SWAp donors. She said:

But what they have done is that they've organised themselves so that they rotate: in this position that we call the co-ordinating developing partner. So, whoever they've designated for the role for this year, that person will represent all their interests when we do our programme meetings. (SAAP5)

SAAP1m also pointed to the role of consultation within policy development specifically the 2008-2016 Health Sector Plan. However, it is unclear whether consultation (consistent with good aid) took place in the development of other documents.

New Zealand aid personnel also highlighted the importance of the strong relationships needed to build collaboration and stressed the importance of ensuring the right people are involved in the process including NGOs.

Then there is real need for individuals, particularly the ones that lead those agencies in the sector, to trust each other, work well with each other and to firstly come up with joint programmes, because the NHS needs to work well with the Ministry of Health – or the Kidney Foundation and health NGO's that can support whichever function ... I guess, by human nature, you probably are a little bit patch-protecting of your own lot, particularly also in a contestable funding environment, so it's challenging, but I think in a small place like Samoa, the impetus to actually work together should over-ride that – to achieve whatever service objectives you have, anyway, for the country. (NZAP1f)

NZAP1m drew attention to the importance of the 'right people' and this was expanded on to sit within a strong collaborative process.

My third point was good process, so I am big on process and I think again, if you don't involve the right people then you simply don't know what you don't know and you don't get that kind of buy-in and leadership at a broad level that you need. (NZAP1m)

Practitioners did not have much to say about collaboration but PRA1m raised concerns regarding the timing of consultation and noted it was difficult for practitioners to be involved when they had so many competing priorities:

It's a good idea to get everyone to coordinate under one umbrella but different countries will have different approaches depending on what they want to do with their funding. It came during the time that the sector plan was also developed and I didn't feel that the plan was well consulted ... the people were not consulted. If you look at that plan now, I think we could have done better in terms of putting in place a plan – what needs to be done. I know very well (that) in 2005 they were working on the separation and had the doctors' strike at the time. There was a separation into two entities and then there was the sector plan that was discussed at that time. There were a lot of things happening and not many people came to the consultation. (PRA1m)

His views probably captured the views of all practitioners whose focus was on health provision.

## *Prioritisation*

Aligned with Samoan ownership, NZAP1m identified clearly the belief that prioritisation rested with Samoa.

We work with Samoa at the strategic level to identify and analyse Samoa's development issues, to identify what their priorities are. (NZAP1m)

The three participant groups displayed strong variation in their conceptualisation of priorities, their implementation, and determination. For example, while all described priorities, one of the New Zealand aid personnel also raised issues regarding prioritisation and went further to offer solutions to questions of prioritisation. It was that clear that the varying conceptualisation of priorities was a major challenge.

Samoan aid personnel health priorities were determined based on the Health Sector Plan together with other Government accountability documents such as the Strategy for the Development of Samoa. Priorities were closely associated with budget allocation.

The Strategy for the development of Samoa is a widely consulted document that we put out on a four-year basis and it means going out to the public across the country to confirm the priorities of the government ... That is also the document on which we base our discussions with our development partners. So, the aid programmes don't come structured: they wait until we indicate what the priority needs for Samoa are. (SAAP5f)

We have a Health Sector Plan. So, this is where we focus our work – this is where the funding goes, so that we can do the work to achieve the objectives. (SAAP1m)

Health promotion and prevention is the key. But because the bulk of the budget goes to curative and treatment, the donors would just come in and fill in the gap – a huge gap –for health promotion and prevention. (SAAP3f)

SAAP2m who had been involved in implementation, notes the use of differing standards for priorities specifically with regards to an infrastructure project. Interestingly he drew attention to the different views of New Zealand and Chinese aid:

One of the challenges here is that we basically follow New Zealand/Australian standards of practice. The Chinese say they follow international WHO standards of practice. It's sometimes, you know like when we look at things, they are not entirely what we believe is the standard that we want, and so, and that's how we have made these changes. So, we have a team, a three-person team, who are there with the Chinese all the time so that we ensure that things are done the way that they should be. (SAAP2m)

All practitioners were particularly vocal on issues of practice due to their involvement in service delivery. While they recognised the necessity of prioritisation and the constraints associated with limited resources, they believed that self-determination should be central in priority setting.

There should be, right from the beginning, an understanding – I think right from the planning stage process – should be in place in terms of budget, personnel; you know, right in place, so

when they finish up and leave there are people well-trained to carry on the project. Some of the examples I'm talking about are we've had WHO-led projects on TB, on filariasis, and leprosy and also projects like rheumatic fever. When you look at rheumatic fever right, when we were students there was a national rheumatic fever programme here in Samoa, well-run and well-resourced, and those people left, some of them have died, and there was no sustainability. (PR1m)

PR2m also discussed infrastructure prioritisation. Practitioners rated infrastructure such as buildings, vehicles and equipment as aid priorities for enhancing health service delivery.

Our first priority was really infrastructure because everything was run down and while the SWAp was discussing infrastructure improvement, the Chinese came and built a hospital. Capacity building was the other thing we wanted to improve and equipment; I think those are the main ones, plus vehicles and other things so the service can reach the district hospital. (PR2m)

To them, local service delivery was a fundamental priority in terms of equity. At the same time, local service delivery also offered a solution to the high costs of overseas treatment.

Having a high-quality health aid here is really looking at, for instance, our patients that are referred to New Zealand for surgery. It started in 2000, the budget was 200,000 tālā a year; when I left it was 10 million. I was predicting in the next 3 years it would be 15 million, so in order to have quality of services, it is our doctor services here that needs to provide things that are very simple like the removal of kidney stones, this costs 20,000 dollars in New Zealand but costs very little here. (PR2m)

Practitioners also identified risks relating to changes in disease priorities (as set by donor projects). They questioned what had happened to the so called 'old priorities' and suggested a process was needed to re-establish priorities alongside re-emerging diseases such as leprosy.

After those priorities are all set up we can ask the partners and say 'look these are our priorities, this is what we have determined is good for the whole of Samoa, to make our lives better in terms of health. You need to put your money in this one here ... I'm talking about leprosy and all that, it's unheard of now, nobody's talking about it but the numbers are increasing. Very recently the WHO consultant came and did a study around the number of leprosy patients, which are going up and up and up. But at the same time nobody is talking about leprosy ... it will come from health as a priority. (PR1m)

NGOs said they determine their health priorities and focus areas according to their organisational objectives. However, despite a shared understanding of priorities, NGOs provided detailed information but they said they were sometimes unable to fulfil donor requirements and internal capacity could be an issue too.

We talked to one donor who was very receptive to our ideas but did not, at the end of the day, grant us money. I think there was one area where we did not fulfil according to their requirements – it's to do with governance. I think it depends on the proposals, because sometimes recipients do not fulfil donor requirements. But they are mainly receptive. Despite all the questions, to make sure the money is worth it, at the end of the day they will receive us.

They do encourage us to put in applications and say "whatever you need, put in your applications and we'll support it". For us it's really about trying to make sure we don't bring in too many Australian Youth Ambassadors or too many volunteers when we don't have the

capacity to look after them in terms of the proper skills transfer, but also disappointing them. Because if the volunteer comes in and we are not properly set up for them, it's not a good experience for them and that ends up being a failure all round and leaves a bad taste in everybody's mouth. (NGO1f)

NGO2m felt that some Government infrastructure prioritisation was misguided. He said:

It is not a priority to have those buildings that we've just opened the other day. Why have a hostel for nurses? Health workers are not just nurses: health workers are laboratory (workers), pharmacists, the cleaner ... It should be called a Health Hostel then. That is a project that I think is a waste of money. That is a bad project in my view. (NGO2m)

In his view, prioritisation required taking account of long-term impacts. He also indicated the influence of culture and planning for the longer term:

Our Samoan culture: we are very good you know at trying to get money and not very good in how we should spend that fund. We think in terms of "if it doesn't benefit you immediately, why waste your time?" You don't think in another ten, twenty odd years from now our rates of diabetes will go down because of this programme that you are doing. (NGO2m)

### *Capacity Building*

Managing to ensure results was an important factor in effective aid. Participant responses in this category very much focused on the human resource capacity of the Ministry of Health and the data collection systems. As noted in chapter four, policy and planning capacity within the Ministry of Health totals 10 staff across policy, SWAp and specific health areas and those interviewed were also aware of planning capacity as well as the shortfall of capacity in various clinical specialist areas. SAAP1f summed up the resource constraints with these words:

I have the Policy Development and Formulation which also focuses on Energy, National Health Accounts and Development as well as policy analysis and monitoring, but also Strategic Planning. Not only that, I have just recently, during the Ministry of Health realignment last year, proposed for a Research Section which focuses directly and specifically on health research. (SAAP1f)

In a similar vein, one frustrated Samoan aid staff member said:

What team? I'm a "one-man band". (SAAP3f)

All participant groups identified capacity requirements as seriously important to good aid. They discussed capacity building initiatives but less detail was given about how capacity is incorporated within decisions made.

As noted in Chapter Four, the health ministry had their own unit which was responsible for the Health Sector Plan as well as the development of new policies aligned to this. While a different group was responsible for the Sector Wide Approach. As noted in chapter five at the time of this study the SWAp

unit included three staff with responsibility for the SWAp, its Monitoring and Evaluation Framework, Programme Operational Manual and Joint Partnership Agreement. All participants stated that good aid projects included strategies for capacity building.

I guess the benefits are very much not only countrywide but are also generated inside the NHS, you know, like how do the capacity building of the staff and new technology that is going to come in affect them? (SAAP2m)

It was very clear that human capacity building was not a new issue for aid personnel. For example, Health Ministry staff recalled historical capacity constraints.

When I came in during the Health Reform Programme, the NZ Aid programme didn't really work and they funded the Child Health Project. Now there are two sides to that: firstly, because the people at the same time who were running the project were not effective enough to fight for the case and secondly, maybe they didn't really have the capacity to co-ordinate and facilitate a sector-wide approach to the project. (SAAP3f)

In the aftermath of Cyclone Evan, another Samoan aid staff member reflected on emergent needs.

For instance, now we propose that we need to improve/increase the level of our disease surveillance, particularly in our communities, so we are doing a lot of those things now that require extra funding ... and they also have offered human resource. We also propose that we need some staff administrators to help review ... so they are offering and we have to suggest how many and what sort of role they play. (SAAP1m)

SAAP2m stressed the need for a targeted approach to capacity building. In addition, the possibilities including capacity building needs in specific clinical areas was discussed. He said that sending patients offshore for treatment was costly.

The doctors who can see patients – the doctors who can operate ... the disease perspective in Samoa has changed a lot to non-communicable diseases, chronic diseases – that means they need highly specialised surgery. This is reflected in the rate of people being referred to NZ for specialised treatment and that amount of money goes there only for treatment ... But, I feel that if there is an effective alternative, we need to look at that also ... we need to look at the planning skill people, and elevating the level of the care. (SAAP1m)

Practitioners also expressed the need for capacity building in targeted areas.

In order to have those facilities, you have to have the workers – doctors. So that's why we focus on Fiji producing 3-5 ... After that 3-5 will do ENT, so now they will be covered as well ... We need to train technicians as well ... If only one person, I can tell you it's tiring because one time I was the only ENT in the country, I can tell you this is a nightmare sort of thing. So that give you an idea of what is quality service. (PR2m)

PR2m suggested that alongside in-country capacity building, off-shore capacity building must also continue especially specialist capacity building.

To me as a person: the good thing about health aid was the overseas attachment that we used have, because training away from here in another fully equipped hospital – it improves your

knowledge, improves your skills and you are able to come back and improve the quality of the service here. (PR2m)

PR3f identified capacity spread for health service planning and delivery. She also spoke in support of capacity spread including rural Samoa, for example, the need for geographically targeted policy.

I think Samoa is now at a stage where, from a doctor's point of view, we have quite a lot of doctors, but they are just unwilling to make the sacrifice for the small reward that they get and I think our government could look at how we could remedy that situation, whether we give financial incentives to get people out there ... There have been people that have been interested in coming to Savaii and who have asked for something a little bit more and been declined and so have refused to come. (PR3f)

Samoaan aid personnel saw the need to expand policy and planning capacity. SAAP3f said:

We have to develop the research capacity of the Ministry of Health, not only in its co-ordination of research facilitation role but also in identifying from it policy issues that leads to or warrants developing policies. (SAAP3f)

For New Zealand aid personnel, capacity building was 'fundamental'. They emphasised the evolving nature of capacity, supporting developing country leadership over programmes, acknowledging that external assistance may still be sought.

We are handing it over to a system that hasn't always had to do that level of planning and don't always have the tools or the formats or the frameworks. So, I think it is the right thing to do – to hand over that responsibility. We need to recognise that Samoa may need to develop that capacity, they need to be able to pull in some support themselves. (NZAP1m)

NZAP1m went further, stressing the need for them to develop their own expertise in health aid delivery.

For us, we've had to try and build our capacity to engage in an on-going way because I'm not a health specialist, so we've had to try and structure ourselves so that we have good health support from Wellington. I've had to upskill my own capacity to speak health sensibly because I'm engaging with professional health people, so we need to be fielding the right kind of people for that policy engagement. (NZAP1m)

NGOs summed up the health capacity issue with these words.

I would say its lack of capacity, I think it is mainly because of non-compliance, not following the steps, not following the process, not picking the right team, not targeting the needs of the people ... It doesn't happen often, but there are times when ... So we need to continuously monitor and battle with these things. (NGO2f)

We had our HIV and STD Voluntary Confidential Counselling and Testing Service – this project is an ongoing process linked in the static clinics and the needs of this service were not met because there was a lack of capacity there. And that's why we sent nurses to Fiji for more training in that area. Since then they were able to develop two new initiatives and since then improve in that area. (NGO2f)

## *Monitoring and Evaluation*

All three groups of participants acknowledged the necessity of managing for results and monitoring and evaluation. On this point, they did not refer to the framework or the information collection systems. SAAP3f commented:

We can't just develop things out of thin air without getting all the appropriate information that we need, so that is one of the lapses (SAAP3f)

SAAP1m described current and desired monitoring and evaluation approaches but did not elaborate on how this might be achieved. He said how data is routinely collected within rural hospitals and usually this aligned with donor requirements:

We go out to the field, collect our data, collect data from the hospital and that is where we start analysing them. We don't ever cheat ... We have a syndromic information form. We make it as easy as possible for ... just a "tick" and then collect and detailing it and look at what sort of thing ... just fill in the name and everything, circle or whatever the doctor ticks. If not, the nurse might tick and the doctor just certify. So that's not a lot of paperwork – just a "tick" and a sign ... So, we get this information, we are obligated because it's part of our international health regulations, we report to the legal office of the WHO. This information and other information from our information system, we correlate and analyse and justify to our partners. (SAAP1m)

SAAP1f said data was collected and used for planning:

We also conduct surveys like demographic surveys and STEPS (STEPwise approach to surveillance) so it is from there that we get the information and then we see whether there is a problem and whether it warrants development of policy or strategy. (SAAP1f)

In SAAP3f's view monitoring and evaluation against a global framework and external indicators such as MDGs (Millennium Development Goals) and WHO indicators was given prominence.

We have a monitoring and evaluation framework and we have a core list of health indicators and with those indicators, that's where we now focus because it's also linked to our sector plan and we have included WHO standard indicators for health and MDG's targets and indicators. (SAAP3f)

Like Samoan aid personnel, New Zealand aid personnel also emphasised the importance of a monitoring and evaluation system at every point of the planning process beginning with high-level intergovernmental talks monitoring progress on various initiatives informed by monitoring and evaluation frameworks:

We do have discussions with Samoa annually around what we are achieving against that strategy ... We have ways of monitoring quality through the implementation of an activity and at the end of an activity we evaluate. (NZAP1m)

He added that New Zealand aid staff were able to provide more in-depth analysis of existing frameworks, highlighting both gaps and needs within this system. He also stressed the importance of

a robust programme logic model to support monitoring and evaluation. This is consistent with the 'managing for results' focus of the Paris and subsequent aid Declarations (OECD, 2008). In his view, this was not always happening.

We need to strengthen the health system, there needs to be a really coherent model for how Samoa wants to deliver and strengthen health and that all of those parts of the system, whether it's the diagnostic and lab, whether it's the tertiary capacity, the primary health care capacity, the blood bank – all of those things have to work together and you need strength across all of them. We would regard a project that is not successful as something that's not delivering, that ultimately is not impacting on people's lives. That's how we define outcomes, as essentially good change for people, so at any step in the programme you can lose that ultimate impact if the inputs aren't enough for the things that you want to do. If the things that you want to do aren't enough to achieve the outputs that you want. The outputs themselves are the wrong ones or insufficient to achieve the outcomes, so any of those things can go wrong. (NZAP1m)

Robust information collection and analysis systems were also valuable in building public awareness and pressure.

Basic health information is another. I do think that having good information and having that accessible and available to the population starts to build domestic pressure for strengthening of the health services and that is vastly more effective than any kind of policy dialogue that we might have at a central level. (NZAP1m)

Practitioners also stressed programme logic as central to rigorous monitoring and evaluation. They outlined a range of factors which influenced outcomes. PR2m discussed existing indicators, the complexities in measurement and the attribution of outcomes achieved without taking into account other environmental factors such as workforce capacity and development.

So, there are levels of indicators that we have to look at and each level has its own usefulness and its own advantages and that is to enable us to have a proper look at the performance of the sector (within) the local, national and international settings.

I think that is why most people don't understand, if you look at how your maternity mortality rate is going up more mothers are dying, the service is bad – probably that nurses are not properly trained – simple things that should have prevented bleeding but she is dead, so these are the things why not only improving structure but improving ongoing training of personnel. If you have a knowledgeable, skillful worker, then a lot of deaths are preventable. (PR2m)

Another practitioner drew attention to the need for quality data collection. Like the aid personnel, they appreciated the importance of systems.

It is part of my priority; and without information, all this health planning – you can't make plans – you don't know what is going on. You are not linked to your other hospitals in rural areas; you are not linked to Savaii, so you don't know what is going on there. You find death in the other hospital, but you don't know it from here, and what's the problem. You only have to go there manually and search the thing ... This is part of our clinical hospital and one thing I was trying to improve in the new hospital is the system – the collection of data. (PR2m)

Practitioners highlighted planning weaknesses they had witnessed from an on-the-ground, data collection perspective also. They found the lack of baseline data problematic and a barrier to good aid.

PR2m explained further by proposing how a system might work and the current lapses, arguing that both systems, personnel capacity and sustainability, must be built and integrated into aid processes for this to occur.

Communication is extremely important. Patients information systems because that's where you know where will be your priority in the next three or five years. So, without information, it is just like a blind person trying to find where he is going. (PR2m)

Like the other two groups, NGO participants also emphasised the importance and complexity of aid monitoring and evaluation. They saw the importance of monitoring and evaluation in decision-making as a work in progress.

We are not totally sold on the cancers being identified and the figures are just unreliable, so we are working to establish a Cancer Registry together with the Ministry of Health and National Health Service. (NGO1m)

In addition, monitoring and evaluation frameworks changed. NGO1m monitored its activities, recording patient numbers and condition, which they are beginning to use to inform change.

For the outreach, which is one of our major deliverables on that programme, is that we keep figures and report back on how many people we are seeing. We keep records of how many people come in to the Resource Centre ... We are starting now to get a fairly good idea of what's happening with people with cancer. So, we have identified some fairly basic problems and basic issues with what's coming out of the Health Sector and the health system. It's just about how we use that information and delicately work with them to address it. (NGO1m)

NGO3f said their organisation collected data and measured outcomes through a broader framework aligned with its parent organisation overseas. This information was also provided to the Samoa Ministry of Health.

We have our own data collecting system. It's called the Information Management System. It is an electronic system and we share this data with the Ministry of Health mainly for National Reporting. We collect our data because we have our own reporting system. (NGO1f)

## **What are the challenges to good aid and what can be done?**

In response to question two, all participants stressed that capacity was the major obstacle to the planning and delivery of aid and impacted all areas of their decision-making. Capacity impacted not only on the institutional capacity of the Health Ministry itself, but its capacity to engage in partnership-based planning and decision-making with other sectors as well.

Drawing on this, part one of this section focuses on capacity. This is followed by a discussion of other challenges highlighted, which were closely aligned with the Paris principles namely participation, collaboration, prioritisation and monitoring and evaluation. In each, capacity is again highlighted.

## Capacity

Many factors impacting capacity were outlined. Practitioners particularly identified that programme sustainability was negatively impacted by health professional's external training.

Second was external training:

At the moment, we are sending everybody to Fiji where they have the Diploma and the Masters, so we have some young people, doctors now going there. As I say, you keep losing doctors, but we still have to keep training more to replace them. (PR2m)

The trade-offs which often surrounded decisions made about who and what sector should benefit from capacity building were also mentioned. It was stated that capacity building should be expanded into planning and service delivery, as well as monitoring. Capacity building and infrastructure had become a trade-off decision also. SAAP2m gave an example of when:

I think we put priority on where we see that we need help in a very practical sense. Now you know, like the catch-22 situation, where the donor might say either HR or that, okay? And so, it's a very difficult call, because when you want to put in infrastructure so the HR people can have a good environment to work in and they will be able to receive, but if they make that call, that makes it very difficult. (SAAP2m)

Capacity gaps were already a major challenge to sustainable service provision. In addition, the need for professional upskilling was also urgent for practitioners to keep up to date with medical research and new and advanced specialisation.

As far as the HR capacity is concerned, we are gradually using that to build up our knowledge ... It's a difficult task because in medicine the concept is teaching and practice, training and practice, and so, it's getting very difficult, as decisions become more complicated the need for more knowledge becomes greater and greater, and it will divide yourselves into specialists, sub-specialists, sub-sub-specialists and then there's always the improvement in technology, and that is also a hard call for us in terms of the limited resources that we have. (SAAP2m)

NGO1m identified that technical policy planning capacity was a weakness in health decision-making.

I would say it's lack of capacity, I think it is mainly because of non-compliance, not following the steps, not following the process, not picking the right team, not targeting the needs of the people ... It doesn't happen often, but there are times when ... So, we need to continuously monitor and battle with these things. (NGO1m)

The lack of continuity in donor staff was frustrating:

That's the funny part: because the donors keep changing their representatives. Maybe one or two would remain in the team and the rest will change as the review Missions or the joint Missions change, so during negotiations there are also representatives. (SAAP1m)

### *Participation in decision-making*

Participants saw stakeholder participation in decision-making as essential to good aid. Participation required building stakeholder relationships, trust, shared understandings, and outcome driven collaboration and ownership. However, gaining stakeholder participation was clearly a tremendous challenge.

PR3f, working in a hospital, noted their distance from ownership in decision-making and how this was due to capacity:

I don't think we have been part of discussions but I have been told things because ... is quite a small hospital with only four doctors, so the one manager we have will, every once in a while, mention something that they are working on getting things done in ... but I haven't really contributed in the decision-making process. (PR3f)

PR3m (who also had NGO governance experience) also stressed the necessity of participation of both NGOs and women's committees to access villages.

I'm talking about the NGOs, and village/women's committees which have a very useful role in health education, coverage, mass screening, of mass administration of tablets for filariasis. (PR3m)

NZAP1f noted the importance of relationships in Fa'a Samoa and longstanding efforts to build relationships were noted by New Zealand aid personnel.

This is a culture that values relationships very highly and so a lot of things that get done, get done within that context ... I know they've taken some time to "gel" together as a sector, but because the health sector has taken a stab at it for quite a long time now, sometimes it's hard to see if there is a coherence to it or at least a genuine effort to work together. (NZAP1f)

In NZAP1m's view, trust and strong relationships were sometimes problematic, particularly with NGOs:

I think there has not been a very robust dialogue and good trusting relationships, they've struggled over the years to really be able to come up with good solid programmes that they agreed could work ...

On the other hand, while NGOs may have had the capacity to participate they were firmly aware that they were seldom invited or involved in project decision-making. Their involvement was less than that of other groups. They listed the groups that they could have been part of but weren't – and aligned this with reflecting practices on the ground. (NZAP1m)

A NGO reported that while on paper they were a member of a SWAp committee:

... Ever since I started working here I have not been involved in any discussions with the SWAp committee. They just told me that we should be there, but I was never invited. It might be because they forget or ... I don't know. (NGO1f)

## *Collaboration and consultation*

Collaboration and consultation were closely aligned to all participation ideas. The inclusion of NGOs was seen as crucial to improving relationships and developing collaboration in implementation and outcome achievement. Meaningful consultation and collaboration was seen to involve all stakeholders from the users of health services through to government departments and planners and NGOs. However, it was recognised that collaboration and consultation was extremely time and resource intensive.

New Zealand aid personnel regarded collaboration and partnership as a negotiated process in planning and implementation:

We identify where they are lacking and we try to take steps to strengthen them, but it is a partnership so it is a negotiated position. Sometimes we might like to see things a little bit further ahead than they would otherwise be, but that's not always shared locally.

I think that some of the specific things that I was looking for, other than the broad DAC criteria, was basically whether there has been any effort to have those initiatives, be consulted with effective communities, because I think often it's quick to say "yes, we talked to this agency and they agreed – good", but it's really whether there has actually been that extra effort needed to talk to the affected communities, which is always a challenging one. I think there are reasons why sometimes you don't get to that stage, whether it's for efficiency, because it takes "enough" time, but also it's a question of resourcing as well. If you are going to be out consulting a broader area than just talking to the responsible agencies. (NZAP1f)

PR1m believed there was a need to make enough space for ensuring collaboration, and ownership as integral to decision-making within a partnership model. This is consistent with Aid Declarations discussed in previous chapters (OECD, 2012). Space for collaboration and gaining community buy-in through culture was raised by practitioners:

In terms of the SWAp co-ordinating: fully independent – it's very important to get the "buy-in" from everybody – the stake-holders of health, because if you don't do that, people don't want to be involved.

It's a different way of life there, we can use that and the culture to improve delivery of our services, use skilled people there in the engagement of our community in our programmes, whatever programmes, NGO, government, health sector, it's really determined by our engagement of the community. (PR1m)

Another practitioner associated collaboration with building sustainability into aid planning processes. His words also reinforce earlier discussion about capacity, that 'time spent away from work' was a significant barrier to consultation. He simply couldn't afford that. Practitioners also referred to the impact of changing donor priorities on sustainability and the ability to achieve continuity within programmes.

None of them are sustained at the moment, most of the things ... an example is this one: NZ was running the leprosy (programme) and when they left, because of poor relationships, I think relationship is the thing that really destroyed them, because if a new person comes in, he has a different attitude. I know muddies the whole thing, then the whole programme failed. (PR2m)

NGO2f discussed collaboration challenges – was it feasible, or doable, that NGOs participate in every decision even if they were asked? Despite challenges, one practitioner had assumed board membership on an NGO.

Very much involved with an NGO called the Samoa Cancer Society – I’m the Vice-President of that, so it takes up a lot of my time. I have been the President of the Samoa Medical Association for a couple of terms and been Secretary of that Association for many years. (NGO2f)

Another practitioner, who also had a governance role on an NGO, had been able to establish collaborations with new donors.

The Indian government have offered, I think every year, two new machines and that is a really, really good thing. We had an Ambassador from Turkey call in the other day and we gave them a list of what we wanted – all the way from Turkey! I think Israel as well. (PR2m)

NGO2m felt that little consultation was undertaken regarding available funding:

I think part of the limitations of that is that the Ministry doesn’t adequately publicise or release information about what money they do have. It’s only when we go and say “we want to do this, can you give us support?” that the (Ministry says) “oh, we’ve got money for things like that”, whereas I think it should be better advertised or publicised that funding is available. (NGO2m)

NGO1m felt that consultation and gaining community buy-in was challenging from a cultural perspective and with funding constraints:

We have debated, for instance, whether you give money when we do presentations in the village. At the end of the day we strongly felt that we were there to help and we didn’t want to spend our money on that. But we gave a nominal amount and we do that to be consistent with Fa’a Samoa. (NGO1m)

A final comment must go to a member of the New Zealand aid personnel, who while she supported collaboration, asked “but where does this go to, does it lead to better outcomes?” Again, placing emphasis on the importance of planning within the decision-making process.

Don’t get me wrong: they (the planners) can probably point to lots of workshops and national forums which we sometimes get invited to do and we would go and say “this sounds good” and then we think “so what is going to come out of this?” It’s actually looking for the on-going collaboration between the different groups: it is something that is not so visible. (NZAP1f)

### *Prioritisation*

As in section 2, aid personnel’s conceptualisation of priorities differed in scope. Samoan aid personnel discussed strategic documents’ priorities, and practitioners honed in on the need for priority self-determination, infrastructure, changing priorities, and donor prioritisation. NGOs raised their own organisational priorities and compliance issues. It was that clear that the varying conceptualisation of priorities provided a challenge.

New Zealand aid personnel were particularly vocal on this matter and stated that prioritisation methods were a significant determinant of good aid and outcomes. They raised specific issues as crucial in the determination of priorities. These included factors such as budget allocations identified by Samoan aid personnel, sustainability and evidence base.

SAAP1f also described their ongoing attempts to prioritise, and to work through inconsistencies.

At the same time we are trying to get the donors to think that primary health care is the key and now primary health care is the 'buy-in' for donors so if we have anything we will propose it. You see, with the SWAp, if you think about it, there is still a lot of money that goes into infrastructure and the clinical side, medical equipment and supplies, but we are trying to balance it up with the local budget, so more money is going from the donor side to help with promotion and prevention which is primary health care, and much less is going to curative treatment, but mostly infrastructure and medical costs. (SAAP1f)

SAAP1f also described where health sector priorities are negatively impacted by policies in other sectors:

Balancing of development and health: you see government's infrastructure – huge infrastructure, huge buildings – and at the same time, we, the health sector are importing fatty foods and all the unhealthy foods and drinks. At the same time, we have to balance it, so it's difficult, it's a challenge. (SAAP1f)

NZAP1m also commented on the reflection and integration of priorities throughout the process and the involvement of other aid partners, particularly in planning from the Health Sector Plan down to the Programme of Work.

In my experience, in terms of supporting health sector programmes that we jointly financed with Australia and the World Bank, it was still not very coherent and it didn't seem to be policy driven. Some of the initiatives that were being put through to the programme to be supported i.e. what we saw as in the policy as being a priority based on whatever Needs Analysis was done prior to that, wasn't really reflected in the programme of works. (NZAP1m)

NZAP1m also identified the risks of external prioritisation as a potential barrier to good aid, diverting attention and funds at the expense of major Pacific issues such as NCDs (Non-Communicable Diseases).

A lot of health aid has been what we call 'vertically programmed' which means some organisation somewhere identifies a big issue – it could be HIV/AIDS, could be Malaria, could be NCD – and because that's their particular focus they say "it's terrible – we've got to address HIV/AIDS because it's threatening the world, or NCDs is a tidal wave of cost facing poor countries. That tends toward them wanting to focus in on those particular issues and build a direct response to those issues. That is problematic ... if you programme in for a particular health issue then you will inevitably draw resources away from other health issues and you may well undermine the health system. (NZAP1m)

Ad hoc prioritisation also emerged through disaster relief and while information previously showed that this prioritisation was crucial and flexibility was valued, it is unclear whether health planners looked at these changes in priorities and considered how they would affect future programme delivery.

NZAP1f also highlighted priorities emerging outside the process through political intervention.

There is also the “directive from the Minister” in New Zealand to say “look at supporting this and look into this sector and see if you can support something in there”, and then we do what we can to try to follow established protocols and processes in terms of checking with the partner government and whoever else needs to be involved. (NZAP1f)

### *Monitoring and evaluation*

The availability and quality of information and data provided was noted by all as the third significant challenge to good aid and results-based decision-making and practice as expressed within the Paris Declaration. Two challenges here are the need and importance of data across the decision-making process and also the systems. The ‘right people’ and ‘effective systems’ to collect, analyse and disseminate data and raise concerns about current data collection, were the key words used time and again and they impacted on each other.

While all participants agreed monitoring and evaluation was important, capacity had a critical impact on data and systems. This issue was particularly acknowledged by aid donors. Data collection was both huge and necessary to inform policy, but the mechanisms and expertise to gather this material was lacking. NZAP1m stressed the importance and the challenges involved in planning, developing, monitoring and evaluation frameworks, and where external capacity had already been brought in as a solution.

Again, we do feel that there is room to significantly improve the quality of the programme logic so that outputs are much more strongly aligned to what we feel is the best evidence of achieving some change in those indicators. If you can get that, then you can get a stronger link between the two and you can report more fully to show what they are doing is achieving change. (NZAP1m)

PR1m highlighted the capacity implications and the implications for the quality of the data itself:

The biggest problem here is collecting data; broken down systems which make it difficult to find things. If you see the reports now, they are still using reports of five or six years ago – totally not a reflection of what is going on here, so the information is patchy. So, what’s improved, which is one of my first things here, is the IT thing of the hospital – making sure it’s communicating so that you know the outcome of patients, so you get a monthly report of this thing, but here you find that most of the thing is manual and people are so busy, shortages of staff, and you will never be able to know what will be a priority next year, because you don’t have the data. (PR1m)

Multi-level data collection described in section two left much room in the process for slippage, in the actual data collection as well as the recording system itself, and how the department had tried to streamline this.

You go out and do a site visit and ask them a couple of questions about “how do you record, how do you do this?” Some nurses do it differently: they all have different versions of recording the information and when we go we get one page all differently formatted and we get another page, there is one column missing that should be there that was on another page. So that was essential information that they missed out and that is information that we need too. (SAAP3f)

PR2m identified the need for good information across the process incorporating planning, delivery and monitoring, and evaluation. He described how their information impacts their service delivery from planning to monitoring.

If you have a system that every time a patient is seen it's on a computer, everybody that is admitted is on a computer, you can actually monitor from here what is going on with that patient and you can answer. (PR2m)

Being able to streamline as much as possible was particularly important because different donors had different reporting systems. This was made apparent by an NGO1f's comment:

We have our own data collecting system. It's called the Information Management System. It is an electronic system and we share this data with the Ministry of Health mainly for National Reporting. We collect our data because we have our own reporting system ... they all have different types of data collection systems. We collect data from our own clinics and our mobile clinics. We don't collect data from anywhere (else), except for our Community Based Distributors. (NGO1f)

NGO2m raised concerns about whether data was up to date:

They keep on quoting the 2002 STEP survey by WHO, but this is 2013 – how many more surveys have they done to accurately reflect what is going on? (NGO2m)

With information systems development, NZAP1m described both efforts and challenges being faced to develop systems across the whole sector to enhance information collection and measure outcome achievement.

There is a lot of debate going on around health information, health monitoring at the moment. Samoa has not solved its health information systems at all. We are investing in that, so there is a plan to develop a health information system that is going to work on the over-arching (system), defining what and where are the needs for health information, what are the existing systems, what are the systems that are needed to actually deliver that information where it's needed. Once that overall design is done, to start investing in the quality of the various systems, including the IT systems to produce that ... the challenge ahead is to get stronger reporting systems between the GPs and the health system, the NHS and the MOH, and the right kind of data at different levels ... It is a complicated area, there are a lot of stakeholders involved and we need some kind of fairly neutral and high quality technical support in that area to try and help negotiate all of those different tensions and issues. (NZAP1m)

## Summary

All participants were in agreement that good aid should reflect partnership model characteristics including being participatory, entailing specific roles and responsibilities, centring around Samoan ownership and leadership, ensuring access and being both predictable and sustainable. Culture was seen as significant by some participants, particularly in programme implementation, gaining community buy-in and collaboration and producing good aid.

In practice, however, participants identified through numerous examples that good aid was not easy to enact. Issues of capacity, time, resources, data collection and collaboration, particularly with NGOs, were identified. Donor aid personnel highlighted ways they were trying to address and support this, but this was not easy to put into practice in a small island state, where concerns of capacity, migration, time for decision-making and competing priorities existed.

Capacity however was the major challenge to good aid, with limited resources and political leadership, imposing constraints on potential solutions. Challenges are also very much related to the institutional capacity of the health department and other departments to carry out our partnership-based planning in decision-making.

In describing how good aid worked, participants had varying views about the scope of aid prioritisation; Samoan aid personnel discussed priority source, New Zealand aid personnel discussed barriers to prioritisation, practitioners discussed service delivery priorities, and NGOs organisational priorities. Capacity's importance to effective aid was reinforced by participants' focus on human capacity and through varying conceptualisations impacted on by the planning, implementation and monitoring roles played.

Participants spoke of the necessity and complexity of managing for results and implementing strong monitoring and evaluation. Samoan aid personnel described existing monitoring and evaluation systems and external targets, while New Zealand personnel stressed the importance of implementing broad frameworks, particularly establishing strong monitoring and evaluation frameworks, including programme logic supported by strong systems. Practitioners described existing systems as well as speaking of the importance of broader frameworks and systems. NGOs also raised a number of points similar to those raised by the other participant groups including points about existing systems and broader frameworks.

Again, all groups agreed that inclusive partnerships featuring collaboration and consultation were crucial to implementing good aid. Samoan aid personnel were more inclined to describe existing arrangements, while New Zealand aid personnel detailed issues relating to consultation and collaboration. Practitioners identified issues such as time cost to busy clinicians. Within the NGO group, participants described a range of existing collaboration arrangements from ad hoc meetings to sub- sector group involvement and exclusion.

Participants' perceptions of challenges to good aid were also varied, while some groups were comfortable with their participation in decision-making, other groups realised they were not participating in some decision-making groups or processes. Some participants also suggested that ensuring ownership and leadership in effective aid presented challenges. New Zealand aid personnel referred to the capacity for leadership and the need to build this while a practitioner questioned whether all those in the sector felt as if they had ownership. Practitioners specifically also identified challenges in securing predictable and sustainable funding to address human capacity and migration concerns.

External and prioritisation methods were raised by aid personnel as challenges to prioritisation which supports good aid. In managing for results, the varied, and sometimes contradictory, perspectives of capacity focus and spread raised by all participant groups presented challenges to ensuring capacity supports good aid. The existence of frameworks and information systems to manage for results is another challenge raised by New Zealand aid personnel and practitioner groups. Finally, the barriers and complexity involved in ensuring partnerships are inclusive was challenging, particularly according to New Zealand personnel and practitioners, while it was not perceived as a focus of challenge for Samoan aid personnel.

It is also important to note that sitting across all these areas are the challenges of limited resources and political leadership, imposing constraints on potential solutions. Challenges are also very much related to the institutional capacity of the health department and other departments to carry out partnership-based planning in decision-making.

# CHAPTER SIX: CASE STUDY – THE SAMOA HEALTH SWAp

## Introduction

I present an embedded case study of the Samoa health SWAp WHICH gives further insights into the process of implementing the Paris principles. It highlights the potential role for stakeholders having a place at the decision-making table and the roles and responsibilities set out through this piece of work. Available information gives perspective to both the desired objectives and the actual experience as documented in the review.

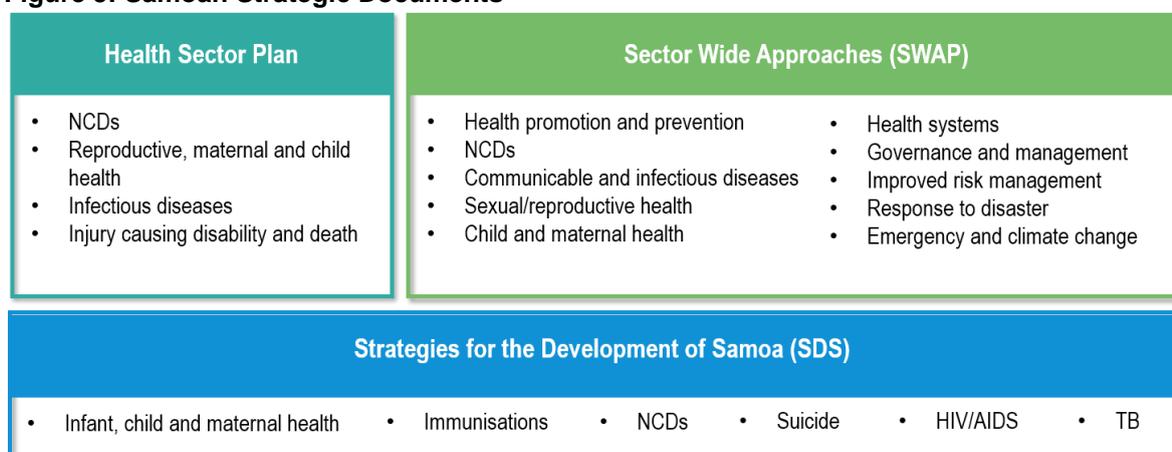
The Samoan government and development partners agreed to establish a Health SWAp in 2008 to fund the implementation of much of the HSP (Davies, 2013). This more harmonised and aligned approach was thought key to improving the Samoan Government’s effectiveness in managing the Health Sector Plan and improving health services. Three main areas were covered concerning health promotion, service delivery, and the regulatory environment.

Evaluators have assessed SWAp development and implementation with particular reference to aid declaration principles. This is of particular relevance to my study analysing aid delivery within a partnership model.

## Strategic Environment

The Sector Wide Approach was selected to implement much of the Health Sector Plan, while the SDS set out the Government’s cross sectoral objectives to advance Samoa including improving the Health of Samoan people.

**Figure 5: Samoan Strategic Documents**



Source: Ministry of Health, 2008; Government of Samoa, 2012.

## The SWAp

A Joint Partnership Agreement (JPA) underpinned the SWAp, outlining roles and responsibilities in governance and management. The parties to the JPA are the Government of Samoa (GoS), AusAID, New Zealand Ministry of Foreign Affairs and Trade’s Aid Programme (MFAT), International Development Association (World Bank), UNFPA, UNICEF and WHO. Comprising two distinct categories, the four ‘pool partners’ (GoS, AusAID, NZ MFAT & World Bank) provided pooled funding for the SWAp (Davies, 2013). The remaining signatories were donors who did not intend to pool funding at the time of establishment. International aid principles were also reflected as development partners committed to ‘applying the partnership commitments espoused in the Paris Declaration on Aid Effectiveness’.

Under the SWAp’s Partnership Agreement, donors committed to increased use of Government of Samoa systems and procedures. While progress has been slow, feedback suggests that this is associated with donor flexibility, as well as Samoa systems capacity. For example, the sector programme uses the WB procurement systems and the insistence by the WB for prior approval of both large and relatively small items has resulted in considerable tension within the partnership. As there are a number of non-SWAp donors, several strategies are used to support harmonisation at governance level through the partnership agreement and at operational level through dialogue about HSP outputs and outcomes, not only the SWAp.

Table 12 describes the clearly set out role of various Samoan stakeholders in funds management, administration discussion and procurement in addition to grouped donors discussed previously.

**Table 12: SWAp roles**

<b>MINISTRY OF HEALTH</b>	<b>MINISTRY OF FINANCE</b>	<b>HEALTH PROGRAMME STEERING COMMITTEE</b>	<b>A SWAp COORDINATION UNIT</b>
<p>‘Overall responsibility for program administration, financial management and procurement’ as well as an ‘overall coordinating role for implementation of the Program’.</p> <p>Other health sector agencies, including NGOs and private sector bodies, will also be involved in delivering aspects of the Program.</p>	<p>‘Executing agency’ and has joint responsibility with MoH for management of the financial contributions of the DPs.</p>	<p>Brings together high-level GoS officials from various Ministries and representatives of DPs and other health sector bodies to ‘provide coordination among local stakeholders and external dialogue and coordination with DPs’.</p>	<p>Responsible for day-to-day Program administration, procurement and financial management.</p>

Source: Davies (2013)

While Civil Society and Non-Government Organisations don't have a formal and specific role within the SWAp, they are described in Samoa's Aid Coordination Policy as being partners in the development process and participants/representatives in sector consultations and institutional frameworks (Government of Samoa, 2010). In the health sector, NGOs are members of the Aid Coordination Committee (ACC), the Health Sector Aid Coordination Committee (HSAC), and the Health Sector Forum participants (Government of Samoa, 2010).

### *Implementing the SWAp*

The following figure demonstrates how the SWAp was implemented, monitored and modified during the study period involving a range of stakeholders across government. Within a calendar cycle the annual SWAp Programme of Work is reviewed and confirmed, interim progress is monitored and reviewed by development partners before performance is formally reported to Government.

Multiple documents also inform the SWAp implementation including the Strategy for the Development of Samoa and a range of Health Sector documents including the HSP, Medium-Term Expenditure Framework, Programme Operational Manual, Programme of Work and Annual Report. The SWAp's Joint Partnership Agreement and Programme of Work set out stakeholder's roles and responsibilities and the work falling under the SWAp. There are also a significant number of stakeholder groups who influence the SWAp from the Cabinet Development Committee, who look at priorities across government, to the Aid Coordination Committee, who coordinate the allocation of aid across government, and the Health Programme Steering Committee who coordinate dialogue between stakeholders across the health sector, particularly with both SWAp and non-SWAp development partners in the aid provided.

**Figure 6: SWAp aid decision-making process (Davies, 2013; Ministry of Finance, 2013)**



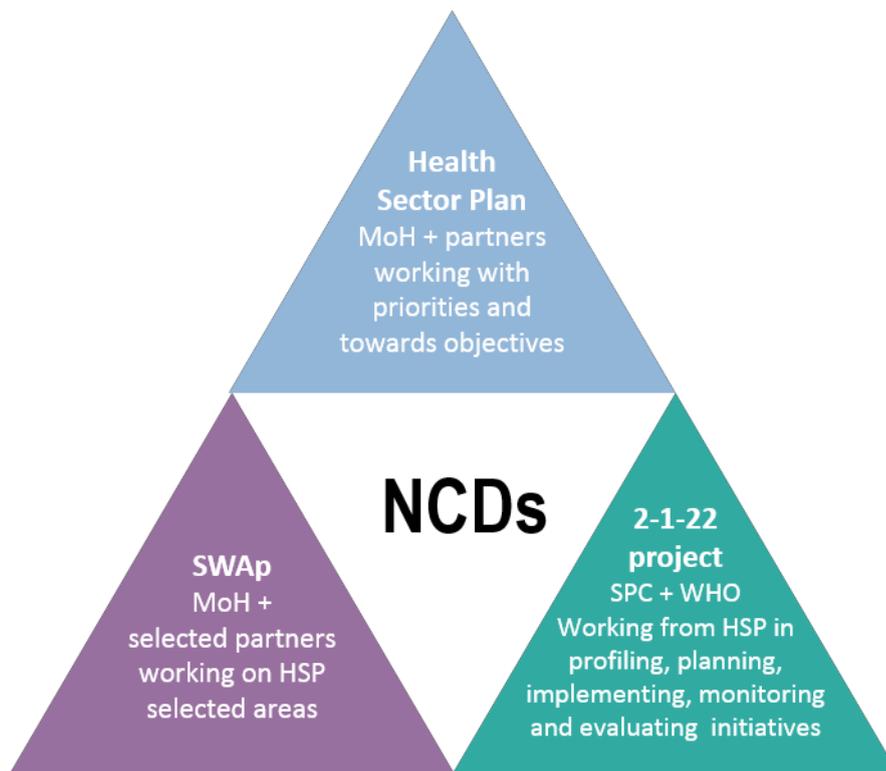
## **NCDs**

The provision of NCD assistance provides an on the ground, real life example of the complexity of participation and partnership efforts around the SWAp, where various donor partners operate under different relationships and assume different roles (OECD, 2010). In figure five, three major NCD-related documents are shown with no reference and discussion of how partnerships and processes align. The OECD review has also highlighted collaboration complexity where the World Health Organisation is developing collaboration as a 'non-pooled' party to the SWAp, while the Secretariat for the Pacific Community is not formally involved in the SWAp at all (Vaillancourt, 2012). While the Samoan Government is engaging partners about assistance related to the whole HSP beyond solely SWAp, my research will also consider the efficiency cost that managing these varying relationships is placing on the health system.

Outside the SWAp, official documents provide detail about programme focus but little information about partner's roles and relationships with other initiatives. Significant NCD work was ongoing outside the SWAP during the study period. The SPC collaborated with the SWAp partner, the WHO, through its 2-1-22 project bringing SPC and WHO into one team working with 22 countries to assist PICTs to improve the health of their populations by establishing a comprehensive approach to profiling, planning, implementing and monitoring and evaluating sustainable initiatives to combat NCDs and associated risk factors in their populations. 2-1-22 built on what is already happening in countries and provided a comprehensive integrated programme of support for them to progress further at respective stages of prevention and control, coordinated and harmonised efforts of regional support agencies, countries and development assistance agencies, AusAID and the New Zealand Aid programme. Additionally, a small number of projects are jointly funded by SWAp and the World Health Organisation but from the documents available it is not apparent what cohesion exists beyond co-funding. It is also interesting to note that despite the WHO being a partner it is referred to separately here.

In contrast to this, a Tanzanian example demonstrates effective coordination between multiple bilateral and multilateral partners. Tanzanian donor partners established the Development Partners Group for Health comprising more than 10 agencies who developed and implemented a system where at least three donors are continuously leading work programmes and a website provides an overview of all sector policy documents and processes (Action for Global Health, 2010). I intend to highlight collaboration within my fieldwork and consider the role and potential for extending SWAps in my analysis.

**Figure 5: Samoa NCD work**



Source: Ministry of Health, 2008.

It is notable that China is not involved in the SWAp. In contrast to collaboration, Boak and Ndaruhutse (2011) argue that China's prioritisation of trade over aid effectiveness is the reason it has not engaged in SWAps (OECD, 2011). I will explore how this 'official' position impacts on the ground and whether collaboration, commerce and trade can coexist in aid disbursement during my fieldwork to assess what impact these factors have had in decision-making.

## **Aid Principles in Action**

### *Ownership*

Ownership in a Samoan context has been considered by Negin in his series of papers looking at the development of SWAps within the region. He argues that documents set out Samoan leadership and ownership particularly in the scale of change required. Negin also highlights the existence of a solid foundation through planning and expenditure frameworks for a joint donor funded support programme (Negin, 2010).

### *Alignment*

While the SWAp is clearly aligned with national and sectoral priorities, alignment of systems and processes is still a work in progress (Davies, 2013) reflecting a similar situation globally (OECD, 2011). Under the health SWAp, World Bank procurement processes were adopted as an interim solution until donors were confident that GoS systems were adequate and it's said that resolution of this matter will be critical to the ongoing success of the programme (OECD, 2010).

### *Harmonisation*

The development of Aid Coordination and Health Steering Committees provide a harmonised approach to planning, managing and delivering, as set out in the above diagram, and some donors are aligning specific aspects of the Health Sector Plan within the SWAp approach. Another group of donors supports aspects of the Health Sector Plan but, as stated above, available information suggests that processes are not fully harmonised outside the SWAp. Though prioritisation is said to be central in developing harmonisation, available documents do not make evident how decisions about the number and sometimes ranking of priorities are made.

### *Managing for Results*

Again, both official documentation and governance groups align with a managing for results focus. The existence of both a Monitoring and Evaluation Framework and Programme Operational Manual indicate a growing focus on managing for results and with the Medium-Term Expenditure Framework, (MTEF) a visible link between planning and budgeting. Coordination mechanisms also support a participatory approach to managing for results. Further analysis cannot be made on the extent to which these documents fulfil principle requirements as they were not made available.

### *Mutual Accountability*

Health summits and aid coordination mechanisms provide a forum for regular and relatively widespread reporting by all groups to support participation and accountability by all groups. It was more difficult to ascertain what information is provided to donor partners about aid flows. De Renzio, Foresti, and O'Neil (2006) discuss the accountability of agencies to Government and while it is understood that Samoan Annual Reports are submitted to parliament, not all of these reports have been published or provide the breadth of information needed to understand spending and results. Considering the New Zealand context, the New Zealand Aid Programme is made accountable through reporting to parliament and MP's Select Committee questions and answers. There is no discussion of how aid is accountable to the Chinese state in the Chinese Foreign Aid documents either. Agulhas' (2006) claim regarding difficulties in making donors accountable to partner countries and De Renzio, Foresti, and O'Neil's (2006) argument about ambiguity in donor agencies accountability to recipient countries citizens hold true here.

### *Inclusive Partnerships*

Health summits and CSO membership of coordination committees provide some evidence of CSO involvement in decision-making in the Samoan context, however it is not apparent what role these organisations play within groups. Reviews (Davies, 2012; Vaillancourt, 2012) have suggested that despite this official involvement, the CSO voice is not being sufficiently integrated within SWAp and is distant from Rauh's (2010) description of strategic actors who actively negotiate and resist donor agendas.

Global partnerships and the importance of political leadership for aid effectiveness is the newest principle and is reflected at the national level through the Prime Minister's Chairmanship Cabinet Development Committee and Aid Development Committee. Although again further information has not been available to indicate within these groups how the Prime Minister supports effective aid.

### **Review**

Three recent reviews and evaluations of Samoan aid delivery assess SWAp activity. I will examine the extent to which these reviews show movement towards partner country ownership and planning focus described as SWAp features (WHO, 2013) and partnership model key characteristics (OECD, 2005). I will also discuss whether and how these features have contributed to health outcome improvement.

Specifically, reviews have looked at the SWAp:

- Comparing it with SWAps from other sectors in Samoa (Vaillancourt, 2012);
- Contrasting with SWAps elsewhere in the region (Negin, 2010; Vaillancourt, 2013); and
- Providing close analysis within the Samoa health context (Davies, 2013).

Additionally, MoH's Mid-Term Review of the HSP contributes further perspectives to SWAp assessment, given some HSP work items fall within SWAp.

SWAp review and evaluation have been analysed with caveats including particular questions about the visibility of developing partner ownership. The three SWAp-focused evaluations have been donor funded and driven by the New Zealand Aid Programme, Australian Aid and the World Bank and authored by donor partner country consultants. They range in scope from preliminary assessment (Negin, 2010) to a phased review (Vaillancourt, 2012). All three pieces of SWAp work have used similar methodology, drawing largely on document review and analysis. Limited fieldwork interviews have taken place, raising questions about how recipient perspectives are incorporated, particularly given the absence of aid users perspectives altogether.

SWAp and HSP review's specific scope is a further limitation. These evaluations exclude system performance focusing on the elements of the health sector plan which SWAp funds. Given the existence of donor assistance outside the SWAp, conclusive statements cannot be made about the impact of all health assistance on SWAp. These reviews allow some conclusions to be drawn about the majority of New Zealand assistance on health outcomes. The Samoa HSP mid-term review examines progress in implementing the Plan, complementing the other reviews as a broader implementation focused piece of work. My case study is a small contribution to looking at planning and implementation across the health sector bringing existing reviews together. However future evaluations should be Samoa-led and look towards a broad approach which encompasses all of the Ministry of Health's work, from planning to implementation and incorporating all perspectives to review whether outcomes outlined are being met.

Limitations considered, analysis from all reviews showed progress towards SWAp outcomes have been hampered by poor planning and implementation, and failure to put in place appropriate indicators within a monitoring and evaluation framework with strong information collection systems to measure progress. In contrast to reported indicators, the absence of monitoring and evaluation including systems may be associated with the invisibility of operational level detail outlining priorities, sequenced activities and costs, an issue also acknowledged by the Government of Samoa (2013). My own analysis also supports the existence and impact of a weak monitoring and evaluation framework; this was evident in SDS data, highlighted in reviews by both partners, and the absence of visible process is referred to again (Government of Samoa, 2013; Vaillancourt, 2012). The HSP review makes recommendations involving refining and decreasing indicators, simplifying monitoring, and ensuring indicators utilise more consistent and tighter terminology. More straightforward and organised data collection processes are also proposed with a central data repository. It would appear here that a lack of focus in planning and gaps in implementation have produced outcomes opposite to what WHO (2013) envisaged for SWAps. Work recommended for the second half of the HSP focuses on bridging the gap between outcomes sought and operational activity, and the integration of development assistance with a greater outcomes-focus and amended processes (Government of Samoa, 2013). This review concluded that a full assessment of progress cannot be made until Stepwise Approach to Surveillance (StEPS) 2013 survey has been conducted.

In contrast to planning findings, all three reviews affirm that relationship change is occurring and describe the positive impacts of coordination, relationships and capacity consistent with what was envisaged by WHO (2013). Importantly the reviews also illustrate that improvements in one area can also flow on to impact other areas. The reviews described partnership and coordination areas positively, particularly related to SWAp's first objective of managing the health sector plan, describing future directions. Negin (2010) suggested that partnership and coordination efforts must be ongoing, flexible and worked at; while Davies (2013) notes some successes in development partner partnerships. Finally, Vaillancourt (2013) describes developing and evolving partnerships and cites development and the use of tools for coordination is underway. Negin (2010) also places particular emphasis on calls, also made elsewhere, to expand a partnership model to regional and multilateral partners who implement programmes outside the SWAp mechanism and how to involve civil society and Non-Government Organisations within this approach (Boak & Ndaruhutse, 2011; OECD, 2011; European Union, 2012; SPC, 2012).

Capacity is addressed by all three papers describing how partnership principles implement alignment and harmonisation and support greater efficiency as well as ongoing challenges. Negin (2010) looks at implementation capacity and argues that over time transaction cost efficiencies may be gained from local activity. Vaillancourt's (2012) discussion of capacity looked at strengthening procurement capacity and the importance of alignment towards exclusive use of national procurement procedures. SWAp reviews also point to important planning gaps which have the potential to contribute to addressing earlier issues, highlighting training and experience gaps of highly qualified, well-trained experts in the management exigencies of a SWAp, and utilising civil society capacity.

Consistent with Rwangomba (2011) on improvements in aid effectiveness, two evaluations did also include areas of improvement for development partners. Vaillancourt (2012) suggests that Development Partners consider and strengthen their capacities, accountabilities and business models of the DPs to better meet the

needs of countries implementing SWAps. While Davies (2013) argues that improved governance from development partners is needed.

Monitoring and evaluation has been considered as a significant impact on measuring effectiveness by all three reviews, but more particularly by Vaillancourt (2012) and Davies (2013), with both agreeing that further detail is required to accurately and comprehensively measure impact. Vaillancourt (2012) looked at how performance and outcomes might be improved under a SWAp, suggesting that strengthening the focus on results will be central and this might be done by clearly articulating SWAp-specific objectives and indicators, and by improving results frameworks, evidence-based interventions, and research and evaluation. While Davies (2013) adds more detail to this in his evaluation about the impact of the SWAp process concurring that measures are ambiguous and suggesting monitoring processes have been poor.

Evaluations take little consideration of NGO perspectives or role in SWAp planning and implementation. Davies (2013) notes that NGOs have had insufficient opportunity to participate in the SWAp. It appears that where relationship change has occurred, it has largely excluded NGO voices.

## **Summary**

Samoan health aid planning and aid disbursement has centred on the SDS, the HSP and most recently the SWAp to implement much of the HSP's Programme of Work. Led by two different Ministries, these strategic documents are not subject to the same decision-making processes nor reflective of identical priorities. While SWAp partners' roles have been set out, the broader context and environment for Samoan aid disbursement and SWAp implementation is both complex and crowded. The area of NCD assistance shows these complexities at work where it is often difficult to tell what cohesion exists beyond confounding. Both aid principles in action and review underline the challenges which exist. Some progress has been achieved through the Swap in terms of collaboration but there is still work to be done.

## CHAPTER SEVEN: DISCUSSION

### Introduction

Despite the fact that huge amounts of aid have gone into health in PICTs, the health situation has not improved. As well documented, factors which contribute to this situation include: a) an increase in new health issues such as NCDs alongside traditional issues such as malaria and a re-emergence of diseases such as leprosy; b) the tremendous increases in birth rates and youthful populations in every PICT, and the high costs of ensuring basic health care for these groups. In addition, there are difficulties in ensuring equitable provision of health services in small widely dispersed nation states such as Vanuatu, which has over 80 inhabited islands each with their own languages and culture. Budgetary pressures and limited human resource capacity are other important factors in the delivery and access to quality health services especially in PICTs, which are experiencing significant levels of outmigration of planning and clinical staff (Connell & Negin, 2009). Each of these factors highlight very compellingly some of the structural issues impacting the development, delivery and use of health aid in PICTs generally, and in my Samoa case study.

My study focused on how health aid spending decisions are being made. More specifically, I wanted to see how the best returns for people and nations could be achieved when health aid spending and decision-making was carried out in an ethical and financially responsible way, and with the aim of establishing sustainable health systems for the future.

I used the Paris Principles of Aid Effectiveness as my evaluating framework, as this offered a way to explore and identify factors which would support the effective and efficient delivery and use of health aid in small nation states such as Samoa. As documented, partnerships between national government and donor partners are the central platform of the Paris Declaration, Accra Agenda for Action (2008) and Busan Partnership Document (2011). Partnerships were also reiterated and reinforced in the Pacific Principles of Aid Effectiveness (2007); specifically that national governments lead and take ownership of the aid decision-making processes and the harmonisation of resources in a process marked by mutual accountability. The partnership model's overarching theme was that working together and pooling knowledge and resources was the strategy to achieve better health decision-making, resource allocation and outcomes.

A number of points preface this discussion. Firstly, in Samoa – and likely other PICTs with small populations – people may wear many hats. For example, in my study a practitioner was also head of an NGO and a significant number of other participants were members of NGOs. As a result, participants were likely to look at aid spending from a number of different perspectives. Secondly, my fieldwork was impacted by the 2012 cyclone (Evan) and inevitably participants' perspectives were influenced by the multiple effects of this tragedy as well as the demands of post disaster recovery work.

This chapter is organised according to perceptions of how health aid decision-making takes place in Samoa, and whether and how these aligned with the global models of aid effectiveness and the Pacific Principles. It is also likely that these case study findings will resonate with the experiences of other small nation states and

together may highlight that, despite PICTs agreement to international and regional principles of aid delivery, practicing and applying these principles is a difficult challenge. The discussion is presented in seven sections concluding with reflections on looking to the future and a brief discussion of the Chinese model of aid. These sections are:

- What is good aid?
- Partnerships and collaboration
- Factors impacting health decision-making and participation
- Whose decisions – national, regional or global?
- Participation
- Looking to the future
- The Chinese Way

## **What is good aid?**

Access to health care and the provision of high-quality health care was stressed by participants as being important to aid that improved peoples' health and access limitations were also highlighted. Access included the availability of services but service provision by appropriately skilled people to deliver services was also discussed. Health planners especially stressed that good aid required robust IT systems not only to record and share patient information but also as a standard requirement for identifying priority health areas by which to inform health decision-making. This finding aligns with the work of the Alliance for Health Policy and Systems Research. (2004)

Sustainability and predictability was also important to those in planning and service delivery roles as a critical foundation for decision-making particularly planning and delivery functions. However amongst partners, there was some variation in how sustainability and predictability was conceptualised. Samoan aid personnel referred to the risks of aid dependency and how this impacted sustainable systems building. One practitioner looked to address operational challenges, referring to ensuring a cadre of the right people were given scholarships or were in the education pipeline so as to ensure health services continued and were not cut short. All things considered and given present human and other resources the practitioner's focus was on delivery (PR1m) and playing their role in health service delivery.

## **Partnerships and collaboration**

The main theme of the Paris Principles is partnerships working together through visioning and, planning, and through managing for results and the focus of my study was on partnerships through the planning cycle. Despite some discussion of the Paris Declaration, it is important to note that participants did not explicitly refer to the existence or implementation of regional aid effectiveness principles. However participants' understanding of the principles of ownership, predictable aid, and the monitoring and evaluation framework were quite consistent with the Paris and the Pacific regional principles (PIFS, 2007). It was also noted that participants did not discuss or refer to international aid targets such as the millennium or sustainable development goals. Instead they referred to Health Sector Plan objectives. To guide their daily work, few of the practitioners used the terms Paris Declaration, Accra Agenda for Action, Busan Partnership or Pacific Aid Effectiveness Principles, nor had they been involved in or invited to participate in health planning. However,

the findings showed that practitioners were so heavily engaged and focused on their own professional roles that even if they been invited it would be unlikely that they could attend. This factor relates directly back to human resource constraints. So, it can be said that while not all practitioners claimed ownership over health planning they did demonstrate a fierce ownership of their place within the system.

Despite their distance from decision-making, these NGOs were particularly vocal regarding the importance of relationships and partnerships in decision-making and how these directly impacted on and were related to sustainability. This finding aligns with those of the Association for Women's Rights (2010) with respect to the importance of CSO and NGO's closer involvement with Government. However, despite NGO's desire to increase participation in decision-making, some relationship and partnership challenges still exist. Fairbairn-Dunlop (1991) described the risk that closer NGO government connections can have negative connotations on aid effectiveness by weakening the watchdog role NGOs traditionally play. This warrants further research on the CSO role in Samoa and its impact.

Apart from those directly engaged in health planning, the concept of participatory decision-making was perhaps a new model or not seen to be relevant to the participants in this study. It could be expected that because of Samoa's adherence to international and regional participatory frameworks, participation would feature prominently in discussions on the aid decision-making process. This was not so. Nor was there much animated discussion on where – or at which point – participation should and could take place, as shown in the International Association of Public Participation's work on the spectrum of public participation. (IAP, 2006). Conceptualisation of participation and other facets of good aid warrant further research to identify how those on the ground view the roles of various stakeholders in aid decision-making processes and how this connects with improved health outcomes.

## **Factors impacting health decision-making and participation**

While finances were a critical factor in health aid decision-making, other important influences included: a) human capacity building; b) data collection, and monitoring and evaluation systems. Each of these is discussed in this section.

### *Human resources /capacity*

The unanimous description of capacity as critical by the study participants reinforces very compellingly that people are the key to the delivery of good health aid and robust aid planning. This finding fits the regional and international literature (OECD, 2001; PIFS, 2007) and is consistent with concerns raised by Overton (2011) and Balogun (2005) that increasing country ownership over development agendas will make harmonisation and alignment with recipient country goals easier.

While appropriately skilled and experienced staff were available to plan for and deliver services their ability to contribute was constrained by the small number of suitable personnel - the planning personnel for national health delivery features five staff. As noted, a practitioner described how ownership was also negatively impacted by the fact that they could not participate given the timing constraints. There is no doubt that the size of the Samoa health ministries, planning staff and practitioners was problematic and so in turn impacted

on participation in decision-making and health service delivery. This finding is consistent with research findings from other small island nations around the world (Hotchkiss, 1994; Singleton, 1990; Thurab-Nkhosi, 2000)

As noted, New Zealand were very much aware of this issue; an aid personnel recounted that capacity challenges relating to small staff numbers sometimes resulted in donor partners playing a more significant role in project design than would be expected or desirable, just to ensure projects reached the implementation stage.

A strategy of forward-looking and flexible visioning of aid is consistent with international literature that 'predictable health aid' is crucial for effective service delivery especially given recurrent costs, such as staff salaries over time and the costs of long-term drug therapies for chronic illnesses (Action for Global Health, 2011; WB & WHO, 2008). The impact of migration challenges on health planning in PICTs, as highlighted by Connell and Negin (2009), was noted by a New Zealand aid personnel in this study. This participant noted that as part of the New Zealand aid planning they intentionally supported capacity building in planning, and systems management, including flexible aid particularly in response to natural disasters supported by a framework for humanitarian assistance (Ministry of Foreign Affairs and Trade, 2013). This flexibility in the delivery of aid was a critical need stated by Samoan aid personnel also.

While planning to ensure a cadre of skilled and competent health professionals and support staff were stated outputs in Samoa's Health Sector Plan (MOH, 2008), participants did not mention the plan's capacity outputs and issues were described in varied and sometimes contradictory ways. Given the breadth of challenge and lack of awareness regarding current capacity planning there is a need for a managing for results focus which incorporates capacity at a strategic level as outcomes rather than outputs and that incorporates all parts of the health system. This will in turn provide a strong and focused direction for addressing outcome shortfalls which are presently unanswered. This would also align with the OECD (2008) recommendation that capacity building should be organised and integrated into decision-making.

### *Systems*

The robustness of the health planning systems regarding record keeping and access has been briefly discussed. In the absence of computerised systems this process was challenging, time-consuming and prone to error. One of the hardest things faced was the absence of people, or minimal participation of skilled people in IT, in health research and planning systems generally. This factor complicated the establishment of appropriate data collection, monitoring and reporting procedures by which to inform planning and track progress made.

International, regional and national priorities underline the importance of managing for results to achieve multiple targets; however, the absence or shortage of people, frameworks and systems made this complex. Managing for results decision-making ensures the right people are involved and are supported by the right systems. This has significant implications with regards to producing high quality and equitable aid which improves health. However, the significant cross cutting and interdependent nature of this principle also presents critical challenges including trade-offs. The cross cutting issues and interdependences are reflected by the wide-ranging views of participants. All participants highlighted the urgency of robust data accompanied by frameworks and systems throughout decision-making in order to manage for results. Within this group,

NGO participants also discussed managing for results but spoke largely about their own organisational experience.

It is interesting to highlight that in Samoa these planning constraints and complexities exist alongside the presence of a health strategy supporting Ministry of Health planning which is an element commonly identified as absent in other countries generally and in the difficulties expressed with managing for results. (Wood et al., 2011). MOH Samoa does have a high-level plan; however there is an absence of prioritisation and sequencing at an operational level which, in turn, is contributing to difficulties in monitoring and evaluation. More specifically for example, managing for results is constrained by the absence of programme logic and data collection methods, complicating efforts to manage for results. This complexity aligns with the literature. (European Commission, 2013; Wood et al., 2011) and is consistent with international reviews of aid effectiveness principles with respect to 'managing for results'. (OECD, 2011) Complexities such as these highlight challenges faced by small nation states in respect of the viability of implementing the essence of international aid agreements

Practitioners and aid personnel participants understood the importance of having good data for decision-making but emphasised that relatively new information systems development to support this collection are still being worked on. Their suggestions included that more collaborative service provision between practitioners, district hospital and national hospital could enable more informed treatment and drive better outcomes (Sap1m). In addition, the public availability of national surveys such as the Demographic Health Survey (Ministry of Health Samoa, 2009) and the World Bank (2008) reports would also raise awareness of present and future health planning goals. Monitoring and evaluation has repeatedly been described as a work in progress in the literature (European Commission, 2013; OECD, 2010; Wood et al, 2011) and is agreed crucial by both donor and recipient partners and aid users (Kittani & Moulin, 2014). As suggested by OECD (2008), strong data collection to inform decisions is directly associated with system maturation. For Samoa, the lack of cohesion between the MOHMOH major planning document and MDG and SDG goals addressing child mortality, maternal health, HIV/AIDs and other diseases (United Nations, 2016), along with the absence of data commentary, indicates strongly that concerted action is needed to address the complexities which underpin this process (European Commission, 2013; Wood et al., 2011). The implementation of a strong information system with appropriate capacity and training is central to strong planning, programme logic, monitoring and evaluation across the aid process and into quality and ethically provided health systems.

#### *Whose decisions – national, regional or global?*

One of the most widely debated issues in aid generally, and in health aid specifically, is; who is setting the agenda and how are decisions made (Liuvaie, 2009; Overton, 2011)? In fact, this factor was the genesis of my research on how decisions regarding health aid could be more effectively made.

This aspect was hard to determine given the short time-frame of this study along with the undoubted influence the cyclone had on national decision-making as well as health decision-making. In some cases, a small number of participants referred to the big aid picture as in the Paris, Accra and Busan principles but most didn't refer to these but tended to focus on their own particular roles within the health systems.

Despite this, participants were in agreement that Samoa had sovereignty over health aid decision-making ownership, and also prioritisation rested with Samoa and this was encapsulated in the Samoan national reports. There was quite fierce emphasis on this point of national ownership. They did not see health decision-making as being taken over by donors but stated quite strongly Samoa's ability to determine their own priorities. This point is in contrast to the literature (Dissanyake, 2009; WHO, 2012)

At the same time, these participants understood very well that health provision was heavily reliant on aid. So in practice, in a number of areas prominence had been given to national goals over regional and international goals generally, as in the case of tsunami-related interventions for example. This difference was exemplified in aid personnel's explicit reference to key strategic documents specifically the Health Sector Plan and alignment with good aid. By comparison, while the practitioners and NGOs interviewed mentioned health issues within the HSP, they did not explicitly refer to those goals. Those involved in aid decision-making in Samoa were unified when describing aid's objectives though.

Also, although national ownership was stressed, participants were keenly aware of actual decision-making difficulties existing at both strategic and operational levels. In addition, these differences were not only underscored by ambiguous and differing perceptions of priorities and flexibility, but also by resource constraint. Most significant was the absence of operational priorities and sequencing. Participant's highlighted policy objectives without citing operational priorities and available strategic documents exclude operational priorities and the process for arriving at these. Reinforcing ownership, supporting participation, and responding to this challenge and making prioritisation integral and creating clarity in decision-making requires a change to planning processes and particularly inclusion of a prioritisation process from the highest level to the operational level.

## **Participation**

While participation in decision-making is stressed in literature such as that developed by the International Association for Public Participation (2006), it has played out in specific ways in Samoa.

Firstly, the importance of participatory models and processes were described very much within the context of participant's own role and participation in decision-making 'on the spot' / or on the ground rather than national decision-making.

Secondly, practitioner's limited participation in decision-making together with the absence or non-utilisation of monitoring data has contributed to a lack of definition and sequencing of priorities. Examples of prioritisation requiring clinical input and data include offshore treatment versus local, investment in new Apia located buildings versus improving rural health provision. Clinical input and robust data is critical in ongoing review and revision of priorities and future planning if the national vision of 'a healthy Samoa' is to be achieved and this goal should be highly visible and underpin all actions outlined in the health sector plan This lack of definition is identified by Gish (1992) as not uncommon and it is especially concerning for small island nations. Further research might explore the impact of clear prioritisation on trade-off issues such as infrastructure versus service delivery.

## Looking to the future

### *Inclusive partnerships*

In the literature, and more specifically the Paris and subsequent aid agreements, participation, collaboration and consultation by all groups are outlined as essential in effective aid delivery. (OECD, 2005; 2008; 2011)

Participants agreed strongly with these ideals; clearly stating that consultation was crucial to good aid and ensuring 'buy-in' throughout the aid process, reflecting international prioritisation of this joined up approach (SPC, 2012; European Commission, 2012). Some systemisation of collaboration occurred and some participant groups were also able to identify collaborative opportunities, responding to specific events and the entrance of new donors. However, they were also able to identify situations where patch protectiveness presented obstacles. For aid personnel not directly involved in aid decision-making, collaboration was distinctly more complex. In contrast to partnerships, participants in NGOs strongly recognised their distance from inclusive collaboration and consultation activity aligned with international literature. Many practitioners were formerly aid personnel and had maintained some relationships however those now in service delivery roles placed greater emphasis on the costs of consultation than is reflected in the literature.

### *NGO inclusion*

The NGO participants have not yet been included in decision-making processes; they are outside the inclusive partnerships, as outlined by Ross, Powell and Hoverman's (2008) participation factors. Practitioners and NGOs emphasised their desire to participate and contribute to a shared work programme on health challenges (NGO2m). Practitioners, particularly, expressed some frustration about their involvement specifically that they would have liked to be engaged but didn't have the time (Pr1m). In contrast, aid personnel focused on the communication which existed during the Health Sector Plan development process (SAAP2f) and annual health sector forums.

However as discussed extensively in previous chapters NGO experiences of collaborating and consulting have varied and those interviewed did not make explicit links between consultation, collaboration and good aid. This was less strong than the frustration expressed by practitioners who were sometime partners. It is also notable that some funding models reviewed existed outside national frameworks and donor partners and this may be an additional significant barrier to making inclusive partnerships and good aid work.

Domestically, some knowledge of and agreement to Paris Principles existed however multiple challenges were faced on the ground. Participant's perspectives on the centrality of people, frameworks and systems to making good aid work also illuminate some of the most significant challenges faced. Lewis and Macpherson (2008) also illuminates the importance of the current environment and specifically identifying challenges and continuing the momentum for change within the context of an internationalised strategy. Participants' views emphasise the need for change across capacity building, participation, collaboration, prioritisation and monitoring and evaluation. Here capacity, prioritisation, monitoring and evaluation and collaboration and consultation will be discussed.

While ownership was emphasised strongly by all participants as resting with Samoa, documentation showed strongly that there is further work to be done in enacting ownership and leadership at operational levels. Actions on the ground particularly in the area of prioritisation was still very much a work in progress. The failure to prioritise and sequence clearly and at all levels provides a challenge to plan and achieve improving health outcomes. The absence of common planning processes regarding prioritisation and review was reflected in multiple external reviews (Davies, 2013; Vaillancourt, 2012) and my assessment of documentation. Responding to this challenge requires a change to planning processes and particularly inclusion of a prioritisation process, reinforcing Samoan ownership and leadership. Participant's perspectives have also highlighted that differing donor partner procurement requirements are a challenge to priority implementation specifically aligning internal systems and processes. These inconsistencies should be prioritised for addressing in partner discussions. Additionally it may be valuable to pilot a regional response to this given the emphasis on this in regional aid principles.

Participants stressed challenges in managing for results including drawing on appropriate capacity, which was complicated by a range of factors including outward migration, training opportunities and trade-offs in focus. Addressing and strengthening capacity requires a broad and strategic outlook to decision-making by the Samoa government. Beginning in the planning process, a cross government or health sector workforce development plan (starting from students undertaking health tertiary study) must be developed to integrate capacity throughout decision-making in a concerted way with specific capacity objectives and targets to reinforce ownership.

The other major challenge identified by participants was managing for results, and specifically the availability and quality of monitoring and evaluation information. To address the monitoring and evaluation challenges, planning must be undertaken in a more concerted way with the development and implementation of evidence-based results frameworks where indicators are constructed during planning alongside the construction of data collection systems. Data collection and results frameworks are referred to in official documentation but the absence of all plans and systems makes assessing whether on the ground aid is effective or problematic. Managing for results and monitoring and evaluation systems must be visible and accessible to all in order to support transparent decision-making. The capacity to enact these systems changes is not discussed but represents a pressing area for consideration, if data challenges are to be addressed. The 'right people' and 'effective systems' to collect, analyse and disseminate data and the concerns about current data collection, were the key words used time and again and they impacted on each other.

Participant's varied descriptions of their role and relationships also highlighted the variability of relationships and collaboration. Building and strengthening relationships and forming shared understandings will also be crucial to addressing the data challenge where information is collected and analysed; and groups trust the data and the collectors sufficiently to work with their findings. Robust information and systems will also better inform the public in general and support good governance (Kittani & Moulin, 2014). High quality information will also impact other Government sectors, particularly given the impact of issues such as work to provide safe drinking water and its effect on improving health. Improved relationships and shared information usage will also positively impact prioritisation building from existing shared understanding and the importance of robust prioritisation as highlighted in a recent review. Expanding the conceptualisation of prioritisation as a process

which flows down from the strategic to operational level is a logical and not onerous method to strengthen aid decision-making and improve outcomes.

Participants varied conceptualisation of partnerships also demonstrated that inclusive partnerships are a challenge given the very different roles and involvement of aid personnel, practitioners and NGOs within the Samoan health sector. This is further complicated by the absence of systemisation for collaboration and consultation. Ensuring and enshrining the participation of all partners within decisions made will be a critical contributor to better decision-making and outcomes. Again, planning processes must include and systematise collaboration and communication through a communications and engagement strategy to sit alongside and throughout the aid process. Literature also supports the emerging complexity (Action for Global Health, 2010; Rwangombwa, 2011; Sjostedt, 2013) on the ground and in this case study challenges and tensions are evident in decision making and practice in practice.

Some aid personnel stated that collaboration and consultation has developed resulting in ownership through less fragmentation and more coordination. However this is largely at the high level planning and monitoring stage within decision-making, while it is unclear if and how operational level collaboration operates. This strongly suggests recipient countries' implementation capacity continues to be taxed and further work to effectively manage scaled-up ODA through systematised collaboration is needed. It is certainly too early in the Samoan context to concur with international reviews (2008) suggesting that the Paris Declaration principles implemented at national level are driving consultation and collaboration, and achieving complementarity between the global, regional and national. (World Bank, 2008)

## **The Chinese example**

Some participants mentioned aid given by Chinese donor partners, reflecting international and regional patterns where donor Governments are working to establish stronger aid relationships with China. Expanding Samoa's relationship with China to a broader range of areas which are costly or not a priority for other donor partners firstly and including the Chinese more formally in common planning and decision-making may improve health outcomes through greater efficiencies (meeting human resource challenges through for example Chinese specialists offering treatment in Samoa or Samoa patients receiving treatment in China) and more informed planning and service delivery. A strategy such as this is highly comparable with Hanson's (2011) proposal to test engagement strategies with China in the Pacific. Rather than displaying Sinophobia and fearing Chinese donors and relationships (Callick, 2011), and falling to the risk of being a guinea pig there is an exciting and rare opportunity to draw upon some elements of Sinophilia (Callick, 2011) while acknowledging there may differences in implementation. These include learning how China has achieved its development success together with facilitating multi-donor initiatives including China and drawing China in more closely to collaborate and coordinate in the Samoan aid environment. This opportunity could be implemented by building on the strong sense of ownership in Samoa, supporting visible prioritisation in planning, improved managing for results by having available and utilising all relevant information and formal engagement mechanisms.

## Summary

The Paris principles represented a really important step forward in ensuring and working to achieve effective aid and work is already underway which has reinforced areas such as Samoan ownership. In areas such as this, the Paris Principles were both well-suited and fitted to the Samoan context and were being applied well. However, participant experiences supported by some literature has shown that there are also difficulties in implementing this model from the international to the national context and Samoa's implementation of the partnership model needs to be addressed now if decisions are to result in improved outcomes.

Participant views describing what good aid is, how it works, and challenges to good aid highlighted differences between ideals set out in international aid agreements and on the ground practice. Participants thought good aid encompassed ownership, access and predictability, the supporting literature in this area also. The development and maintenance of appropriate capacity and the systemisation of planning, service delivery and monitoring and evaluation, was viewed by participants as crucial. Many of those interviewed supported systems development to ensure that collaboration is enshrined and that high level prioritisation flows down to the operational in a concerted manner. Newer donors, such as the Chinese also offer opportunities for partnership however it is unclear currently how this would measure up against international and regional aid principles. While Paris Principles are being implemented in a limited way in Samoa currently, suitable for its limited human and financial resources, enhancing monitoring and evaluation with the right capability and the right systems will provide stronger evidence for improving aid decision-making and producing better health outcomes.

## CHAPTER 8: CONCLUSION AND RECOMMENDATIONS

Despite huge investment in health aid, and a 200 percent increase in Government health spending over the study period, health outcomes continue to be poor in a range of areas. Additionally the growing impact and cost of natural events (World Bank, 2011) provide strong impetus to ensure health outcomes are improving and value for money is achieved. The potential of effective development assistance to improve outcomes was recognised through participatory models, and aid declarations. Paris (and subsequent) principles, were designed and agreed upon globally to support effective aid, improving people's lives including their health. However while international partnership models represent the ideal, on the ground implementation of these models is complicated. Currently the partnership model is being implemented in a limited way as suitable to limited human and financial resources. The existing model includes challenges in the Samoan context which must be addressed if health outcomes are to be improved. Multiple global and national goals raise questions of who is responsible for these and regional efforts at improving aid effectiveness give rise to queries about whether principles are critical in their purported relevance to Pacific conditions or merely adding another layer of compliance. A critical assessment of their role and relevance must be undertaken as part of rethinking aid.

Though this research is Samoa focused, recommendations made here are relevant for consideration by other PICTs who as small island nations are implementing partnership models with a focus on participation. One area of potential exploration might be whether the difficulties of participation and role may be similar to those experienced in other small island nations with regards to health planning particularly where capacity is a factor. Additionally partnership models are also influenced by broader issues of resource, political leadership which may have a specific impact and where a young increasingly urban population offers economic potential.

Changing demographics in Samoa and the Pacific also offer expanding opportunities to address questions raised in this study. There is a young and highly literate population and in the region donors are working more collaboratively with China and have also noted New Zealand's integrated approach to an aid project in the Cook Islands. Culture provides a steady backdrop throughout the Pacific and is an important determinant in improving health outcomes which Government has done little formal exploration into. There are opportunities to draw on culture to improve health literacy amongst an almost universally literate population. Underpinning efforts to accelerate improvement is available information and collection systems. Growing opportunities to improve health must be sought using an integrated and dedicated approach across the aid system, improving the calibre of information and expertise that decisions are based on.

The application of the partnership process as outlined in the Paris Agreement is examined through perceptions of good aid, how good aid works and the challenges faced. As discussed throughout my research, different donor partners have different models for aid delivery and this presents some opportunities for innovation, responding to challenges and in a rethought aid process. I also highlight issues that were surprising, such as participant's reflection on participation within a partnership model and suggest some implications of my work on existing knowledge, in addition to future research and practice. I will also indicate where limitations have impacted my research.

I have examined whether the partnership model leads to better decisions by exploring the policy context, specifically aid policies in the health sector in Samoa and their contribution to promoting a healthy population.

Furthermore I have also considered Samoa's health policy development in the context of Lewis and MacPherson's (2008) work on revolutions and globalisation in health policy to assess the impact of this policy change in Samoa. Beginning with a broad definition of aid as any provision of foreign exchange or goods and services from a developed country to one termed as developing and, where there is no obligation to be repaid. (Liuvaie, 2009) My focus on partnership and participation has included a case study of the Samoa Health SWAp, comparing and contrasting with other donor partners as appropriate, to understand the aid processes and how partners conceptualise, administer, deliver, monitor and evaluate outcomes. I looked at the experiences of three groups – aid personnel, practitioners, and NGOs – who believe in good aid, highlighting where differences between groups and even within groups arose. I also looked at the partnership model at work and how the aid process works currently. Drawing on multiple levels of health aid disbursement, I identified challenges in implementing the partnership model successfully in Samoa. In this chapter my discussion will include how these challenges and opportunities might contribute to a strengthened partnership model in Samoa.

Despite changing aid architecture, few have investigated the effects or the process of implementing these changes (Sjöstedt, 2013). This is also a critical precursor to the analysis of how the partnership model has impacted and also rethinking aid delivery. Throughout this study I have drawn on both the literature and the interviews with 14 participants representing aid personnel, practitioners and Non-Government Organisations who responded to the following objectives:

- To critically examine the role, rationale, philosophies, policies and expectations of aid donors, recipients and other players in the conceptualisation, planning and delivery of health aid in Samoa.
- To explore the relationship between aid and health in Samoa (e.g. decisions regarding priority, design implementation and evaluation, and relationships with other health donors) and how these reflect national partner's aims and expectations and achieve robust health outcomes. The influence of culture as a factor in aid delivery is a consideration here.
- To rethink how aid could be better conceptualised and delivered to enhance outcomes for the future.

## **Findings**

Responding to the serious health situation in Samoa, all participants had strong ideas of what good aid was and how it worked. Participants identified that good aid was participatory, including ownership and leadership, with access, predictability and sustainability on the ground including human resource. Good aid was perceived to work with a collaboration and consultation, prioritisation, capacity building, and monitoring and evaluation focus.

The application of the Paris Declaration highlighted the challenging points in the models currently espoused specifically collaboration, human resources and systems. Assessing what can be done involves continuing to build on previous work while trialing new approaches and acknowledging limited resources and global regional policy as well as political leadership.

Using the Paris Principles of Aid Effectiveness as my evaluating framework to explore factors which would support the effective health aid delivery it was notable that despite strong understandings of what good aid was knowledge and articulation of these and subsequent aid principles was limited to those in senior strategic

roles with government. New Zealand aid personnel also strongly supported and utilised in their own work Paris and subsequent aid principles.

Those in front line and operational roles carried out their roles with a focus good aid as related to their role and focused on day-to-day tasks. Those in operational roles did not feel part of the health system as a whole and were largely excluded (due to time and relationships) from strategic discussions where principles would have featured. Regardless of principle awareness, participants thought that good aid encompassed principle ideals of ownership, access and predictability, which supports the literature in this area.

Rethinking aid must include improving monitoring and evaluation provides opportunity to manage for results with the right information and systems to support and inform decision-making. Improving the quality of information will be central to enhancing monitoring and evaluation as well as a range of other areas including collaboration and relationships. The capacity to implement and use these systems will also be crucial to maximising this opportunity.

Rethinking aid must include a concerted focus on collaboration and consultation and improve relationships by seeking to bring all partners together, maximising buy-in, and making central trust and ownership by stakeholders. Alongside this it will be important to acknowledge that coordination takes both time and effort and can involve trade-offs when not within stakeholder's core role.

All participants recognise the importance of collaboration and consultation to good aid and improving collaboration and consultation would have a positive impact on other challenges such as capacity. Participants unanimously identified capacity as central and as such a wide-ranging focus is needed.

### *The unexpected*

As referred to earlier in the previous chapter, participants on the ground in Samoa, sometimes placed different emphasis and context on elements of the partnership model in contrast with OECD (2005; 2008; 2001) definitions. While the partnership model and related aid declarations highlighted the central nature of participation, those interviewed placed less emphasis on the fact of their participation in the decision-making process and more importance on issues that emerged within the process.

While the literature highlighted the multiple understandings and debate over aid which often co-exist at a high level, those involved in aid decision-making in Samoa were unified when describing aid's objectives and Samoan ownership of the process, which aligned with the ownership principle consistent. Participants identified directly or indirectly the association between health aid and the Health Sector Plan. Both donor and recipient partner participants spoke about the aid relationship and arrangements in an ongoing way and participants did not discuss alternative models for aid provision. Good aid was discussed in detail and reflected here and very much within the context of the prevalent partnership model.

Despite some discussion of the Paris Declaration, it was also interesting that participants did not explicitly refer to the existence or implementation of regional aid effectiveness principles, though the Paris Declaration was acknowledged by some. However, the importance placed by participants on ownership, predictable aid, and monitoring and evaluation frameworks are in fact consistent with regional principles. (PIFS, 2007) Further more

participants did not discuss international aid targets such as the Millennium or Sustainable Development Goals preferring instead to HSP objectives.

The Samoan culture or Fa'a Samoa was not discussed in any detail either. Though culture was envisaged as a significant factor for exploration with participants to identify how to build on successful cultural elements in decision-making, culture was not universally highlighted across decision-making as significant. In specific contexts it was highlighted as important, New Zealand Aid Personnel associated culture as central to relationships and the view of practitioners was that culture was important at village level engagement and service delivery.

Though participants described good aid within the context of the partnership model, it is also important to note that some components of good aid reflected in the literature were not highlighted by participants. The Mutual Accountability principle highlights aid relationships embedded in accountability mechanisms and slow progress in this area was reported due to ambiguous processes and responsibility definition. This concern was reinforced when participants did not highlight accountability mechanisms and good aid raising the question of whether responsibility definition, in particular is an issue for consideration. This is also associated with participant's lack of discussion about participatory processes and whether and how the public's perspective was part of the decision-making process. It is a limitation of the study that these questions were unable to be asked of aid users.

Within the managing for results principle, good governance is considered by those such as Neumeyer (2003) who described it as respecting the political, civil and human rights of citizens, consistent with the rule of law and placing emphasis on and associated with the harmonisation principle also in terms of building institutions and establishing governance structures as the basis for decision making. (Liuvaie, 2009; Ministerial Review Team, 2001; OECD, 2003) However this was not raised within good aid discussions, though the importance of consultation identified by UNESCAP (2012) was referred to by some participants though not connected to good governance. Aid users' assessment of health aid good governing would be an interesting future enquiry.

## **Recommendations for further research**

Drawing on research findings a number of recommendations for further research are as follows:

### *Health Sector Planning – Engagement and Integration*

While the issue of donor proliferation is not as pronounced as that referred to by the World Bank, (2008) it is important to research where and how greater integration with other partners may increase implementation capacity and support increases in both economic and human resources.

It is recommended that relationships and communication, consultation and collaboration mechanisms be captured through the development of an *engagement strategy* going forward. There is a demonstrated need for this to reinforce ownership, improve relationships and prioritisation methods, enshrine consultation with all groups, consolidate trust, define roles across the sector, and develop shared understandings and outcomes as well as developing principles setting out how consultation and collaboration occurs at all levels

An engagement strategy would involve:

- new partners into the Health Sector Plan, SWAP and their Governance arrangements and preserving partnerships between Governments;
- NGOs brought into planning in a formal way for example membership on key strategic and operational groups;
- definition of partner's roles and responsibilities;
- discussion and shared understandings around issues such as good governance;
- support improved monitoring and evaluation.

Currently NGOs have little inclusion in health planning and this impacts in a range of ways including NGO's minimal access to funding under a SWAp model. (Agha, Foresti, & O'Neil, 2006) Engaging partners and defining roles will allow all partners to play a formal part while confirming ownership not being impinged on. Working towards this strategy will also allow questions of integration to be considered by all within a clear framework to identify where integration is desired and the rationale, priorities and actions required for this to occur. An engagement strategy will also address issues raised by specific groups, such as the importance of sustainability to practitioners, and the importance of being heard and having debate which was raised by the sector. Developing an *engagement strategy* would also provide a relationship basis, and the time, and space to discuss difficult decisions about spending and the potential consolidation of programmes. One area of focus and potential consolidation is NCDs, including the unravelling of the various types of pool, non-pool, development policy and also the other partners who exist as demonstrated by the numerous groups who are involved in the NCD work discussed earlier. Additionally it would create space to discuss and debate necessary but apparently unaligned programmes such as the Medical Treatment Scheme. This could also potentially address concerns raised in the literature review about distorted funding priorities and support costed planning. Development of such a strategy would also allow for discussion on whether and how funding might be could be allocated around strengthened relationships such as providing funding direct from Ministry of Health to NGOs.

### *Chinese aid*

Further research on the potential for Chinese partnerships as outlined in the engagement strategy above should be undertaken. Research about this relationship specifically is particularly important as little knowledge currently exists. Further studies might look at expansion in Samoa's relationship with China to a broader range of areas which are firstly and including the Chinese more formally in common planning and decision-making may improve health outcomes through greater efficiencies (through for example Chinese specialists offering treatment in Samoa or Samoa patients receiving treatment in China) and more informed planning and service delivery (through better data collection systems). Secondly, greater Chinese involvement in planning and shared design and delivery particularly creating complementary activities and agreement on how high level objectives related to operational objectives and activity would enact the partnership model and provide Samoan opportunities for improved alignment and harmonisation.

### *Workforce*

Capacity was a critical factor in the delivery and access to quality health services made more difficult by significant levels of outmigration of planning and clinical staff. (Connell & Negin, 2009) Small numbers of planning staff were one issue which presented a specific obstacle in managing for results and addressing and strengthening capacity requires a broad and strategic outlook to decision-making by the Samoan government.

It is recommended that a cross government or health sector workforce development plan (starting from students undertaking health tertiary study) be developed to integrate capacity throughout decision-making in a concerted way with specific capacity objectives and targets to reinforce ownership. A strategy to inform forward planning - forecasting is urgently needed and would also support capacity based improvements in monitoring and evaluation and systems development and maintenance. Research to inform such a strategy should look at human resources over last 10 year period as basis.

### *Culture*

Participants said elements of Fa'a Samoa were within everything and were integral in gaining community buy in at village level. Collaboration on the ground however has been complex and cultural models of top down driven collaboration and seniority led relationships also present some challenge to partnership and collaboration. Culture was not explored however in depth in this thesis and further research might look more closely at culture in health service delivery. This could include for example a) review of health literacy generally and b) any culturally related challenges and enablers in the identification and the effective delivery of health aid. Eventually this could also result in clinical guidelines on to incorporate cultural concepts to support health literacy. There may also be value in a broader study looking at the interplay between culture and public services as important considerations in policy making. .

Traditional leaders and decision-makers are not universally visible or positioned according to documents and participants however elements of Fa'a Samoa are said to be within everything also according to the literature and are integral in gaining community buy in at village level. Further research might look more closely at culture in health service delivery and firstly scope the state of health literacy in Samoa and secondly identify Samoan culture relevant to health promotion and provide options about how the two could be brought together in specific actions to improve health outcomes. Eventually this could also result in clinical guidelines on how to incorporate cultural concepts to support health literacy. There may also be value in a broader study looking at the interplay between culture and public services as important considerations in policy making. . Culture is still an integral part of life in PICTs and my study also explores whether culture does or could play a role in the decision-making to improve allocation decisions. (Lasry, Carter & Zaric, 2011)

### *Gender and youth*

The impact of gender and youth particularly the youthful nature of the Samoan population was out of scope for this study however it is evident that with huge youth numbers for example, research into where best to put limited resources to plan for and address current and future needs of this group is needed. It is recommended that future data be disaggregated by gender and age study be carried out to identity current state of health to inform future planning.

## **Research implications**

This study has emphasised the paucity of Samoa-led reviews, reflecting a similar absence of recipient country-led reviews globally. Consistent with the Paris and subsequent Declarations, and together with the strong sense of ownership which already exists amongst Samoan participants in this study, further research might build on the Forum Island Country peer reviews currently being undertaken and usefully track the development of ownership in the context of Samoa-led reviews and the impact that this growth has on future decision-

making. Multiple roles, and how people can have capacity for decision-making too, might be considered for investigation.

Future research may also explore further the unintended effects arising from aid effectiveness principles. As mentioned previously, 'The Inverse Sovereignty Effect: Aid in the Pacific' project assesses the effects of development aid on the economic and political sovereignty of Pacific countries (Embassy of France in Wellington, 2014) and my findings regarding the Health Sector in Samoa have relevance to this. The impact of ambiguity in donor partner's roles in official documents might be explored as a potential factor in diminished ownership, in terms of giving rise to leadership in implementation. Discussing whether and how this is an issue, and addressing it, will allow focus on and dialogue to define what good aid practice means and will also allow analysis of possible changes to decision-making processes.

The inability of current research to attribute investment to outcomes is an important question in future research which is inextricably involved with monitoring and evaluation. Research which explores what aid can or should contribute to, or be attributed to, as well as the place and value of soft outcomes such as attitude change, is an important investigation, particularly where all partners are under increasing impact to show aid's investment value.

Further research and most likely at the end of term review of SWAp should consider whether further decentralisation should take SWAp out of MOH. Potential changes to roles and responsibilities must combine the literature with the perspectives of MOH, NHS practitioners and NGOs to identify whether a new organisation is required for coordination, and the positioning of any new organisation and the revision of roles and responsibilities across the sector.

Associated with this, further research on the CSO role in Samoa and its impact, is significant for building and entrenching participation in future decision-making. Conceptualisation of participation and other facets of good aid warrant further research to identify how those on the ground view the roles of various stakeholders in aid decision-making processes and how this connects with improved health outcomes.

The evidence presented in this research about the application of the partnership process as outlined in the Paris Declaration raises inevitable questions about whether this is the right model for the Pacific and further research might look across PICTs and identify whether similar complexities exist and their impact on outcomes. This may support the need for a broader assessment of aid declaration's suitability for PICTs within the OECD framework and whether participatory models of this type add significant value. Any reassessment would however have to contend with the viability of developing an alternative model which would be agreed to by PICTs, donor countries and donor organisations. This chapter seeks to assess and discuss what can be done within the existing international framework.

## **Research limitations**

This research is a case study of only one country and while findings may be relevant to other PICTs, no direct comparison has been constructed within this research. As a starting off point however there are comparable situations which have been studied within other small island nations.

As discussed in the introduction to this research, there have been limitations on what document evidence has been made available. Other contemporary reviewers have had access to a wider range of documents however, document control issues have been cited with these. I was fortunate to have access to a range of participants not interviewed by other studies, though some had been in their roles for less than the period I had sought in my original study design. Despite the range of people interviewed I was unable to access Chinese donors, due to the ethics restrictions imposed. This would be an interesting avenue for future investigation, particularly given the flow of Chinese donor information during the last part of my study. Though I could have looked at other donors or multiple donors, I decided to focus on one primary and one secondary donor to place greater emphasis on the relationship between small numbers of partners. Additionally, I was unable to interview aid users and this would provide a fascinating avenue for future investigation particularly in terms of participatory processes.

My research period is also notable in its recent nature; however, I felt this was valuable in order to assess how a contemporary model was functioning within the current period and to consider future directions. My period of fieldwork coincided with a number of reviews, and therefore it is possible that some participants who were interviewed by multiple researchers were fatigued. However, when I met participants face to face they were fully engaged with this area of discussion.

Potentially however, the next insightful review will come at the conclusion of the Health Sector Plan cycle when both the Health Sector Plan and first SWAp have been completed in their entirety. The literature review and the participant experience of these contradictions with the partnership aid model created the need for further investigation and dialogue between aid partners about whether this is an issue, how this is an issue and how this can be addressed. This discussion will allow focus on and allow for dialogue to define what good aid practice means and analyse possible changes to decision-making processes. Regional efforts at improving aid effectiveness have supported these complications and a critical assessment of their role and relevance must be undertaken as part of rethinking aid.

Within the Paris principles there are further opportunities which also exist for further strengthening monitoring and evaluation as well as expanding relationships with newer donor partners such as China. While this research adds to what is currently a paucity of work in this area, it has also highlighted multiple perspectives and areas for further information gathering. Further Samoa-led reviews will add to the richness of participants' voices which my study has brought out and continuing work into the 'inverse sovereignty effect' will identify the longer-term and the on the ground impacts of the Paris principles ownership application. Contribution and attribution research would be a logical next step into identifying whether and how in the long-term aid is impacting and further work into the potential for ongoing decentralisation would align with both the views of some participants and international literature on the positive impact of decentralisation.

A limitation of this work includes its case study method and the absence of Chinese donor partner and aid user perspectives. It is also important that alongside its recent nature it was in the midst of a number of reviews, with a significant end of health sector plan and SWAp review still to come.

My fieldwork was also impacted by Cyclone Evan were many of those interviewed were unable to be interviewed during my fieldwork period and those who were spoken to were playing multiple roles and were diverted to some extent from day to day business as usual activity and were working extended hours.



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## **Appendix One Interview schedule**

Questions for interviews with aid partners and local practitioners and NGOs

### ***Your role***

What is your position in your organisation?

How long have you worked here?

How is your organisation involved in the aid process?

What does your organisation expect to achieve from aid delivery?

What is your role/ roles in donor discussions / programmes?

Does your organisation have a 'set of guidelines' or 'guiding principles' when considering a project? Tell me about these.

### ***Perceptions of the aid process***

In your view, what would be the three main things you look for in a good aid project?

Are you always able to achieve these? Why? Why not?

What would be three things that would mark a not so good project?

### ***National Aid Guidelines and frameworks***

In your experience, what is the usual process followed when donors come to talk about health aid? (steps)

Did you find donors receptive to local ideas about a) programme focus b) how a programme should be carried out and c) location?

Yes / no and give reasons for your answer please.

Sometimes nations agree to carry out projects which might not have been a main national priority at the time.

Can you recall a time when this might have happened?

Yes/ No and please provide examples if available?

In your view, has the faaSamoa culture influenced the ways decisions have been made at all?

Yes / No and please give reasons/ examples (both positive and negative)

### ***Your views***

What aid do you think is important to build effectiveness in health sector in Samoa?

Why do you prioritise these areas?

How would you define high quality health aid in Samoa?

Give reasons for your answer

How do you measure high quality health aid?

Give reasons for your answer

How do you get the data to measure progress and how is this reported back? (do you ask the doctors, the health planners, the people in the street, look at hospital data etc)

How do you report back to donors?

### **Culture**

Have the health projects you have been involved with incorporated a Fa'a Samoa in any way Yes/ No. Give reasons for your answer

Has the faaSamoa impacted on how health aid has been used? Yes/ No. Give reasons

### **Collaboration and partnerships**

How do you work together?

What are the main agencies your department works with in aid planning and implementation?

List and discuss

Have you heard about the SWAP? Yes/ No If so, what are your views about the benefits of SWAP

Thinking about organisations working together through arrangements like Sector Wide Approaches, (SWAPs).

Do you think this arrangement has impacted on your work? If so how?

Has this impacted on the project's effectiveness?

Do you think that the SWAP model could be extended? If so how?

### **Effective aid**

How does Samoa measure effective health aid?

Why?

Do you agree with this - why and why not?

Thinking about partnerships and international agreements like the Paris Aid Declaration how have principles like ownership and managing for results and impacted on your aid work and aid relationships?

## Appendix Two: Ethics Approval



### M E M O R A N D U M Auckland University of Technology Ethics Committee (AUTEC)

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To: Peggy Fairbairn -Dunlop  
From: Rosemary Godbold, Executive Secretary, AUTEC  
Date: 30 October 2012  
Subject: Ethics Application Number **12/274 Aid and Health in Samoa: A study of New Zealand and China Health Aid 2000-2012.**

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Dear Peggy

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the point raised by a subcommittee of the Auckland University of Technology Ethics Committee (AUTEC) and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement by AUTEC at its meeting on 12 November 2012.

Your ethics application is approved for a period of three years until 30 October 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 30 October 2015;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 30 October 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at <http://www.aut.ac.nz/research/research-ethics/ethics>).

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold  
Executive Secretary  
**Auckland University of Technology Ethics Committee**  
Cc: Odette Frost [odette.frost@krusenet.com](mailto:odette.frost@krusenet.com)

# Appendix Three: Consent Form



*Project title: Aid and Health in Samoa: A Study of New Zealand and China Health Aid 2000 – 2012*

*Project Supervisor: Professor Peggy Fairbairn - Dunlop*

*Researcher: Odette Frost*

- I have read and understood the information provided about this research project in the Information Sheet dated 25 September 2012.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes  No

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....  
.....  
.....  
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on 30 October 2012 AUTEK Reference number 12/274**

Note: The Participant should retain a copy of this for

## Appendix Four: Information Sheet

### Participant Information Sheet



19 October 2012

#### **Aid and Health in Samoa: A Study of New Zealand Health Aid 2000 – 2012.**

Talofa lava, my name is Odette Frost and I am inviting you to participate in my PhD research on Aid and Health in Samoa. I work for the Ministry of Pacific Island Affairs in New Zealand but the information you provide is for the purpose of my PhD research only. Your participation is voluntary and if you agree to participate you may withdraw at any time prior to the completion of data collection.

This research will contribute to my PhD thesis. I am examining New Zealand aid to health in Samoa and how Samoan and donor partners plan, administer, deliver, monitor and evaluate health aid. My research will focus on health planning, partnership approaches to health and health services. To explore these issues I aim to interview health planners, practitioners and community members who have been users of donor provided health services. I have been awarded a New Zealand Aid Programme Postgraduate Fieldwork Award to undertake these interviews.

#### **How was I identified and why am I being invited to participate in this research?**

You have been identified as someone who has been involved in health aid planning, and programmes in Samoa. Your name and contact details were given to me by another participant. You were identified due to your involvement in the health aid decision making process for two years or more in the 2000-2012 period.

#### **What will happen in this research?**

For my research I will be carrying out individual interviews. These will take not more than an hour and will be arranged at a time and place that is convenient to you. I will send you the question schedule before the interview takes place.

#### **What are the discomforts and risks?**

The interviews will be totally confidential. Additionally I will not engage in any casual conversation in relation to interviews or interview material and will take care to ensure that the interviews are not overheard in any way shape or form.

If during the interviews there are any questions you do not feel comfortable to answer you will be free to decline to answer these question(s). There's a low risk you may feel embarrassed about the sensitive nature of this topic and you have the opportunity to discontinue your answer, not answer questions, or stop the interview whenever you like.

#### **How will my privacy be protected?**

Your privacy will be protected by excluding your name, position and organisation from this research. A pseudonym will be attached and participants will be known by as a member of one of the three groupings, aid partner, practitioner or community group.

Additionally, your employer will not know that you have participated in this research. While we cannot guarantee your anonymity, all steps will be taken to do so. I will not engage in any casual conversation in relation to interviews or interview material.

**What are the benefits?**

It is anticipated that research findings will contribute to improving health outcomes in Samoa. The research also provides you with an opportunity to reflect on how the work you are involved in is contributing to better health outcomes for Samoan people. This interview will contribute to my (Odette) PhD research.

**What opportunity do I have to consider this invitation?**

I will contact you to find out whether you are available for interview in one week.

**Will I receive feedback on the results of this research?**

I will provide you with a transcript of our interview for your approval and summary research findings will be distributed to you also for your consideration.

**How do I agree to participate in this research?**

If you agree to participate in the research when I contact you on the day of our interview I will provide you with a Consent Form to fill in and sign.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Tagaloatele Peggy Fairbairn – Dunlop, [peggy.fairbairn-dunlop@aut.ac.nz](mailto:peggy.fairbairn-dunlop@aut.ac.nz) (0649) 921 9999 extn. 6203.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Dr Rosemary Godbold, [rosemary.godbold@aut.ac.nz](mailto:rosemary.godbold@aut.ac.nz) , (0649) 921 9999 ext 6902.

**Whom do I contact for further information about this research?*****Researcher Contact Details:***

Odette Frost

[Odette.frost@krusenet.com](mailto:Odette.frost@krusenet.com)

Faafetai lava for your consideration.

**Approved by the Auckland University of Technology Ethics Committee on 30 October 2012, AUTEK  
Reference number 12/274.**

## Appendix Five: New Zealand Assistance to Samoa

Sector Assistance (Ministry of Foreign Affairs and Trade, 2013)	Samoa 2002-2012 (Ministry of Foreign Affairs and Trade, 2013)
Agriculture, Forestry and Fishing (NZD\$238,858)	<ul style="list-style-type: none"> <li>• Samoa Small Enterprise Development</li> </ul>
Banking and Financial Assistance (NZD\$655,841)	<ul style="list-style-type: none"> <li>• Small Business Enterprise Centre – 2011 – 2016</li> </ul>
Business and other services (NZD\$2,800,000)	<ul style="list-style-type: none"> <li>• Small Business Enterprise Centre</li> <li>• Private Sector Review Assistance</li> <li>• Private Sector Support Facility</li> <li>• Private Sector Review Assistance</li> <li>• Women in Business Development Advanced Training</li> </ul>
Communication (NZD\$100,000)	<ul style="list-style-type: none"> <li>• Televised Samoa</li> </ul>
Disaster prevention and preparedness (NZD\$1,642,476)	<ul style="list-style-type: none"> <li>• Tsunami response</li> </ul>
Education (NZD\$71,115,304)	<ul style="list-style-type: none"> <li>• Training</li> <li>• Scholarships</li> <li>• Curriculum Development</li> </ul>
Emergency Assistance (NZD\$60,000)	<ul style="list-style-type: none"> <li>• National medical centre &amp; Ministry of Health headquarters (USD\$56.96 million)</li> </ul>
Energy Generation and Supply (NZD\$87,214)	<ul style="list-style-type: none"> <li>• Feasibility study and design</li> </ul>
Environment (NZD\$381,565)	<ul style="list-style-type: none"> <li>• Conservation project</li> </ul>
General Budget Support (NZD\$7,133,288)	<ul style="list-style-type: none"> <li>• Post Tsunami budget assistance</li> <li>• Budget support trial</li> </ul>
Government and Civil Society (NZD\$9,644,651)	<ul style="list-style-type: none"> <li>• Courts strengthening</li> <li>• Training</li> <li>• Review</li> </ul>
Health (NZD\$15,365,809)	<ul style="list-style-type: none"> <li>• Medical Treatment Scheme</li> <li>• Renal health</li> <li>• Child health</li> <li>• National hospital</li> <li>• Population policy and reproductive health</li> </ul>
Industry/Mining/Construction (NZD\$101,485)	<ul style="list-style-type: none"> <li>• Handicrafts Association</li> </ul>
Other multi sector (NZD\$1,280,011)	<ul style="list-style-type: none"> <li>• Special Projects</li> </ul>
Other Social Infrastructure and Services (NZD\$930,244)	<ul style="list-style-type: none"> <li>• Human Resource Strategy</li> <li>• Training</li> <li>• NGOs</li> </ul>
Support to NGOs (NZD\$3,823,714)	<ul style="list-style-type: none"> <li>• NGO support</li> </ul>
Trade/tourism (NZD\$4,632,339)	<ul style="list-style-type: none"> <li>• Tourism support fund</li> <li>• Rebuilding</li> <li>• Tourism development</li> </ul>
Transport and Storage (NZD\$1,900,600)	<ul style="list-style-type: none"> <li>• Air service support</li> </ul>
Unspecified (NZD\$298,385)	<ul style="list-style-type: none"> <li>• Inter – Government discussions</li> <li>• Cyclone Heta</li> </ul>
Water Supply and Sanitation (NZD\$218,784)	<ul style="list-style-type: none"> <li>• Water supply project</li> <li>• Engineer secondment</li> </ul>

## Appendix Six: China Assistance to Samoa

Assistance forms	Samoa 2006-2014
(Information Office of the State Council People's Republic of China, 2014)	(Brant, 2015)
Total Foreign Assistance appropriation: USD\$14.4 billion	Appropriation from China: USD\$207.99 million
<ul style="list-style-type: none"> <li>• Grants (36%)</li> <li>• Interest-free loan (8%)</li> <li>• Concessional loan (56%)</li> </ul>	<ul style="list-style-type: none"> <li>• Grant</li> <li>• Concessional loan</li> </ul>
<b>ASSISTANCE</b>	
Goods and materials	<ul style="list-style-type: none"> <li>• 10 schools</li> <li>• 1 sports complex</li> <li>• 1 aquatic centre</li> <li>• Parliamentary and Ministry of Justice and Courts Complex</li> <li>• National University of Samoa Marina Training Centre</li> <li>• Tooa Salamasina Hall</li> <li>• Convention Centre and Offices</li> </ul>
Technical cooperation	<ul style="list-style-type: none"> <li>• Samoa-China agriculture development demonstration farm project</li> <li>• Samoa national broadband highway project (USD\$22.51 million)</li> </ul>
Human resources development cooperation	<ul style="list-style-type: none"> <li>• Sports coach provision</li> <li>• Chinese language teachers</li> <li>• 16 engineers and technicians to assist with installing SIDS audio visual devices</li> </ul>
Emergency humanitarian aid	<ul style="list-style-type: none"> <li>• Road repair</li> </ul>
Assistance: Other (self-defined category)	<ul style="list-style-type: none"> <li>• SIDS Donation - provision of vehicles, communication and information devices, simultaneous interpretation equipment, generators, furniture, office equipment, and water tanks (USD\$6.45 million)</li> <li>• Head of State Funeral Donation (\$0.1 million)</li> <li>• Samoa 50 Years Independence (USD\$0.4million)</li> <li>• South Pacific Games vehicles (USD\$0.4 million)</li> <li>• 2009 Tsunami Relief Fund (USD\$0.13 million)</li> </ul>
<b>HEALTH ASSISTANCE</b>	
Medical Facility Construction	<ul style="list-style-type: none"> <li>• National medical centre &amp; Ministry of Health headquarters (USD\$56.96 million)</li> </ul>
Medical equipment and pharmaceuticals	<ul style="list-style-type: none"> <li>• CT Scanner (USD\$1.19 million)</li> </ul>
Medical teams dispatched	<ul style="list-style-type: none"> <li>• Chinese medical team (cost not specified)</li> </ul>
<b>REGION (Brant 2015)</b>	
Assistance: Human Resource Development and Cooperation/Medical Teams	

Source: Information Office of the State Council, People's Republic of China, 2014; Brant, 2015.

## Appendix Seven: Health Sector Plan Work Programme

### 1. HEALTH PROMOTION AND PRIMODIAL PREVENTION

**Objective: To strengthen health promotion and primordial prevention**

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
1.1.1	Effective healthy public policies developed and implemented	<p>Evidence of the implementation of the National Health Promotion and Prevention Council decisions.</p> <p>Develop and implement an infant and young child feeding policy.</p> <p>Develop and implement an Effective Communicable Disease Policy and Plan of Action</p> <p>Compliance with International Health Regulations</p> <p>Evidence of increasing healthy living practices</p> <p>Evidence of appropriate policies developed in response to emerging health issues, including health threats arising from increased urbanization</p> <p>Annual reduction in sales of tobacco in Samoa</p> <p>Implementation of legislative restrictions to passive smoking exposure in public places</p>	<p>MOH, all sector partners</p> <p>NCD Strategy and Action Plan</p> <p>MOH and all partners</p>
1.1.2	Improve environmental health	<p>Evidence of collaboration with and between health sector partners to create safe and healthy village environments for Samoan families and children</p> <p>Evidence of strengthened programs related to poverty, vulnerability and hardship</p> <p>Design and implement effective programs to reduce endemic typhoid, diarrhea, filariasis and tuberculosis in Samoa</p> <p>Design and implementation of programs to reduce all communicable diseases in Samoa</p> <p>Implement and monitor the Health Care Waste Policy</p> <p>Develop a Safe Water Policy and Plan of Action</p> <p>Evidence of improved water quality through testing and monitoring</p>	MOH, all sector partners

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
<b>1.1.3</b>	Community actions strengthened	<p>Evidence of collaboration with community, cultural, and religious social structures in health promotion and primordial prevention campaigns</p> <p>Evidence of community action to support improved diet and exercise options for Samoans – e.g. home fruit and vegetable gardens; work with school canteens</p> <p>Evidence of community initiated actions on health</p> <p>Evidence of collective advocacy on health</p>	MOH, all sector partners
<b>1.1.4</b>	Build up personal healthy life skills and choices for individuals	<p>Evidence of increasing healthy living practices</p> <p>Evidence of increasing sector partner programmes aimed to enhance life skills and healthy choices</p> <p>Evidence of increasing awareness on available health options and health choices</p> <p>Evidence of regular evaluation of the effectiveness of existing programs</p> <p>Annual reduction in amount of alcohol consumed and monitoring of meaningful indicators of alcohol-related injury and/or illness.</p> <p>Annual reduction in tobacco consumed and monitoring of indicators of tobacco related illnesses</p>	MOH, all sector partners
<b>1.1.5</b>	Continue and strengthen health services reorientation	<p>Evidence of the share of health responsibilities by district level health services and non-government health sector</p> <p>Increase over time in share of resources dedicated to health promotion</p>	MOH, all sector partners

## 2. STRATEGY: QUALITY HEALTH CARE SERVICE DELIVERY

**Objective: To improve access and strengthen quality health care delivery in Samoa**

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
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2.1.1	Control and manage selected communicable and non-communicable diseases	<p>Development in priority order of clinical protocols that are evidence-based, adapted to local conditions and cover the range of health care settings in Samoa, including specific patient referral pathways</p> <p>By 2018, all communicable and non-communicable diseases of significance in Samoa will be managed by these clinical protocols</p> <p>Protocols specify resource, staffing, training and technology implications and programmatic implementation</p> <p>Regular clinical audits of the implementation of these protocols</p> <p>Strengthen closer working relationships including negotiating referral pathways with traditional healers, involving village mayors</p> <p>Decrease hospital readmission and post-operative infection rates (NB This indicator will require development to PATIS hospital system report programming)</p> <p>Establishment of chronic disease registers and evidence-based programmes for screening and early intervention, including at least cancers, diabetes and rheumatic heart disease</p> <p>Compliance with International Health Regulations</p>	All health care institutions and agencies
2.1.2	Improved reproductive, maternal and child health	<p>Clinical audits of the implementation of safe motherhood protocols across health care system</p> <p>Increased intake of vegetables and fruits by households</p> <p>Increase in preschools and schools complying with school healthy food / canteen standards</p> <p>Increased availability of micro-nutrient fortified foods in shops (e.g. iodized salt, flour fortified with iron and other micro nutrients)</p> <p>Each annual audit shows evidence of increasing compliance of main hospitals with WHO/UNICEF Baby Friendly Hospital protocol</p> <p>Annual increase in the proportion of pregnant women attending ante natal clinics in the first 20 weeks of gestation</p>	<p>All health institutions and agencies, MWCS, Women's Committees in Villages and Traditional Birth Attendants</p> <p>MOH, MESC and partners All sector partners</p>

	Outputs	Indicator	Means of Delivery
		<p>Evidence-based interventions to reduce anemia in children are implemented</p> <p>Decrease in the proportion of babies born less than 2500 grams or over 4500 grams</p> <p>Annual decrease in the proportion of women attending antenatal clinics who are anemic at 36-40 weeks</p> <p>Strengthen closer working relationships including negotiating referral pathways with Traditional Birth Attendants, involving village mayors</p> <p>Increase in the proportion of babies exclusively breastfed at 5 months</p> <p>Annual decrease in the number of infants admitted to MTII and TTM hospitals with diarrhea and respiratory tract infections</p> <p>Annual increase in the proportion of babies fully vaccinated at 18 months to at least 90 % for all vaccines on schedule within 5 years</p> <p>Annual reduction in the incidence of rheumatic fever</p> <p>Annual increase in the proportion of rheumatic fever patients complying with treatment</p> <p>Develop and implement a national pap smear screening programme</p> <p>Develop and implement a national well women's health screening programme (to include pap smear, breast screening, blood pressure and blood glucose checks etc)</p> <p>Increase in the proportion of new school entrants who receive a comprehensive community health assessment</p> <p>Sexually Transmitted Infections programme designed, resourced and effective at measuring and then reducing prevalence rates</p> <p>Increase in the proportion of women using modern contraceptive methods</p> <p>Evidence of strengthened coordination of health services with family and children services in Ministry of Health</p> <p>Evidence of decreasing rates of children brought to hospital suffering from injuries</p>	

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
<b>2.1.3</b>	Improved health care physical infrastructure and equipment	<p>Establishment of an Asset Management Policy and Plan for all publicly funded health care facilities and equipment</p> <p>Priority medical equipment purchased/upgraded and utilised</p> <p>Establishment and monitoring of regular preventive maintenance programme for health care infrastructure</p> <p>Standardised physical infrastructure and equipment for different levels of care at referral and district level hospitals in line with services to be provided at these different locations and levels of health care</p> <p>Improve facilities and equipment at the national referral hospital (TTMH)</p>	<p>National Health Service</p> <p>All health care institutions</p>
<b>2.1.4</b>	Implementation of professional and service standards	<p>Applicable health services standards developed for each professional group and health service provider</p> <p>Performance indicators and/or audit strategy developed for each health profession</p> <p>Regular, timely and comprehensive reports by NHS and other health services against these performance indicators to MOH</p> <p>Evidence of policy and regulatory action taken by MOH in response to performance reporting</p> <p>Quarterly clinical audits completed and aggregated results reported to MOH, highlighting areas of concern</p>	All health care institutions and agencies
<b>2.1.5</b>	Skilled and competent health professionals and support staff	<p>Increase in number of Samoan students undertaking health-related studies</p> <p>Reduction in staff turnover rate in all health sector employees every year</p> <p>Development and Implementation of appropriate career paths for health workers</p> <p>Median age of staff cohorts, reflecting succession planning and workforce sustainability</p> <p>Professional supervision structures and processes for both clinical and professional staff developed reflecting professional standards</p> <p>Implementation of staff appraisals for MOH and NHS staff</p> <p>Progress toward workforce progress targets across the health sector, starting with their development</p>	<p>Academic institutions including in particular NUS and OUMS</p> <p>All health care institutions and agencies</p>

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
<b>2.1.6</b>	Accessibility and affordability of healthcare services and supplies	<p>Improve public access for all Samoans to publicly funded health care facilities with clear guidelines on accessibility and affordability, complementary to private sector</p> <p>Elimination of deficits in NHS Pharmacy stock of WHO Essential Medicines list</p> <p>Development of public dental health program with clear guidelines on accessibility and affordability, complementary to private sector</p>	<p>MOH</p> <p>NHS</p> <p>NHS, MOH and All health care institutions/agencies and sector partners</p>
<b>2.1.7</b>	Strengthened community healthcare sector	<p>Development of community health capacity and programme activities and standards in Districts</p> <p>Development and implementation of distinct roles, standards and workforce for District hospital services and development and implementation of referral protocols for patients being referred to MTII and TTM hospitals</p> <p>Increase in the proportion of suspected mental health cases referred to the mental health unit who are followed up</p> <p>Rate and type of preventable hospital admissions decrease consistently over the plan period</p> <p>Reduction in the rate of amputation amongst diabetics as a measure of system of care effectiveness</p>	<p>MOH and NHS</p> <p>All providers</p>
<b>2.1.8</b>	Essential clinical and diagnostic supportive health services	<p>Establishment and annual progress in the implementation of a development programme for laboratory, pharmacy, sterilisation, radiology and allied health services</p> <p>Service standards for each of these services established and implemented</p>	<p>NHS</p> <p>MOH and NHS</p>
<b>2.1.9</b>	Establish Consumer Complaints and Community Engagement for health care services	<p>Consumer complaints mechanism required by MOH Act designed and implemented</p> <p>Decreased Rates of complaints received by MOH</p>	MOH

### **3. GOVERNANCE, HUMAN RESOURCE FOR HEALTH & HEALTH SYSTEMS**

**Objective: To strengthen regulatory governance and the leadership role of the Ministry of Health**

	<b>Outputs</b>	<b>Indicators</b>	<b>Means of Delivery /Responsible Agency</b>
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<p><b>3.1.1</b></p>	<p>Strengthened strategic linkages with other sectors and sector partners</p>	<p>Health Sector Plan (HSP) approved, funded and implemented</p> <p>Evidence that sector partners' Corporate Plans, development partners plans, govt. investment are increasingly aligned with HSP</p> <p>MOUs and Contracts agreed and implemented with sector partners and service providers to reflect this alignment</p> <p>Coordinating and financial planning role of MOH strengthened</p> <p>NGO health sector strengthened as integrated component of health system</p>	<p>MOH and all sector partners</p> <ul style="list-style-type: none"> <li>- through Corporate Plans</li> <li>- country level application of Strategies</li> </ul> <p>MOH</p> <p>All partners</p>
<p><b>3.1.2</b></p>	<p>Increased accountability and transparency at all levels</p>	<p>Sector partner specific Communication Strategies developed, approved and implemented</p> <p>Internal &amp; External audit reports reveal good financial probity including procurement</p> <p>Public Service Commission monitoring finds appropriate implementation of human resource policies</p> <p>Ministry of Finance &amp; Audit offices monitoring finds accurate financial accounting, reporting and probity</p>	<p>MOH and all sector partners</p>
<p><b>3.1.3</b></p>	<p>Increased availability of appropriately qualified and skilled health workforce</p>	<p>Human Resources for Health Plan 2008-2015 developed, approved and implemented</p> <p>Increase over time of qualified specialists in Samoa, consistent with priorities identified in the Human Resources for Health Plan</p> <p>Increasing utilisation of Samoa nationals with relevant expertise and competencies to fill key positions in Samoan health sector</p> <p>Professional credentialing for health service providers introduced for all professions and strengthened</p> <p>Evidence of continuing professional education and competency based re-credentialing</p> <p>Evidence of increasing numbers of midwives to meet demand.</p>	<p>MOH and other health sector partners</p>

	<b>Outputs</b>	<b>Indicators</b>	<b>Means of Delivery/Responsible Agency</b>
		<p>Develop, approve and implement Health Service Marketing Strategy to aggressively attract Samoans to health careers</p> <p>2 yearly review of the implementation of Human Resources for Health Plan 2008-2015</p>	
<b>3.1.4</b>	Effective statutory bodies	<p>Accountable and effective Professional Boards/Councils established under legislation:</p> <ul style="list-style-type: none"> <li>- NHS, Medical, Nursing, Dental, Pharmacy, Allied Health Service Providers</li> </ul> <p>MOH monitoring reports and NHS reports to NHS Board &amp; CEO indicate quality standards being met within budget with transparent due diligence</p>	MOH, all sector partners
<b>3.1.5</b>	Evidence-based policies, monitoring and regulatory frameworks	<p>Consolidate and communicate existing policies across health sector</p> <p>Establish performance monitoring and regulatory framework for MOH with NHS and all other health service providers</p> <p>Evidence of performance monitoring leading to policy and regulatory action to improve health services</p> <p>Professional and Service Standards developed, approved and implemented for all health service providers</p> <p>Evidence of effectiveness of monitoring and regulating by MOH</p>	<p>MOH, sector partners</p> <ul style="list-style-type: none"> <li>- regional &amp; international strategies</li> </ul>
<b>3.1.6</b>	Legislative framework in place	<p>All health-related legislation reviewed and updated by 2008</p> <p>Evidence of sound administration of legislation, including legislation specified in Schedule 1 of MOH Act 2006</p>	<p>Ministry of Health and Attorney General's Office</p> <p>MOH</p>
<b>3.1.7</b>	Strengthened national educational institutions	<p>Evidence that National University of Samoa, Faculty of Nursing and Health Science and Oceania University of Medicine curriculum are acceptable to health professions, employers and students</p> <p>Curriculum quality assured by Samoan Quality Assurance Authority</p> <p>Increase in yearly numbers of new health graduates in all health professions</p>	MOH, Academic institutions

	<b>Outputs</b>	<b>Indicators</b>	<b>Means of Delivery/Responsible Agency</b>
<b>3.1.8</b>	Health Systems Strengthened in Samoa	<p>Health sector research and surveillance capacity improved for evidence-based policy and clinical strategies.</p> <p>Establish information database on all Human Resources for health in Samoa</p> <p>Compliance with health-related regulations and conventions endorsed by Samoa – Compliance IHR, CRC, CEDAW, WHO, Tobacco Free Initiative etc.</p>	MOH, all sector partners

#### **4. PARTNERSHIP COMMITMENT**

**Objective: To strengthen health systems through processes between the Ministry and health sector partners**

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
<b>4.1.1</b>	Complementarities in sector planning	Health indicator links evident in other sector plans and policies	All sector partners
<b>4.1.2</b>	Strengthened communication and collaboration	<p>Sector partner-specific Communication Strategies implemented</p> <p>Evidence that private practitioners are effectively utilised in public sector, where cost effective</p> <p>Effectiveness of National Councils and Advisory Committees in health</p> <p>Strategic Sector policies and strategies widely consulted and approved</p> <p>Public feedback is positive</p>	All sector partners
<b>4.1.3</b>	Effective response to international and regional programmes	<p>International and regional initiatives translated and applied where appropriate to sector programmes</p> <p>Sharing of information on development assistance funding schemes and programmes</p>	All sector partners

## 5. FINANCING HEALTH

**Objective: To improve health sector financial management and long-term planning of health financing**

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
<b>5.1.1</b>	Improve equitable allocation of resources	<p>Funding allocation based on well researched health priorities guided by governance principles</p> <p>Establish benchmarks for accessibility and affordability for vulnerable groups and annually monitored against these benchmarks</p> <p>National Health Accounts produced every two years and findings incorporated into health financial decision-making by government and health care financiers</p>	MOH, all sector partners
<b>5.1.2</b>	Improvement on efficiency, accountability and transparency of the health sector	<p>High Standards of Performance measures monitored and reported</p> <p>Partner-specific Performance management system implemented</p> <p>Sector partner-specific Communication Strategy implemented</p> <p>Evidence of outsourcing and subcontracting based on performance, efficiency and cost effectiveness</p> <p>Audit reports verify compliance with GOS probity requirements</p> <p>Effective Contractual relationships between the MOH and partners in place including monitoring systems to ensure safety of practice and most effective/efficient use of financial resources</p> <p>Public feedback</p>	MOH, all sector partners
<b>5.1.3</b>	Long-term financing plan for Samoa health sector	Health Resourcing Policy and Action Plan developed and implemented, led by Ministry of Health	MOH all health service with providers

**6. DONOR ASSISTANCE****Objective: To ensure greater development of partner participation in the health sector**

	<b>Outputs</b>	<b>Indicator</b>	<b>Means of Delivery</b>
<b>6.1.1</b>	Increased donor participation in health	Evidence of 10% increase in effective donor assistance to the sector  Increased harmonisation of donor assistance with government prioritised areas  Evidence of country-led as opposed to donor-led assistance	MOH, all sector partners
<b>6.1.2</b>	Increased access and utilisation of donor resources under regional and international programmes for health	Evidence of 10% increase in regional and international programmes based on government of Samoa prioritised programmes	Donor Partners and Donor Funded Organisation  All health service providers
<b>6.1.3</b>	Increased number of stakeholders and donors at health sector meetings	Evidence of increase in number of stakeholders participating at health sector meetings	All sector partners



