Collective Community Ownership of Health and Social Issues

CCOHSI PROJECT

Viseisei Sai Health Centre
LOVE ALL, SERVE ALL

EMPOWER PACIFIC
Putting People First
COUNSELLING & SOCIAL SERVICES

EUROPEAN UNION

Collective Community Ownership of Health and Social Issues (CCOHSI) – A Pilot Project

In Ba Province (Nadi, Lautoka, Ba and Tavua), Fiji Islands

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List of Abbreviations

CCOHSI – Collective Community Ownership of Health and Social Issues
CDP – Community Development Project
CHW - Community Health Worker
DMO – Divisional Medical Officer
FID – Fijian of Indian Descent
GBV – Gender Based Violence
KAPB – Knowledge Attitude Practice and Barriers
M&E – Monitoring and Evaluation
MoHMS – Ministry of Health and Medical Services
MoYS – Ministry of Youth and Sports
MoWCPA – Ministry of Women, Children and Poverty Alleviation
NCD – Non-Communicable Disease
SI – Social Issues
SNAP - **S**moking, poor **N**utrition, **A**lcohol and Kava abuse, lack of **P**hysical Activity
SRH – Sexual and Reproductive Health
STEP- WHO STEPwise approach to Surveillance
SDMO – Sub-Divisional Medical Officer
SDHS – Sub-Divisional Heath Sister
STI – Sexually Transmitted Infection
VSHC – Viseisei Sai Health Centre

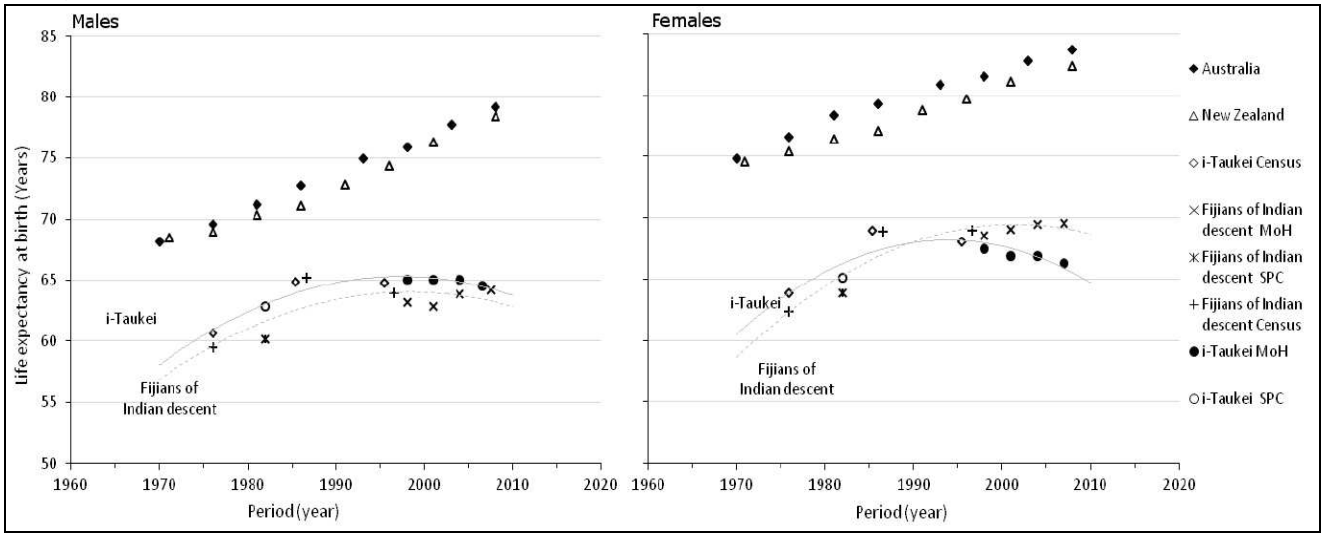
COLLECTIVE COMMUNITY OWNERSHIP OF HEALTH AND SOCIAL ISSUES (CCOHSI) - A PILOT PROJECT IN BA PROVINCE, FIJI ISLANDS.

The CCOHSI project activities were designed to raise awareness and empower communities and its structures to take ownership of their health and social issues, specifically in the areas of Non-Communicable Diseases (NCDs), Sexual and Reproductive Health (SRH) and Social Issues (SI).

Background:

NCDs remain the **leading cause of mortality in the Fijian population resulting in over 80% of all adult deaths**, 40% of which are premature[1]. Overall average life expectancy, 66 years for males and 71 years for females, is low and work absenteeism due to illness high[2]. The Fiji Ministry of Health and Medical Services' (MoHMS) National STEP survey[3] reported an increase in prevalence from 2002 to 2011 in the following: Hypertension from 24.2% to 31%, Diabetes: 19.6% to 29.6%, Overweight and Obesity: 58.5% to 66.9%[4]. **Adult mortality in Fiji is 3 times higher** than in Australia and New Zealand due to the worsening prevalence of NCDs, however this can be prevented and reduced by modifying lifestyle risk factors as shown in other countries[5]. Viseisei Sai Health Centre (VSHC) has 7 years experience in working with the community to reduce lifestyle NCD risk factors, identified by the World Health Organisation (WHO) as key factors, which contribute to diabetes, cardiovascular disease, chronic respiratory diseases and cancer. The identified risk factors include smoking, poor nutrition, alcohol abuse and lack of exercise. VSHC undertook the first community based STEPs survey in 2012, which confirmed the National STEPs survey results undertaken by the MoHMS in 2002 and 2011. On the basis of these data, VSHC adopted many of the health promotion strategies recommended by the National Wellness Centre of the MoHMS. It recruited and trained Health Educators, Health Promotion Officers and Community Health Workers (CHWs) to provide advocacy and education in the community.

Figure 1**: Life expectancy at birth by ethnicity in Fiji, Australia and New Zealand 1975-2008** (Taylor et al, 2013)[6]



The above graph shows that In Fiji life expectancy in both ethnicities increased until 1985 (to 64 years for males; 68 for females) then forming a plateau in males of both ethnicities and Fijian of Indian Descent (FID) females, however declining in iTaukei females to 66 years in 2007. In comparison life expectancy has gradually been rising in Australia and New Zealand over the same period of time.

In sexual and Reproductive Health, data from a previous EU funded VSHC project has shown that in rural women *the higher the number of children the greater the number of* ***unplanned pregnancies***[7]. This suggests socio-economic disempowerment and a lack of adequate information, awareness and understanding about

contraception for women and their partners to make informed choices. The World Bank data[8] has shown that in Fiji families with larger number of children, those with single mums and those in rural areas have a higher risk of poverty. This perpetuates socioeconomic inequalities in society and contributes to a cycle, which places women and their families in a state of continuing disempowerment. Unprotected sex also increases the risk of contracting Sexually Transmitted Infections (STIs) and cervical cancer. Fiji and the Western Pacific has some of the highest STI rates in the world[9], coupled with low contraception usage[2]. Infertility, which can be a consequence of STIs, often results in social stigmatisation of females, leading to abuse and domestic violence. Cervical cancer, caused by Human Papilloma Virus (HPV) is the second most common cancer in Fijian women[2], and second highest cause of cancer deaths in Fiji[10]. ***Women with cervical cancer present late in*** Fiji with case fatality of about 80%, many of these are young women with young children. Despite this, data from VSHC's previous project shows that up to 72% of rural women are unaware of the disease, and in Fiji less than 10% have had Pap smear screenings[11]. The HPV vaccine for girls prior to their first sexual exposure protects them from cervical cancer with incidence rates reducing by up to 70%. This demonstrates the urgent need to raise awareness and information in the community about their Sexual and Reproductive Health. Teenage pregnancy is a major concern in Fiji, accounting for around 7% of all pregnancies in 2016[2] and a higher than average adolescent birth rate for Pacific Island states[12]. Not only are teenage mothers faced with the sudden and large responsibility of caring for a child, they face disruption to their education and career prospects which can begin a downward spiral of unemployment, poverty and poor physical and mental health for both mother and child. Support can be limited, incurring social isolation, and further disempowerment.

Furthermore, The Ministry of Women, Children and Poverty Alleviation (MoWCPA) have identified **Gender Based Violence** and **Child Protection** as major issues in the Fijian community. **Violence against Women (VAW) is reported to be high with 64%** amongst women experiencing violence from their intimate partner in their lifetime in Fiji[13]. Empower Pacific has over 20 years of experience in working in these areas.

The project therefore prioritised Non-Communicable Diseases, Sexual and Reproductive Health, and Social Issues as they share common predisposing factors as well as consequences. The project activities were designed to raise awareness and empower communities and its structures to collectively take ownership of their health and social issues.

PROJECT RELEVANCE AND DESIGN

VSHC, since its inception in 2011, has accumulated extensive experience in community engagement and empowerment on health related issues.

The key lessons learnt from previous projects include:

- ✓ Advocacy and awareness raising at the grass roots must be ongoing to effect any sustainable change.
- ✓ Community leaders are potentially the most effective change agents.
- ✓ The leadership needs to be empowered with information and skills.
- ✓ Many existing community structures such as Village Health Committees and Advisory Councils need strengthening.
- ✓ Trained, motivated and supervised Community Health Workers can be effective in engaging the community and stakeholders into collective action in raising awareness in the community on health and social issues.
- ✓ The community needs to take ownership of its own health and social issues to affect any meaningful gain in achieving mental, physical, social and spiritual wellness.
- ✓ Networking with key stakeholders needs to be strengthened so that scarce resources are used effectively.

VSHC has developed a wide network of key stakeholders and has worked closely with both the MoHMS and Fiji National University in advocating for strengthening Public and Community Health practices.

The project was undertaken with a human rights based approach and is aligned to the **Sustainable Development Goals (SDGs)**.

Figure 2: 2030 Agenda for Sustainable Development

United Nations (2015) **Sustainable Development Goals**[14]

SDG 1 (No Poverty), SDG 3 (Good Health and Wellbeing) and SDG 5 (Gender Equality) especially are consistent with the Vision and Mission of the founders of the Viseisei Sai Health Centre who have a strong background in health. Sexual Reproductive Health and Social Issues such as Gender Based Violence and child abuse have a huge impact on the first 5 SDGs. All the SDGs are interlinked and need to be addressed if our societies are to flourish. They are also aligned with the broader development agenda of our funding partner, the European Union, entitled 'OUR WORLD, OUR DIGNITY, OUR FUTURE'.

The 2030 Agenda for Sustainable Development adopted at the United Nations Summit on Sustainable Development in September 2015, recognises NCDs as a major challenge for sustainable development. NCDs were not addressed in the Millennium Development Goals. As part of the Agenda, Heads of State and Government committed to develop national responses to the overall implementation of this agenda, including to:

i. Reduce by one third premature mortality from NCDs
ii. Strengthen responses to reduce the harmful use of alcohol
iii. Achieve universal health coverage
iv. Strengthen the implementation of the WHO Framework Convention on Tobacco Control
v. Support the research and development of vaccines and medicines for NCDs that primarily affect developing countries
vi. Provide access to affordable essential medicines and vaccines for NCDs

This project has had a **focus on empowering the community to reduce lifestyle risk factors** such as:

- Smoking tobacco
- Alcohol and kava abuse
- Poor nutrition with lack of portion control, excess fats, oil, sugar and salt use
- Lack of physical activity
- Unsafe sexual practices and lack of contraceptive use
- Poor health seeking behaviour, such as not accessing screening for cervical cancer
- Gender Based Violence (GBV)
- Child abuse
- Poor sanitation and hygiene
- Unhealthy environment
- Improper waste disposal and lack of recycling

Addressing National Priorities

VSHC's approach is consistent with the MoHMS's "National Strategic Plan 2016-2020" (NSP)[1] In this the MoHMS recognises "the importance of social determinants of health (e.g. income, housing, food markets, education, transportation, public safety, social norms including gender equality, access to media etc.) further emphasises the need for a multi sectoral approach to health". The National Strategic Plan notes a "large increase in the overall population by about 20,000 in the Western Division from 2007 to 2013." The Lautoka/Yasawa subdivision had a population increase of 15.7% and the Nadi sub division had an increase of 9.9%. The MoHMS recognises that the majority of the population of the West resides in rural communities. It also states that a third of Fiji's population lives in poverty, predominantly in rural areas where agricultural output has been decreasing. The project has targeted the communities of Nadi, Lautoka, Ba and Tavua as beneficiaries of this project.

The **Healthy Islands**[15] concept was developed in 1995 at the first Pacific Health Ministers Meeting in Yanuca Island and has recently undergone review in 2015 at the Eleventh Pacific Health Ministers Meeting. The Healthy Islands concept is embedded in the National Strategic Plan and states that Healthy Islands are where:

- Children are nurtured in body and mind
- Environments invite learning and leisure
- People work and age with dignity
- Ecological balance is a source of pride
- The ocean, which sustains us, is protected.

The Healthy Islands concept had a series of practical strategies, which advocated the following:

i. The promotion of population health to reduce premature morbidity and mortality associated with NCDs as a part of an all of society approach to wellness and well-being.
ii. The creation of environments that invite learning and leisure.
iii. A focus on community empowerment and engagement as well as building effective partnerships to foster improved accessibility to primary health care services in urban, rural and remote areas.
iv. Increasing the number of active community health workers trained in core competencies.

In the **Fiji MoHMS's National Strategic Plan 2016-2020**[1] the following specific objectives have been defined:

Strategic Pillar 1: *"provide quality preventative, curative and rehabilitative health services responding to the needs of the Fijian people including vulnerable groups such as children, adolescents, pregnant women, elderly, those with disabilities and the disadvantaged."*

Strategic Plan Priority Area 1: **NCDs**

- To promote population health and reduce premature morbidity and mortality due to NCDs as part of a whole of society approach to wellness and well-being.
- To reduce key lifestyle risk factors among the population.

Strategic Plan Priority Area 4: **Primary Health Care**

- To strengthen primary health care by improving accessibility of primary health care services in urban, rural and remote areas.
- To extend primary health care service coverage through effective partnerships with communities.

Some key indicators in the NSP include:

i. Reduction in NCD related mortality.
ii. Reduction in prevalence of diabetes.
iii. Reduction in overweight and obesity.
iv. Increased cervical cancer screening
v. Reduction in adolescent birth rate
vi. Increase in contraceptive protection rate

The CCOSHI Project design reflects the priorities of the National Strategic Plan and the Healthy Islands framework. It strives to establish collective community ownership of social and health issues by adopting a grassroots approach where the focus is on individuals who make up the community. Hence this project has had a strong emphasis on Community Development Projects (CDPs) as a key activity to achieve the project objectives.

To bring about meaningful change there needs to be engagement and ownership of community issues by the leadership and structures of those communities as well as the people. Changing behaviour requires **a high level of community engagement and ownership**. This is more likely to be successful if key partners work together. Many initiatives in the community are **unsuccessful because efforts are fragmented, lack a common vision and mission** and are not focused on issues as prioritised by communities themselves. Thus, this project attempted to build on many tried initiatives, experience in working in the community and existing partnerships.

There were several **stakeholders involved** in addressing community health and social issues. Primary Government Ministries including the:

- Ministry of Health and Medical Services
- Ministry of Education, Heritage and Arts
- Ministry of Women, Children and Poverty Alleviation
- Ministry of Youth and Sports
- Ministry of iTaukei Affairs
- Ministry of National Security and Defence

Other government structures include the Ba Provincial Council, which has administrative oversight of all the iTaukei villages in the Province of Ba. The District Officers and Advisory Councillors provide support for communities and settlements other than the villages.
The villages have formal structures within them, which identify and escalate any issues of concern to higher authorities. The Turaga ni Koro (village's administrative head) is an appointee of the Ba Provincial Council and has a leadership role within the village to assist with addressing communal issues. Advising the Turaga ni Koro, is a Village Committee and a Village Health Committee. In spite of these structures, many villages and communities are dysfunctional and have poor leadership, existing structures often struggle to be effective and many communal issues remain unsolved. As a result, communities are disempowered from taking any collective action especially in health and social issues. Settlements and non-village communities can also be plagued by similar dysfunctional tendencies through lack of structures, effective leadership, reporting systems and distrust amongst those living together.

CCOHSI Project Objectives

***Overall objective*:** To empower existing community structures and leaders to take ownership of and express the communities' need to tackle targeted health and social issues which impinge on human rights and socio-economic productivity.

Specific objectives

1) To establish an enabling environment for VSHC and Empower Pacific to work with Local Authorities through inclusive policy making, to address targeted health and social priorities in Non Communicable Diseases, Sexual Reproductive Health, and Social Issues such as Domestic Violence and Child protection in Fiji.

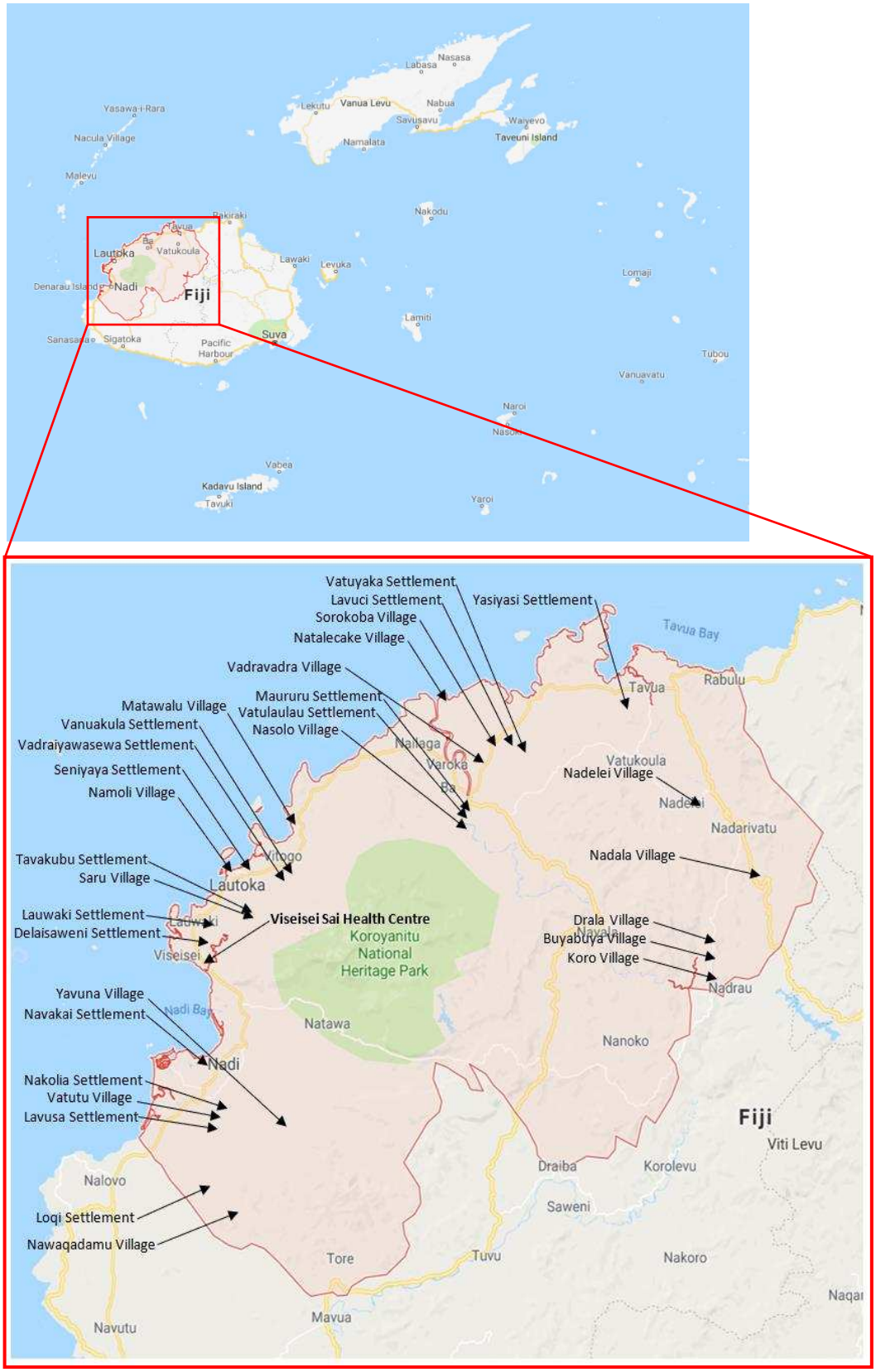
2) To enhance the capacity of communities in Ba Province to support sustainable improvements in specific modifiable lifestyle factors in health and social indicators by empowering leaders and community structures.

Activities were under the following categories:

1. Advocacy in the community and with key stakeholders about the project through meetings and discussions
2. Training and capacity building by conducting workshops and mentoring on field visits.
3. Facilitating meetings and introductions to establish networking between the communities and key enabling stakeholders.
4. Health Promotion and Health education workshops and activities.
5. Outreach screening and targeted health services for NCDs, SRH and Social Issues
6. Developing strategies and facilitating the design, implementation and completion of Community Development Projects
7. Research and monitoring and evaluation.

Area Covered by the Project

Figure 3: This map of Fiji highlights the Ba Province and the location of the 30 communities



IMPLEMENTING AGENCIES

1. Viseisei Sai Health Centre (VSHC)

VSHC was set up as a charitable Civil Society Organisation in 2011 with a motto of "Love All Serve All". The key focus was to empower the community to protect its health by modifying lifestyle risk factors and accessing health services in a timely manner. The WHO has identified key lifestyle risk factors, which result in adverse health that cause **significant economic and social burden** on both the communities and Government and impinge on the **basic human rights** of individuals.

Vision: *"To make quality, comprehensive health care accessible to all regardless of race, religion or socio-economic status so that everyone can enjoy good physical, mental, social and spiritual health."*
Mission: *"To provide a community health service by mobilising resources and collaborating with the community, government and NGOs to provide free, quality health service with an emphasis on health promotion and disease prevention"*
Working in collaboration with the MOHMS.
VSHC has a Memorandum of Understanding (MoU) with the MoHMS to provide primary health care in collaboration with the guidance of the Lautoka/ Yasawa Sub Divisional Medical Officer. Approximately 100 outpatients a day access the services provided at the health centre.
In addition, the VSHC Trust with the assistance of development partners undertakes projects designed to empower communities in health and social issues.

Project Track Record: Since its establishment in 2011, VSHC has undertaken the following projects consistent with its vision and mission:
1. In response to the national NCD crisis, VSHC conducted the first community based life style risk survey for NCDs in Fiji. The survey used the WHO validated STEP tool. This survey included 2765 adults (25-64 years of age) in the Viseisei Health Zone, Lautoka[16]. Based on the baseline survey VSHC developed and implemented an intervention program to reduce community life style risk factors. This project was supported by the School of Public Health and Community Medicine of University of New South Wales, Australia.

2. "Empowering Communities to Wellness" in Viseisei Health Zone: This community empowerment project to reduce life style risk factors continued between 2012 and 2016 with the support of the Fiji Community Development Program funded by the Australian AID program. The interventions included working with grass roots community structures and relevant stakeholders to identify key issues, which impact on health and community development.

3. "Strengthening Rights of Rural women and Girls in Reproductive Health in Ba Province" funded and supported by the European Union. In response to the high unplanned pregnancy rates and high cervical cancer and STI rates, as well as the disempowered state of most women and girls in rural areas, VSHC designed a project to empower rural women and girls in their reproductive health (RH). Over 11,000 women and girls from 161 rural communities in Ba province were provided with rights based health education and information in areas such as safe sex, family planning and cervical cancer as well as their right to live without violence. Approximately 5300 women and girls were provided with a specialist reproductive health clinical services, which included 4000 Pap smears screening for cervical cancers[7]. A baseline survey on Knowledge, attitude, practice and behaviour (KAPB) regarding safe sex, family planning and cervical cancer and its screening was undertaken in 1500 women and girls[11,17].

2. Empower Pacific

Empower Pacific have been providing essential counselling, social work, training and community services throughout Fiji for last 23 years. The organisation started work in 1994, under the name Family Support and Education Group (FSEG). It changed its name to Pacific Counselling and Social Services in 2007 to reflect the fact that it had become a broad focus multimodal agency providing a holistic range of individual and community support services as well as providing training and setting benchmark standards for counselling and HIV prevention work across the Pacific. In 2012, having grown significantly, it was rebranded as Empower Pacific to further embrace the diversity of its work which has broadened the capacity for holistic psychosocial and economic development work. It provides a widely diverse range of services, which is a holistic focus on addressing the multiplicity of vulnerability of individuals and communities and supporting the most vulnerable and marginalised groups in the communities to achieve social, emotional, physical and financial wellbeing.

Also, one of the key activities of Empower Pacific is to provide training in professional counselling and HIV services in 12 Pacific Island Countries. Currently the organisation in partnership with University of the South Pacific (USP-Pacific TAFE) has developed a Diploma of Counselling course, which is also facilitated by the organisation. Empower Pacific's vision is to be an organisation of integrity that is committed to promoting sustainable personal and professional development to enhance the wellbeing of all people. Its mission is to empower individuals and communities to reach their full potential by providing access to professional holistic health and social development services. Empower Pacific seeks to enhance the full potential of communities by working in partnership with government and other community agencies to ensure a holistic model of professional health service.

In 2005, upon the request of the Ministry of Health & Medical Services, Empower Pacific extended its counselling and social services to Lautoka Hospital and nearby health facilities. The integration of these services proved to be a success and contributed to health sector strengthening. The success of these services in health facilities around Western Division led to expansion of these services to other health facilities around Fiji. It is now almost 13 years that Empower Pacific has been providing these very important services to Ministry of Health and Medical Services.

Similarly the organisation is also providing its services to other government ministries, which include Ministry of Women, Children, and Poverty Alleviation and Ministry of Justice. It also very closely works with other Civil Society Organisations, International organisations and Faith Based Organisations. Approximately 20,000 individuals access Empower Pacific's services annually.
Website www.empowerpacific.com

CCOHSI PROJECT IMPLEMENTATION

The project duration has been 27 months with commencement in January 2016. The project was made possible through the funding from the European Union. Empower Pacific partnered the Viseisei Sai Health Centre in delivering some components of the activities.

All activities followed Community Development Principles and Values:

The main thrust of this project was Collective Community Ownership of Health and Social Issues. In order to do this it was important to gain the cooperation of the community through advocacy, education and mentoring. This required a concerted effort on the part of staff members identified to work with the selected communities. At all times every effort was made to adhere to the 'Community Development Principles and Values'[12]. These were followed:

- **Democratic:** The will of the majority was carried out, but only after all voices were heard and considered and minority rights were protected.
- **Inclusive:** The many barriers to participation in society; poverty, disability, age, race and ethnicity are some other characteristics that often marginalize people. A healthy community embraces diversity and recognizes that all community members have a right to be heard and participate in processes that affect their lives. Care was taken to be inclusive. This was easier in the village setting where the communities are more cohesive. Settlements were a challenge because often the communities were divided with power struggles and jealousies making consensus difficult.
- **Non-authoritarian:** Organizational structures should be as flat as possible, with all participants being seen as equally important and as much as possible have equal input. This was more of a challenge in the villages where traditional structures vest authority onto the chief and his advisors relying on the Turaga ni Koro to represent the ordinary members of the village community. Thus, the village structure is hierarchical. However, each village has a committee, which advises decision-making. A sub-committee is the village health committee. The project worked closely with this committee ensuring that it was revitalised and effective.
- **Community self determination:** Community members have been encouraged to come together to discuss their concerns, assess options and arrive at their own conclusions. They may have sought advice from "experts", but have had to consider it along with other sources of information and their own experience and make their own decisions that are right for them. The mentors assigned by the project worked hard in this consultative process. VSHC facilitated multi sectoral stakeholders to be involved so that best advice was made available about solutions and all available resources.
- **Community Ownership:** Communities were encouraged to develop their own assets, but also "own" their problems and issues. When communities accept that it is "their" problem, then they are more likely to work together to develop a solution, and the solution will be better than one provided solely by external "experts". This whole project was based on promoting this principle. The emphasis during the CDPs was to nurture collective community ownership. This required the mentors to work closely with the community health worker who was their main intermediary with the community. Several consultative meetings were held to ensure ongoing community involvement.
- **Enhance natural capacities and networks:** There are sources of strength in every community; for example, informal networks and social support systems such as women's and youth groups, or certain individuals that have particular talents or are able to help others in need. This project identified these existing community assets/structures and worked with them. In many instances the existing structures needed to be strengthened.
- **Social justice and equity:** This has been fundamental to community development and is implicit in all the activities of the program. This in a practical sense meant that there was fairness and transparency in all the processes involved in the formulation and conduct of the CDP.
- **Universality:** Activities were made available to everyone in the selected communities for this Pilot project.

- **Service Integration:** The sector based networking and activities were integrated across the stakeholders. This ensured the best use of available resources without duplication.
- **Upstream:** By this is meant that where possible problems will be sorted out at their root cause thus preventing them from happening. Therefore, instead of trying to treat diseases (downstream) such as NCDs, cervical cancer etc. this project promoted lifestyle modification to reduce risk factors.

Preparation and Planning Phase

In this phase there were several important things undertaken which included:

- Advertising and hiring staff;
- Liaising with our partners Empower Pacific
- Engaging Government and non-government stakeholders
- Engaging the communities
- Purchasing equipment and vehicle
- Overview planning for 27 months
- Planning of different phases
    - Preparation- 3 months
    - Field work, reporting and monitoring and evaluation – 21 months
    - Follow up/analysis/reporting- 3 months

Implementation Phase

1. Staff Training

Staff deployment was staggered according to their facility, thus staff training was only undertaken once most of them were on board.

- General training included:
    - The CCOHSI Project, health as a human right, public health, empowerment of people with accurate information and promotion of ownership.
- Specific areas included:
    - Lifestyle risk factors (**SNAPSS**: **S**moking, poor **N**utrition, **A**lcohol and Kava abuse, lack of Physical **A**ctivity, **S**tress, unsafe **S**ex)
    - NCDs such as Diabetes, Hypertension, Cancer and their complications
    - Sexual and reproductive health including safe sex practices, STIs, contraception and cervical cancer/Pap smear
    - Social issues including gender based violence and child protection
    - Public speaking and presentation skills
    - Conduct and evaluation of workshops
    - Community Development Projects under third party financing
    - Monitoring and Evaluation; Log Frame
    - Conduct of Research
    - Report writing
    - Data Management and setting up data bases
    - Project Visibility
    - Ethical Practices
    - Inter-sectoral engagement

The team leaders and external educators conducted staff capacity building sessions in the first couple of weeks, and then throughout the project. There were 26 formally recorded staff capacity building sessions were conducted along with ongoing 50 formally recorded monitoring and evaluation sessions throughout the project period. However, it is important to note that because of the different skills mix of the team members there was ongoing capacity building and sharing of knowledge throughout the project. We also had 2 Australian Volunteers who mentored and supervised the team as required. Lauren Deakin, a nurse by

profession who has completed Masters in Public Health and Tropical Medicine, and Lauren Toll, a physiotherapist, completing her Masters in Public Health have been invaluable in assisting the team leaders and the Project Manager.

2. Stakeholder Consultative Meetings

These were undertaken early in the project so that there was a clear understanding of the project objectives and discussions were held about collaborations and opportunities for involvement.

Stakeholders involved in the early consultative meetings included:

- Ba Provincial Council and its village representatives; Turaga ni Koros
- District Officers of Lautoka/Yasawa, Ba, Nadi and Tavua who are responsible for informal settlements
- Divisional Medical Officer and other Ministry of Health and Medical Services representatives such as sub divisional medical officers and nursing sisters responsible for the rural communities and zone nurses
- The Health Committees of villages and settlements, if established.
- Ministry of Youth and Sports through their Divisional Office in Lautoka
- Ministry of Women, Children and Poverty Alleviation through their Divisional Interest Officer Western
- The stakeholders provided VSHC and Empower Pacific with their networks, which was vital for inter sectoral engagement for the common goal of community empowerment

3. Communities and Stakeholder Engagement

The CCOHSI Project recognised that there are several government and non-government community structures, which exist to assist in the consultation processes. These include formal government structures such as the District Commissioner's Office comprising of staff with special expertise in community development. The interest of those communities outside the formal village structure come under the jurisdiction of the District Officer serving each subdivision and answerable to the District Commissioner.

In addition, there is an iTaukei structure headed by the Provincial Office, under the Ministry of iTaukei Affairs, which coordinates the day-to-day interests of the village dweller. The project team initiated meetings to build partnership and a common understanding of the project with the following **government** and **community stakeholders.**

PRIMARY GOVERNMENT STAKEHOLDERS

- **Ministry of Health and Medical Services (MoHMS)**
  VSHC already has been working collaboratively with the MoHMS since its inception in 2011. The Divisional Medical Officer (DMO) and the Divisional Nursing Officer (DNO) West are the administrative heads for the MoHMS in the Ba Province. They together with their subdivisional counterparts in Nadi, Lautoka, Ba and Tavua were involved in the planning phases of all health related project activities. The subdivisional staff especially the Zone Nurses were involved in the intervention phase of the project, especially in working with CHWs within the villages and the communities.
- **Ministry of iTaukei Affairs**
  The Ministry of iTaukei Affairs protects iTaukei interests and works closely with the Ba Provincial Council. VSHC has collaborated with the BPC in previous projects especially on health advocacy. The Ba Provincial Council appoints the Turaga ni Koro who is an executive member of the Village Council which advices on all issues affecting the village community. The Health Committee is a sub-committee of the Village Council which reports to the Tikina (group of villages) Council. The Tikina Councils report to the Ba Provincial Council. The Health Committee alongside the Village Council nominates the CHWs for the village.
- **Ministry of Agriculture, Rural and Maritime Development and National Disaster Management**
  This Ministry co-ordinates infrastructural and socio-economic development at district level and is headed by the Commissioner Western's Office. The National Planning Officer is a key member. The Commissioner Western supervises the District Officers (Dos) in the Nadi, Lautoka, Ba and Tavua

districts where the project is being implemented. The Dos role is to look after settlements other than formal villages. Most FIDs and iTaukeis who have moved away from their villages and other minority groups make up these settlements. These communities have Advisory Councillors appointed by the DO. The Advisory Council discusses issues of concern and escalates these to the DO. Many of these settlements are dysfunctional and lack community cohesiveness and are also prone to have significant health and social issues. The project has targeted 15 such communities for the CDPs so it is essential that this is a collaborative effort the Ministry and the District Commissioner and the DOs.

- **Ministry of Women, Children and Poverty Alleviation (MoWCPA)**
  Prevention of Domestic Violence and Child Protection are the two main social issues that the MoWCPA plays an important role. This Ministry therefore is a key stakeholder. The CCOHSI Project worked closely with the Divisional Women's Interest Officer, the senior representative of the Ministry in the Western Division. Fortunately, VSHC has worked with her and her Ministry in past projects especially for young mothers empowerment
- **Ministry of Youth and Sports**
  This Ministry works primarily with youth and offers multiple empowerment and life-skills programs. Youth form a significant and important part of the community, are often marginalised and are often not involved in community decision making processes. CHWs and HCs were encouraged to work with collaboratively with this Ministry for the empowerment of youth in their communities.

PRIMARY COMMUNITY STAKEHOLDERS

These included:

(i) Community members
An inclusive strategy was used to involve a representative group. There was no discrimination based on gender, age, socio economic status, religion, race, or political affiliation. Efforts were made to be inclusive to ensure that the decisions taken represented community views. Care was taken to consult the marginalised.

(ii) Community Health Workers (CHWs)
CHWS are members of the community with an intimate knowledge of the community. However, not all communities have CHWs. The MoHMS in its National Strategic Plan 2016-2020 states "…. Increasing the number of active CHWs trained in core competencies" The project sees this cadre to be key advocates for community development hence a considerable amount of effort will be spent with this stakeholder group.

(iii) Turaga ni Koros
The Turaga ni Koros are appointed by the BPC as village leaders to engage the villagers in various projects such as clean up, preparing for a village function, and settling minor disputes. The Turaga ni Koros can be influential in engaging the community on projects. They also are key to the village decision-making process. As such the project will be working with them in all CDPs in villages.

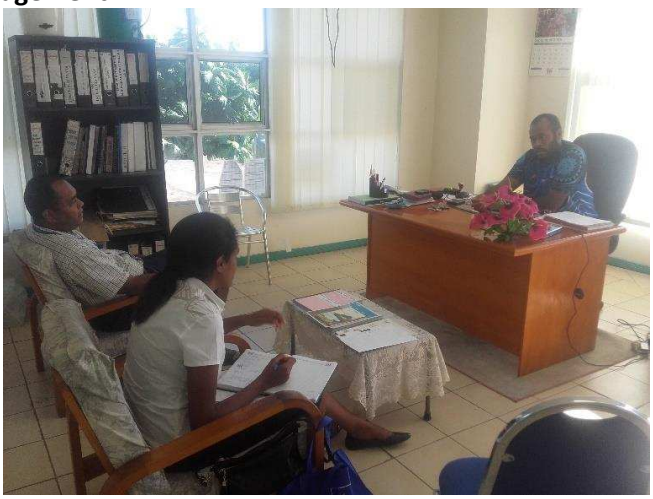
(iv) Advisory Councillors
The Advisory Councillors are appointed by the DO to advocate for issues affecting those communities which are not part of the village. Their role is similar to that of the Turaga ni Koro hence their importance as key stakeholders in the CDPs involving the non village communities.

(v) Faith based organisations (FBO)
The FBOs can have a significant role on the community and its values. They can influence community values and behaviour which impacts on their health and social issues. Their advocacy potential will be utilised where possible.

(vi) Women's groups
The Soqosoqo Vakamarama and settlement community women's clubs are active in voicing women's issues. By and large women are more aware of key health and social issues in the community but quite often they are marginalised from the decision making process especially in villages.

Stakeholder Engagement

Dr. Swaran, Professor Rajat, Mosese and Koroi meeting with the Commissioner Western, Lautoka



CCOHSI team members Mosese and Renivani meeting with Jese, (Sub Divisional Health Inspector) in Lautoka

CCOHSI team meeting with Divisional Medical Officer and Divisional Health Sister at VSHC

CCOHSI team members Mosese and Jenny meeting with Makareta, the Divisional Women's Officer

CCOHSI team meeting with the Roko Tui Ba, the Divisional Medical Officer and the Director of Nursing Western at Western Health Centre, Lautoka

CCOHSI's Mosese meeting with Master Wise, Project Officer for WASH Program Fiji at BPC.

4. Selection of the 30 Communities

The Ba Province is large with over approximately 107 villages and many more settlements. As a pilot, 15 villages were chosen randomly using computer software to remove bias. 15 settlements were then chosen close to these villages where possible.

Table 1: **The 30 CCOHSI Communities**

	Lautoka	Ba	Nadi	Tavua
Villages	Saru	Sorokoba	Nawaqadamu	Nadelei
	Matawalu	Natalecake	Yavuna	Drala
	Namoli	Nasolo	Vatutu	Koro
		Vadravadra		Nadala
				Buyabuya
Settlements	Tavakubu	Vatuyaka	Loqi	Yasiyasi
	Delaisaweni	Lavuci	Navakai	
	Lauwaki	Maururu	Nakolia	
	Vadraiyawasewa	Vatulaulau	Lavusa	
	Vanuakula			
	Seniyaya			

5. Scoping and Scouting

Prior to engaging with the community, the CCOHSI team met with key government officials of the Ba Province. These included the Divisional Medical Officer, Divisional Nursing Officer, Sub Divisional Medical Officer, Sub Divisional Health Sister, District Officer, and Ba Provincial Council Officials. We identified each village's Turaga ni Koro and each settlement's Advisory Councillor, their Zone Nurse and Community Health Worker, if there was one appointed. We also sought advice on current local issues highlighted in the region.

Groups of 2-3 project team members were assigned to work with the CHWs and made visits to the communities meeting the leadership, the Talatala (the village priest), and youth and women's representatives. Local protocols were respected. In these talanoa (discussions) sessions we detailed several key issues e.g. road access, number of households, general sanitation issues, access to clean water, existing community decision making structures. We also found out whether the community would be receptive and whether other projects were underway in the community.

In villages and settlements, the health promotion team approached the Zone Nurse to inform her regarding the planned outreach education and screening. This allowed the team to work in collaboration with the zone nurses, avoiding duplication of outreach services. This also increased the profile and recognition of the Zone Nurse, the CHW as well as the CCOHSI team within the community. The CHW informed the Turaga ni Koro for his approval as he plans and approves all activities and programs conducted in the Village. The CHW alongside the CCOHSI Health Promotion Team and the community Health Committee then delivered the flyers house-to-house informing the community of the outreach services. The Turaga ni Koro also assisted by announcing the program during the village meetings. In settlements the team visited the CHW and the Advisory Councillor to inform them regarding the planned outreach program. The CCOHSI Health Promotion team then assisted the CHW and Health Committee to distribute flyers house to house. Outreach was always conducted in a venue, which was accessible to and comfortable for all community members who attended.

Recruitment for Stakeholders Workshops: In organizing the stakeholder's workshop, key stakeholders were invited to participate in the training. These included community leaders, Turaga ni Koro, Advisory Councillor, the CHW, Health Committee members, the Women's Group, the Youth Group, the Men's Group, Faith-based

groups representatives and reps from other existing committees such as Agriculture, Rural and Maritime Development and National Disaster Management, the Water Committee, the Crimes Committee or Development Committee. The attendance at the workshop depended on individual invitations followed up by personal reminders. On the day of the workshop the project team members needed to visit homes to ensure attendance. Often meetings and workshops were delayed so that participants would not miss out on the program.

6. Zone Nurse Workshops
An initial workshop was conducted for Zone Nurses involved in the 30 communities. Subsequently they attended various stakeholder and young mums workshops. A second workshop for all zone nurses was undertaken for World Cancer Day (04.02.2017) to up skill them on common cancers and their prevention as well as screening.

7. CHW Training Workshops
Most of the communities had CHWs previously trained by the MoHMS and with the assistance of Sub Divisional Health Sisters they were identified and contacted. Eight communities (mainly settlements) did not have a CHW, these being Tavakubu Settlement, Seniyaya Settlement, Nakolia Settlement, Vatuyaka Settlement, Lavusa Settlement, Vatulaulau Settlement, Yasiyasi Settlement and Delaisaweni Settlement. The project in partnership with key stakeholders recruited, trained and deployed CHWs for these communities.

8**. Stakeholder Workshops**
These stakeholder workshops were to ensure that the various local authorities, Turaga ni Koros, Advisory Councillors, Health Committee members, faith based organisations, women and youth leaders received information on NCDs lifestyle risk factors, SRH and Social Issues. They were able to discuss together their communities' issues and identify problems they wished to tackle under CDPs.

9. Setting Up or Revitalising Health Committees
Health committees were set up or revitalised in all 30 communities with the help of the Turaga ni Koros and the District Office. Health Committee members were identified and up skilled by the project team. The trained CHW became an integral part of the community health committee. The Zone Nurse and the Health Inspector became key collaborators in carrying out health activities for their community.

10. Outreach Health Education, Screening and Targeted Clinical Services
The communities were provided with outreach health and social issues education. This included education on gender based violence and child protection. In addition, clinical services including screening for SRH risks and NCDs was provided. Most of the Zone Nurses participated in these activities as they form part of their service duties.

11. Assist in facilitating 30 Community Development Projects through Third Party Funding
The CCOHSI team initially assisted the community members and stakeholders in identifying health and social issues that were areas of concern and priority for them. These communities required mentoring and supervision throughout the process as many participants were unfamiliar with the consultative process and the concept of CDPs. This mentoring included the identification of and prioritisation of the community health and social issues, developing a proposal, executing the CDPs and writing reports. The CHWs and the Health Committee members were mainly responsible for the CDPs. The CHWs were ultimately responsible for the finances and their acquittals in the communities.

12. Research
Research was undertaken in the form of pre and post questionnaires and focus group discussions to gauge impact of all the interventions during the project.

13. Supervision and Mentoring

The CHWs, Turaga ni Koros, Advisory Councillors are other key stakeholders involved in the CDPs needed to be mentored and supervised in the activities by the assigned project staff to ensure accurate dissemination of information and quality of the actions undertaken.

14. Monitoring and Evaluation

Dynamic monitoring and evaluation templates were developed for all activities for timely and appropriate delivery of activities and outputs. There has been systematic capturing of data during the action period via reports, log of activities, attendance sheets, pre and post questionnaires and evaluations.

15. Analysis, Reporting and Publications

During the last 3 months of the project intensive work was undertaken to conduct follow up, analyse data, capture the activities, report on the outcomes and write reports for publication. Information from these will be disseminated to all the relevant stakeholders and government authorities, which could assist in future policy direction.

Outreach Screening in the Communities

Outreach screening for diabetes and hypertension in Loqi Settlement in collaboration with MoHMS

Outreach screening in Natalecake Village in collaboration with MoHMS

CCOHSI health educator Warsha presenting on NCDs during outreach in Matawalu Village

Outreach screening held at Navakai Hart Home Community Hall and in the VSHC clinic bus

Nakolia Settlement community members filling out forms while waiting for screening

Women's health and Pap smear education in Saru Village in collaboration with MoHMS

ACHIEVEMENTS AND RESULTS

All activities were for EMPOWERMENT OF ALL TARGET GROUPS.

Provision of information and training, stakeholder information sessions, sharing of knowledge and local needs amongst stakeholders and recognition of constraints within the communities has been part of all workshops. All activities have been **interactive and participatory** where the participants have actively involved in learning from each other, providing feedback and identifying and developing projects based on local knowledge and circumstances. Relevant, evidence based information on the key health and social issues in a human rights setting has been undertaken. The medium for discussion has been English and the vernacular (iTaukei and Hindi). Understanding of the relevance, the bigger picture and the importance of inter sectoral networking for a shared local vision was promoted.

Ownership by community structures: The Ba Provincial Council, CHWs, Zone Nurses, Turaga ni Koros, Advisory Councillors, Health Committees, teachers, women's advocates, youth groups and faith based organisations was encouraged as much as possible. All have been encouraged to participate in information and problem sharing and to develop local solutions and often with external assistance from various government departments. The attempt always was to create an **enabling environment** for the various stakeholders to **develop a shared vision**.

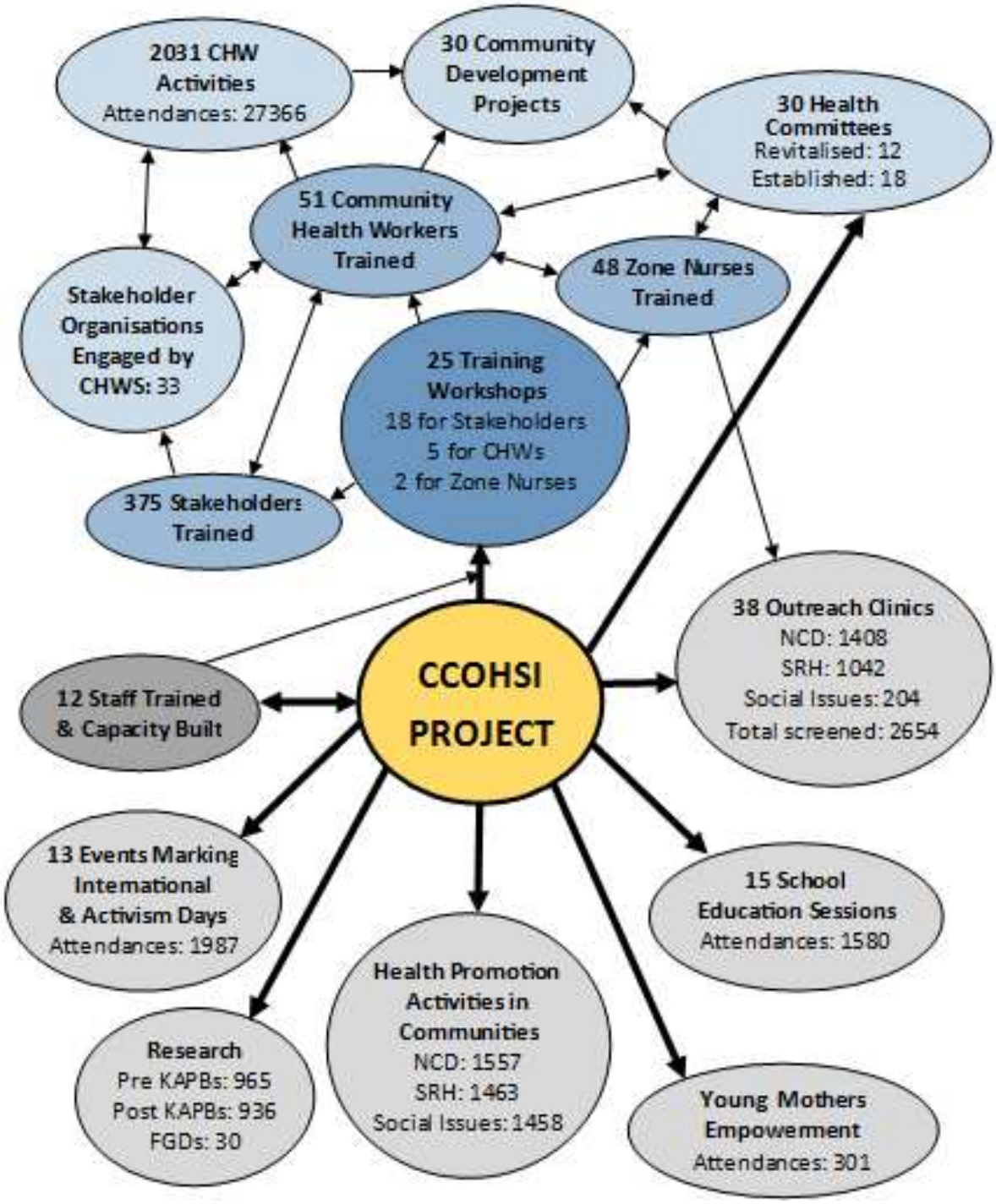
All project expected outputs were achieved or surpassed. Despite many challenges of working with disempowered communities the CCOHSI team worked hard to stay according to time plan.

The champions from the project point of view have been the Community Health Workers. They became the main liaison person for most of the activities after their initial training. A lot of mentoring and supervision was initially required from the team.

Table 2: **Overall Expected Vs Actual Output for Project Activities**

Activity	**Expected**	**Output**
Zone Nurse workshop attendances	30	48
CHWs trained	30	51
Stakeholder Workshop	15	18
Revitalised Health Committees	30	30
Outreach Education attendances	1000	8221
Outreach Screening attendances	1000	2654
Research subjects	900	952
Community Development Projects completed	30	30
Young Mums Empowerment attendances	0	301

Figure 4: CCOHSI Project Output Diagram



FGDs: Focus Group Discussions; CHW: Community Health Workers; NCD: Non-Communicable Diseases; SI: Social Issues; SRH: Sexual and Reproductive Health; KAPB: Knowledge, Attitude, Practice and Barriers

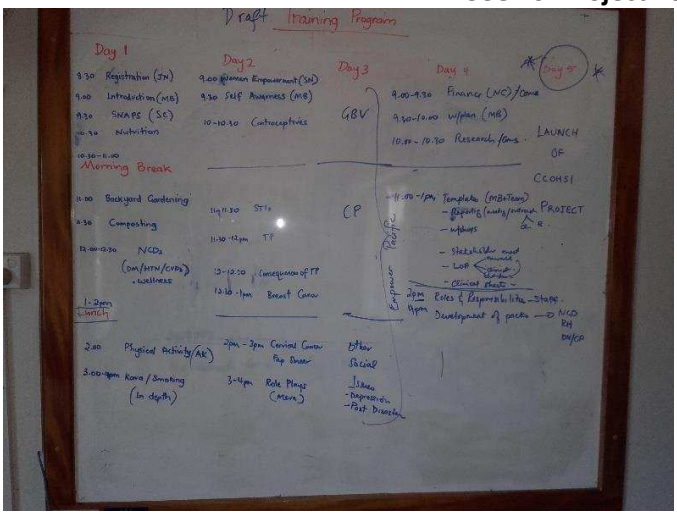
Staff Training and Deployment

Intensive training of CCOHSI team was initially taken over one week followed by ongoing sessions to up skill, which was both institution-based and practical on field training.

Table 3**: Staff Training and Capacity Building**

Date	Description
04/02/2016	Promoting Community to take ownership of their health & integrating SRH/NCD/SI
10/02/2016	Staff capacity building on report writing- feedback on the new report writing template
19/02/2016	Education session for staff on SRH to strengthen public awareness
08/03/2016	Women's Empowerment – Parity/ Breast feeding/Teenage Pregnancy/ Gender Equality
09/03/2016	Research
04/03/2016	Importance of M&E of health promotion activities - NCD/SRH
01/04/2016	Leadership and Work Ethics - Empowering Communities for Wellness
04/04/2016	Overview of CCOHSI Project Relevance and Objectives/NCD & SRH
05/04/2016	Recap SRH/Family Planning/Breast & Cervical Cancer/Diabetes/Hypertension
07/04/2016	Social Issues - Domestic Violence/Child Protection Workshops
08/04/2016	Reporting Templates/Research questionnaire/reporting & Communication lines
22/04/2016	Motivational Interview - Social Issues for staffs & CHWs
05/05/2016	M&E training with EU Consultant- Natalia - Logical framework
06/05/2016	M&E training with EU Consultant- Natalia - Logical framework
20/06/2016	Lesson Plan on Presentation in the communities & What is Health Promotion
08/07/2016	Community Development Project - Introduction/Overview of structure/ troubleshooting
22/07/2016	Empowering Communities for Wellness
28/10/2016	Pinktober - Breast Cancer/ Prostate Cancer detection-presentation
02/09/2016	Gender Equality & Social Inclusion & Nutrition Workshop
18/11/2016	Health Promotion and Wellness Training
16/01/2017	Community Development Project Review workshop
10/02/2017	Gifts of life/SNAP/ Social Issues and environmental Health
22/05/2017	Nutrition in NCD
08/09/2017	Movement for Life Presentation for World Physiotherapy Day
08/01/2018	Research update
08/03/2018 - 16/03/2018:	Data Management & Statistical Analysis Workshop

CCOHSI Project Team Orientation



CCOHSI Team 5 day orientation plan


CCOHSI team during orientation


Amelia Ake presenting on cervical cancer

Community scouting and outreach schedule for April


Koroi presenting on SNAP to the CCOHSI team


Professor presenting on community engagement

Staff Capacity Building

CCOHSI team capacity building meeting at VSHC with Natalia (European Union Helpdesk)

Human values and leadership at work and in life workshop at VSHC with Dato Jagadeeshan

Rylene, Koroi and Warsha during Dr. Tukana's lifestyle risk factor education at VSHC

Professor Rajat, Rusiate and Warsha during a CCOHSI team planning meeting at VSHC

CCOHSI, VSHC team and CHWs participating in Dr. Tukana's lifestyle risk factor education

Capacity building with Dr. Tukana (Review of VSHC Wellness Program and tour of Viseisei Village gardening and composting projects)

Table 4: **Overall Project Health Promotion and Educational Activities**

Activity	Number of Attendees by Educational Topics				
	NCD	SRH	SI	General	Total
Zone Nurse Workshops	23	48	23	0	**48**
CHW Workshops	106	106	139	37	**139**
Stakeholders Workshops	375	375	375	0	**375**
School Education	1036	364	922	715	**1580**
Outreach Education	1557	1463	1458	0	**1557**
CDP Activities	1585	331	286	1221	**2234**
Young Mums Workshops	122	301	301	301	**301**
Special Events	182	896	1069	300	**1987**
Total	**4986**	**3884**	**4573**	**2574**	**8221**

Overall the number of individuals receiving health promotional education and information was **8221**. More detailed information is described under the various workshops and educational activities.

Zone Nurse Training

The Divisional Medical Officer Western and the SDHS attended the first workshop for the identified Zone Nurses and their supervisors. They were appraised of the CCOHSI project objectives and implementation. Since all the health interventions proposed in the project were consistent with the MoHMS guidelines the Zone Nurses were generally enthusiastic in their support. The project health activities would assist the Zone Nurses in their work e.g. screening for NCDs, providing contraception, and screening women for cervical cancer. This component of the project has been a mutually learning experience and partnership. The Zone Nurses better understand the value of the Community Health Worker and the Health Committees. The project team has a clearer understanding of the role of Zone Nurses and the difficulties they face.

A second workshop for Zone Nurses responsible for the 30 communities was undertaken on World Cancer Day to discuss importance of screening for cancers and recognising overt cancers. The Zone Nurses later joined in the stakeholder workshops for their respective communities.

Table 5: **Zone Nurse workshops by education type conducted in the Project**

Date	Workshop	NCD	SRH	SI	CCOHSI Project education	Total
27/04/2016	CCOHSI Workshop	23	23	23	23	23
03/02/2016	World Cancer Day	0	25	0	0	25
Total		**23**	**48**	**23**	**23**	**48**

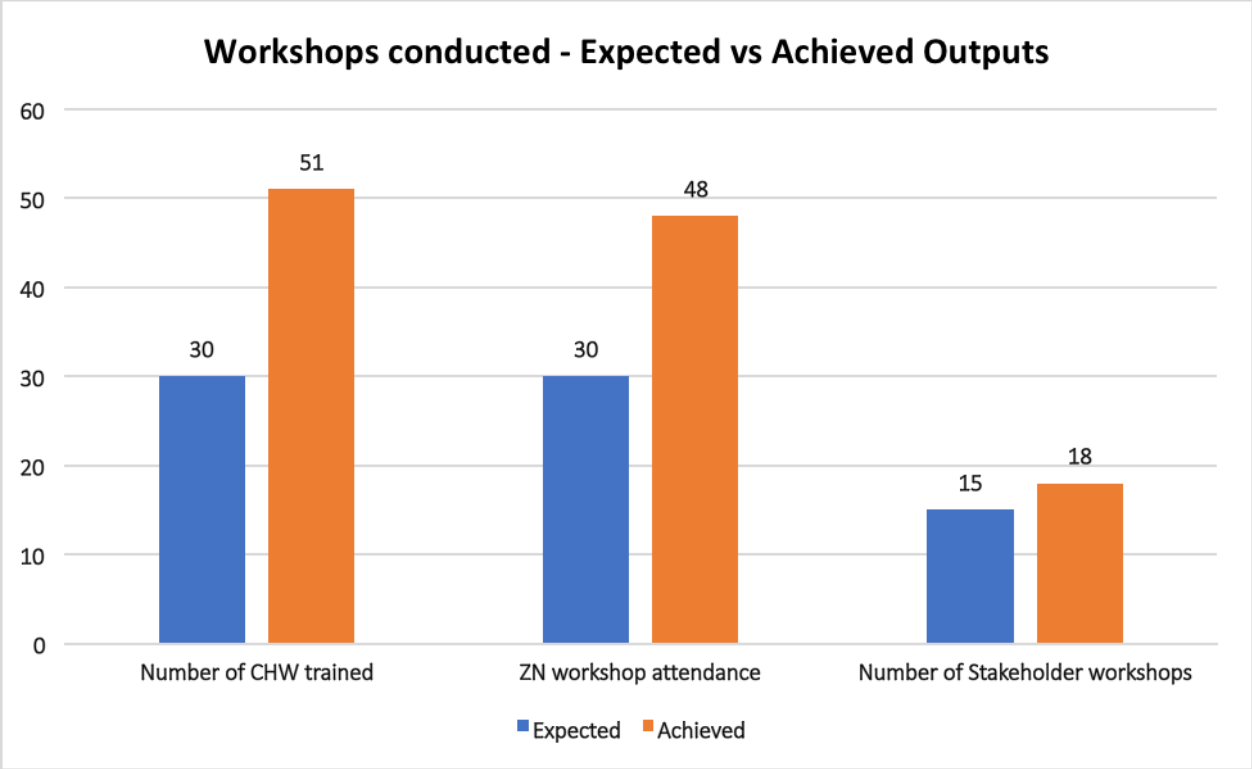
Many of the Zone Nurses joined the following activities during the project:

- Profiling
- Stakeholder's workshops
- Outreach education and screening
- CDP workshops
- Young mothers empowerment workshops
- CDP activities

The following benefits have resulted for the Zone Nurses from the CCOHSI project. The Zone Nurses:

- have become more engaged with the community and stakeholders
- have increased their visibility in the community
- have developed better working relationships with CHWs
- were better able to meet required MoHMS targets
- strengthened their knowledge in health and social issues of the community
- developed better relationship with relevant stakeholders outside of MoHMS
- became more aware of access to services available for communities
- broadened their approach to health care with emphasis on preventative health and community ownership
- were upskilled in referring social issues such as domestic violence and child abuse
- increased their access to the community by raising their profile.

Figure 5: **Expected v Achieved outputs of CHW training, Zone Nurse Workshop attendance and stakeholder workshops conducted**



All training and workshops for up skilling stakeholders achieved more than the initial expected results of the project.

Zone Nurse Workshops

Ba Province Zone Nurse workshop held at Western Health, Lautoka

CCOHSI meeting with Sister La, Ba Health Centre.

Group discussion at the Ba Zone Nurse workshop at Western Health, Lautoka

Zone Nurses and Stakeholders participating in CCOHSI Outreach and Stakeholder meeting in Vatuyaka Settlement, Ba

Dr. Swaran Naidu presenting on different types of cancers at the VSHC Zone Nurse Cancer workshop

Nisha, CCOHSI Counsellor, presenting on Social Issues to the Zone Nurses at the Cancer Workshop

Community Health Workers Training

The CHWs received training in health promotion to reduce lifestyle risk factors for NCDs and SRH. They also received training on discussing social issues such as domestic violence and child protection. The CHWs were informed on their role in advocacy and were encouraged to speak in interactive sessions. They were trained in engaging community members and stakeholders in owning community health and social issues. They were advised that they would be the main contact point for the project in their villages or settlements. Their role as CHWs was reinforced defined and they were made aware of their limitations and boundaries. Understanding confidentiality and respecting people's privacy was an integral part of their training. 25 CHWs attended the initial five-day training program**.** Further training had to be undertaken for another 26 individuals over the ensuing 2 years as the need arose. The CHWs became the voice of the community. They were the conduit between the community, the Health Committee, and through the Zone Nurse with the health system. They also became aware of engagement with the other stakeholders involved in community development. CHWs were the main force in the community for the community development projects and became vital and central to the execution of all activities in the communities.

Many of the existing CHWs were not very active prior to the start of the project. The active ones were from Nasolo Village, Natalecake Village, Lavuci Settlement, Vadravadra Village and Navakai Settlement. Those from other communities were struggling; not well engaged with some of the Zone Nurses, Health Committees, community leaders or Turaga ni Koros and often having difficulty gaining recognition in the communities. Their CHW profile was raised in these situations. Where there was no CHW appointed in a community, a suitable person was identified for the role and trained and mentored throughout the project. After the training none of the male recruits trained actually worked as CHWs but assisted in some community activities.

Table 6: **CHWs Trained by Age Category And Gender:**

Age category (years)	Female	Male	Total
20-29	4	1	5
30-39	14	3	17
40-49	11	0	11
50-59	15	1	14
60-69	4	0	4
Total	**48**	**3**	**51**

CHW training and Capacity building

Table 7: **CHW training and capacity building sessions**

Dates	CHW Workshop	Number of Attendees by Educational Topics				
		NCD	SRH	SI	General	Total
23/05/16 - 27/05/16	CHW Training Forestry	25	25	25	0	25
25/07/16	CHW CDP Training	18	18	18	18	18
11/10/16 - 13/10/16	Youth Office- CHW training	9	9	9	0	9
09/11/16 - 10/11/16	VSHC CHW Training	7	7	7	0	7
02/12/16	VSHC 16 Days of Activism Awareness	0	0	17	0	17
31/01/17	VSHC CHW Training	9	9	9	0	9
05/09/17	VSHC CHW Training	1	1	1	0	1
08/12/17	Shirley Park 16 Days of Activism Awareness	0	0	16	0	16
2016 - 2018	Young Mothers Workshops	37	37	37	37	37
Total		**106**	**106**	**139**	**55**	**139**

CHW Training

CHWs Kelenoa and a Nakolia Settlement representative presenting on the causes of teenage pregnancy at their CHW Workshop held at VSHC

Koroi running an 'energiser' at CHW training at VSHC

CHWs presenting on NCDs at their CHW Workshop at Ministry of Agriculture Office, Lautoka

CHW Workshop, composting education by CCOHSI team at Ministry of Agriculture Office, Lautoka

Group work facilitated by Mosese and the CCOHSI team at CHW training held at Ministry of Youth and Sports Conference Room

A healthy cooking demonstration at the initial CHW Workshop held at Ministry of Agriculture Office, Lautoka

The CHWs were trained in health promotion with an emphasis on wellness. There was discussion in advocating using the principles of 'The 7 Gifts of Life' which if abused cause disease. The seven gifts are:

1**. Thinking** positively
2**. Breathing** fresh air
3**. Eating** healthy nutritious food
4. D**rinking** water
5. M**oving** and being physically active
6. R**esting** with enough sleep
7. R**eproducing** responsibly with healthy relationships

CHWs were also given tools to promote healthy lifestyles in the communities based on the MoHMS's SNAP model.

1. SNAPSS:

The project has added 2 more Ss to SNAP ie stress reduction and safe sex to the existing 'smoking, nutrition, alcohol and physical activity'.

Smoking: **All smoking is bad for health.** Smoking causes cancers and promotes heart disease and other NCDs. It has a negative effect on the fetus and the pregnant mother and causes respiratory problems in children.

Nutrition**:** A healthy plate, portion control, adequate fresh fruits and vegetables, decrease in use of salt, sugar, unhealthy fizzy drinks, increasing use of water for drinking, decrease in fatty foods and oil and a balanced diet makes for good nutrition.

Alcohol & Kava: **Abuse of alcohol and kava drinking is a major health and social issue.** Individuals need to understand the adverse effects of alcohol on health and family as well as society. Decrease or cessation of Kava drinking is essential in reducing many adverse social effects on the family and society.

Physical Activity: Being mobile and active was strongly recommended with some moderate physical activity approximately 30 mins a day 3 to 4 times a week. Promoting walking in groups, Zumba, or volleyball

Stress reduction**:** Positive thinking, self awareness, right conduct, respect for others rights and tolerance are all directed to reducing stress. Socio economic empowerment, good health and physical, social and mental wellness are key.

Safe **S**ex: Impact of unsafe sex with unplanned pregnancies, STIs and their consequences leads to health and social problems.

2. NCDs: Brief overview of NCDs was also covered with need for screening and management of those with disease was touched upon. Compliance with SNAP as above and medications was to be advocated for management of those with NCDs.

3. SRH: Topics covered were safe vs unsafe sex and its consequences of unplanned pregnancies and STIs; teenage pregnancies, cervical cancer and its screening,

4. Empowerment of Women and girls and Gender Equality

5. Social Issues: Gender Based Violence, Positive parenting, Child abuse and child protection, services available; Laws governing these and our obligations

6. CHWs roles, responsibility, boundaries: Resources and reporting mechanisms were developed and practical training with these was undertaken during the project.

Activities Conducted by CHWs During the Project

As a result of their training, mentoring and empowerment the CHWs undertook many activities within the project period including health promoting activities and engaging with stakeholders to take ownership of the communities' issues. Health promotional activities included (refer to table 25):

- Backyard Gardening
- General Health Education
- Non-Communicable Disease Education
- Sexual and Reproductive Health Education
- Social Issues Education
- Composting Education and Demonstration
- Waste Management Education
- Sanitation and Hygiene
- Healthy Cooking Demonstration
- Clean up Campaigns
- Physical Activity and Community Fun Days
- Water Management Education
- Farming and Animal Management Education
- Disaster Management Education

Table 8: **Stakeholders Engaged by CHWs and Health Committees**

Government Organisations and Personnel	**Other Organisations**
Ministry of Health and Medical Services: • DMO Western, SDMOs, SDHS from Nadi, Lautoka, Ba and Tavua • Health Inspectors • Zone Nurses	Viseisei Sai Health Centre
	Empower Pacific
	iTaukei Land Trust Board
	Fiji Electricity Authority
Ministry of Agriculture	Water Authority Fiji
Ministry of Labour, Industrial Relations and Productivity	Diabetes Fiji
Ministry of Women, Children and Poverty Alleviation	South Pacific Business Development (microfinance)
Ministry of Education, Heritage and Arts	Fiji Sugar Corporation
Ministry of Youth and Sports	Red Cross
Ministry of Industry and Trade and Tourism	Consumer Council Fiji
Ministry of Waterways	University of Fiji
Ministry of Land and Mineral Resource	International Planned Parenthood Federation
Ministry of iTaukei Affairs Ba Provincial Council	Pacific Feeds
	Fiji Women's Crisis Centre
Ministry of National Security and Defence • Fiji Police Force • Fiji Military Force	Ba Women's Forum
	Peace Corp
Ministry of Local Government, Housing, Environment, Infrastructure and Transport • Fiji Roads Authority • Rural Local Authority • Municipal Councils o Lautoka City Council o Nadi Town Council o Ba Town Council o Tavua Town Council	

Challenges of Retention and Deployment of CHWs

There were several challenges in retention and deployment of CHWs. CHWs are mainly volunteers, generally disempowered to begin with and often mobile for personal reasons.

Some examples of challenges by communities:

- **Seniyaya settlement –** 4 CHWs needed to be recruited and trained over a period of time because of attrition. The reasons for leaving included lack of recognition and support from the community, personal illness, or having moved from the community
- **Vatulaulau Settlement –** 3 trained -1 dropped off because of personal social problems; 1 migrated overseas
- **Nakolia Settlement –** The first CHW (male) did not have community support as he was also a member of the Crime Committee, while the second CHW was not active because of other family commitments. Eventually a mother and daughter in law team did the work as the mother needed assistance with English language

Recognition by communities was harder for **settlements** due to their own lack of structure and social cohesion.

Stakeholder Training Workshops

Stakeholder workshops were conducted to ensure that the various local authorities, Turaga ni Koros, Advisory Councillors, Health Committee members, faith based organisations, women and youth leaders, CHWs and Zone Nurses together as a group received information on NCD lifestyle risk factors, Sexual and Reproductive Health and Social Issues. These stakeholders were then able to discuss their communities' issues and identify health and social priorities they wished to tackle together under CDPs. These workshops provided a space and an opportunity to network, work on common areas of concern and start planning on possible community development projects. A total of 375 individuals were trained during these workshops.

Table 9: **Stakeholders Workshops Conducted:**

Dates	Area	No. of Attendees for Various Topics				
		NCD	SRH	SI	CDP	Total
31/05/2016	Naviago Village/ Vitogo Village/ Matawalu Village/ Vadraiyawasewa Settlement/ Vanuakula Settlement	36	36	36	36	36
15/06/2016	Saru Village/Tavakubu Settlement	21	21	21	21	21
29/06/2016	Namoli Village	23	23	23	23	23
21/07/2016	Seniyaya (Lovu) Settlement	23	23	23	23	23
04/08/2016	Navakai Settlement/Yavuna Village	17	17	17	17	17
16/08/2016	Vatutu Village/Nakolia Settlement	16	16	16	16	16
31/08/2016	Nawaqadamu Village/Loqi Settlement	15	15	15	15	`15
21/09/2016	Sorokoba Village/Vatuyaka Settlement	26	26	26	26	26
29/09/2016	Lavusa Settlement	11	11	11	11	11
04/10/2016	Vadravadra Village/Lavuci Settlement	20	20	20	20	20
06/10/2016	Natalecake Village	21	21	21	21	21
19/10/2016	Nasolo Village/ Vatulaulau Settlement	12	12	12	12	12
15/11/2016	Tavualevu Village /Yasiyasi Settlement	20	20	20	20	20
06/12/2016	Nadala Village	26	26	26	26	26
07/12/2016	Koro Village/ Drala Village/ Buyabuya Village	19	19	19	19	19
02/03/2017	Lauwaki Settlement/ Delaisaweni Settlement	18	18	18	18	18
31/03/2017	Maururu Settlement	30	30	30	30	30
05/04/2017	Nadelei Village	21	21	21	21	21
Total		**375**	**375**	**375**	**375**	**375**

Formation or Revitalisation of Community Health Committees

Community Health Committees were previously mandated to oversee the cleanliness of their communities. Under this project, their role was widened to health promotion, advocacy and prioritising health issues.

Table 10: **Table of Number of Existing Vs Newly Formed Health Committees by Community Type**

Community Type	Existing		Newly Formed
	Active	Inactive	
Villages	10	4	1
Settlements	2	2	11
Total	**12**	**6**	**12**

Twelve new Health Committees were formed: 11 were in settlements and 1 in a village. Of those that had an inactive Health Committees, 2 were in settlements and 4 in villages. Of the 12 that were active in some form 10 were from villages and 2 from settlements. They required still needed capacity building in health and social issues undertaken during stakeholder workshops and on field assistance with CDP. All 18 Health Committees that were existent were revitalised.

Health Promotion Outreach

There were 38 outreach health promotion/education sessions, which were conducted together with the screening activities.

Table 11: **Health Promotion Activities Conducted by CCOHSI Team in Communities**

Dates	Area	No. of Attendees for Various Topics			
		NCD	SRH	SI	Total
06/06/2016	Vitogo Village	56	56	56	56
08/06/2016	Naviago Village	69	69	69	69
13/06/2016	Vanuakula Settlement	29	29	29	29
20/06/2016	Vadraiyawasewa Settlement	34	34	34	34
20/06/2016	Dreketi Sangam Primary School (Parents)	25	0	25	25
22/06/2016	Saru Village	74	74	74	74
27/06/2016	Matawalu village	51	51	51	51
07/07/2016	Tavakubu Settlement	65	65	65	65
27/07/2016	Seniyaya Settlement	54	54	54	54
03/08/2016	Namoli Village	87	87	87	87
05/08/2016	Navakai Settlement	31	31	31	31
15/08/2016	Yavuna Village	90	69	90	90
18/08/2016	Vatutu village	43	43	43	43
18/08/2016	Nakolia Settlement	35	35	35	35
31/08/2016	Nawaqadamu Village	22	22	22	22
08/09/2016	Loqi Settlement	33	33	33	33
22/09/2016	Sorokoba Village	36	36	36	36
23/09/2016	Vatuyaka Settlement	47	47	47	47
30/09/2016	Lavusa Settlement	54	54	54	54
05/10/2016	Vadravadra Village	41	41	41	41
05/10/2016	Lavuci Settlement	15	15	15	15
11/10/2016	Natalecake Village	25	25	25	25
20/10/2016	Vatulaulau Settlement	31	31	31	31
21/10/2016	ATS Nadi	24	24	24	24
27/10/2016	Mulomulo Muslim Primary School (Parents)	45	45	45	45
03/11/2016	Nasolo Village	33	33	33	33
15/11/2016	Tavualevu Village	47	47	47	47
17/11/2016	Yasiyasi Settlement	21	21	21	21
19/11/2016	Lauwaki Settlement	48	0	0	48
23/11/2016	Saru MGM Primary School (Parents)	28	28	28	28
07/12/2016	Koro Village	26	26	26	26
08/12/2016	Drala Village	27	27	27	27
08/12/2016	Buyabuya Village	33	33	33	33
20/03/2017	Nadala Village	37	37	37	37
21/03/2017	Drala Village	27	27	27	27
23/03/2017	Maururu Settlement	37	37	37	37
01/08/2017	Drasa Primary School (Parents)	51	51	0	51
03/08/2017	Meighania Muslim Primary School (Parents)	26	26	26	26
Total		**1557**	**1463**	**1458**	**1557**

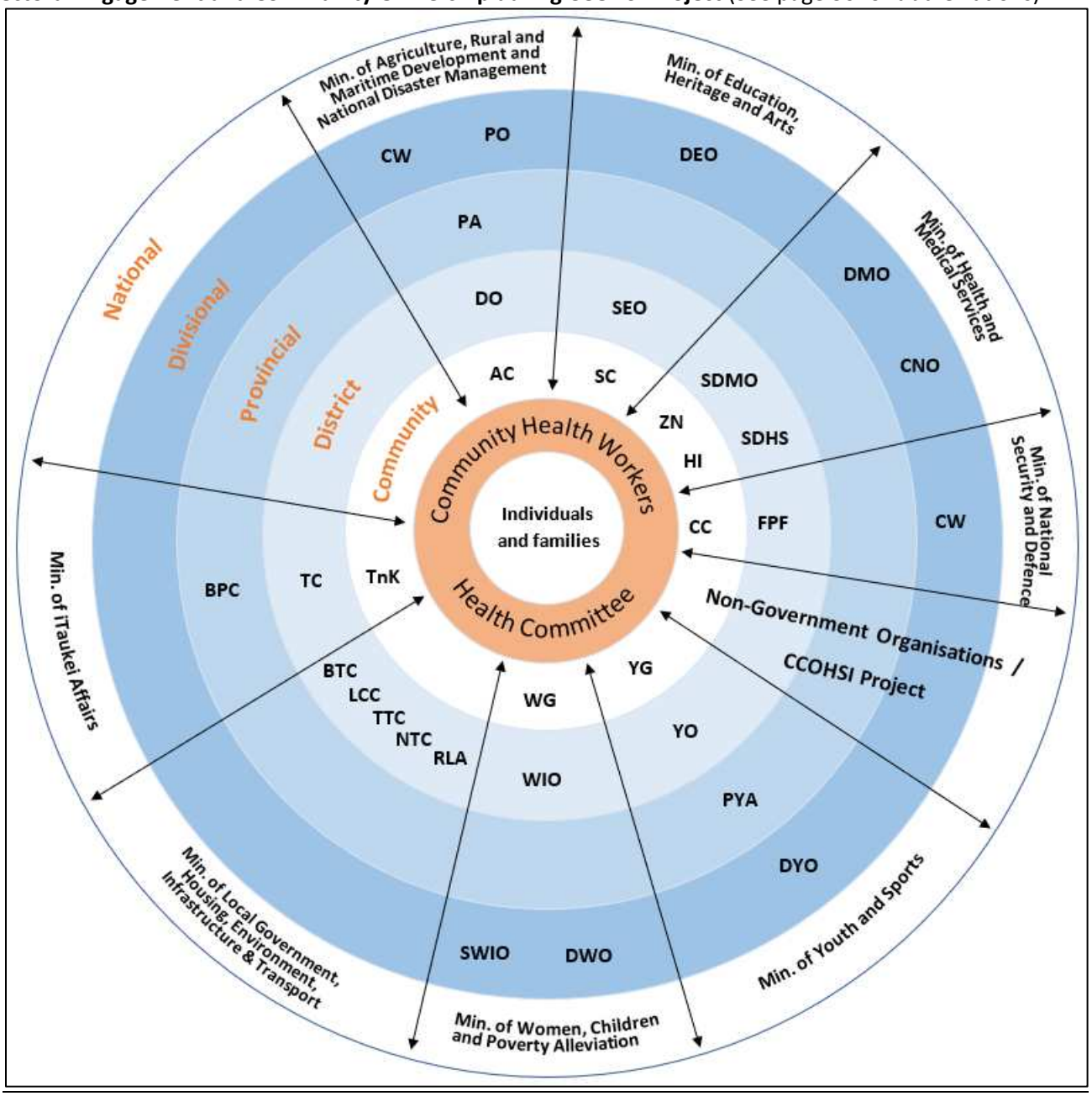
CCOHSI team members were often invited to speak at schools on WASH program, Health and Hygiene, TB awareness, Drug and Alcohol, Positive Parenting, Child Protection, Wellness and NCD risk factors, Gender Equality, Safe Sex & HIV education.

Table 12: **Health Promotion in Schools**

School	NCD	SRH	SI	General	Total Attendees
Drasa Muslim Primary School	0	0	68	0	**68**
Dreketi Sangam Primary School	88	0	88	0	**88**
Lovu Sangam Primary School	86	0	86	0	**86**
Dreketi Sangam Primary School	0	0	84	0	**84**
Vatuyaka Sangam Primary School	22	14	22	0	**22**
Togo Primary School	86	0	0	79 (hygiene)	**86**
Vatulaulau Sanatan Primary School	47	0	0	0	**47**
Mulomulo Muslim Primary School	150	150	150	0	**150**
Khalsa Primary School	0	0	0	239 (TB)	**239**
Drasa Primary School	311	0	311	311 (hygiene)	**311**
Mulomulo Muslim Primary School	200	200	0	0	**200**
Dreketi Sangam Primary School	0	0	113	0	**113**
Drasa Primary School	0	0	0	25 (hygiene)	**25**
Gurkul Primary School	0	0	0	15 (hygiene)	**15**
Meighania Muslim Primary School	46	0	0	46 (hygiene)	**46**
Total	**1036**	**364**	**922**	**715**	**1580**

Inter-sectoral linkages and engagement/ownership to build resilience within the communities
The project strengthened the inter-sectoral linkages through advocacy, consultation and networking in order to assist the sectors to have a better understanding of the health and social issues. The key issue of sustainable lifestyle changes was emphasised so that there was maximum collaboration in finding solutions. **CHWs, Health Committees and community's leaders** have become familiar with the benefits of these inter sectoral linkages and as a result of the project have become up skilled to engage with the various stakeholders.

Figure 6: **Diagram Showing the Pivotal Role of Community Health Workers and Health Committees in Inter-sectoral Engagement and Community Ownership during CCOHSI Project** (See page 36 for abbreviations)



See below for explanation of abbreviations.

Abbreviations used in Figure 6

Ministry of Youth and Sports
DYO - Divisional Youth Officer
PYA - Provincial Youth Administrator
YO - Youth Officer
YG - Youth Group

Ministry of Agriculture, Rural and Maritime Development and National Disaster Management
CW – Commissioner Western
PO – Planning Officer
PA - Provincial Administrator
DO – District Officer
AC – Advisory Councillor

Ministry of Women, Children and Poverty Alleviation
DWO - Divisional Women's Officer
SWIO - Senior Womens Interest Officer
WIO – Womens Interest Officer
WG – Womens Group

Ministry of iTaukei Affairs
BPC – Ba Provincial Council
TC – Tikina Council
HC – Health Committee
TnK – Turaga ni Koro

Ministry of Health and Medical Services
DMO – Divisional Medical Officer
CNO – Chief Nursing Officer
SDMO – Sub Divisional Medical Officer
SDHS – Sub Divisional Health Sister
CHW – Community Health Worker
ZN – Zone Nurse
HI - Health Inspector

Ministry of National Security and Defence
CW – Commissioner Western
FPF – Fiji Police Force
CC – Crimes Committee

Ministry of Education Heritage and Arts
DEO - Divisional Education Officer
SEO - Senior Education Officer
SC – School Committee

Ministry of Local Government, Housing, Environment, Infrastructure & Transport
LLC – Lautoka City Council
NTC – Nadi Town Council
BTC – Ba Town Council
TTC – Tavua Town Council

With the strengthening of Community Health Workers their roles gradually developed to become very central as the communities' advocate and the vital link not only for those working for the MoHMS but the many government and non-government organisations. With their empowerment came initiative and ownership. Their involvement in the Health Committee was crucial in identifying and executing community development projects related to health and social issues. This group of volunteers became central to all aspects of the CCOHSI project execution. With adequate support and mentoring CHWs can have a crucial role in the national effort towards wellness and reduction in lifestyle diseases in the communities. From the experience in the 30 communities it has become apparent that strengthening CHWs and Health Committees is the way to go not only for grassroots empowerment but also for inter-sectoral meaningful engagement for change.

The trained CHWs were:

- Active in the communities
- Worked in collaboration with Zone Nurses
- Conducted profiling of their communities and understood the project
- Worked well with the CCOHSI team and with their communities
- Took ownership of health and social issues within their communities.
- Became active member of Health Committees
- After initial engagement with stakeholders under CCOHSI mentoring they engaged independently with stakeholders on behalf of the communities
- Undertook several health promotion activities within the community
- Oversaw the development of proposals and implementation of CDPs
- Managed third party financing for CDPs
- Reported monthly on activities undertaken
- Assisted in completing final reports of CDPs
- Became empowered and have a voice in community meetings
- Work collaboratively with their Turaga ni Koros or Advisory Councillors
- Zone Nurses have an empowered CHW to assist in public health activities
- Impact on community leadership and Health Committee to be more effective
- Community members have access to stakeholder services through CHW

Mentoring and Facilitation of CDP Activities by CCOHSI Project Team

The team undertook ongoing education in health and Social Issues during CDPs at the request of CHWs and Health Committee s. These not only provided information, but also was an integral part of up skilling the CHWs and Health Committees building their confidence and resilience.

Table 13: **Mentoring and Facilitation of Activities by CCOHSI team members during CDPs**

Type of Activity	Number of Sessions	Number of Attendees
Healthy lifestyle for NCD prevention	67	1,512
Health promotion in SRH	19	404
Social Issues	13	264
Healthy Cooking demonstrations	23	452
Waste Management/ Composting	41	976
Health Committee meetings	51	NA
TB awareness	2	272
WASH programmes	3	47
Slab Construction for toilets	1	12
Backyard Gardening for healthy nutrition & Physical exercise	17	140
Physical Activity for health	1	26
Total	**238**	**4105**

Young Mothers Workshops

88 marginalised and disempowered young mums (mostly single) were identified and assisted through several workshops within the CCOHSI Project areas, which were also attended by CHWs, Zone Nurses and various stakeholders. Refer to empowerment of young women (p. 56) for a breakdown of workshops and attendants.

Special Events

Several special events were organised during the project, which promoted health and social issues awareness, HUMAN RIGHTS, WOMEN'S RIGHTS AND RIGHTS OF THE MINORITY GROUPS such as the LGBQT community and the survivors of AIDS and HIV. Basic Human values such as LOVE, PEACE, NON VIOLENCE, TRUTH, RIGHT CONDUCT and EQUITY of SERVICE and JUSTICE for all was implicit in all these activities. We were heartened by the support from various government and non-government organisations' support during these activities and were proud to be able to provide a space and voice for minority groups. The Elimination of Violence against women was central to most of these activities. There were 2 events at Shirley park with marches through Lautoka town to raise awareness in these areas. International Women's Day celebrations have been undertaken with great enthusiasm with marches, speeches, singing and dancing. Women from the market vendors group in Lautoka joined each of these.

Table 14: **Health and Social Issues Promotion at Special Events**

Dates	Special Events	NCD	SRH	SI	General	Total Attendees
17/06/2016	EU CCOHSI Project Launch	100	100	100	0	100
18/06/2016	Health Promotion Workshop, VSHC (Dr. Tukana)	22	0	0	0	22
02/12/2016	UN 16 Days of Activism, Viseisei	0	0	69	0	69
08/12/2016	UN 16 days of Activism, Nacula	0	18	0	0	18
09/12/2016	UN 16 days of Activism, Nacula	0	18	0	0	18
08/03/2017	International Women's Day March, Lautoka	0	0	200	0	200
09/03/2017	International Women's Day, Nadi	0	0	500	0	500
07/04/2017	World Health Day, Lautoka	0	0	0	300	300
24/10/2017	International Rural Women's Day, Lautoka	0	250		0	250
08/12/2017	UN 16 Days of Activism, Lautoka	0	200	200	0	200
18/01/2018	Women's Entrepreneurial Leadership and Youth Symposium (MoYS)	0	50	0	50	50
22/02/2018	Western Women's Craft Fair (Ministry of Women, Children and Poverty Alleviation)	0	200	0	0	200
02/03/2018	International Women's Day of Prayer (Namoli Village)	60	60	0	60	60
Total		**182**	**896**	**1,069**	**410**	**1,987**

Special Events

CCOHSI Project Launch 2016, Viseisei Village

International Rural Women's Day 2017

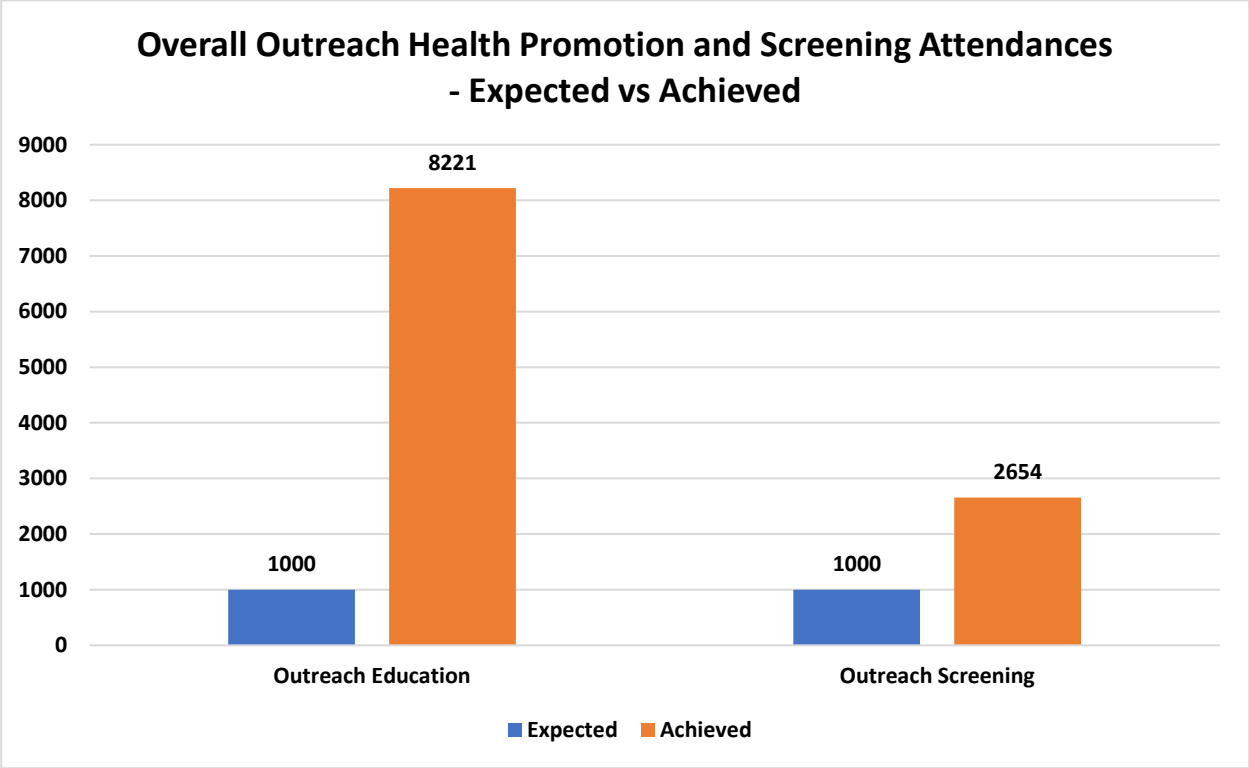
March participants at International Women's Day 2017, Lautoka

16 Days of Activism march participants 2017, Lautoka

CCOHSI team members representing the project during World Health Day 2017, Lautoka

16 Days of Activism March 2016, Viseisei Village

Figure 7: **Overall Outreach Health Promotion and Education- Expected vs Achieved**



The expected outputs for outreach health promotion and education as well as screening for NCDS, SRH and SI were significantly exceeded.

Outreach Health Promotional Activities Beneficiaries by Gender

At least 60 to 70% of all activities' beneficiaries were females. This gender distribution was evident in all activities which reflects several issues such as the timing of activities where more males may be working, poorer participation of males in health-related activities; females having a better health seeking behaviour. Having more female participation has its benefits as women generally contribute more to the lifestyle behaviours in families such as eating habits of the family and empowering women has to be a priority. However in many rural communities, males still have a dominant role in family decisions. Empowering women with knowledge and access to health and social services is empowering not just the women, but the family and society. For the health and social messages to infiltrate and affect behaviour change there is need to engage the young, the adults and the elderly. Approximately 25% of our beneficiaries that received direct health promotion, from the CCOHSI team, was 19 years or under.

Impact of training (Pre/Post Education analysis)

Change in knowledge and awareness was measured during the trainings through a pre and post questionnaire on the topics that were covered. Participant evaluations were also completed at the end of the workshops.

a) Zone Nurses

The Zone Nurses showed increased knowledge of all topics presented. A total of 19 Zone Nurses completed evaluations at the workshop, with all finding the workshop presentations good to very good. All the nurses reported learning during the workshop, mostly on counselling and social issues, and all found the workshop content useful and easy to understand. Eight of the nurses suggested for more time in future workshops.

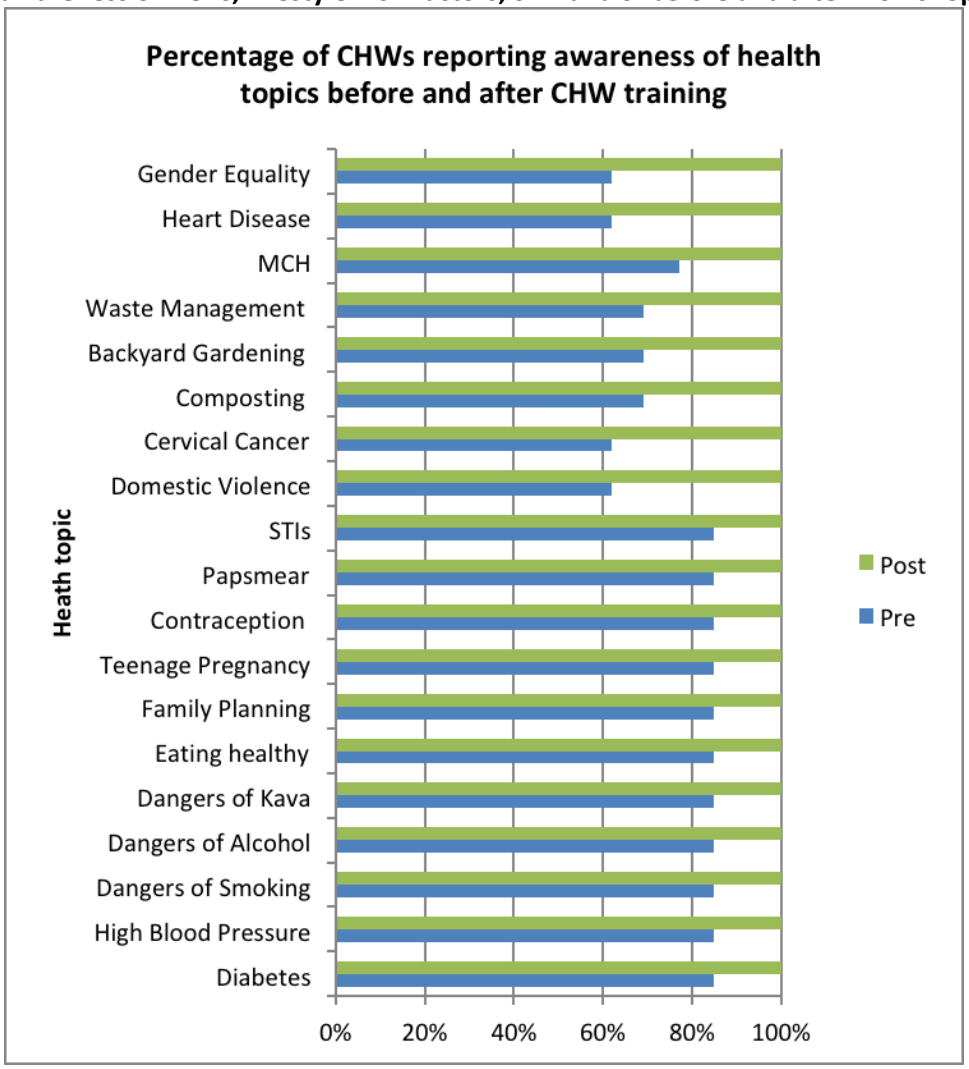
b) Community Health Workers Pre and Post Training

The percentage of CHWs who were aware of NCDs, lifestyle risk factors, SRH and social issues increased from 77% to 100% after attending the workshop, with the biggest increases shown in the topics of Domestic Violence and cervical cancer. Pre and post questionnaires showed that average knowledge scores increased from 8.5/17 (50%) to 14/17 (82%) after the workshop, a percentage increase of 32%. The largest knowledge gains were made in SNAP.

Evaluations showed NCD and SNAP were seen as the most useful or interesting topics discussed, with over half of CHWs saying they would use this information in their work through ways such as educating their community, or engaging with their Health Committee or other stakeholders. CHWs reported increased knowledge and confidence as a result of attending the workshop, with others wanting to make changes to their lifestyle through improved diet, exercise or backyard gardening. Almost all information was rated as useful, interesting and easily understood, though a main suggestion for improvement was to translate the workshops into Fijian language.

All awareness questionnaires were purely related to whether they had heard of the above health topics, whereas knowledge was for more in-depth understanding of the subject.

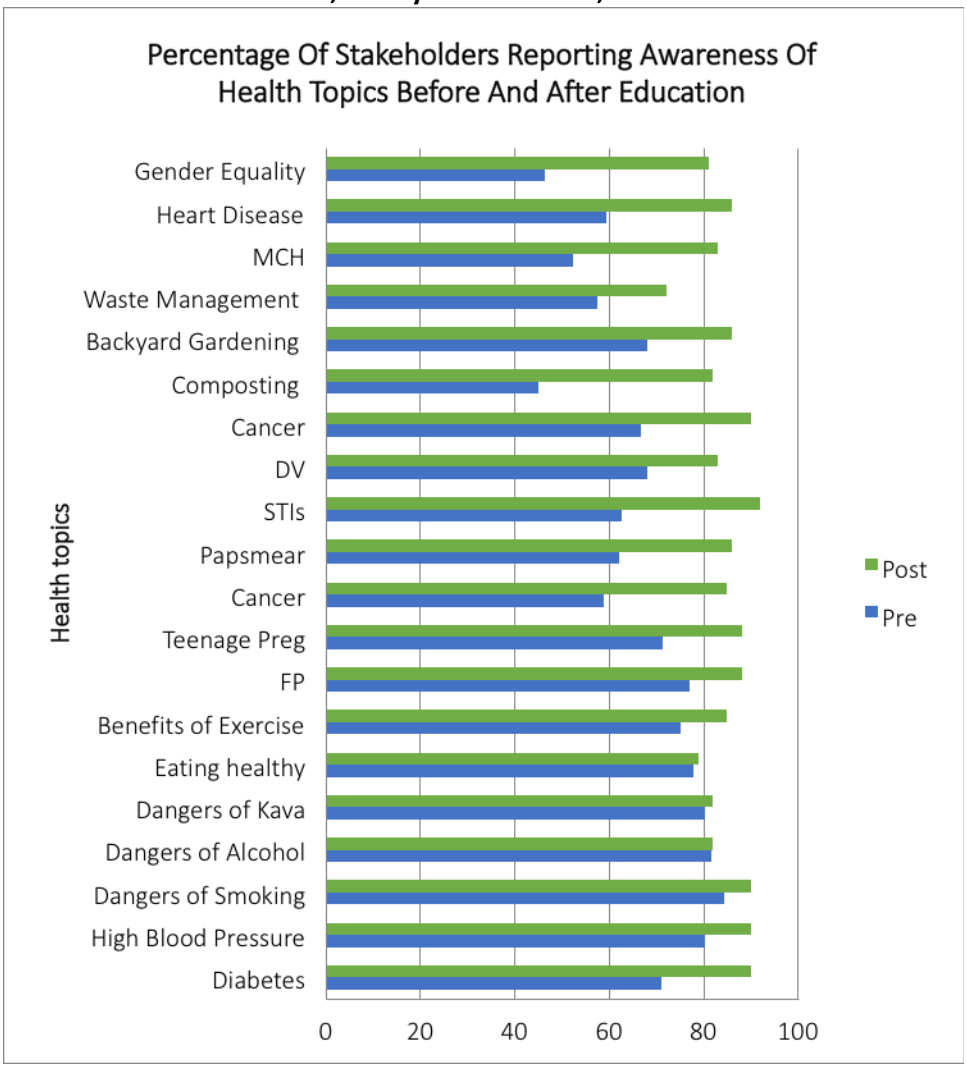
Figure 8: **CHW awareness of NCDs, Lifestyle Risk Factors, SRH and SI before and after workshop**



c) Stakeholders Pre and Post Workshop

Results showed increased awareness amongst stakeholders in all topics after the workshop (85%) compared to before (67%), with the biggest increases shown in composting, Gender Equality and MCH. The largest knowledge gains were made in SNAP, while the overall average knowledge score increased from 4.5/17 (26%) in the pre-workshops assessment to 13.3/17 (78%) after the workshop, showing a percentage increase of 52% The majority of stakeholder evaluations stated that NCD and SNAP were the most useful topics learnt about, followed by SRH and SI. Participation in the workshops resulted in increased knowledge or improved mindset for participants, as well as instigating them to change their lifestyle through diet and exercise, and focus on their relationships. All information presented was seen as useful, interesting and easy to understand. The main suggestion for improvement was to increase amount or length of time of the workshop.

Figure 9: **Stakeholders awareness of NCDs, Lifestyle Risk Factors, SRH and SI before and after workshop**



d) Community Members Pre and Post Outreach Health and Social Issues Education

The percentage of community members who were aware of NCDs, lifestyle risk factors, SRH, and social issues increased from 68% to 87% after attending the outreach program, with the biggest gains shown in composting, backyard gardening and waste management.

There was an increase in knowledge for community members on all topics after the outreach, with SNAP showing the biggest change. The average knowledge score for community members increased from 4.3/17 (25%) in the pre-workshops assessment to 12.4/17 (72%) after the workshop, showing a percentage increase of 47%.

Figure 10: **Community Members awareness of NCDs, Lifestyle Risk Factors, SRH and SI before and after Outreach Education**

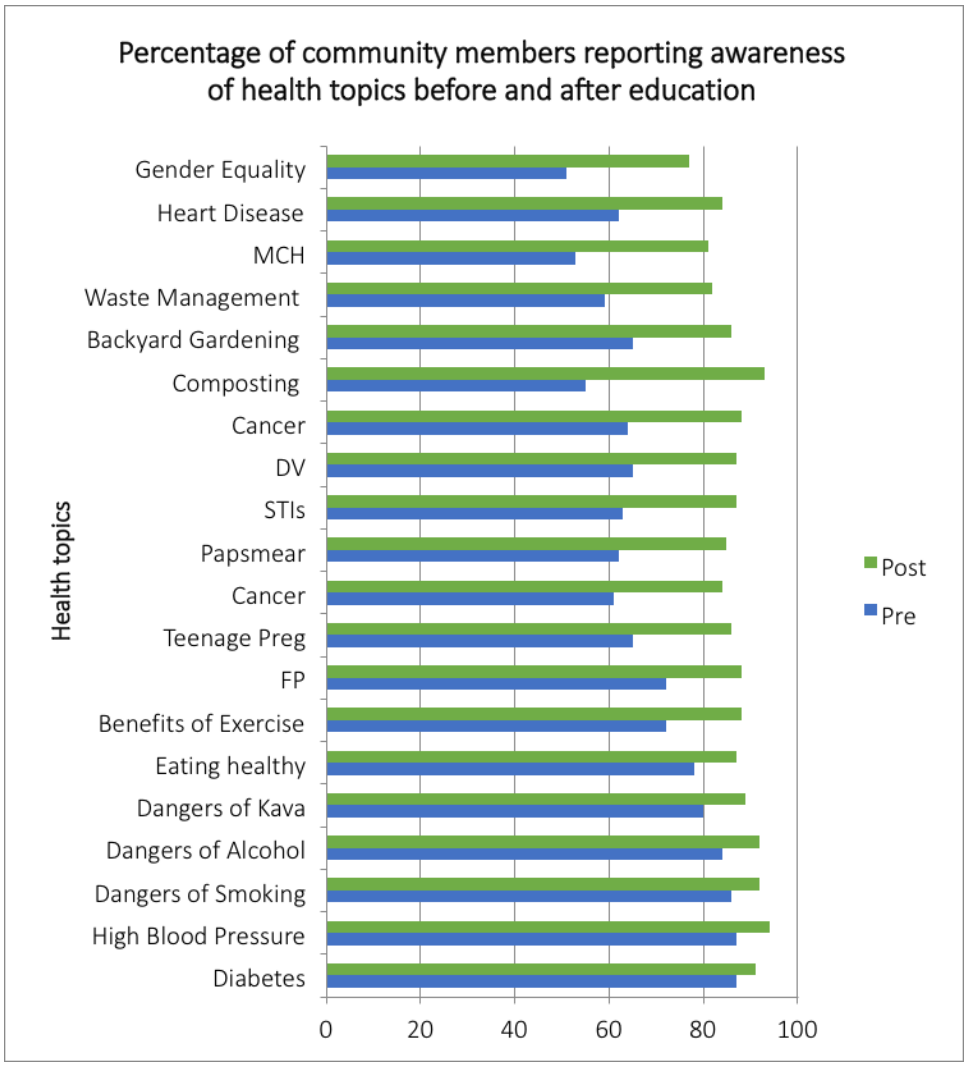
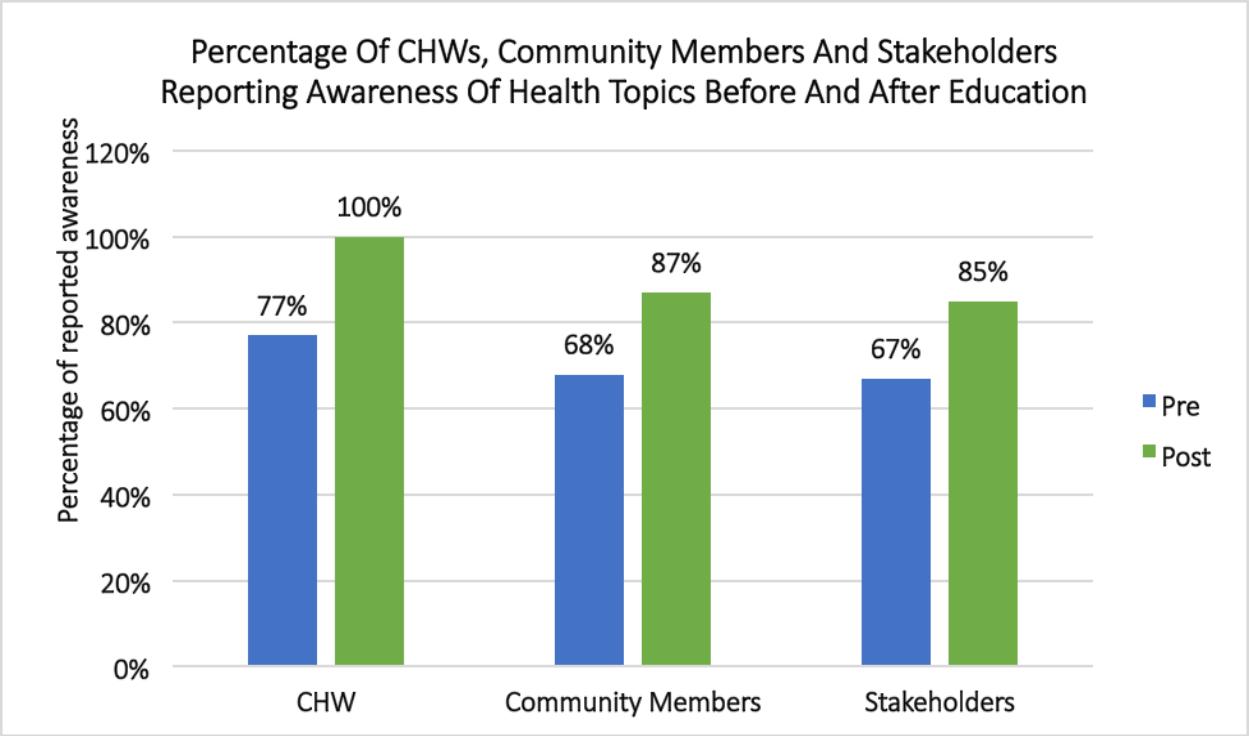
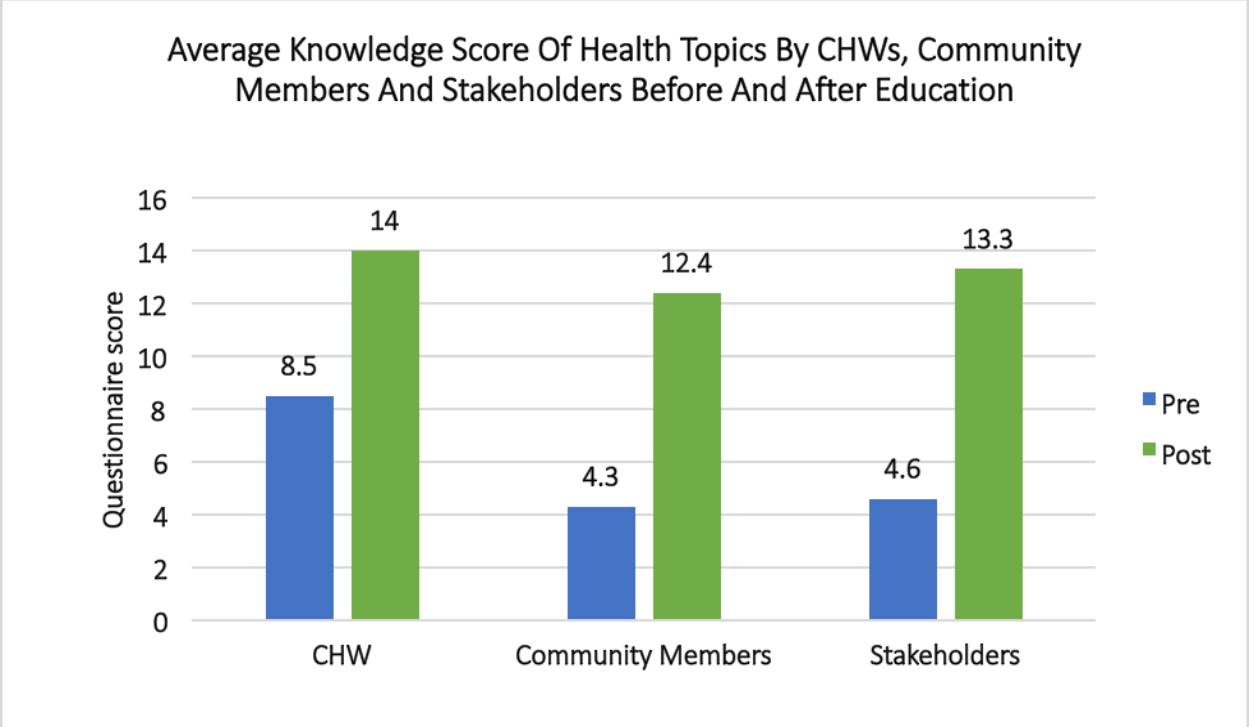


Figure 11: **Percentage of CHWs, Community Members and Stakeholders Reporting Awareness Of Health Topics Pre And Post Education**



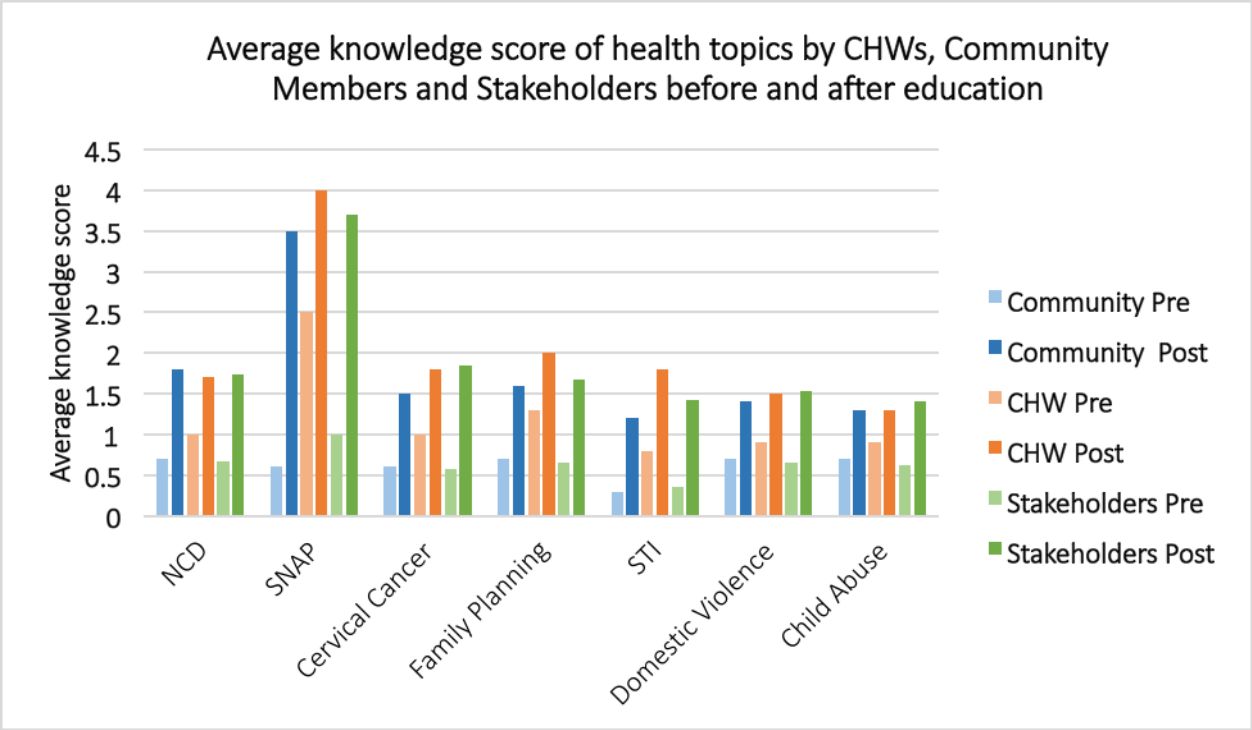
Overall awareness increased in all after the workshops.

Figure 12**: Average knowledge scores for CHWs, Community Members and Stakeholders pre and post workshop**



Average questionnaire scores increased in all participant groups on the health related topics discussed during the workshops

Figure 13: **Pre and post workshop average knowledge score for Community Members, CHWs and Stakeholders on all health topics**



The overall knowledge improved in all major topic areas of health promotion amongst all the groups. The knowledge in SNAP increased the most amongst all the participants. This has to do with the lifestyle risk factors and is very important information that needs to be understood by the stakeholders, advocates and the community members to effect lifestyle changes.

CLINICAL ACTIVIITES: NCD Screening

Figure 14: **Age Category Distribution of those screened for NCDs**

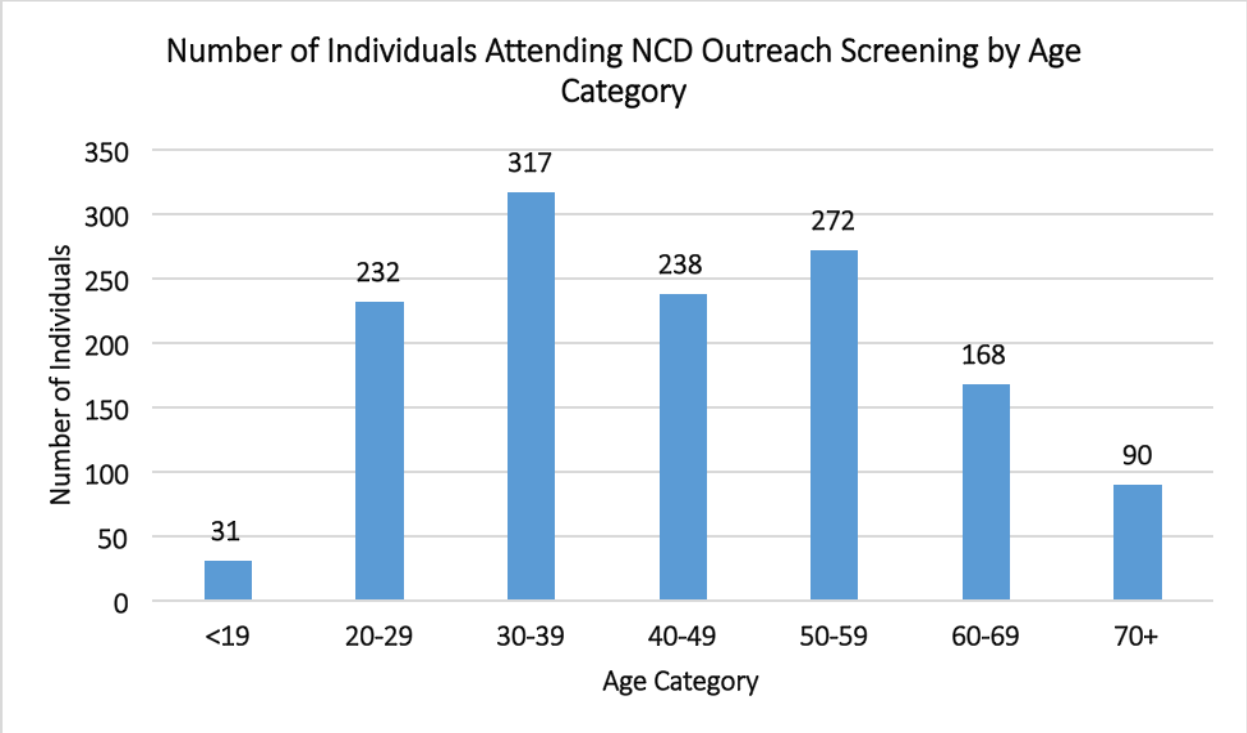


Table 15: **Number of Screening conducted for NCDs, SRH and SI During Outreach Clinics**

Dates	Area	NCD	NCD Ref	SRH	SRH Ref	Total Screenings
06/06/16	Vitogo Village	56	4	30	0	86
08/06/16	Naviago Village	73	0	17	1	90
13/06/16	Vanuakula Settlement	29	2	15	0	44
22/06/16	Saru Village	64	1	23	3	87
27/06/16	Matawalu Village	45	5	11	1	56
28/06/16	Vadraiyawasewa Settlement	34	4	10	0	44
07/07/16	Tavakubu Settlement	62	4	16	0	78
27/07/16	Seniyaya Settlement	48	8	21	1	69
30/07/16	Saru Youth Soli Day	21	0	0	0	21
03/08/16	Namoli Village	84	6	28	1	112
05/08/16	Navakai Settlement	25	1	13	0	38
15/08/16	Yavuna Village	54	24	15	0	69
18/08/16	Vatutu Village	33	3	16	0	49
18/08/16	Nakolia Settlement	35	1	12	0	47
31/08/16	Nawaqadamu Village	21	1	8	0	29
08/09/16	Loqi Settlement	29	1	13	0	42
22/09/16	Sorokoba Village	35	5	14	2	49
23/09/16	Vatuyaka Settlement	47	4	15	0	62
30/09/16	Lavusa Settlement	49	3	22	0	71
05/10/16	Vadravadra Village	38	1	4	0	42
05/10/16	Lavuci Settlement	14	0	7	0	21
11/10/16	Natalecake Village	25	0	15	0	40
20/10/16	Vatulaulau Settlement	29	0	16	1	45
21/10/16	ATS Nadi	0	0	16	0	16
27/10/16	Mulomulo School	48	0	10	0	58
03/11/16	Nasolo Village	27	0	9	0	36
15/11/16	Tavualevu Village	41	11	12	2	53
17/11/16	Yasiyasi Settlement	27	2	10	1	37
19/11/16	Lauwaki Settlement	48	0	10	0	58
23/11/16	Saru MGM Celebration	29	0	9	0	38
06/12/16	Nadala Village	0	0	7	1	7
07/12/16	Koro Village	26	5	5	0	31
08/12/16	Buyabuya Village	23	4	5	0	28
08/12/16	Drala Village	33	0	17	0	50
09/03/17	Koroivolu Park	0	0	14	0	14
20/03/17	Nadala Village	0	0	19	3	19
23/03/17	Maururu Settlement	46	0	19	2	65
04/04/17	Vitogo Village	0	0	33	0	33
30/04/17	Nawai Public School	0	0	22	4	22
01/05/17	Mulomulo Muslim	0	0	62	6	62
02/05/17	Naria Ra	0	0	37	5	37
03/05/17	Nadelei School	0	0	48	8	48

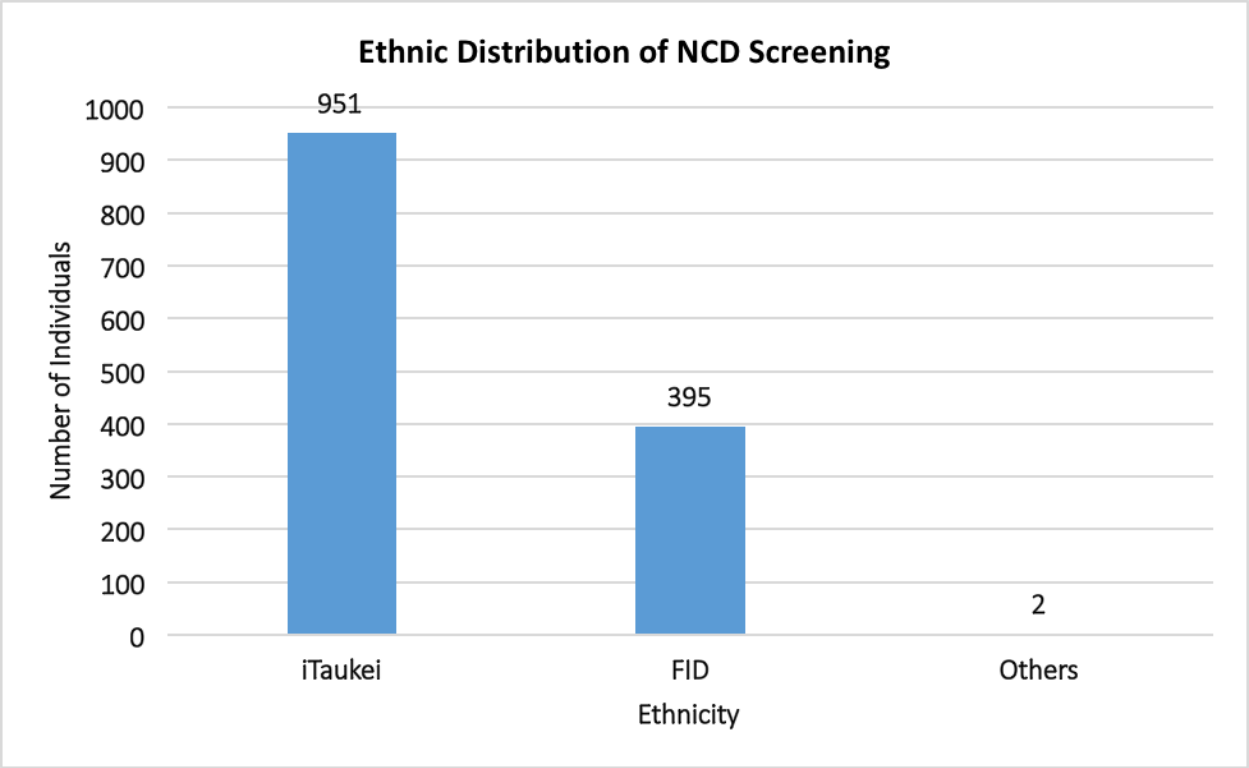
04/05/17	Khalsa School	0	0	50	7	50
05/05/17	Lovu Sangam	0	0	59	4	59
26/05/17	Navakai Settlement	59	0	15	0	74
16/06/17	Saru Church	0	0	15	0	15
01/08/17	Drasa Primary	51	0	18	4	69
07/10/17	Namosi School	0	0	40	2	40
08/10/17	Nadi Young Mothers	0	0	3	0	3
06/03/18	Final Young Mothers	0	0	10	1	10
2016-2018	VSHC	0	0	127	39	127
Total Screenings		**1408**	**100**	**1042**	**99**	**2450**

Table 16**: Summary of new counselling and social work cases by community type**

	New counselling and social work cases	**New social work cases**	**Total Social Issues cases**
Villages	21	6	27
Settlements	82	18	100
VSHC	56	21	77
Total	**159**	**45**	**204**

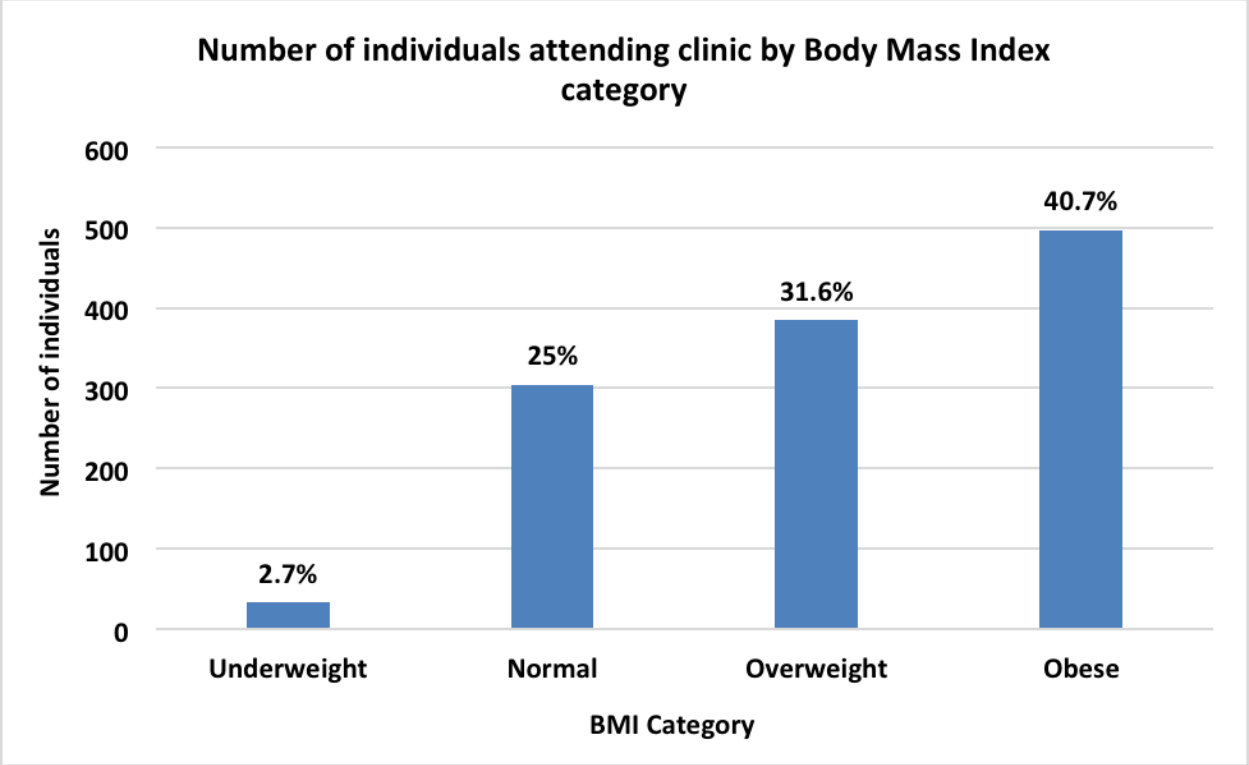
38 outreach clinics were conducted where screening for NCDs, SRH and SI were undertaken. A total of **2654 screenings** were conducted for either one or both of the above. 1408 individuals had Diabetes screening with either a random or fasting blood sugar, and measurements were taken for blood pressure (BP) and body mass index (BMI). They were advised according to the findings. At least 100 individuals were referred to either their local health centres or hospitals for follow-ups due to these findings. Majority of those screened were from the age groups where NCDs are a problem and almost 70% were females. For Sexual and Reproductive clinics, 1042 women were screened, counselled and provided with services; 99 were referred for specialist care. Sexual Reproductive Health cases were screened for need for family planning, and cervical cancer with pap smears. Social Issues new cases were seen either by self-referral or by referral from the CHW, Zone Nurses or CCOHSI team members. 204 new cases were identified during the project period.

Figure 15: **Ethnic Distribution of NCD Outreach Screening**



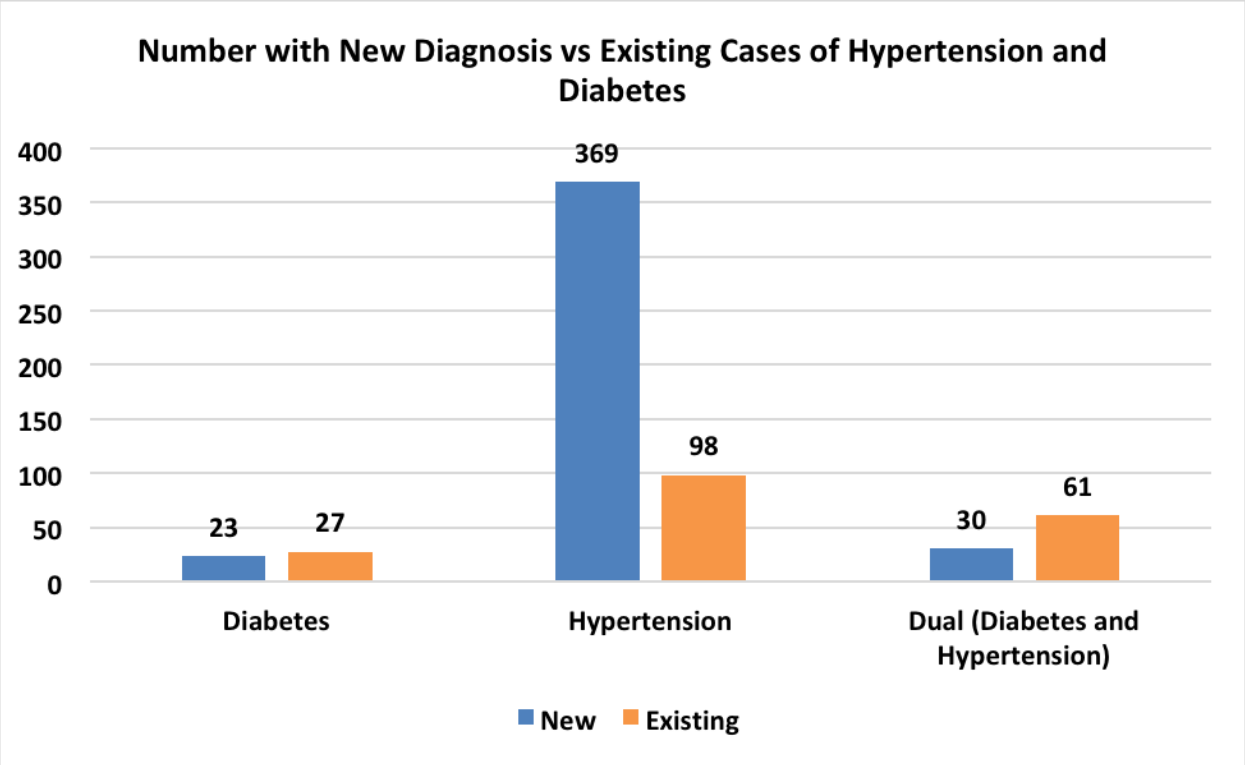
Seventy percent of those attending the NCD screenings were iTaukei.

Figure 16: **Body Mass Categories of those attending Clinics**



Almost 72% of those attending outreach NCD screenings had BMI in the overweight or obese range.

Figure 17: **Number of New Diagnosis vs Existing Diabetes, Hypertension or those with both (Dual) Hypertension and Diabetes**

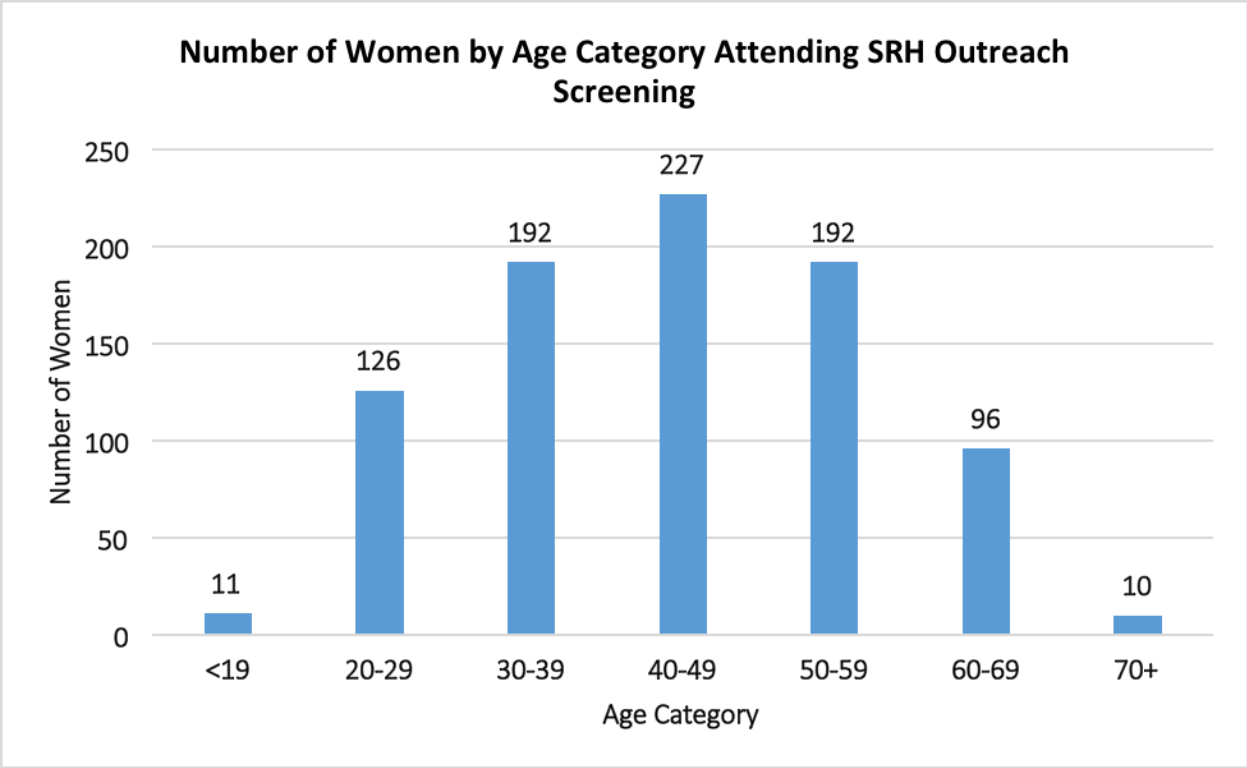


The proportion of those newly diagnosed with Diabetes and hypertension was very high for the group. This most likely reflects the fact that those who suspect they may have these attend the outreach clinics more. Also the high numbers of the new diagnosis may reflect poor health seeking behaviour or denial of knowledge of HT or Diabetes.

SRH Clinics

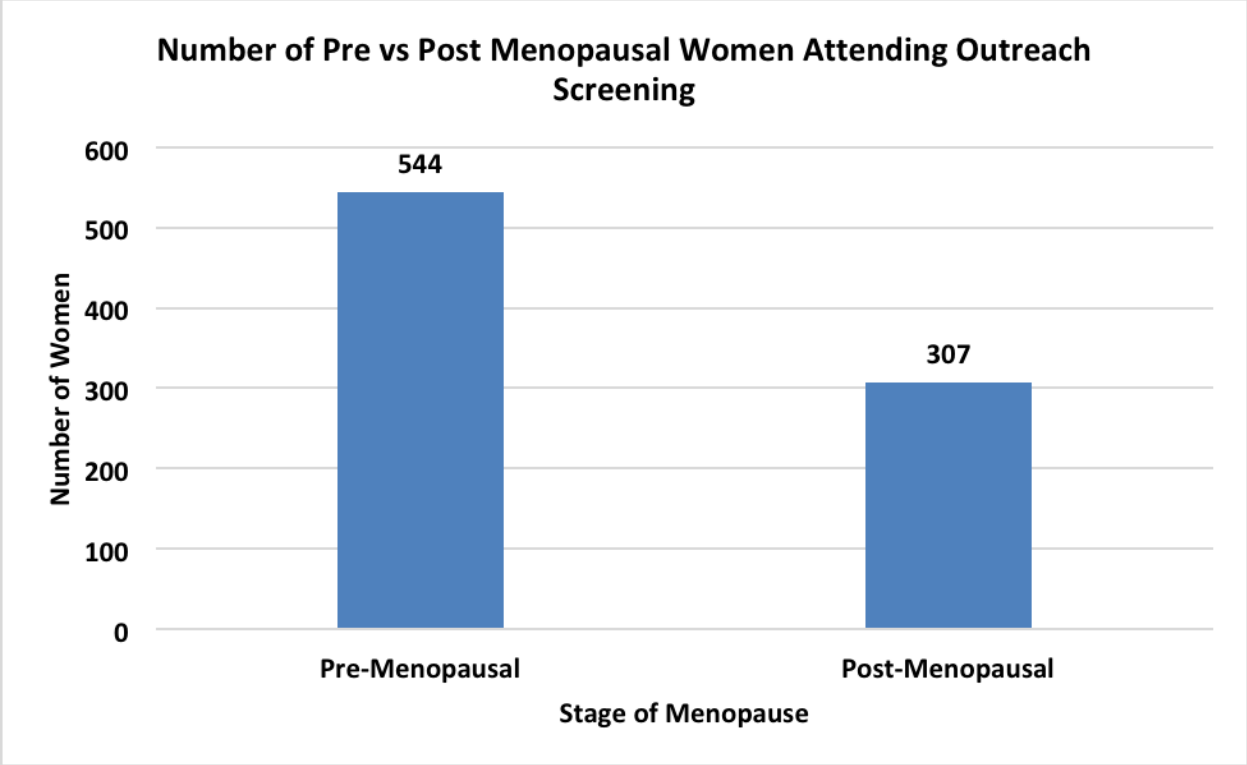
A total of **1042 women** were screened in the SRH clinic. Of these, 794 had Pap smears; 200 for the first time, 141 had family planning counselling, 19 had family planning given and 54 had STIs which was treated. 86 women needed referral for specialist gynaecological services. Of the women who attended SRH clinical outreach 57.5% were iTaukei while 42.5 % were FID.

Figure 18: **Age distribution of women attending SRH clinics**



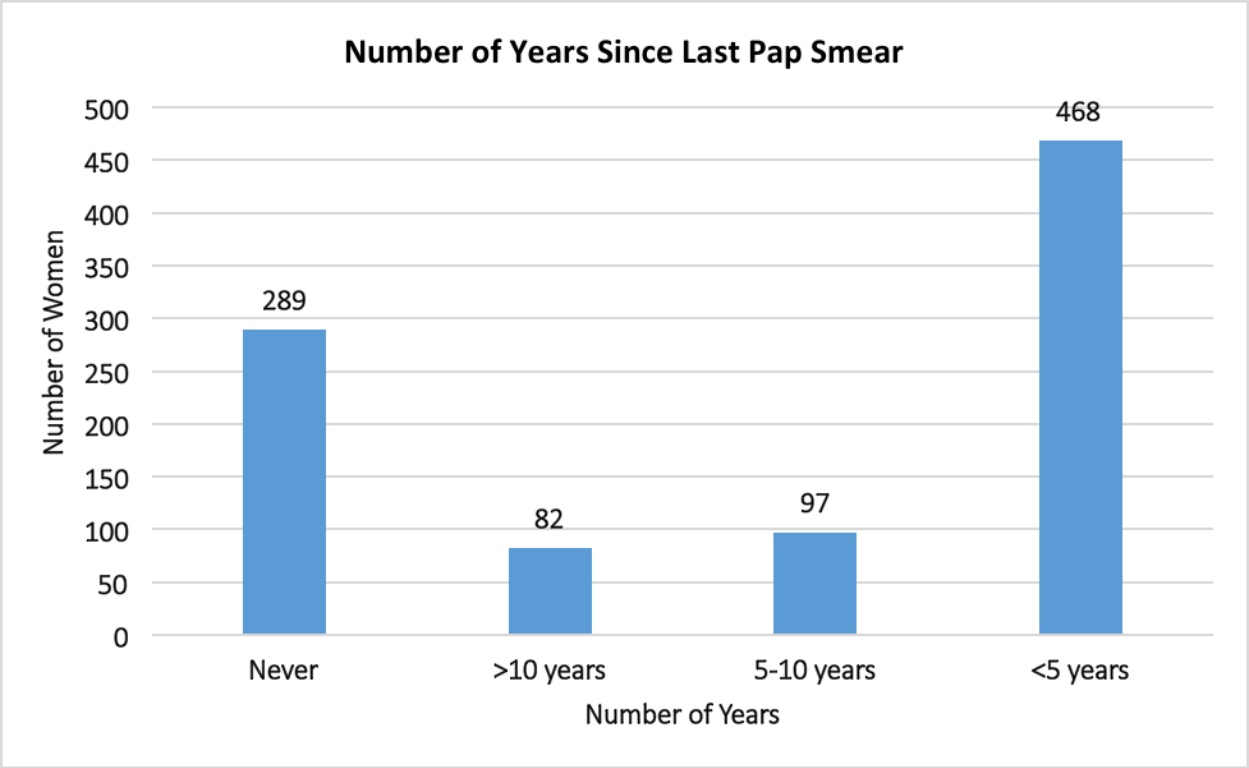
The age category of women attending SRH outreach had a normal distribution showing equal access to outreach clinics by women of all ages.

Figure 19: **Premenopausal vs Postmenopausal Status**



63% of women attending outreach SRH clinics were pre-menopausal.

Figure 20: **Number of Years Since Last Pap Smear**



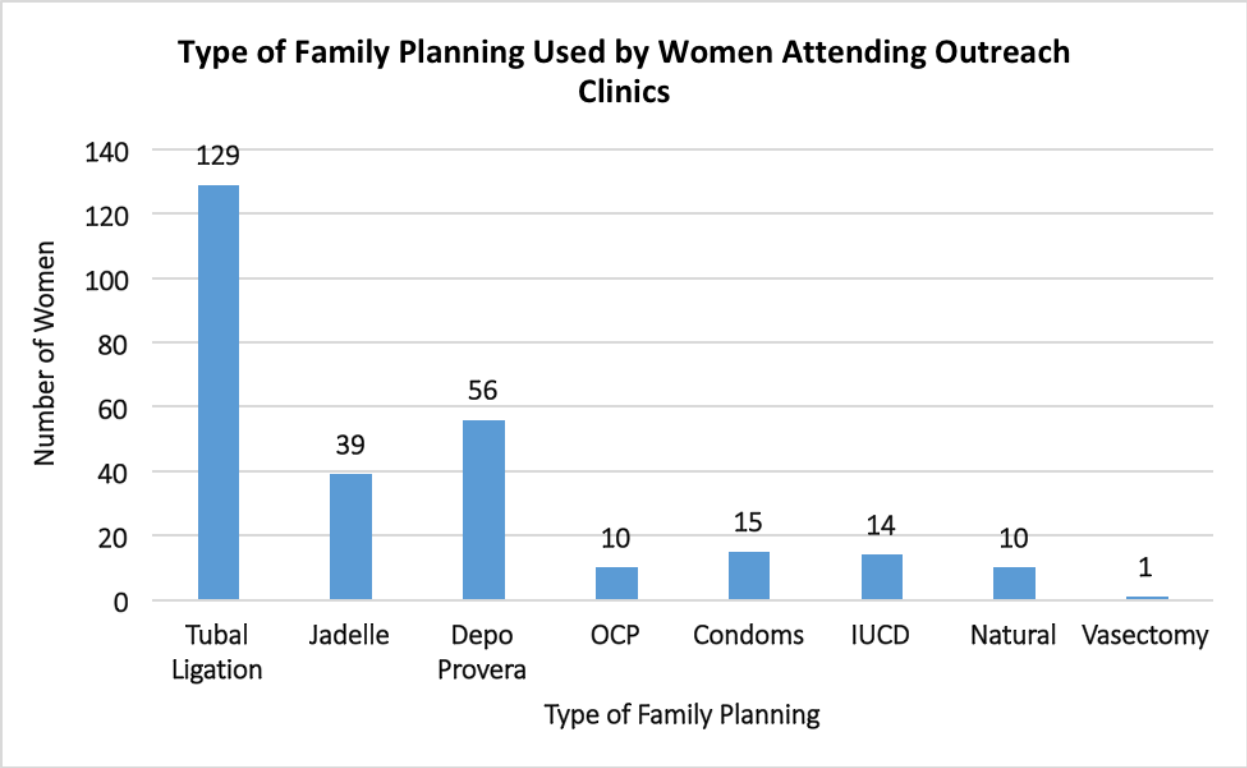
Of those that came to have a Pap smear 30% had never had one before; 8.7% had the previous one more than 10 years earlier; and 10.3% had it between 5 to 10 years. Only 50% of the women had had a Pap smear within the previous 5 years

Table 17: **A summary of Pap Smear Results**

Normal	Benign Cellular Changes (BCC)	Low Grade Epithelial Abnormality (LGEA)	High Grade Epithelial Abnormality (HGEA)	Squamous Cell Carcinoma (SCC)	Unsatisfactory
575	**212** Of these: 59 - Bacterial Vaginosis 25 - Candida 52 - Trichomonas Vaginalis 73- Atrophy 3 – Reactive changes 1 – Actinomyces	**8**	**7**	**2**	**8**

Even in a small sample of 812 Pap smear results there were 2 cases of early cancers detected from the follow up of high grade epithelial abnormality Pap results. These 2 women were treated and should have a very high survival rate as they were detected very early through Pap smears. There were 8 cases of low grade epithelial abnormality (LGEA) and 7 of high grade epithelial abnormality (HGEA). All received appropriate follow up and treatment as required. The overall detection rate for a HGEA was 0.86%, which is consistent with literature. All abnormal cases were followed up for either colposcopy with biopsy as required. The BCC cases were requested for repeat in a year after appropriate management. Cases of infection were either referred or treated by the team.

Figure 21: **Types of Contraceptives Used by Women attending SRH clinics**



There were 373 women who reported a type of family planning that they used. Tubal Ligation was the commonest form noted. Many of those who had had a tubal ligation were post menopausal. Depo Provera (injectable Progestogen) and Jadelle (Long acting progesterone implant) were the commonest forms of current contraceptives being used by women. 141 women received Family Planning counselling and 13 were started on a new family planning.

EMPOWERMENT OF YOUNG MOTHERS

Background

The young mums (teenage pregnancy, generally single) are a minority group, underprivileged, marginalised vulnerable group of individuals in the society. Most had unplanned pregnancy which is a reflection their initial disempowerment in both information and access and use of contraceptives.

Once they become pregnant they become further disempowered as their original goals and educational/career aspirations are significantly delayed or "unachievable" as the needs of the pregnancy and the child take precedence. Majority of young mums live in poverty.

Working alongside communities to identify their own specific needs on health and social issues is an integral part of the mission of Viseisei Sai Health Centre. It was through this collaboration that Community Health Workers (CHWs) from Viseisei Village initially identified the need for more support programs for the high number of disempowered young mothers in their village. This ran in conjunction with the CCOHSI project, targeting mothers from the thirty CCOHSI communities spread across four districts in the Western Division of Fiji (Nadi, Lautoka, Ba and Tavua).

The aim of the young mother's workshops therefore was to educate and empower young mothers to make informed decisions regarding their reproductive health and to provide them with the necessary opportunities to expand their career prospect for economic gain and positive social outcomes. This became a crosscutting issue for CCOHSI across areas of sexual and reproductive health, social issues, women's rights and empowerment, child protection, maternal health, education, employment and inter-sectoral engagement.

Needs assessments

Working with CHWs and Zone Nurses, the VSHC team identified mothers in or nearby CCOHSI communities who could benefit from the program, predominantly those aged 15-25 years old, single and unemployed. However, inclusion was not strictly limited to these criteria and mothers were assessed on a case-by-case basis. Once identified a needs assessment was conducted to better understand the mother's demographics, social situation, and career or educational goals.

In total, 93 mothers from 22 communities across the districts were assessed. The majority of mothers were unemployed, did not complete their secondary education, became pregnant due to not using contraception, were overdue for Pap smear, not accessing government or community services, and shown less respect from their family and community since becoming pregnant. Some mothers had no support at all from their family or father of their child. Finding a job was the preferred method to improve earning ability for the mothers, but the major barriers to achieving their goals, was lack of money and childcare. When asked to qualitatively describe their experiences of being a young mother, the major themes were challenging, hard work and sacrifice, with some mothers having to quit their job or studies to focus on raising their child. All participants were of Itaukei ethnicity, as no mothers of Fijian Indian Descent (FID) could be identified in the assessment process. This does not necessarily reflect the real situation with FID teenage pregnancy.

Empowerment Strategy:

The project consisted of a series of workshops in each district. Community Health Workers and Zone Nurses were also invited to attend in order to build their capacity to support young mothers in their communities. Each workshop consisted of the following:

1. **Reproductive Health and Empowerment**

CCOHSI team members including nurses, health promotion officers and social workers discussed sexual and reproductive health (including cervical cancer, Pap smears and STIs), family planning, healthy relationships, empowerment, self-awareness, and child feeding and nutrition. The VSHC clinic bus was available for Pap smears and family planning at selected workshops in Nadi and Lautoka.

2. Stakeholder Services

Presentations from various government departments and organisations aimed to connect the mothers with avenues of social, educational or employment assistance that they can access. These included:

Table 18: **Stakeholders engaged with through the project**

Ministry of Justice (Births, Deaths and Marriage Registry)	Process and importance on registering birth of child
Ministry of Youth and Sports	Youth groups and programs
Department of Women (DOW)	Women's groups and services
Department of Social Welfare	Welfare payments and children's rights
National Employment Centre (NEC)	Employment services
Roko Tui Ba	iTaukei affairs
Department of Cooperatives	Financial literacy
Technical College of Fiji (TCF)	Education and training opportunities
Fiji Council of Social Services (FCOSS)	Microfinance and small business

Participants were also able to register with NEC during the workshop, and form social networks with the aim of creating women's groups or youth groups for official registration with DOW or Ministry Youth and Sports

3. Financial Literacy

The third workshop focused on financial literacy including microfinance, savings, and small enterprise and managing a household budget. This assisted mothers in learning how to manage a household budget, as well as those who wished to establish a small business to support their livelihood.

A separate final workshop was held on March 6th 2018 in conjunction with International Women's Day (IWD) celebrations. Previous participants, Zone Nurses and CHWs from all districts were invited, as were representatives from all involved stakeholders. The theme for the workshop was 'Empowerment and Overcoming Barriers', tying with the IWD theme of 'Press for Progress.'

Young Mothers' Empowerment

Mothers registering with NEC during Nadi workshop

Mothers, children, Zone Nurses and CHWs at completion of Ba workshops

Mothers accessing services in VSCH clinic bus during Nadi workshop

Workshop participants with their children during Lautoka series workshop

Group discussion on SRH issues, Tavua workshop

Stakeholder panel discussion in final workshop, Lautoka

Young Mothers' Outcomes

Of the 88 young mothers, 31 were from Lautoka; 18 from Ba; 23 from Nadi; and 16 from Tavua.
Fourteen mothers registered with NEC and 12 mothers underwent Pap smears in the clinic bus. Questionnaires were conducted before and after the sexual and reproductive health sessions, with increases in knowledge on this topic shown in all districts. Additionally, the workshops served as an educational and capacity building exercise for Zone Nurses and CHWs who are now able to link young mothers with services available to assist them.
Follow up assessments were completed with the majority of mothers between three and nine months after the completion of the final workshop in each area. Significant numbers of mothers had become employed, enrolled in or completed education or training, undergone Pap smears, accessed stakeholder services or commenced family planning. Almost all mothers who had achieved a goal felt the skills they learnt in the workshops helped them to do so. Four mothers have completed free short courses in Basic Sewing or Hospitality, five were invited to attend a four-day Women's Entrepreneurial Leadership Youth Symposium, and several others enrolled with Technical College Fiji. These were all a result of linkages made with Ministry of Youth and Sports and Technical College Fiji during the workshops.

Perhaps the most important outcome was the majority of mothers who reported becoming empowered, inspired or motivated to make changes in their life as a result of attending the workshops. Being empowered to take control of their reproductive health prevents further unplanned pregnancies and breaks a chain of poverty, unemployment and poorer health that is associated with teenage motherhood as well as children of teenage mothers. Increased confidence and self-worth can also prevent mothers falling into abusive relationships, with employment creating financial independence that allows them to choose their own path rather than becoming reliant on partners or families. These outcomes create improvements in the health and social issues within communities that the CCOHSI program aimed to address.

Table 19**: Young Mothers workshops attendance in all districts**

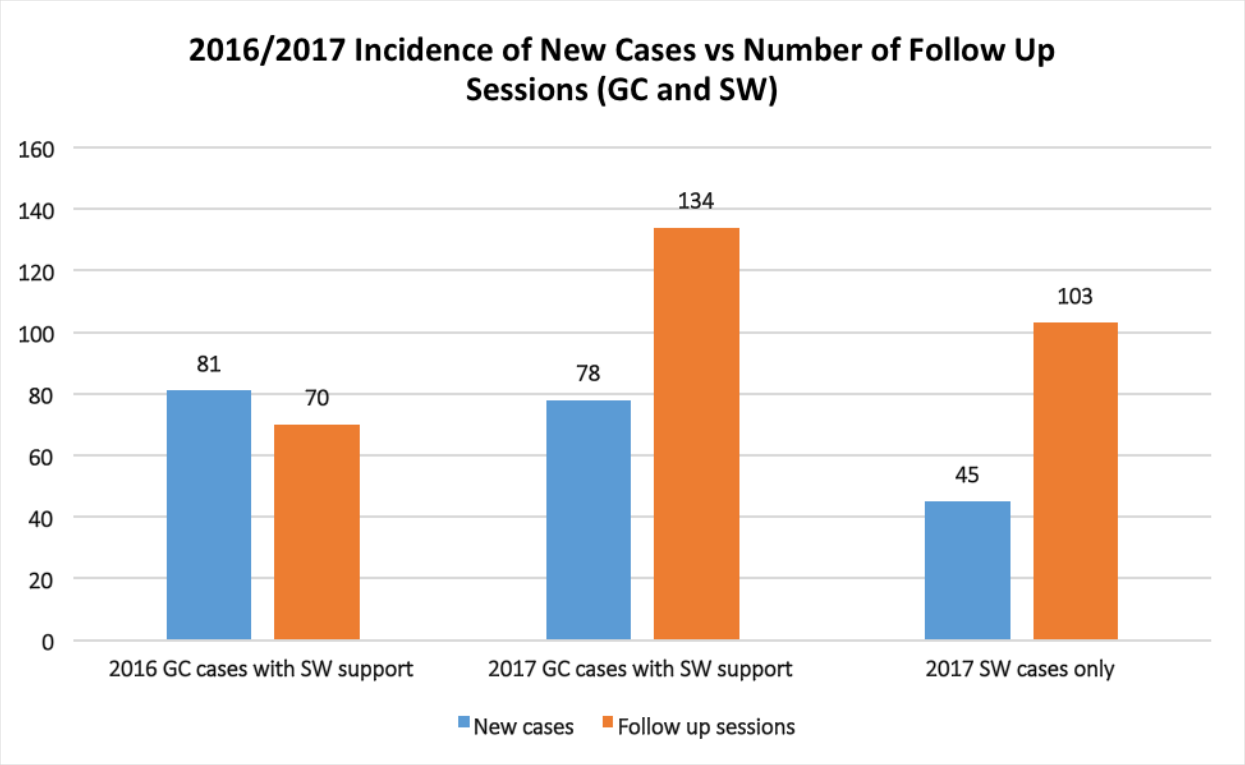
Dates	Area	Mothers	CHWs	*Others	NCD	SRH	SI	General	Total
14/11/16	Lautoka	14	2	0	16	16	16	0	**16**
18/01/17	Lautoka	8	1	9	0	18	18	0	**18**
24/02/17	Lautoka	19	1	6	26	26	26	0	**26**
24/03/17	Lautoka	15	2	1	18	18	18	0	**18**
21/06/17	Nadi	11	3	6	20	20	20	0	**20**
20/07/17	Nadi	20	4	8	0	32	32	0	**32**
10/08/17	Nadi	13	3	5	0	21	21	0	**21**
02/10/17	Tavua	16	2	1	19	19	19	0	**19**
03/10/17	Tavua	14	2	9	0	25	25	0	**25**
30/10/17	Ba	15	5	3	23	23	23	0	**23**
31/10/17	Ba	15	6	8	0	29	29	0	**29**
06/03/18	Final (All)	28	6	20	0	54	54	54	**54**
Total		**188**	**37**	**76**	**122**	**301**	**301**	**54**	**301**

*Others included Zone Nurses and other government and non-government department stakeholders that attended or assisted in facilitating the workshops.

SOCIAL ISSUES – EMPOWER PACIFIC REPORT

A total of **511** Counselling/Social work support sessions were facilitated during the period for **204** new clients and **307** ongoing clients' sessions for general counselling and social work. Out of the **511** that accessed Empower Pacific services, **133** clients attended more than one session with the counsellor/ social worker. Of those opting for general counselling sessions 74% were females and 26% males.

Figure 22: **2016/2017 Incidence of New Cases Vs Number of Follow Up Sessions for General Counselling (GC) And Social Work (SW) Cases**



More intense cases were referred in the second half of the program resulting in the increase in the number of ongoing sessions. Through social work, clients were able to access socio-economic support i.e. food and clothing support; education access; safety support for Gender Based Violence, Child protection and attempted suicide, relevant information on laws and legal support and the involvement of the department of social welfare on cases of child protection and welfare assistance.

Table 20**: General Counselling and Social Work New Cases by Community** from (04.04.2016 to 04.10.2017)

Counselling and Social Work cases by community	**No. of new cases**	**Social Work cases only**	**No. of new cases**
VSHC (cases from non-CCOHSI communities)	56	VSHC (cases from non-CCOHSI communities)	21
Lauwaki Settlement	8	Lavuci Settlement	2
Lavuci Settlement	5	Nakolia Settlement	2
Lavusa Village	2	Nasolo Village	3
Matawalu Village	2	Namoli Village	1
Nakolia Settlement	7	Nawaqadamu Village	1
Natalecake Village	3	Saru Village	1
Navakai Settlement	5	Saweni Settlement	4

Naviago Village	4	Seniyaya Settlement	1
Nawaqadamu Village	1	Vadraiyawasewa Settlement	4
Saru Village	1	Vatulaulau Settlement	1
Saweni Settlement	13	Vatuyaka Settlement	1
Seniyaya Settlement	13	Vitogo/Lovu	1
Sorokoba Village	2	Tavakubu Settlement	1
Vadraiyawasewa Settlement	2	Yasiyasi Settlement	1
Vitogo Village	5		
Vanuakula Settlement	4		
Vatulaulau Settlement	9		
Vatuyaka Settlement	1		
Vatutu Village	1		
Tavakubu (Vunamaoli) Settlement	14		
Yavuna Settlement	1		
Total	**159**	**Total**	**45**

Settlements overall had more counselling and social work cases than villages

Education and Awareness on Social Issues:

During education awareness & workshop sessions, a number of topics were presented to the communities in the villages and settlements upon request of CDP Mentors and Community Health Workers or Zone Nurses, as follows:

1. Child Abuse
2. Gender-Based Violence
3. Healthy Relationship
4. Positive Parenting
5. Conflict Resolution
6. Drug and Alcohol Abuse

The total number of participants that were engaged in the Social Issue Education sessions was **4573**.

Strengths of service:

- Since the inception of the community development project work, education & awareness, client assessment and trainings people have been made aware of the confidential help that is available and other interventions provided through professional counselling and social work. This resulted in an increase in the number of cases being referred for counselling and social work especially towards the end of the project.
- The availability and enthusiastic support of Sai health Centre administrative and Medical team enhanced client interventions to meet their needs.
- Working with clients in their home and community settings provided a holistic service which met client's needs appropriately. Advantages to this are comfort of being in a familiar environment which enables clients to open up more, as well as providing an insight for the counsellor and social worker on what is happening in the client's life.
- Members of the CCOHSI team and the community health workers could build on their ability to identify and refer cases with sensitivity and professionalism.
- Utilisation of stakeholder engagement to connect social work clients with existing services provided by government and non-government organisations to assist their needs

Challenges faced during service provision

1. Difficulty in contacting clients with no phone or reception
2. Cultural barriers of clients to disclose information
3. Sensitive child care issues

4. Lack of agency resources to provide additional support to the clients
5. Physical location of clients, unable to reach them in a timely manner
6. Lack of client resources to attend to ongoing session
7. Language and communication barriers

Limitations to care delivery at a systematic level include services for people with mental health disabilities and their carers and families (including transport, accommodation and qualified carers), appropriate care facilities, safe homes or rehabilitation centres, and under-resourced and underfunded stakeholders.

Outcome of interventions

1. Clients were supported to identify appropriate positive coping strategies, address maladaptive thinking patterns, identify strategies that can help raise self-esteem, reduce self-harming behaviours and build resilience, and manage symptoms and medication compliance.
2. Raised awareness on domestic violence and child abuse through the provision of information on domestic violence and child protection laws in Fiji. This enables clients to be aware of their rights and the support available under these laws.
3. Discussed impacts of domestic violence on both women and children. This provided clients with the understanding that domestic violence affects not only them but their children as well and some of these effects manifest in maladaptive behaviours in children as they grow older.
4. Empowering clients through awareness on their human rights, responsibilities, identifying their personal support networks, working with them on aspects of positive communication and awareness on the support available as a way for them to be aware of the importance of their emotional and mental well-being not only for themselves but for their children also.
5. Work done with children, looked at supporting them to understand their emotions and the link with their thoughts and actions in regard to the different situations they encounter. Also awareness on their rights and responsibilities and relevant laws in Fiji of which they fall under.
6. Assisting children by accessing socio-economic support, referring to relevant stakeholders for further assistance and providing awareness to parents on positive discipline. Some of the more at-risk child cases were removed from the unsafe environment and with the support of relevant stakeholders these children were placed in safe homes.
7. With social work support clients were able to get access to clothes, food, wheelchairs and other material items identified through a needs assessment and with support from relevant stakeholders such Welfare Office, community members, and Bayley Welfare.
8. Through advocacy, clients were accompanied to places such as legal aid, the police station, safe houses, rehabilitation and medical facilities for emotional support and assist them with procedures they are unfamiliar or unconfident with.

Sustainability of interventions

1. Stakeholder engagement provides to some extent ongoing support for some of the clients seen
2. Awareness sessions during trainings and in the communities will enhance individuals to be aware of abuse, legal implications of abuse and be able to seek help and refer those that need assistance to appropriate authorities.
3. Training sessions conducted with community health workers helped to raise awareness on topics such as abuse and social issues where as part of their roles, they can identify and make appropriate referrals with the understanding of confidentiality. Through the awareness sessions and support from staff, it has been noted that community health workers are now confident in identifying and making referrals while keeping confidentiality in mind.
4. The number of cases being referred for counselling by the medical staff increased as by the end of the project period, which is indicative of their confidence in the counselling and social work provision.
5. There was an increase in the number of referrals from the community with a lot of intense cases being referred for counselling and social work interventions showing the peoples trust in disclosing sensitive issues for support.

Overview of Social Issues cases during the Project Period

Domestic Violence Cases and Gender Based Violence

All gender based violence cases were given psychological support, information on violence and its impact on victims and children, opportunity to explore their own situation and choices available to them, space to consider the choices and its impact on their lives, services available and contacts for these services and an avenue to vent their feelings in a safe space. They were given information on their rights to be free from violence regardless of whatever the situation was. Referrals to other services- all cases were given information and relevant contacts for services available to them.

Relationship Family Issues

There were 30 cases seen for relationship and family issues. Most of these cases were subjected to domestic violence but preferred to work on their relationships. All the cases were given the appropriate support; information on GBV and its impact where necessary; information of services available and contacts; opportunity to explore their risks, safety and choices available; and supported to work on their goals.

Child Abuse/Child Welfare Cases

Out of the 13 children that were attended to during the program period; two were teen pregnancy cases and one was violence related. All child cases were assessed for risk of abuse and provided with relevant supports and therapeutic interventions. Family therapy sessions were conducted where needed to enhance child support and parenting skills. All cases were given information on the child protection laws, services available with their contacts and engaged with stakeholders where necessary. When working with children the human rights approach was used similar to all other cases especially for those who were more vulnerable to being abused.

Attempted Suicide/Suicidal thoughts and Self Harm behaviour

5 cases were seen during the period. Two cases of high risk were managed to reduce risk of self-harm and supported to enhance skills and knowledge to address the behaviour over a long term period. None of the cases seen and assisted with cognitive behaviour therapy interventions reattempted self-harm behaviour or report risk of self-harm on follow-ups after the counselling sessions. Most reported better emotional management and coping skills during times of stress or when exposed to triggers of self-harm behaviour.

Depression/Anxiety/Panic Attacks

14 cases were seen with high levels of stress, with some that were on anti-depressant medications.

Diagnosed Mental Illness

5 cases of diagnosed mental illness were seen in the communities that were covered. Most of the cases were given assistance with referrals for mental health assessments by the mental health nurses and were provided with medication from Hospital. Two of the cases were provided with assistance to get patient to hospital and one was admitted. Family therapy sessions were conducted to enhance medication compliance, better patient care and enhanced understanding of mental illness.

Socio Economic Issues

The 41 socio Economic issues cases that were seen during the period were provided with information on services available, psychological support, engaged with community members who could provide any form of support and given food packs when available. Those that qualified for social welfare assistance were given support to make the applications.

- Training was conducted to enhance coping and knowledge on how to provide hygienic healthy meals for the family on minimal budget, which was attended by 18 women with approximately 12 children. Most of the participants were living below poverty levels.
- 34 grocery packs were distributed to families provided by local community members
- A disabled child who could not chew food was donated a blender which helped him to be better fed and less sickly. Engaging this family with other community members ensured long term support for the child and family.
- Three new wheel chairs were provided for the needy in the community
- Education assistance provided in the form of information and referrals to relevant agencies.

Table 21: **Social Issues cases**

Presenting issue/ reason for Referral	**Relevant Notes**	**GC New Cases**	**SW (New cases)**
Suicide related information/support	e.g. Family member attempts/suicide	7	-
Anxiety	This indicates anxiety only (all other cases have an element of anxiety)	1	-
Attempted Suicide/Suicidal Thoughts		2	1
Attempted suicide/Relationship/Family Issues		1	-
Teenage Pregnancy		2	2
Teenage Pregnancy/Child abuse		-	1
Teenage Pregnancy/Child Abuse/Accessing Education		-	1
Teenage Pregnancy/Relationship/ Family issues/Health and Information Advocacy		-	1
Unplanned Pregnancy/Gender Based Violence		1	-
Unplanned Pregnancy/Adoption		-	1
Depression	Diagnosed	5	-
Domestic Violence	Extreme needing intervention	2	-
Gender-Based Violence (Victim)	Working with clients on empowerment	4	1
Gender Based Violence/Stress		1	-
Gender Based Violence/Child Abuse		-	1
Diagnosis of NCD (i.e. cancer, diabetes etc)	Extreme cases – clients were given counselling on behaviour change, self-care plan including diet and exercise, many more clients were seen in the outreach)	5	-
Non-Communicable Disease/Stress		1	-
Substance Misuse (Alcohol & Other Drug issues)	Clients voluntarily came for assistance - 2 from outreach and 1 from health centre	3	-
Parenting Issues (include parenting skills)	Parents came out during outreach sessions or were referred by CHW	7	1
Relationship/Family Issues (non-violent)		31	2
Stress	Includes admission to stress wards. Many of these were stress disorder (panic attacks) or normal functioning affected – normal functioning restored with the assistance of nurses and MO in the clinic	18	2
Self-Harm (not suicide but Incl. eating disorders)	Other cases were seen in child protection cases	2	-
Victim of Crime (not gender based)	Occurrence that is out of the victims control	2	-
Coping with stress of major illness/injury or surgery (incl: amputation)	Some diabetic patients, loss of normal functioning	4	-
Coping with stress of major illness/injury or surgery (incl: amputation) /Relationship /Family Issues		-	1
Coping with stress of major illness/injury or surgery (incl: amputation) /Socio-economic Issues (i.e. clothing, food etc)		-	1
Coping with stress of major illness/injury or surgery (incl: amputation) /Health and Information Advocacy		-	1
Health and Information Advocacy/ Socio-economic Issues (i.e. clothing, food etc)		-	3
Health and Information Advocacy		-	1

Family of Patient – Grief and Loss including death of loved one		3	-
Grief and Loss (eg. Terminal illness) not incl. vitro death or miscarriage	This can be loss of relationship, unable to let go, loss of jobs, having to adjust to a new lifestyle (counsellor helped to restructure life/thinking around new limitations, accept limitations now exist but strategies to work around, its normal to go through this process, some self-referrals others were referred)	5	-
Socio-economic Issues (i.e. clothing, food etc)	Less counselling focus, main activities are provision of services, referral to services, stakeholder/community connections (social welfare assistance, food packs/distributions/clothing). The community connections were vital as they are now able to assist families in need	17	12
Coping with family member illness/injury/surgery		1	2
Socio-economic Issues (i.e. clothing, food etc.)/Other		-	5
Child Abuse/Welfare (including those at risk of abuse – i.e. physical, emotional, sexual, neglect)	High incidence – this involved 16 cases (15 individual children and 1 family with 3 children affected)	14	-
Homelessness/Accommodation	Able to find accommodation for this client (although this is usually very difficult)	1	-
Homelessness/Accommodation Socio-economic Issues (i.e. clothing, food etc)		-	2
Accessing Education	Helping clients access education	1	-
Diagnosed mental health illness	Many cases where the family did not know what was wrong with the client, large impact on both the client and the family, family therapy sessions were undertaken, mental health nurses were involved and assessed the patients (VSHC assisted with transport)	5	-
Diagnosed mental health illness /Socio-economic Issues (i.e. clothing, food etc.)		-	1
Rape/Sexual Assault (victim) over 18 years	Clients were empowered/supported to do a police report and undertake the reporting process	1	-
Abortion	Client was pressured into having an abortion (at risk of having a backyard abortion), assisted to make her own choices	1	-
Other and Social Work Interventions	This category is broad but involved writing applications for social welfare assistance, bus fare assistance, education about services, helping clients to write applications/access services, helping with follow up of applications)	5	1
Coping with family member illness/injury/surgery (include family member mental health)	Mostly for bed ridden clients, enhance family ability to look after the unwell family member	5	-
Offending Criminal Behaviour		1	-
Child Welfare		-	1
Total		**159**	**45**

COMMUNITY DEVELOPMENT PROJECTS (CDP) UNDER THIRD PARTY FINANCING

The 30 selected communities conducted community development projects in health and social issues identified as priority areas to be addressed within these communities. A proposal was written by the community and submitted for approval following which they undertook a 6-month CDP. Under the EU funding there was provision for $1500 (FJD) per community. The guidelines for the CDP required the community health worker to be involved and responsible together with the entity undertaking the project, which was mainly the health committee. This meant the communities had to include the trained CHW and give her recognition, voice and space in the Health Committees.

Objectives of CDPs: To promote wellness, human rights and local ownership of health and social issues.
The CDPs contributed*:* To enhance the capacity of communities in Ba Province to support sustainable improvements in specific modifiable lifestyle factors in health and social indicators by empowering community members and community structures. In carrying out CDP activities for each community, the CHW and the Health Committee took the lead role in organizing their activities. This was an exercise in further empowering the community structures, the CHWs and the Health Committees

The CHW and the Health Committee members live in the community hence were best placed to discuss with and come up with issues relating to health and social problems that they wished to address in their CDPs. They understand their communities and came up with the best educational approaches, the environment and type and timing for activity that best suits the community. They took ownership of the project and the program.

If the CHW and the Health Committee organized a workshop on NCD and Waste Management, they contacted the Zone Nurse and the Health Inspector to facilitate it. Sometimes the CCOHSI team members facilitated however the community did the entire organisation of activities. The CHW and the Health Committee would inform the community members of the date of the workshop, the catering arrangements for the participants and the venue of the workshop. All purchasing was done by the CHW with the support of the Health Committee.

The role of the CCOHSI mentors for each community was to support the CHW to contact the stakeholders or facilitators. They acted as catalysts, bringing the community and other government stakeholders together for the project.

Waste Management and NCDs were the most common problem identified in both villages and settlements and its activities conducted under CDP included waste separation, composting, 3 ‘Rs’ (reduce, reuse, recycle), burn and bury, community clean up campaigns, communal pits digging for waste disposal, sanitation and hygiene. The CDP activities under NCD prevention included backyard gardening, healthy cooking, physical activity and Health Promotion. For SRH there was health education on Family planning, reproductive health, STIs and cervical cancer, while SI consisted of awareness and education on Gender Based Violence, child protection and positive parenting. Environmental Management included planting of trees, digging and cleaning of drains and animal management, and Communicable Disease education and activities such as WASH programs, TB awareness and diarrhoeal diseases. Water Management was more of an issue in villages.

Table 22: **CDP Activity Priorities Identified and Activities Undertaken in Villages**

Community	Prioritised Activities						
	NCD	SRH	Waste Management	Water Management	SI	Environmental Management	Communicable Diseases
Namoli Village	X	X			X		
Saru Village	X		X		X		
Matawalu Village	X		X			X	
Vatutu Village	X		X				
Yavuna Village	X		X	X			
Nawaqadamu Village	X	X	X		X	X	
Nasolo Village	X	X	X			X	
Natalecake Village	X		X		X	X	X
Sorokoba Village	X		X	X			
Vadravadra Village	X	X			X		
Buyabuya Village	X		X	X		X	
Drala Village			X			X	
Koro Village			X				X
Nadala Village	X		X	X		X	
Nadelei Village	X		X	X		X	

Table 23**: CDP Activity Priorities Identified and Activities Undertaken in Settlements**

Community	Prioritised Activities						
	NCD	SRH	Waste Management	Water Management	SI	Environmental Management	Communicable Diseases
Seniyaya Settlement	X		X		X		
Tavakubu Settlement	X		X		X	X	
Vanuakula Settlement	X		X		X		
Vadraiyawasewa Settlement	X		X		X		
Delaisaweni Settlement	X		X			X	
Lauwaki Settlement			X			X	
Loqi Settlement	X		X			X	
Navakai Settlement	X	X	X		X		
Nakolia Settlement	X		X			X	
Lavusa Settlement	X		X			X	
Maururu Settlement	X		X			X	
Lavuci Settlement	X		X		X	X	X
Vatulaulau Settlement	X				X		
Vatuyaka Settlement	X		X		X		
Yasiyasi Settlement	X		X				

Table 22 and Table 23 indicate the health and social issue priorities identified by both settlements and villages for their Community Development Projects. 90% of communities prioritised Waste Management and NCDs as issues to address through their Community Development Projects.

Photos from the 30 Community Development Project Activities

Compost set up in Nadala Village during a waste management education workshop

A Delaisaweni Settlement community member showing off his home grown coriander

Herbs grown by the year 6 and 7 students at Vatulaulau Sanatan Dharam Primary School in Vatulaulau Settlement

Koroi running a composting workshop and demonstration in Vadraiyawasewa Settlement

Ministry of Agriculture Officer presenting to Yasiyasi Settlement members on farming and animal management services available through the Ministry of Agriculture

Seniyaya Settlement healthy cooking and NCD workshop

NCD and alcohol awareness workshop held in Vatuyaka Settlement in collaboration with the MoHMS

Healthy cooking demonstration run by Nasolo CHW, Alumeci, and Dietician Ilisabeta

Tavakubu Settlement community members presentation on domestic violence at their Social Issues and Waste Management Workshop

Counsellor and CCOHSI team member, Nisha, presenting the Social Issues Workshop to the Seniyaya Settlement Community

Staff Nurse Ake discussing Sexual and Reproductive Health with the women of Vatulaulau Settlement

Sports Fun Day held in Saru Village where soccer, volleyball, rugby, netball and children's games were played

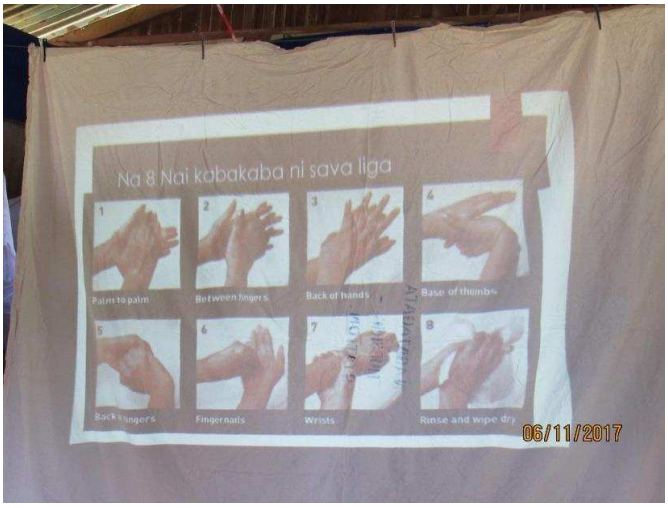
Children playing tug-o-war during the Vadravadra Village Fun Day

Nasolo Village community members playing volleyball during their Fun Day

Children playing tunnel-ball at the Lavusa Settlement Family Day held at Togo Primary School

Community members from Seniyaya Settlement playing Volleyball

Community members from Natalecake playing volleyball during their clean up campaign day



WASH presentation during a Waste Management Workshop in Buyabuya Village

Waste Management Workshop in Delaisaweni Settlement

Waste Management Workshop held in Seniyaya Settlement

Community members from Lauwaki Settlement using their new skip bins for solid waste disposal

Lauwaki Settlement community members during one of their clean up campaigns

Community members during their clean up campaign in Natalecake Village

Challenges in implementing CDPs in communities

1. Natural disasters and bad weather were often a drawback in carrying out the project and CDP activities. For backyard gardening, drought and rains both affect the germination of the seeds causing delay in some communities. In the wet season, programs were cancelled or postponed due to flooding or poor road conditions. Tropical Cyclone Winston hit the Western division of Viti Levu, Fiji on 20th February 2016. This had a huge impact on the already disempowered communities. The government imposed an emergency due to natural disaster for two months, which impacted the initial engagement of stakeholders for our CDP work.
2. Geographical location was a challenge as many communities in the interior of Tavua had very difficult road access and rough terrain. The public transport comes only twice a week to Tavua town and there is limited phone network coverage.
3. Some communities that were initially selected were later noted to be involved in other projects, and subsequently withdrew from the CCOHSI project
4. Difficulty in engaging communities living in settlements in activities, meetings and workshops due to a lack of community structure and leadership
5. Retention of CHWs as they are volunteers and often have other personal issues
6. Due to the above factors seventeen communities required extensions to their CDP, ranging from one week to two months.

All the 30 communities completed their CDPs successfully. As a result they have realized that most health related activities do not require a lot of funds. What is required is the commitment of the community members to work collectively for the good of all in the community.

Research

To understand communities' Knowledge, Attitude, Practice and Barriers (KAPB) in the key lifestyle risk factors for NCDs, questionnaires were conducted by CCOHSI team in all participating communities before and after implementation of the CDPs. Focus Group Discussions were also undertaken one month after completion of CDPs in each community to conduct a qualitative assessment of the impact of the activities.
965 individuals completed pre KAPB questionnaires and 936 individuals completed post KAPB questionnaires. All participants gave signed consent and were required to be over 18 years of age. Data collected will be analysed for publication in peer-reviewed journals under the title of "Impact of Health Promotion Activities on Knowledge, Attitude, Practice and Barriers Regarding Risk Factors for Non-Communicable Diseases in Communities in the Ba Province".

Good stories emerging from Community Development Projects
Several important CDPs were completed successfully. A few are mentioned here.

1. Lauwaki Settlement: A successful waste management initiative
Lauwaki Settlement has a total population of about 769 people whereby there are 181 houses for 224 families, with most of the population being FID. Lauwaki Settlement has long standing issues surrounding waste water management and solid waste disposal. Community members often dump solid waste close to the main road, outlet drains and mangrove swamps. This results in blocked drains and subsequent flooding during rainy weather, increased risk of breeding sites for vector borne diseases and attraction of stray animals. As Lauwaki Settlement is an informal settlement, outside the municipal Lautoka City Council boundary, there is no formal system for rubbish collection.
Lauwaki Settlement chose to focus their CCOHSI **Community Development Project** on addressing improper solid waste disposal. Various strategies were used to decrease improper rubbish disposal in the area. When the Ministry of Health's, Health Inspector was invited to present at Water, Sanitation and Hygiene (WASH) education of the community the community members were advised about waste disposal and some were given notices or fined for dumping rubbish. Multiple clean up campaigns were also organised under the CDP and a free pick up of the rubbish was arranged with the Rural Local Authority.

The CCOHSI team conducted three Waste Management workshops for the settlement in Lauwaki area, which was divided into four sections for workshops to be conducted. The 3 workshops were at different areas to help disseminate the information to the people. The CHW, Sakina Bibi, and the Lauwaki Health Committee worked hard to gather people through distribution of flyers, scouting and using the megaphone to inform of the workshops. Discussion on ways of addressing solid waste by separation and minimisation and reusing, reducing and recycling (3Rs) education was undertaken. Eventually, a user pay system was agreed upon for use of skip bins for the settlement. Since, the initiative was a first of its kind, it took the community members' a period of time to accept the new initiative as common practice.

The CHW Sakina persevered and continued to advocate to relevant stakeholders. The continuous advocacy yielded results as the **District Officer, Health Inspector and Agricultural Officer with the mentors from the CCOHSI team** participated in a stakeholders' meeting within the Lauwaki Settlement Health Committee. This led to a wider inspection of the Lauwaki Settlement area that included areas not covered by the project. The support of the Rural Local Authority assisted the Health Committee in its mission. The CCOHSI mentors assisted the CHW in acquiring quotations for the skip bins. A community meeting was called to inform all about the usage of skip bins for a nominal fee for the pickup of the bins. For the record of payments, the CHW keeps a receipt book.

The Health Committee worked with the **Lautoka Local Rural Authority** after the skip bins were placed. The Health Inspectors visited those houses that were not paying up the rubbish fees or not using the skip bins and inquired as to where they were placing their rubbish this helped in curbing the dumping of rubbish into the mangroves, and to raise awareness on proper solid waste disposal. There was also a signboard erected by the Lautoka Rural Authority in areas of high dumping as a method of increasing awareness.

Sakina continues her waste management awareness regularly, with the help of the Lauwaki Health Committee and the collection of funds is still ongoing, past the completion of the CDP project. As well as the waste management and skip bin initiative, the Lauwaki CDP also addressed drainage and flooding issues in the community through drainage clean up and awareness education in the community. The community also participated in health promotion activities, including physical activity and backyard gardening, run by the CHW.

2. Yavuna Village: Sustainable water initiative

Yavuna is a rural village in the highlands of Nadi, approximately 15 km from Nadi Town. Most essential services are in Nadi town including medical, Police, Lands Department, District Office, and judiciary. The Village has an iTaukei population of 225 of which many are subsistence farmers and a small proportion have formal employment in Nadi Town.

The village **water supply has been mainly from a creek uphill and only 10 out of 45 households received a limited supply of water in the taps**. In the dry season, the villages' 10,000 litre water tank was filled by the government water supply truck twice a week. The villagers also used the creek and river for bathing and other daily needs resulting in the prevalence of water borne diseases such as Typhoid, diarrhoea and dysentery.

The **Yavuna Village community identified having a safe and sustainable water supply as a priority for their CDP under the CCOHSI Project**. The CHW, Health Committee and Turaga ni Koro were encouraged to take the lead role to work with the village members in their health promotion activities by the CCOHSI mentors who worked behind the scenes to assist them in liaising with the relevant stakeholders. **The engagement of the relevant authorities was crucial in bringing about a positive development for the facilitation and construction of proper water infrastructure for the safe water supply to the villagers** who over the years were manually fetching water from the nearby river. It was noted that the Yavuna Village water issue was already recorded at the District Office level. There had been numerous previous discussions and education undertaken on prevention of Typhoid as there had been several outbreaks in the past however no sustainable change had been achieved. The team was also informed that such project initiative would require both community and government partnership, which had not eventuated in the past years. This was not encouraging but it did not deter the CCOHSI team from visiting other relevant stakeholders such as the Health Inspectors office who confirmed that Yavuna Village was a hotspot for Typhoid; the Ba Provincial Office that has the legal authority of village development work and the Water Authority of Fiji that is responsible for safe water supply to the people of Fiji.

Meanwhile, the trained CHW, Turaga ni Koro and Health Committee continued their health promotion efforts on sanitation and hygiene, healthy cooking, composting, promotion of backyard gardening and physical activities and prevention of smoking. Engagement of the stakeholders by the CCOHSI team and Health Committee required persistence and perseverance with high level offices such as the District and Provincial Office. As a result of continued advocacy with different stakeholders, **Water Authority of Fiji introduced a water harvesting program whereby 25 water tanks were distributed to some village residences**. The tanks were big enough to cater for at least three to four families during dry spells. The CDP third party finances assisted with the purchase of roof gutters for water to flow into the tanks. Even with these provisions, the CCOHSI Project team and the Yavuna Village Health Committee continued to push for a sustainable water supply. The Turaga ni Koro and the Health Committee took ownership of this issue and continued to raise these water supply issues at both District and Provincial Office level. **The hard work and the long wait finally paid off as the Water Authority Fiji installed a $67,000 bore hole** that was commissioned by the Minister for Industry, Tourism, Trade, Mineral Resources and Lands, Mr. Faiyaz Koya.

It is truly incredible how a mere $1500 FJD of community development funding has not only empowered the Yavuna Village community with knowledge of health and social issues and inspired confidence in community leaders but how it was also able to attract a $67,000 government grant to solve a significant water issue spanning over 25 years. With the capacity building from CCOHSI team and their own experience in liaising with the relevant authorities, there is no doubt that the Yavuna Health Committee and the Village Council is now capable of taking ownership of their own health and social issues.

3. Lavuci Settlement: TB Awareness Campaign and World TB Day

Lavuci Settlement has had a number of TB cases in recent years. During the commencement of the Lavuci Settlement CCOHSI CDP, a nearby community, Nasolo Village, experienced a death from TB infection. The **Health Committee had identified that TB awareness** was one of the ways to assist the community to take ownership of health and social issues. The **Lavuci CHW) Kelera Naqase**, held multiple meetings with stakeholders including:

- Other CHWs from nearby communities
- Local Zone Nurses
- CCOHSI Mentors

and came up with the idea of working with the schools to raise TB awareness as a part of World TB Day event, held on the 24th March annually. Kelera and the CCOHSI Mentors brainstormed ideas on how this could be carried out and decided to organize both an **essay writing competition for older students and a drawing competition for younger students.** Kelera also liaised with the Ba Zone Nurses to carry out awareness and screening on the day. She visited two schools initially with the CCOHSI Mentors and the Zone nurse, to explore the possibility of having a World TB day celebration involving the above mentioned activities and was very encouraged with the response received. During the weeks that followed she visited **Vatuyaka Sangam Primary School, Ratu Filimoni Primary School, Ratu Filimoni kindergarten and Sanatam Dharam Primary School**.

There after Kelera continued to work with the schools to get the competition going. During this time, she also received assistance from the teachers who taught **TB awareness in the schools** for the children. She collected the entries to be judged and gave them to the mentors for judging. As per her request, the certificates and flyers were prepared by the CCOHSI mentors to support her.

Despite the MOHMS deciding to hold the National World TB Day Celebration in Sigatoka, **Kelera persisted and insisted that Lavuci needed awareness as it was the hotspot for TB cases in Fiji and with the support of the Ba Zone Nurses,** got the approval from the MOHMS to go ahead with her initial plan for the World TB Day event to be held at the same time as the National event in Sigatoka. **The Ba Zone Nurses supported the day by providing screening and awareness during this program.**

Kelera was once again put in a challenging situation when Ministry of Education (MoE) decided to allow the program to be held in schools but did not allow all of the schools in the zone to be at the National TB Day Program at Khalsa Primary School. However CHW - Kalera and her team decided that they would still go ahead with the program and take the same program to the other two schools while presenting the winners from those schools their trophies and participants their certificates. Kelera also managed to get quotations and purchased trophies to be presented for the winners and requested the mentors to help purchase tokens as gift packs for the quiz questions. By Friday the 24th of March she was ready with her team for the program. Participants included over 200 school students, teachers and parents, representatives from Lavuci Community including Kelera (CHW), CCOHSI team members and 6 MoHMS staff (3 Zone Nurses and 3 Medical interns for TB screening)

The program commenced at 10am with a presentation from MoHMS Nurses on TB. Students and teachers were invited to ask questions throughout and correct answers to quiz questions were awarded. The presentation to the winners of the drawing and essay writing competition was then presented. The program ended with refreshments and optional TB screening by the MoHMS team. **It was evident from the responses given by the students and teachers that the effort to raise awareness on TB was successful.** For the students to be able to take part in the competition they had to have knowledge and the teachers made extra effort to bring about awareness to ensure their students would be competitive in taking part.

Photos from CCOHSI Project Good Stories

Clean up by the community in Lauwaki Settlement

Community members and Sakina (CHW) using the new skip bins in Lauwaki Settlement

CCOHSI Team and stakeholders discuss the Yavuna Village Water Project. Stakeholders include: Yavuna Turaga ni Koro, Yavuna CHW, Subdivisional Health Inspector Nadi and Water Authority representatives

The new Yavuna Village Borehole

Adi, Zone Nurse Ba, presenting prizes for the TB Drawing competition for the World TB Day Celebration

Students from Khalsa Primary during the TB program for World TB Day Celebration

Table 24: **Monitoring & Evaluation (M&E) Sessions**

Date	Description
05/05/2016	M&E training with EU Consultant- Natalia - Logical framework
06/05/2016	M&E training with EU Consultant- Natalia - Logical framework
09/05/2016	Project launch preparation for EU exhibition
01/06/2016	Monthly schedule/ Work plan for June and Analysis of Data/develop graphs
09/06/2016	Discussion on Outreach - Input vs Output/results
14/06/2016	Scouting & activities for 30 Communities with Zone nurses & CHWs
21/06/2016	Importance of Self Analysis/ Positive Attitudes and Individual roles
28/06/2016	Debriefing on Outreach at Matawalu & lesson learnt
30/06/2016	Debriefing on Stakeholders training & Team building activity
05/01/2017	Planning for 2017/ Identifying challenges in communities in CDPs
11/01/2017	Planning for the CDP Activities for the communities
13/01/2017	Review of CDPs implemented in 2016
10/04/2017	Field work evaluation & capturing good stories
26/04/2017	EU help desk - Importance of M&E
27/04/2017	EU help desk - Importance of M&E
08/05/2017	CDP work to plan
15/05/2017	CDP reporting and Research
22/05/2017	CHW mentoring and CDP financial reporting
29/05/2017	Follow up on CDPs/ Reports
05/06/2017	Young Mothers Empowerment/ Nadarivatu CDP trip debrief
13/06/2017	Health promotion mentoring on CDPs
19/06/2017	Monitoring & Evaluation/ Visibility boards/ Health Committee sustainability
10/07/2017	Financial accountability of CDPs
17/07/2017	CDP financial update/ EU visibility and Most Significant Change stories(MSC)
24/07/2017	Young Mothers empowerment Financial tracking & reporting on CDPs
31/07/2017	CHW reporting & allowance/ Pre and Post KAPB
07/08/2017	Weekly Log of Activity (LOA)/ Ongoing CDP audit
07/08/2017	CCOHSI Project outputs - Recap and M & E
14/08/2017	Staff safety during Outreach/ ongoing CDP reporting
04/09/2017	CDP follow ups
04/09/2017	Elimination of Violence Against Women (EVAW) planning
11/09/2017	Project recap/ SRH follow up
15/09/2017	Waste Management & CDP audit
18/09/2017	Social issues/ M&E -19 CDPS
27/09/2017	Sustainability in Communities and M&E
29/09/2017	Event planning - 16 Days of Activism
04/10/2017	Project update
11/10/2017	Active community follow up
16/10/2017	Team communication, research data entry and CDP reporting
23/10/2017	Project recap
06/11/2017	Monitoring & Evaluation on Reports
10/11/2017	CDP reporting evaluation
27/11/2017	CCOHSI Update
01/12/2017	16 Days Activism
05/12/2017	16 Days Activism stakeholder engagement
08/01/2018	Research update
12/02/2018	Data feedback M & E
19/02/2018	Data Review
08-16/03/2018	Statistical Analysis Workshop

There were several monitoring and evaluation activities. Log of Activities were kept for all activities with verifications from attendance sheets, reports and pictures. There were weekly monitoring and evaluation meetings conducted. Every month there was planning for the following month as well as evaluation of previous activities (Table 24)

Data Management and Analysis

From the start of the project all activities were captured in a Log of Activity (LOA). The Data Manager ensured that she kept a daily record and then followed this up with requests for attendance sheets and report activities from team members to complete the LOA, which contained vital information and allowed the team to keep a tab on all activities and outputs by time frame.

Data was collected of all Training, Meetings, Capacity Building, Health Promotion/Educational, Clinical and Research activities as well as any follow-ups and on field mentoring. There were simple monthly activity reports by Community Health Workers, which captured their activities. Data was analysed using Excel for reports

Data sets were developed for research activities and all data entered and checked.

All research data was cleaned and coded for data analysis by statistician.

SUSTAINABILITY THROUGH CAPACITY BUILDING AND INTERSECTORAL LINKAGES

The project in its approach had capacity building at several levels:

1. Individuals, families and neighbourhoods
2. Communities- Villages and settlements
    a) Turaga ni Koros
    b) CHWs
    c) Health Committees
    d) Women's groups including Young mums
    e) Youth groups
    f) Schools
3. Other stakeholders: Civil Society Organisations, Government departments

<u>Project Staff</u>

All the staff members have become very experienced in conducting community based public health and social issues project and working with various government and non-government stakeholders. These individuals will be able to deliver in other project where community engagement for empowerment and ownership of issues are required.

Staff Capacity Building in the Field

Jenny, CCOHSI Research Officer, presented at the Fiji Medical Association on the work of Viseisei Sai Health Centre

Koroi educating students on Puberty, WASH and NCDs at Lovu Sangam School

Warsha, CCOHSI Health Educator, supporting the Lavusa Health Committee in group work

Staff Nurse Ake assisting Professor Gyaneshwar demonstrate Pap smears at the VSHC World Cancer Day workshop for Nurses

Community Health Workers' Capacity Building

- CHWs can easily and confidently engage with their Zone Nurses (increased communication)
- Increased visibility and recognition and acceptance by their communities
- Members of their community Health Committee - with a voice on community matters.
- Better advocates for their community health and social issues
- Have become a vital link between community and authorities and have been able to tap into resources and services available from stakeholders
- Able to report on activities as required
- Increased confidence and better communication with both the community and stakeholders
- Assisted with formation of women's and youth groups
- Increased capability in referral of social issues cases to Zone Nurses
- Provided assistance with identifying and encouraging Young Mothers for workshops
- CHWs are recognised by MoHMS and Ba Provincial Council
- A few CHWs have been nominated to be advisory councillors
- Have become prominent with government and non-government stakeholders
- Worked with other NGOs
- Promote women's empowerment and gender equality

As all the CHWs working under this project are women, it has promoted women's empowerment and gender equality tremendously.

- Capacity building of CHWs through CDPs
  - Played a major role in the organisation of CDPs
  - Community engagement
  - Proposal writing
  - Receipt collection, acquittals and finance management
  - Working according to allocated budget
  - Report writing
  - Personal organisation

The above model has worked very well where the CHWs were more advocates for Health and Social Issues, community advocate with the stakeholders and the main liaison person linking the community members to services. All the CHWs are now capable of working closely with their Zone Nurses and Health Committees to advocate for changes within their communities.

Table 25: **Activities conducted by Community Health Workers demonstrating how much their capacity had been built.**

All CCOHSI Communities	Activity / Education	Number of sessions	Number of participants
Health Promotion	General Health Education	67	961
	Non-Communicable Disease Education	132	1988
	Sexual and Reproductive Health Education	63	925
	Social Issues Education	49	743
	Composting Education/Demonstration	65	577
	Backyard Gardening	290	2271
	Waste Management Education	79	1147
	Sanitation and Hygiene	22	273
	Healthy Cooking Demonstration	62	943
	Farming and Animal Management Education	8	185
	Water Management Education	14	196
	Disaster Management Education	1	11
	Clean up Campaigns	127	1552
	Physical Activity	243	3880
	Fun Day	24	673
Stakeholder Engagement	VSHC	188	2348
	Government	343	5299
	Non-Government	23	379
	Community Groups	127	2316
	Health Committee Meetings	88	632
	Young Mothers Program	16	67
Total		**2031**	**27366**

Zone Nurses

- Zone Nurses became more visible in the community due to attendance at stakeholders workshops/health education workshops
- Assisted with screening and profiling of communities which in turn assisted them
- Assisted with identifying Young Mothers in communities
- Assisted with Health Promotion in communities
- Attended stakeholders and health education workshop and became an integral part of the communities.
- In some communities they assisted CHWs with CDP writing (Ba)
- Drawing up work plans and programs with Community Health Workers
- Collaboration with CDPs in health screening and health education and promotion workshops
- Improved NGO/Government relationships
- Working on/referral of social issues with Social Workers (especially child protection and domestic violence cases)
- Increased confidence
- Zone Nurse and CHW initiative – (e.g. TB program maximised in 4 other schools following World TB Day at Khalsa Primary School, Ba)

Turaga ni Koros

- Supportive and embracing of health promotion
- Started working better with CHWs and increased recognition of Zone Nurses
- Introduction of CDP into Village Council and Health Committees
- Increase CCOHSI staff confidence in engaging with the community
- Better understanding of health and social issues and their relevance to daily life
- Allow CCOHSI to promote health topics (even if they choose not to comply with them personally i.e. grog use)
- Personal development and communication skills developed
- Declaration of smoke free halls in communities
- Key player in the execution of CDPs
- Taking ownership and undertaking activities outside of the CCOHSI project
- Empowerment and improved reporting
- Breaking boundaries and traditional restrictions for health promotion (i.e. Namoli Village - planting of vegetables and play sports in the village, going for a walk outside the village when a death occurs)
- Able to recognise their capabilities, limitations and how they can overcome barriers
- A key player in maintaining sustainability of project principles due to better relationships with Zone Nurses, CHWs and other stakeholders

With empowerment in health and social issues, the Turaga ni Koros are more likely to be effective leaders and communicators for change within their communities and have more meaningful engagement with stakeholders.

Community Health Committees

- Formation of new Health Committees for settlements
- Reactivation and revitalisation of current Health Committees
- Improve proposal writing skills
- Health Committees are made up of volunteers, harnessing the goodwill of the community (CHWs, Turaga ni Koros, Land Owners, Women's Leaders, Youth Groups, Religious Groups)
- Improved communication and relationships within the community (each health committee representative from each respective group (youth, women's, religious groups) brought together for a common cause with shared activities and responsibility
- Execution of CDPs
- Managing finances and maintaining the CDP proposal budget
- Monitors and supports the CHW within the community
- Zone nurses also use Health Committees
- Pooling resources - Individuals with skills and education (e.g. school teachers) joined the committee and assisted leaders with report writing, proposal/letter writing
- Capacity was built to a point where the community was able to independently engage with stakeholders for issues to be addressed (e.g. in Ba, the road upgrade decreased the risk of flooding for both Vatuyaka Settlement and Maururu Settlement and in Nadi the installation of a sustainable water supply in Yavuna Village) – which will help sustainability
- Strengthened ties, barriers broken and improved relationships between land owners, community members and Health Committees (e.g. Land owner a member of the Seniyaya Health Committee, Lauwaki agreement to put up CDP board and declared no dumping rubbish)
- Increased clarity on real/actual land owners - the practice of faux land owners taking advantage of disempowered communities has stopped (e.g. Vadraiyawasewa Settlement)

Revitalised Health Committees with an active CHW and with support from Turaga ni Koros or Advisory Councillors can have a major impact with ongoing health and social issues in their communities.

COMMUNITY OWNERSHIP AND EMPOWERMENT:

Most of the communities embraced the ownership eventually. The disempowered communities that we worked with had several issues such as:

- Socio economic disadvantage with several members living in poverty
- Poor health literacy- whereby the idea of health has not been wellness but "health" meant seeing medical personnel, hospitals and health centres
- Lack of understanding of individual and community's role in ensuring their own wellness
- A hand out mentality where 'others' are supposed to help mostly with funds to tackle issues

This project has shown many in the community that its members and structures can tackle lifestyle risk factors for health and social issues. Having a CHW, a Zone Nurse and a Health Committee that is integrated and aware means they can mobilise human resources as well as other resources available in the many government and non-government stakeholders and sectors. In follow up visits to CHWs and health committees many are conducting activities newly initiated or sustain those that were conducted during the project. Longer time is required to see the full impact of the project on ownership. However, there is little doubt that the communities and its various structures are feeling more empowered.

Schools, students and children

- Undertaking the facilitation of CDPs (Lavusa, Lavuci, Vatuyaka, Vatulaulau, Lovu Sangam, Khalsa, Togo, Nadelei Catholic, Nawai, Ra High School, Rt Filimoni, Waileilei, Nadi Special School) The knowledge and ownership of health and social issues.
- Health Promotion - composting, gardening, WASH, physical activities, healthy cooking
- CCOHSI health promotion presentations for National Preschool Week – Viseisei Primary School, Gurukul Primary School, Mulomulo Primary School, Meighania Primary School, Dreketi Primary School, Drasa Primary School

Impact on vulnerable women and children- Empowerment

- Overall women attended all activities 2:1 to males so has had access to information, health promotion and clinical sessions as well as the CDP activities- Women' Empowerment.
- Housing assistance for domestic violence abuse victims in collaboration with other stakeholders
- Removal of abused children to safe homes in collaboration with social welfare and other stakeholders
- Support for sexual assault victims
- Support for disabled people and those in need of ambulatory aids
- Supplies for impoverished families (e.g.30 food packs were distributed communities)
- Support for attempted suicide cases and those with addictions
- Young mothers upskilling and training workshops with improved reproductive and child health awareness as well as many now have employment or have gone back to seek education
- CHWs themselves have been empowered
- Women took part in marches through Lautoka town calling for elimination of Violence against women
- Over 1000 women received health promotion and screening for NCDs and SRH issues

Environmental impact

The commonest issues identified by communities have been the need for proper waste management.

- 28 of 30 communities worked on these for their CDPs, learnt about separating waste, composting and proper disposal of waste
- Gardening, planting of fruit trees
- Drainage digging and cleaning drains have led to decreases in flooding and water borne diseases.
- Water management was also an issue with some interior communities, where water harvesting and repair of piping has been undertaken.
- Proper animal management and tethering.

VSHC and Empower Pacific Partnership in the Project:
Bringing civil societies or non-government organisations together for a shared vision has worked very well in the CCOHSI project. The two organisations have slightly different thrust in areas of service but several common features such as service and empowerment of individuals and communities for better health and prosperity. Empower Pacific brought in counselling and social service skills, which were vital to proper delivery of the project activities. They were able to take the messages to the community through the community outreach model that VSHC uses. VSHC's strength in Primary health care and wellness complemented Empower Pacific's efforts. The 2 organisations staff built the capacity of each other and worked in a terrific environment of team building and cooperation. This partnership delivered the project with services, knowledge and resources shared for maximum impact.

CHALLENGES AND LESSONS LEARNED
Community work is always challenging for various reasons:

1. Initial meaningful engagement takes a lot of time and effort
2. Community leaders need support and mentoring as they build capacity.
3. CDPs can be effective in building capacity but require commitment, patience, and persistence on the part of development partners.
4. Financial grants are helpful but not the key motivating factor.
5. CHWs need support, mentoring and financial incentives.
6. Inter sectoral engagement is key to maximising effective mobilisation of resources.
7. Engagement of stakeholders requires education and information to develop a shared vision on CDPs.
8. CDP need to be specific, measurable, achievable, relevant and time bound to be successful.
9. A relevant M&E template is essential to ensure that goals are realised.

Evaluation of the Project
Two senior external (external from VSHC and Empower Pacific) health professionals are conducting the evaluation of the project. Their report will be available in due course.

RECOMMENDATIONS

1. CHWs from all villages and settlements should be trained, mentored by Zone Nurses to participate in community Health Committees and be the main advocate for health and social issues in their community. CHWs are to act as the link between the community and government and non-government stakeholders to address community health priorities.
2. CHWs be renumerated for their services in the community as this will ensure ongoing participation.
3. Health and Social Issues Community Development Projects should be promoted as an effective strategy for building sustainable capacity within communities to identify key community concerns and find solutions for them. A similar strategy can be adopted for non health issues.
4. Programs should be developed to identify community leaders and provide them with training and support.
5. Community Health Committees should be strengthened in all communities.
6. The MoHMS needs to define the job description of the Zone Nurse and recognise the crucial role this position has in the wellness program. The ZN should work more closely with community structures and should be included as a resource member of the Village Health Committee and provide the Village Health Committee with regular updates on health indicators.
7. Health Centre personnel should include a Health Promotion Officer whose role is non clinical.

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    - Health Inspectors from Nadi, Lautoka, Ba and Tavua
    - Zone Nurses and CHWs for the 30 communities

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6. Ministry of Youth and Sports
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8. Ministry of National Security and Defence
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