Project Completion Report
The Project for Prevention and Control of Non Communicable Diseases(Fiji)

May 2020

Japan International Cooperation Agency
(JICA)

HM
JR
20-063

Project Completion Report

THE PROJECT FOR PREVENTION AND CONTROL OF NON COMMUNICABLE DISEASES

THE MINISTRY OF HEALTH AND MEDICAL SERVICES

AND

JAPAN INTERNATIONAL COOPERATION AGENCY

February 2020

Table of Contents

List of Abbreviations

Abbreviation	Full Form
ADRA	Adventist Development and Relief Agency
AOP	Annual Operational Plan
BMI	Body Mass Index
BP	Blood Pressure
C-POND	The Pacific Research Center for the Prevention of Obesity and Non-Communicable Diseases
CBG	Capillary Blood Glucose
CCC	Client-Centered Counselling
CEHS	Central and Eastern Divisional Health Services
DAC	Development Assistance Committee of the Organisation for Economic Cooperation Development
DFAT	Australian Government Department of Foreign Affairs and Trade
DMO	Divisional Medical Officer
DON	Director of Nursing
EP	Empower Pacific
FBO	Faith Based Organisations
FC	Family Cares
FHSSP	Fiji Health Sector Support Program
FNU	Fiji National University
FJD	Fijian Dollar
FNPF	Fiji National Provident Fund
HbA1c	Hemoglobin A1c
HC	Health Centre
HW	Health Worker
IEC material	Information, Education and Communication material
ITS Lab	Information Technology Services Laboratory
JCC	Joint Coordinating Committee
JICA	Japan International Cooperation Agency
JPY	Japanese Yen
KPI	Key Performance Indicators
M&E	Monitoring and Evaluation
MBBS	Bachelor of Medicine & Bachelor of Surgery
MI	Motivational Interviewing
MoHMS	Ministry of Health & Medical Services
NCD	Non-communicable Disease
NHN	National Health Number
NIBIOHN	National Institutes of Biomedical Innovation, Health and Nutrition
NIPH	National Institute of Public Health
NWG	Nursing Working Group
PDM	Project Design Matrix
PEN	Package of Essential Non-Communicable Disease Interventions
PHIS	Public Health Information System
PO	Plan of Operation
PS	Permanent Secretary
RD	Record of Discussions
SPSS	Statistical Package for The Social Sciences
Sup	Supervisor

USP	The University of the South Pacific
WHO	The World Health Organization

I Basic Information of the Project

1. Country:

Fiji

2. Title of the Project:

The Project for Prevention and Control of Non-communicable Diseases

3. Duration of the Project (Planned and Actual) :

May 2015 – May 2020 (5 years)

4. Background:

Non-communicable diseases (cardiovascular diseases, diabetes type 2, some cancers and chronic respiratory diseases) account for up to 75% of all deaths in Fiji. The NCD burden is largely due to lifestyle and behavioural choices. MoHMS has chosen to address the issue by focusing on the prevention of NCD by promoting the concept of wellness. In 2012 MoHMS requested technical cooperation to the Government of Japan to strengthen the system of NCD prevention, in particular cardiovascular diseases and diabetes. JICA conducted surveys in 2012 and 2014 to determine the scope and size of the assistance required to address this development issue. This led to the formulation and implementation of the Project.

5. Overall Goal:

Wellness of Fijian residents is improved.

6. Project Purpose:

Evidence-based Non-communicable Disease (NCD) prevention and control is strengthened at the Ministry of Health & Medical Services (MoHMS) and the Central Division.

7. Implementing Agency:

Ministry of Health & Medical Services

II Results of the Project

1. Results of the Project

1-1 Input by the Japanese side (Planned and Actual)

Item	Actual Input
(1) Expert dispatch	14 experts in total. 7 long-term experts; 2 came as Chief Adviser, 2 came as Project Coordinator/Health Promotion, 2 for Community Health/NCD and 1 Project Coordinator. There were 7 short-term experts who assisted in the following areas: Epidemiology Nutrition Data analysis/evaluation Monitoring/revision of training materials Health promotion Technical Advisory mission
(2) Receipt of training participants	Total of 13 persons have gone for training in Japan. Two senior MoHMS officials went on a familiarization tour of relevant agencies and facilities. Ten went on a two week training course on *Primary Health Care Nursing toward NCD Prevention* and a research officer went for a month- long data analysis training.
(3) Equipment provision	**JPY 6,585, 944.0** was spent on 27 pieces of office equipment, medical gadgets and a vehicle.
(4) Overseas activities cost	A total of **JPY 41, 487,295.0** was spent on the following: Staff salaries of Fijian project staff Office supplies and consumables Activity fees Travel expenses (tickets, allowances) Publication costs (IEC materials) Note: Above given equipment provision costs (JPY6,585,944) is included here.

1-2 Input by the Fijian side (Planned and Actual)

Item	Actual Input
(1) Counterpart assignment	The following officials have been assigned: Project Director (Permanent Secretary, MoHMS) Project Manager (Head of Wellness Centre) There was a cumulative total of 60 counterparts, some of whom were members of the Joint Coordination Committee, the Nurses Working Group, enumerators for surveys, staff of the MoHMS who provided support services.
(2) In-kind contribution	Office space and furniture, electricity
(3) Operational costs	A total of **FJD 119, 445.0** was spent on the following: vehicle insurance catering for meetings & training workshops allowances for enumerators meals, accommodation and allowances for training participants purchase of equipment printing of IEC materials

1-3 Activities (Planned and Actual)

The project appears to have been implemented in two phases ostensibly with little connection between the two. In fact one of the stakeholders who was interviewed thought there were two JICA projects; one conducted in communities and the second in the workplace. The first phase focussed on two communities: Baulevu and Nuffield medical areas, and the second phase focused initially on two workplaces: Fiji National Provident Fund (FNPF) and Lyndhurst.

For Output 1, planned activities included a baseline survey on the current situation of NCD prevention and control in the Central division and then based on the findings, intervention strategies were to be developed to strengthen NCD service delivery at health centres and nursing stations. From 2015 to the end of April 2017, the project team in the first phase, did indeed conduct the baseline survey to determine intervention prototypes that would be used for the prevention and control of NCDs. The baseline survey was conducted in early 2016 in Baulevu medical area which was a rural community and Nuffied medical area which was a semi-urban area. The survey was to get a snapshot of the NCD risk profile in the two areas and to develop appropriate NCD prevention interventions that could be trialed in the two areas and subsequently rolled out in the Central Division. The two intervention prototypes developed and trialed were the Client-Centered Counselling (CCC) and Family Cares (FC). The initial three-month trial of the prototypes in urban and rural communities yielded inconclusive results and so a second trial was recommended.

While CCC approach focused on following up high risk clients, the FC approach targeted the general healthy population. Both approaches are regarded as important to combat NCD effectively, however FC was dropped during the second phase for three main reasons.

Firstly, it required a massive awareness campaign among the entire Fijian population in order to be successful. The results of the survey in the first phase showed that the Fijian population is generally satisfied with their current body sizes regardless of the worsening obesity trend in Fiji. This could be the main reason for the result showing that none of the participants among the first intervention group continued to measure their weight with family members in the second phase.

Secondly, FC approach was also not widely practiced in other countries. The idea of FC arose from the results of the initial survey which showed a weak correlation between BMI and HbA1c. The use of a measuring tape was also justified as more economical compared to the use of a scale. Regardless of the measuring device, Fijian people don't monitor their weight if they don't feel the weight loss is necessary for their lives. Simply applying the theory without considering the real-world setting was the issue in applying FC approach in Fiji.

Thirdly, the scope of the work was too great given the limited time period of the project in order to conduct both population based and high-risk focused interventions in an effective way.

While FC was completely unsustainable some clients of CCC were still following the health workers' advice. This may have been due to follow-up by nurses and perceived higher risk of NCD by the clients because of abnormal readings. However, there was no formal training offered to the health workers to be able to conduct effective and standardized counselling for the behavior change in a client centered way. The proposed CCC during the first phase was neither based on the current evidence nor practiced in other countries. Eventually a health facility-based intervention using the Motivational Interview (MI) approach was selected as the intervention to be used in the health facilities by MoHMS.

MI is a client -centered counseling approach which had already been introduced in Fiji by other agencies such as the DFAT-funded Fiji Health Sector Support Program and WHO albeit to a limited extent. For the sake of sustainability of the intervention, integration of existing international practices was regarded as important rather than bringing new approaches without international standards.

Also as part of Output 1, there was to be the development and operationalization of a NCD prevention package that would include the revised NCD intervention strategies, training manuals, a wellness calendar, a Personal Health Record Book and tape measure. The National Food and Nutrition Centre was consulted in the production of ICE materials that included flip charts and other awareness-raising materials. There was also the establishment of the Joint Coordination Committee (JCC) of the Project with Terms of Reference. The JCC met annually from 2015-17.

For output 2, the Nursing Working Group (NWG) was established in March 2016 with Terms of Reference and monthly meetings of the group were held thereafter. Training courses for MoHMS personnel were conducted both locally and in Japan to build the capacity of nursing personnel in NCD service delivery at primary health care facilities. A training workshop was held locally on data analysis using an advanced statistical analysis program, SPSS. Ten nursing supervisors were selected to undergo a two-week training course in Japan on *Primary health care nursing toward NCD prevention* in late August to early September 2016. Upon their return from Japan, the nurses worked on seven sub-projects to apply newly acquired knowledge from the training in Japan and to support outcomes of the Project. The seven sub-projects were as follows:

- Targeting child malnutrition by educating mothers at Korovou Health Centre
- Counselling on healthy eating during and after pregnancy at Nausori Maternity Unit
- Strengthening primary intervention of diabetic foot complications at Nausori Outpatient Department
- Healthy Workplace Program in Samabula health Centre
- Hospital discharge planning: from a home-based nursing view
- Addressing obesity in Wainimakutu Primary School and
- Training of Community diagnosis

The Research Officer in the Wellness Center, MoHMS, was sent for month-long training in data analysis in Japan to assist in the data analysis and write-up of the baseline survey.

For Output 3, a Monitoring and Evaluation (M&E) monitoring team was formed for the Project and nine meetings were held in the first two years of the project. The meetings discussed the M&E framework, M&E forms to be used and training required to strengthen the capacity of staff in M&E at sub-divisional and divisional levels. M&E tools of NCD prevention and control services were to be adapted to the local context and local medical personnel trained to monitor and evaluate the performance of the NCD prevention package developed in Output 1. This is a work in progress with data still being collected.

For Output 4, the results of the baseline survey in Baulevu and Nuffield medical areas were presented at three international conferences in Japan and in the publication of an article in the Fiji Journal on Public Health. There were at least seven presentations on the project results at national and regional meetings and workshops. There were also three media releases on

project activities in both Fiji and Japan. The JICA website also has information on the project activities.

The PDM was amended midway in the project. With the exception of two local staff, the entire project team was changed with new experts recruited from Japan and the intervention prototypes trialed in the first phase were dispensed with. The scope of work in the original PDM was simply too great for the project timeframe and the content of the proposed intervention prototype, Family Cares and Client Centered Counselling, were deemed inappropriate for the Fijian context. The 4th JCC meeting which was supposed to have been held in 2018 was postponed until results of the revised interventions could be presented and a revised version of the PDM produced by the new team. The most recent version of the PDM was presented at the 4th JCC meeting held in June 2019 (see Annex 1).

For Output 1, the focus shifted from the CCC and FC to the tried and tested method of Motivational Interview (MI) as the primary intervention tool for the prevention and control of NCDs. The baseline survey had not produced verifiable results for the urban area (Nuffield medical area) as it was logistically more challenging so rather than work with the urban households, the study was shifted to the workplace, where many urban dwellers spend much of their day. A three-month pilot Healthy Workplace program was implemented where the use of MI counselling was conducted in two large companies that had workers from different socio-economic backgrounds, Fiji National Provident Fund (FNPF) and Lyndhurst, a garment factory. The results of this pilot study would then be used to scale up the workplace wellness program in the Central division and health promotion activities at health facilities. The workplace intervention of weight loss program was also implemented in a rural community at Kasavu Village, Baulevu. The MoHMS, in choosing the MI approach, was fully aware of the expected lower retention rates of the clients in the communities compared to those in the workplaces.

An endline survey was included as a key activity for Output 1 to assess the status of wellness clinics that currently exist in the Central Division, the impact of training medical personnel in the MI approach and the effectiveness of the Information, Education and Communication (IEC) materials produced. A new set of IEC materials was produced that included a flip chart, a fridge magnet of a healthy plate, a DVD on healthy recipes, a wellness record book for clients and posters and flyers.

For Output 2, the NWG continued to meet, but on a quarterly basis as opposed to the monthly meetings held previously. The NWG meetings allowed a forum for the ten nurses that were sent to Japan for training to report on progress made with their small projects. It also provided a space for nurses to discuss and exchange ideas.

The training of health personnel focused on teaching 175 nurses the MI tool in a series of training workshops facilitated by the Project and conducted by Empower Pacific. The tool was already part of the WHO Cardiovascular Risk Assessment and Management (PEN) Training Manual and the Australian-funded Fiji Health Sector Support Program (FHSSP) had already trained 500 health workers in the technique nationwide. The MI approach was used in strengthening the follow-up of high risk cases in health centres and nursing stations. Training on nutrition counselling and behavior change was provided to some 26 participants from the Central division, Fiji and Kiribati.

For output 3, monitoring and evaluation of the NCD prevention package was replaced by capacity building of staff at sub-divisional and divisional levels in epidemiology to enable the

staff to analyse the wellness screening data. Indicators for workplace wellness have been proposed as have indicators for following up high risk groups in the community.

Output 4 was strengthened by the dissemination of project findings through conference, meeting and workshop presentations.

2. Achievements of the Project

2-1 Outputs and Indicators

The achievement level of outputs at the time of writing is summarized below.

Output 1: Evidence-based practices for NCD prevention and control are performed and implemented at primary health care level in the Central division

Indicator	Current Results
1-1 Final tools and materials for NCD interventions is authorized by the MoHMS before the end of Project 5th year.	Final tools and materials produced to date include the following: NCD Calendar 2019 My Healthy Plate fridge magnet My Wellness Record Book Tips for Healthy Weight Loss Flipchart Healthy Fijian Recipes Cooking Video Demonstration Flow Chart of Counselling Posters Endorsement has been given by the NWG, DHS and NCD Adviser. Approved by DMO Central, DON and PS.
1-2 Report on evidence-based NCD prevention and control is completed at the end of all the surveys to be conducted.	The endline survey report is 95% complete and will be completed by the end of the evaluation period.

Achievement level of Output 1 is high based on documentary evidence that shows 95% has been achieved for each of the Indicators 1-1 and 1-2 at the time of the terminal evaluation.

Output 2: Operational capacity of NCD service delivery is enhanced at primary care facilities.

Indicator	Current Results
2-1. Post-training follow-up and evaluation of MI are carried out.	Progress has been reported in the following documents: Project Monitoring Sheets Versions 1-8 Meeting minutes of 4th JCC Meeting Meeting Minutes of 15th, 16th, 17th & 18th NWG meetings FNPF Follow up Report Lyndhurst Follow up report Kasavu Village Screening Report Nausori Wellness Clinic Report Health workers trained in MI at health centres and nursing stations were followed up during the endline survey and they were unanimous in reporting an increase in number of high-risk patients visiting the health facilities. Stories of reverse cases post-MI training have been received from many of the health centres

	during the endline survey. A total of 90% of eligible health workers in the Central division have been trained in the MI approach thus far. Wellness clinics have been established for follow-up of high-risk patients from communities and workplaces.
2-2. MI training packages are developed.	A generic training package has been compiled and the training to date has been provided by Empower Pacific (EP). Copyright issues have been sorted out with EP and a training package has been compiled with the logos of the Ministry and JICA.

Documentary evidence shows the achievement level of Output 2 is high based on 100% of Indicator 2-1 being achieved and 100% of Indicator 2-2 at the time of the terminal evaluation. Indicators 2-1 and 2-2 replaced the five indicators in the original PDM. This amendment was made and endorsed at the 4th JCC meeting held in June 2019.

Output 3: Capacity of monitoring and evaluation (M&E) for NCD service delivery is enhanced at divisional and sub-divisional level.

Indicator	Current Results
3-1. Availability of Quality Control Package of MI.	A wellness registration book has been piloted for clients to record vitals on consecutive MI counselling sessions at the wellness clinic. The following auditing tool for MI was presented at the 19th Nurses Working Group meeting in October 2019. It is to be used by supervisors and clients in assessing the MI competency of the health worker but it is subject to revisions before it can be used in the field.

1.1 COMPETENCY ASSESSMENT FOR MOTIVATIONAL INTERVIEWING at WELLNESS CLINIC by OBSERVATION OF COUNSELLING

Name of HW: EDP: Date: Supervisor/Assessor:

1st column - tick decision by supervisor2nd column -Tick if supervisor agrees with HW decision. Mark 0 if HW did not.	Patient 1		Patient 2		Patient 3		Patient 4		Remarks
Time		**Time**			**Time**		**Time**		
Start	**End**	**Start**	**End**		**Start**	**End**	**Start**	**End**	
:	:	:	:		:	:	:	:	
Sup	HW	Sup	HW		Sup	HW	Sup	HW	
Asks permission to carry out the session									
Checks how the client feels about their results									
Assesses the clients stage of change									
Picks up on issues that are important to the client									
(O) Uses open ended questions to elicit how client thinks and feels about change									
(A) Affirmation of Strengths & Self-efficacy									
(R) Uses reflective statements to show that the clinician is listening									
(S) Uses summaries to bring together what the client has said									
Actively supports client choice and personal responsibility									
Encourages client to discuss desires, abilities, reasons and needs related to behavior change									
Duration of the counseling		**Duration of the counseling**			**Duration of the counseling**		**Duration of the counseling**		
:		:			:		:		

Note: Please note the few columns given are for reassessment should they need to re-test

* document findings; (include NHN, name, age, height, weight, BP, CBG,BMI, waist circumference, action plan and follow up plan)

* writing of referral note/letter

	* writing of follow up appointment notes
3-2. Availability of Epidemiology Training report	An 8-page report entitled SPSS Workshop for Ministry of Health Staffs 24th-26th July 2018, Professional ITS Lab, University of the South Pacific

Achievement level for Output 3 is medium as 60% of Indicator 3-1 has been achieved and 100% has been achieved for Output 3-2 at the time of the terminal evaluation.

Documentary evidence would suggest that funding constraints prevented an epidemiology expert from running the epidemiology training. The report is about the training received by MoHMS personnel in SPSS, the statistical software package. The epidemiology training report was an amendment made to the PDM that was endorsed by the JCC in June 2019 but it has failed to materialize.

Output 4: Good practices and lessons learnt from the Project are shared nationwide (with the Pacific Island countries).

Indicator	Current Results
4-1. Evidences and experience of the project are shared with relevant personnel engaged in NCD prevention and control in Fiji, Kiribati and other Pacific countries via workshops, international conferences at least once a year.	Presentations have been made at the following international forums: *Preliminary results of the Healthy Weight Loss program: Prevention of Onset of NCDs* by Dr Naomi Hamada presented at the Prince Mahidol Award Conference 2019, Bangkok Presentations on the surveys in Nuffield and Baulevu were made by NIPH and NIBIOHN at : 31st Eastern Regional Conference of Japan Association for International Health May 2016 Asia-Pacific Academic Consortium for Public Health 2016
4-2. Evidences and experience of the project are updated regularly on the health journals and website during the Project period.	There has been one journal publication produced : Community-Based Initial Survey for Prevention and Control of Non-Communicable Diseases in Central Fiji; Silatolu A, Nomura M, Nishi N, Kinoshita S, Kikuchi M, Matsuura S, Prasad A, Miyoshi M, Ishikawa M, Miura H, Tukana I;FIJI JOURNAL OF PUBLIC HEALTH; Volume 5, Issue 2, 2016 Uploads on the JICA website of project activities.

Achievement level of Output 4 is high as documentary evidence shows 100% of Indicator 4-1 has been achieved while 60% of Indicator 4-2 has been achieved at the time of the evaluation report.

2-2 Project Purpose and Indicators

Project Purpose: Evidence-based NCD prevention and control is strengthened at the MoHMS and the Central Division.

Indicator	Current Results
1. Achievements and/or evidences obtained through the Project are reflected in health policy and/or strategy by the end of the Project.	The results of the endline survey and MI training provided by the Project are featured in Strategic Pillar 1 of the Annual Operation Plan of the MoHMS for 2019/2020, Central Division Business Plan for 2019/2020 and Priority Area 1 of the Suva Subdivision Operational Plan for 2019/2020. Wellness clinics and MI are also featured in the next NCD Strategic Plan for 2020-2024.
2. More than 80% of primary health care facilities in the Central Division are practicing NCD interventions to reduce NCD risk factors.	The endline survey shows that 33 of the 42 health centres and nursing stations in the Central Division are employing MI counselling in tackling NCDs which constitutes 79% of the total number of facilities. 90% of eligible health personnel have been trained in the MI tool so the number of health facilities that will benefit from the trained personnel will likely rise.

Achievement level is high as 90% of Indicator 1 has been achieved and 95% of indicator 2 has been achieved at the time of the evaluation report.

3. History of PDM Modification

Ten of the seventeen indicators (59%) and seven of the forty two activities (17%) in the original PDM were deleted when the PDM was revised midway through the project after consultation with MoHMS and JICA offices. by the new team of experts (see Annex 1 revised PDM). The ten indicators were replaced by five new indicators bringing the total number of indicators in the revised PDM to twelve. The reduction in listed activities was largely because they'd already been done by the old team and were considered obsolete. To delete close to 60% of the original indicators is significant for any project but there were several reasons for the overhaul in indicators. Firstly all those indicators that were tied to the initial intervention prototypes, CCC and FC, were removed as the interventions were deemed unsuitable. They were replaced by indicators that measured the use of MI instead. Secondly, the scope of the project was considered by JICA Fiji as too great given the project timeframe.

III. Results of Joint Review

1. Results of Review based on DAC Evaluation Criteria

(1) Relevance: High

Fiji's 5-year and 20-year National Development Plan (Min. of Finance, 2015)recognizes NCDs as a serious health issue that needs addressing so one of the key National Development Targets for 2016-2035 is *Reduction in number of deaths due to NCDs*. In discussing strategies to tackle the NCD epidemic, the Plan states that collaboration and partnership with the private sector, NGOs and development partners will be actively fostered. The objective and activities of the JICA Project on the Prevention and Control of NCDs which includes the wellness at work programme being implemented by Lyndhurst and the engagement of Empower Pacific in delivering the MI training certainly supports the partnerships promoted in the National Development Plan.

The Ministry of Health and Medical Services National Strategic Plan 2016-2020 has NCDs as its Priority Area 1 along with seven other priority areas. A strategy to address the NCD problem is a "whole-of-society approach" to reduce risk factors such as obesity, raised blood pressure and blood glucose. The NCD Strategic Plan 2015-2019 identified five areas for action that included Wellness Fiji at nursing station and health centre levels and the development of a wellness toolkit. The National Wellness Policy for Fiji (2015) requires the implementation of evidence-based initiatives for prevention and control of NCDs as stated in the Strategic Plans. The JICA project has assisted both Strategic Plans and national policy in establishing a process for the prevention and control of NCDs and through the evidence gathered at the time of project evaluation.

The Annual Operational Plan (AOP) for MoHMS for 2019/2020 has significant funding allocated to the Wellness Division for NCD service delivery which includes preventative screening and staff training in MI. The Suva sub-division Operational Plan for 2019/2020 includes staff training in MI.

The JICA Project, through the training and knowledge products it has provided, has been consistent with the development needs of Fiji and is of great relevance to the country.

The approach and intervention tools proposed at the start of the project worked well in the rural setting but needed more creative ideas, such as an effective booking system and by sharing the best practices of counseling time so to fit conditions within the urban areas. The intervention tools initially proposed, CCC and FC, were considered insufficiently robust thus the decision was made midway through the project that the initial project plan and approach had to be revised. The decision to change the intervention tool to MI, necessitated the training of more nurses in the MI counselling approach. The shift in focus from urban communities to workplace wellness was justified given that the number of office workers in Fiji has increased significantly in the past decade. In Suva alone, from 2011-2014, the number of paid employees went from 32,798 to 49,331, a staggering increase of 50%. So the most productive part of the day for many urban dwellers is spent in the workplace. The implementation of the project in the Central Division before rolling it out nationally was also very prudent given the that the Division is the most challenging in terms of population size and mobility. Lessons learnt from the Central Division can then be used in the national implementation of the tools and approach.

The Project is unanimously regarded by the stakeholders as being very relevant to Fiji's development needs and despite the initial setbacks, the results have been well received.

(2) Effectiveness: High

The package of five IEC materials has been endorsed by the MoHMS and has been distributed widely to the 42 health facilities in the Central Division. The materials are being used extensively by the nurses in promoting wellness in the communities. The endline survey revealed the positive impacts of MI on both the health workers and the clients. The number of reverse cases from MI counselling is growing steadily although there is scope for greater growth. Interviews with clients from four different wellness clinics revealed some common factors that have contributed to their weight loss and reversed biochemistry results: personal interest shown by nurses, increased knowledge on healthy diet and increased enthusiasm once they start to see positive results. The nurses have also benefitted from the MI training by cultivating greater empathy, improving communication skills and becoming more approachable.

There have been a couple of follow-up studies of MI-trained personnel. In one study, ten health personnel were assessed by an MI trainer at their respective duty stations to determine if they had benefitted from the MI training. They were assessed pre- and post-MI training, using ten different criteria, to determine any changes in counselling skills as a consequence of the training. All showed significant improvement in scores for all ten counselling criteria with one score increasing by as much as 69% post-MI. The health workers had successfully implemented what they'd learnt at the training.

In another study, eighteen participants were visited at their health centres to conduct interviews with them re their views on the MI tool, its strengths and weaknesses, changes in patient management and the practicality of using MI in the workplace. Of the 18 participants, 62% were found to always use the MI approach during counselling sessions. In listing the strengths of MI they mentioned patients taking ownership of their health, improved relationship with their clients, reverse cases in biochemistry of clients and improved listening skills. In listing the weaknesses of MI, the lack of space and thus confidentiality and time constraints were the top two listed. The participants were actively practicing what they had learnt at the training and doing so on a daily basis.

An MI training package has been produced by the Project which will be used by MoHMS staff trainers when training colleagues in the MI tool. It has the course materials to be delivered over a 5-day period. The package was compiled in collaboration with Empower Pacific and will prove an invaluable tool for the sustainability of the project effect.

A competency assessment for MI is proposed and has yet to be piloted in a wellness clinic. The assessment is two-fold. The MI-trained nurse is assessed by her superviser while counselling a client using the MI approach. Obviously the superviser or MI facilitator should also be trained in the MI approach. The second part of the competency assessment will involve asking the client after the counselling session whether they understood what the session was about and what they have learnt from the health worker. The auditing tool for the latter assessment will be revised according to the results of piloting if it is necessary. Another proposed auditing tool for MI is the wellness record book and documenting the vitals on each subsequent visit.

The knowledge generated by the Project has been disseminated widely through presentations at three international conferences, three articles in the local dailies, at least ten presentations at national and regional health symposiums, meetings and workshops. There are also the

uploads on the JICA website. The awareness-raising on project findings and lessons learnt has ensured a high profile for the Project.

The indicators for the purpose of the project are well on the way to being fully achieved by the end of the project. Evidence from the project is reflected in national plans and strategies for 2020 onwards, particularly the use of the MI tool in NCD prevention and control. More than 80% of health facilities in the Central Division will be practising NCD interventions with the tools and resources promoted by the Project and MoHMS. Activity results particularly for Outputs 1 and 2 have ensured that the Project purpose has almost been achieved and thus effectiveness is rated high.

(3) Efficiency: High

The project period was five years as per the original RD. The revised interventions were necessary to achieve the outputs within the specified timeframe. Government of Fiji provided the necessary activity costs in a timely manner, which contributed to efficient and effective activities guided by the project. The inputs were both quantitatively and qualitatively appropriate. The long-term experts recruited from Japan were highly skilled and did their best to deliver the activities in a timely manner. Short-term experts basically failed to deliver the activities efficiently due to a lack of understanding of the context of Fiji given the short period of time they were in country.

Coordination among NCD development partners with inputs by JICA led to synergetic effects to a certain degree. These include the collaborative work with WHO PEN officer, Fiji Health Sector Support Program funded by the Australian Government, Faith Based NGOs and Diabetics Fiji. Developed IEC materials were shared with academic institutions, NGOs, Mobile phone companies and Fiji Institute of Human Resources as part of strengthening the existing health promotion activities.

(4) Impact: High

The overall goal of the project will be achieved as the project effect but because it involves behavioural change, it will take time for the project effect to become manifest. The process, however, has been put in place to ensure that the overall goal will be realised in time to come and that in itself, is a major accomplishment of the project. The national 20-year development plan (2016-2035) has as one of its main targets, a reduction in the number of deaths due to NCDs through a multi-sectoral approach and through partnerships. The project, in working with the Ministry of Education and with private companies like Lyndhurst, has shown through the Trachoma elimination and weight loss program respectively, that a multi-sectoral approach and public-private partnerships can work to improve the wellness of Fijians. The project has proven the concept of wellness and the positive impact that it can have on people's lives, both physically and emotionally.

The intervention promoted by the project, the MI approach, is a wonderful tool that can be applied in a variety of settings. For example, nurses started to use MI not only for NCD area but also for existing counseling opportunities for Family Planning counseling, Breastfeeding counseling, nutrition counseling for obese or malnourished children etc. This can be regarded as ripple effects of MI training. Given the number of medical personnel in the Central Division

that have been trained in MI by the project, the effectiveness of the wellness clinics that have been successfully established in the Central Division, should continue to grow with time. The MI approach is culturally appropriate for the Fijian context because the Fijian tradition is an oral one as opposed to written. The MI approach is thus suitable because it doesn't involve reading but rather talking through the problem and coming up with viable solutions. Flip chart developed by NCD project have s been officially used by FNU nursing students' practicum attachment in the rural settings. This can also be regarded as a ripple effects of project achievement.

A major impediment to the achievement of the overall goal is the health system as it currently operates. The burden of NCDs is largely in the urban areas because of the combination of poor diet and lack of physical activity. The lack of manpower servicing the health facilities in the most populous sub-division in Fiji i.e Suva, is a major constraint to strengthening the effectiveness of the wellness clinics. It is one thing to have the wellness clinics and MI training as part of the corporate plans, it is quite another to implement them in the face of limited staff with great demands on their time. Another impediment is more cultural particularly among the I Taukei community. They are generally not pro-active when it comes to their health and only react when a major crisis happens. So getting them to visit the wellness clinic more than once particularly if they are not feeling sick, is a major challenge. It requires a change in mindset and interviews with both clients and health workers show that repeat visits is a work in progress. The evidence produced thus far by the project shows a clear link between weight loss and lower blood pressure. The attitude to food therefore needs to change in terms of both quantity and quality of food consumed. The IEC materials produced by the project have been well received largely because the visual aids are both informative and humorous. A number of clients who have been interviewed have been very diligent in attending their counselling sessions because they made an informed decision to change their diet and have seen the positive results in their biochemistry. They have taken it upon themselves to promote the wellness clinics to their families, colleagues and church members. When beneficiaries become advocates, a ripple effect is created that could prompt others in the community to be more pro-active with their health.

(5) Sustainability: Fair

Sustainability is always a challenge for any donor-funded project regardless of the sector. For developing countries like Fiji, it has almost become the norm that when the donor funds dry up, the initiative also comes to an end. The issue of NCDs, however, is very topical making the project's contribution very relevant. The fact that NCDs are specifically mentioned in the 20-year development plan shows that its prevention and control is a Government priority.

For sustainability of the project effect the MoHMS has to take ownership of the project. The decision on whether to scale up the project initiatives to the national level, when to do so and how, needs to be discussed at the higher echelons of the Ministry. Budgetary constraints are usually the first reasons given for why a successful project is not scaled up. Perhaps the more pertinent issue for the Ministry is to relook at current strategies to see how existing resources may be used to maximize gains. Which other partners can be engaged in the upscaling? What protocols would need to be established for upscaling? Are the graduates being produced by FNU suited for furthering the wellness cause?

To maintain the momentum of the project effect, MI training has to be incorporated in the Strategic Plan of the Ministry. MI training is in the Annual Operation Plan of the MoHMS for 2019/2020, Central Division Business Plan for 2019/2020 and Priority Area 1 of the Suva Subdivision Operational Plan for 2019/2020. Wellness clinics and MI are also featured in the next NCD Strategic Plan for 2020-2024. Workplace wellness MI is also in the Annual Operation Plan for 2019/2020 and in the next NCD Strategic Plan for 2020-2024. The institutional framework necessary for continuation of the project effect would appear to be in place, however, there is one complication. Although MI training is included in the Ministry's AOP, the suggested indicators cannot be integrated into the Public Health Information System (PHIS) until MI has been rolled out in the other divisions. The roll out is contingent on the indicators being refined and collected over the next year in the Central division through a revised registration book.

The roll out to other divisions is also hampered by the lack of nurses trained in MI in areas outside the Central division. A Train the Trainers in MI skills was conducted by the Fiji Health Sector Support Program funded by the Australian Government but the trainers subsequently failed to train their colleagues. MI skills are also not part of the current nursing curriculum so the current crop of nursing graduates lack MI skills. Discussions have commenced on addressing the inclusion of MI training in the nursing curriculum.

Current organizational reform of MoHMS has potential risk upon the sustainability of the project. There could perhaps be greater cooperation between the Wellness Centre and the CEHS as the latter are mandated with operationalising the plans. For staff in the health facilities to take ownership of the MI approach, it should be in their job description and the relevant KPIs formulated for performance monitoring. There is a large pool of retired nurses and there are the community health workers. Could these human resources be mobilized to sustain project effect? Another critical consideration is the absorption of the local project staff into the Ministry at the end of the project. This will also ensure that the human resources necessary for the continuation of the project effect are readily available.

For the sustainability of the workplace wellness program, the Fiji Institute of Human Resources has indicated their interest in becoming involved in the wellness movement. This potential partnership should be actively pursued as the Institute has both public and private members and their engagement could be a way of getting more buy-in from the private sector. Large companies like Courts and Lyndhurst have been the project's local champions in promoting workplace wellness with both businesses recognizing the benefits of having a healthy workforce. Vodafone and Westpac are also actively championing workplace wellness so a groundswell is beginning to build among employees in the commercial sector. The businesses are funding their own programs so that the project effect is sustained without the need for any external funding. There will eventually need to be a system in place and protocols that require businesses to consent to sign up on healthy eating guidelines and physical activity guidelines.

Other partnerships that should be explored for sustainability of the project effect are with faith based organisations (FBO) and teaching and research institutions like FNU and C-POND. The faith based organisations have tremendous influence in the community that could be used for advancing wellness education. Wellness encompasses emotional and mental health so spirituality and the church could be an entry point. One such FBO that is very active in promoting lifestyle changes is ADRA, an NGO operated by the Seventh day Adventist Church. Wellness staff are being invited to speak at church conferences which is a positive step in reaching out to the masses. The FNU offers a semester-long course in MI to MBBS and Public

Health graduate students. Given that FNU is a Government entity, it could be engaged in providing quality assurance of the MI training. Collaboration with C-POND for further research in the prevention and control of NCDs should be actively pursued.

In summary, the need for NCD prevention and control is great, the institutional framework exists however the human resources inside the Ministry is wanting. Apart from the lack of skilled manpower, the funds from the Government side is probably the biggest challenge. All things considered, the sustainability is deemed to be fair.

2. Key factors Affecting Implementation and Outcomes

The start of the project was delayed due to processes largely out of the control of the first Chief Adviser. The proposed interventions, CCC and FC, required the approval of the Ethics Committee which took three months to secure. The proposal was submitted for the Committee's approval in September 2015 but approval was not granted until December 2015, by which time many of those who were going to implement the survey went off on their annual holidays. Many Government staff take leave during the December/January period so the field survey didn't commence until February 2016. When the field survey eventually started then the most destructive cyclone ever to hit Fiji, TC Winston, struck on February 20th & 21st 2016 bringing the field survey to an abrupt halt. The impact that TC Winston had on logistics and human resources of the project cannot be overstated. One of the survey sites suffered extensive damage and all Government personnel and resources (including the project vehicle) were deployed to the cyclone relief work. As a result of the natural disaster, the field survey was suspended for two weeks.

When the field survey was eventually completed in March 2016, the survey team had been reduced by half as eleven of the original twenty nurses enlisted for the survey were deployed to the cyclone relief work. In spite of the logistical issues, the rural community (Baulevu medical area) yielded credible results but the survey in the urban community (Nuffield medical area) was less successful. It was difficult to find people at home during the day and surveys during the evening were considered intrusive by the community. The poor execution in the urban setting meant that the results were inconclusive. The experimental design was perhaps not as robust as it should have been and the mid-term reviewer was not convinced of the effectiveness of the proposed interventions so a repeat of the survey was recommended. Two years after the commencement of the project and the proposed interventions, CCC and FC, were yet to be finalized for use.

Staffing was also problematic. The long-term experts had to split their time between Fiji and Kiribati which also impacted progress. The personnel issues continued in 2018 when Dr Hamada was the only long-term expert working on the project from July to October 2018 due to delays in the recruitment of the new Project Coordinator and Community Health/NCD experts. The absence of the two long-term experts also impeded the implementation of project activities. There was also the cancellation of sending the short-term expert in epidemiology to run the training course which was a key activity for Output 3.

The personnel issues were not restricted to the Japanese side. Four of the six Fijian nationals on the project team resigned for better paying jobs in the private sector. The handover of jobs and time spent in recruitment of new staff also impacted project delivery. Some of the nurses and dieticians trained in MI by the project were posted to other parts of the country. Four of

the ten nurses that went on the two-week training course in Japan retired before the end of the project including a key counterpart, the Divisional Health Sister (Central Division).

So the key factors that affected implementation and outcomes were basically an overly ambitious project scope, personnel changes in the project team and high staff turnover in the Ministry.

3. Evaluation on the results of the Project Risk Management

(1) Risk management results

Actions undertaken by JICA to address the slow progress of the project was a complete overhaul of the project team and a revision of the PDM. A new Chief Adviser was appointed and began in May 2017. Taking over a project when the outputs and targets have been set is not an easy task and major revisions had to be made to the PDM. It resulted in ten of the original seventeen indicators being deleted and replaced by five new indicators. Seven of the original forty two activities were deleted but the whole review process would have taken time, further adding to delays.

Two new long-term experts were recruited in the latter part of 2018. The short-term expert in epidemiology was not recruited and so a joint epidemiology training course with USP was organized instead. As a result, the course content was changed to a training course in the use of the statistical software package, SPSS.

The issue of high turnover of Ministry staff is something that the Ministry has yet to effectively address.

(2) Results of the use of lessons learnt

According to the evaluation report of NCD project in Sri Lanka, NCD project in Sri Lanka in the past, the role of zone nurses for the continuous health promotion at settings and upskilling of communication skills of health workers were emphasized as important. This NCD project in Fiji has used the lessons learnt especially on strengthening the communication skills of zone nurses.

4. Lessons Learnt

The slow progress made in the first two years of the project highlights the difficulties of working in a culture that has a different concept of time and health. Donor-funded projects in the wider Pacific region need to allow a year to get the administrative matters sorted before any activities are rolled out. Bureaucratic processes take longer than they would in other more developed countries, recruitment and retention of capable staff is a challenge when the project regulation does not allow for competitive remuneration rates and getting community buy-in takes a long time. It is the reality of doing projects not only in Fiji but in the region.

A positive lesson learnt in this project that other donors could heed is to get buy-in from the most senior officials in the Ministry. To have the Permanent Secretary as the Project Director is rare and it is a reflection of the high regard that the Fiji Government has for this JICA project. When the senior officials support the project, all their subordinates will do likewise. The project

did very well to have completed the community survey within the first year of implementation. The project had support from the wider community because it was working with a Government ministry and particularly with medical personnel. Nurses are respected in the community and are well known so using them as enumerators in the field survey lent credibility to the project. JICA could use the high level Government support as leverage for any subsequent projects that it may choose to fund.

The most important lesson learnt is to keep the project design simple and achievable. The initial PDM was overly ambitious given the project timeframe. It didn't allow for the delays that were inevitable. For projects that require behavioral or lifestyle changes to effect the project outcomes, it is imperative that there be flexibility with time. Donor expectations need to be realistic. There should have been more time allowed at the start of the project for dialogue with local stakeholders to find out how health centres work, the Fijian attitude to food and their concept of good health, before designing an appropriate approach for the Fijian context. Had such exploratory work been done in the first instance, an intervention like FC would not have been proposed and much time and effort would have been spared. When designing the interventions, the role of short-term Japanese experts should be limited due to lack of cultural sensitivity. Exchanging opinions frankly should have also been strongly encouraged when discussing the ideas without considering etiquette. The design of overly ambitious projects in the area of NCD is not uncommon and other donors have experienced similar issues. Expectations were simply too high to produce tangible results, but forgetting that even developed countries have struggled to produce similar results.

The need for cultural sensitivity is necessary when dealing with behavioral changes. Most of the effective achievement of the project were possible through the close consultation with local people, such as counterparts and hired staff. It was rare to see so many local people hired for a JICA project, but this was necessary when dealing with culturally sensitive issues such as behavior changes. For example, the content of flip charts was thoroughly discussed with many local people which made possible the popularity and awareness amongst the local population. They have given the project a local voice and provided the Japanese long-term experts with the local knowledge and cultural finesse that was an asset when dealing with local communities. However, this achievement was also possible because Japanese experts managed to stay in Fiji long enough to familiarize themselves with the Fijian culture and context even if their grasp is still not perfect. At least, they managed to build the trust with Fijian counterparts at the MoHMS so that they can exchange their opinions frankly, which would not have been possible if they were short-term consultants. It would have been advantageous if MoHMS would have hired a NCD Project Officer, which was agreed in the Record of Discussion, to work with the Japanese long term experts so that many of the practical experiences and knowledge gained would remain in the Ministry.

IV. For the Achievement of Overall Goals after Project Completion

1. Prospects to achieve Overall Goal

Overall goal: Wellness of Fijian residents is improved

Indicator	Current Results
1-1 Number of patients who completed the 3rd MI counselling at Wellness Clinic by trained staff on MI/ Number of first visits only is increased	The data from four health centres shows mixed results for number of first visits. Korovou HC has shown a steady increase in number of first visits increasing by 69% over an 18-month period. For all four health centres the number of clients completing 3rd MI counselling has decreased and so the retention rate has been low. i. "Percentage of wellness clients with normal ranges (BP and CBG readings)" and II. "Total number of visits" of wellness clinic have also been suggested to collect as for references to supplement the indicator 1-1. These 3 indicators will be soon in place with the new wellness registration book.
1-2 Achievements and/or evidences obtained through the project are reflected in business plans of entire divisional health offices.	MI training is in the Central Division Plan 2019-2020 and in the next NCD Strategic Plan for 2020-2024.

The prospects for achieving the overall goal are reasonable but much depends on the availability of key personnel that have been involved with the project from the start. The data on numbers of returnee clients at the wellness clinics has to be collected over a number of years. It is not possible to draw any conclusions from the limited data set gathered to date. The person who has been the public face of the wellness movement, the Director of the Wellness Centre and NCD National Advisor, is due to retire next year and will leave a huge void.

2. Plan of Operation and Implementation Structure of the Fijian side to achieve the Overall Goal

There is a succession plan in place to replace the Director Wellness Centre/National NCD Adviser when he retires in 2020. The replacement comprises a team of doctors and health promotion experts who have been earmarked to take over the operation of the Wellness Centre, pending the approval of senior management in the Ministry. If the new team has the same vision, passion and knowledge as the incumbent then chances of the sustainability of the project effect are high and the prospects for achieving the overall goal appear good.

Formalising the partnership with the Fiji Institute of Human Resources is critical to the sustainability of the workplace wellness programme. To advance project effect in the community, partnerships with faith based organisations should be pursued. There is much scope for collaboration between the Wellness Centre and the FNU who can assist in producing counsellors and in training community health workers in MI. One way in which data can continue to be collected to support the achievement of the overall goal is by collaborating with C-POND, a WHO-designated collaborative centre for prevention and management of NCD.

The total number of health workers in the Central Division is a cause for alarm. To have less than 200 staff servicing the health centres in the most populous Division of the country, which includes the Suva-Nausori corridor where some 200,000 people reside, is shocking. It is no

wonder the nurses have little time for MI counselling with such a large volume of patients to deal with. The Government may want to consider out-sourcing NCD screening and counselling. There is a wealth of knowledge and experience to be tapped in the pool of retired nurses. Unemployed graduate dieticians could also be engaged to ease the workload of staff in the health centres.

3. Recommendations for the Fijian side

For the next JICA-funded project in the health sector, ownership by the host government would be facilitated by having a Fiji national in one of the senior project management posts rather than having all the long-term experts brought in from Japan. National NCD project officer from the MoHMS has been vacant since March 2016 till the end of the project. The recruitment of a National NCD Project Officer would be timely to ensure that the Project interventions are scaled up.

The Ministry is looking to further the project effect in the workplace space where many urban dwellers spend the greater part of the day. An entry point has been identified with the Fiji Institute of Human Resources and with the current system in Government, it would be more prudent use of resources to get organizational buy-in rather than approach the businesses individually. One of the weaknesses of this project has been the lack of empirical data. In the case of a workplace wellness program, it would be easier to generate data since you have a captive audience going into work everyday as compared to those in the community who go for counselling at their whim. Proof of concept has been provided through this project with the processes and tools necessary to control NCDs clearly demonstrated. Workplace wellness programs would generate a larger database which would then allow for a proper epidemiological study to be conducted.

Due diligence ought to be carried out by the Ministry when nominations are made for training opportunities in Japan. The fact that 40% of the trainees that went to Japan for the two week training course in 2016 retired before the project ended was a poor investment. It would seem much more strategic to send participants for capacity building who would return and contribute to the project outcomes at least for the rest of the project timeframe.

Annex

Annex 1a: List of Counterparts (MoHMS)

No.	Name	Position
1	Mr. Philip Davies	Permanent Secretary, Project Director
2	Ms. Susan Kiran	Permanent Secretary, Project Director
3	Ms. Bernadette Welch	Permanent Secretary, Project Director
4	Dr. Meciusela Tuicakau	Acting Permanent Secretary, Project Director
5	Dr. Josefa Koroivueta	Acting Permanent Secretary, Project Director
6	Dr. Isimeli Tukana	Head of Wellness Centre, Project Manager
7	Sr. Margaret Leong	Head of Nursing and Midwifery
8	Dr. Eric Rafai	Head of Research & Innovation/Deputy Secretary for Public Health, Project Manager
9	Mr. Shivnay Naidu	Director, Health Information Research and Analysis
10	Ms. Muniamma Gunder	Director Planning & Policy Development
11	Dr. Joan Lai	National Advisor-Oral Health
12	Mr. Kanal Kuma	National NCD Project Officer
13	Dr. Tevita Qoriniasi	Divisional Medical Officer, Central
14	Sr. Akosita Sukanaivalu	Acting Director of Nursing, Central
15	Sr. Silina Ledua	Director, Nursing Services
16	Ms. Saupati Asueli	Divisional Dietitian Central
17	Sr. Ana Kalokalo	Sub Divisional Nursing Manager Suva
18	Sr. Rosalia Bolabiu	Sub Divisional Nursing Manager Navua
19	Sr. Olivia Tuigau	Sub Divisional Nursing Manager Rewa
20	Sr. Penina Druavesi	Divisional Health Sister, Central
21	CN Sakaraia Vunakece	Sub Divisional Nursing Manager Tailevu
22	CN Emoni Nawaka	Actg Sub Divisional Nursing Manager Vunidawa
23	Ms. Kriti Chand	Supervisor Dietitian, Nausori Health Center
24	Mr. Andrew Prasad	Divisional Advocacy/Programme Officer-NCD
25	Dr. Lisi Finiasi	Medical Officer Diabetic Hub
26	Dr. Pablo Romakin	Sub Divisional Medical officer Suva
27	Dr. Ilisapeci Lasaro	Sub Divisional Medical Officer Tailevu
28	Dr. Sravaniya Dasi	Sub Divisional Medical Officer Rewa
29	Dr. Anaseini Maisema	Sub Divisional Medical Officer Navua
30	Dr. Josaia Tiko	Sub Divisional Medical Officer Nasinu
31	Dr. Josaia Qovu	Sub Divisional Medical Officer Naitasiri
32	Sr. Margaret Amonaki	Sr. In charge, Raiwaqa HC
33	Sr. Ranita Prasad	Sr. In charge, Makoi HC
34	Sr. Ana Seru	Sr. In charge, School Health Suva
35	Sr. Akisi Delaitubuna	Director of Nurse, Valelevu HC
36	Sr. Metuera Qarau	Sub Divisional Nursing Manager, Nausori HC
37	Sr. Akeneta Matanitobua	IST Coordinator
38	Sr. Makereta Bainivalu	Nursing Manager, Nausori HC
39	Sr. Luisa Finau	Director of Nurse, Samabula HC
40	Sr. Mereseini Kamunaga	IST Coordinator
41	Sr. Miriama Vere	SDHS, Koroou HC
42	Dr. Dave Whippy	Divisional Medical Officer, Central
43	SN Litiana Sera	District Nurse, Baulevu NS
44	SN Arieta Vereivalu	MCH Home Based Nurse, Suva HC

45	SN Suli Drova	SOPD Nurse, Nausori HC
46	Ms. Kiti Sorovaki	NIM
47	Sr. Vaciseva Vuki	Siter in Charge, Nuffield HC
48	Mr. Josua Ligairi	PEN Coordinator
49	Ms. Neelam Swastika	Zone Nurse, Samabula HC
50	Ms. Rusila Railiko	Dietitian, Navua Hospital/HC
51	Ms. Violet Vereivalu	Dietitian, Makoi HC
52	Ms. Makrao Terani	Zone Nurse, Makoi HC
53	Ms. Salome Tukana	Supervisor Dietitian, Suva HC
54	Jovilisi Kedrayate Tamanalevu	Zone Nurse, Korovou HC
55	Ana Raiyawa	SOPD Nurse, Korovou HC
56	Kelera Kanabicibici	SOPD Nurse, Nausori HC
57	Kuini Haniteli Sewale	Zone Nurse, Nausori HC
58	Mereseini Senivaivai	Zone Nurse, Vatukarasa NS
59	Seruwaia Tawake	Dietitian, Vunidawa HC
60	Laisiasa Ratumaiyale	District Nurse, Laselevu HC

Annex 1b: List of JICA Experts

Long-term Experts

	Name	Assignment	From	To
1	Dr. Shinya Matsuura	Chief Advisor	2015/05/10	2017/05/08
2	Mr. Satoru Kinoshita	Project Coordinator/Health Promotion	2015/05/10	2017/05/08
3	Ms. Masako Kikuchi	Community Health/NCD	2015/11/10	2018/03/09
4	Dr. Naomi Hamada	Chief Advisor	2017/04/09	2020/05/10
5	Ms. Yuki Irie	Project Coordinator/Health Promotion	2017/04/09	2018/07/22
6	Ms. Shinomi Takahashi	Community Health/NCD	2018/10/07	2020/05/10
7	Ms. Chiho Tanaka	Project Coordinator	2018/12/15	2020/05/10

Short-term Experts

Year	Name	Assignment	From	To
2015	Mr. Nobuo Nishi	Leader/Epidemiology /Nutrition	2015/06/06	2015/06/13
	Ms. Miki Miyoshi	Epidemiology/Nutrition	2015/06/06	2015/06/13
	Ms. Midori Ishikawa	Epidemiology/Nutrition	2015/06/06	2015/06/13
2016	Mr. Nobuo NIshi	Epidemiology	2016/01/30	2016/02/13
	Ms. Marika Nomura	Epidemiological Study	2016/02/06	2016/02/20
	Mr. Nobuo NIshi	Data analysis /Evaluation	2016/08/13	2016/08/20
	Ms. Marika Nomura	Epidemiological Study	2016/08/13	2016/0825
	Dr. Satoko Horii	Monitoring/Revision of Training Materials	2016/11/19	2016/11/30
2019	Ms. Izumi Murakami	Health Promotion	2019/01/08	2019/03/08

Technical Advisory Mission

Year	Name	Assignment	From	To
2015	Ms. Masako Kikuchi	Attendance at the 1st JCC	2015/09/19	2015/09/26
2017	Dr. Mitsuo Isono	Attendance at the 3rd JCC	2017/03/19	2017/03/23

Annex 1c: List of Trainings

	2016
1	Data Analysis training for Research Officer, MoHMS- July/August, Tokyo, Japan
2	Primary Health Care Nursing toward NCD prevention for ten nursing supervisors, 27 August-10 September, Tokyo and Shiga Prefecture, Japan
3	Physical Activities and Nutrition training for 11 nurses, 5-6 October, Suva, Fiji
4	IT Refresher Course for nursing supervisors, 28-29 June, POLHN Lab, Suva, Fiji
5	Pilot Training on Community Health Diagnosis & PDCA Cycle, 3-4 November, Vunidawa HC, Fiji
6	Training on Preventive Medicine Learn from Countermeasures of NCDs in Remote island Regions of Japan for Asia and Pacific countries attended by a nurse based in Suva Health Centre
7	Data Analysis training for Research Officer, MoHMS- July/August, Tokyo, Japan

	2017
1	Monitoring & Evaluation for NCD Service Delivery Training Workshop, 14-17 March, Suva, Fiji
2	Data Analysis workshop linked to M&E training conducted on 25 April
3	Training course on Community Health Nursing for NCD Prevention and Control, Pilot training conducted at Serua/Namosi Sub-Divisional office, 27 March
4	Monitoring & Evaluation for NCD Service Delivery Training Workshop, 14-17 March, Suva, Fiji
5	Data Analysis workshop linked to M&E training conducted on 25 April

	2018
1	Pilot training on Nutrition Counselling and Behavioral Change for 7 dieticians and 15 Nurse from Fiji and a delegation of 4 persons from Kiribati, 23-26 January, Suva, Fiji
2	Motivational Interview Awareness Session at the PEN Training for Health Workers Central/Eastern Division 6-7 July, Pacific Harbour, Fiji
3	Motivational Interview and Behavior Change Training for 30 participants, 26-30 November, Suva, Fiji
4	SPSS Workshop for Ministry of Health staff, 24-26 July, Suva, Fiji

	2019
1	Motivational Interview and Behaviour Change, 3-7 June, Suva, Fiji
2	Motivational Interview and Behaviour Change, 17-21 June, Suva, Fiji
3	Motivational Interview Training 26-30 November 2018, Suva, Fiji
4	Pre-evaluation Survey for Motivational Interviewing, 27-31 May, Suva, Fiji
5	Training of Trainers for Motivational Interviewing Training 21-25 October, Suva, Fiji

Annex 2: List of Products

	IEC Materials
1	NCD Calendar (2019/2020)
2	My Healthy Plate fridge (magnet/cardboard)
3	My Wellness Record Book (1st and 2nd versions)
4	Tips for Healthy Weight Loss Flipchart (big/small types)
5	Healthy Fijian Recipes Cooking Video Demonstration (9 Episodes)
6	Flow Chart of Counselling
7	Posters

	Journal Article
1	Silatolu A, Nomura M, Nishi N, Kinoshita S, Kikuchi M, Matsuura S, Prasad A, Miyoshi M, Ishikawa M, Miura H, Tukana, I. (2016) Community-Based Initial Survey for Prevention and Control of Non-Communicable Diseases in Central Fiji. Fiji Journal of Public Health 5(2)

	Reports
1	Report of Initial Community Survey for Prevention and Control of Non-Communicable Diseases In Fiji, May 2017, 138pp
2	SPSS Training Report, July 2018, 8pp
3	Preliminary Results of the Healthy Weight Loss Program: Prevention of onset of NCDs, October 2018
4	Kasavu Village Screening Report, October 2018, 11pp
5	Motivational Interview Training Report 26-30 November 2018, 14pp
6	Report on Post-Training Follow-up on Motivational Interviewing and Behavior Change, March 2019, 8pp
7	Pre-evaluation Survey for Motivational Interviewing, 27-31 May 2019, 4pp
8	Motivational Interview and Behavior Change Training Report 3-7 June 2019, 24pp
9	Motivational Interview and Behavior Change Training Report 17-21 June 2019, 33pp
10	Training of Trainers for Motivational Interviewing Training Report 21-25 October 2019, 10pp
11	End-line Survey Report, January 2020

	MI training package
1	Facilitator's guide
2	Participant's copy
3	MI competency assessment

	Registration book
1	Wellness Clinic Registration

	Dissemination of the Project activities
1	Fiji TV https://www.facebook.com/breakfastatfijione/videos/495032924708636/ https://www.facebook.com/breakfastatfijione/videos/239106793785346

ANNEX 3a: Project Design Matrix (PDM) Version 1

Date: 18 August 2016

Project Title: The Project for Prevention and Control of Non-Communicable Diseases

Project Period: 5years from the date indicated in R/D

Target Area: Central Division of the Republic of Fiji

Target Groups:

1: Health personnel engaged in Non-Communicable Diseases (NCD) prevention and control in the Central Division: the Ministry of Health and Medical Service (MOHMS), 1 divisional office, 5 sub-divisional offices, primary health care facilities under MOHMS (such as health center, clinic and nursing
2: Residents in the Central Division: approx. 360,000

Narrative Summary		Objectively Verifiable Indicators	Means of Verification	Important Assumptions	Achievement	Remarks
Overall Goal						
Wellness of Fijian residents is improved.	1	The incidence of diabetes doesn't increase in the Central Division	STEPS report / mini-STEPS report			
	2	Achievements and/or evidences obtained through the Project are reflected to business plans of entire divisional health offices.	Business plans of divisional health offices			
Project Purpose						
Evidence-based NCD prevention and control is strengthened at the MHMS and the Central Division.	1	Achievements and/or evidences obtained through the Project are reflected to health policy and/or strategy by the end of the Project.	(1) Health policy and/or strategy (2) Project reports (3) Baseline and end line surveys	(1) The Fiji side properly allocates necessary budget and distribute personnel for maintaining and enhancing benefits derived from the Project. (2) Policies and implementation system of NCD prevention and control and wellness approach don't change significantly.		
	2	More than 80% of primary health care facilities in the Central Division are practicing the package of NCD interventions				
	3	% of people monitoring waist circumference/height ratio (cm) and weight (kg) increases in the Central Division				
	4	% of high-risk people in adherence to the health guidelines increases in the Central Division.				
Outputs						
1 Evidence-based practices for NCD prevention and control are performed and implemented at primary health care level in the Central division	1-1	A package of NCD interventions conducted on trial in the pilot areas is finalized in the 2nd Quarter, 2017.	(1) Project reports (2) Package of NCD interventions	(1) Trained counterparts do not leave their position so as to affect the outputs of the Project. (2) The Fiji side properly allocates necessary budget and distribute personnel for the project activities.		
	1-2	A final package of NCD interventions is authorized by the MOHMS before the end of project 4th year.				
	1-3	Report on evidence-based NCD prevention and control is completed at the end of all the surveys to be conducted.				
2 Operational capacity of NCD service delivery is enhanced at health centre/nursing station level.	2-1	Trainings of business improvement are completed by the end of project 2nd year.	(1) Project reports			
	2-2	More than 80% of eligible health personnel at all sub-divisional health offices and primary health care facilities in the Central Division received training for application of the interventions and/or reformed measures by the end of project 3rd year.				

	2-3	Proposals of activities for NCD prevention and control are submitted to the divisional health office in line with the guidelines by the end of project 4th year.				
3 Capacity of monitoring and evaluation (M&E) for NCD service delivery is enhanced at divisional and sub-divisional level.	3-1	Divisional and Sub-divisional health offices conducted more than 80% of planned monitoring and evaluation activities at project 3rd year.(PDCA Cycle)	(1) Project reports (2) Guidelines for monitoring and evaluation of NCD prevention and control			
	3-2	Guidelines for monitoring and evaluation of NCD prevention and control at divisional and sub-divisional levels are developed by the end of project 4th year.				
4 Good practices and lessons learned from the Project are shared nationwide (with the Pacific Island countries)	4-1	Evidences and experience of the project are updates regularly on the health journals and website during the Project period.	(1) Project reports			
	4-2	Evidences and experience of the project are shared with relevant personnel engaged in NCD prevention and control in Fiji, Kiribati and other pacific countries via workshops, international conferences, at least once a year.				

Activities	Inputs		Pre-conditions		
1 Evidence-based practices for NCD prevention and control are performed and implemented at primary health care level in the Central division	**Japanese Side**	**Fijian Side**	Counterpart organizations do not adverse to the implementation of the Project		
1-0 To prepare for an initial survey	Experts (1) Long-term Experts - Chief advisor / NCD Prevention and Control - Coordinator / Donor Coordination (2) Short-term Experts - Health education, Public Health Nursing, Management, Planning, Monitoring and Evaluation, Operational research, Training Management, etc. Equipment and materials (1) Necessary office equipment, computers and others (2) A vehicle for project activities (when necessary) (3) Other necessary equipment for project activities Training in Japan and/or third-country Local cost Necessary costs for the project activities	Counterparts and administrative personnel (1) Project Director: Permanent Secretary for Health, Ministry of Health (2) Project Manager: Deputy Secretary, Public Health, Ministry of Health (3) Project counterpart: Ministry of Health Facilities, equipment and materials (1) Office spaces in the Ministry of Health (2) Land, building, vehicle, and other facilities necessary for project activities Local costs (1) A part of operational expenses necessary for implementation of the project activities such as personnel costs of counterparts, activity costs including travel expenses, office equipment and supplies, utility costs such as water and electricity, etc.			
1-1 To update data of primary health care facilities in the Central division and whole Fiji, along with systems, staffing, equipment, and funding					
1-2 To conduct an initial survey on current situation of NCD prevention and control such as community residents' knowledge and behavior, community health staffs' knowledge and skills, etc. in the Central Division.					
1-3 prepare and submit an initial survey report					
1-4 To revise or newly develop intervention strategies to strengthen NCD service delivery at health centre and nursing station level based on the initial survey results					
1-5 To produce manuals and tools for a prototype NCD interventions.					
1-6 To conduct training for Data Analysis					
1-7 To conduct trainings towards nurses and/or dietitians in the pilot sites for NCD service delivery at primary health care level					
1-8 To develop monitoring sheet for NCD service delivery in the pilot sites through PDCA cycle and revise manuals and tools					
1-9 To monitor and review performance for NCD service delivery in the pilot sites through PDCA cycle and revise manuals and tools					
1-10 To prepare for post survey					
1-11 To conduct post-survey to verify efficacy and feasibility of the services					
1-12 To prepare and submit a report on the post-survey					
1-13 To finalize the prototype interventions, manuals and/or tools as a package to strengthen NCD service delivery at primary health care level based on the post survey results					
1-14 To conduct resource estimation and set out implementation plan for expanding the interventions and/or reformed measures to entire area of the Central Division (and whole Fiji)					
1-15 To monitor and review performance for NCD service delivery in the Central Division based on the package finalized in 1-13					
1-16 To prepare for an end line survey					
1-17 To conduct an end line survey on current situation of NCD prevention and control such as community residents' knowledge and behavior, community health staffs' knowledge and skills, etc. in the Central Division.					
1-18 prepare and submit an end line survey report					
1-19 To monitor and review performance for NCD service delivery in the Central Division based on results of the end line survey					
2 Operational capacity of NCD service delivery is enhanced at health centre/nursing station level.			**＜Issues and Countermeasures＞**		
2-0 To assess operational capacity of district office, sub-district office, health centres, and nursing stations					
2-1 To review and discuss competency manuals/guidelines and training modules for nurses					
2-2 To conduct training of trainers (TOT) in ①NCD service delivery at primary health care level and ②PDCA cycle management					
2-3 To localize or newly develop fresher training course for nursing management (e.g. PDCA Cycle management)					
2-4 To conduct trainings of trainers (TOT) in refresher course					

	2-5 To facilitate refresher training of nurses at primary health facility level					
	2-6 To develop the performance improvement trainings for NCD services delivery					
	2-7 To facilitate trainings of trainers (TOT) in performance improvement course - NCD service delivery					
	2-8 To assist the accreditation process on trainings and materials developed through the Project at MOHMS Headquarters, Fiji Nursing Association, Fiji Institute of Nutrition and Dietitian					
3	**Capacity of monitoring and evaluation (M&E) for NCD service delivery is enhanced at divisional and sub-divisional level.**					
	3-0 To assess existing systems of monitoring and evaluation of health services including NCD prevention and control.					
	3-1 To localize the M&E manual for medical officers and health sisters at divisional and sub-divisional levels					
	3-2 To conduct trainings of trainers (TOT) in refresher M&E course					
	3-3 To facilitate refresher training of medical officers and health sisters					
	3-4 To develop the M&E trainings for NCD services delivery					
	3-5 To facilitate trainings of trainers (TOT) in M&E course - NCD service delivery					
	3-6 To assist the accreditation process on trainings and materials developed through the Project at MOHMS Headquarters					
4	**Good practices and lessons learned from the Project are shared nationwide (with the Pacific Island countries)**					
	4-0 To review and discuss about good practices/strategies to scale up pilot-practice to nationwide in Fiji					
	4-1 To prepare and submit manuscripts of project findings/achievement to Fiji Journal on Public Health (FJPH); original academic/scientific research papers, structured abstracts, perspectives (reviews, opinion pieces), or field notes					
	4-2 To disseminate the lessons learned and good practices of the project at meetings/conferences hosted by the MOHMS					
	4-3 To present project activities at divisional or national meetings					
	4-4 To make a presentation or organize side-events on the international/pacific-regional conferences; such as WPRO, pacific health Ministers meetings and etc.					

ANNEX 3b: Project Design Matrix (PDM) Version 2 **Ver. 2 Date: 22 March 2017**

Project Title: The Project for Prevention and Control of Non-Communicable Diseases Project Period: 5years from the date indicated in R/D

Target Area: Central Division of the Republic of Fiji

Target Groups:

1: Health personnel engaged in Non-Communicable Diseases (NCD) prevention and control in the Central Division: the Ministry of Health and Medical Service (MOHMS), 1 divisional office, 5 sub-divisional offices, primary health care facilities under MOHMS (such as health center, clinic and nursing station)

2: Residents in the Central Division: approx. 360,000

Narrative Summary		Objectively Verifiable Indicators	Means of Verification	Important Assumptions	Achievement	Remarks
Overall Goal						
Wellness of Fijian residents is improved.	1	The incidence of diabetes doesn't increase in the Central Division	STEPS report / mini-STEPS report			
	2	Achievements and/or evidences obtained through the Project are reflected to business plans of entire divisional health offices.	Business plans of divisional health offices			
Project Purpose						
Evidence-based NCD prevention and control is strengthened at the MOHMS and the Central Division.	1	Achievements and/or evidences obtained through the Project are reflected to health policy and/or strategy by the end of the Project.	(1) Health policy and/or strategy (2) Project reports (3) Baseline and end line surveys	(1) The Fiji side properly allocates necessary budget and distribute personnel for maintaining and enhancing benefits derived from the Project. (2) Policies and implementation system of NCD prevention and control and wellness approach don't change		
	2	More than 80% of primary health care facilities in the Central Division are practicing the package of NCD interventions.				
	3	The prevalence of people with SNAP (Smoking, Nutrition, Alcohol and Physical Activity)-related risk factors are reduced at the Central Division.				
Outputs						
1 Evidence-based practices for NCD prevention and control are performed and implemented at primary health care level in the Central division	1-1	A package of NCD interventions conducted on trial in the pilot areas is finalized in the 2nd Quarter, 2017.	(1) Project reports (2) Package of NCD interventions	(1) Trained counterparts do not leave their position so as to affect the outputs of the Project. (2) The Fiji side properly allocates necessary budget and distribute personnel for the project activities.		
	1-2	A final package of NCD interventions is authorized by the MOHMS before the end of project 4th year.				
	1-3	Report on evidence-based NCD prevention and control is completed at the end of all the surveys to be conducted.				
2 Operational capacity of NCD service delivery is enhanced at primary care facilities	2-1	Attendance rate of in-service training on community health nursing by the end of project 2nd year. (baseline 0 → 80% of eligible health personal)	(1) Project Reports (2) TrainingReports (3) Competency Assessment Reports (4) Nursing Report			
	2-2	Attendance rate of in-service training on intervention package to be developed through Output 1 activities by the end of project (baseline 0 → 80% of eligible health personal)				
	2-3	Post-test & training evaluation (baseline & target to be confirmed)				
	2-4	Self Competency Assessment (critically thinking & overall) (baseline & target to be confirmed)				
	2-5	Revised training manual on community health nursing (baseline 0→1)				
3 Capacity of monitoring and evaluation (M&E) for NCD service delivery is enhanced at divisional and sub-divisional level.	3-1	Divisional and Sub-divisional health offices conducted more than 80% of planned monitoring and evaluation activities at project 4th year.(PDCA Cycle)	(1) Project reports (2) Guidelines for monitoring and evaluation of NCD prevention and control			
	3-2	Guidelines for monitoring and evaluation of NCD prevention and control at divisional and sub-divisional levels are developed by the end of project 5th year.				

4	**Good practices and lessons learned from the Project are shared nationwide (with the Pacific Island countries)**	4-1	Evidences and experience of the project are shared with relevant personnel engaged in NCD prevention and control in Fiji, Kiribati and other pacific countries via workshops, international conferences, at least once a year.	(1) Project reports (2) Relevant documents (e.g. journals, websites)		
		4-2	Evidences and experience of the project are updates regularly on the health journals and website during the Project period.			

Activities		**Inputs**		**Pre-conditions**		
1	**Evidence-based practices for NCD prevention and control are performed and implemented at primary health care level in the Central division**	**Japanese Side**	**Fijian Side**	Counterpart organizations do not adverse to the implementation of the Project		
1-0	To prepare for an initial survey	Experts (1) Long-term Experts - Chief advisor / NCD Prevention and Control - Coordinator / Donor Coordination (2) Short-term Experts - Health education, Public Health Nursing, Management, Planning, Monitoring and Evaluation, Operational research, Training Management, etc. Equipment and materials (1) Necessary office equipment, computers and others (2) A vehicle for project activities (when necessary) (3) Other necessary equipment for project activities Training in Japan and/or third-country Local cost Necessary costs for the project activities	Counterparts and administrative personnel (1) Project Director: Permanent Secretary for Health, Ministry of Health (2) Project Manager: Deputy Secretary, Public Health, Ministry of Health (3) Project counterpart: Ministry of Health Facilities, equipment and materials (1) Office spaces in the Ministry of Health (2) Land, building, vehicle, and other facilities necessary for project activities Local costs (1) A part of operational expenses necessary for implementation of the project activities such as personnel costs of counterparts, activity costs including travel expenses, office equipment and supplies, utility costs such as water and electricity, etc.			
1-1	To update data of primary health care facilities in the Central division and whole Fiji, along with systems, staffing, equipment, and funding					
1-2	To conduct an initial survey on current situation of NCD prevention and control such as community residents' knowledge and behavior, community health staffs' knowledge and skills, etc. in the Central Division.					
1-3	prepare and submit an initial survey report					
1-4	To revise or newly develop intervention strategies to strengthen NCD service delivery at health centre and nursing station level based on the initial survey results					
1-5	To develop a prototype of NCD interventions, producing manuals and tools					
1-6	To conduct training for Data Analysis					
1-7	To conduct trainings towards nurses and/or dietitians in the pilot sites for NCD service delivery at primary health care level					
1-8	To develop monitoring sheet for NCD service delivery in the pilot sites through PDCA cycle and revise manuals and tools					
1-9	To monitor and review performance for NCD service delivery in the pilot sites through PDCA cycle and revise manuals and tools					
1-10	To develop a NCD prevention package to operate the revised NCD interventions in the current health system					
1-11	To conduct a trial for the package in the pilot sites					

Activities	Inputs	Pre-conditions		
1-12 To conduct a verification on efficacy of the package				
1-13 To finalize the package to strengthen NCD service delivery at primary health care level based on the verification results				
1-14 To conduct resource estimation and set out implementation plan for expanding the package and/or reformed measures to entire area of the Central Division (and whole Fiji)				
1-15 To monitor and review performance for NCD service delivery in the Central Division based on the package finalized in 1-13				
1-16 To prepare for an end line survey				
1-17 To conduct an end line survey on current situation of NCD prevention and control such as community residents' knowledge and behavior, community health staffs' knowledge and skills, etc. in the Central Division.				
1-18 prepare and submit an end line survey report				
1-19 To monitor and review performance for NCD service delivery in the Central Division based on results of the end line survey				
2 Operational capacity of NCD service delivery is enhanced at primary care facilities				
2-1 To revitalize and/or training course on "community health nursing" for NCD prevention				
2-1-1 To identify scope of work for enhancing operational capacity for NCD service delivery		<Issues and Countermeasures>		
2-1-2 To provide training of nursing supervisors: leadership course				
2-1-3 To revitalize and/or revise training course on community health nursing" for NCD prevention and control				
2-1-4 To provide training with eligible health personnel at all primary health care facilities				
2-1-5 To evaluate training course and revise it if necessary				
2-2 To introduce intervention package to be developed through Output 1 activities to all primary health care facilities				
2-2-1 To provide training with nursing supervisors				
2-2-2 To provide training with eligible health personnel at all primary health care facilities				
2-2-3To assist primary health care facilities to carry out the intervention package at the entire area of the Central Division.				
3 Capacity of monitoring and evaluation (M&E) for NCD service delivery is enhanced at divisional and sub-divisional level.				
3-0 To assess existing systems of monitoring and evaluation of health services including NCD prevention and control.				
3-1 To localize the M&E tools of NCD prevention and control services for medical officers and health sisters at divisional and sub-divisional levels				
3-2 To conduct trainings for facilitators in M&E course of NCD prevention and control services				
3-3 To support facilitator to conduct workshops for medical officers and health sisters				
3-4 To incorporate the package of NCD service delivery identified by output 1 into the localized M&E tools for NCD services delivery				
3-5 To support facilitator to conduct workshops of updated M&E trainings based on 3-4 for medical officers and health sisters				
3-6 To assist the accreditation process on trainings and materials developed through the Project at MOHMS Headquarters				
3-7 To monitor and evalute performance for NCD prevention package in the framework.				

Activities		Inputs		Pre-conditions		
4	**Good practices and lessons learned from the Project are shared nationwide (with the Pacific Island countries)**					
	4-0 To review and discuss about good practices/strategies to scale up pilot-practice to nationwide in Fiji					
	4-1 To prepare and submit manuscripts of project findings/achievement to Fiji Journal on Public Health (FJPH); original academic/scientific research papers, structured abstracts, perspectives (reviews, opinion pieces), or field notes					
	4-2 To disseminate the lessons learned and good practices of the project at meetings/conferences hosted by the MOHMS					
	4-3 To present project activities at divisional or national meetings					
	4-4 To make a presentation or organize side-events on the international/pacific-regional conferences; such as WPRO, pacific health Ministers meetings and etc.					

ANNEX 3c: Project Design Matrix (PDM) Version 3 **Ver. 3 draft as of June 19 (4th JCC, 24 June 2019)**

Project Title: The Project for Prevention and Control of Non-Communicable Diseases **Project Period: 5years from the date indicated in R/D**

Target Area: Central Division of the Republic of Fiji

Target Groups:

1: Health personnel engaged in Non-Communicable Diseases (NCD) prevention and control in the Central Division: the Ministry of Health and Medical Service (MOHMS), 1 divisional office, 5 sub-divisional offices, primary health care facilities under MOHMS (such as health center, clinic and nursing station)

2: Residents in the Central Division: approx. 360,000

Narrative Summary		Objectively Verifiable Indicators	Means of Verification	Important	Achievement	Remarks
Overall Goal						
Wellness of Fijian residents is improved.	1	[Number of patients who completed the 3rd MI counseling at Wellness Clinic* by trained staff on MI /Number of 1st visits only] is increased. *Wellness clinic is in charge of Non-Pharmacological Interventions for prevention of NCDs	Wellness Registration book at Health Centres / Nursing Stations			
	2	Achievements and/or evidences obtained through the Project are reflected to business plans of entire divisional health offices.	(1) National Wellness Center Business Plan (2019-2020) (2) National Operational Plan(NOP)MoHMS(2019-2020) (3) National Operational Plan Central/Eastern, Western and Northern Divisions (4) NCD Strategic Plan(2020-2024)			
Project Purpose						
Evidence-based NCD prevention and control is strengthened at the MOHMS and the Central Division.	1	Achievements and/or evidences obtained through the Project are reflected to health policy and/or strategy by the end of the Project.	(1) National Operational Plan (NOP) The Ministry of Health and Medical Services (2019-2020) (2) National Operational Plan Central/Eastern, Western and Northern Divisions (3) National Wellness Center Business Plan (2019-2020) (4) NCD Strategic Plan(2020-2024) (5) Project reports (6) Baseline and end line surveys (7) PHIS Form	(1) The Fiji side properly allocates necessary budget and distribute personnel for maintaining and enhancing benefits derived from the Project. (2) Policies and implementation system of NCD prevention and control and wellness approach don't change significantly.		
	2	More than 80% of primary health care facilities in the Central Division are practicing NCD interventions to reduce NCD risk factors.				
Outputs						
1 Evidence-based practices for NCD prevention and control are performed and implemented at primary health care level in the Central division	1-1	A final tools and materials for NCD interventions is authorized by the MOHMS before the end of project 5th year.	(1) Project reports (2) Tools and Materials of Weight of Weight Watch Programs and MI (3) National Wellness Center Business Plan (2019-2020) (4) Tools and Materials of Weight Watch Programs and MI (5) Report of Baseline and Endline surveys (6) Reports of interventions results at workplaces and communities (7) Minutes of National Health Executive Committee Meeting (8) Lists of tools and materias endorsed by PS after consultations at Nurse Working Group Meeting	(1) Trained counterparts do not leave their position so as to affect the outputs of the Project. (2) The Fiji side properly allocates necessary budget and distribute personnel for the project activities.		
	1-2	Report on evidence-based NCD prevention and control is completed at the end of all the surveys to be conducted.				
2 Operational capacity of NCD service delivery is enhanced at primary care facilities	2-1	Post training follow-ups and evaluation of MI are carried out	(1) Project Reports (2) Training Follow-up Reports (3) Nursing Report			
	2-2	MI Training Packages are developed				

3	**Capacity of monitoring and evaluation (M&E) for NCD service delivery is enhanced at divisional and sub-divisional level.**	3-1	Availability of Quality Control Package of MI	(1) Project reports (Epidemiology training reports) (2) MI Auditing Tool			
		3-2	Availability of Epidemiology training report				
4	**Good practices and lessons learned from the Project are shared nationwide (with the Pacific Island countries)**	4-1	Evidences and experience of the project are shared with relevant personnel engaged in NCD prevention and control in Fiji, Kiribati and other pacific countries via workshops, international conferences, at least once a year.	(1) Project reports (2) Relevant documents (e.g. journals, websites, minutes of meetings, report etc)			
		4-2	Evidences and experience of the project are updates regularly on the health journals and website during the Project period.				

Activities		**Inputs**		**Pre-conditions**		
1	**Evidence-based practices for NCD prevention and control are performed and implemented at primary health care level in the Central division**	**Japanese Side**	**Fijian Side**	Counterpart organizations do not adverse to the implementation of the Project		
1-1	To conduct an initial survey	Experts (1) Long-term Experts - Chief advisor / NCD Prevention and Control - Coordinator / Donor Coordination (2) Short-term Experts - Health education, Public Health Nursing, Management, Planning, Monitoring and Evaluation, Operational research, Training Management, etc. Equipment and materials (1) Necessary office equipment, computers and others (2) A vehicle for project activities (when necessary) (3) Other necessary equipment for project activities Training in Japan and/or third-country Local cost Necessary costs for the project activities	Counterparts and administrative personnel (1) Project Director: Permanent Secretary for Health, Ministry of Health (2) Project Manager: Deputy Secretary, Public Health, Ministry of Health (3) Project counterpart: Ministry of Health Facilities, equipment and materials (1) Office spaces in the Ministry of Health (2) Land, building, vehicle, and other facilities necessary for project activities			
1-2	To revise or newly develop intervention strategies to strengthen NCD service delivery at health centre and nursing station level based on the initial survey results					
1-3	To develop a prototype of NCD interventions, producing manuals and tools					
1-4	To conduct training for Data Analysis					
1-5	To conduct trainings towards nurses and/or dietitians in the pilot sites for NCD service delivery at primary health care level					
1-6	To monitor and review performance for NCD service delivery in the pilot sites through PDCA cycle and revise manuals and tools					
1-7	To develop a NCD prevention package to operate the revised NCD interventions in the current health system					
1-8	To conduct a trial for the package in the pilot sites					

	1-9	To conduct a verification on efficacy of the package
	1-10	To finalize the package to strengthen NCD service delivery at primary health care level based on the verification results
	1-11	To conduct resource estimation and set out implementation plan for expanding the package and/or reformed measures to entire area of the Central Division (and whole Fiji)
	1-12	To monitor and review performance for NCD service delivery in the Central Division based on the package finalized in 1-10
	1-13	To conduct an end line survey
	1-14	To monitor and review performance for NCD service delivery in the Central Division based on results of the end line survey
2	**Operational capacity of NCD service delivery is enhanced at primary care facilities**	
	2-1	To identify scope of work for enhancing operational capacity for NCD service delivery
	2-2	To provide training of nursing supervisors: leadership course
	2-3	To provide training with eligible health personnel at all primary health care facilities
	2-4	To evaluate training course and revise it if necessary
	2-5	To introduce intervention package to be developed through Output 1 activities to all primary health care facilities
		2-5-1 To provide training with nursing supervisors
		2-5-2 To provide training with eligible health personnel at all primary health care facilities
		2-5-3 To assist primary health care facilities to carry out the intervention package at the entire area of the Central Division.
	2-6	Assist primary health care facilities to strengthen the follow-up system of high risk group
3	**Capacity of monitoring and evaluation (M&E) for NCD service delivery is enhanced at divisional and sub-divisional level.**	
	3-0	To assess existing systems of monitoring and evaluation of health services including NCD prevention and control.
	3-1	To localize the M&E tools of NCD prevention and control services for medical officers and health sisters at divisional and sub-divisional levels
	3-2	To conduct trainings for facilitators in M&E course of NCD prevention and control services
	3-3	To support facilitator to conduct workshops for medical officers and health sisters
	3-4	To incorporate the package of NCD service delivery identified by output 1 into the localized M&E tools for NCD services delivery
	3-5	To support facilitator to conduct workshops of updated M&E trainings based on 3-4 for medical officers and health sisters
	3-6	To assist the accreditation process on trainings and materials developed through the Project at MOHMS Headquarters
	3-7	Conduct training of epidemiology for the capacity building of MoH staffs at the central, divisional and sub-divisional levels to analyze the wellness screening data.

Local costs
(1) A part of operational expenses necessary for implementation of the project activities such as personnel costs of counterparts, activity costs including travel expenses, office equipment and supplies, utility costs such as water and electricity, etc.

＜Issues and Countermeasures＞

4	**Good practices and lessons learned from the Project are shared nationwide (with the Pacific Island countries)**						
	4-0	To review and discuss about good practices/strategies to scale up pilot-practice to nationwide in Fiji					
	4-1	To prepare and submit manuscripts of project findings/achievement to Fiji Journal on Public Health (FJPH); original academic/scientific research papers, structured abstracts, perspectives (reviews, opinion pieces), or field notes					
	4-2	To disseminate the lessons learned and good practices of the project at meetings/conferences hosted by the MOHMS					
	4-3	To present project activities at divisional or national meetings					
	4-4	To make a presentation or organize side-events on the international/pacific-regional conferences; such as WPRO, pacific health Ministers meetings and etc.					


JICA