フィジー諸島共和国
地域保健看護師現任教育プロジェクト
事前評価調査・実施協議報告書

平成17年４月
（2005年）

独立行政法人　国際協力機構
人間開発部

序　　文

独立行政法人国際協力機構（JICA）は、「宮崎イニシアティブ」に基づき、2000年度から2004年度まで、沖縄国際センターにおいて島嶼地域保健行政研修コースを実施しました。この沖縄での研修事業において、地域保健看護師活用とそのための人的資源開発への支援を要請する声が高まったため、JICAは2003年10月に技術協力プロジェクト形成のための調査団をフィジー国に派遣し、人材育成分野の協力の方向性について検討を行いました。

フィジー国政府からは、同調査結果を踏まえて、地域保健看護師の能力向上を目的としたプロジェクトの実施要請が日本政府に提出され、それを受けてJICAは2004年６月から、プロジェクト形成のための長期専門家をフィジー国保健省に派遣し、地域保健看護師をめぐる現状と問題点を分析するための情報収集、プロジェクト案策定を行い、2004年９月には事前評価調査団を派遣しました。同調査では、プロジェクト実施の必要性を調査するとともに、具体的な協力内容、活動計画について協議を行い、さらに2004年11月には同調査団の評価分析担当団員を派遣し、評価５項目による事前評価ならびにプロジェクト・ドキュメントの作成を行いました。

これらの調査結果を踏まえ、フィジー国政府とJICAフィジー事務所の間で実施協議が行われ、2005年４月１日から2008年３月31日の予定で地域看護師現任教育プロジェクトを実施することで合意に至り、2005年３月22日に合意議事録（R/D）の署名交換を行いました。

本報告書は、事前評価調査及び実施協議の内容を取りまとめたものです。

ここに、これらの調査においてご協力を賜りました関係各位に対し深甚なる謝意を表しますとともに、今後ともご指導、ご支援を賜りますようお願い申し上げます。

平成17年４月

独立行政法人　国際協力機構

理事　松岡　和久

目　　次

付属資料

略　語　一　覧

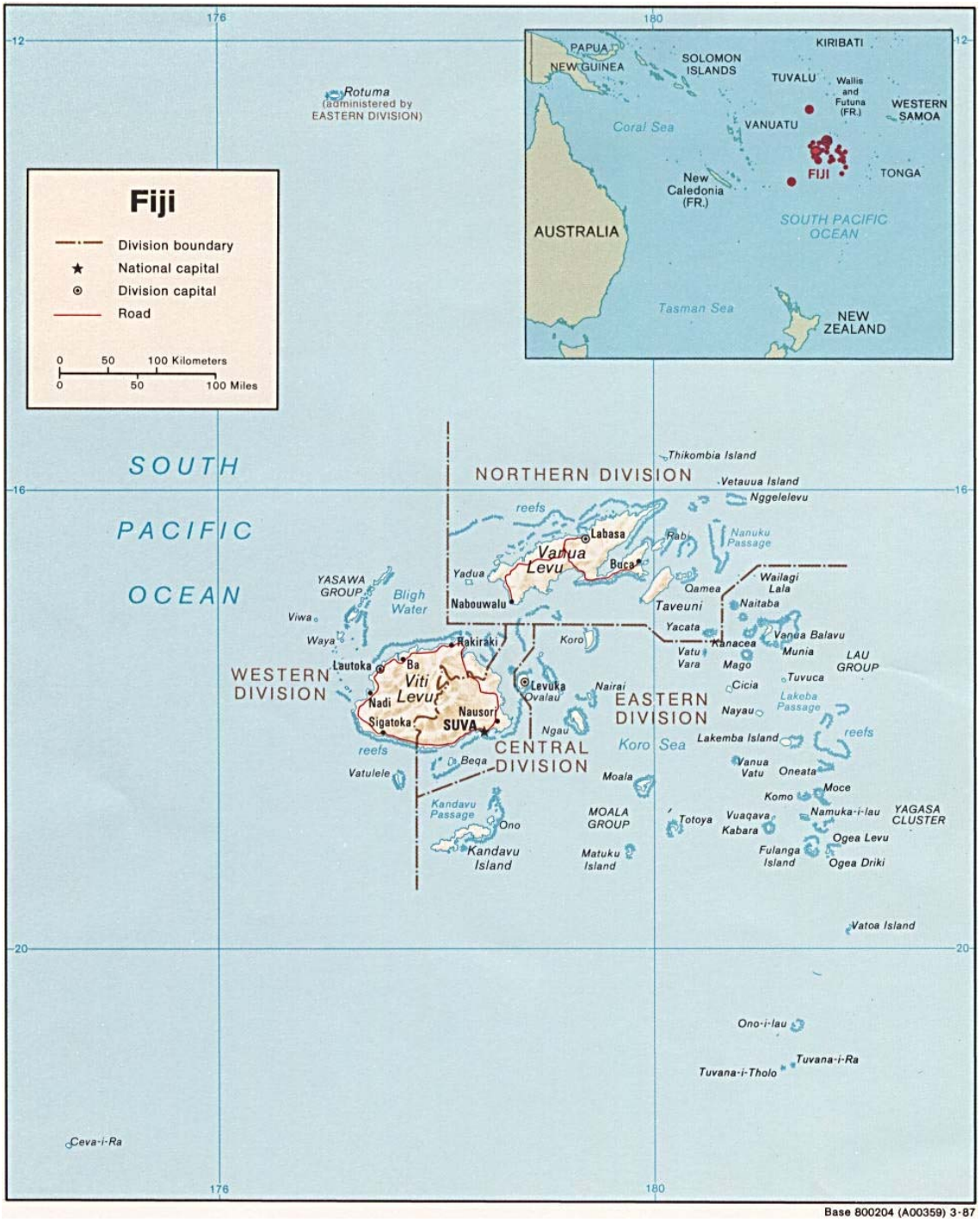
略語	正式名称	
AusAID	Australian Agency for International Development	オーストラリア国際開発庁
JCC	Joint Coordinating Committee	合同調整委員会
M/M	Minutes of Meetings	議事録
ODA	Official Development Assistance	政府開発援助
PCM	Project Cycle Management	プロジェクト･サイクル･マネジメント
PDM	Project Design Matrix	プロジェクト･デザイン･マトリックス
PO	Plan of Operation	活動計画表
R/D	Record of Discussion	協議議事録

本プロジェクト関係機関及び関係者

英文名称	邦訳名称	略語
Ministry of Health	保健省	MOH
Chief Executive Officer	次官	CEO
Director of Corporate Service	運営計画課	－
Division of Public Health	公衆衛生課	－
Division of Health Service Development	保健事業計画課	－
Division of Nursing and Health System Standard	看護薬剤課	－
National Nursing Advisor	全国看護指導監	NNA
Divisional Health Service	地方保健局	－
Director of Divisional Health Service	地方保健局長	DHS
General Manager of Community Health	地域保健課長	GMCH
Manager Nursing Services (Community Health)	地方看護指導監	MNS
Chief Medical Officer (Community Health)	地域保健主任	－
Sub-Divisional Medical Officer	地区医師長	SDMO
Sub-Divisional Health Sister	地域看護師長	SDHS
Health Sister in charge of Hospital	病院看護師長	－
Health Center	ヘルスセンター	－
Nursing Station	看護ステーション	－
Community Health Nurse	地域保健看護師	CHN
Senior Health Sister	シニア地域看護主査	－
Health Sister	地域看護主査	－
Zone Nurse	ゾーン看護師	－
District Nurse	ディストリクト看護師	－

Fiji School of Nursing	フィジー看護学校	FSN
Fiji School of Medicine	フィジー医学校	FSM
National Health Promotion Center	国立ヘルスプロモーションセンター	NCHP

フィジー諸島共和国地図



保健省協議

ミニッツ署名式

ナウソリ地区ヘルスセンター

コロボ地区ヘルスセンター

ナワラ地区看護ステーション（外観と内部）

コロボ産科病院内部

事業事前評価表（技術協力プロジェクト）

担当部：人間開発部第３グループ
保健人材育成チーム

１．案件名 フィジー地域保健看護師現任教育プロジェクト
（和）フィジー地域保健看護師現任教育プロジェクト
（英）Project for In-service Training of Community Health Nurses

２．協力概要

(1) プロジェクト目標とアウトプットを中心とした概要の記述
地域保健の最先端で活動する地域保健看護師が地域保健活動を効果的に行うために必要な地域保健看護師の役割と機能の再定義を行う。そのうえで、地域保健看護師の指導者層への働きかけを通じて現任教育の仕組みを強化することにより、地域保健看護師の地域保健活動運営能力を改善することを目的とする。

(2) 協力期間：2005年４月から2008年３月（３年間）

(3) 協力総額（日本側）：1.86億円

(4) 協力相手先機関：フィジー保健省中東部地方保健局

(5) 国内協力機関：国立保健医療科学院、沖縄県福祉保健部

(6) 裨益対象者及び規模等
直接裨益者：中部地方の地域保健看護師（120名）とその指導者（21名）
間接裨益者：中部地方における住民（325,000人）

３．協力の必要性・位置づけ

(1) 現状及び問題点
フィジー国では保健医療従事者の不足が深刻であり、特に医師は海外流出が多いため外国人医師を受け入れているほどの状況であるため、医師の少ない僻地においては看護師の役割が重要となっている。また近年、糖尿病、高血圧など生活習慣病が増加し、死亡原因の87％（2000年）を占めるという状況において、生活習慣病の予防や健康教育など、生活に根づいた保健活動を実施する地域保健看護師の重要性が増している。しかしながら、地域保健看護師は基礎教育または卒後教育において、地域住民を主体とした健康増進活動を実践するための十分な訓練を受けておらず、保健省で行っている研修は特定の保健課題（性感染症、産科ケア、予防接種等）に限られている。
本件では、地域保健看護師が日常業務上の問題・課題を議論し、解決法を模索するための手法と機会を現任教育で提供することにより、地域保健看護師が住民のニーズに応じた地域保健活動を計画・管理するための能力向上を支援する。

(2) 相手国政府国家政策上の位置づけ
フィジー国の国家開発計画の重点分野である「村落開発」の開発課題の一つとして地域医療サービスの向上があり、「貧困撲滅」の課題の一つとして保健サービスへのアクセス向上がある。また、保健省の「保健省戦略計画2005-2008」においても、質の高い保健サービス提供のための人材育成の必要性が、重要課題の一つとして掲げられている。

(3) 我が国援助政策との関連（プログラムにおける位置づけ）
我が国は2000年に開催された第2回太平洋・島サミットで表明された「宮崎イニシアティブ」を受け、人材育成の支援として大洋州地域を対象とした島嶼地域保健行政研修をJICA沖縄国際センターで行っている。また、2003年に開催された第3回太平洋・島サミットでは生活習慣病対策・感染症対策など保健分野での更なる協力が掲げられており、本案件の目的と一致する。

４．協力の枠組み

〔主な項目〕

(1) 協力の目標（アウトカム）

１）協力終了時の達成目標（プロジェクト目標）と指標

中部地方において地域保健看護師活動の業務管理運営が現任教育を通じて向上する

〈指標〉

・地区別及び地域保健看護師の年間活動報告書が作成される

・地区組織活動の活動数が増加する

２）協力終了後に達成が期待される目標（上位目標）と指標

中部地方において地域保健看護師の行う地域保健活動の質が改善される

〈指標〉

・地域保健看護師の業務管理基準の評価点が向上する

・住民の地域保健サービスに対する満足度が向上する

(2) 活動及びその成果（アウトプット）

成果１：地域保健看護師とその指導者の役割と機能が再定義される

〈指標〉地域保健看護師とその指導者の指導内容が具体化された業務基準の作成

活動：

1-1　地域保健看護師、地域看護主査等の業務基準の見直しを地区内の保健職種と合同で行う

1-2　地域保健看護師に求められる経験年数別能力基準表を作成する

1-3　地域保健看護ハンドブックを作成し配布する

成果２：地域保健看護師の指導者の現任教育についての知識が強化される

〈指標〉各地区における優先課題についての年次報告書と年間現任教育計画

活動：

2-1　各地区に現任教育タスクフォースを設置する

2-2　地区の指導者研修を開催する

2-3　各地区の現任教育の優先分野を明確にする

2-4　各地区において地域保健看護師を対象とした現任教育年間計画を作成する

成果３：地域保健看護師の指導者の現任教育についての知識が強化される

〈指標〉現任教育の実施が明記された地区別年間保健計画

活動：

3-1　各地区の現任教育タスクフォースが地域保健看護師に月例現任教育を実施する

3-2　現場での個人指導を行う

3-3　各地区の現任教育のモニタリングを行う

3-4　現任教育に関する教材を作成し、配布する

成果４：現任教育モデルが他地方及び他国に紹介される

〈指標〉プログレスレポートの発行回数、セミナー／ワークショップの開催数及び参加者数

活動：

4-1　報告書を作成する

4-2　成果を学会等で発表する

4-3　プロジェクトモデルを広めるために他地域、大洋州の関係者を対象としたセミナー/ワークショップを開催する

(3) 投入（インプット）

1）日本側（総額1.86億円）

長期専門家2名

短期専門家（現任教育計画、保健計画、情報管理等）

研修員受入れ

指導者研修実施に必要な経費、運営委員会に必要な経費

供与機材：研修の実施に必要な機材（コンピューター、プロジェクター等）

2）フィジー国側

カウンターパート・運転手人件費

プロジェクト事務所

研修施設

その他ローカルコスト

(4) 外部要因（満たされるべき外部条件）

・地域保健看護師の労働条件が悪化しない

・地域保健看護師の異動／退職率が現状のままにとどまる

５．評価５項目による評価結果

(1) 妥当性

1）事業実施の必要性

フィジー国では医師不足が深刻なため、医師の少ない僻地においては看護師の役割が重要となっており、看護師の中でも、生活習慣病の予防や健康教育など、生活に根づいた保健活動を実施する地域保健看護師の重要性が増している。地域看護師の活動を強化するためにも現任教育は重要だが、基礎教育または卒後教育において地域住民の生活様式に応じた健康増進活動を行うために必要な知識・技術を十分に修得しておらず、保健省で行っている現任者教育は特定の保健課題（性感染症、産科ケア、予防接種等）に限られているため、指導者層のマネジメント能力の向上が求められている。

2）フィジー国の保健分野の計画との整合性

フィジー国では保健セクターに高い優先度を与えており、予算配分比率も高い。「保健省戦略計画2005-2008」の中でも、５つの基本戦略の一つとして人材育成を掲げ、質の高い保健サービス供給のための人材育成強化策を提示しており、フィジー国政府の政策とも合致している。

3）我が国援助政策との関連性

我が国は2000年に開催された第2回太平洋・島サミットを受け、大洋州地域を対象とした島嶼地域保健行政研修を行っており、沖縄の地域保健の経験を本案件に活用することが可能である。また、2003年に開催された第３回太平洋・島サミットでは保健分野での更なる協力が掲げられており、本案件の目的と一致する。

4）対象地域の選定

対象地域は首都スバのある中部地区であるため保健省、看護学校、３次医療機関など保健分野の主要施設へのアクセスもよく、住民の教育レベルも高い。また、他ドナーの同種のプロジェクトが実施されていない点からも、パイロット事業としてプロジェクトを実施する場所として適切と判断される。

(2) 有効性

本件の実施機関である保健省中東部地方保健局では、既に様々な研修プログラムを実施している。本件の現任教育は各地区での地域保健看護師の月例会議の場を利用して実施され、新たなシステムを導入することはないため、同保健局には本件の目標達成のための能力が十分に備わっていると考えられる。また、地域保健看護の活動を休止して研修を受講するわけではないため、地域保健看護師からの参加も得やすい。

(3) 効率性

本件は人材育成に焦点が当てられており、大規模な機材購入、施設建設は伴わない。日本側の専門家派遣についても、長期専門家については現任教育全体の運営を計画・管理できる人材を充て、短期専門家については、長期専門家で対応できない専門的分野、特殊な分野について必要期間のみ投入する計画になっており、対象地域の裨益人口が比較的小規模であるのに合せた、適切な人数設定になっており、効率的な専門家配置となっている。

(4) インパクト

地域保健看護師を対象とした現任教育は現在フィジー国で行われておらず、現任教育の導入による地域保健看護師の能力向上が実現されれば、地域保健活動の強化につながり、その効果は大きい。また本件により現任教育の必要性が広く認識され、評価が高まれば、他地区あるいは栄養士など他の地域保健活動従事者へも現任教育が実施されることが期待できる。

(5) 自立発展性

本件の実施機関は既存の組織であり、カウンターパートを中心として現場の看護指導者及び地域保健看護師を指揮する系統は既にできあがっている。本件実施中、また終了後においても、このような管理体系が維持されれば、組織能力の不足という理由で本件の進行が妨げられることはないと考えられ、プロジェクト終了後も行政自らがその成果を継続し、普及させることが期待できる。

6．貧困・ジェンダー・環境等への配慮

本件については社会環境に対する直接的負の影響はほとんどない。

7．過去の類似案件からの教訓の活用

同じように現任教育を実施しているラオスの子供のための保健サービス強化プロジェクトでは、研修後にその成果を業務に反映させるため、定期的なスーパーバイズを行い効果をあげているため、本プロジェクトにおいても、研修と同等にフォローアップの実施に重点を置く。

8．今後の評価計画

2006年９月頃　　中間評価
2007年９月頃　　終了時評価
2009年頃　　事後評価

第１章　調査概要

１－１　調査の背景

2000年４月に行われた第２回太平洋・島サミットにおいて大洋州地域への貢献策「宮崎イニシアティブ」が発表された。これを受けてJICAでは、2000年度から2004年度まで国別研修「島嶼国地域保健行政」を実施している。同コースでは、大洋州諸国と似た地形･気候を有する沖縄県の戦後復興期から現在までの保健行政の取り組みを大洋州諸国に紹介し、各国での応用を目指しており、2004年度までの実績で大洋州９か国から27名が参加した。

さらに、2003年５月に開催された第３回太平洋・島サミットにおいて採択された「沖縄イニシアティブ：より豊かで安全な大洋州のための地域開発戦略」の中には、感染症や生活習慣病の対策、予防接種の実施などについて、我が国による支援が明記されている。

この背景のもと、大洋州における地域保健サービスの更なる改善に貢献するために、大洋州地域の保健人材育成に関する技術協力プロジェクトの形成を目指して、その拠点と期待されるフィジー諸島共和国（以下､「フィジー国」と記す）及び周辺国を対象としたプロジェクト形成調査団が2003年10月に派遣された。

現在、フィジー国ではオーストラリア国際開発庁（AusAID）の支援の下地方分権化を進めており、保健省においても保健事業年間計画の策定を地方保健局の責任とするなど、より地域特性・現場の意見を汲み上げる制度を構築しつつある。他方、地域保健を担当する看護師等の人材には、現場の問題を分析し活動計画を立てるための十分な能力が備わっていないことから、現任教育制度の強化が急務となっている。この背景により、フィジー国の地域保健看護師（Community Health Nurse）を対象とした人材育成プロジェクトが提案され、今年度新規案件として採択、実施されることとなった。

１－２　調査の目的

先方政府の要請を踏まえ、プロジェクト形成調査及びパイプライン専門家によって収集された既存情報に基づいて、プロジェクト実施の必要性・妥当性を評価する。また、プロジェクト実施に関する具体的な協力内容、活動計画についてプロジェクト及びフィジー国政府関係者と協議を行い、プロジェクトの方向・基本計画についての合意を形成する。

１－３　団員構成

氏　名	担　当	所　　属	派遣期間
北林　春美	総　　括	国際協力機構 人間開発部　第三グループ長	2004/9/27～10/7
比嘉　政昭	地域保健 人材計画	沖縄県北部福祉保健所　所長	2004/9/27～10/7
南　　和江	協力計画	国際協力機構　人間開発部 第三グループ　保健人材育成チーム	2004/9/27～10/7
笹田　志穂	評価分析	㈱レックス･インターナショナル	2004/11/27～12/11

１－４　調査行程

(1) 2004/9/27～10/7：北林団長、比嘉団員、南団員

	日　付	活　　動
1	9/27（月）	移動（東京－ナンディ）
2	9/28（火）	07:00　ナンディ着、スバへ移動 14:30　JICAフィジー事務所表敬 15:40　在フィジー日本大使館表敬 16:20　専門家打合せ（JICAフィジー事務所）
3	9/29（水）	09:00　専門家打合せ（JICAフィジー事務所） 15:00　保健省・中東地区保健局協議 16:50　AusAID訪問
4	9/30（木）	08:00　国立ヘルスプロモーションセンター訪問 10:30　コロボ産科病院、コロボヘルスセンター訪問 12:30　サワ村訪問（地域保健活動見学） 16:00　ナワラ看護ステーション訪問
5	10/1（金）	08:00　フィジー看護学校訪問 09:40　植民地戦争記念病院訪問 11:30　バレレブ医療区訪問（地域保健活動見学） 15:00　中東地区保健局協議（PDM草案作成）
6 7	10/2（土） 10/3（日）	ミニッツ案作成、打合せ
8	10/4（月）	12:00　JICAフィジー事務所打合せ 15:00　保健省最終協議
9	10/5（火）	ミニッツ修正、JICAフィジー事務所打合せ
10	10/6（水）	08:45　在フィジー日本大使館報告 10:20　JICAフィジー事務所報告 14:30　ミニッツ署名 移動（スバーナンディ）
11	10/7（木）	移動（ナンディー東京）

(2) 2004/11/27～12/11：笹田団員

	日　付	活　　動
1	11/27（土）	移動（東京－ナンディ）
2	11/28（日）	07:00　ナンディ着、 スバ到着後、専門家と打合せ
3	11/29（月）	JICAフィジー事務所打合せ 保健省中期計画発表ワークショップに参加
4	11/30（火）	専門家とPDM・事前評価表作成作業
5	12/1（水）	専門家とPDM・事前評価表作成作業

6	12/2（木）	Vinidawa地区病院･ヘルスセンター、Lutu看護ステーション訪問
7	12/3（金）	中東部地方保健局協議
8	12/4（土）	ワークショップ準備
9	12/5（日）	事前評価表作成作業
10	12/6（月）	保健省協議（JICA事業、評価手法、プロジェクト内容について説明）
11	12/7（火）	看護師対象のワークショップ（JICA事業、評価手法、プロジェクト内容について説明）
12	12/8（水）	専門家打合せ
13	12/9（木）	JICAフィジー事務所報告
14	12/10（金）	保健省及び中東部地方保健局報告
15	12/11（土）	移動（スバーナンディー東京）

１－５　主要面談者

＜フィジー国側＞

(1) 保健省

Dr.Lepani WAQATAKIREWA	次　官
Mr.Asaeli TEMEVITOAKULE	計画運営課長
Dr.Timaima TUIKETEI	公衆衛生課長
Ms.Ligieta NADAKUITAVUKI	看護薬剤課長
Ms.Lola TUILOMA	全国看護指導監
Ms.Rucieli TAUKEI	看護薬剤課 課長補佐官
Dr.Salimoni TUQA	中東部地方保健局長
Dr.Sala SAKETA	中東部地方保健局 地域保健課長
Ms.Mereani TUKANA	中東部地方保健局 中部地方看護指導監

(2) AusAID

Ms.Susan IVATTS	First Secretary
Ms.Shily NARAYAN	Activity Manager
Ms.Di BARR	Deputy Director, Fiji Health Sector Improvement Program (FHSIP)
Mr. Geoff SCAHILL	Health System Adviser, FHSIP

(3) 国立ヘルスプロモーションセンター

Mr. Manasa NIUBALEIRUA	Head
Mr. Iuosse SALUSALU	Senior Health Promotion Officer, Social Marketing Division
Mr. Sera WAQA	Health Promotion Officer, Research Division

Mr. Nanasa RAYASIDAWU	Health Promotion Officer, Community Organization Division
Mr. Philip KOUAI	Senior Health Promotion Officer, Audio Visual Production Division

(4) フィジー看護学校

Ms. Iloi Tagiyawa RABUKA	Principal
Mr. Kavekini NEIDIR	Senior Tutor, in charge of curriculum
Ms. Litia W. MAKUTU	Tutor

(5) 植民地戦争記念病院

Dr. Salimoni TUQA	Director, Cent/East Health Services
Dr. Lo ALEFAIO	Manager, Clinical Services
Ms. Sereana T. BALEKIWAI	Acting Manager Nursing
Ms. Losabin TAWAGA	Acting General Manager

＜日本側＞

(1) 在フィジー日本大使館

宮田　健二	公使参事官
久保　真弓	二等書記官

(2) JICAフィジー事務所

池城　直	事務所長
鈴木　央	事務所員

(3) 日本人長期専門家

山田　幸子	ヘルスプロモーション（パイプライン専門家）

１－６　調査方法

プロジェクト形成調査団及び長期専門家が収集した既存資料を確認し、必要な情報については追加収集を行った(特に保健統計資料)。それらの情報を分析するとともに、各種医療施設(病院、看護ステーション、ヘルスセンター等）の視察を行い、そこに勤務する医師、看護師との意見交換により、プロジェクト対象として想定していた地域保健看護師が抱える課題について確認した。プロジェクト基本計画の作成にあたっては、調査団と日本人専門家で作成した原案を提示し、保健省及び中東部地方保健局との協議を経て修正した。

プロジェクト・サイクル・マネージメント（PCM）ワークショップについては、長期専門家が既に実施済みであったため、調査団では行わなかったが、コンサルタント派遣時に中部地方の地域保健看護師の指導職を集めて、JICA事業やプロジェクト概要等について説明するワークショップを実施した。

第２章　調査結果

２－１　総　括

フィジー国では、近年糖尿病、高血圧等の生活習慣病が増加するとともに、HIV/AIDS感染者の増加も見られ、適切な予防活動や食生活をはじめとする住民の行動の変容への働きかけが保健分野の課題となっている。こうした活動を実施するためには、それぞれの地域に根ざした保健活動の活性化が必要とされており、地域社会の最先端において活動する地域保健看護師の役割がきわめて重要である。フィジー国においては、看護ステーションやヘルスセンターに配属された地域保健看護師がその任を担うべきであるが、現状では十分にその役割を果たすことができない状況にある。

地域保健看護師は、1人当たり10か村程度を担当し、外来診療、妊産婦検診、家族計画、在宅看護等多くの業務を実施することが求められており、地域保健活動に十分な時間を割くことができないという状況にある。また、看護学校における基礎教育や卒後教育において地域保健活動に必要な知識や技術を十分に教えられておらず、保健省の実施する現任者研修も各種の保健プログラム（性感染症対策、産科ケア、予防接種等）の医療技術を中心としたテーマに限られている。現場の地域保健看護師も自らの管理運営能力や地域診断技術が不十分であること、監督者からの十分な指導や教育を得られないことに対する不安や不満を述べていた。

２－２　地域保健看護師に関する調査

(1) 看護師の職務区分

フィジー国では、臨床活動と地域保健（公衆衛生）活動に従事する看護師が下表のように区別されている。フィジー看護学校等を卒業した看護師は病院（臨床)、ヘルスセンター（地域保健)、看護ステーション（地域保健）のいずれかに配属されるが、人事異動により臨床と地域保健活動の両方を経験することを奨励されている。臨床と公衆衛生の間の人事異動サイクルは、一部に例外もあるものの、通常２～４年とされている。

フィジー国における看護師区分（ナースプラクティショナーは除く）

総　称	主な業務	勤務先	名　　称
病院看護師 (Clinical/Hospital Nurse)	臨床活動に従事	病院	病院看護師長（指導職） 病院看護師
地域保健看護師 (Community Health Nurse)	村落レベルで公衆衛生活動に従事（外来診療を含む）	ヘルスセンター	地域看護師長（指導職)＊ シニア地域看護主査（指導職)＊ 地域看護主査（指導職)＊ ゾーン看護師 母子保健看護師 家族計画看護師 外来看護師 特別外来看護師
		看護ステーション	ディストリクト看護師

＊本報告書では、地域保健看護師の指導職位にある看護師を総称して「指導者」とする。

(2) 地域保健看護師の活動

地域保健看護師の業務は、地域における一次保健医療サービスの提供であるが、以下に見るとおりその業務内容は非常に多岐にわたる。

・母子保健サービス
・予防接種
・健康教育
・家族計画
・学校保健
・精神障害者、ハンセン氏病患者、結核患者の在宅治療と訪問指導
・高齢者介護
・糖尿病、高血圧症などNCDのスクリーニング
・コミュニティヘルスワーカーの指導
・保健活動に関わる地域との調整

ヘルスセンターや看護ステーションに来る患者数の正確なデータはないが、１日10～20名程度の施設も多く、地域保健看護師は週に1回は担当の村を巡回診療する（移動手段は徒歩か公共バス）。巡回指導では、ディスペンサリー（簡易診療所）が設置されている場合はその施設を利用しており、地域住民の情報についてはコミュニティヘルスワーカーの協力を得ることも多い。しかし、それらの活動で必要となる機器の管理や業務遂行・レポート作成のための手順等については標準化されておらず、看護師任せとなっているのが実情である。

なお、現地調査において、地域保健活動の将来的な課題として強化の必要性が示唆された事項は以下のとおりである（ただし、現場の状況を細かく観察し、討議する時間が少なかったため、既に取り組まれている課題についても含まれている可能性がある）。

・母子保健活動
  - 母子手帳の活用（予防接種、発育・発達、疾病記録、妊娠記録等）
  - コミュニテイでの栄養士を活用した離乳食指導
  - 子供の発達チェック表の整備活用
  - 在宅療養児の支援
  - 家庭でできる乳幼児の感染症予防対策（教室の開催、パンフレット等）
  - 育児相談（両親支援）
・学校保健活動の強化
  - 急性感染症・エイズ教育・性感染症等の教育
  - 生活習慣病対策（たばこ、アルコール、肥満、健康運動）
  - 歯科保健対策（擦掃指導、フッソ洗口等）
・生活習慣改善活動
  - コミュニイティヘルスワーカーを活用した地域活動の展開
  - 健康習慣普及活動（ビデオ上映、実践指導、コミュニィティエンパワーメント、個人のエンパワーメント）

- 各種イベントの開催（研修会、発表会、ウォーキング大会、ヘルシーメニュー等）

・登録患者管理
- 結核、らい、精神、糖尿病、リュウマチ熱患者管理の年間評価

・障害者福祉
- 専門医師、看護師、福祉関係職種による巡回相談会の実施
- 地域ボランティアの育成

・環境衛生・食品衛生活動
- ヘルスインスペクター、看護師、医師と地域保健対策委員会メンバーによる集落内巡視の実施
- 安全な飲用水の確保
- 衛生的な便所と手洗いの整備
- シャワー等の整備
- 集落内排水管理
- 安全な食品の供給
- 食中毒予防

・感染症・食中毒等の流行調査及び疫学的分析
- 感染症・食中毒の流行状況を分析し、発生防止に役立てる。

・コミュニィティヘルスワーカー研修の強化
- 各種の情報源、啓発活動の実施、ボランティア育成等の活動が期待できるので研修を強化し、自主活動を促進する

２－３　プロジェクト実施の必要性

(1) 地域保健看護師の活動における課題

地域保健看護師の活動における課題の一つは、地域住民への１次保健医療サービス提供と保健増進指導を一手に担わねばならないという業務の多様さにある。１人の地域保健看護師が10～20村を担当し、ヘルスセンターでの外来診療、妊産婦検診、家族計画、予防接種だけでなく、訪問看護や巡回指導も行うなど、非常に多くの知識と技術が求められている。それに加え、人口動態、母性管理、乳幼児・小児管理、外来受診など8種類に及ぶ報告書類に定期的に記録しなければならず、こうした情報管理も大きな業務となっているが、収集された記録を分析する任務はなく、業務の運営・管理の能力について学ぶ機会は与えられていない。地域保健活動は、従来から行われていた母子保健、感染症対策などに加え、健康づくりなど保健ニーズの変化に伴い活動も多様化している。フィジー国においても今後は住民ニーズに基づいた健康政策として展開していくために、地域のニーズを把握し事業を企画立案し、活動の進行管理や評価まで行う能力が求められている。

そのため、地域保健活動に従事する者が業務を遂行するための能力を継続的に強化するための現任教育の必要性が認識されている。

(2) 地域保健看護師指導者の課題

フィジー国においては、健康増進に関する地域保健活動を全保健職種及び全行政・非行政組織で取り組む方針であるが、各職種の役割分担が明らかになっていない。地域保健看

護師を対象としたPCMワークショップの問題分析（パイプライン専門家が実施）でも、住民参加型の地域保健活動のための看護師の知識不足が主な問題点としてあげられた。現在の指導者世代は看護学校で地域開発手法を学んでおらず、経験はあっても知識として体系化して学んでいない事柄も多いため、後輩の看護師たちに十分な指導力を発揮しにくい。若手の看護師は必要な知識・技術は看護学校で学んでいるが、その実践や地域活動にあたっては未熟な部分も多く、周囲からの助言・指導が必要になる。看護師指導者は地域保健看護師よりは研修の機会に恵まれているが、研修の多くはトップダウン型であり、地域保健活動推進のための総合的能力強化のための研修は実施されていないのが現状である。

３か月に１回、指導者会議が行われ、ヘルスセンター、看護ステーションに勤務する地域保健看護師を対象に毎月連絡会が行われているが、指導者の指導能力・地域保健に関する知識が不十分であるために、地域保健看護師の技能が向上しないことが問題となっている地区もある。

本来、現場の看護師の強化はその上位職者（指導者）によって進められるべきであるが、地域保健看護師の指導者には下位看護師を「指導」するための知識、ノウハウが不足しているのが実情である。地域保健看護師の能力強化を行うためには、まず指導者の指導能力強化が不可欠であると考えられることから、指導者に対する指導者研修の実施についても必要性が確認された。

第３章　プロジェクト基本計画

３－１　基本方針

前章の状況を勘案し、本プロジェクトでは①地域保健看護師の業務指針及び業務手順の見直し、②看護師指導者の能力強化、③指導者による継続的な地域保健看護師育成・指導によって、地域保健看護師の現任教育システムを強化し、その業務遂行能力の向上を図ることとした。

保健省では、AusAIDの支援を受けて、地方分権化に向けた組織改編及び行政能力向上に取り組んでいるが、本プロジェクトは、地域の最先端で活動する地域保健看護師の業務運営能力向上を支援することで、フィジー国の地方分権化政策を草の根レベルから強化するものとして位置づけることができる。特に、地域保健看護師が住民のニーズや保健省の重要課題、活用可能な資源を考慮して保健活動を各自で計画・管理が可能になるよう、業務運営能力強化のための活動を行う。これらの支援により、最終的には保健省の使命である、質の高い保健サービスの提供を目指す。なお、本プロジェクトにおける現任教育には、看護学校等で行われている基礎看護コース終了後の専門課程コースは含まない。

育成・指導の内容は、既に保健省や他ドナーの援助で実施されている医療技術ではなく、地域診断、活動計画策定・評価、啓発普及手法などを中心とする。また、研修の方法も長時間の研修やセミナーで業務に支障を及ぼさないようなシステムつくりを心がける。

３－２　協力概要（R/Dにて合意した内容を記載）

(1) プロジェクト名：地域保健看護師現任教育プロジェクト

(2) 協力期間：2005年4月1日～2008年3月31日

(3) 対象地域：フィジー中部地方

(4) 協力対象者：中部地方に勤務する地域保健看護師及びその指導職看護師

(5) プロジェクト要約

＜上位目標＞

中部地方において地域保健看護師の行う地域保健活動の質が改善される

＜プロジェクト目標＞

中部地方において地域保健看護師の業務管理能力が現任教育を通じて向上する

＜成果＞

１）地域保健看護師の役割と機能が再定義される

２）地域保健看護師の指導者の現任教育についての知識が強化される

３）各地区において、地域保健看護師を対象とした現任教育が機能する

４）現任教育のプロジェクトモデルが他地方及び他国に紹介される

第４章　評価５項目による評価結果

４－１　妥当性

(1) 案件内容の公共事業・政府開発援助（ODA）としての適格性

本件における技術移転対象者は地域保健看護師であり、最終的受益者は一般市民である。しかも、ある特定の階級、性別、職業、人種等に限られた市民ではない。地域保健サービスは、今後も民間セクターによって提供される可能性のきわめて低い分野である。以上から、本件は公共性が高く、ODA対象案件として適格といえる。

(2) 我が国の援助政策との整合性

我が国は2000年に開催された第２回太平洋・島サミットで積極的な太平洋島嶼外交を展開していく方針を表明した。さらに、第３回太平洋・島サミットではより豊かで安全な大洋州のための地域開発戦略を策定し、保健分野に関しては感染症、生活習慣病対策、予防接種の実施などについての支援を明記した。

(3) 相手国のニーズとの合致

フィジー国では医師不足が深刻なため、医師の少ない僻地においては看護師の役割が重要となっており、看護師の中でも生活習慣病の予防や健康教育など生活に根づいた保健活動を実施する地域保健看護師の重要性が増している。地域保健看護師の活動を強化するためにも、現任教育は重要であるが、基礎教育または卒後教育において健康増進活動を行うために必要な知識・技能を十分に修得しておらず、保健省で行っている研修は臨床的課題に限定されているため、地域保健活動のマネジメント能力向上が求められている。「保健省国家戦略計画2005-2008」の中でも、５つの基本戦略の一つとして人材育成を掲げ、質の高い保健サービス供給のための人材育成強化策を提示しており、本件の活動内容はフィジー国政府のニーズとも一致している。

(4) 日本の技術の優位性

我が国では、看護師だけでなく医師、保健師、栄養士、作業療法士などすべての地域保健活動従事者を対象とした現任教育の実施が地域保健法で規定されており、各自治体において様々な研修が実施されている。また沖縄においては、保健所保健婦が地域に駐在し、生活に密着して保健婦活動を住民に展開する保健婦駐在制度など独自の地域保健活動を実施してきた経緯がある。具体的には沖縄県僻地特別対策として行われている現任教育で使用されている、年間計画作成方法、現任教育マニュアル、地域保健看護師に求められる能力基準表などをフィジー国の現状に合せて改正して適用する。このように日本の経験を本プロジェクトに活用していくことで、プロジェクト目標の達成に大いに寄与できると考えられる。

４－２　有効性

(1) 計画の論理性

プロジェクトの計画の内容は、様々な調査結果を踏まえ、付属資料４に示されるような

プロジェクト・デザイン・マトリックス（PDM）で説明されている。プロジェクト目標である地域保健看護師の能力を向上させるために、①業務内容の見直しと確認、②指導者（グループ）の設置、③研修実施とモニタリング、④成果の紹介という４つの成果が設定されている。これらの成果を達成するための活動は、投入とプロジェクト期間から無理のないように計画されている。

(2)期間内の達成可能性

本件の実施機関である保健省中東部地方保健局では、既に様々な研修プログラムを実施している。本件の現任教育は各地区での地域保健看護師の月例会議の場を利用して実施され、新たなシステムを導入することはないため、同保健局には本件の目標達成のための能力が十分に備わっていると考えられる。また、地域保健看護の活動を休止して研修を受講するわけではないため、地域保健看護師からの参加も得やすい。

４－３　効率性

本件は人材育成に焦点が当てられており、大規模な機材購入、施設建設は伴わない。現任教育の実施場所は既存の保健施設であり、プロジェクト・チームの執務スペースは中東部地方保健局内に提供されることとなっている。日本側の専門家についても、長期専門家については現任教育全体の運営を計画・管理できる人材を充て、短期専門家は、長期専門家で対応できない専門的分野、特殊な分野について必要期間のみ投入する計画になっており、対象地域の裨益人口が比較的小規模であるのに合せた、適切な人数設定になっており、効率的な専門家配置となっている。

４－４　インパクト

(1) 社会・経済的インパクト

＜制度的インパクト＞

地域保健看護師を対象とした現任教育は現在フィジー国で行われておらず、現任教育の導入による地域保健看護師の能力向上が実現されれば、地域保健活動の強化につながり、その効果は大きい。また本件により現任教育の必要性が広く認識され、評価が高まれば、他地区あるいは栄養士など他の地域保健活動従事者へも現任教育が実施されることが期待できる。

＜社会・文化的インパクト＞

１）裨益集団の特徴：中部地方住民が最終受益者であり、人種ではインド系（32%）よりフィジー系（60%）住民の比率が高いが、特定の階層を対象としたものでなく一般市民を対象にしている。中部の特徴としては、教育レベルが高く、平均余命が長く高齢者比率が高い点があげられる。また北部などと比べ、ドナーによるプロジェクト実施の機会が少ない。

２）裨益集団の規模：プロジェクト開始後３年間の最終受益者数は、325,000人。

３）便益の内容：現任教育を受けた地域保健看護師によって、効果的な地域保健活動を受けることができる。

＜技術的インパクト＞

１）技術移転対象者の数：地域看護指導者21人、地域保健看護師120人

２）技術移転の内容

① 地域保健看護師の業務基準、経験年数別技能基準、地域看護オリエンテーションハンドブックの作成技能

② 現任教育のための指導者研修方法

③ 現任教育手法

＜経済的インパクト＞

プロジェクトの結果、地域保健看護師業務の運営が改善されることで、地域保健活動が強化されれば、対象地域における疾病予防に寄与し、国民医療費の増加を抑止するという意味で、経済的損失を防ぐ効果が期待できる。

(2) 負のインパクト

本件は人材育成に焦点が当てられており、大規模なインフラ建設は伴わず、環境面に悪影響を及ぼすことはない。その他、貧富の差の助長、女性の権利の低下といった社会・文化面に悪影響を与えることもない。また、現任教育を受けることによる看護師の海外流出に関しては、海外での需要が高いのは病院看護師であることから、懸念されるような事態にはならないと思われる。

４－５　自立発展性

(1) 組織能力

本件の実施機関は既存の組織であり、カウンターパートを中心として現場の看護指導者及び地域保健看護師を指揮する系統は既にできあがっている。本件実施中、また終了後においても、このような管理体系が維持されれば、組織能力の不足という理由で本件の進行が妨げられることはないと考える。

(2) 財政面

プロジェクト終了後も先方機関が円滑に活動を続行できるための予算を確保できるかについては、2004年12月現在、明確な予測ができるだけの情報はないが、現任教育の継続のための費用はそれほど多額ではないため、大きな負担にはならないと推測される。

(3) 社会的・技術的受容性

本件は地域保健活動の強化を上位目標としており、本プロジェクトにより地域住民への保健サービスが将来的に改善されるため、社会的に十分に受け入れられるものと思われる。また、カウンターパートの１人は既に沖縄でのJICA島嶼地域保健行政研修コースに参加し、日本の経験を学んでおり、その他の看護指導者に関しても既存の技術・専門知識を本件に十分活用できると考える。

４－６　結　論

上記評価５項目の観点から判断すると、予測不能な要因は何点かあるものの、実施を妨げるような絶対的な理由はないと考える。本件終了後の上位目標の効果が効率よく現れるためには、現任教育を受けた直接裨益者が意欲的な地域看護活動をすることが必要である。より協力的な活動を継続するためのインセンティブづくりが制度的に行われることが望ましい。

第５章　実施協議の概要

５－１　協議の経過

事前調査評価団の本団が2004年９～10月に派遣されたあと、11月末から12月にかけてコンサルタント団員が派遣され､現地専門家と協力してフィジー国におけるプロジェクト実施の背景、保健分野の概況と課題､プロジェクトの概要を取りまとめたプロジェクト･ドキュメントが作成された。その後は、現地専門家、JICAフィジー事務所、フィジー国側関係機関との間でプロジェクト目標、成果、活動について具体的な協議が行われた。結果、事前評価調査団時のマスタープランに若干の修正を加えて、2005年３月22日にプロジェクト開始のための実施協議が行われ、R/D及びM/M（PDM、PO、プロジェクト･ドキュメントを添付）の署名･交換が行われた。

なお、実施協議の過程において特筆される箇所は以下のとおり（協力概要については、最終的な計画を第３章に記載済み)。

(1) フィジー国側プロジェクト実施体制の変更

	事前評価調査時	最終決定
プロジェクト ダイレクター	保健省次官	保健省次官
プロジェクト マネージャー	中東部地方保健局長	中東部地方保健局長
プロジェクト マネージャー補佐	中東部地方保健局　地域保健課長	中東部地方保健局　地域保健課長
カウンター パート	①中部地方看護指導監 ②全国看護指導監 ③保健省看護薬剤課課長補佐	①中部地方看護指導監 ②中東部地方保健局地域保健主任 ③全国看護指導監

(2) 合同調整委員会（JCC）の変更

	事前評価調査時	最終決定
委員長	プロジェクトダイレクター	プロジェクトダイレクター
委員 フィジー国側	・プロジェクトマネージャー ・プロジェクトマネージャー補佐 ・カウンターパート ・保健省運営計画課長 ・保健省看護薬剤課長 ・保健省公衆衛生課長 ・保健省保健事業開発課長 ・フィジー看護学校長 ・国立ヘルスプロモーションセンター所長	・プロジェクトマネージャー ・プロジェクトマネージャー補佐 ・保健省運営計画課長 ・保健省看護薬剤課長 ・保健省公衆衛生課長 ・保健事業開発課長 ・外務省 ・人事院 ・財政省

	事前評価調査時	最終決定
日本側	・JICAフィジー事務所長 ・長期専門家	・JICAフィジー事務所長 ・長期専門家
オブザーバー	・在フィジー日本大使館代表者 ・その他委員長が認めた者	・在フィジー日本大使館代表者 ・その他委員長が認めた者

(3) プロジェクト運営に関わるコスト分担について

付属資料５のプロジェクト･ドキュメントに記載のとおり合意している。特に、各種タスクフォースの会合や指導者研修等で旅費が多く発生すると考えられるが、保健省の人員に係る旅費については、保健省負担となる旨重点をおいて日本側より説明し、関係者間の合意を得ている。

５－２　協議参加者

＜フィジー国側＞

Dr.Lapani.WAQATAKIREWA	保健省次官
Mr.Asaeli TAMANITOAKULA	保健省計画運営課長
Ms.Ligieta NADAKUITAVUKI	保健省看護薬剤課長
Ms.Lola TUILOMA	全国看護指導監
Dr.Salimoni. TUQA	中東部地方保健局長
Dr.Sala SAKETA	中東部地方保健局　地域保健課長
Ms.Mereani TUKANA	中東部地方保健局　中部地方看護指導監
Dr.Solo Qaranivalu	中東部地方保健局　地域保健主任
Dr.Susana NAKALEVU	スバ地区医師長

＜日本側＞

池城　直	JICAフィジー事務所長
鈴木　央	JICAフィジー事務所員
Mr.Alex Konrote	JICAフィジー事務所　現地所員
山田　幸子	長期専門家（ヘルスプロモーション）

付　属　資　料

１．要請書

２．事前評価調査団議事録（M/M）

３．協議議事録（R/D）

４．実施協議議事録（M/M）
（PDM、PO、プロジェクト･ドキュメント添付）

５．プロジェクト･ドキュメント（和文）

1．要請書

MINISTRY OF FOREIGN AFFAIRS AND EXTERNAL TRADE
P.O. BOX 2220, GOVERNMENT BUILDINGS, SUVA, FIJI
email: foreignaffairs@govnet.gov.fj
8th & 9th Floor, Suvavou House

Tel: 3309862
Fax: 3301741

Our Ref: 1465/20/5

Note No: 391/04

The Ministry of Foreign Affairs and External Trade of the Government of the Republic of the Fiji Islands presents its compliments to the Embassy of Japan and has the honour on behalf of the Ministry of Health to request the latter for a technical cooperation on "Project for Strengthening Health Workers in Fiji".

In this regard, the Ministry has the further honour to forward herewith, with its endorsement of the proposal, the duly completed form in respect of the technical cooperation request by the Ministry of Health.

The Ministry of Foreign Affairs and External Trade of the Government of the Republic of the Fiji Islands avails itself of this opportunity to renew to the Embassy of Japan the assurances of its highest consideration.

Embassy of Japan
Dominion House
Suva

24th May 2004.

MINISTRY OF FOREIGN AFFAIRS AND EXTERNAL TRADE
GOVT OF THE REPUBLIC OF FIJI

cc: Resident Representative, JICA

APPLICATION FORM FOR JAPAN'S TECHNICAL COOPERATION

1. Date of Entry: Day 16 Month April Year 2004

2. Applicant: The Government of Fiji

3. Project Title: Project for Strengthening Frontline Health Workers in Fiji

4. Implementing Agency: Ministry of Health

Address: 88 Amy Street, Suva

Contact Person: Mrs Rigieta Tuidraki-Tawakiri

Tel. No.: 3221520 Fax No. 3321163

E-Mail: rtuidraki-tawakiri@health.gov.fj

5. Background of the Project

The majority prevalent health problems in Fiji are mainly attributed to the change of lifestyle despite its possibility to improve health status through well targeted preventative and educational programs. Chronic non-communicable disease has replaced infectious and parasitic disease as the main cause of morbidity and mortality in the country. However, infectious and parasitic diseases also remain as major causes of morbidity with diseases of circulatory system and digestive system.

In order to tackle with the above health situation, the Ministry of Health has developed the Strategic Plan for 2003 – 2005 with the Ministry's Mission Statement, Vision and Values. Under the Strategic Development Plan, ten (10) issues have been identified as Key Result Areas for the Health Services to 2005. Furthermore, the Ministry of Health formulated Annual Corporate Plans for 2003 and now for 2004. In the 2004 Corporate Plan, the Ministry of Health prioritizes strengthening and empowering the decentralized health services, which is efficient, effective and of high quality. This transition requires substantial competences both institutional administrators and front line health workers in communities, but technical support has not been reached to frontline level. Thus, Fiji Ministry of Health requests to the government of Japan a technical assistance project by JICA with a title of Supporting Frontline Health Workers Project in Fiji.

6. Outline of the Project

(1) Overall Goal

Quality of health services is improved in a targeted Division in Fiji.

(2) Project Purpose

Capacity of Community Nurses for planning community health activity is improved..

(3) Outputs

1. Establish counseling mechanism for a better planning at each Sub-Divisional Health Services.
2. Strength supervisors' capacity for providing appropriate advice to their staff (community nurses).
3. Gain ability to revise community health plan of community nurses every year.

* Community nurses include nurses who work in health centers, hospitals and work for community.

(4) Project Activities

0-1. Establish project advisory committee.
0-2. Establish project steering committee.
0-3. Select pilot sites.

1-1. Develop Planning, monitoring, and evaluation system for community health activity.
1-2. Formulate regular case conference on planning, monitoring, and evaluation with community nurses and their supervisors.
1-3. Establish Individualized instruction system (Preceptor system) for community nurses.

2-1 Conduct training program on human resource development and management
2-2. Train supervisors during regular case conference and individual instruction.

3-1. Conduct regular case conference on health activity planning.
3-2. Conduct workshop to present Community Nurses' achievement.

(5) Input from the Recipient Government

(a) Counterpart personnel:
- Project Director: Chief Executive Officer, Ministry of Health
- Project Manager: Director of Health Service Standard, Director of Divisional Health Services
- Counterpart: Nursing Sisters at Sub-Division

(b) Office space

(c) Training Facility: Fiji School of Nursing
(d) Running Expenses

(6) Input from the Japanese Government

(a) Preparation: Health Promotion Planning (7M/M)
(b) Long term experts:
- Team leader: Community Health Management(36M/M)
- Health Promotion (36M/M)
- Project Coordinator (36M/M)

(c) Short Term Experts:
(d) Training Fijian personnel in Japan:

7. Implementation Schedule

Month January Year 2005 ~ Month December Year 2007 (3 Years)

8. Implementing Agency

Staffing

The Chief Executive Officer of MOH will bear overall responsibility for the administration and implementation of the project. The Director of Health Service Standard and Director of Divisional Health Services will be responsible for the managerial matters of the project. Sub-Divisional Nursing Sister will be assigned to the project as counterparts which bear responsibility for implementation of the project.

Budget

1. Salaries of Counterpart staff
2. Maintenance and Operational Cost
   A) Supplies and Materials
   B) Communication
3. Transportation of Counterpart Staff
4. Import taxes, duties, and VAT charges

9. Related Activities

- Fiji Health Sector Improvement Project by AusAID

10. Beneficiaries

Direct Beneficiaries

- Community Nurses at Nursing Stations, Health Center, and Sub-Divisional Hospitals in a targeted Division (42-92 facilities)
- Nursing Sisters at Sub-Division in a targeted Division (3-8 Sub-Divisions)

Indirect Beneficiaries

- Community Health Workers in a targeted Division
- Health Committee in a targeted Division
- People in a targeted Division

11. Security Conditions

12. Others

MINUTES OF MEETING OF THE PREPARATORY STUDY OF THE TECHNICAL COOPERATION PROJECT FOR IN-SERVICE TRAINING OF COMMUNITY HEALTH NURSES IN THE REPUBLIC OF THE FIJI ISLANDS

Japan International Cooperation Agency (hereinafter referred to as "JICA") dispatched the Preparatory Study Team (hereinafter referred to as "the Team"), headed by Ms. Harumi Kitabayashi, to the Republic of the Fiji Islands from September 28 to October 7, 2004 for the purpose of discussing the framework of the requested project entitled "the Technical Cooperation Project for Supporting Front-line Health Workers" which, after mutual consultation, was renamed as "the Technical Cooperation Project for In-service Training of Community Health Nurses" (hereinafter referred to as "the Project").

During its stay in Fiji, the Team conducted field surveys and had a series of discussions on the Project with the authorities and stakeholders in Fiji.

As a result, the Team and the Fiji authorities concerned agreed to report to their respective governments the matters referred to in the document attached hereto.

Suva, October 6, 2004

北林春美

Harumi Kitabayashi
Leader
Preparatory Study Team
Japan International Cooperation Agency
Japan

Lepani Waqatakirewa

Chief Executive Officer
Ministry of Health
Republic of the Fiji Islands

The Attached Document

1 Background of the Project

The Government of Japan and JICA has implemented a country training course titled Community Health Administration" in Okinawa Prefecture as one of the follow-up activities of the "Miyazaki Initiative" adopted at the Japan-Pacific Islands Forum Summit Meeting (hereinafter referred to as "PALM") held in Miyazaki in 2000. Leaders of nursing officers from Pacific countries were invited to Okinawa with an aim of sharing experiences of community health development and personnel development with health officers in Okinawa.

After the PALM2003 held in Okinawa, a fact-finding study team was dispatched by JICA to Fiji in October 2003 for formulation of a technical cooperation project in human resources development in health sector which will make use of the results obtained in the Community Health Administration course. Based on the recommendation of the above-mentioned team, the Government of Fiji requested the Government of Japan a project targeting at empowerment of Community Health Nurses in Fiji.

The Government of Japan decided to accept the request, and an expert was dispatched to Ministry of Health (hereinafter referred to as "MOH") by JICA in June 2004, for formulating a detailed plan of the Project with the relevant officials of the Government of Fiji. This preparatory study team was dispatched to discuss the proposed plan and to work out the framework of the technical cooperation.

2 Issues to be addressed by the Project

Community Health Nurses as the frontline of the public health service in Fiji are expected to execute wide range of responsibilities under the new position description of health officers stipulated by MOH. Many Community Health Nurses, however, felt that they have not acquired sufficient knowledge and practical skills that enable them to manage their tasks effectively. Needs for supporting system for the Community Health Nurses together with development of cadre of their supervisors/ advisors were expressed by different level of nursing officers. The Nursing Stations in the rural areas are managed by single Community Health Nurses, who have limited opportunities for refreshing their skills.

In-service training courses currently provided to the Community Health Nurse are mainly on the subjects related to specific health programs (e.g. HIV/AIDS, STI, PAP smear, Obstetric emergency). Skills development in the area of management and promotion of community health activities are to be strengthened, because Community Health Nurses are expected to function as the coordinator and facilitator of community participation and development activities to improve the health situation of the country.

3 Tentative Framework of the Project

Based on the result of the discussions, considering funding and technical feasibility, and timeframe of the Project, a tentative framework of the project is worked out as follows. It is subject to modifications through further discussions and evaluation before it is finalized.

Definition of Key Words

Community Health Nurses are: registered nurses who are working at Health Centers as Zone Nurses or at Nursing Stations as District Nurses. They are responsible for various health services and activities in their districts, including clinical attention, prevention, and health education. They are the frontline workers of the public health service and thus expected to promote and coordinate health activities in the communities.

In Service Training for this Project is: the training to be offered to the Community Health Nurses and/or their supervisors such as Sub-division Health Sisters, Senior Health Sisters, and Health Sisters with the aim of equipping them with necessary skills for implementing their job requirement effectively. The training may take various forms, i.e. lectures, on-the-job-training, case presentations/discussions, role playing, and personal counseling, so that the trained Community Health Nurses can directly apply the skills to their work and the feedback from the work can be incorporated in the training. The establishment of the in-service training system, i.e. planning, implementation, and evaluation as continuing process rather than irregular events is also emphasized.

(1) Title of the Project

Project for In-service Training of Community Health Nurses

(2) Target Area

Central Division

Note:

① Development and evaluation of the in-service training system will be conducted in the all Sub-divisions of the Central Division during the Project period.

② When the effectiveness of the system is proved in the Central Division, its expansion nationwide may be considered later.

(3) Target groups

① Supervisors of Community Health Nurses, i.e. Sub-divisional Health Sisters, Senior Health Sisters and Health Sisters at the Health Centers.

② Community Health Nurses, i.e. Zone Nurses at Health Centers and District Nurses at Nursing Stations.

(4) Duration of the Project

Three (3) years from 2005

(5) Master Plan of the Project

1) Overall goal

Community Health Nurses perform their tasks effectively.

2) Project Purpose

Management skills and competency of Community Health Nurses are strengthened with support from Senior Health Sisters and Health Sisters.

3) Outputs

① Roles and functions of Community Health Nurses are redefined and reinforced.

② In-service training system for Community Health Nurses in Sub-division is improved.

4) Major Activities

①-1 Review and revise Position Description for Community Health Nurses, Health Sisters, Senior Health Sisters and Sub-divisional Health Sisters.

①-2 Establish competency requirement standard for Community Health Nurses.

①-3 Develop and distribute a management handbook for Community Health Nurses.

②-1 Conduct trainers' training on human resource development for Senior Health Sisters and Health Sisters. The subjects for training are:

- ②-1-1 Introduction to method and process of in-service training,
- ②-1-2 Communication skills including Counseling, Leadership, Coaching and Preceptorship,
- ②-1-3 Health Planning, Monitoring and Evaluation (Participatory Project Cycle Management, Precede-Proceed Model),
- ②-1-4 Information Management, and
- ②-1-5 Community Development (Community Capacity Building).

②-2 Develop annual in-service training schedule for Zone / District Nurses at Sub-divisional level.

②-3 Implement in-service training for Community Health Nurses using following methods:

- ②-4-1 Case discussion,
- ②-4-2 Role playing,
- ②-4-3 Community Health Practice (mini-project), and
- ②-4-4 Preceptorship.

②-4 Conduct monitor and evaluation for in-service training at Sub-division level.

②-5 Develop materials for in-service training.

②-6 Conduct seminars or workshops at divisional, national and regional level for mutual exchange and dissemination of the Project model.

4 Roles and responsibilities of Implementing Organizations

(1) Implementing organization of the Project

Ministry of Health is the responsible organization of the Project with the following officials in charge. MOH will be responsible for allocating budget for the Project.

① Project Director: the Chief Executive Officer

② Project Manager: the Divisional Director of CentEast Health Services

③ Assistant Project Manager: General Manager of Community Health, CentEast Health Services

④ Counterparts to Japanese Experts:
Manager Nursing (CH) Central, CentEast Health Services
National Nursing Adviser, Nursing and Health System Standard Division
Principal Assistant Secretary of Health System Standard, Nursing and Health System Standard Division

(2) Joint Coordinating Committee of the Project

A Joint Coordinating Committee will be organized to review the plans and achievements of the Project. The members of the committee will consist of the following officers.

① Chair: Chief Executive Officer

② Fiji Member:
Project Director
Project Manager
Assistant Project Manager
Director, Corporate Service Division
Director, Nursing and Health System Standard Division
Director, Public Health Division
Director, Health Services Development Division
National Nursing Adviser, Nursing and Health System Standard Division,
Principal, Fiji School of Nursing
Head, National Center for Health Promotion

③ Japanese Member

Resident Representative of JICA

Japanese Experts assigned to the Project

④ Observer

Representative of the Embassy of Japan

Other personnel invited by the Chairperson

5 Issues to be further clarified

1) For the purpose of understanding the present (baseline) situation of the target groups a training needs assessment survey is to be conducted before the Project starts. The result of the survey will be utilized for formulation of operational plans of in-service training, as well as monitoring and evaluation of the Project activities.

2) The management handbook for the Community Health Nurses is to be clarified in terms of the subjects to be covered and method of its utilization.

6 Steps Forward

1) A consultant will be dispatched to Fiji in November 2004 by JICA, who will cooperate with JICA expert to prepare the Draft Project Document which describes the situation and problem analysis, Project strategy, Project Design Matrix (PDM), Plan of Operations (PO), and ex-ante evaluation of the Project by five (5) criteria, namely, relevance, effectiveness, efficiency, expected impact, and sustainability.
2) The result of the ex-ante evaluation is to be approved by the vice president of JICA.
3) The Record of Discussions is to be signed by the Chief Executive Officer and Resident Representative of JICA.

RECORD OF DISCUSSIONS BETWEEN JAPAN INTERNATIONAL COOPERATION AGENCY AND AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE REPUBLIC OF THE FIJI ISLANDS ON JAPANESE TECHNICAL COOPERATION FOR PROJECT FOR IN-SERVICE TRAINING OF COMMUNITY HEALTH NURSES

The Japan International Cooperation Agency (hereinafter referred to as "JICA"), through its Resident Representative of JICA Fiji Office, exchanged views and had a series of discussions with the Fiji authorities concerned with respect to desirable measures to be taken by JICA and the Government of the Fiji Islands for the successful implementation of the above-mentioned Project.

As a result of the discussions, the Resident Representative of JICA Fiji Office and the Fiji authorities concerned agreed to recommend to their respective Governments the matters referred to in the document attached hereto.

Suva, March 22, 2005

Mr. Tadashi IKESHIRO
Resident Representative
Fiji Office
Japan International Cooperation Agency
JAPAN

Dr. Lepani WAQATAKIREWA
Chief Executive Officer
Ministry of Health
REPUBLIC OF THE FIJI ISLANDS

THE ATTACHED DOCUMENT

I. COOPERATION BETWEEN JICA AND THE GOVERNMENT OF THE FIJI ISLANDS

1. The Government of the Fiji Islands (hereinafter referred to as "Fiji") will implement the Project for In-service Training of Community Health Nurses (hereinafter referred to as "the Project") in cooperation with JICA.

2. The Project will be implemented in accordance with the Master Plan which is given in Annex I.

II. MEASURES TO BE TAKEN BY JICA

In accordance with the laws and regulations in force in Japan, JICA will take, at its own expense, the following measures according to the normal procedures under the Colombo Plan Technical Cooperation Scheme.

1. DISPATCH OF JAPANESE EXPERTS
   JICA will provide the services of the Japanese experts as listed in Annex II.

2. PROVISION OF MACHINERY AND EQUIPMENT
   JICA will provide such machinery, equipment and other materials (hereinafter referred to as "the Equipment") necessary for the implementation of the Project as listed in Annex III. The Equipment will become the property of the Government of Fiji upon being delivered C.I.F. (cost, insurance and freight) to the Fiji authorities concerned at the ports and/or airports of disembarkation.

3. TRAINING OF THE FIJI PERSONNEL IN JAPAN
   JICA will receive the Fiji personnel connected with the Project for technical training in Japan.

III. MEASURES TO BE TAKEN BY THE GOVERNMENT OF THE FIJI ISLANDS

1. The Government of Fiji will take necessary measures to ensure that the self-reliant operation of the Project will be sustained during and after the period of Japanese technical cooperation, through full and active involvement in the Project by all related authorities, beneficiary groups and institutions.

2. The Government of Fiji will ensure that the technologies and knowledge acquired by the Fiji nationals as a result of Japanese technical cooperation will contribute to the economic and social development of Fiji.

3. The Government of Fiji will grant in Fiji privileges, exemptions and benefits to the Japanese experts referred to in II-1 above and their families, which are no less favorable than those accorded to experts of third countries working in Fiji under the Colombo Plan Technical Cooperation Scheme.

4. The Government of Fiji will ensure that the Equipment referred to in II-2 above will be utilized effectively for the implementation of the Project in consultation with the Japanese experts referred to in Annex II.

5. The Government of Fiji will take necessary measures to ensure that the knowledge and experience acquired by the Fiji personnel from technical training in Japan will be utilized effectively in the implementation of the Project.

6. In accordance with the laws and regulations in force in Fiji, the Government of Fiji will take necessary measures to provide at its own expense:

   (1) Services of the Fiji counterpart personnel and administrative personnel as listed in Annex IV ;

   (2) Land, buildings and facilities as listed in Annex V ;

(3) Supply or replacement of machinery, equipment, instruments, vehicles, tools, spare parts and any other materials necessary for the implementation of the Project other than the equipment provided by JICA under II-2 above ;

(4) Means of transport and travel allowances for the Japanese experts for official travel within Fiji ; and

(5) Suitably furnished accommodation for the Japanese experts and their families.

7. In accordance with the laws and regulations in force in Fiji, the Government of Fiji will take necessary measures to meet:

(1) Expenses necessary for transportation within Fiji of the Equipment referred to in II-2 above as well as for the installation, operation and maintenance thereof;

(2) Customs duties, internal taxes and any other charges, imposed in Fiji on the Equipment referred to in II-2 above ; and

(3) Running expenses necessary for the implementation of the Project.

IV. ADMINISTRATION OF THE PROJECT

1. The Chief Executive Officer for Health, as the Project Director, will bear overall responsibility for the administration and implementation of the Project.

2. Director of CentEast Health Service, as the Project Manager, will be responsible for the managerial and technical matters of the Project.

3. General Manager of Community Health, CentEast Health Service, as the Assistant Project Manager, will assist the Project Manager with its managerial and technical matters of the Project.

3. The Japanese Experts Team will provide necessary recommendations and advice to the Project Director and the Project Manager on any matters pertaining to the implementation of the Project.

4. The Japanese experts will give necessary technical guidance and advice to the Fiji counterpart personnel on technical matters pertaining to the implementation of the Project.

5. For the effective and successful implementation of technical cooperation for the Project, a Joint Coordinating Committee will be established whose functions and composition are described in Annex VI.

V. JOINT EVALUATION

Evaluation of the Project will be conducted jointly by JICA and the Fiji authorities concerned, at the middle and during the last six months of the cooperation term in order to examine the level of achievement.

VI. CLAIMS AGAINST JAPANESE EXPERTS

The Government of Fiji undertakes to bear claims, if any arises, against the Japanese experts engaged in technical cooperation for the Project resulting from, occurring in the course of, or otherwise connected with the discharge of their official functions in Fiji except for those arising from the willful misconduct or gross negligence of the Japanese experts.

VII. MUTUAL CONSULTATION

There will be mutual consultation between JICA and the Fiji Government on any major issues arising from, or in connection with this Attached Document.

VIII. MEASURES TO PROMOTE UNDERSTANDING OF AND SUPPORT FOR THE PROJECT

For the purpose of promoting support for the Project among the people of Fiji, the Government of Fiji will take appropriate measures to make the Project widely known to the people of Fiji.

IX. TERM OF COOPERATION

The duration of the technical cooperation for the Project under this Attached Document will be three (3) years from 1 April, 2005.

ANNEX I	MASTER PLAN
ANNEX II	LIST OF JAPANESE EXPERTS
ANNEX III	LIST OF MACHINERY AND EQUIPMENT
ANNEX IV	LIST OF THE FIJI COUNTERPART AND ADMINISTRATIVE PERSONNEL
ANNEX V	LIST OF LAND, BUILDINGS AND FACILITIES
ANNEX VI	JOINT COORDINATING COMMITTEE

ANNEX I

MASTER PLAN

1. Objectives of the Project

(1) Overall Goal:

Quality of community health services by community health nurses is improved in Central Division.

(2) Project Purpose:

Management skills and competence of community health nurses are reinforced through in-service training in Central Division.

2. Outputs

(1) Role and function of community health nurses are redefined.
(2) Supervisors' knowledge for in-service training is reinforced.
(3) In-service training for community health nurses functions in each sub-division.
(4) Project model of in-service training is presented to other divisions/countries.

3. Activities of the Project

(1) Role and function of community health nurses are redefined.
   1) Review and revise the Position Description (PD) for community health nurses, health sisters, senior health sisters and sub-divisional health sisters.
   2) Establish the Competency Requirement Standard (CRS) for community health nurses.
   3) Develop and distribute handbook for community health nursing management.

(2) Supervisors' knowledge for in-service training is reinforced.

1) Form the in-service training task force in each sub-division.
2) Implement trainers' training in human resource development for sub-divisional medical officers, senior health sisters and health sisters.
3) Define prioritized training needs within each sub-division.
4) Develop annual in-service training schedule for community health nurses at sub-divisional level.

(3) In-service training for community health nurses functions in each sub-division.

1) Conduct regular training for community health nurses by the task force.
2) Conduct individual consultation.
3) Conduct monitoring for in-service training within each sub-division.
4) Develop and distribute materials for in-service training.

(4) Project model of in-service training is presented to other divisions/countries.

1) Publish reports for in-service training
2) Present progress and results at conferences/meetings.
3) Conduct seminars or workshops at divisional, national and regional level for mutual exchange and dissemination of the Project model.

ANNEX II

LIST OF JAPANESE EXPERTS

1. Long-term experts
   (1) Chief Advisor/ expert in Health Promotion
   (2) Coordinator
   (3) Others mutually agreed upon as necessary

2. Short-term experts in :
   (1) In-service Training
   (2) Community Health Management
   (3) Community Health Nurse
   (4) Others mutually agreed upon as necessary

ANNEXIII

LIST OF MACHINERY AND EQUIPMENT

The following equipment necessary for the implementation of the Project will be provided by JICA. The request for the equipment will be made through the submission of an application form (A4 form) by the Fiji side on annual basis.

1. Equipment for training activities

(1) Photocopiers

(2) Computers

(3) Printers

(4) Multi-media projectors

2. A vehicle for supervision

3. Other equipment and materials necessary for the implementation of the Project

ANNEXIV

LIST OF FIJI COUNTERPARTS AND ADMINISTRATIVE PERSONNEL

1. Project Director:
   Chief Executive Officer for Health

2. Project Manager:
   Director of CentEast Health Service

3. Assistant Project Manager:
   General Manager of Community Health, CentEast Health Service

4. Technical Counterpart:
   (1) Manager Nursing Services Central, CentEast Health Service
   (2) Chief Medical Officer CentEast, CentEast Health Service
   (3) National Nursing Advisor, Division of Nursing and Health System Standard, Ministry of Health

5. Administrative personnel:
   (1) Driver
   (2) Other personnel mutually agreed upon as necessary

ANNEX V

LIST OF BUILDING AND FACILITIES

1. Sufficient space for the implementation of the Project
2. Offices and necessary facilities for the Japanese experts
3. Facilities such as electricity, gas and water, sewage system, telephones and furniture necessary for the activities of the Project
4. Other facilities mutually agreed upon as necessary

ANNEXVI

JOINT COORDINATING COMMITTEE

1. Function

   The Joint Coordinating Committee will meet at least once a year and whenever necessity arises, and work:

   (1) To authorize the annual work plan of the Project;
   (2) To review the overall progress of the Project as well as the achievements of the above-mentioned annual work plan;
   (3) To review and exchange views on major issues arising from, or in connection with, technical cooperation; and
   (4) Other relevant issues relating to the implementation of the Project

2. Composition

   (1) Chairperson:

   Chief Executive Officer for Health

   (2) Members:

   Fiji Side

   1) Director of CentEast Health Service
   2) Director of Nursing and Health System Standard, Ministry of Health
   3) Director of Public Health, Ministry of Health
   4) Director of Corporate Service, Ministry of Health
   5) Director of Health Service Development, Ministry of Health
   6) General Manager Community Health, CentEast Health Service
   7) Official of Ministry of Foreign Affairs
   8) Official of Ministry of Finance and National Planning
   9) Official of Public Service Commission

Japanese Side

1) Resident Representative of JICA Fiji Office
2) Japanese Experts assigned to the Project

Observer

1) Official(s) of Embassy of Japan in Fiji
2) Other personnel invited by the Chairperson

4．実施協議議事録（M/M）
（PDM、PO、プロジェクト・ドキュメント添付）

MINUTES OF MEETINGS
BETWEEN
THE JAPAN INTERNATIONAL COORPERATION AGENCY
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE REPUBLIC OF THE FIJI ISLANDS

The Japan International Cooperation Agency (hereinafter referred to as "JICA"), through its Resident Representative of JICA Fiji Office, exchanged views and had a series of discussions with the authorities of the Republic of the Fiji Islands with respect to desirable measures to be taken by JICA and the Government of Fiji for the successful implementation of the Project for In-service Training of Community Health Nurses (hereinafter referred to as "the Project").

As a result of the discussions, JICA Fiji Office and the Fiji authorities concerned (hereinafter referred to as "both sides") agreed upon the matters referred to in the document attached hereto. This document is related to the Record of Discussions on the Project signed by JICA and the Fiji authorities concerned.

Suva, March 22, 2005

Mr. Tadashi IKESHIRO
Resident Representative
Fiji Office
Japan International Cooperation Agency
JAPAN

Dr. Lepani WAQATAKIREWA
Chief Executive Officer
Ministry of Health
REPUBLIC OF THE FIJI ISLANDS

THE ATTACHED DOCUMENT

1. PROJECT DESIGN MATRIX

The Project Design Matrix (hereinafter referred to as "PDM") was elaborated through discussions between JICA and the Fiji authorities concerned. Both sides agreed to recognize PDM as an important tool for project management, and the basis of monitoring and evaluation of the Project. The PDM will be utilized by both sides throughout the implementation of the Project.

The PDM will be subject to change within the framework of the Record of Discussions when the necessity arises in the course of implementation of the Project with the mutual consultation of both sides.

The PDM is attached in ANNEX 1.

2. PLAN OF OPERATION

The Plan of Operation (hereinafter referred to as "PO") has been formulated according to the Record of Discussions, on the conditions that the necessary budget will be allocated for the implementation of the Project by both sides. The schedule will be subject to change within the framework of the Record of Discussions when necessity arises in the course of implementation of the Project with mutual consultation of both sides.

The PO is attached in ANNEX 2.

3. PROJECT DOCUMENT

Both sides jointly have prepared the Project Document for the rationalization of the plan and justification of the Project implementation.

The Project Document is attached in ANNEX 3.

ANNEX1 PDM
ANNEX2 PO
ANNEX3 Project Document

TECHNICAL COOPEATION PROJECT

FOR

IN-SERVICE TRAINING OF COMMUNITY HEALTH NURSES

IN THE REPUBLIC OF THE FIJI ISLANDS

PROJECT DOCUMENT

TECHNICAL COOPERATION

BETWEEN

GOVERNMENT OF REPUBLIC OF THE FIJI ISLANDS

AND

THE JAPAN INTERNATIONAL COOPERATION AGENCY

Table of Contents

Abbreviation List

AusAID	Australian Agency for International Development
EPI	Expanded Program of Immunization
IMCI	Integrated Management of Childhood Illness
IUD	Intra-Uterus Contraceptive Device
JICA	Japan International Cooperation Agency
JOCV	Japan Overseas Cooperative Volunteers
MCH	Maternal and Child Health
MOH	Ministry of Health
NCD	Non-Communicable Diseases
NGO	Non-governmental Organization
PacELF	Elimination of Lymphatic Filariasis in the Pacific
PCM	Project Cycle Management
PIF	Pacific Island Forum
PHC	Primary Health Care
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNICEF	United Nations International Children's Emergency Fund
USP	University of the South Pacific
WHO	World Health Organization

1. INTRODUCTION

The Government of Japan hosted the Pacific Islands' Leaders Meeting (PALM) in 2000, inviting representatives from 16 countries and regions of the South Pacific Forum (SPF). The meeting promoted partnership between Japan and the Pacific Islands Countries (PICs) and produced 'Miyazaki Initiative' that promotes long-term cooperation for sustainable development and regional issues.

In May 2003, the "Okinawa Initiative: Regional Development Strategy for a More Prosperous and Safer Pacific" was adopted at the Japan-Pacific Islands Forum Summit Meeting (PALM 2003). Under this initiative, a regional development strategy was established and a joint action plan to realize sustainable development was formulated. Better health is one of the five priority targets.

The Japan International Cooperation Agency (JICA) has implemented a national training course entitled "Community Health Administration" in Okinawa Prefecture in Japan as a follow-up activity of the 'Miyazaki Initiative.' Leaders of nursing officers from Pacific countries were invited to Okinawa to share experiences of community health development and personnel development with health officers in Okinawa, which has a great geographic similarity with island nations.

After PALM 2003 held in Okinawa, a fact-finding study team was dispatched by JICA to Fiji in October 2003 to formulate a technical cooperation Project in human resource development in the health sector, which will use the results obtained in the Community Health Administration course. Based on the recommendations of the above team, the Government of Fiji requested from the Government of Japan to implement a Project targeting the empowerment of community health nurses in Fiji.

The Government of Japan accepted the request, and a long-term expert was dispatched to the Ministry of Health (MOH) by JICA in June 2004, formulating a detailed plan of the Project. In September 2004, a preparatory study team was dispatched to discuss the framework of the Project entitled "Technical Cooperation Project for In-service Training of Community Health Nurses." The study team conducted field surveys and held a series of discussions on the Project with authorities and stakeholders in Fiji. Finally, in November 2004, a short-term expert, who is in charge of preparing the ex-ante evaluation and the Project Document, was dispatched to assess the necessity and relevance of the Project.

The Project Document is elaborated through collaboration and consultation among the staff of the related directorates in the MOH, JICA Fiji Office and JICA experts, based on the draft Project Design Matrix (PDM) and Plan of Operation (PO).

The Project Document aims to:

1) Clearly describe the socio-economic status, development policy, health sector issues, and community health nursing issues in Fiji;
2) Explain the rationale of the Project; and
3) Provide a basis for implementing the Project throughout the Project life cycle.

2. BACKGROUND OF THE PROJECT

2-1 Socio-economic Context

2-1-1 Political trends

(1) Geography and Population

The Fiji Islands is a republic comprising more than 300 islands covering 18,272 km^2. Fiji lies at the crossroads of the Pacific Ocean, and is referred to as the hub of the South Pacific as it lies on the main sea and major air transport route in the region. In 2003, the population was estimated to be approximately 860,000, 75% of whom live in Viti Levu Island. The Western Division in Viti Levu has the largest population among the four divisions in the country. Approximately 51% of the population is Fijian, and 44%, Indian.

Table 1 Population by division and by racial group (2003)

	Central		Eastern		Western		Northern		Total	
Fijians	196,425	60%	39,911	91%	129,178	38%	72,891	46%	438,405	50%
Indians	105,208	32%	650	1%	203,163	60%	75,312	47%	384,333	44%
Others	23,714	7%	3,098	7%	7,607	2%	10,143	7%	44,562	6%
Total	325,347	100%	43,659	100%	339,948	100%	158,346	100%	867,300	100%

Source : Ministry of Health (MOH)

(2) History

After Fiji became a British colony in 1874, more than 60,000 Indian laborers were brought to Fiji to work on the plantations. From independence in 1970 to early 1987, the government has been dominated by indigenous Fijians, the ethnic conflicts on the issues of land and political rights worsened, and in 1987, the army staged coups. Although the 1998 Constitution aimed at reconciliation of the two ethnic groups, a civilian coup took place with the support of soldiers who stormed the parliament in 2000. A general election was held in 2001, and the need to establish a new Constitution for good governance has been recognized.

(3) Foreign Policy

The relationship with Australia and New Zealand is close, while Fiji is trying to strengthen relations with South East Asian countries in its "Look North" policy. Fiji plays a very important role in the South Pacific Forum, assisting its neighboring countries in their development. The capital city, Suva, has a number of offices of regional and international organizations such as the Pacific Islands Forum, University of the South Pacific.

2-1-2 Economic trends

(1) General Features

Fiji's economy has diversified away from its initial dependence on agriculture. Today, tourism, sugar and textiles are the main industries, and GDP per capita reached US $ 2,300 in 2002. The economy suffered collapse in the aftermath of the military coups and the political crises of 1987 and 2000. However, it has now recovered, the GDP increasing by 4.4% in 2002 mainly due to improvement of the tourism sector. Australia is Fiji's biggest trading partner accounting for 60% of Fiji's total trade. The unemployment rate reached 14% in 2001.

(2) Income Distribution and Poverty

According to the Fiji Poverty Survey conducted by the Fiji government and UNDP, the proportion of people living below the poverty line was estimated to be 25%. Sixty percent of households living in extreme poverty are engaged in agriculture. The most vulnerable group is landless sugarcane laborers, most of whom are Indian. Although the government implements a social security system such as the Family Assistance Allowance and Poverty Alleviation Fund, mutual aid in communities and families works well as a social safety net.

The following table indicates average household income by sub-division in 1995. Central Division[1], the target area of the Project, has a relatively high income level, but there is no wide income disparity by division.

Table 2 Average weekly household income by sub-division (1995, Fiji $)

	Sub-division	Division	Household income		Sub-division	Division	Household income
1	Rewa	Central	73	8	Serua	Central	38
2	Ra	Western	51	9	Namosi	Central	37
3	Ba	Western	47	10	Lau	Eastern	34
4	Kadavu	Eastern	42	11	Nadroga	Western	33
5	Lomaiviti	Eastern	41	12	Tailevu	Central	33
6	Naitasiri	Central	39	13	Bua	Northern	32
7	Macuata	Northern	39	14	Cakaudrove	Northern	30

Source : Atlas of Fiji, University of South Pacific

2-2 Description of the Health Sector

2-2-1 Disease Patterns

Since Fiji's female educational indicators are favorable such as the female literacy rate being 91%, the natural population increase rate is low at 1.3% in 2002. In addition, due to brain drain and military coups, outward migration has been increasing. The infant mortality rate has been decreasing, from 41 in 1975 to 17 in 2002, which shows a better health situation than Samoa and all but New Zealand and Australia among the Pacific islands countries.

Table 3 Trends in basic health indicators[2]

	1988	1999	2000	2001	2002
Population	749,849	845,033	854,796	861,003	872,985
Infant mortality rate	19.7	17.2	16.2	15.4	17.7
Maternal mortality rate	60	40	57	40	35
% of women using contraceptive methods	36%	40%	43%	44%	36%

Source : MOH

[1] Central Division has high proportion of Fijians and a high population density. As for the health sector, Central Division has relatively richer health resources than other three divisions due to its access to the capital city where the MOH, Fiji School of Nursing and many hospitals are located.

[2] Since Fiji is a small country with a population of 850,000, difference in health situation and disease patterns by division is not clear. For example, infant mortality rate by division shows that trends in infant mortality change year by year. Due partly to insufficient health information system, finding health statistics by division is difficult

Today, the percentage of pregnant women attended to by trained personnel is 98%, while few women use traditional birth attendance (TBA); thus, the maternal mortality rate has been improved. Gender disparity is not seen among health and educational indicators.

Table 4 Health indicators

Population growth rate	Urban population rate	TFR	Life expectancy	% of women attended by health personnel	Access to safe water	Literacy rate
2002	2002	2002	2001	1998	2000	2001
1.35	52%	3.05	69.3	98%	85%	93%

Source : WHO

One of the health challenges Fiji faces is an increasing prevalence of non-communicable diseases (NCD), such as hypertension and diabetes. These increases are due to changes in lifestyle, physical activity levels, eating patterns and smoking habits. Although many developing countries now face the same problem, the situation where more than 80% of deaths are due to NCD is striking, specific to the South Pacific.

Table 5 Trends in leading cause of death

	1996	1997	1998	1999	2000
1	Circulatory diseases	Circulatory diseases	Circulatory diseases	Circulatory diseases	Circulatory diseases
2	Endocrine & metabolic diseases	Endocrine & metabolic diseases	Endocrine & metabolic diseases	Neoplasm	Injury & poisoning
3	Neoplasm	Respiratory diseases	Neoplasm	Injury & poisoning	Neoplasm
4	Respiratory diseases	Neoplasm	Respiratory diseases	Infectious parasitic diseases	Infectious parasitic diseases
5	Infectious parasitic diseases	Infectious parasitic diseases	Injury & poisoning		

Source : Strategic Plan 2003-2005, MOH

Table 6 Major cause of hospitalization

	1991	1995	1996	1997	1998
1	Circulatory diseases	Respiratory diseases	Circulatory diseases	Respiratory diseases	Infectious parasitic diseases
2	Respiratory diseases	Circulatory diseases	Injury & poisoning	Circulatory diseases	Respiratory diseases
3	Injury & poisoning	Injury & poisoning	Respiratory diseases	Injury & poisoning	Circulatory diseases
4	Genitourinary	Genitourinary	Digestive diseases	Digestive diseases	Injury & poisoning
5	Digestive diseases	Digestive diseases	Genitourinary	Infectious parasitic diseases	Genitourinary

Source : Annual Report 1997&1998, MOH

2-2-2 Health Administration

The Ministry of Health has four divisions. The ministry is currently implementing decentralization in cooperation with AusAID since 1999, the organization structure has been reformed. The number of divisions and staff has decreased. The headquarters of the ministry is in charge of policy formulation and

budget allocation, while divisional Health Service is responsible for service implementation. The present management structure of the MOH is as follows:

- Public Health Division
- Nursing and Health System Standard Division
- Health Service Development Division
- Corporate Service Division

2-2-3 Health Budget

The total budget allocated to the MOH, Fiji $ 136 million in 2005, is about 8% of the total national budget and 3% of GDP. Since health is a top priority area for the government, along with education, the health budget is larger than the defense budget.

Table 7 Trends in health budget (F$)

Year	National budget	Health budget	% of Health budget
1995	820,534,500	71,057,400	9%
1996	960,724,400	78,168,700	8%
1997	1,088,657,320	86,863,450	8%
1998	1,108,256,400	84,144,950	8%

Source : Annual Report 1997&1998, MOH

Allocation of budget is determined by the budget committee, composed of the headquarters and directors of divisional Health Service. Budget allocation for each division is decided based on requests to headquarters.

The budget for in-service training, F$ 440,000 in 2004, is included in the policy and administration program. This amount includes expenditure for post-graduate programs of both the Fiji School of Nursing and Fiji School of Medicine, and the allocation is small for in-service training.

Table 8 Breakdown of health budget in 2004

Items	Amount (1,000F$)	%
Established staff	59,118	48.8%
Unestablished staff	11,338	9.4%
Goods and services	21,925	18.1%
Value-added Tax (VAT)	13,384	11.0%
Capital construction	4,963	4.1%
Capital purchase	3,281	2.7%
Others	7,174	5.9%
Total	121,173	100.0%

Source : MOH

Table 9 Breakdown of health budget by program in 2004

Programs	Activities	Amount (1000F$)	%
Policy and administration	General	7,708	6.4%
	Research	709	0.6%

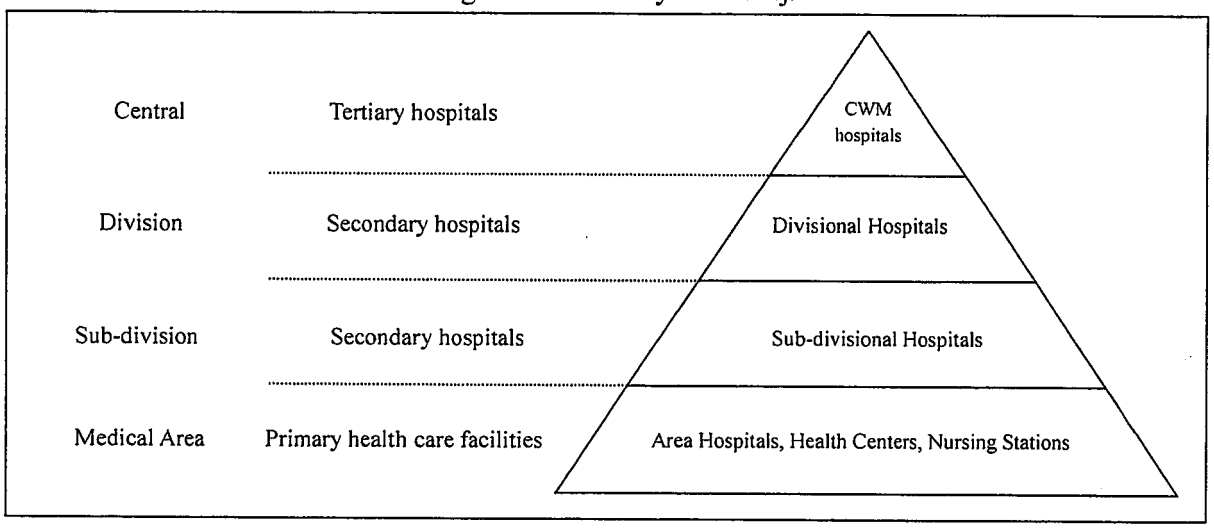
Health services	Urban hospitals	55,665	45.9%
	SD Hospitals, HCs, Nursing stations	33,200	27.4%
	Public health services	4,083	3.4%
	Drugs and medical supplies	14,575	12.0%
Common services	Hospital support services	1,557	1.3%
	Fiji school of nursing	2,983	2.5%
Institutional services	Old people's home	689	0.6%

Source : MOH

2-2-4 Health Service Provision

The referral system, indicated in the following diagram, functions well in Fiji. Central Division has a Colonial War Memorial Hospital (CWM hospital), which, with the divisional hospital of Central Division, is the top referral hospital. Sub-divisional hospitals are mainly responsible for MCH services, internal medicine and first aid.

Diagram 1 Referral system in Fiji



2-3 National Strategies of Fiji

The vision of the Strategic Development Plan 2003-2005 is "Peaceful and Prosperous Fiji." Its strategies are as follows:

a) Strategies for stability
- **Alleviating poverty (improving access to Health Service)**
- Enhancing security and law and order
- Promoting national reconciliation and unity
- Strengthening good governance
- Reviewing the constitution
- Resolving the agricultural land lease issue
- Implementing affirmative action

b) Strategies for growth
- Maintaining macro-economic stability
- Raising investment levels for jobs and growth

- Reforming the public sector to reduce the cost of conducting business
- **Rural and outer island development (strengthening community Health Service)**
- Structural reforms to promote competition and efficiency

Corporate Plan 2005 formulated by the MOH has five strategies as follows:

1) Provision of health services
2) Protection of health
3) Promotion of health
4) People in health
5) Productivity in health

2-4 Past, Current Projects/Assistance

Japan is the main donor in Fiji whose total amount of development assistance was US$18 million in 2002. AusAID, the major donor in the health sector in Fiji, emphasizes macro policy formulation and health promotion activities at community level.

2-4-1 Japan

Since the establishment of the JICA Fiji office in 1984, JICA has been supporting the development of Fiji by dispatching experts and JOCV. Since the income level of Fiji is high, grant aid cooperation is conducted only for regional Projects that benefit neighboring poorer nations.

Table 10 Past cooperation by JICA and grant aid by Government of Japan (All sectors)

Modules	2003	2002	2001	2000	Total amount up to 1999
Technical cooperation (million yen)	989	780	960	760	14,880
No. of training in Japan	83	92	94	75	1,273
No. of experts	8	15	8	11	244
No. of development studies	18	20	48	14	606
No. of JOCV	14	24	20	15	224
No. of senior volunteers	13	15	9	7	6
Equipment (million yen)	74	46	65	70	1,782
Grant aid (million yen)	-	1,059	54	-	12,763

Source : JICA

Past Japanese assistance for the health sector

1) Grant aid
   Construction of Fiji School of Nursing (1984)
   Construction of CWM hospital (1991)
   Construction of pediatric ward of CWM hospital (1998)
   Construction of Pharmaceutical service center (2002)
2) Dispatch of Experts
   Epidemiology (1995-1998)
   TB Control Programme (2003-2005)

3) Provision of Medical Equipment
   1995: Vehicles for mobile clinic, etc
   1998: Vaccine, Hypodermic syringe, etc (for PacELF)
4) Area-focused training course in Japan for community health administration course as follow-up of PALM (2000-2004)
5) Grass-roots grant aid (total F$813,000 for 13 Projects, 1999-2004)
   Provision of generator (Tavua hospital, 1999)
   Provision of ambulance [3](St. John Ambulance, 2001)
   Provision of ambulances and radio telephone (Fiji Red Cross, 2002)
   Provision of medical equipment (CWM hospital, 2004)

2-4-2 AusAID

AusAID implemented a Project for health sector reform from 1999 to 2004, and is currently supporting capacity building for decentralized Health Service as a part of the Fiji Health Sector Improvement Program.

As for nursing education, AusAID supports revising the curriculum of the Fiji School of Nursing and capacity building of lecturers, and also supports community-level health activities including community health nurses. The past and current Projects of AusAID are as follows:

1) Health Management Reform Project (1999-2004, Aus$9 million)
   Objectives: Improvement of health services by strengthening management capacity for decentralization
   Activities: Organization reform and human development for integration of medicine and community health
2) Taveuni Sub-Division Community Health Project (1999-2004, Aus$11 million)
   Objectives: Improvement of community health through community participation
   Activities: Strengthening of PHC, improvement of health management, human development
3) Fiji Health Sector Improvement Program: FHSIP (2004-2009, Aus$25 million)
   Objectives: Improvement of health system for health promotion of the whole nation
   Activities: Capacity building for decentralized health system
   AusAID implements the community health development component in Tailevu and Serua/Namori sub-division, the target area of the JICA Project for two years.

2-4-3 WHO

WHO has been providing technical support to all PICs through the Western Pacific Regional Office in Manila and the Fiji Office in Suva. The target areas in Fiji are EPI, infectious disease control including TB, HIV/AIDS, NCD, IMCI, reproductive health, and health sector reform. WHO and JICA have been assisting PIC immunization programs by providing vaccines and eliminating filariasis. In addition, a Japanese expert has been dispatched by JICA to join TB control of WHO in the region.

2-4-4 SPC (Secretariat of the Pacific Community)

SPC is an international organization whose mission is improving living standards in the Pacific region. Today, 27 countries have joined the SPC, its branch office is in Suva, and it covers public health. A public health program has been implemented since 2003 for two years in Fiji and is expected to contribute to strengthening the management of health workers.

[3] Transportation fee for sending ambulances from Japan to Fiji was provided by Grant Aid.

3. PROBLEMS AND THE CURRENT SITUATION OF THE HEALTH SECTOR

3-1 Institutional Framework for the Sector

3-1-1 Organization of the MOH

(1) Divisional Health Service

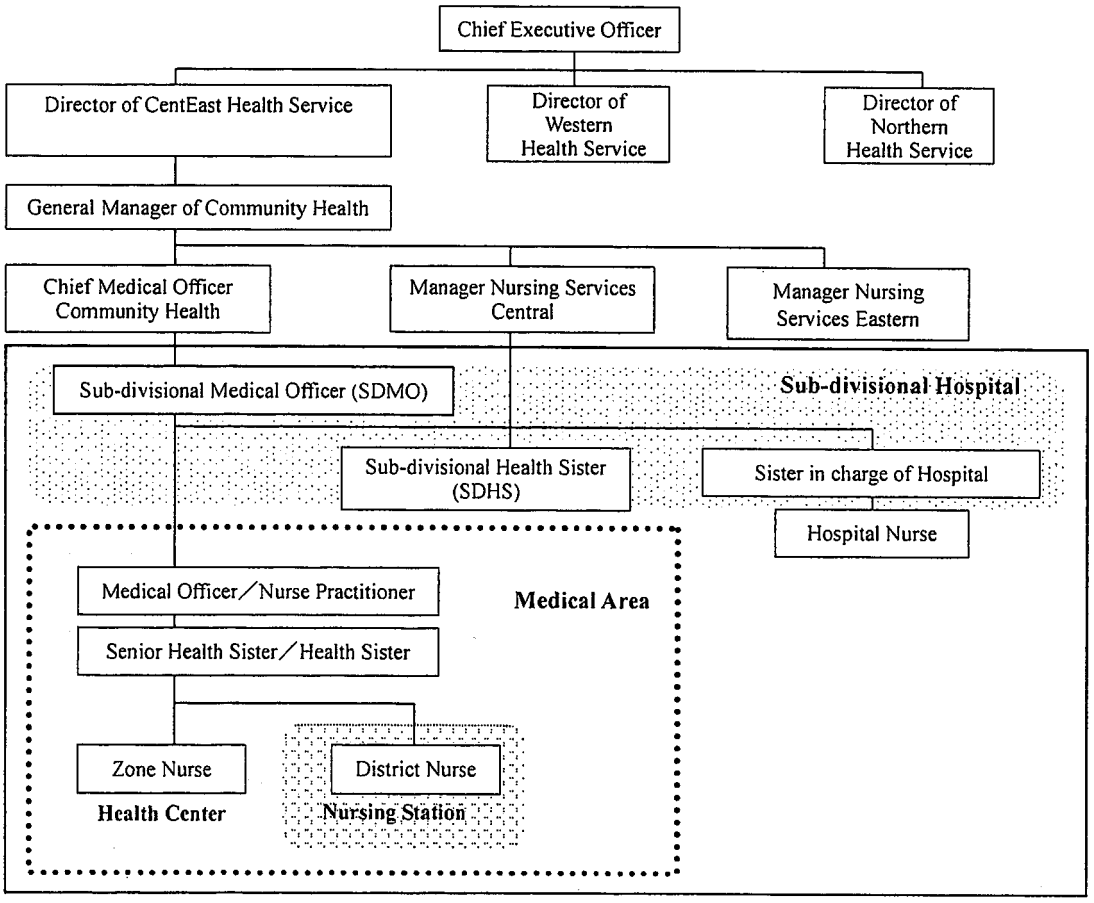
The MOH has three divisional health Service i.e. CentEast, Western, and Northern, which are responsible for health administration below geographical divisional level. The director of the divisional health service covers both medical and public health services. Manager nursing services, under the general manager of community health, administrate nurses in each sub-division. Regarding human resource development for community health nurses, the responsibilities of the MOH and divisional Health Service are shown in Table 11.

Table 11 Responsibilities for human resource development

MOH	Divisional Health Service
1. Formulation of workforce strategy 2. Formulation of national human development plan 3. Employment of foreign doctors 4. Coordination with private sector 5. Health management reform 6. Formulation of national training plan 7. Development of personnel reporting system	1. Administration of staff 2. Employment of staff 3. Management of personnel reporting system 4. Formulation of divisional training plan 5. Implementation of trainings and workshops

Source : MOH

Diagram 2 : Organization of divisional health service of the MOH



The budget for CentEast Health Service for 2004 was F$44,024,388, which was 36% of the total health budget. Expenditure for the operation of health services accounts for 87% of the budget. The training budget for CentEast was F$44,024 in 2004. The MOH Central Office used to plan, implement and monitor training programs, but divisional Health Service will also plan training programs of their own from 2005 fiscal year.

(2) Sub-divisional level

Central Division has five sub-divisions, and health services in each sub-division are administrated by sub-divisional medical officers (SDMO) who also work as heads of sub-divisional hospitals and community health services. Sub-divisional health sisters (SDHS) under SDMO and manager nursing services administrate community health nurses in each sub-division. Dispensaries are established at nursing stations, and community health workers provide first aid and medicine.

3-1-2 Responsibilities of Community Health Nurses

(1) Duties of nurses

In Fiji, there are community health nurses and clinical nurses.

Table 12 Duties of nurses

	Community health nurse	Clinical / hospital nurse
Duties	Providing community Health Service including OPD activities	Providing clinical services
Place of work	Health centers, nursing stations	Hospitals

SDHS, senior health sister, health sister are leaders who train community health nurses, and these leaders have to be qualified as follows.

Table13 Qualifications of community health nurses

Position	Grade / Salary	Qualifications
Staff Nurse	NU06	1. Certification as General and Obstetric Nurse is essential. 2. Preferable to be a qualified midwife and have a certificate in Public Health Nursing. 3. Preferable to have 2-3 years' experience as a clinical nurse.
Health sister	NU05 F$14,766 ~17,361	1. Qualifications required for appointment as a Staff Nurse and with a minimum of five years post-registration experience. 2. Certification in Public Health Nursing or Midwifery is essential, Midwifery is essential for Maternal Health Sister post. 3. For posts in specialized areas, a minimum of three years' experience in that discipline is essential. A relevant graduate qualification and with a minimum of three years' post-registration experience may also be considered. 4. Consistently good reports and assessed ability to supervise staff and manage resources.
Senior health sister / SDHS	NU04 F$17,248~ 20,048	1. Qualifications required for appointment at NU05 level with 3 years' successful experience in that level. 2. Consistently good reports and ability to contribute at supervisory level.

Source : Information on staff employment, MOH

(2) Activities of Community Health Nurses

Nurses who graduate from the Fiji School of Nursing are posted to a hospital, health center, or nursing station, and are expected to experience both clinical and community health service. In general, young nurses are assigned to remote areas and move to other areas in a few years. Community health nurses tend to be assigned for more years in one place.

Table 14 Activities of health centers and nursing stations

	Health centers	Nursing stations
Population in catchments area	Average 5,000 people (5～10 villages)	Average 2,000 people (located in remote area)
Full-time staff	Doctors or nurse practitioner, SDHS (only in Suva), community health nurses	One community health nurse
Activities	Primary medical service, dental service, MCH, Diabetes checkup	Primary medical services (unable to prescribe antibiotics), MCH

Note : Population in each catchment area in Central Division has a wide gap between 2,987 and 57,708.

The main activities of community health nurses are as follows. Only in Suva, Rewa sub-division which have relatively large populations, are school health nurses assigned.

- MCH services
- Immunization
- Health education
- Family planning
- School health
- Home-based care for patients with mentally illness, patients with leprosy and patients with TB
- Care for the elderly
- NCD screening for diabetes and hypertension
- Training of community health workers
- Coordination with communities

Community health nurses and supervisors in each sub-division are expected to have a monthly meeting, but not all sub-divisions hold the meeting regularly. In addition, nurses working in nursing stations are relatively young and need training. However, support for these young nurses is decided by the supervisors, and the training program has not yet been standardized.

Table 15 No. of health facilities by division (2002)

	Central	Eastern	Western	Northern	Total
Divisional hospital	1	0	1	1	3
Specialized hospital	3	0	0	0	3
Sub-divisional hospital	4	4	5	3	16
Area hospital	1	2	1	1	5
Total No. of beds	637	90	516	284	1,527
Health center	19	12	26	18	75
Nursing station	21	33	25	21	100
Population per nurse*	1394	347	1110	974	1039

Note: including clinical nurses Source : CentEast Health Service

Table 16 No. of health facilities in Central Division by sub-division (2003)

Sub-division	Population	Sub-divisional hospital	Area hospital	Health center	Nursing station
Suva	186,308	0	0	7	3
Rewa	69,174	0	1	3	5
Tailevu	21,704	1	0	3	4
Naitasiri	22,692	1	0	3	5
Serua/Namosi	24,592	1	0	4	3
Total	324,470	3	1	20	20

Source : CentEast Health Service

3-1-3 Training system of nurses

(1) Fiji School of Nursing (FSN)

1) Curriculum

FSN is the only governmental nursing school in Fiji, and was established in 1894. At present, FSN has a basic nursing course, nurse practitioner course, public health nursing course, nurse management course and midwifery course. Community nursing practice for the basic nursing course is implemented for five weeks in the second year and for ten weeks in the third year. Due to the shortage of medical doctors, nurses are trained to provide a variety of medical and health service.

Table 17 Curriculum of Fiji School of Nursing (2004)

Courses	Qualification	Period	Quota	Certificate	Remarks
Basic Nursing	High school graduation	3 years	110～200	Diploma	Quota for 2003 was 200, curriculum was revised in 2004
Public health nursing	3 years' experience after registered as nurse	6 months	10～15	Certificate	Lectures & seminars for physical assessment given for 10 weeks
Midwifery	5 years' experience after registered as nurse	7 months	25～40	Certificate	
Nurse practitioner[4]	Registered nurse or Registered midwife	1 year	10～12	Advanced diploma	Established in 1999, posted to health centers after graduation
Nursing management		9 months	25～35	Certificate	Lectures given by telephone-conference twice a week

2) Postgraduate education

As shown in Table 17, although postgraduate courses are implemented, a systematic training program for career development has not been established. In addition, most training conducted at each division is concentrated on vertical programs. Although community health nurses have many opportunities to join training planned by both the MOH and donors, it is difficult to learn management skills for community health service at present. In addition, not all sub-divisions conduct monthly meetings in practice.

[4] This job title was introduced in 1999 to supplement the shortage of doctors. Since the main duties of nurse practitioners are OPD activities, they will not be a target of the Project.

Table 18 Annual training plan for community health nurses in CentEast Health Service

Course title	No. of days	No. of participants
Nursing standards and their revision	2	18
Coaching	2	18
Program development of training for supervisors	3	20
Emergency medical care (including drip treatment)	na	20
Training for cervical cancer examination	3	20
IUD insertion	3	14
HIV/AIDS infection control	3	na
Case control for STI	2	10

Source: CentEast Health Service

3-2 Analysis of the Current Situation and Problems

3-2-1 Resignation of nurses

In Fiji, the outward migration of medical doctors to Australia and New Zealand is increasing because of poor working conditions and living standards. Since there is a shortage of nurses in Australia, nurses also migrate from Fiji. It seems that most nurses who migrate are those who have longer experience as clinical nurses than community health nurses.

As indicated in Table 19, 39 posts for clinical doctors are vacant. Due to the shortage of doctors, the government employs foreign doctors. Since doctors prefer to work in urban areas, there are few doctors who work on the islands. Therefore, the role of community health nurses, responsible for health activities in remote areas, is becoming increasingly important.

Table 19 No. of norm and filled posts of doctors working in hospitals (2004)

Division	norm	No. of filled posts
CentEast	104	85
Western	66	54
Northern	32	25
Total	206	167

Source : MOH

Table 20 Health manpower by division (2004)

	Central	Eastern	Western	Northern	Total
Medical doctors	157	10	126	49	342
Dentists	18	2	14	10	44
Nurses	680	Included in Central	437	244	1361
Pharmacists	30	0	19	11	60
X-ray technicians	33	2	17	5	57
Lab technicians	67	3	32	18	120
Doctors in private sector	44	0	31	6	81

Source : MOH, Fiji College of General Practitioners

CentEast Division has most serious shortage of nurses as the following table shows; the shortage is severe in island areas, i.e. Eastern Division.

Table 21 No. of norm and filled posts for nurses (including clinical nurses, 2004)

	Norm	Filled posts	Short/Over
CWM hospital	352	357	5 over
Lautoka divisional hospital	200	187	13 short
Labasa divisional hospital	97	104	7over
CentEast Health Service	321	279	42 short
Western Health Service	244	249	5 over
Northern Health Service	115	139	24 over
Old peoples' home	8	4	4 short

Source : CentEast Health Service

3-2-2 Importance of In-service Training

A problem faced by community health nurses is the wide variety of their jobs. Most of nurses are in charge of 10 to 20 villages for both health promotion and provision of primary care services. In addition, they have to make eight types of report such as population, MCH activity, and OPD, without having the opportunity to learn information management.

Problems of activity of community health nurses are as follows:

- Only one nurse with a little experience is sometimes assigned at a nurse station.
- Data collection and analysis is insufficient due to lack of information management skill.
- Both supervisors and community health nurses have not acquired health planning skill well.
- Training for management of community health has not yet been implemented,
- Content of monthly meetings varies with supervisors in each sub-division.

In-service training develops community health nurses' essential skills and ability to implement community health activities. Today, there is a wide diversity of community health activities with the change in health needs in Fiji. Community health nurses are expected to have abilities such as the assessment of people's health needs, planning necessary action, and monitoring and evaluation of activities. Abilities that community health nurses are expected to acquire are as follows:

- planning
- information management and research
- management for Project implementation
- support for individuals, families and groups
- teamwork, coordination, mobilization of social resources
- evaluation

The expected level of these abilities should be clearly defined based on experience and position.

In Fiji, the role of community health nurses in community development has not been clearly defined. There is a wide gap between the expected capacity and the real situation. Insufficient leadership of supervisors, insufficient knowledge of community development, and limited management training are bottlenecks among community health nurses. Supervisors who have enough experience in nursing cannot undertake coaching because they have not acquired community development skill. Young nurses who have learned the necessary skills at nursing school lack experience in practice. The existing meetings both for supervisors and community health nurses have not worked well in refreshing their skills on these issues.

4. PROJECT DESIGN

4-1 Outline of Project Design

The MOH has implemented organization reform and capacity development of both the headquarters and divisional health services for health decentralization with support from AusAID. The Project will contribute to strengthening decentralization at community level by supporting the activities of community health nurses who work as front-line health workers. The main objective of the Project is human resource development, which is a strategic goal of the MOH National Strategic Plan, focusing on the capacity development of community health nurses.

In-service training for this Project aims to establish regular learning opportunities that provide the necessary skills for implementing their jobs. Post-graduate courses such as those conducted at the Fiji School of Nursing will not be the target of this Project.

In-service training of community health nurses is planned by sub-divisional health service and implemented by SDHS under the supervision of SDMO. The Project will improve the capacity of community health nurses by strengthening the leadership of supervisors. Before establishment of in-service training, the Project redefines the role and function of community health nurses (Output 1), and strengthens supervisors' knowledge for training (Output 2). Then, in-service training will be implemented to establish the in-service training system (Output 3), and the Project will support establishing this training as a system in each sub-division. In addition, the process and outputs are expected to be introduced to other divisions and countries as a model of in-service training for front-line Health Service (Output 4).

4-2 Implementation Structure

4-2-1 Project Operation Unit (POU)

The Project office will be set up in the office of CentEast Health Service, which will implement the Project. POU will be established for the daily management of the Project activities. The members of POU are as follows:

- Project manager: Director of CentEast Health Service
- Assistant Project Manager: General manager of community health, CentEast Health Service
- Counterparts: Chief Medical Officer (Community Health), CentEast Health Service
  Manager Nursing Services Central, CentEast Health Service
  National Nursing Adviser, Nursing and Health System Standard Division, MOH
- Project Chief Adviser/ Health Promotion expert (Japanese)
- Coordinator (Japanese)

The POU is responsible for planning, implementing and monitoring the Project under the supervision of the Joint Coordinating Committee (JCC). The POU collects data on the implementation plan and progress of the Project, and submits reports to the JCC. When changes to the Project design, which may result in significant change in Project strategy, are suggested, the POU is to refer matters to the JCC. The POU joins the joint evaluation meetings organized by JICA twice for the Project duration and disseminates the progress of the Project.

4-2-2 Joint Coordinating Committee (JCC)

Members of the JCC will consist of the following officers:

1) Chair: Chief Executive Officer, MOH (Project Director)
2) Fiji members:
   - Project manager
   - Assistant Project manager
   - Director, Nursing and Health System Standard Division, MOH
   - Director, Public Health Division, MOH
   - Director, Health Service Development Division, MOH
   - Director, Corporate Service Division, MOH
   - Official of Ministry of Finance and National Planning
   - Official of Ministry of Foreign Affairs
   - Official of Public Service Commission
3) Japanese members
   - Resident Representative of JICA
   - Japanese experts assigned to the Project
4) Observers
   - Representative of the Embassy of Japan
   - Other personnel invited by the Chairperson

The JCC will be organized to provide necessary supervision and advice on matters relating to the overall direction of the Project, policy/technical aspects of the Project and coordination with other programs as needed. The JCC will review the progress and performance of the Project at least once each year. The JCC will revise the overall direction of the Project when needed.