Health promotion strategies in the Solomon Islands: Case studies of NCD management and WASH promotion in Honiara and Western Province

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Abstract

The Solomon Islands is undergoing an epidemiological transition in which it faces the double burden of noncommunicable diseases (NCDs) and infectious diseases, many of which are caused by poor water, sanitation, and hygiene (WASH) practices. Using a Rapid Rural Appraisal approach with key informant interviews, focus group discussions, and a household survey, this report analyzes perceptions from public health professionals and community members on health promotion strategies regarding NCDs and WASH-related diseases. In the study, four major case studies emerged: the Regional Eye Centre in Honiara, a sanitation project in Namoliki led by a civil society organization (CSO), a community outreach project at the Helena Goldie Hospital (HGH) in Munda, and the Rural Development Programme's borehole project in Dunde. Across the cases, three important themes emerged regarding communication, dependency, and resilience; although the cases in Honiara and Munda differ drastically in terms of funding and non-governmental organization (NGO) presence, they face similar issues in communication. In conclusion, the Munda public health workforce, although less resourced than Honiara, has a special resiliency that has enabled its health promotion strategies to be sustained.

Keywords: community outreach, community engagement, public health, health education, health promotion, disease prevention, Pacific Islands, local perceptions

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Introduction

The Solomon Islands is undergoing an epidemiological transition in which it faces the double burden of noncommunicable diseases (NCDs) and infectious diseases, many of which are caused by poor water, sanitation, and hygiene (WASH) practices (WHO and the Ministry of Health and Medical Services, 2012). While plenty of academic and grey literature acknowledge the gravity of these health concerns (Maka'a, 2017; Thompson & Miller, 2016; Wilson, 2018), there has yet to be a coordinated health promotion plan to combat these issues. The National Health Strategic Plan lays out a framework with suggestions but has not yet moved to implementation (Ministry of Health and Medical Services, 2016). Literature has called this lack of coordination a "state absence," where the retreat of the government has created a space for extra-local actors, such as civil society organizations (CSOs), to fill (Dinnen & Allen, 2016). This report argues that the State is present in both Honiara and Munda; however, there are challenges and nuances about the relationship that need to be acknowledged. With a focus on NCDs and WASH-related health in Honiara and Munda, this report uses a case-based approach to consider how CSOs and government agencies interact with each other and with local communities to employ health promotion strategies.

Academic literature on health promotion is limited in the Solomon Islands. Existing studies focus on theoretical analyses and the failures of governments and non-governmental organizations (NGOs) (Asad & Kay, 2014). They have a problems-based approach to research. This study seeks to frame the concept of government, CSO, and community relations from a grassroots perspective. By interviewing local health educators and community outreach professionals, as well as members of the communities they operate in, this study contributes to the research area by providing local perceptions of NGO, government, and church-based health promotion. It highlights the valuable experiences of those who are on the frontlines of NCD management and WASH promotion and provides a detailed account of four case studies in Honiara and Munda.

Methods

Data for Honiara was strictly qualitative and was collected through Key Informant Interviews and panels at the National Referral Hospital and SWIM in Honiara. Data for Munda was collected using the Rapid Rural Appraisal approach over three days, during which Key Informant Interviews and Focus Group Discussions were conducted by a multidisciplinary team of students (Chambers, 1994). This qualitative data was supplemented by a household survey, which was distributed to 28 households in Dunde, to gather quantitative information on different socioeconomic, nutrition, water use, and health aspects of the families (HHS). Both the household survey and the field guides used for the interviews can be found in Appendix

A. The field guides were not strictly adhered to due to the participatory, open-ended nature of the interviews. The interviews did not strictly follow the structure of the field guides due to the participatory, open-ended nature of RRA; rather, general themes regarding health issues, health promotion, non-state actors, and funding were discussed.

Ethics approval to conduct this research was obtained from the University of Queensland Human Research Ethics Committee B (No. 2016001857) and from the Solomon Islands Ministry of Education and Human Resources Development. The informal consent process for each research activity is described in the Field Guides (Appendix) and included seeking verbal consent from all participants for their participation, audio recordings and photos, and de-identifying all data before storing and analysis.

Limitations of the study methods include language barriers between the researchers and participants, the short time-frame of the RRA in Munda, and the low number of Household Surveys completed. One of the planned key informant interviews was not completed because the participant had personal matters to attend to.

Research Activity	Themes Explored	Participants	Date	Location	Artefacts
KII 1: Doctor at the National Referral Hospital (also included a presentation to the group)	NCDs, diabetes, management approaches, policy, NGOs, multi-sectoral approach, hospital, funding	Consultant physician at NRH who also works at the National Diabetes Centre, male, 30s-40s	May 10th, 2018	National Referral Hospital, Honiara	Notes
KII 2: Ophthalmologist at the Regional Eye Center	NCDs, hospital, Regional Eye Centre, NGOs, government, government-NGO partnership, funding,	Ophthalmologist at Regional Eye Center, female, 40	May 10th, 2018	Regional Eye Centre, Honiara	Notes
P 1: Live and Learn (LL) panel	NGOs, WASH, government, policy, capacity-building, government-NGO partnership, funding, bribery, gender, community-based	LL team leader, female, 40s; LL school officer, female, 30s; Manager for sanitation enterprise, male, 30s; LL worker, male, 20s-30s	May 14th, 2018	SWIM, Honiara	Notes

KII 3: Live and Learn staff	NGOs, government, WASH	Male, 20s-30s	May 15th, 2018	Namoliki	Notes
KII 4: Ministry of Health officer (also included a presentation to the group)	WASH, government, policy, politics, capacity-building, government-NGO partnership, funding, wantokism	Advisor for the RWASH sector, a division of the Ministry of Health, male, 50s	May 15th, 2018	SWIM, Honiara	Notes and audio recording
P 2: Gizo hospital tour	Malaria, NCDs, diabetes, hospital, community outreaches	Director of Medical Services in Western Province, male, 50s	May 17th, 2018	Gizo Hospital	Notes
KII 5: Retired Health Educator	Health promotion, personal hygiene, NCDs, diabetes, WASH, government, funding, hospital, alcohol	Retired health educator at Helena Goldie Hospital, female, 80	May 28th, 2018	Community Hall, Dunde	Notes and audio recording
KII 6: Health Education Department	Malaria, TB, community outreaches, health promotion, prevention, funding	Staff at the Health Education Department of HGH, female, 20s	May 30th, 2018	Helena Goldie Hospital, Munda	Notes
KII 7: Assistant Nursing Officer and Hospital Supervisor	Reproductive health, community outreaches, health promotion, immunizations, WASH	Assistant Nursing Officer, female, 40s; Acting Hospital Supervisor, female, 40s	May 30th, 2018	Helena Goldie Hospital, Munda	Notes
KII 8: Reproductive Health Coordinator	Reproductive health, immunizations, community outreaches, health promotion, prevention, funding, politics, government	Reproductive Health Coordinator, female, 30s	May 30th, 2018	Helena Goldie Hospital, Munda	Notes

KII 9: Department of Rehabilitation	Community outreaches, disability, NCDs, diabetes, funding, health promotion,	Director of Department of Rehabilitation, male, 40s-50s	May 30th, 2018	Helena Goldie Hospital, Munda	Notes and audio recording
KII 10: Tour of Helena Goldie Hospital	NCDs, diabetes, TB, hospital, hygiene	Reception staff, male, 30s; Swiss doctor, female, 50s; Swiss doctor, male, 50s	March 30th and June 1st, 2018	Helena Goldie Hospital, Munda	Notes and audio recording
FGD 1: Women	NCDs, diabetes, community outreaches, perceptions, WASH, RDP, politics	6 females, 30s-60s	May 29th, 2018	Community Hall, Dunde	Notes and audio recording
FGD 2: Youth	NGOs, RDP, government, Save the Children	Males and females, 18-20s	May 28th, 2018	Community Hall, Dunde	Notes and audio recording
KII 11: Council of Elders member	NGOs, government, funding, RDP, perceptions	Male, 70s	May 28th, 2018	Community Hall, Dunde	Notes and audio recording

Results

Honiara

Honiara is the capital city of the Solomon Islands and has a population of 70 thousand (Solomon Islands National Statistics Office, 2010). Because it is the only metropolitan centre in the country, most of the government Ministries and CSO offices have concentrated here. As a result, there is involvement by both government and nongovernmental actors in health promotion.

Case study 1: Noncommunicable Diseases in Honiara

At the National Referral Hospital in Honiara, 80 percent of the patients there are seen for NCDs, with one heart attack and one stroke every other day (KII 1). NCDs are the primary reason for the full wards at NRH and cost the government SBD $35,883 per admission (KII 1). Additionally, diabetes is the major cause of preventable blindness in the Solomon Islands (KII 2).

The Regional Eye Centre (REC) is a newly built government facility in Honiara which specializes in treating preventable blindness, with a special emphasis on diabetic retinopathy ("Regional Eye Centre," 2018). It is a success story of a partnership between the government and an NGO, the Fred Hollows Foundation, in which the two entities worked collaboratively over five years to design a sustainable and manageable centre. Although the construction was funded by Fred Hollows, the government had input at every step of the process, including where the testing rooms were located, the location of the bathrooms, and the use of solar panels and rainwater tanks (KII 2). Upon completion, the ownership of the building was fully passed to the government, and the current dynamics are smooth and united. According to an ophthalmologist at the REC, "we are all working for the same thing." Today, the government is the main funder of programs and controls the operation of the Eye Centre, whereas Fred Hollows assists with the funding of supplies, equipment, maintenance, and training. The government is slowly taking over responsibility and the goal is for the REC to be fully government-funded in the future.

Case study 2: WASH-Related Health in Honiara

Live and Learn is an NGO operating in periurban communities around Honiara to improve WASH contexts. Through community-based efforts and a new "sanitation enterprise" strategy, Live and Learn empowers local communities to invest in and install their own toilets (P 1). They also promote health through awareness raising and creating "WASH clubs" in the social sphere. Although Live and Learn emphasizes community empowerment and autonomy in its work, unfortunately, even a small lapse in communication can lead to failure. In the case of the informal settlement of Namoliki, Live and Learn deliberated with the community and came to an agreement on a location to install a toilet; however, for no apparent reason, the toilet ended up immediately adjacent to the central river. A Live and Learn staff had to immediately shut down the toilet, and nobody took ownership of the mistake. The unused toilet is still in Namoliki today.

<u>Munda</u>

Munda township is located on New Georgia Island and is located next to Dunde village (Furusawa, 2009). According to the household survey, the Dunde community believes that the biggest health problems in the community are WASH-related diseases, noncommunicable diseases, and infectious diseases, in declining order (HHS, Table 1). The main body in charge of health promotion in Munda is the Helena Goldie Hospital, which is owned by the United Church but receives funding from the Ministry of Health and Medical Services (MHMS)("Helena Goldie Hospital, Munda," n.d.; UnitingCare Health, 2014).

Case study 3: Noncommunicable Diseases in Munda

Half of the respondents to the household survey listed noncommunicable diseases (mostly referring to diabetes, but also mentioning heart attack and "lifestyle diseases") as a major health concern in Dunde (HHS). This was echoed in the women's focus group discussion, where it was agreed upon that "the main health problem here is diabetes," as well as in the key informant interviews of health and medical professionals conducted in the community and at Helena Goldie Hospital (FGD 1, KII 5, KII 9, KII 10). An unfortunately familiar consequence of diabetes is the amputation of the foot or leg. Amputations due to diabetes happen regularly at Helena Goldie Hospital (KII 10), and they are the most common cause of disability in adults in the area (KII 9).

None of the participants were aware of any NGOs operating in the area to promote healthy lifestyle choices and/or NCD management and only knew of outreach efforts through the hospital (KII 5, KII 6, KII 7, KII 8, KII 9). Among the respondents who worked for the hospital, there was a willingness to collaborate with external actors as a way to maintain or improve their community outreach efforts, also known as "touring" (KII 5, KII 6, KII 9). This was because of the universal lack of funding for all departments interviewed at the hospital. Funding was consistently brought up as the main challenge faced by the departments, as it severely limited the amount of touring they could do (KII 5, KII 6, KII 8, KII 9). The hospital discontinued touring for personal hygiene promotion; one department could only do three tours last year instead of their goal of five or six; another department has resorted to asking local politicians for help during election season (KII 5, KII 6, KII 8).

"If the government has money, we have workshops." (KII 5)
"No funds, our work stops." (KII 9)

Despite this, the health professionals have maintained a positive outlook on their programs. There is strong support for NCD-related health promotion, even though they lack the resources. The retired health worker sets an example for her community through her own actions, prompting the community to think, "Look at her, she's old, but she's still running around like a chicken." The professionals only need money for fuel to get around but are otherwise happy to tour locally. The women in the focus group discussion said the community is trying to spread the message as well.

Case study 4: WASH-Related Diseases in Munda

Diarrhea and other diseases related to poor water, sanitation, and hygiene were the biggest health concerns revealed in the household survey data. Some community outreach existed in the past when the

retired health educator would visit households and talk about safe drinking water and proper hygiene; however, it is unlikely those outreach efforts sustained after her retirement (KII 5). Currently, the health educator at Helena Goldie Hospital only tours for malaria and TB, while the reproductive health department tours schools to advocate for hand washing with soap and give preventative tablets for hookworms, a common disease caused by poor hygiene and contaminated drinking water (KII 7). Similar to the outreach efforts for NCDs, these tours strictly depend on funding.

The prominent WASH project in Dunde is the Rural Development Programme (RDP), which has been implementing new boreholes and upgrading wells around the community. The government-run program consulted with the community's WASH Committee to determine where the pumps were put, based on elevation and where existing wells were (FGD 1). Despite its successes, the project was not well received from women in the community. A woman living in Dunde felt uncomfortable using the new pumps, as some were placed very close to people's houses and caused tension with the homeowners, who complained about people leaving trash around the facilities (pers. com.). The women's focus group, when asked about the accessibility of the pumps, said "I think it's still not enough." Many of the women continued to use their wells because the bore pumps were too far away.

Discussion

This paper adds to existing literature by using specific case studies from Honiara and Munda to make comparisons between urban and rural settings in the Solomon Islands, as well as between NCD and WASH health promotion strategies. The case studies revealed three major themes in health promotion in the Solomon Islands.

Communications between government, civil society organizations, and communities

One of the major themes that emerged from the interviews was the importance of clear and constant communication between all actors in a health development project. Literature often downplays the role of the government in development projects in "weak states," often essentializing NGOs as "anti-State" and suggesting that "when NGOs collaborate with the State, they cease to be a progressive force" (Asad & Kay, 2014; Bebbington, 2005). The case study of the Regional Eye Centre, however, adds to the growing body of literature that stresses government-NGO communication (McCarter et al., 2018; Redman-MacLaren et al., 2012). It presents an example of a successful, mutually respectful partnership in which the government's input was prioritized despite its position as the beneficiary. The result was a culturally appropriate design that the doctors felt comfortable and well-suited to use.

There are two counterexamples for failures in communication. The cases of the toilet in Namoliki and the boreholes in Dunde demonstrate the perils of poor communication between government, CSOs and communities. The result of the improper toilet placement in Namoliki was the immediate and permanent closure of the facility and unfortunate waste of resources. The poor inclusivity of the RDP bore pump deliberations led to feelings of discomfort and dissatisfaction among the women in the community.

Dependency on funding for health promotion programs in Munda

The most apparent trend that emerged from the case studies is the heavy reliance on funding in Munda. The reproductive health, rehabilitation, and health education departments, which do work in both NCD management and WASH, all explained that their work strictly depended on their funding and that they had recently been unable to reach their goals for community outreach efforts. Because their work revolves around funding, community health promotion in Munda is vulnerable to government and politics. "Problems" within the government and MHMS were brought up by multiple interviewees, who blamed bureaucracy, corruption, and "wantokism" (Pidgin for nepotism) for the lack of funding (KII 3, KII 8, KII 9). One department's resort to ask their MP for donations every election season also exemplifies the unsustainable nature of outreach funding in Munda and emphasizes the subjectability of health promotion to government goings-on. Similarly, the Dunde community's lengthy wait for the RDP to finish installing the boreholes points to a culture of forced dependency on the national government.

Although health and development sectors have historically focused on training individuals under the umbrella of capacity building, more recent literature has called for institutional strengthening as well (McPhail-Bell, MacLaren, Isihanua, & MacLaren, 2007; Redman-MacLaren et al., 2012). Institutional strengthening in the form of stable funding and autonomy will be needed so the hospital can effectively reduce NCDs and WASH-related diseases. Right now, the Munda health programs' reliance on unpredictable funding reinforces the power imbalances between HGH's local initiatives and the State, and ultimately weakens the hospital's capacity to promote health.

Resilience and a positive outlook on health promotion despite challenges

Despite the constant challenges surrounding funding and communication, the interviewees all displayed resilience and personal motivation to improve NCD and WASH contexts in Honiara and Munda. Speaking on the partnership that gave life to the Regional Eye Centre, the ophthalmologist said, "It has enabled us to do what we couldn't do before" (KII 2); Live and Learn is now deliberately working to minimize communication errors and improve community-government linkages (P 1); the staff at Helena Goldie Hospital carry on with barely any funding; and, the women of Dunde promote personal health and

hygiene by being role models and using their social networks to spread knowledge (KII 5, KII 6, KII 7, KII 8, KII 9, FGD 1). When the government pushed to convert the hospital to a health centre, they said, “We hold on to our hospital. We don’t want it to be closed, or become just a health centre” (KII 5). Because of this collective determination, Honiara and Munda health workers have continued to tackle the Solomon Islands’ biggest health issues. Their positive outlooks have contributed to the staying power of health promotion in the country, undeterred by changes in government.

Recommendations

There is evidently a will to improve health promotion in Munda; however, the health professionals interviewed at Helena Goldie Hospital do not have the same resources that the Eye Centre and NGO have in the capital city of Honiara. It is difficult to make recommendations because it is both unrealistic and inappropriate to expect an external organization to zero in on this community. However, if this were to happen, a strengths-based approach focusing on community empowerment, rather than top-down charitable giving, would lead to more sustainable outcomes. A topic that needs to be researched is sustainable income generation methods that health promotion organizations could employ to become less dependent on outside funding. The Helena Goldie Hospital already holds fundraisers and makes some money from selling food, however, alternative options should be explored to help break the current cycle of dependency.

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Appendix A

HHS. Household Survey

Village:	Date:	Household Code:
Name of surveyor:	Time start:	Time finish:

HOUSEHOLD SURVEY

1. Name of respondent: .....

2. How many people in the household?

	Household Member	Sex (circle)		*Butubutu*	Relationship (Wife, brother, sister, daughter, son grandchild etc.)	Year born	Education class
1	*Respondent*	M	W		*Respondent*		
2		M	W				
3		M	W				
4		M	W				
5		M	W				
6		M	W				
7		M	W				
8		M	W				
9		M	W				
10		M	W				
11		M	W				
12		M	W				

Gardening

3. How many gardens does this household have?

……

4. Who in the household mainly attends the gardens?

Household member	How many times a week?	How many hours per day?	Subsistence, cash or both?*

* S = Subsistence; C = Cash; B = Both

5a. Is subsistence farming of importance to this household? Yes No Why/Why not?

……

……

5b. What are the most important garden crops you grow?

……

……

……

Household Fishing

6. How many people from this household fished or collected from the reefs or mangroves last week?

Total ☐ Male ☐ Female ☐

7. How often do members of this household go fishing? (include trochus, crab etc.)

Who in the HH (Specify - Male, Female, adult, child, etc.)	How many months of the year	How many days in one week	How many hours in one day	What kind of fishing glening etc.

8. What fishing techniques do members of the household use when fishing? How does one choose which fishing practice to use in the field?	Handline from beach ☐ Handline from canoe ☐ Deep bottom fishing (*pollet*) ☐ Spear (canoe): ☐ Speargun (diving) ☐ Night □ Daytime □ Trolling: ☐ Cast netting : ☐ Gillnet: ☐ Other ……
9. a) Can you please list five frequently caught fish by members of this household?	1. …….. 2. …….. 3.…… 4. …….. 5.……
b) Has this changed over the past 5 years? ○ Yes / ○ No	
10. What do you do with any extra fish you catch?	Sell ☐ Where: _____ Barter/trade ☐ Give away ☐
11. a) How would you describe the **catches** of marine resources (fish, shellfish and beche-de-mer) by this household over **the past year?** ○ **Very bad** ○ **Bad** ○ **OK** ○ **Good** ○ **Very Good** b) What do you think fish catches will be in 10 years-time? ○ **Very bad** ○ **Bad** ○ **OK** ○ **Good** ○ **Very Good** c) Has forest density changed in the past 10 years? ○ Yes / ○ No	
d) What is your view of conservation? …… ……	

Consumption: Food/Diet/Consumables

12. What did you eat last night?

……

……

……

13. How many times last week did your household eat fresh fish? _____

14. How many times last week did your household eat tinned fish? _____

15. How many times last week did your household eat rice? _____

16. a) On a scale of 1 to 2, how healthy would you rate your daily diet? (5) Very Good; (4) Good; (3) OK; (2) Bad; (1) Very Bad

17) Where do you normally get fresh fish from?

……

18. **How often do you eat/drink store brought foods?**

(tick box & rank from 1 – 4)

1 = Every day/Most days

2 = Every week

3 = Not often

4 = Never

	Tick
Tinned fish	☐
Tinned meat	☐
Cooking oil/butter	☐
Sugar	☐
Biscuits	☐
Bread	☐
Flour	☐
Noodles	☐
Cooking oil/butter	☐
Coffee mix/tea/Milo	☐
Sweet drinks	☐
Other (Please specify)	
……	☐
……	☐

19) Have the costs of store food changed dramatically over the past few years? ○ Yes / ○ No

20) **How would you describe the current status/condition/health of the following, on a scale:** (5) Very Good; (4) Good; (3) OK; (2) Bad; (1) Very Bad or N/A (not applicable).

Please explain why.

Resource	Score	Why?
Garden land area		
Garden fertility		
Time to catch enough fish		
Time to garden		
Time to cook		
Cost of store food		
Availability of food in market		
Availability of fuel for cooking		

Socio-economic

21. Where does the cash money in this household come from? (tick relevant box and rank according to level of importance, i.e.

1 = most money;

2 = second most important income source;

3 = third most;

4 = fourth most;

5 = Fifth most;

6 = least important income source)

Sources of income	***Rank (1-6)***
☐ Fishing/seafood collection	☐
☐ Royalties (land/fishing rents	☐
☐ Cash crops	☐
☐ Other Agricultural activities (specify)	
Specify: _____	
☐ Remittances	☐
☐ Other (i.e., store, wages)	☐
Specify: _____	

C: *Community*

22. Do you or other members of this household belong to any community groups (women, church, youth group, other)? Which ones?

……
……
……
……

23. What kinds of things would you like to see done in your village to make it better?

……
……
……
……

Waste

24. a) On a scale of 1-5 (1=very unhappy; 5 = not happy), do you think rubbish is a problem in the community?

b) What is the most common waste generated in this household? (Please list at least five in order of most to less)

……
……
……
……

c) What do you with your waste?

……
……

d) How do you dispose of plastic bags?

……

e) How do you dispose of solid waste?

……

d) Who should try to improve rubbish management?

……
……

e) (*if appropriate – e.g. plastic ban has not yet been implemented*)

Do you think the Province/Govenremnt should ban plastic bags? Yes ○ No ○

Why/Why not?

……
……

f) Do you think plastic is an environmental hazard? Yes ○ No ○

Household and Water Sanitation

25. a) Does your family have access to use a toilet? ○ No

○ Toilet belongs to this household ○ Toilet shared with other households

b) If yes, what type of toilet? *(skip if no toilet access)*

○ pour-flush or flush (i.e. uses water) OR ○ Dry

AND ○ sealed pit or tank (no liquid can escape) OR ○ unsealed pit or tank (liquid waste can seep into ground)

c) On a scale of 1-5 (1=very unhappy; 5 = not happy), how happy are you with this toilet situation?

26) **Water sources**

a) What is the main source of water your household used for **DRINKING** purposes during the **DRY** season? What other sources did you use? *(ask which was the main source and number this 1, then ask if any other sources and tick these)*

○ Community Water Tank ○ Household Water Tank

○ Community Well ○ Household Well

○ Community Bore ○ Household Bore ○ Other: ……

b) How safe do you think this water is to drink? (on a scale of 1 – 5, when 5 is very safe, and 1 is not safe)?

c) What is the main source of water your household used for **DRINKING** purposes during the **WET** season? What other sources did you use? *(ask which was the main source and number this 1, then ask if any other sources and tick these)*

○ Community Water Tank ○ Household Water Tank

○ Community Well ○ Household Well

○ Community Bore ○ Household Bore ○ Other: ……

d) How safe do you think this water is to drink? (on a scale of 1 – 5, when 5 is very safe, and 1 is not safe)?

e) What is the main source of water your household used for **NON-DRINKING** purposes (e.g. washing, cleaning, bathing) during the **DRY** season? What other sources did you use? *(ask which was the main source and number this 1, then ask if any other sources and tick these)*

○ Community Water Tank ○ Household Water Tank

○ Community Well ○ Household Well

○ Community Bore ○ Household Bore ○ Other: ……

f) How safe do you think this water is to drink? (on a scale of 1 – 5, when 5 is very safe, and 1 is not safe)?

g) What is the main source of water your household used for **NON-DRINKING** purposes during the **WET** season? What other sources did you use? *(ask which was the main source and number this 1, then ask if any other sources and tick these)*

○ Community Water Tank ○ Household Water Tank

○ Community Well ○ Household Well

○ Community Bore ○ Household Bore ○ Other: ……

h) How safe do you think this water is to drink? (on a scale of 1 – 5, when 5 is very safe, and 1 is not safe)?

i) How happy are you with your current water supply situation (on a scale of 1 – 5, when 5 is very happy, and 1 is very unhappy)?

Health

27a). What do you think are the biggest health problems in your community?

……

……

b). How often does this household go to the clinic/Aid post/Hospital?

(please specify which service)

……

……

c) How happy are you with the current state of helath services available to you (on a scale of 1 – 5, when 5 is very happy, and 1 is very unhappy)?

……

……
28. Where is the house located in the village (zone)? *(surveyor to complete)*
Comments:

FG. Field Guides

KEY INFORMANT INTERVIEW: FRED HOLLOWS REPRESENTATIVE

Introduction to discussion/activity
The University of Queensland (UQ) and the University of California (UC) are conducting a learning activity, teaching students field research methods and skills and what is called Rapid Rural Appraisal. In the process, they will learn not only about research techniques but also the Solomon Islands and some of the issues surrounding environmental and community health facing communities today. All the information will be returned to the Dunde community. The focus is on social issues, natural resources, food and nutrition, and water and sanitation.

Participation is entirely voluntary. You can leave at any time. Please give **verba**l consent that you are willing to participate. All answers provided by participants will be kept confidential and will only be viewed by researchers from UC, UQ, and SINU. Dunde owns the information. This is primarily a teaching activity, giving the students an opportunity to learn some of the methods associated with what is called Rapid Rural Appraisal – a tool used to inform development activities and interventions by governments and NGOs.

Introduction
I am interested in studying Public Health issues in the Solomon Islands, including avoidable eye health problems and interactions between nongovernmental organizations and the government. I am hoping to learn more about how NGOs work to improve health in the Solomon Islands

2-3 Core Questions

1. What outreaches has Fred Hollows done in the Solomon Islands in recent years?
    a. What were the outcomes?
        i. How many eye surgeries were completed?
        ii. How much demand was there for the surgeries?
        iii. How does Fred Hollows decide which patients to operate on?
2. Fred Hollows, with funding from the New Zealand Ministry of Foreign Affairs and Trade and the New Zealand public, constructed the Regional Eye Centre in Honiara. According to the website, as soon as the build was completed in 2015, Fred Hollows handed over ownership to the Solomon Islands' government. Can you shed light on the deliberations involved in the handing over of the eye centre from the NGO to the SI government?
    a. Were there conditions to be met by the government? By Fred Hollows?
    b. What input did the Solomon Islands government have in the construction of the site?
    c. The website says the Centre is now managed by a local team within the SI Ministry of Medical Health and Services. **How involved is the NGO now in the Centre's operation?**
    d. Have there ever been disagreements between the Ministry of Health and the NGO on the management of the Eye Centre? How were those resolved?
3. What are some challenges that have arisen or may come up relating to Fred Hollows' relationship with the government?

KEY INFORMANT INTERVIEW: HOSPITAL VISITS

Introduction to discussion/activity

The University of Queensland (UQ) and the University of California (UC) are conducting a learning activity, teaching students field research methods and skills and what is called Rapid Rural Appraisal. In the process, they will learn not only about research techniques but also the Solomon Islands and some of the issues surrounding environmental and community health facing communities today. All the information will be returned to the Dunde community. The focus is on social issues, natural resources, food and nutrition, and water and sanitation.

Participation is entirely voluntary. You can leave at any time. Please give **verba**l consent that you are willing to participate. All answers provided by participants will be kept confidential and will only be viewed by researchers from UC, UQ, and SINU. Dunde owns the information. This is primarily a teaching activity, giving the students an opportunity to learn some of the methods associated with what is called Rapid Rural Appraisal – a tool used to inform development activities and interventions by governments and NGOs.

Introduction

I am interested in studying Public Health issues in the Solomon Islands, including avoidable eye health problems and interactions between nongovernmental organizations and the government. I am hoping to learn more about how NGOs work to improve health in the Solomon Islands

2-3 Core Questions

1. Background on hospital
    a. How many people does it serve every week?
    b. Can you tell me a short history on the hospital?
    c. What demographic comes to the hospital the most?
    d. Who manages the hospital? Who do they respond to?
2. What do you see as the biggest health concern for this area? For Solomon Islands as a whole?
    a. What would be the best way to address these problems
    b. How long has this been a problem?
    c. What is the hospital doing to help it?
    d. What are other entities doing to help it?
    e. What community outreach do you do to improve health in a non-medical way?
    f. What would you like to do?
3. What NGOs are you aware of in the area that are trying to improve health? Any health promotion programs?
    a. Do you think they are working well?
    b. Does the hospital collaborate with the NGOs to deliver services or exchange information?
    c. Do you think better collaboration would lead to more effective health programs and better outcomes?

Appendix B

KII 1. Key Informant Interview: Doctor from National Referral Hospital, Honiara, May 10th, 2018

Presentation: Influences of lifestyle on health

- Changing trends: lifestyle diseases (cancer, lung, diabetes) emerged in the 80s
- The National Referral Hospital's (NRH) patients are 80% non-communicable diseases (NCDs)
    - One heart attack every second day
    - One stroke every 1-3 days
- Anecdote: was working as a physician in Central Province and was getting a new case of NCDs every day. Said, "we need to talk" about lifestyle diseases and prevention
    - Started doing public health awareness and screening
- Impact of NCDs
    - Full wards: 70% of beds are occupied by NCD patients
    - Long stay: 30 days → 3 years due to things like amputations, infections
    - Expensive and not enough doctors
        - Costs government $35,883 per admission, estimated $2M in 2017
        - "We are the NRH by name, but we can't do much" (as in what Australia does) so they send out patients
    - Impact on family: breadwinner dies and can't support family → cycle of poverty
    - Sick workforce
- Drivers underlying NCD rise
    - Globalization, urbanization, aging, social determinants of health
    - Behavioural: tobacco, diet, inactivity, alcohol
    - Metabolic risk factors: blood pressure, overweight
- Betel nut
    - Causes mouth cancer
    - 62.6% of people do it
    - People claim it's part of their culture, but it's not; used to just be for men but now it's women and children too
    - 33% smoke or drink
- **"Managing NCDs is like mopping a wet floor. You need to turn the tap off first"**
- Management approach
    - Primary: health promotion, created a NCD unit in the Ministry of Health and Medical Services (MHMS)
        - Coordinate the rollout
        - "Solben protocol"
    - Secondary: treatment
- National Diabetic Clinic
    - Challenges: limited workforce, lack of facilities and equipment, shortage of money, lack of coordination

Question and answer portion

- There is a system to prioritize people and make other people wait; the government decides and the hospital doesn't control
- Funding comes from the Solomon Islands budget
- The MHMS controls the paramedics but things are changing; the hospital is gaining more control
- Who is in charge of the hospital? Hierarchy: Minister of Health → 3 secretaries → Secretary of Curative Care → all hospitals → CEO of hospital → directors of hospital → head of department (him) → consultants

Interview portion

Management approaches are not coordinated - you need organized tap-turners

- The question is how they should be organized. By government? NGOs?

- He gives talks to the public and then recommends checkups
    - His target: early diagnosis
- Problem with management is that people don't know their roles

The National Health Strategic Plan lays out an approach to NCDs

- A multi-sectoral approach: includes the Minister of Agriculture, Minister of Infrastructure, Minister of Finance, etc.

The Doctor's plan

- Quit being just a consulting physician at the National Referral Hospital to work at the Diabetes Centre. Wanted to take a more upstream approach. Wants to quit the medical side
- Planning a pilot project that aims to screen EVERYONE in a province
    - Separate them into 3 groups
        1. Healthy → come back in 1 year
        2. Shows risk factors → come back in 6 months
        3. Diabetic → send to provincial hospital
    - Monitor and change lifestyle
    - Will create own team with "the right skill mix" to go there
- Challenge: funding
- Sees NGOs as an opportunity to get funding for his program

Key Informant Interview: Ophthalmologist at the Regional Eye Centre, Honiara, May 10th, 2018

Creation of the Regional Eye Centre

- Requirements from the government:
    - Building must be moveable → the whole thing was built to be portable
    - Have low bills so that the government can fund it → building is run on solar power and a diesel generator, it has rainwater tanks, and has its own waste treatment → almost self sustaining
- Input from the government in the creation of the REC
    - Government had lots of input in the design of the facility (e.g. wanted the testing rooms to be in a private area, changed the toilets to be accessed from the inside instead of outside to prevent the public from using them)
    - Over 5 years of deliberations between government and Fred Hollows

Current dynamics between Fred Hollows (NGO) and the government?

- She is an ophthalmologist for the government
- "We're all working for the same thing"
- The Regional Eye Centre is fully owned by the Solomon Islands Government (SIG) and managed locally - good ownership
- They collaborate with a general manager from Fred Hollows, who has an office in the REC and she manages the actual building (e.g. maintenance, cleaning, repairs)
- Programs are funded by the government, while some consumables and most equipment are funded by external and auxiliary positions
    - Government is slowly taking over responsibility
    - All training funded by Fred Hollows
- Fred Hollows steps in when ordering supplies
- Fred Hollows helps with maintenance of equipment: regional team from the NGO tours around Pacific countries to upkeep equipment. This process has been standardized for multiple countries, which lowers costs of maintenance overall

Disagreements between government and Fred Hollows?

- Only minor ones that are overcome quickly through speaking with the Fred Hollows general manager
- Example of something that went wrong: In Fiji, Fred Hollows hired their own nursing staff when they built an eye care facility in Suva, even though there was already a nursing staff in place from the government. The Fred Hollows-employed nurses were paid more, which caused tension between the groups
- At the REC, had to negotiate security for the building by asking the NRH to share their security staff with the REC (next door) - now some problems with understaffed shifts for security

Overall thoughts on the partnership?

- "It has enabled us to do what we couldn't do before", equipment and space
- Now have standards for the operating theatre; there's no protocol in the NHR
- E.g. the NHR has linen issues when they run out of clean sheets and cannot operate; REC has their own laundry machines and so doesn't have to rely on others
    - The NHR is running out of supplies right now
        - The payments don't come consistently and orders for more supplies take a long and variable time to get to the hospital
        - No room in the budget to order more supplies
        - There is only about a month's worth of supplies left for the hospital and nobody knows when they will be getting more resources
        - Auxiliary programs have stopped because there is a need to prioritize the hospital's resources (e.g. the diabetic outreaches have stopped)
- The biggest challenge is converting the REC to becoming fully government-funded and independent

P 1. Panel and Q&A: Live and Learn (Team Leader, School Officer, Henderson community member and WASH company manager, community worker), Honiara, May 14th, 2018

What Live and Learn does

- Local NGO that promotes WASH in schools and communities

Speaker 1 introduction

- She is a team leader who works in two periurban communities (Henderson and Namoliki)
- In Namoliki, works with UNHabitat and Ministry of Lands to give land back to traditional landowners (government acquires the land then gives out leases)
    - Namoliki situation is a little bit better than Henderson because only have to deal with traditional landowners
- Engages with church leaders and WASH committees
- Capacity-training on technical skills to build toilets
- Give DRR info on how to select toilets on land situation
- Incorporates in program gender, empowering women, ethnicity, special needs

Speaker 2 introduction

- She is the WASH school officer for Live and Learn and looks after 7 schools all under Honiara City Council
- One program surveyed 7 schools as case studies to understand and identify the problems (situation analysis) → information shared with government and education authority
    - Create WASH clubs for students and WASH committees for teachers
    - Then, trainings on hygiene awareness
    - Challenges: water supply (periurban communities not connected to Solomon Water), children don't know how to use facilities (e.g. they thought the urinal was for drinking)
    - Success: at the very least, they had an introduction to hygiene, and there was less open defecation

Speaker 3 introduction

- He is the manager for the Henderson WASH company that sells toilets
- Toilets for sale: pour flush, ventilated improved pit, going to start selling slabs because they are more affordable
- In the future, planning to sell menstruation kits with spare underwear, reusable sewed pads
- Raise awareness in communities
    - 11 WASH committee members communicate to the rest of the community
    - Include church leaders

Speaker 4 introduction

- Periurban communities are complex; many dialects from 9 provinces, so choosing a leader is difficult
- Some structures are recognized and some are not (formal vs. informal structures) - challenge is finding who to look to
- Issues
    - A big issue is land: people are "squatters" so they don't buy toilets because they could be demolished at any time
    - Affordability: many people's only jobs are selling fruit, betel nut, and illegal alcohol so can't get enough money to invest in a toilet
- Improvements to make
    - Listen to the community
    - Should add sanitation to existing retail businesses or service providers rather than build standalone sanitation enterprise, instead of finding new people to man the business
        - We could have used this idea and inserted it into existing retail businesses
    - We also need to understand that there are other stakeholders who are interested in the idea
        - School authorities

        - Need to look for people who have the common interest
    - Importance is sustainability
        - "Live and Learn or the NGO will go at one point. Only the Ministries, they will stay. And if they stay they are the ones that will carry on with the idea. If Live and Learn goes tomorrow, and there is no partnership with the Ministries, then definitely the whole idea will just go away."

Q&A

What are your partnerships with the Ministry like now and what do you hope they will be like?

- They are wholly engaged with our meetings - stakeholders meetings where Live and Learn briefs them on sanitation situation in the communities
    - Ministries mold their policies around the meetings
    - WASH in schools policy
- The partnership is rigid and firm
- Have also engaged the media to spread the news
- A lot of sharing (previously didn't happen); now the government knows the NGOs are out there and connecting with them more
- **"Communities connecting with the relevant government Ministries"**
    - Project is all about strengthening those links and getting them to talk about who's doing what - coordination
    - Also helps NGOs know who's doing what to avoid overlap
    - When communities have questions or need something, they will know who to go to within the government (national or provincial) for advice, even when Live and Learn pulls out
- When we started with the program there weren't any government ministries or local governments working with informal settlements on WASH - now a bit more interest - but no real responsibility quite yet, just engaging more
    - Health workers and hygiene promoters from city actually going into communities through the businesses

How to engage women?

- Make sure there's a rep for everyone in the community discussions (special needs, women)
    - Trainings on leadership and decision-making, why it's important that men and women understand their roles and how they complement each other

Restrictions on types of projects based on funding?

- The way Live and Learn operates, we do submissions to donors and tell them what we want to do
    - Restricted in this way - project is designed to identify communities and target deliverables, so hard to reach every community even if there is the demand
    - "Dependent": donor wants to achieve their end goals and you want to do stuff too
    - Need to balance with communities because they might want something but something else is more important
    - No funding for the proposals, so hard to invest sufficient funding to support the vast amounts of consultations you'd like to do first
    - Ultimately, donor has a priority (always sectoral: WASH, education, primary health, etc.) ideally need to identify the communities that already want to do something about WASH
        - Hard because every NGO does it on their own and there's no coordinated process and not enough funded
    - Takes a necessarily long time to build and connect with communities - frustrates donors

Price of toilets?

- $678 for pour flush and selling for $724 - marginal interest to accommodate staff salary - quite high for community context

Instances of non-community-based organizations working on the same issue?

- Church-based organizations

        - Seventh Day Adventists core fundamental belief is health
    - Understanding between NGOs of who's working where, and try not to step on each other's toes
    - New National Policy is very important for this reason, because it organizes people and makes sure one NGO is working without a subsidy and one is next door, or taking contradictory approaches
        - Clear on what approaches to be taken, all have to work in line with the national policy

Election time MPs

- International RWASH policy is a no-subsidy program with the exception of health centers and schools - trying to make families and communities prioritize their own sanitation
    - Conflict arises when an MP comes in and gives free handouts of toilets in return for votes
    - "Creates a dependency syndrome"

Advantages or disadvantages of being a local NGO?

- Big NGOs like World Fish and OXFAM have accreditation from Australian government to receive funding from them - Live and Learn is trying to get that accreditation
- Don't get other perks that they get - we struggle
- World Fish comes in with flashy cars and boats, and so the communities are receptive to them
- Would prefer if these big NGOs came and worked through local NGOs instead of doing their own thing, but that is not a reality - "It will be nice."

Thoughts on rainwater tanks?

- Problem is that not everyone has access to a rainwater tank, or the iron roofing to collect water
- Good because during rainy season, your water turns to chocolate, so people turn to bottled water

Does the nature of an informal settlement and unsure land rights lead to short-term WASH solutions?

- Not about how long-term the land is or who the owner is (Chinese business, rich Solomon Islander, government), entirely depends on how much a community or household is willing to invest for a toilet
- A status thing: people don't want to be the only one without a toilet, or if nobody has a toilet, they just resort to the easiest thing (OD)
- Specifically in Henderson and Namoliki, some people have multiple cars or buses but don't have a toilet → priorities

Women taking large roles in advocating for toilets?

- Because when their kids get sick from diarrhea in the night it's the women who go to the hospital
- They take care of the kids, so when the kids are healthy, the women have more time to do other things
- Safety and security

Business approach: Sanitation marketing

- Need to stick to a few different designs because it costs the least, then later on can diversify stock and customize after promotion
- City Council has been the one selling subsidized toilets to whole of SI, couldn't meet the demand - so the sanitation enterprise is trying to relieve the pressure on government
- Better to work with smaller enterprises, because shop owners have business knowledge
    - Here's some funding, if you want, build this stuff and sell to the community
    - Train retail sellers to install the toilets
    - Easier than setting up a whole business
    - Probably be better if privately owned

Informal vs formal structures?

- Best to work with both
- Some people in informal structures can be bossy and muscular
- Formal structure people are good-looking with white-collar jobs
- If you don't work together, the white-collars will put the toilets in and they would be demolished by the informal radicals

How often do MPs follow through?

- Every 4 years, when election time comes
- In between, to get support base strong
- Republic of China and Taiwan have been dishing out money to politicians for their votes to be recognized by the UN as a country -- corrupted politicians over the last 30 years and created dependency on handouts
    - Large discretionary funds ($27 million in her politician - where does it go)

Hopes for the future on partnership with the government?

- We would like to see the government taking ownership of it, and becoming responsible, not seeing it as you NGOs and we're here but taking the responsibility that should be theirs
- No government, we pay the taxes, licenses, etc. help us!
- National RWASH policy is not for informal settlements so there's no government program

KII 3. Key Informant Interview: Live and Learn staff, Namoliki, May 15th, 2018

Does Live and Learn operate in Namoliki?

- Yes, they helped put in a toilet. They sold the toilet to the community to install.
- Leaders within the informal structure resisted because they said there was no space, and said that the community doesn't care because everyone practices open defecation anyways.

Has the Ministry of Health and Medical Services been here, too?

- Yes, but they only came when we (Live and Learn) started engaging with Namoliki. They (Ministry) came and looked around, looked for a good space for the toilet.

Did they help?

- "Not at all." They did it for show and so that they could put their name on the project and say they were doing stuff in the community. They saw the Live and Learn was there and wanted to be part of it.
- He told me to ask the Ministry of Health (who I was meeting later in the day) why they aren't working with Live and Learn. It needs to be prioritized because they need to align with the universal SDGs.

What happened with the project?

- The community decided to put the toilet somewhere, but then he has no idea why, but the toilet ended up being built right next to the river. He had to shut down the toilet because it was unsafe and would contaminate the river.

KII 4. Key Informant Interview: Ministry of Health and Medical Services RWASH Sector Officer, SWIM, Honiara, May 15th, 2018

Presentation portion

Current situation

- Did a baseline study in 2015 led by WaterAid (not active in Solomons anymore) and MHMS, and other partners - of rural only
    - A household survey on whether they had access to water, handwashing with soap,
    - Results were bad
        - 54% households have access to improved water sources (within 30 mins) mostly public tap stands because not many have home connections
    - "Sanitation is the biggest problem in the country" only 13% of all households have access to improved sanitation
        - That means 86% practice open defecation or use an unimproved toilet (hole in ground)
    - Only 16% practice handwashing with soap at the appropriate times regularly
- WSO estimates that poor access to improved WASH 8% of all deaths in the country are caused by access to water supply for sanitation and hygiene (5 people die every week) - beats malaria
    - "1 in 3 of all children in the Solomons are stunted", the local term is "small big man" or "small big woman" because it's so common
- Coverage is actually going down for WASH

2009-2010 Sector-wide approach program funded by Australian DFAT

- Aim to increase coverage, strengthen Environmental Health Division (EHD), mainstream sanitation and hygiene in the project process
- "Before there were hardly any sector regulations in place"
- Came in 2007 after working for Kavitas, said how do I build my system, they said however you want

RWASH Policy approved by Cabinet in 2014

- First of its kind for RWASH subset
- Followed by a strategic plan in 2015
- CLTS Toolkit launched in December 2015
- Policy key elements
    - Water supply: make it easy to manage, have engineering standards that aren't too fancy and difficult to understand
        - Community owned and managed: "not government, nor NGOs nor the private sector can help maintain systems, so it is up to the community largely to manage and maintain their own systems, so they need to raise their own funds"
            - Comes with organizational and technical skills that need to be provided for the community
        - Try to include schools and clinics
    - Sanitation and hygiene (biggest change)
        - Before was fully subsidized: provided material and even constructed the household toilets, focused on a single technology (pour flush) regardless if they had a reliable water supply or not → system breaks down because only 15% of systems are managed properly → toilets break down → OD in bush
        - Key element is no subsidy since February 2014
            - Instead, discuss with communities on sanitation, raise awareness of open defecation and effect → creating demand (CLTS)
            - Exceptions: people with disabilities, schools and clinics and atoll islands
        - Sanitation marketing to meet the demand they create - make sure there are enough and good products for households to buy, and services
    - Cross cutting issues: climate change, gender

- Outsourcing to NGOs
    - "Our strategic targets are so high, that just development cannot meet these targets, so we need to engage civil society and the private sector."
    - "Hugely ambitious, overly ambitious, totally not reachable, to be honest" to have universal coverage to basic water and sanitation and hygiene by 2024, but at least it's the first time we've had targets
    - Need to look at coordination of the sector
        - WASH stakeholder group with NGOs, development partners (DFAT, EU, World Bank, UNICEF) and other Ministries (e.g. education, development and planning)
        - High-level oversight committee which looks at policies, strategic plan, big funding inputs (Ministry of Health, Finance, Development Planning and Aid Coordination, and 3 key donor partners)
        - Key document they use: RWASH database of the "who, what, where" of efforts so they don't overlap
        - RWASH Information System (RIS): a framework for indicators (use SDGs) - haven't fully rolled it out yet - next month
            - Looks at access to basic water supply and sanitation, and status (the functionality and compliance with regulations)
            - Basically didn't have RWASH monitoring until now
            - "If you don't know what's going on, how can you plan for the future too?" Finally have engineering standards
            - "Monitoring will become more and more important as we are looking more towards outsourcing"
        - Joint Monitoring Program looks at safely managed and water quality: difficult to obtain safely managed status in this country, because we don't have the water quality testing resources to test - it would be basically 0
- Strengths of government RWASH program: have a lot of institutional knowledge, have a good spread across provinces, generally have a lot of funding support
- Weaknesses: hard to change everyone's thinking, hard time convincing own staff to follow the policy, aid dependent
- Successes: a lot of documents that help guide the sector, RWASH program has established itself in the sector so everyone knows them and comes to them and comes through them so they know what is going on (what they're supposed to do - "we are the government after all"
    - Established position as sector lead
- Challenges: SI procurement system makes it very difficult and long to make purchases for materials (takes at least three weeks for a small thing)
- RWASH is just a part of EHD, but gets 10x the funding as any other part

Requires capacity-building

- Engineering: new engineering design practices, new standard designs for toilets etc.
    - Need to train supervisors, health inspectors, NGO staff

  Community engagement and prepare them for the new systems
    - 4-5 days in communities
    - Incorporate gender, disability

  M&E is totally new for RWASH program: how to record and manage data, and use the system (often nothing happens with all the data)
- Sanitation and hygiene
    - Barriers: people aren't changing their behaviour, need to decide what kind of message to send
- Developed a contact management course (3 days) very popular for outsourcing

- Not finished..

Interview portion

0:00-3:08 What kind of partnerships do you have currently with NGOs?

- Don't have any formal ones with MOUs
- But we do cooperate a lot with them
- Have regular coordination meetings 3 times a year, regular interaction between government and NGOs about their projects and if they develop new proposals, they ask for the government's perspective
- Not mandatory for NGOs to come ask for advice but they do it anyways "the door is always open", but they do have to follow the policy and engineering standards
- The government's role is to enforce the guidelines
    - Some things are hard to enforce - "very difficult to tell a member of parliament or Minister to stop that"
    - Have to be careful about approaching these things
    - Some politicians and donors are difficult to touch or convince them to comply, but NGOs, they are easy
        - "WorldFish and Caritas, they don't want to be seen breaking the rules, because if they get negative press it affects their funding from anywhere"

3:09-4:30 Does the government fund these NGOs?

- Sometimes; $5 million grant for sanitation in North Malaita to UNICEF, who is hiring Caritas Australia to help implement

4:31-6:37 You mentioned earlier you were sitting on $19 million for WASH, but other NGOs I've spoken to said they weren't getting enough support from the government.

- The EU project he's a part of (started 2013/14) had a much higher initial budget back then, and was already talking about contracting NGOs and private sector. Some other donors heard about it, and they thought there was so much money coming into the sector that they began pulling out. Thought the EU would cover their budget for WASH so they used it. But if you look at the average cost of a pipe supply system/gravity-fed system for water, it's $400-450,000 so then all of a sudden $20 million doesn't translate into a huge number of projects. You can't spend the whole $20 million on outsourcing either, you still implement yourselves, and then you have all this capacity building and trainings and all that stuff, so it's actually out of the budget for this year that there's only a quarter meant for outsourcing ($4 million). It was more last year, but because they don't like outsourcing that much, they reduced the budget for this year.

6:38-8:20 The makeup of the $20 million budget

- Half of the money is for implementation by RWASH/the government itself even though there's no way they could manage that many projects, but that's what they want because they don't like outsourcing that much. NGOs say they're waiting for EU to come around with the money, but there's not actually that much around, and not a whole lot of willingness around our office to do that too. (he said don't quote me on that and don't let my colleagues read it)
- This is new: EHD and RWASH were always seen as the main implementers in the country and now all of a sudden they have to invest in others, why? We're the best! We're doing a great job. Slowly it's beginning, but it's not enough yet. We are not an ideal partner, I will say, the government.
- I'm not the boss, I'm just an advisor. If I was in charge, I'd do a lot of things differently, but I'm not.
- But we are by far the best funded.

8:21-9:50 Response to others saying the government lacks responsibility and ownership of WASH problems. Why is that?

- "Poor management. The problem with countries like this, is that the whole program can basically stop functioning or barely move forward because of one single person in a leading position who doesn't want to do anything. If some person high up doesn't want to do things, it just doesn't

happen. That's the problem with a country like this. In the Netherlands or America, there are always a lot of people there that make sure everything moves ahead, even if one person may be sick or not well or whatever, there are outside systems or pressures.

9:51-11:30 Is that normally due to corruption?

- Corruption can be an issue, I don't think at the moment that it's an issue, "I think it's just unwillingness, not agreeing with the changes that have been introduced, and simply just the path or resistance trying to slow down and block everything."
- 2011: "Had a very poor program manager, and all sorts of internal politics going on, and I couldn't get anything done. The only thing I really got done was draft the engineering standards, because I didn't need anyone to do that. I could get some engineers from NGOs and all that to help me out. I couldn't anything in terms of processes and systems in place, because no one supported me, until I got a director that was forward-looking and had the strategic oversight and was open-minded. Otherwise nothing would have happened. Wouldn't have had CLTS, wouldn't have had a policy or strategic plan or any of that stuff." - Depends on a single person and "at the moment, not much has happened because we have some of the wrong people in place".

11:31-13:00 How can this situation be improved?

- "That's what I scratch my head about every day. It is very difficult. As an expat, it's risky for me to go in full attack."
- "It's very difficult to remove people from positions here. There is a process in place: three official warnings, public service, be proven, before you get sacked."
- "The problem in a small country like this, if you have connections, it's very hard. Then the person who tries to sack the person might get sacked, because the other guy has bigger connections."
- "One of my current colleagues tried to sack the provincial officer a couple of years ago, but that that provincial officer's second cousin was the Secretary of the Ministry and his first cousin was the Prime Minister, so he nearly got sacked."
- "It's total wantok, it's all nepotism."
- "Let's say you have these kinds of performance-based systems, and you start sacking people left and right because they don't perform, and then who are you going to hire? This is 600,000 people in the whole country. Where are you going to find all your skilled people from? At some point, you're going to run out because they don't perform. It's not a reason not to sack people, but then again all your offices are empty. And then what?

P 2. Presentation 2: Walking tour of Gizo Hospital with the Director of Medical Services in Western Province, Gizo Hospital, May 17th, 2018

Introduction to hospital

- Minor surgeries, don't have any specialists at the hospital
- Most common admits are diabetes
    - Some very long term patients because of infections, can stay up to a month
- 90+ beds in the hospital
    - Patients from as far as Choiseul, patients get here by boat
    - Have smaller health facilities around the islands which provide basic health services (e.g. malaria tests)
    - Doctors also dispatch by boat to reach people
- Medical conditions not found in Australia: syphilis, gonorrhea, chronic hepatitis
- Lots of complications of chronic diseases like heart diseases, diabetes
    - People usually come in at advanced stages of chronic disease like end-stage renal disease
- Four medical doctors at the hospital and many more nurses, who get more involved with patient care and do more procedures than in Australia
    - All doctors are trained overseas (Fiji, New Zealand)
- Often no resources to do the tests, so doctors rely on their medical skill to diagnose, hard to get resources to the provincial level in Solomon Islands
    - No biopsies done, all sent overseas and take over 6 months
    - Right now, all supplies come from overseas
    - Only can do blood tests (isolate parasites, mostly malaria) and some stool tests, STIs
- National body that is mandated to allocate funds to the country; they don't have any control on the movement of supplies and drugs - frustrating
- Small agreement between Gizo hospital and a hospital in Queensland to do some samples for them

Malaria

- 2016 prevalence was close to 0 and it's going up
- A lot of effort to get rid of it, goal is to eliminate it by 2030 but progress is very slow
- Community work to get rid of breeding sites
- Outreaches to community: health promotion department collaborates with malaria teams to go into communities to raise awareness on how to protect themselves, give mosquito bed nets, do house sprays, coordinate cleanups of stagnant water
    - Teach and do public addresses, funded by the MHMS

KII 5. Key Informant Interview: Retired Health Educator, Dunde Village, May 28th, 2018

0:00-2:35 Background

- First registered nurse from Western Province
- Worked as a nurse in clinics and hospitals around the country for 6-7 years, then switched to a health educator in 1969 for government, then worked for Helena Goldie for 20 years, then retired 6 years ago, stays home now but involved with youth and women in community for health promotion talks
- I changed my job to a health educator because my own children are not healthy, because I leave them with my sister here in the village, I must change my job and I must teach my sister and my family to keep up - personal hygiene, village environment, etc.
- To sister: Clean up the house: keep the pots and pans away, put them nicely, feed my children with proper kaikai, keep them clean and safe

2:36-9:05 Health promotion topics

- Personal hygiene
- Village environment
- Home
- Nutrition: so many malnourished children around (runny nose, skin diseases)
- Latrines: children get worms, everyone gets skin problems
- Simple sicknesses: scratches, red eyes, runny nose
- Over time, new problems arise: TB (still a lot), leprosy (not seen very much anymore)
- Pneumonia, skin diseases
- Family planning is the biggest problem: talk about family planning, spacing children out, health of the mother, health of the home, then contraceptives last → first topic she talks about
- Modern sicknesses: STDs, gonorrhea, HIV, alcohol, new drinks
    - You forget the skin diseases and village hygiene and leprosy because of the new diseases - but we still need to talk about these things (e.g. rubbish disposal, toilets, clean water, all the things that families use all the time, diets, gardening)
- Changing of diet: tells her family, don't feed your baby with all these snacks from the shops

9:06-10:00 Talks about things people see

- Go into homes and see rubbish everywhere, so people understand what she's talking about
- Nurses also come to take her on her tours, sees improper WASH and people saying there's no water to wash the baby - teach them ways to clean the baby
    - Talk about baby's skin, underweight, didn't receive immunizations, pregnancy health, breastfeeding, child feeding, so many things to talk about
- Proper water, "everybody must drink clean water", "try to find a way to get something, like a tank, or maybe we contact the water suppliers to supply some tanks or dig a well, or whatever"

10:01-12:10 Intersectionality of health promotion

- When you work in health promotion, you have to contact the family planning people, you contact the water supply people, you talk about the TB nurses, you talk about HIV doctors, because you don't talk on one thing. When you talk on one thing, there are other things. If you talk about nutrition, you have to go to diets, go to agriculture, go to fisheries, all those things…"

12:11-17:00 Water supply

- "I talk about mostly water, too." Visits where people get their water, asks people where they get their water, e.g. using stream water for drinking. She will teach people how to more safely manage their water, e.g. if they use stream water for drinking, she will instruct them to boil the water when the stream gets drier. "Talk about water, something else will come up from that"
- Her daughter works for the government and is trying to improve all the water supply in Gizo: improve wells in communities, providing new tanks to schools, etc. in villages.
- The new RDP bore holes are around in the community. Maybe they're doing it for the coastal families, but up-road here we all have bore holes. It works but in some communities they're

broken. Way back in the 80s, there was a water supply through the village but it doesn't work anymore.

- Here in Munda, every family have tanks to drink. We don't drink the bore hole water, but maybe we'll boil it when it doesn't drink. People think it tastes nice. People in other parts of this island still drink from wells and streams, say they've been drinking it for many years but don't get sick.

17:01-23:30 Best success in changing a community's health?

- Personal health mostly for women. They look nice and tidy, they clean. When they come to antenatal clinics, they look very smart.
    - In the 60s, they were dirty and their children were dirty.
    - To promote cleanliness, we just keep on educating them. We'll have workshops, community health talks, public talks, talks in the marketplaces, talk in the communities in church areas.
    - **"If the government has money, we have workshops"**
    - "The church hospital here, we do touring (Helena Goldie). But since there's no more funding, I checked and we don't do any touring in personal hygiene now." So we don't know if the improvements are sustaining.
    - The men also tidy up and groom themselves well.
- Child feeding: mothers feed their children biscuits or just dried rice. Some mothers are good, some are lazy.
    - Some mothers continue breastfeeding after 6 months, but she's lazy. Those things, I talk very strongly about.
    - Due to poor family planning, too.
    - Use implants and copper T, but some women complain about implants

23:31-26:00 Government's influence on what you do?

- **The things to do come from me, then I ask the government for the money.** Not them tell me to do it, it's up to me. I ask the Ministry of Health, I need some money because I want to put up a workshop here because of this, and they understand. They provide the money, the transport, a little bit of pocket allowance. Money has to be for transport.
- They will tell that this is a problem (e.g. family planning, HIV, TB) then it's up to me to plan then ask them back. This is how much money I need to go for 2 weeks workshop. We contact and communicate with each other.

26:01-34:10 Funding issues

- **Nowadays, money everywhere around the world is not available.**
- Asked 2-3 weeks ago if the person who took over her position at HGH if they still do touring, and he said not since she finished - not receiving the money. No more follow-ups to villages.
- Sometimes the nurses are not paid here, monthly or fortnightly. So the fisheries company (Taiyo) around Munda pay nurses' salaries.
- Other people who used to fund the hospital don't anymore, so no more money for the touring.
- She thinks it's New Zealand who gives the money, but stopped. The government gives some.
- They don't do anymore tourings. It's sad.
- Asked the people who are in her old position, try to write to other people to ask. One time she needed money to make a home kitchen to demonstrate cooking, and World Vision gave her money. If they can ask, then maybe they can manage.
- The hospital does a lot of its own fundraising, selling food or anything. Other business owners support. Everyone who is looked after by the hospital supports the fundraising. Other people from other islands also support the hospital. And the church itself helps too.
- **We hold on to our hospital. We don't want it to be closed, or become just a health center.** We have two doctors now who really improved the hospital. There are nice beds inside, we have an ambulance. 60-70 beds, general, maternity, children, and new TB ward.
- People come and see the hospital, go back to where they're from and support the hospital.
- The two doctors now do everything as good as possible to continue the hospital.

34:11-40:40 Who's in charge of running the hospital?

- The United Church of Solomon Islands is in charge of running the hospital.
- The United Church sits on the hospital board to talk about things. Know who to contact. The government also comes and sits for the "hard talks", otherwise the church board will contact the government to inform them
    - Involves government in more serious things, like running out of drugs government organizes for central hospital to send more if they have some
    - Referrals used to pay for trip back but now (since this year) the government only pays for the trip there
    - Anything serious that the hospital can't deal with, she contacts the government and they usually respond, unless the government has their own problems.
- The church and government agree about things.
- The government wants to turn the hospital into a health centre or clinic, but the United Church won't allow it. The church has their own power to say no, and the government respects the church.
- The hospital is looked after by the United Church but it's not private, it belongs to every other church
- Eye Team is here from Honiara for a few days to see patients

44:25-45:30 Are you aware of any NGOs operating in the area to promote health?

- Women's groups are strong in the provinces, and they hire NGO women's groups to attend some courses, otherwise not sure.

45:31-50:27 Biggest health concern for the community?

- In Munda, alcohol: homemade brews, people as young as form 3, smoking marijuana
- Not new but developing higher and higher
- Betel nut is not really a problem but mouth cancer
- If Helena Goldie has the money, they do outreaches on alcohol use, but they usually just talk about it every day during outpatient visits (marijuana, alcohol, betel nut)
    - Effectiveness depends on how much they care about the negative health impacts
    - It's like food, **"they know all about the bad ones and the good things about food, but it depends on them"**
    - Her son listens to the Australian doctor who told him the same thing his mother said

50:28-53:00 Keys to the success of a health promotion program?

- Keep on seeing the problem, see what's causing problems to the health of people. "If you don't understand the problem, you cannot change the people."
- Personally tries to eat well, look her best, make herself something os that when she talks about something people respect her. **"Look at her, she's old but she's still running around like a chicken"**

57:20-1:00:00 What do you wish the government would do differently so you could promote health better?

- She trained church leaders, teachers, women, village leaders, to teach them how to promote health. If the government did that, it would help.
- New problems are developing (alcohol, marijuana, teenage pregnancy, HIV).
- Doesn't matter how large the scale is, just stick to walking around in Munda if you can't get money for petrol. Next month, will go see the health education department and tell them to do it.

KII 6. Key Informant Interview: Staff from Health Education Department, Helena Goldie Hospital, May 30th, 2018

- Biggest health concern for the community is malaria and tuberculosis (TB)
- TB has had a spike in recent years because people have become less careful with preventing the spread of disease
- Health Education department is just two people, her and her boss, who tours to different villages nearby to do outreaches in schools and communities
- Main outreaches are to spread awareness on malaria and TB: teach people cleanliness and hygiene, how to manage mosquitoes (removing mosquito breeding sites and standing water)
    - Go to community halls in villages near Munda, and schools to teach cleanliness and hygiene
    - Also spread information during outpatient visits on prevention
- Main challenge: not enough funding to go on the outreaches
    - Supposed to do five outreach tours per year, but only did three last year
    - The department is happy to do the outreaches, but just need the money to get there (fuel for cars and boats) and some basic materials (projectors for community outreaches to engage audience, a generator in case the location doesn't have electricity)
    - Funding just comes from the Helena Goldie Hospital, she isn't sure how the money got there
        - Budget is only around $5000 for the whole year, which is not enough to do the outreaches they want to do
    - Not aware of any donors, but either way they go through the hospital first and don't directly communicate with the health education department
- Would be open to working with NGOs for support for their outreaches?
    - Yes

KII 7. Key Informant Interview: Assistant Nursing Officer, Acting Hospital Supervisor, Helena Goldie Hospital, March 30th, 2018

Can you tell me about what you do here?

- Nurse and midwife, spend a lot of time in the maternity and labour ward, up to 5 deliveries per day
- Reproductive health department: antenatal clinics, child care, postnatal care, family planning
    - There is a program to do outreaches
    - Yesterday, they went to a school in a village to immunize 3+, 6-year-olds for tetanus and polio and talk about the importance of hand washing with soap

School visits: Immunizations and hand washing

- Once a month, go to a different school every month
- Run by the Reproductive Health Department at HGH, which integrates with the Health Promotion Department

Do you partner with other organizations for outreaches?

- It's just the hospital: health promotion, NCDs, TB all go together for the outreaches, but it's just from within the hospital
    - Before one of them worked at HGH, she worked at the Ministry of Health, which partnered with the Solomon Islands Planned Parenthood Association (SIPPA), an NGO with branches in Gizo, Malaita and HQ in Honiara. Provide services like family planning, corner for adolescents to get information, services for people with STIs (there's a nurse)
        - A good relationship
        - Ministry and SIPPA meet often, whenever they want to talk, work very closely in partnership when there's a disaster (e.g. flooding)

KII 8. Key Informant Interview: Reproductive Health Coordinator, Helena Goldie Hospital, May 30th, 2018

Introduction

- Coordinates touring for the Reproductive Health Department
- Mainly works with women and children up to 5 years old
- Search for children who they know have not had their immunizations yet (keep track of who they are at the hospital; when they are born or come in for their first immunizations, they are put in the register), because they don't have the resources to come in to the hospital if they live far away
    - Go to schools to give the immunizations, around the lagoon
    - Also give preventative tablet for hookworm to more children (more than immunizations) for the most susceptible age
        - Tablets last for 3 months, but don't have the resources to go to the same school every three months so they just give them when they can
        - But must go to give the immunizations for 6-year-olds because those are the most important, that is the priority

Funding

- Most of the funding comes from the MHMS and some donors (e.g. UNICEF)
    - This hospital is run by United Church
    - Donors don't give just money, e.g. to fuel
    - E.g. UNICEF gives money to the MHMS, who pays for things like vaccines and materials for the hospital to use (doesn't give much cash to the hospital)
        - MHMS comes to the hospital to interview them before they receive anything
- "Me askem on government for givem fee because because our department touring next month"
    - Currently not enough funding to the hospital, so the department is currently asking the politician to pay the fee so they can run to the constituency and immunize the children at school visits.
    - 3 MPs representing three constituencies around here
    - "We don't ask for money, we just ask them to pay fees to buy the fuel" and prescriptions
    - So far ⅔ of the MPs are doing it, and it's happening next month, still doing communications with them
    - She's not sure where this money from the MP comes from - "We just ask for assistance, how the money come we not gatem good idea"
    - Almost election time, one next year and a smaller one next month: I get this chance to ask them for help, "for makem cover full place, all of my children for immunization, then the election will come" "When I ask them, they didn't say no, because the election is next month"

Challenges with working with the government?

- Hard to talk to the government directly, "we need to go through channels so lelebet hard"
- So we stay at the provincial level, sometimes the national level comes down here to interview us
- Any money that comes has to go to the provincial level (Western Province), and then THEY distribute. They are the ones who are face-to-face with the donor partners, and we don't talk to them. It would be better if we talked to the donor partners directly so they can see what we are doing - "we're the ones that carry out everything" - they know best.

Have you ever worked with an NGO in the past?

- No

KII 9. Key Informant Interview: Department of Rehabilitation, Helena Goldie Hospital, March 30th, 2018

0:00-5:00 Can you tell me about what you do?

- Do community-based rehabilitation (CBR), deal with people with disabilities within communities and provide physiotherapy - doctors refer to him and he will see them in the communities
    - Also just talks to patients in the wards
- Do outreaches in communities, visit people in homes and meet with their families and communities - train them how to take care
    - Here is different than in other countries. “People in rural areas don’t have the knowledge to take care of people with disabilities. They don’t know them, they neglect them, they don’t want to take them to church activities or community activities. They just leave them alone at home.” “So most of the people in the communities don’t even know that there are people with disabilities in the communities.”
        - His responsibility is to help them be seen; teach them, educate them on how to look after them, and take people with disabilities out so they can be seen by the communities
- This hospital looks after a broad area and face financial problems, so can’t go out to remote villages - four years now since the team (with other departments: health promotion, reproductive - they have a little bit of money so they can go out, but other departments like laboratory and NCDs and rehabilitation can’t go out).
    - Rehabilitation department only goes out as a group with other departments, “one basket”, and all go together because they only have a very little bit of money. So used to go out as a group. Now there’s not enough money to go out on a boat, can only go by bus.

5:01-7:14 How often do you go out into the community?

- Tuesdays and Thursdays every week for the visiting program to different villages (including Dunde)
- Dunde has a high level of disabilities, so he goes there more. But it depends on what sort of assistance or activities he needs to do in the communities.
- Only he goes, and sometimes he feels sick or tired so it doesn’t happen

7:15-15:24 Examples of activities he does in the communities?

- Dunde, one patient with muscle weakness from TB and lower blood supply to legs, who can walk with a bit of assistance. He provided a pick-up/walker frame to her and trained her how to walk with the frame. Previously, she couldn’t walk alone, but now she can walk slowly to the toilet and back, the shower and back, independently. She couldn’t walk for 10 years.
- One person could walk but didn’t have accessible sanitation, so he contacted the Environmental Health Department for toilet facilities. Then he went to the community and the community and families helped to build the toilet for free. He organized it: talk together, come up with solutions, community came together.
    - “That’s what rehabilitation needs to do”
    - Department of health environment is part of the MHMS, provides money and materials depending on how much money they have
    - “Currently, all of this year, they told us that they ran out of money, so they cannot provide us sanitation materials”. “So we’ll see”
    - Next month, a meeting with all the departments in the Western Province will meet to see what’s really going on with the money
- Provide awareness, talk about disabilities, normal and abnormal development for infants to mothers for early therapy so children can catch up

15:25-19:25 Most common disabilities?

- Most common issues for children are downe syndrome, cerebral palsy
- Most common disability for adults is amputation due to diabetes

- Sees them in the hospital for amputation, then goes to their community for follow-ups to asses the whole environment, have to train them how to walk, see what places are inaccessible to talk to the community to help make it more accessible and maintain it.
- Awareness talks once a month; before I used to go to the communities, but the communities have too many commitments and cannot attend the programs, so he changed to target the church people because they are more receptive and easier to talk to. So he makes a small group (6-10 people) with church leaders, who will make their own program to pass on the knowledge.

19:26-25:59 Biggest successes?

- Dunde community really listens to what he tells them to do, and know exactly what he means, and understand their responsibilities
    - "Important that all people have the same rights, same opportunities" "We we do, they do. What we eat, they eat. Equal rights, equal opportunities. We are the same"

26:00-27:10 Challenges?

- Need to rely on the hospital for funds for transportation and logistics. If they had the funds, they could go to the outer islands. No funds, our work stops.

27:11-31:03 Have you ever partnered with NGOs?

- So far, no. Might in the future if they come and arrange with him, hopefully if they have a program that comes then they could coordinate something - he's flexible.

KII 10. Key Informant Interview: Reception Staff, Helena Goldie Hospital, Munda, March 30th and June 1st, 2018

Renovations to hospital at a standstill because of a shortage of resources

- Funding comes in materials (Rural Development Fund sends boxes of tools and materials) and less often cash (when it comes directly from the government) - currently out of materials
- Laboratory needs to be renovated
- This week, the Eye Centre is touring to operate on people at HGH

0:00-3:35 Background of the hospital

- Whole of Roviana Lagoon and from Zela (6 hours by boat)
- All referrals go to Gizo because they have all of the equipment
- 3 doctors here doing very well, "we always have full house", about 60 beds
- The departments are laboratory, operating theatre, outpatient department, eye clinic, pharmacy, maternal health, reproductive health, health education, diabetes
    - Three sections: supportive, paramedics and medicals

3:36-5:00 TB and diabetes

- Have a lot of cases of diabetes, there are amputations here for diabetes (the more complicated ones go to Honiara or Gizo)
- TB and diabetes are the most common diseases here
    - "Recently, since I've came to this hospital, I've noticed heart problems, diabetes, and TB."
    - Building a new TB ward

At 5:00, the two Swiss doctors joined the group and took over the tour of the hospital - stopped recording.

- Since they've been at the hospital, they changed completely changed the cleanliness - it was a "catastrophe" before because it was unhygienic
- Made the nurses keep the wards meticulously clean, change sheets, not let the patients eat in bed if possible - used to not have this practice and people were getting infected (e.g. flies moving from one patient's open wound to another)
    - Now have fewer infections, floors and ceilings are clean, have alcohol for disinfecting, don't let patient's family sleep in the empty beds
    - Seem to have changed the mindsets and habits of all the nurses
- Brought hospital beds and an ambulance when they came here from Switzerland, here for 2 years
- Some materials were given by Red Cross

KII 11. Key Informant Interview: Council of Elders, Dunde, May 28th, 2018

Original transcript provided by Amanda.

18:00-22:45 No plan for NGOs in Dunde, but a lot of them go through government; "Rural areas no happy tumas, think those NGOs have to come here."

- "When the NGO wants to come to our village, they should ask us what we want. That's why we want NGOs to come straight to us and not go to the government, because when they go to the government, the money is not in the right place, there are so many areas where the money doesn't go to the right people."
- "Most NGOs centralize in the capital. Their implementation in communities is not very effective because it depends on their funding, or it depends on the person who organized the program. Most of the time the coordinators misuse the funds and the projects were not completed. A lot of times, there are disputes, land disputes… a lot of things that can impact the program."
- RDP came here, Save the Children, social welfare tried to promote gender equality but they don't come regularly - only certain times (1-2 times per year).
- NGO implementation and framework sometimes does not really work in our community.

22:46-23:55 What would you like to see the NGOs do differently?

- Want them to come see the communities, whatever project can accommodate the community, especially agriculture.

24:04- Have you heard of the presence of the Taiwanese government in the community?

- "Doing very good here, come straight to the community."
- Doing agriculture sites, mainly fruits and vegetables, food and nutrition; around for 15 years but stopped.
- Land usage disputes - lost interest and stopped 3 years ago.
- When it was still operating it was good, until they gave up to the agriculture department the problems arose
- Taiwanese more on the ground and engaged with community vs. Agriculture Department were more office people
- EU seaweed farming not here.

FGD 1. Focus Group Discussion: Women, Dunde, May 29th, 2018

2:25-8:00 Biggest health problems in the community?

- "The main health problem here is diabetes."
- Biggest contributors to diabetes: "Our way of eating has changed."
- "The help from the community is: don't eat to much food from the store. Go back to our home food, local food. Because our blood suits our local food. If we turn to store food - rice and tea every morning, biscuits, noodles, taiyo - then that causes the problem. We get our legs chopped off from diabetes. The doctor says that you should go back to your local food."
    - Here in Dunde, we drink a lot of tea and sugar in the morning. It's a normal thing in our kitchen to drink... and eating a lot of imported foods from the shops. (RA)
- "Our nurses make awareness. We have a diabetes clinic at the Helena Goldie, and sometimes it goes around giving awareness talks." Tell community not to eat too much imported food, "but we are used to drinking tea and sugar."
- Other organizations in the community to spread awareness? No, just the hospital
- How often do they come to this community? It depends on their plan of the year or mission of the hospital or clinic, and many times it depends on the funding.
    - Don't see any nurses coming recently.
    - Sometimes they will be invited to come, but they're not interested.
- People are aware that they should eat better, but they don't care; "they put sugar in the tea when the nurses aren't looking."

8:01-9:50 Any other organizations that have implemented projects in Dunde?

- RDP just installed water pumps, improved the dug wells (added pumps and covers)
- Added 40 pumps around the area
- Put two pumps in per zone, but it depends on the coordinator of the project. Last year they installed less than 20 pumps.

9:51-11:57- Accessibility of the pumps?

- "I think it's still not enough"
- Use the pump water for swim, washing, toilet, and drink from the tank
- "The pump is 4 steps from my house" - "not most of them, some of them are a big distance from the tank."
- Since the water supply was disrupted by the earthquake in 2007, Munda was a water problem, so the alternative was to dig out wells. Most households have dug out wells. Some of them are identified by RDP, most of them have yet to be identified.

12:00-12:39 Safety of the water sources?

- I think the open well is not really safe
    - Sometimes people fall in the wells
    - Sometimes the mosquitoes will breed inside the well

12:40-13:10 Why do you prefer to use the well water rather than the pumps?

- Because the bore pumps are far away.

13:11-14:25 Did RDP or the community request the project?

- They selected areas where they put the pumps, far away from where there were wells already
- They put pumps in the far back area, but the seaside areas already had wells
- Community did not give their opinion

14:26-19:15 MP and water tanks

- Dunde used to have pipes for a water source, but then logging came in and the health officers tested the water and disqualified it, and after 20 years there is no replacement. Now they are improving the wells
- The MP here gave water tanks
    - Zone leaders went around to the families and asked them what they need, to decide who to give the water tanks to

- (Do you think the way they distributed the tanks was fair?) No - it depends on the leader, the person who collects the data. “If that person do not favour you, then you will be without tank for many years. It depends on his favour or her favour.” (RA)
- Our constituency MP looks after a big area, and sometimes he doesn’t have enough tanks, and sometimes people don’t wait - they just go up and take for themelves.
- “Again, I think it’s the MP’s fault, because we should have this every year, but he waits until it’s the 4th year.” (facilitator: like election year? everyone laughed and agreed)
- I think maybe 3-4 houses share one tank - I think the MP can provide a tank for each individual
- If you’re a voter of the MP, or one of them, then you’ll be the favour of the election, or the middle man. “If you’re not a voter of the MP, then you will be disregarded” (RA)
    - “It’s unfair.”

20:00-20:20 Would you say the implementation of the bore pumps have helped the community?

- Yes
- (Do you think there are enough water sources for the community?) Not enough yet. If there’s a dry season, 3 or 4 months…
- Go to the river to collect water 10km away when the rainwater tanks run out.

20:21-27:24 What improvements would you like to see for the water sources?

- “That is our prime concern here, to get better water, so that accessibility is on our side” (RA)
- There’s a water source south-west of Dunde that we should use, but it could cost us a million dollars to take that water source (RA) - still just a proposal by the government to tap that source
    - Still needs engineering work, technical work, the worst is land disputes because you have to pay compensation to go through their land to access the water
    - The government has representatives come to talk to the community leaders, “but leadership in the community is centralized in the males. Females and young people don’t have a voice.” (RA)
        - The male leaders have different priorities than everyone else, these projects benefit them more
- (Do you think the government and/or organizations could improve their communication if they talked directly to more women and young people?) All agree.
    - It’s just accepted that the channel goes through the elders, who inform the community
    - “Because in the past we had honest leaders, and today we have different attitudes.”
    - “They withhold the money sometimes”, they want to accumulate more for themselves
    - Example: ~30 years ago, the leaders rejected Solomon Power, and until now they still don’t have electricity.
    - “So, it is a problem of leadership. It is a problem that they have more powers than us. What they decide is final” (RA)

27:25- How do you think the situation of greedy leaders can be improved?

- “I think it will be if they all die” “It’s funny, but it’s true.”
- “It’s a way of Melanesian. They always choose men and not women and children. Their voices are not heard.”

FGD 2. Focus Group Discussion: Youth, Dunde, May 28th, 2018

Original transcript provided by Amanda.

13:00-17:40 International NGOs will come in to our community. The objective was to help us, and help the children, and help all of us. Established in Gizo then come in on a contract basis, 3-5 years, then they go away.

- E.g. Kastom Gaden Association (where he worked for 2 years) taught people how to plant and till the land. It still exists but never reached us again, not sure if because of distance or lack of finances.
- "Most of the NGOs help us so much. They gave us water tanks here, that was RDP project, in our community they allocate tanks, one for each group." And then they gave us a pump to draw water from the well.
- "Yes, NGOs are very effective in some sense. They help us a lot. But in their absence, we find a way. I think it's a symptom of the third world: breastfeeding. Maybe we should change that mentality, I think."
- Negative of NGOs is "The time is very short", only stay for 3 years at a time, which isn't enough.

17:46-20:35 What makes an NGO successful here?

- Funding
- Bottom-up development (e.g. UNDP)
- Work with the right people in the community - "In our Melanesian society, if someone has a bad reputation or is misusing funds, we totally reject that person. We ignore them." "Some NGOs are successful because they work with the right person, and some are not successful because they work with the wrong person."

20:36-21:15 What improvements could an NGO make to be more long-lasting and impactful?

- "They should change their strategy and approach in meeting people and how they work with the people."

21:20-22:40 What services do NGOs provide that governments don't, or vice versa?

- NGOs come down to our level in rural places, work with the people.
- "The government is stationed, they stay in the office and do what they want. They play on the computer."

22:45- Successful NGOs?

- Save the Children: work with students and young people, go to secondary schools and do awareness on how to protect themselves, look after themselves. "It really helps." Promotes women's and children's rights.
    - International organization funded by AusAID

Table 1. Community Perceptions of Health Problems in Dunde