Evaluation of Men as Partners in Reproductive Health through Organized Workforce

for the

United Nations Population Fund (UNFPA)

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## List of Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>CBD</td>
<td>Community Based Distribution</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CBT</td>
<td>Community Based Training</td>
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<td>CIP</td>
<td>Central Islands Province</td>
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<td>FEF</td>
<td>Fiji Employers’ Federation</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FSMed</td>
<td>Fiji School of Medicine</td>
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<td>FTUC</td>
<td>Fiji Trade Union Council</td>
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<td>FSPI</td>
<td>Foundation for the Peoples of the South Pacific - International</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>MAP</td>
<td>Men as Partners</td>
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<tr>
<td>MHMS</td>
<td>Ministry of Health and Medical Services (Solomon Islands)</td>
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<td>MIRH</td>
<td>Male Involvement in Reproductive Health</td>
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<td>MOH</td>
<td>Ministry of Health (Fiji)</td>
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<td>PCDF</td>
<td>Partners in Community Development Fiji</td>
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<td>PICs</td>
<td>Pacific Island Countries</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>SI</td>
<td>Solomon Islands</td>
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<tr>
<td>SICCI</td>
<td>Solomon Islands Chamber of Commerce</td>
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<td>SICTU</td>
<td>Solomon Islands Council of Trade Unions</td>
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<td>SITA</td>
<td>Solomon Islands Teachers Association</td>
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<tr>
<td>SMEC</td>
<td>Small and Medium Enterprises Council</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>ToT</td>
<td>Training of Trainers</td>
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<tr>
<td>TOR</td>
<td>Terms of Reference</td>
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<tr>
<td>TPAF</td>
<td>Training and Productivity Association of Fiji</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WTO</td>
<td>World Trade Organization</td>
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Executive Summary

The purpose of this evaluation was to assess the design, efficiency and effectiveness of the project, assess the short term impact and potential relevance of the project in the mid to long term, document lessons learned and best practices, identify viable approaches in the context of UNFPA Programme of Assistance to identify more effective strategies for expanded approaches to MIRH in the Pacific.

The involvement of The International Labour Organization (ILO) in this program rests upon its’ Gender Equity, Workers with Family Responsibility and Social Dialogue strategies; and, on the overarching strategy to open dialogue between employers and employees, recognising that family life and workplace productivity are related. It is a well conceived and innovative strategy with great promise. It relies on a technical partnership with UNFPA for the preparation of training materials and media information and for either providing, or negotiating for, technical inputs at workshop sessions.

Since its inception MIRH has set the foundation for what must now become a greater expansion across and down the levels of the workforce. However, it is evident to many that this information should also be made available to the general population, and that a combination of workforce and Community Based Training (CBT) approaches would make a major contribution to gender relationships in the Pacific (see 5. Additional Comments).

This evaluation presents a synopsis of the views expressed to the consultant in the Solomon Islands and the Fiji Islands within a short timeframe in June-July 2007. Details of project implementation are available in Annual Reports and are not duplicated or evaluated here. The information gathered was quite consistent within and between the two nations visited, providing some validation of the essentially common human issues identified and discussed. In addition, the same frank and open manner in the exchange of information and opinion signifies a new ability for open discussion on sensitive issues of gender partnering and family life.

The project has been very well received, follow-up has been requested and many participants have held training activities on their own initiative, while some have built the MIRH materials into other training opportunities. IEC materials have been distributed and people want more, but request the use of local languages. The need for presenters of this content to be health professionals was often expressed. The inputs of medical personnel were greatly appreciated, as was their professional and secular approach to the sensitive content. Some comment was made that presenters need to maintain a factual approach and guard against moralizing and paternalism. Careful selection and training of presenters will be needed to avoid this recognized potential.

The evaluation reveals the importance and the acceptance of the fundamental rationale for MIRH; the relationship between home life and workplace productivity, and raises discussion on the relationship between population growth and rural development and the relationship between family size and poverty.

Recommendations include the change of name to Male Involvement in Family Health and a resourced programme of activities to extend further into the workforce, particularly to ‘at-risk’ industries, and to include females; and, a concurrent broader dissemination of information and materials by CBT to the general population.
1. Introduction

The overall objectives of the project was to contribute towards improved RH status of the population in Fiji and the Solomon Islands through the provision of adequate RH information, counselling and services in line with the principles adopted at the International Conference on Population and Development (ICPD) (See Appendix 1).

The output of the project will have contributed to the RH sub-programme (MYFF Output P103) i.e. ‘to have increased the capacity of men to make informed decisions on RH issues, gender issues, parenting, healthy lifestyles, responsible behavior, sharing of responsibilities, healthy couple communication and counseling skills’. It was anticipated that the project would empower men to reduce their involvement in risky behaviors that contribute to sexual problems, communication breakdown, stress, domestic violence, family break-up and poor work performance.

The implementation strategy was to target specific groups of men in male dominated industries through well established employer and union tripartite arrangements, fostered and maintained by the ILO as part of its ‘Decent Work’ program. Specifically, the project worked through the Fiji Employers Federation (FEA), the Fiji Trade Union Congress (FTUC), the Solomon’s Islands Council of Trade Unions (SICTU) and the Solomon Islands Chamber of Commerce and Industry (SICCI). In partnership with UNFPA for the provision of technical support in MIRH materials and in training, the ILO facilitators, employers and trade unions collaboratively implemented the programme in a variety of settings.

This evaluation comprised a document review, a number of small group discussions and individual discussions with key informants in Honiara in the Solomon Islands and Lautoka, Nadi, Suva, Labasa, Ba and Rakiraki in the Fiji Islands.

2. Findings and Conclusions

2.1. Findings of the desk review.
Previous evaluation reports on MAP and MIRH projects\textsuperscript{1,2,3,4,5} reveal:

- the need to focus on youth and to respond to their demand for information.
- the need to provide workshops and IEC materials in the languages of the Pacific.
- a lack of a strategy to deal with the sensitivities relating to culture in discussing sexual health issues in gender mixed groups.
- men’s limited understanding of both male and female anatomy and physiology and of their female partners’ physical and emotional needs during pregnancy.
- the MIRH suffered from a lack of inception stage that would have allowed for the standardisation of teaching materials and staff training in their use.
- no formal evaluation has been conducted on the issue of men’s behaviour change.
- the MIRH project was of short duration, did not articulate well with the prior MAP and was concluded without a strategy for sustainability.
- limitations in MIRH project design and in baseline information made it difficult to identify progress towards project outcomes.
- resources allocated to the media strategy and to behaviour change research were insufficient.
the Solomon Islands incorporated the MIRH approach into their strategic plans to combat HIV and AIDS, while the Ministry of Health Fiji concurrently developed a Men’s Health Policy that includes a focus on men’s role in the family.

2.2. Findings of a brief literature review

Becker\(^6\) review of couple studies found that ‘reproductive health interventions targeted at both partners have resulted, in most cases, in higher rates of contraceptive use and are especially important to reducing transmission of sexually transmitted diseases, including AIDS. The author concludes that couples are the most appropriate focus for reproductive health programs, but acknowledges that costs of program expansion and other issues must be addressed’. Due to limited resources in Pacific health budgets care must be taken that the inclusion of men’s health has the potential to erode resources for women’s health.

Bhalero\(^7\) confirmed in India that the involvement of prospective fathers in clinic attendance produced a significantly lower perinatal mortality and a higher acceptance of postpartum sterilization than in a comparison group.

Clark\(^8\) illustrated a number of issues that have arisen in Scandinavia, which are of interest here in that they detail the social complexities of programs such as MIRH and forecast some of the issues that may arise in the Pacific. Unresolved issues included concerns about how to address gender in programs that want to encourage men's participation; how to address men's reproductive rights while consolidating and expanding the reproductive health rights of women; whether and how essential it is to serve male clients only by male providers; and how to balance the strategy of treating couples with the needs of individual women and men.

Figueroa\(^9\) in Mexico points out ‘how men have either been completely ignored in fertility analysis or are considered as another, usually problematic, factor in the fertility of women, the main focus of analysis. Men's fertility is seldom considered’. He proposes new indicators to measure men's fertility and wanted pregnancies; for instance, an individual's reproduction rate, estimating the average number of live born children per male, and the average number of children conceived by common accord.

Fisek and Sumbuloglu\(^10\) conducted a study in rural Turkey in which the experiment group of husbands and wives were given specific information while the comparison group was not. Information presented to wives was designed to overcome specific factors that hindered contraceptive use. The emphasis for husbands was on the adverse effect of high fertility for the family and for the nation. Data collected revealed a significant increase in acceptors in both study groups, with a greater increase in the experiment group and a corresponding decrease in discontinuation rates. Measurable changes in attitudes occurred, but these were not statistically significant.

Helzner\(^11\) discusses the importance of taking into account the interplay between men's and women's roles, rather than focusing on women's situation (or men's) alone. He examines the gender dynamics of contraceptive methods and other issues of male control related to women's reproductive health and cautions against implementing men’s involvement programs that result in worsening existing male dominance.

Raju and Leonard\(^12\) summarize 20 case studies on male involvement in reproductive health programs in India. They emphasize partnership between men and women with the objective of improving women’s reproductive health, decreasing maternal morbidity
and mortality, and improving child welfare. The document includes a discussion of common findings and recommendations for future actions.

Terefe\textsuperscript{13} studied the relative efficacy of home visitation with and without husband participation on the use of modern contraception in Ethiopia over 12 months. A greater proportion of couples in the experimental group were practicing modern contraception at 2 months (25\% versus 15\%) and 12 months (33\% versus 17\%) following home visit intervention. By 12 months, experimental subjects were less likely to have defaulted and more likely to have started using modern contraception following an initial delay.

2.3. Findings of the Solomon Islands and Fiji Islands discussions

The consultant conducted interviews and a focus group discussion in Honiara between the 16\textsuperscript{th} and 22\textsuperscript{nd} June and in Fiji on the 25\textsuperscript{th} and 3\textsuperscript{rd} July 2007. Several telephone conversations and email exchanges took place prior to these times.

2.3.1. Solomon Islands

In the Solomon Islands (SI) there was a broad agreement that the participants of the ToTs had ‘learned a lot’ and that the information provided was an ‘eye-opener’. The project was well identified with the ILO and the underlying rational of MIRH approach was well understood. Some discussants thought that the programme had not been made as widely available to the organised workforce as it could have been. A longer and more effective preparation period and inclusion of the Small and Medium Enterprises Council (SMEC) would have improved the programme reach. Comment was made that the programme had not been resourced beyond the ILO participants’ expenses and that they, themselves, had gone on to implement the programme ‘from the heart’ and out of concern for their community. A follow-up program is expected, and it is anticipated that it will be conducted across a broader industry base.

It was suggested that the trade unions could play a greater part if their constitutions referred to family life as a duty of care and an important contributor to workplace performance. This would encourage employers to see the relationship with productivity and to support workers with family responsibilities where possible. However, while employers may become more considerate of family needs they would still be bound by the realities of the workplace and the need for men to take leave or make time up if they were absent from work for family reasons. Although paternity leave was a new concept now articulated in enterprise agreements all discussants agreed that it is never applied for.

It was agreed that the project needs to extend further into and beyond the formal workplace, as there is a large informal workforce operating in SI. Further still there are large numbers of unemployed and relatively uneducated young men in Honiara and large numbers of subsistence farmers in the provinces. It was considered that the provision of brochures, pamphlets and other IEC materials in Tok Pigin and inclusion of the content in the "Fast-track’ program on One News (TV) and on health promotion radio spots would assist in getting information to these people, in digestible ‘bits’.

Comment was made that although young men tended to joke and tease each other about matters of sexual health that this was still a valid form of communication in which new information could be exchanged and informally passed on. Several discussants had observed in their community liaison work that it was necessary to build relationships with these young men before they were receptive to new information, but once
relationships and trust were established they were highly receptive. Further comment was made on the fact that these informal and unemployed groups were actually structured around ‘leaders’, some of whom are churchmen, while others are naturally skilled at organising work groups for community improvements. Training such leaders would be an important strategy to get information to young men. It is a fact of urban SI society that ‘big men’ emerge through their own reputation and are elected as leaders rather than acquiring leadership through familial and hereditary rights.

While some male role models known to have good family relations could be identified, it was thought that the best application of their celebrity would be limited to the media, as they may be considered by the average man to be unapproachable due to their position. Soccer players were thought to be potentially the most influential in this ‘soccer-mad’ nation.

Although the project initially targeted the male workforce, some females also participated in the ToT. Their presence was considered positive and it was agreed that more women need to be involved in this project. There was a danger that men, working in isolation from women, may mistake women’s perceptions and go off ‘on the wrong track’. One insightful discussant recalled how, during one workshop, the men had dominated the discussion and that the women’s comments about men’s misconceptions were heard after the workshop had finished. Another had observed that female participants had participated well and used the opportunity to learn and discuss. The suggestion came that an equal number of male and female participants would be better in the future. This point is of interest as the expectation that the parameters of gender relationships could be altered by informing men alone may be naïve. However, SI society is a mixture of both patrilineal and matrilineal structures, so no single approach will apply across the nation.

Several participants in the ToT had subsequently run workshops for their staff and associates. The Solomon Islands Teachers Association (SITA) had run three workshops for teachers in the Honiara SITA branch, the first with males only and other two with mixed gender groups. The mixed groups were considered to be far more effective. The sensitivity of the content was overcome by setting some ground rules before the workshop began. These were based on respect for the other participants, an open acknowledgement of cultural sensitivities, the relevance of the information for the participants’ own lives and the link between reproduction and the realities of emerging national economic stresses. This strategy overcame the potential difficulties and the workshops then proceeded.

The role of teachers (there are 5,800 teachers in the Solomon Islands and 250 new graduates per year) in disseminating RH and gender relationship information has enormous potential, not only among school children but among the general community. Teachers are dispersed across the nation and command a great deal of community respect. As an example, the Malaita Province has 58 schools (23 high schools) but only four RH nurses. The teachers’ role routinely extends beyond the classroom to the general community and communities commonly construct their local schools from their own resources, indicating the great value placed on education.

To support the development of this potential it would be necessary to increase the RH content in the teacher training curriculum and to engage the nine Education Authorities located in the provinces. It was suggested that the RH content in existing teacher training curricula could be strengthened, as could the health sciences subject taught in high school curriculum, designed to prepare young people for adult life.
The issue of connecting with existing public and community structures provides an important opportunity for disseminating RH and MIRH information and for connecting men with specialised clinical reproductive health services (such as vasectomy and STI/HIV testing). The RH nurse in the Central Islands Province (CIP) has started working through the Provincial Council. This approach has proven successful elsewhere. The disjuncture of MHMS service zones and administrative boundaries with those of local government wards presents problems of coordination of services to and within communities. The strategy of aligning health zones with local government structures provides potential to access the community that has not been fully explored in SI but is recognised for its potential.

One of the formal employer groups in Honiara had offered free medical check-ups to all of their staff, due to high rates of absenteeism and sick leave applications. They found that 56% of their male workforce had an existing STI. This alarming statistic was reflected in all levels of staff. It was confirmed that men who suspected they had an STI tended to deny the symptoms until they were overwhelmed by fever or dysuria. The serious implications for their spouses and partners are obvious. Comment was made that unmarried men are more willing to undergo STI testing than married men and that married men often seek treatment from private medical practitioners rather than attend a public STI clinic, but that treatment is commonly ineffective, due to either; the prescription of the wrong anti-biotic, or, partial treatment due to the failure to complete the regimen. It was generally commented that the MIRH program had generate increased awareness of the need for RH health counselling and clinical check-ups, however, no evidence was obtained to that effect.

Some questions remained as to methods of the wider dispersal of MIRH information to the general community. All agreed that the content of the program should be made available to all men entering, or of, reproductive age. All discussants agreed that SI was experiencing a cultural change that allows a more open discussion of family issues, particularly in urban areas, that men were generally becoming more concerned with family matters, but that the presentation of anatomical information remained sensitive in mixed gender groups of rural people. It was thought that the increasing realisation of the national economic situation and rising personal financial pressures create a need for new cultural approaches and solutions that eventually overcome this constraint in both educated and uneducated groups.

### 2.3.2. Fiji Islands

Discussions in the Fiji Islands were largely consistent with those in The Solomon Islands. All participants in prior ToTs gave very positive responses as to the content and its application to their lives. Many had gone on to discuss the content with family and friends and among others in the workforce. All considered that the materials should be made more widely available than through the organised workforce alone, but supported the approach that the ILO and UNFPA had taken as a solid starting point. Further work could be done through the organised workforce as the initial project start has been limited to only a few workplaces and industries. There would be a need to extend to other trades unions and to small enterprise councils to continue developing the approach in the formal workforce.

The important rational for ILO involvement in reproductive health was widely understood to be the relationship between family health and happiness and the productivity of the worker in the workplace. This rationale is eternal and, therefore, it will continue to provide an important entry point for ILO partnerships with others in introducing health
promoting programs and materials. It is a very effective approach. Consolidation of some favourable conditions of employment, such as paternity leave, in enterprise agreements could continue to provide structural assistance to achieving the MIRH objectives.

Discussants thought that more follow-up workshops would be needed to cover their own workforces adequately, but some had initiated discussions themselves and found among their peers a great interest in knowing more. Others thought that many important sectors had not been invited (e.g. maritime workers in Fiji) yet may be the groups most at risk of both STIs and marital disharmony. Some employees thought that their supervisors needed to attend this program to understand their workers situations better. They were keen to hear when the next workshop would be provided. Others who had attended the ToT workshops had since gone to STI clinics for voluntary STI/HIV tests. Another stated he had cut down on drinking and that his wife had noticed and thanked him for it. Some suggested that the ILO could negotiate with the Training and Productivity Association of Fiji (TPAF) the inclusion of MIRH in the TPAF list of endorsed training programs, so that further workshops could be funded from the 1% of salary that employers pay to TPAF for training assistance.

Some mildly adverse comment was received about the follow-up workshops being presented in a paternalist and moralising way. There is a real risk of this happening with this content, so the selection and training of presenters should include some briefing on factual content delivery. The need for sensitivity in these areas extends to the need to respect other people’s beliefs and to gear delivery to the recipients’ level of education. Content must be provided in a secular manner and at a level that acknowledges the prior knowledge and status of the recipients. Participants all agreed that medical and health professional staff must be involved in the workshops and they expressed great respect and thanks for the medical staff who had attended.

One interesting point arising in Fiji was that high school students who elect to study arts or commerce subjects will miss out on health sciences, life skills and reproductive health education in their school years. This comment was stressed by several people who had found themselves at a reproductive age knowing very little of the facts of reproduction, or the skills of partnering in spousal relationships. Consultations with doctors and nurses at clinics had not been informative and had concentrated only on medical issues and had not touched on the other aspects of partnering and parenting.

It was suggested that educational gap be filled by a change to the school curriculum that requires all students to study health and life skills. [UNFPA/UNICEF and SPC have already commenced the process of reviewing school curricula for the inclusion of Family Life Education]. Comments were made that this would have to be conducted in such a way as not to alienate parents – so some parent preparation programs could be needed, and materials presented in such a way as not to generate a reaction. Several made suggestions as to how to disseminate the materials more widely. It was agreed that a negative moralising approach (don’t do this or that) would not work with young people and that materials would have to be presented in an informative way geared towards generating behaviours as much as towards adding to knowledge. As in the Solomon Islands, discussants thought that young people living alternative lifestyles could be approached with this information but that workers needed to develop relationships with them before any trust could be established and information shared.

Comment was widely received about the need to get this information and workshop content further into the workforce and down to lower levels, and to the general population. Several people agreed that an approach to the community through the Provincial Councils (Bose ni Yasana) would be effective; and that women could be
involved through the Soqosoqo Vakamarama as a way to increase discussion in families. (See 5. Additional Comments).

2.4. Conclusions

2.4.1. The design, efficiency and effectiveness of the project

The enthusiasm for embracing the MIHR content and materials was quite evident. The implementation started in the period September – December 2005 and commenced with a ToT in Suva followed by another in Nadi and one in the Solomon Islands, although they commenced without the full set of training materials, which weren’t completed until well into 2006. This may have compromised the effectiveness of the earlier efforts so further follow-up courses for ToT in Nadi (2 days) and Honiara (1 day) were held both of which were accompanied by industry level training. Further materials on training techniques were added as were 11 targeted IEC materials. A further ToT was provided in Suva in November 2006 and thereafter the project ran a number of industry level training programs in Fiji and the Solomon Islands until December 2006. In 2007 the MIRH ToT materials and the 11 IEC materials in Fijian, Hindi and Pigin were finalised. Further industry level training followed (5 in Honiara and 11 in Fiji) as did the training of industrial nurses in both Fiji and Honiara. This process of teaching before the materials were completed may be expected to have reduced effectiveness, although no specific comment to that effect was made.

Formats appeared to vary but there was little overall comment on the method of delivery. There is a tendency to shorten the duration of the workshop when no technical staff are in attendance and to cover materials arising from other agendas, such as information sharing on WTO developments and other business or staff related issues. The presence of health staff at the workshops clearly improves their effectiveness as questions are answered with some authority and discussion can continue beyond the content of the materials presented. Several community workshops had been run after working hours and had been reduced to only 2 hours. Rather than dilute workshop content and shorten duration it may be wiser to re-consider a better point of entry into the industry group and its supporting community.

That the project was efficient is evident from the many staff of employer generated activities that have followed without external funding; borne by employers. This fact alone indicates that employers have seen the humanising benefits of such workshops and discussion groups and the improved productivity and attendance that follow.

The strategy of collaboration between the ILO, trade unions and employers, with the technical assistance of UNFPA and local health staff holds great potential. The most commonly used descriptor was ‘an eye-opener’. The initiative had clearly been very well received and people were waiting for new learning opportunities and thinking about ways to disseminate the information further through their workplaces, families and communities. Many commented that it had made a difference to their own lives and relationships. Several had instituted changes to their workplace practices and were more perceptive of the issues in the lives of their workforce and peers. Many offered their services and assistance if the project were to be extended. The impression gained was that this enthusiasm is due more to the novelty of the information covered and the novelty of its open discussion in the workplace setting, than to the format of the workshops and the materials received.
2.4.2. Short term impact and potential relevance of the project in the mid to long term

The short term impact of the project appears to be very high among the groups attending. It could be anticipated that this will be maintained as new industry groups are exposed to the materials, however, maintaining the programme among those already exposed to it will require some further work on developing the skills upon which the programme depends: communication and counselling. MIRH is highly relevant to the Pacific context and can be expected to make a significant contribution to gender relations in the workforce and beyond it.

2.4.3. Expanded approaches and more effective strategies to MIRH

In the next phase of this project it would be reasonable to create a number of different design approaches to MIRH to accommodate the many and varied workforces and workplace settings. Approaches may include:

Extension: the concentration on male dominated workplaces, such as the mining camps and sugar mills could continue, but be extended to the wider mining or milling community of families supporting the industry.

Selection by Risk: on the basis of known high level risk of exposure to STIs and HIV, such as maritime and port workers, transport workers, the disciplined forces, prisons staff, plantation workers, international travellers, contract workers.

Selection by Demographics: industries nearby squatter settlements with high proportions of young people in reproductive age groups; sports administrators and unions, apprenticeship schemes, trade schools.

Selection by Level of industry/literacy: Information and materials could be produced according to primary, secondary or tertiary levels of industry, broadly determining the level of information requiring at each.

Wider Collaboration: To further progress the acceptance of the programme there must also be some changes to the provision of RH services to allow males a greater role in RH consultations and greater access to clinical services, without reducing resources available for women. Health departments will need to make adjustments in their service provision in anticipation of greater male involvement in RH, such as the provision of vasectomy. Without that accommodation, the initiative could be compromised if it fails at the clinic level.

Ex-sector dissemination: MIRH, by definition, allows only a limited access to all males, so it could be supplemented with approaches to the general population, commencing in high schools and local government and delivered through a wide range of community organisations. (See additional comments).

2.4.4. Future of the MIRH project in the new cycle of programmes 2008-2012

The concentration on trade unions organizations and particular industries in the early stages of the program has been a good place to start, although the program has only
just ‘scratched the surface’ of the organised workforce and a lot more industry and
employer groups need to be involved.

Similarly, the concentration on informing males alone is a limited approach and could
change. Extending information and skills learning to females (spouses and partners) will
allow a greater assimilation of the objectives into the general population. The
expectation that males will increase their involvement in RH independently of their
partners’ wishes and routine practices seems unrealistic, given that the achievement of
the objectives require an improvement in male-female relationships, which must involve
some adjustment to the female participants’ relational skills and expectations as well.

Resourcing of the MIRH program has been minimal relative to the extent of the cultural
changes needed to bring about a real increase in men’s participation in reproductive
health and in improving communication with their female partners. But Fiji and The
Solomon Islands are now experiencing rapid change that allows this material to be
discussed more openly than previously. It would therefore be wise to capitalise on the
change and disseminate information through the media and by the activities of
dedicated and resourced project officers.

Some expressed an urgency to take the content beyond the organised workforce while
others suggested that an extension of the project further into the workforce would allow
the content to filter down to the community. There is no reason why both approaches
could not work concurrently and it could be expected that they would complement each
other to speed the dissemination of information. Those who had already attempted to
disseminate information found that the brochures that had been produced were very
popular but had quickly ‘run-out’.

Expanding the program into other PICs will depend on: the ability of key individuals to
understand the essential rational as it applies in the their own context and to act as
national advocates for the program; congenial relationships between employers and
trade unions, and an agreement for close collaboration with public health authorities and
their clinical and technical staff.

3. Lessons Learned

1. There is a great interest in the content. The first lesson is that the populations
of the Pacific have a great need to know more about reproductive health, their anatomy
and physiology, sexual function and dysfunction, and the methods of improving couple
communication, and spousal and family relationships. The impression gained by the
consultant (with 35+ years of exposure to Pacific cultures) is that issues once too secret
and culturally sensitive to discuss are now the subject of great interest.

2. The need for clinical staff to be present. The ability to respond to questions ‘on
the spot’ greatly enhances the authority and perceived validity of the workshop. It could
be anticipated that the use of locally-based medical and nursing staff as trainers would
encourage participants to access their local services for testing during, or after, the
workshop. It would also be wise in the future for the locally based staff to indicate
whether or not the MIRH training had actually increased rates of clinical review and
testing.

3. The section of a workforce strategy is validated yet it needs to extend its
reach. The workforce has responded well to MIRH and the concentration of male
dominated workplaces has set a strong foundation. Now that the strategy is proven
effective on the basis of its wide acceptance, it now needs to approach the general workforce and a wider industry base.

4. **Greater lead-time is needed in implementation** to allow for as wide as possible industry involvement and to employers to process the conceptual association between family health and productivity.

5. **Mixed-gender groups are able to discuss the content of MIRH.** Most discussants attested to this fact. This signifies the realisation that culture is changing and that these issues need to be addressed openly. Discussants agreed that the workshops require the attendance of both genders in order to discuss the issues fully. Some questions had been raised by women as to why this content was only available to men (and someone raised the question as to whether it was discriminatory). Mixed gender workshops appear to be the favoured mode of delivery.

6. **Integration of MIRH approaches with Ministry of Health strategies and activities will strengthen both.** Little mention was made of the link between the training and subsequent employee health check-ups. Some important comments related to the limited role of RH staff and community nurses, in that there are too few of them to effectively deliver anything but essential medical information and services. The integration of resourced MIRH activities into the roles of community health staff will strengthen the dissemination of the MIRH message considerably, while also encouraging RH staff and STI clinic staff to extend their role beyond the medical aspects of their jobs. It may be an effective strategy for employers to offer clinical check-ups to their employees during the period of the workshop and soon after, or, for public sector employees to arrange clinical check-ups through their local health authority.

7. **High School curricula have content gaps in this area.** Recent initiatives by UNFPA/UNICEF and SPC to review the Fiji Class 3 to Form 7 curricula to include *Family Life Education* will eventually overcome this gap for Fiji. At present, students electing arts and commerce subjects may graduate from high school without exposure to life-skills training or any essential information on reproductive health. Those who do elect science subjects may only obtain a rudimentary exposure to these issues. Most participants of MIRH had not heard this level of detailed information before.

4. **Recommendations**

1. Change the name of the project to *Male Involvement in Family Health* as the content and activities extend beyond reproduction to gender relations, communication and family support.

2. Continue the project to extend further into the organised workforce drawing on workforce productivity improvement resources.

3. Continue to emphasise the 3 fundamental programme rationales: the relationship between a happy family life and increased productivity in the workplace; the relationship between rural development and population growth; and, the financial pressures on parents with large families in struggling economies.

4. Create a project budget within ILO to resource: 1. negotiating access to productivity improvement resources through ILO and associates (such as TPAF in Fiji); 2. to further engage ILO in CBT through its Community Development program and; 3. to disburse to
CBOs to allow the full-time employment of Project Officers and their travel and support in the delivery of ToT and CBT programs.

5. Connect the program activities to Ministry of Health RH and Adolescent RH teams in order to disseminate training information throughout the community health workforce.

6. FSMed to include these materials in the Reproductive Health Training Program (RHTP) and negotiate with Ministries of Health in participating PICs to allocate the implementation of this program to returning graduates of RHTP.

7. Identify, by their successful performance as Community-based Organisation (CBO) for the Pacific Regional HIV/AIDS Project (PRHP), a NGO in each PIC to be involved in managing this project in partnership with Trade Union Organisations, Chambers of Commerce and national Ministries of Health; and, to implement activities through the many local government, social and religious organisations.

8. Engage a consultant to provide advice on the development of a self-monitoring behaviour change tool relevant to Pacific lifestyles and the objectives of MIRH.

9. Review and revise teacher training programs to increase RH and family health content in the curriculum, to provide a vehicle for carrying these messages into high school students.

10. Explore with the Ministry of Education in each PIC the possibility of making life skills a compulsory course within high schools, whereby students who elect to study non-science courses are also exposed to this content.

11. Promote the positive benefits of MIRH by creating opportunities for women to publicly voice a positive opinion of men who demonstrate concern for their wives and children.

12. Reinforce, through use of the media, the existing cultural value placed on Pacific mothers as the continuator of tribal/clan lineages, thereby increasing the cultural support for young mothers.

13. Monitoring by UNFPA to ensure that training programs run by nominated program managers (NGOs) include members of the general community and their endorsed male and female leaders, including provincial ministers for health and other members of local government and civil society.
5. Additional Comments and Recommendations

The discussions in Solomon Islands and Fiji Islands brought up a number of additional points worthy of mention. Many people commented that the formal workforce was still quite limited in Melanesia and that a large proportion of the male population were either, informally employed, or subsistence farmers.

Two particularly interesting comments were made both in countries. While perhaps obvious to external observers, they are not always recognised by those experiencing the problem. These comments provide the additional rationales required for extending the project beyond the organised workforce.

1. Rural development and population size. Local governments at provincial and district levels could be encouraged to see the association between rural development and population size. Across the Pacific, from small atoll nations, or, as in the Solomon Islands and the highlands valleys of PNG, population pressure is beginning to impact in rural areas. While past generations required large families for gardening and fishing, the successive division of arable land and the increasing cost of bringing-up children are felt by subsistence farmers. The changed situation requires either; a more effective collective effort to support a growing population or a change in average family size.

2. Urban poverty and family size. Urban dwellers in the workforce and the many new arrivals from rural areas could be presented with media information campaigns that illustrate the relationship between family size and the ‘cycle of poverty’, combined with an extension of RH information and services into the peri-urban youth of squatter settlements to reach the growing number of young people who are not in the organised workforce.

Additional Recommendations for consideration.

In the Solomon Islands:
1. Allocate a budget to Oxfam to allow the employment of 2 project officers over the next 5 year cycle 2008-2012 and develop a partnership agreement between Oxfam and the SICTU, whereby Oxfam is the managing agency controlling resources and employing technical project officers to conduct training programs facilitated through SICTU and employer groups and on their own initiative through local government and civil society.

Oxfam is currently the CBO for the Pacific Regional HIV/AIDS project (PRHP) and has performed well in project management and project staff selection. PRHP ends in 2008 so Oxfam will be well prepared to take on another task.

In the Fiji Islands:
2. Allocate a budget to Foundation for the Peoples of the South Pacific – International (FSP-I) or another suitable NGO, to allow the employment of 2 project officers over the next 4 year cycle 2008-2012 and develop a partnership agreement between FSP-I, FTUC and FEF whereby FSPI is the managing agency controlling resources and employing technical project officers to conduct training programs facilitated through FTUC and FEF and on their own initiative through local government and civil society.

FSP-I is a well regarded Pacific network of affiliated NGO’s. Its main focus is on community development and it has a long list of successful projects over many years. FSP-I could conceivably implement MIFH through their network in other PICs.
Annex 1. Terms Of Reference

Evaluation of Men As Partners in Reproductive Health Through Organized Workforce
PM13R304

TERMS OF REFERENCE

1. BACKGROUND

The Men As Partners in Reproductive Health Through Organized Workforce is funded by UNFPA and implemented by ILO in Fiji and the Solomon Islands. The project focuses on a systematic way of improving reproductive and sexual health through organized labour networks. The International Conference on Population and Development (ICPD) acknowledges the strategic role of men and their potential to be active partners in reproductive and sexual health.

“Special efforts should be made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood; sexual reproductive behavior, including family planning, prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high risk pregnancies; shared control and contribution of family income; children’s education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children”.

International Conference on Population and Development Programme of Action, Para. 4.27

In the Pacific, the ‘Men As Partners’ project was piloted in Fiji over 2001 to 2004 as a forerunner for other countries, with funding support from NZAID and UNFPA. The pilot project was executed by the New Zealand Family Planning Association (NZPFA), and implemented by the Reproductive and Family Health Association of Fiji (RFHAF). The strategic direction of the MAPs pilot project was largely aligned to the goals of the Country Assistance Programme for Fiji under the RH/SP/SH project (FIJ/98/P03).

The recent Men as Partners in Reproductive Health through Organized Workforce project was approved by UNFPA for the duration of 14 months (September 2005 to December 2006) with a funding level of US$148,731. The project has been executed by the International Labour Organisation, as the project targeted male workers in Fiji and the Solomon Islands, taking advantage of the ILO traditional partners:

Fiji Employers’ Federation (FEF) and Fiji Trade Union Congress (FTUC); and
Solomon Islands Council of Trade Union (SICTU) and Solomon Islands Chamber of Commerce and Industry (SICCI) in the implementation of project activities.

The project aimed at empowering men to make informed choices and responsible decisions on: reproductive health/family planning and sexual health issues, parenting role, sharing of domestic responsibilities, developing healthy couple communication skills, involvement in risky behaviour that contributed to sexual problems, communication breakdown, stress, domestic violence, family break-up and poor performance at the workplace.

2. EVALUATION PURPOSE

The purpose of the evaluation is explore how to formulate male involvement in the 4th Cycle of Programmes. Based on the desk based review/literature reviews on experiences in other countries and consultations, assess the design, efficiency and effectiveness of the project, assess the short term impact and potential relevance of the project in the mid to long term, document lessons learned and best practices, identify viable approaches in the context of UNFPA Programme of Assistance to identify more effective strategies for expanded approaches to MIRH in the Pacific recommend future directions of the MIRH project in the new cycle of programmes 2008-2012 deliver a presentation of the Evaluation findings to the UNFPA Regional Meeting with Programme Partners in July-August 2007

3. LOCATION & TRAVEL

The evaluation coverage will include Fiji and the Solomon Islands. Scheduled meetings and interviews will be held with stakeholders and partners involved in the project in Fiji and the Solomon Islands. A list of contact persons is attached as Annex 1.

4. EVALUATION METHODOLOGY

The evaluation will adopt the following methodologies:
Desk Review of project documents, workshop reports and evaluation responses, etc Interviews with partners and stakeholders listed in the interview scheduled in Annex 1. The evaluator will develop an interview protocol (in consultation with the CST RH Adviser) to ensure consistency and reduce subjectivity in the evaluation process. Focus-group discussions with project stakeholders and beneficiaries to assess impact of the project. The Evaluation Report will include lessons learned and recommendations for the continuation of MIRH project in Fiji, the Solomon Islands and recommendations on replication in other PICs over the new cycle 2008-2012.

5. DOCUMENTATION

UNFPA will provide a full briefing with documentation to assist the evaluation process. The documents below will be included in a package for the evaluation team:

Evaluation TOR
6. EVALUATION CONSULTANT & DURATION OF CONSULTANCY

The consultancy only requires one independent consultant. The consultant should have academic background in one of the following areas: Health/Reproductive Health, Sociology, Population Studies and Development Studies. The consultant should have some evaluation experience in one of the following areas: Reproductive Health, Community Work in health related projects, Work that support Men’s health and well-being. The consultancy will be undertaken in 12 working days within the month of June 2007, with a payment of a lump sum amount upon receipt of the final report.

7. EVALUATION MANAGEMENT & SCHEDULE OF ACTIVITIES

The evaluation timeframe is 12 working days, details listed below.

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<th>Dates</th>
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<tr>
<td>June</td>
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<td>Fiji and SI Mission</td>
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<tr>
<td>June</td>
<td>2 working days</td>
<td>Writing</td>
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<tr>
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<td>Final Report due on Annex 3 provides a sample outline of the Evaluation Report.</td>
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8. EXPECTED RESULTS

The Consultant is expected to deliver the following results:
Submit a Draft Report to UNFPA Office on
Submit the Final Report (three bound hardcopies and three softcopies on CD) to UNFPA Office on
Presentation of findings and recommendations to UNFPA Regional Meeting
## ToR ANNEX 1 – List of contacts in Fiji, SI and in the UN System

<table>
<thead>
<tr>
<th>#</th>
<th>NAME</th>
<th>CONSTITUENTS</th>
<th>ORGANIZATION</th>
<th>Address</th>
<th>PHONE NO.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Felix Anthony</td>
<td>National secretary, Fiji Trades Union Congress</td>
<td>Secretary, Fiji Sugar &amp; General Workers Union</td>
<td>16 Walu st, Marine Drive, Reddy Diamond Bldg, Lautoka</td>
<td>6660746/9921746</td>
<td><a href="mailto:ftuc1@connect.com.ff">ftuc1@connect.com.ff</a></td>
</tr>
<tr>
<td>2</td>
<td>Mikaele Mataka</td>
<td>Secretary, National Union of Hospitality, Catering &amp; Tourism Employees</td>
<td>National Union of Hospitality, Catering &amp; Tourism Employees</td>
<td>15 Sharma Street, Narewa, Nadi</td>
<td>6700377/9921762</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Noel Tofinga</td>
<td>Industrial Officer, Fiji Public Service Association</td>
<td>Fiji Public Service Association</td>
<td>298 Waimanu Road, Suva</td>
<td>3311922</td>
<td><a href="mailto:ntofinga@fpsa.org.fj">ntofinga@fpsa.org.fj</a></td>
</tr>
<tr>
<td>5</td>
<td>Rohit Karan Singh</td>
<td>President, Fiji Local Government Association</td>
<td>Senior Health Inspector, Lautoka City Council</td>
<td>Tawewa Avenue, Lautoka</td>
<td>6660433/9246534</td>
<td><a href="mailto:rouhit2003@yahoo.com">rouhit2003@yahoo.com</a></td>
</tr>
<tr>
<td>6</td>
<td>Antony Nair</td>
<td>Fiji Sugar &amp; General Workers Union</td>
<td>OSH Officer, Lautoka Sugar Mill</td>
<td>Drasa Avenue, Lautoka</td>
<td>9269696/6660800</td>
<td></td>
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<tr>
<td>7</td>
<td>Shiu Lingam</td>
<td>Tropic Woods Employees &amp; Allied Workers Union</td>
<td>Tropik Woods Ltd</td>
<td>Troik Woods Chips Centre, Lautoka Wharf</td>
<td>6664587/9945161</td>
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<tr>
<td>8</td>
<td>Napolioni Likuveiqali</td>
<td>Official, Fiji Public Service Association, Nadi Branch</td>
<td>Customs Officer, Fiji Island Revenue &amp; Customs Authority</td>
<td>Nadi Airport</td>
<td>6722191/9324456</td>
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<tr>
<td>9</td>
<td>Vilikesa Naulumatua</td>
<td>President, Federated Airline Staff Association</td>
<td>Air Terminal Services Ltd</td>
<td>ATS Building, Nadi Airport</td>
<td>6722877</td>
<td><a href="mailto:fasa@ats.com.fj">fasa@ats.com.fj</a></td>
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<td>Name</td>
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<td>10</td>
<td>Sakaria Serau</td>
<td>Fiji Local Government Association</td>
<td>Health Inspector, Nadi Town Council Arcade, Nadi Town</td>
<td>9948646/6700133</td>
<td><a href="mailto:serau_7@yahoo.com">serau_7@yahoo.com</a></td>
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<tr>
<td>11</td>
<td>Jone Seniroga</td>
<td>President, Tropic Wood Staff Union</td>
<td>Senior Security, Tropic Woods Ltd., Drasa, Lautoka</td>
<td>6661388/9971689</td>
<td><a href="mailto:seniroga@yahoo.com">seniroga@yahoo.com</a></td>
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<tr>
<td>12</td>
<td>Nizabeth Hazelman</td>
<td>Chairman Human Resource Committee, Fiji Employers Federation, Suva</td>
<td>FDB Building, Victoria Parade, Suva</td>
<td>9907665/3318514</td>
<td><a href="mailto:nhazelman@fdb.com.fj">nhazelman@fdb.com.fj</a></td>
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<tr>
<td>13</td>
<td>Suka Salusalu</td>
<td>Training Officer, Fiji Employers Federation, Suva</td>
<td>42 Gorrie St, Suva</td>
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<td><a href="mailto:employer@fef.com.fj">employer@fef.com.fj</a></td>
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<tr>
<td>14</td>
<td>Timoci Laqai, FSC</td>
<td>Corporate Risk Manager</td>
<td>Fiji Sugar Corporation</td>
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<tr>
<td>15</td>
<td>Jone Nakauvadra, FSC Ltka</td>
<td>Training Manager</td>
<td>Lautoka Sugar Mill</td>
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<tr>
<td>16</td>
<td>Rupeni Rokodomini</td>
<td>Human Resource Manager</td>
<td>Rarawai Sugar Mill</td>
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<tr>
<td>17</td>
<td>Entonio Elaisa</td>
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<td>Rarawai Sugar Mill</td>
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<td>18</td>
<td>Dusese Bola</td>
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<td>Akhtar Ali</td>
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<tr>
<td>22</td>
<td>Ana Naguilevu</td>
<td>Assistant Human Resource Manager</td>
<td>Williams&amp; Goslings Ltd</td>
<td>Harris Street, Walu Bay, Suva</td>
<td>3312633</td>
<td><a href="mailto:AnaN@wgfiji.com.fj">AnaN@wgfiji.com.fj</a>&gt;</td>
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<tr>
<td>23</td>
<td>Margaret Rounds</td>
<td>Human Resource Manager, Western</td>
<td>Williams&amp; Goslings Ltd</td>
<td>Navutu Industrial, Lautoka</td>
<td>6664090</td>
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<td>Nasau Weirikoro</td>
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<td>Pushp Raj</td>
<td>Chief Executive Officer</td>
<td>Lautoka City Council</td>
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<td>26</td>
<td>Adi Vara Naievo</td>
<td>Training Officer</td>
<td>Air Terminal Services</td>
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<td>6722777/9934783</td>
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<td>27</td>
<td>Timoci Koroiqica</td>
<td>Deputy Mayor</td>
<td>Nadi Town Council</td>
<td>Nadi Town Council Arcade, Nadi Town</td>
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**RESOURCES PERSON**

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<tr>
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<tr>
<td>28</td>
<td>Dr Arvind Chaudhary</td>
<td>Senior Medical Officer, STI/HIV-AIDS</td>
<td>Ministry of Health</td>
<td>Western Health Center, Lautoka</td>
<td>6660411</td>
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### INDEPENDENT EVALUATION BY UNFPA - Contacts for Solomon Islands MIRH Project

**WORKERS**

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<tr>
<th>No.</th>
<th>Name</th>
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<tbody>
<tr>
<td>1</td>
<td>Tony Kagovai</td>
<td>Secretary, Solomon Island Council of Trade Union</td>
<td>Solomon Island Council of Trade Union</td>
<td>Point Cruz, Honiara</td>
<td>22516</td>
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<tr>
<td>2</td>
<td>Johnley Hatimoana</td>
<td>Industrial Officer</td>
<td>Solomon Island Teachers Association</td>
<td>Honiara</td>
<td>22826</td>
<td><a href="mailto:sinta@solomon.com.sb">sinta@solomon.com.sb</a></td>
</tr>
<tr>
<td>3</td>
<td>James Lalawa</td>
<td>National Secretary</td>
<td>Solomon Island Teachers Association</td>
<td>Honiara</td>
<td>22826</td>
<td><a href="mailto:sinta@solomon.com.sb">sinta@solomon.com.sb</a></td>
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<tr>
<td>4</td>
<td>Barry Samson</td>
<td>Assistant Secretary, Solomon Island Council of Trade Union</td>
<td>Solomon Island Council of Trade Union</td>
<td>Point Cruz, Honiara</td>
<td>22516</td>
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<td>Russell Bule</td>
<td>Executive, Solomon Island Council of Trade Union</td>
<td>Solomon Airlines</td>
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<td>Clerk to Assembly, Western Province</td>
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<td>Chairman, Solomon Island Chamber of Commerce &amp; Industries</td>
<td>Managing Director, National Bank ofSolomon Island</td>
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<td>Western Provincial Government</td>
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<td>Mr. Zakaria</td>
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<td>Luke Mataiciwa</td>
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<td>Peter Blumel</td>
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## Consultations with the Donor Agency – UNFPA

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Annex 2. People interviewed

Solomon Islands (Honiara):
Mr. Tony Kagowai - Secretary, Solomon Island Council of Trade Unions
Mr. James Lalawa - Chairperson, Honiara Branch, Solomon Island Teachers Association
Mr. Barry Samson - Assistant Secretary, Solomon Island Council of Trade Unions
Mr. Russell Bule - Executive, Solomon Airlines
Mr. Johnley Augwata - Solomon Security
Mr. Abednigo Maeohu - Health Inspector, Honiara City Council
Ms. Margaret Afuga - Training Dept., Solomon Airlines
Mr. Glyn Joshua - HR Manager, Solomon Islands Ports Authority
Mr. John Adifalka - Solomon Tobacco Co and member Solomon Islands Chamber of Commerce
Dr. Henry Kako - Honiara City Council
Mr. George Pego - RH nurse, Central Islands Province
Ms. Julia Fationo - Oxfam, Honiara
Dr. Junilyn Pikacha - Head of RH/STI, Ministry of Health

Fiji Islands
Lautoka
Rohit Karan Singh - Senior Health Inspector
Mr. Shalen Singh - Health Inspector
Mr. Rajen - City Council Lautoka
Mr. Jone Nakauvadra - Training Manager FSC
Mr. Pushp Raj - Chief Executive Officer, Lautoka City Council
Dr. Arvin Chaudhary - Senior Medical Officer MOH
Ms. Patrina Singh - Williams & Goslings Ltd
Mr. Ravinesh Chandra - Williams & Goslings Ltd
Mr. Jerry Marawa - City Council

Nadi
Mr. Napolioni Likuveiqali - Customs Officer FIRCA
Adi Vara Naievo - Training Officer - Air Terminal Services
Mr. Ledua Panapasa - ATS
Mr. Joketani Drose - ATS
Mr. Rupeni Benua - ATS
Mr. Beniamino Lovecana - ATS
Ms. Christine Hazelman - ATS

Suva
Mr. Zakaria - ILO Director Fiji
Mr. Luke Mataiciwa - Project Coordinator
Ms. Tasneem - Project Support Officer
Mr. Wasid Hussain - Project Administrator
Mr. Noel Tafinga - PSC/FPSA
Ms. Suku Salusalu - Training Officer FEF
Ms. Ana Naguilev - Williams & Gosling
Mr. N Hazelman - Chair, Human Resources Committee FEF and HR Manager Fiji Development Bank
Mr. Aktar Ali - Fiji Electricity Authority
UNFPA Suva
Ms. Urmila Singh - UNFPA Assistant Representative
Ms. Lorna Rolls - Programme Analyst
Dr. Wame Baravilala - RH Adviser
Dr. Adriu Naduva - RH Advise

Ba
Mr. Rupeni Rokodomini - FSC Sugar Mill
Mr. Entonio Elaisa - FSC Sugar Mill

Labasa
Ms. Ana Qaranikula - FSC Sugar Mill

Listed for interview but not interviewed
The following people were either unable to attend discussions or were uncontactable.

Solomon Islands
Mr. Johnley Hatimoana - unable to contact by phone
Mr. Eric Kikolo - not in office
Mr. Peter Goodwin - has left SI
Mr. Daniel Tuhanuku - unable to contact by phone
Hon. Holoti Panapio - in Western Province and unavailable
Ms. Tina Guerra - sent substitute Margaret Afuga
Ms. Emma Sipele - responded by email
Ms. Tirika Kibule - on leave
Mr. Mustazer Ali Khan - sent substitute John Adifalka
Mr. Lesley Mani - confirmed but did not attend
Mr. Gakai Peseika - on leave

Fiji
Mr. Mikaeli Mataka - unable to contact by phone
Mr. Timoci Koroiqica - busy as acting mayor at present
Mr. Vilikesa Naulumatua - contacted but didn’t turn up for the meeting.
Mr. Felix Anthony - out of country
Mr. Antony Nair - contact but not able to meet
Mr. Shiu Lingham - confirmed but didn’t attend
Mr. Jone Seniroga - confirmed but didn’t attend
Mr. Timoci Lagai - contacted but not able to meet
Mr. Nirbhay Singh - confirmed but didn’t attend
Ms. Margaret Rounds - busy but sent representatives
Mr. Nasau Weirikoro - confirmed but didn’t attend
Mr. Dusilele Bola - uncontactable in the workplace
Annex 3. Documents and literature review

A. The following documents provided by UNFPA were reviewed.


2. FPAID, Terminal Report to UNFPA on the Male Involvement in Reproductive Health Project, PMI3R304, April 2004 to September 2005


4. Plange Nii-K, Men as Partners in Family Life and Reproductive Health, March 2000

5. Men as Partners in Reproductive Health through Organized Workforce, Training Manual for Trainers and Peer Counsellors on Reproductive Health, Gender and Counselling Skills (3rd Draft),

B. The following papers in the RHO Archives ‘Men and Reproductive Health’ Annotated Bibliography were reviewed and are available at www.rho.org/html/menrh.htm


**C.** The following paper is referred to in relation to the provision of services through existing structures.

Annex 4. Questions to guide the consultative process.

Program structure

Did the program have a good selection of men from different economic, geographical, social, cultural backgrounds?

What is the impact of the Training Program on men, decisions made, men’s health, sexual health, family life, performance at work

How does this program help men contribute to improve quality of life?

Was there any important issues missed or not covered in the program.

Was the duration of the program adequate?

Was the program held in a suitable venue?

Was the program delivered effectively?

Were there any limitations, if yes-how can it be improved?

Any suggestions and recommendations

Specific Questions:

Is there adequate RH information and services available? Have any new services been provided as a result of this program?

What are the different types of RH services available to men?

Do your staff or workmates have access to RH services?

Are men utilizing RH services, if yes -to what extent? Are they given time off to attend clinics with their wives?

Do you think there is an increase in the utilization of services by men since this program started? Do you have any evidence for this?

Are there any limitations to using these services, if yes how can we improve?

What effect did the Training Program have on men in regards to making informed decision on RH issues?

Are the Trainers actively training others? Are their activities integrated into your workplace programs?

Do you think men are more inclined to plan their families that previously? Are men making responsible decisions on Reproductive Health and family planning?
Are men finding new ways to discuss their sexual health issues or problems? (other than joking and teasing).

Is there a change in men’s parenting role? Do workplaces acknowledge the role that fathers have in picking children from school or attending family gatherings?

Do you think men have adopted a greater concern for their family life? Are they adopting healthier lifestyles?

Do you think there has been a decline in violence towards females as a result of this program? Do you have any evidence for this?

Are men talking more about sharing domestic responsibilities?

Have you seen any evidence that men are developing healthier couple communication?

Has there been an increase in men using counselling services?

Do you think there is a need for more counselling services for men?

Are men still getting involved risky behaviours that contribute to sexual problems?

Have you seen any evidence that men are better able to manage Stress at work and home?

Do you think the rates of relationship break-up has decreased or increased since the program?

Do you still hear talk of domestic violence and family break-up?

Are men performing better in the workplace in terms of communicating their concerns and finding solutions?

Do you have any particular men in your workplace who have become a ‘role model’ for good behaviour towards their wife?

Do you think there is a link between the quality of relationships in the home and the quality of relationships at work?