MenCare+

ENGAGING MEN IN A 4-COUNTRY INITIATIVE

MenCare+ South Africa

Outcome Measurement

Report

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PREPARED FOR:

PREPARED BY:

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LIST OF ACRONYMS

DV	:	DOMESTIC VIOLENCE
FGD	:	FOCUS GROUP DISCUSSION
FPD	:	FOUNDATION FOR PROFESSIONAL DEVELOPMENT
GEA/GEM	:	GENDER EQUITABLE ATTITUDES
GBV	:	GENDER BASED VIOLENCE
HCW	:	HEALTH CARE WORKER
HIV	:	HUMAN IMMUNODEFICIENCY VIRUS
MCH	:	MATERNAL AND CHILD HEALTH
MOSAIC		MOSAIC TRAINING, SERVICE & HEALING CENTRE FOR WOMEN ()
NGO	:	NON-GOVERNMENTAL ORGANISATION
SPSS	:	STATISTICAL PACKAGE FOR SOCIAL SCIENCES
SRH	:	SEXUAL AND REPRODUCTIVE HEALTH
SRHR	:	SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
STD	:	SEXUALLY TRANSMITTED DISEASES
STI	:	SEXUALLY TRANSMITTED INFECTION
WHO	:	WORLD HEALTH ORGANISATION

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EXECUTIVE SUMMARY

This Outcome Measurement Report has been compiled by the Foundation for Professional Development's Programme Evaluation Unit in response to a request by Sonke Gender Justice and Mosaic Training, Service & Healing Centre for Women (MOSAIC) to conduct the End Term Evaluation of the MenCare+ South Africa Programme.

MenCare+ is a global fatherhood programme active in more than 35 countries on five continents. Their mission is to promote men's involvement as equitable, non-violent fathers and caregivers in order to achieve family well-being, gender equality, and better health for mothers, fathers and children. MenCare+ works at multiple levels to engage individuals, communities, institutions and policymakers, and provides media resources, educational programmes and advocacy initiatives to partner organisations around the world. MenCare+ is co-ordinated by Promundo and Sonke Gender Justice in collaboration with its steering committee the MenEngage Alliance, Save the Children and Rutgers. It is generously funded by the Bernard Van Leer Foundation, MacArthur Foundation, SIDA, Oak Foundation, Summit Foundations, United Nations Population Fund and UN Women.

MenCare+ partners conduct group education sessions with youth and couples/parents on sexual and reproductive health and rights, maternal health, new-born health, child health, gender equality and caregiving. The MenCare+ South Africa Programme has been implemented in several communities in the Western Cape. This evaluation focuses on the three communities that are representative of the ethnic and socio-economic contexts in the greater Cape Town area – Mitchells Plain, Gugulethu, and Khayelitsha. All of these communities are adversely affected by crime and violence, including gender based violence. High levels of alcohol and drug abuse contribute to social instability in all three areas and unemployment and poverty are severe.

The purpose of this evaluation was to determine the efficacy and impact of the MenCare+ programme in South Africa and the results will be used to determine future programme implementation and funding. Data was collected using a mixed methods approach. A review of the literature regarding gender equality, masculinity and fatherhood in South Africa was conducted to provide background and context to the evaluation. A comprehensive programme document review was conducted to provide the background of the programme, what research

had already been conducted on the MenCare+ South Africa programme, and to provide an overview of the advocacy efforts of Sonke and MOSAIC. The quantitative data had already been collected by Sonke Gender Justice and MOSAIC using questionnaires (pre and post MenCare+ sessions) and the evaluation team conducted the analysis of the data. The qualitative data was collected using two methods. Firstly, Focus Group Discussions were conducted with 54 MenCare+ programme beneficiaries sampled from the 713 participants in the SRHR groups and 1550 participants in the Parenting groups. Secondly, telephonic interviews were conducted with 35 interviewees including programme stakeholders, programme staff, healthcare workers and social workers.

The young men's attitudes towards gender norms or differing social expectations for men and women did change significantly when comparing pre with post intervention scores. 27.5% of respondents moved from having moderate support for equitable gender norms to having high support for gender equitable norms after the intervention, meaning that they held more gender equitable attitudes after they had attended the MenCare+ sessions; 64% of the young men had high scores on the Gender Equitable Attitudes (GEA) scale and could not possibly score higher after attending sessions (i.e. they already fell into the "high" category on the scale). The data from the focus group discussions supports the quantitative results in that many of the young men changed their opinion on what it means to be a young man. After attending the MenCare+ sessions the men were of the opinion that to be a young man was to be responsible, supportive to your partner and community, and a role model to other young boys and men in their community.

Young men's attitude towards contraceptive use did change positively after the programme, from 13.8 (out of a maximum score of 18) to 15.1 which was found to be significantly different. However, the items "Condoms are an effective method of preventing the spread of HIV and sexually transmitted diseases" and "Condoms are not reliable in preventing pregnancy" did not show any significant changes.

Young men's contraceptive use has increased when compared to pre-programme data. Of those who reported having sex, 57.1% indicated that they used a condom the last time they had sex before attending the MenCare+ sessions; this figure increased to 68.0% after participating in the programme. Additionally young men reported (during the Focus Group Discussions) that they take the responsibility to ensure they have protected sex and always carry condoms with them.

It was found that 32.9% of young men sought health services in the last 3 months at a clinic or hospital after the MenCare+ sessions; 2.4% more than before attending the sessions. The percentage of males who feel comfortable asking health care professional's information about sexuality related issues has increased from 68.2% to 77.5% after attending the MenCare+ sessions. Significant barriers to men accessing SRH services was found during the qualitative analysis. The men mentioned that clinics need to be more 'friendly' towards men, in terms of the infrastructure and décor and in terms of the Health Care Workers' attitudes towards men.

The parenting group's gender equitable attitudes also increased significantly after they attended the MenCare+ sessions. 4.8% of respondents were in the moderate gender equitable attitude category pre and post intervention. 18.1% of respondents moved from the moderate category to the high category after the intervention; which means that they have more gender equitable attitudes/scores after they attended the MenCare+ sessions. 3.4% of respondents also moved from the high to the moderate category. 73.2% of respondents remained in the high category. Interestingly the item "It is not important that a father is present in the lives of his children, even if he is no longer with the mother" decreased significantly after the intervention from 84.0% to 78.6%.

Parents recognised the importance of family planning by attending the MenCare+ parenting sessions; they started talking about family planning with their partners and they are now able to support their partners in this regard. The percentage of parents talking about contraception with their partners have also increased marginally with 3.4% after the programme.

The percentage of couples that used a condom the last time they had sex increased from 43.6% before the programme to 54.5% after the programme, indicating a positive change. Before and after the intervention, the most common type of contraception used by the couples was the implant (pre: 41.1%; post: 42.0%). The parenting group's attitudes towards contraceptives also changed positively after attending the sessions – the most significant change being in the number of respondents who disagreed that "Condoms ruin the sex act" (pre: 54.8%; post: 72,4%).

When selecting only the fathers/couples who were expecting a child when they completed the questionnaire; we found a 6.9% increase in those who went to all prenatal care visits. It should be noted that only 29 fathers indicated that they were expecting a child in both pre and post

questionnaires (during the intervention). Barriers to men attending pre and post-natal care have been identified, such as infrastructure and the attitude of facility staff.

The number of fathers who were present in the delivery room at the birth of their child increased by 10.7%. Health care staff sometimes deny fathers access to the maternity ward; this could be for various reasons including maternity wards that don't have private rooms and cultural beliefs.

Numerous campaign activities were identified by the evaluators including radio programmes, community dialogues, social media, and community newspapers. The campaign activities have been received well by the community according to the interviews with programme staff. They had the following recommendations in terms of campaign activities: religious leaders should be more involved, government departments such as the Department of Social Development should be more involved, and there should be stronger linkages to NGO services in the community.

Numerous evaluation participants expressed the need for the MenCare+ programme to continue and possibly expand within their communities. Young men were concerned that without the continued support of the programme they will revert back to their "old ways".

Both parenting and young men groups suggested that the programme should be tailored to include both males and females to gain a better understanding of the opposite genders' views, opinions and needs.

The young men also suggested that younger boys should be included in the programme because many boys manifest deviant behaviour at a very young age, this could improve the long-term impact of the programme.

INTRODUCTION

This Outcome Measurement Report has been compiled by the Foundation for Professional Development's (FPD) Programme Evaluation Unit in response to a request by Sonke Gender Justice and MOSAIC to conduct the End Term Evaluation of the MenCare+ South Africa Programme.

The MenCare+ South Africa Programme has been implemented in several communities in the Western Cape; this evaluation focuses on the three communities that are representative of the ethnic and socio-economic contexts in the greater Cape Town area – Mitchell's Plain, Gugulethu, and Khayelitsha. All are affected by crime and violence, including gender based violence, alcohol and drug abuse, unemployment, and poverty.

The purpose of this evaluation was to determine the efficacy and impact of the MenCare+ programme in South Africa, the results will be used to determine future programme implementation and funding. Data was collected using a mixed methods approach including both quantitative and qualitative components. The quantitative data had already been collected by Sonke Gender Justice and MOSAIC using pre and post intervention questionnaires. The evaluation team conducted the analysis of the data. Descriptive statistics are graphically presented in tables, frequencies and percentages. Inferential statistical analyses, such as t-tests, were used to determine whether the programme had a significant effect on the programme outcomes. The qualitative data was collected using two methods. Firstly, Focus Group Discussions were conducted with programme beneficiaries (Young Men and Parents) from the three communities mentioned above. Secondly, telephonic interviews were conducted with programme stakeholders, programme staff, healthcare workers and social workers.

Ethics approval for this evaluation was obtained on the 10th of November 2015 from the FPD's Research Ethics Committee, which is registered with the National Research Ethics Council of South Africa.

It was requested by Sonke Gender Justice and MOSAIC that a supplementary 'extended report' be attached to this report with additional information including a comprehensive desk review and an extended discussion of the qualitative results, please find this under Appendix D.

BACKGROUND AND CONTEXT

South African Context

South Africa has been traditionally known as a strongly patriarchal country in which traditional gender attitudes have been and are still common. Men are traditionally seen as the head of the household, are expected to be the provider and protector of the family and is responsible for making decisions. The women's primary role is to care for the children (2). Gender dynamics slowly changed, partly affected by the apartheid law that caused poverty and family disruption. Because of labour migration, men were often physically absent in the family, which changed gender roles in the household. The only responsibility men could take was to provide for their family, whereas women had to be responsible for the child rearing and domestic chores (2). Consequently men were judged on their ability to bring money in; however, because of high unemployment rates and poverty they were not always able to support their family, causing feelings of impotence and shame. In the absence of income and employment as masculine validation, male sexuality, potency and control over women become central to masculinity (3).

Traditional African thinking is informed by communal life – a person realised his or her place and responsibilities within a community of other people (4). This collective mode of existence explains why any person is treated as a member of the family - being addressed as father, mother, brother or sister irrespective of the genetic relationship. The family is of the utmost significance; a child is born into a family community, which includes members of the extended family, living and deceased. Child rearing is the collective responsibility of the extended family as a whole. This view described above is in strong contrast to child rearing practice in western societies were practices are geared toward fostering individual autonomy.

As described in the section above, from the nineteenth century onwards there was a mass movement of African men who came to the cities to work, often as unskilled workers in gold and diamond mines. These men were uprooted from their support system that had been provided by their families. This led to a new form of male identification known as *indlavini* – an Nguni term indicating a masculine identification characterised by violent behaviour, recklessness and disrespect, especially towards elders and the traditions they stood for. Later this was followed by *utsotsi* – a street-wise petty criminal characterised by oppositional

thinking. Alienated from his traditional roots and faced by the harsh realities of life in the city, the utsotsi had no choice but to resort to violence to assert his masculinity. Today, a similar occurrence is observed with the emergence of the gangster as a hero in marginalised communities (5).

More recently, since South Africa's transition to democracy, traditional gender norms and roles in South Africa have begun to be challenged. In recent years more and more women have entered the workplace and become economically active – this is associated with an egalitarian modern view in which the division of time men and women spend in and outside the household is more equal. However, the change from traditional to egalitarian views do not develop to the same extent everywhere, with larger differences between the roles of men and women in poorer, less developed societies (6).

Unpaid care work refers to unpaid domestic work (cleaning and cooking) and caring for others in the home and community. Dynamics across Africa reflect the global reality that men and women do not share equally in the division of unpaid care work. In South Africa a national time-use survey found that women carry eighty percent more unpaid work than men do, while another study found that women's unpaid work was 2.1 hours a day more than men's. Additionally, women spend more time on combined paid and unpaid work than men. In South Africa women spend between 24 and 141 minutes more per day in this category than their male counterparts (7).

The reasons why men do not participate equally in unpaid care work fall into three categories: (a) social norms and gender socialisation that reinforce the idea that caregiving is "women's work"; (b) economic and workplace realities and norms that drive household decision making and maintain a "traditional" division of labour; and (c) policies that reinforce the unequal distribution of caregiving.

In Baba: Men and Fatherhood in South Africa, Richter describes the factors that have been found to be associated with paternal involvement (8):

- Contextual factors such as socio-economic status, which affects a father's ability to provide adequate child support and may also affect mood, men's relationships and co-residence with their partners and their children.
- Expectations about fatherhood, including whether pregnancy was intended,

affect paternal involvement. However, little is known about how males develop a perception of fatherhood, their status as fathers, and the roles associated with being a father.

- Family of origin, including high levels of participation in his upbringing by a man's own father, encourages paternal engagement.
- A healthy relationship with the child's mother has been found to increase involvement with children, as well as positive attitudes towards children and the role of parents.

Richter describes some of the other effects of father presence on children:

- Father presence contributes to cognitive development, intellectual functioning and school achievement. For example, in a study conducted by Mboya and Nesengani, it was found that boys who lived in father-present households had higher academic achievement than boys who lived in father-absent households (9).
- Father presence contributes to emotional wellbeing. Children in father-absent households are more likely to experience emotional disturbances and depression, although these effects may be confounded by socio-economic conditions and maternal stress. Additionally, father presence shows a strong relationship with higher self-esteem among girls, low levels of sexual risk behaviour and fewer difficulties in forming and maintaining romantic relationships (10).
- Father absence or lack of contact with fathers seems to have its most dramatic effects on male children, particularly on their social competence, behaviour control and school success. Father availability tends to have a modulating effect on boys' aggressive tendencies by providing a model of culturally appropriate male behaviour. In the same way, boys in father-absent families tend to engage in what has been called "compensatory identification with hyper masculinity" - a psychological term for the exaggeration of male stereotypical behaviour, such as an emphasis on physical strength, aggression, and sexuality (11). Other research shows that in families without prominent male role models boys and young men can end up searching for alternative sources of masculine identification and

validation, for example joining gangs (12).

In world-wide, cross-cultural comparisons, societies with a greater tendency towards involved fatherhood – where fathers have regular and long-term interaction with wives and children as well as being present for child birth and participating in infant care – were associated with more gender equitable practices in general, including greater involvement of women in community decision making processes (13).

There is a well-established link between inequitable gender norms and violence, and subsequently the link between inequitable gender norms, violence and the spread of the Human Immunodeficiency Virus (HIV). The Sexual Violence Research Initiative describes the evidence showing the association between violence and HIV infection (14).

- Physically violent men are more likely to have HIV and to impose risky sexual practices on their partners. They are more likely to have multiple partners, to have sex more often, to practice transactional sex and to report symptoms of Sexually Transmitted Infections (STIs).
- HIV infected women are more likely to have experienced physical or sexual violence; and victims of violence are at higher risk of HIV infection.
- Men who have been victims or perpetrators of violence against males are highly susceptible to HIV.
- Being a victim of sexual violence as a child can make a women susceptible to risky behaviours which can lead to HIV infection.
- Forced sex in childhood or adolescence increases the risk of contracting HIV as it adds to the likelihood of:
    - Having first consensual sex at a younger age
    - Engaging in unprotected sex
    - Having multiple partners
    - Participating in transactional sex
- People who experience forced sex in intimate relationships often find it difficult to negotiate condom use; and proposing the use of the condom may increase the risk of violence.
- Fear of partner violence and rape impede women’s access to HIV/AIDS information, testing, treatment and counselling.

- Sex workers are among those disproportionately affected by HIV, with an estimated prevalence rate of 30%.
- According to research in South Africa "an estimated 16% of all HIV infections could be prevented if women did not experience domestic violence from their partners."

It is clear from the literature that gender dynamics in South Africa are complex and men's negotiation of traditional versus more progressive gender values and behaviours are varied and multifarious. It can be concluded that factors such as the following must be addressed by Gender Equality Programmes so that real change may be affected:

- Contextual factors, such as socio-economic status, can determine whether or not a father is involved in their child's life. Being able to provide adequate child support is a major enabling factor to being actively involved in caretaking activities. Additionally, the cycle of inequitable gender norms, gender-based violence and HIV cannot be ignored in Gender Equality programmes.
- Men's fatherhood role models can have an enabling or disabling effect on their participation in bringing up their own child. Men who experienced positive male role models as children are much more likely to engage in paternal involvement than those who did not. Additionally they, in turn, pass on the positive gender equitable behaviours to their sons and daughters, creating a break in the cycle.
- The relationship that the father has with the mother of his child has an impact on involvement with children. Working on parenting roles, conflict resolution and co-parenting is extremely important in developing the relationships between mothers and fathers – especially in those who do not live together.

Promoting Gender Equality

Across the world there has been growing recognition that men's full and active support is necessary to achieve equality, end violence against women and mitigate the impact of HIV/AIDS.

The World Health Organisation (WHO) describes three of the most promising methods of promoting gender equality to reduce violence against women (15). These are school-based interventions, community interventions and media interventions. Most relevant to the MenCare+ Programme, and thus this evaluation, are community and media interventions.

Community interventions try to effect change in individuals and whole communities, by addressing gender norms and attitudes. They can include methods to empower women economically and to enlist men as partners against Gender Based Violence (GBV). The Stepping Stones programme is supported by the strongest evidence in South Africa.

Media interventions, such as public awareness campaigns, use mass media to challenge gender norms and attitudes and try to raise awareness throughout society on violent behaviour towards women and how to prevent it. The Soul City programme is cited as one of the best known and most carefully evaluated media programmes in South Africa.

The USAID Interagency Gender Working Group developed the Gender-equality Continuum that categorises approaches to integrating gender into educational interventions (16). Interventions that do not recognise how gender dynamics affect behavioural outcomes are classified as *gender blind*. *Gender aware* interventions actively seek to identify and integrate activities that address the role of gender dynamics to achieve better behavioural and health outcomes. *Gender exploitative* interventions reinforce or exploit harmful gender norms to achieve desired outcomes. *Gender accommodating* interventions seek to compensate for, but do not change, gender norms or reduce other inequalities. *Gender Transformative* interventions actively examine and promote the transformation of harmful gender norms and seek to reduce inequalities between men and women to achieve desired outcomes.

In terms of the Gender Equality Continuum, MenCare+ follows the Gender Transformative approach to integrating gender into educational interventions – the programme's desired outcomes aim to transform harmful gender norms and reduce inequalities between men and women in South Africa. They do this by combining community and media interventions. Firstly,

by affecting change in communities through educational interventions addressing gender norms and attitudes, and secondly through mass media campaigns to raise awareness around gender equality and advocate for change in the policy and legislative environment in South Africa.

MenCare+ Description

MenCare+ is a global fatherhood programme active in more than 35 countries on five continents. Their mission is to promote men's involvement as equitable, non-violent fathers and caregivers in order to achieve family well-being, gender equality and better health for mothers, fathers and children (1). MenCare+ works at multiple levels to engage individuals, communities, institutions and policymakers, and provides media resources, educational programmes and advocacy initiatives to partner organisations around the world. MenCare+ is co-ordinated by Promundo and Sonke Gender Justice in collaboration with its steering committee the MenEngage Alliance, Save the Children, and Rutgers. It is generously funded by the Bernard Van Leer Foundation, MacArthur Foundation, Sida, Oak Foundation, Summit Foundations, United Nations Population Fund and UN Women.

MenCare+ is a high impact implementation of the MenCare programme and is a three year, four country collaboration between Mosaic, Sonke Gender Justice, Promundo US and Rutgers. The programme has been implemented in Brazil, Indonesia, Rwanda and South Africa.

The initiative is designed to engage men, between the ages of 15 and 35 years as caregiving partners in issues concerning Sexual, Reproductive and Maternal Health and Rights. Their vision is to create a society where men are engaged as caregivers and fathers, and where gender equality is a reality in the family context. The programme has the following objectives:

- Men, both young and old, will participate more in caregiving and will be more empowered to make healthier decisions.
- Young men and Couples will have more access to contraceptives and exhibit more positive health seeking behaviours.
- Public and private clinics will provide better sexual and reproductive healthcare services, including domestic violence services.

- There will be a greater respect for the sexual and reproductive health rights of people to whom these rights are denied.
- Workshops with healthcare sector workers on the importance of engaging men in sexual and reproductive rights and maternal health services.
- MenCare+ community campaigns focused on increasing awareness of men's roles in fatherhood and caregiving.
- Advocacy and alliance building with organisations and governments that are working on these issues.

The Programme Partners

Mosaic is a South African organisation that specialises in GBV and Sexual and Reproductive Health Rights (SRHR). It offers social support, access to justice and Sexual and Reproductive Health (SRH) services.

Sonke Gender Justice works to create and necessitate change for men, women and children so that each may enjoy equitable and healthy relationships that may contribute to the development of such a society.

Rutgers WPF co-ordinates the MenCare+ Programme and are well known for their work in the sexual and reproductive health environment.

Promundo US is an international Non-Governmental Organisation that focuses on engaging men and boys in promoting gender equality as a means of preventing violence against women, children and the youth.

MenCare+ South Africa Results Framework

Table 1. MenCare+ Results Framework

Result Area	Output	Outcome
1. Young men and caregivers are better informed and better able to make healthier choices regarding their sexuality, relationships, maternal health and caregiving.	1.1 Implementing organisations have established young men's SRH and caregiving groups.	1.1.1 Participating young men have higher awareness of the importance of SRH and display more gender equitable behaviours.
	1.2 Implementing organisations have established men's and couples fatherhood groups to engage men in SRH and MCH.	1.2.1 Participating fathers become more involved in maternal health and caregiving at home.
	1.3 Implementing organisations carry out community based campaigns around engaged family planning, fatherhood and caregiving.	1.3.1 Changed attitudes towards men as caregivers and allies in family planning.
2. Increasing young men's/ couples access to contraceptives, including male and female condoms, to promote good health.	2.1 Socio-cultural barriers among men addressed with regards to contraceptive use, including male and female condoms.	2.1.1 Increased use of contraceptives, including male and female condoms, by couples.
3. Public and Private clinics provide better sexual and reproductive health care services, including domestic violence services, which more people are using.	3.1 Health Care Workers (HCW) are trained to address the SRH needs of young men to promote contraceptive use, safe sex, and promote their role as allies in family planning.	3.1.1 More young men and women making use of higher quality SRH services.
	3.2 Health workers are trained to engage fathers in prenatal care visits and other maternal health related issues.	3.2.1 Increased engagement of fathers in maternal health related issues.
	3.3 Counsellors are trained to counsel men (Toolkit for Men) to end violence in intimate partner relationships.	3.3.1 Reduction of violence in intimate partner relationships.

4. Greater respect for the sexual health and reproductive health rights of people to whom these rights are denied.	4.1 Partner organisations have strengthened their capacity to engage the local health sector in promoting equal access to SRH/MCH/DV services to young men/fathers.	4.1.1 A health sector/ environment that promotes young men's/ father's rights to SRH/MCH/DV services, at district level.
	4.2 Greater awareness of the policy gaps related to men's access to SRH, MH and violence services.	4.2.1 More favourable policy environment for engaging men in SRH/MCH and stopping domestic violence.

MenCare++ South Africa Programme Activities and Workshops

1) Group Education with young men on SRHR, gender equality and caregiving;

Table 2. Young Men Group Education Sessions

The Sessions covered in this group include:	
Session 1: Getting to know each other	Session 6: Respecting yourself and others
Session 2: The sexual and reproductive body	Session 7: Gender, HIV and AIDS
Session 3: The erotic body, male sexuality and pleasure	Session 8: Alcohol Abuse: risk, violence and HIV/AIDS
Session 4: Gender roles and sexual orientation	Session 9: Where have we been?
Session 5: Contraception and pregnancy	

The target for this group was to reach 572 young men and the programme achieved a reach of 713 young men.

2) Group Education with fathers and their partners on SRHR, gender equality and caregiving;

Table 3. Fathers and partners Group Education Sessions

The Sessions covered in this group include:	
Session 1: Welcome Session	Session 7: Gender Roles
Session 2: Father's Impact/ legacy	Session 8: Non-Violence
Session 3: Pregnancy	Session 9: The needs and rights of children
Session 4: Birth	Session 10: Division of caregiving
Session 5: Family Planning	Session 11: Final Reflections
Session 6: Caregiving	

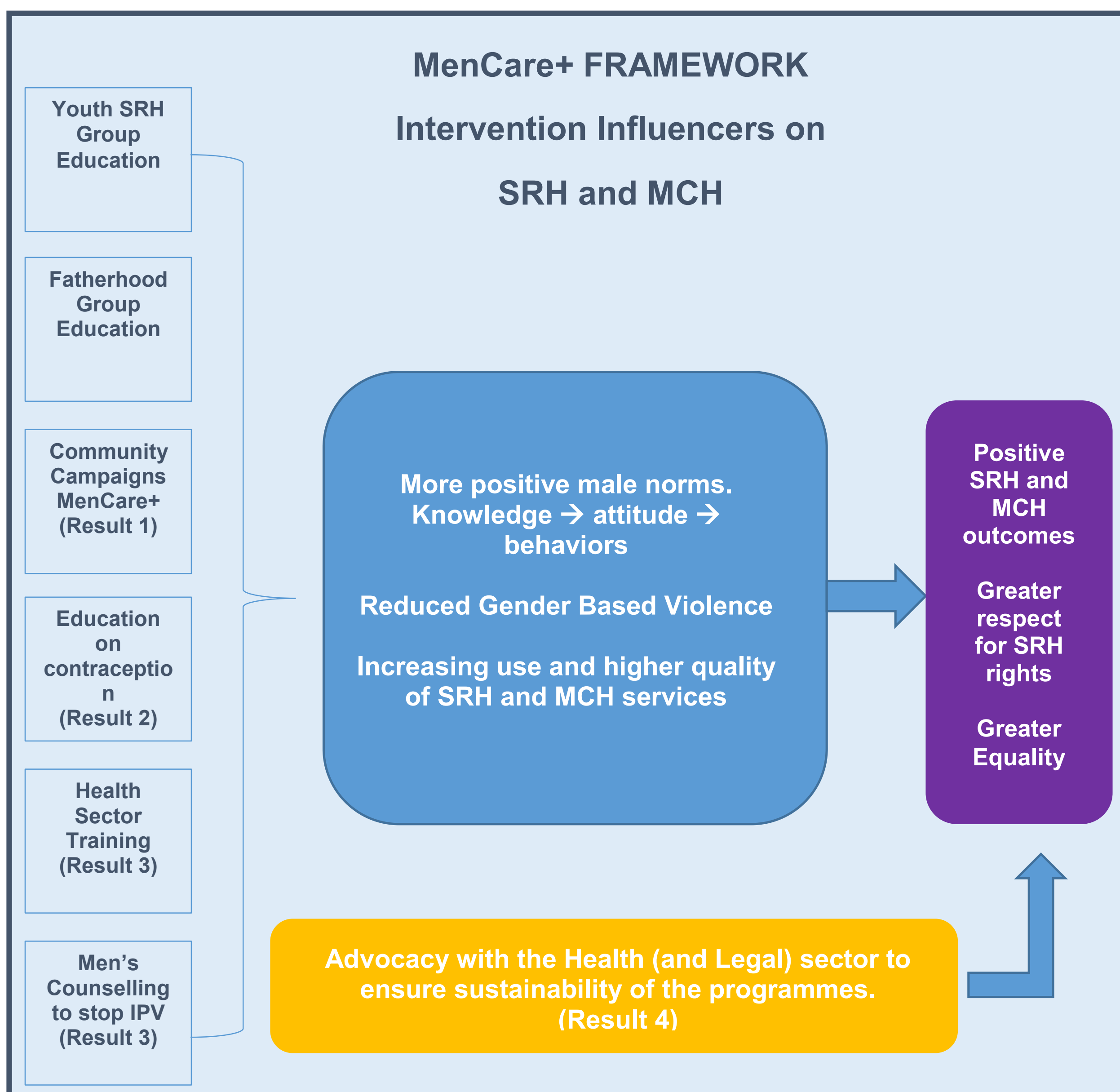
The target for this group was to reach 1536 fathers and their partners and the programme achieved a reach of 1550 fathers and their partners.

3) Counselling and therapy work with men who have used violence;

4) Workshops with health sector workers on the importance of engaging men in SRHR services;
5) Community campaigns promoting MenCare+ to increase awareness of men's roles in fatherhood and caregiving;
6) Advocacy and alliance building with organisations and government on issues to do with engaging men.

MenCare+ South Africa Programme Framework

Figure 1. MenCare+ Framework



Context of the three communities included in the MenCare+ South Africa Pilot

The three communities selected for this Evaluation are representative of particular ethnic and socio-economic contexts in the greater Cape Town area. All are affected by crime and violence, including gender based violence, alcohol and drug abuse, unemployment and poverty.

Table 4.Pilot Community Description

	Khayelitsha	Gugulethu	Mitchell's Plain
Population	400 000 (2011)	100 000 (2011)	310 000 (2011)
Households	118 000 (2011)	30 000 (2011)	67 000 (2011)
Children under 15 years of age	100 000	25 000	85 000
Housing	Formal + informal	Formal + informal	Formal
Language	Xhosa	Xhosa	Afrikaans
Unemployment Rate	38%	40%	24%
Households with a monthly income of R3 200 or less	75%	71%	38%
% of households in formal dwellings	45%	52%	95%
Piped Water	62%	58%	99%
Flush Toilets	72%	63%	96%
Electricity access	81%	97%	99%
Schools	52	N/A	N/A
Clinic /Community Health Centre	7	3	8
District Hospital	1	N/A	1
Psychiatric Facility	N/A	N/A	1
NGOs providing shelter and services for persons affected by abuse and violence	*Nonceba Centre *Rape Crisis *Embizweni *Mosaic *Families South Africa (FAMSA) *Llitha Labantu *Simelela	*Rape Crisis *FAMSA * Llitha Labantu *CWD Domestic Violence Project *Mosaic	*Mitchell's Plain crisis line *Mosaic *NICRO Women's Support Centre

Programme Document Review

As a part of the End term Evaluation, Sonke Gender Justice and Mosaic requested that FPD conduct a review of the programme documents. It was agreed that the implementers would provide FPD with the documents to be included. The table below provides a description of the documents included in the review.

Conference/ Meeting proceedings		
Presentations:		
MenCare+ Partner Meeting Amsterdam	Team South Africa Country Presentation	2015
Abstracts:		
Synthesis of the Formative Research of MenCare+ in Indonesia, South Africa, Brazil, and Rwanda	Harald Kedde, Rachel Ploem, Rutgers WPF	Conference: N/A
The impact of a caring partner/ fatherhood on sexual relationships	Harald Kedde, Rachel Ploem, Rutgers WPF	
Publications		
Changing Gender Attitudes to Reduce Risky Sexual Behaviour: a realistic evaluation	G. T. Nobre (2015)	In fulfilment of Master's Thesis, University of Utrecht
Scaling up MenCare+ in South Africa: identifying barriers and solutions to scaling up men's parenting programmes	C.L. Ward (2015)	In fulfilment of MSc in Public Health, N/A.
Fatherhood, a role in change: a qualitative study on men's experience of fatherhood in a South African setting	E. Samuelsson (2014)	In fulfilment of Master's Programme in Global Health, Karolinska Institute
Involving men in caregiving for Gender Equality: The case of a MenCare+ Fatherhood Group in Cape Town, South Africa	M. Pape (2014)	In fulfilment of a Master's in Education, Gender and International Development. Institute of Education, London, England.
Gender Equality in South Africa: an evaluation of the effectiveness of the MenCare+ Parenting Program in the South African Context	D. Van den Berg (2015)	In fulfilment of Master's in Multiculturalism in a Comparative Perspective. Utrecht University
Improving Men's participation in preventing Mother to Child Transmission of HIV as a maternal, neonatal, and child health priority in South Africa	Van den Berg, W., Brittain, K., Mercer, G., Peacock, D., Stinson, K., Janson, H.,	PLoS Medicine 12(4). DOI:10.137/hournal.pmed.1001811

	Dubula, V. (2015)	
Reports		
Annual Reports		
Annual Report	2014	
Semi-annual report	2015	
Other Reports		
Engaging Men Through MenCare+: Findings from a Formative Study in Cape Town townships	L Hendricks, E Roussouw W. Parker (2013)	
Synthesis Formative Research Report MenCare+	South Africa: L Hendricks, E Roussouw W. Parker (2014)	
Mid-term Evaluation Report	D van den Berg G Nobre M de Wit (2015)	Utrecht University
State of Africa's Fathers: a MenCare+ Advocacy Publication	Van den Berg (editor) (2015)	Adapted from: Levtov R, van der Gaag N, Greene M, Kaufman M, and Barker G (2015). State of the World's fathers: a MenCare+ Advocacy Publication. Washington, DC: Promundo, Rutgers, Save the Children, Sonke Gender Justice, and the MenEngage alliance

Newspaper Articles		
2013	Fatherhood's a struggle for the fatherless	Mbuyiselo Botha Mail & Guardian
	Bringing the value of absent fathers home	Hayley Thompson-de-Boor & Eddy Mavungu Sunday Independent Dispatches
	The consequences of the absent father	Bailey, C. Sunday Independent
	South Africa is a nation of deadbeat dads and the fallout hurts us all	Grange, H The Star
	Is your baby daddy a baddy?	Magwaza, K & Twiggs, L Cosmopolitan
	Grief of ATM fathers	Narsee, A The Times
	ATM dads blamed for dysfunctional kids	Narsee, A Herald
2014	In the name of the father	Tshemese, M Destiny Man
	Men helped to care	N/A

		Tygerburger – Ravensmead
	Men urged to be positive role models for children	N/A Tygerburger-Elsies Rivier
	Project gets men involved in family life	N/A Tygerburger-Elsies Rivier/ Bluedowns
	Father is a mirror	Oduwole, T. Southern Mail
	From good boys to better men: how we raise our boys helps them develop security in their masculinity, which our ultraviolent society desperately needs	Bertelsmann, M Your Baby
	Fathers can give care just as much as mothers	Mohana, M Sowetan
	In the name of (all) the fathers	Peacock, D (Sonke Director) Van den Berg, W (Sonke child rights and positive parenting portfolio manager). Mail & Guardian
	White paper urges paternity leave for fathers	Jackman, R Cape Times
	Formal paternity leave up for discussion by govt	Jackman, R The Mercury
	White paper looks into paternity leave	Jackman, R The Star
	Paternity leave likely to become part of Act	Jackman, R Pretoria News
	Paternity Leave PAINS?	Arnold, F Business Brief
	Law may be introduced to grant paternity leave	Staff writer The Mercury
	Father appeals for law to grant paternity leave	Staff Writer The Times – Career Times
	Paternity leave will give dads a chance to bond too	Van den Berg, W. Cape Argus
	Pa wil ook by nuwe baba wees (“Dad also wants to be with new baby”)	N/A Rapport Sake 24
	10-day paternity leave a step closer	Sidimba, L Sowetan
	Banning corporal punishment will create a less violent society	Bower, C Van den Berg, W (Sonke Gender Justice) Weekend Argus-Saturday Edition
	Tips for parenting in child protection month	N/A Stellenbosch Gazette
	Stand up and protect children	Reporter

		Mthatha Express
	Ouers gevra om lyfstraf vir maand te los ("Parents asked to not use physical punishment for a month")	Nienaber, M Die Burger
	Bêre die roede n maand en vermy ook ligteklappie ("put away the rod for a month and avoid light smacks also")	Nienaber, M Die Burger
2015	Fathers and father figures have new roles to play	Franken, M Polokwane Observer
	One man fights for all fathers	Sosibo, K Mail & Guardian
	Before you spank: spare the rod, spoil the child – but there are better ways to discipline, experts say.	Sokopo, A You
	Sparing the rod will not spoil the child	Botha, M Sowetan
	Deadbeat dads making kids sad	Sanpath, A The Independent on Saturday
	Organisations oppose jail sentence for defaulting dads	Narsee, A Business Day
	Don't jail Papgeld dads	Narsee, A The Times
	Jail for Papgeld dads not ideal	Narsee, A Sowetan
Please see Appendix C for a more detailed description of the Newspaper articles related to the MenCare+ programme.		

Conducting the document review allowed the evaluation team to reach an understanding of the progress of the MenCare+ programme over the past three years.

Formative Research was conducted in 2013 in Khayelitsha, Gugulethu and Mitchell's Plain by Lynn Hendricks and Elzette Roussouw. Warren Parker conducted a secondary analysis of the data to inform the design of the MenCare+ programme. 85 participants participated in Focus Group Discussions and in-depth interviews. The findings of the formative research is described below:

- Men's Healthcare Access: It was found that men were generally reluctant to engage with their own healthcare and described clinics as alienating places. Clinics were seen as mainly for women, and it was difficult to discuss health and illness with female clinic staff. It was recommended that discussions on healthcare needs among men should explore symptomatic and preventative health with a focus on overcoming fears related to attending healthcare facilities.

- Father involvement in antenatal care and early parenting: Healthcare workers noted a growing trend among men in their communities of men having interest in attending antenatal services and being involved in childbirth. There were however a number of facilities in the studied communities that actively discouraged the presence of fathers during childbirth. It was recommended that the inclusion of men in antenatal care, childbirth and prenatal care should be addressed in health service policies and practices, and be promoted in communities as an accepted, important approach to the health of children. Church and community leaders should be provided with information on fatherhood programmes and encouraged to give impetus and support to the initiative.
    - Additionally, support should be provided to disclosure of HIV status as part of antenatal care and prevention of mother to child transmission.
    - Lastly, it was recommended that men who have experienced childbirth and who are experienced fathers be included as key informants in discussion groups to serve as points of reference and to encourage men who are about to be fathers.
- Role of men in parenting: When men discussed parenting, it was clear that there was a strong interest to engage in equality in relationships. Parents were however in need of guidance on how to manage parenting roles. It was recommended that dialogues on fatherhood should include referencing one's own experience of childhood.
- Role of women and men in the community: It was recommended that the social role of fathers and mothers in communities be explored as part of MenCare+, including involvement in broader community activities that foster community involvement in childcare, community health and in activities that engage with violence reduction and prevention.

E. Samuelson from the Karolinska Institute, Department of Public Health Sciences, conducted a qualitative study on men's experience of fatherhood in a South African setting using participants from the Sonke Gender Justice Father Groups in fulfilment of a Master's in Global Health in 2014. The aim of the research was to investigate the experiences of fatherhood in men who have participated in Father's Groups in Cape Town. The data was collected using semi-structured interviews and observations. The findings of this research are discussed below:

- Being a man: it was evident that participants are affected by gender stereotypes and expectations of how men should act and be in order to be considered a 'real man'. Participants did describe that participating in the Father Groups had affected their behaviour, such as alcohol use and violence.
- Being a father: Many participants described how they were not active in their children's lives before participating in the Father Groups, however, afterwards they actively engaged in child care activities.
- Being pioneers: The participants described themselves as 'pioneers' in the sense that they now want to change the existing gender norms in their communities.
- Social Community: The participants mentioned that although they do engage in more gender equitable roles at home - they face criticism and resistance from their community. A possible explanation for this could be that although the men do consider themselves changed, they are still living in the same context as they were before the groups which makes it difficult to practice gender equitable behaviours in everyday life.

The researcher concluded that 'old father and man roles' are existing together with the 'new father and man roles', and there is an ambivalent relationship between the two. It was recommended that broader societal changes must be made (e.g. paternity leave) before any larger change in father and man roles will be observed.

In 2014 M. Pape conducted a small-scale qualitative study in fulfilment of a Master's in Education, Gender and International Development through the Institute of Education, London, England. Focusing on one Fatherhood Group in Cape Town, the study aimed to contribute to filling the knowledge gap in understanding men's involvement in caregiving and how this can contribute to greater gender equality in the context of international development. An analysis of MenCare+ publications, the researcher's experience of attending the MenCare+ Global Meeting conference and interviews with Fatherhood Group participants, their partners, a facilitator and a MenCare+ programme manager was used to answer the research question. This study showed that men's negotiation of traditional and more progressive gender values and behaviours are varied and complex. The findings do show that learning from the Fatherhood Group and the support that men got through attending the group has led to considerable positive change towards greater gender equity in both participants' lives and in the lives of those around them.

A Mid-term Evaluation was conducted by Dirkje van den Berg, Giovanni Nobre and Myrte de Wit from Utrecht University in 2014. Pre and post questionnaires were analysed and focus group discussions were conducted. After the analysis of the quantitative and qualitative data had been conducted, the researchers made the following recommendations:

- Planning Recommendations
    - Programme Managers should regularly check that the trainers are meeting their targets so that action can be taken if reaching targets become difficult.
    - Work Plans should be submitted before the start of implementation so that everyone (programme managers, team members, M&E unit) knows which groups are being implemented by whom and in which area. It was suggested that Google Drive be used for real-time updates.
    - All the Standard Operating Procedures should be finalised and a discussion should be held with the trainers and facilitators so that they know what is expected of them when running the sessions.
    - The trainers should be given the opportunity to go through the manual together, so that all the sessions have the same structure.
- Admin Recommendations
    - The facilitator should fill in the registers, rather than the participants.
    - Registers should be digitalised to mitigate the issues of paper-based registers (lost, mixed up, and incorrectly completed).
    - Set standards and norms for handing in documents (e.g. when should participants hand in the pre/post questionnaire).
- Content Recommendations
    - Participants suggested that topics regarding gangsterism should be included in the SRHR group's programme.
- Measurement and Evaluation Recommendations
    - Questionnaires should be translated into local languages.
    - The space in which participants fill in the questionnaires should be monitored. (E.g. participants should not work together or be distracted.)
    - Make sure only people who participated in the programme fill in a questionnaire.
    - Trainers and facilitators should use a projector and go through the questionnaire with participants before they fill it in.

  - Programme managers should meet regularly with M&E to track the progress of each trainer.
- Implementation Recommendations
  - It should be possible for girls to join the sessions or participate in a similar programme
  - Life after MenCare+: Participants of the Focus Group Discussion indicated that they would like to continue in some way, such as being a MenCare+ activist. Participants should be given support in undertaking initiatives to spread the MenCare+ message in their community.
  - Participants should be connected to other opportunities such as courses, job trainings, job market events, etc.
  - A yearly event should be organised (depending on the budget) to get all the participants from different areas together.

In 2015, Dirkje van den Berg completed an "Evaluation of the effectiveness of the MenCare+ Parenting Programme in the South African Context". He described the way in which gender attitudes, division of caregiving and father involvement changed among participants with a black or coloured racial background. The results showed that the Parenting Programme had a large effect on gender equitable attitudes, but only a small effect on the equal division of caregiving. The only difference between black and coloured participants was linked to cultural practices that the black participants had. The following recommendations were made:

- The participants suggested that the training should be actively promoted in the communities. They put forward the idea of introducing MenCare+ on television, to show success stories and give the right example.
- The participants also requested that the training should include some follow up – they wanted to stay connected with the programme and the people who were in the programme.

In fulfilment of an MSc in Public Health, C.W compiled a report describing the barriers and solutions to scaling up men's parenting programs. Qualitative methods were used to explore various stakeholder experiences of either delivering or participating in MenCare+. Focus Group discussions and interviews with programme providers and participants were used to collect data.

- Intervention characteristics:
    - MenCare+ support groups were considered a suitable and acceptable method to deliver the MenCare+ programme for two reasons. 1) The flexibility of the intervention allows trainers to provide context-specific training relevant to the users. 2) The homogenous groups of individuals lent itself to the sensitive material covered.
    - The participants reported that individuals may not consider participating due to the programme not being culturally adapted. Nevertheless, the participants did think MenCare+ had relevant benefits. Many participants felt that MenCare+ provided an opportunity to contribute to a solution for the prevalent social problems they experience in their communities.
    - Follow-up support groups were mentioned as a means to improve stability of the program. One focus group suggested drop-in centres where men and families could easily access MenCare+ support.
- Delivery characteristics:
    - With regards to human resources, trainer skills were identified as a crucial factor for MenCare+ delivery. One trainer explained that being valued for their role as chairperson in that community influenced their ability to deliver the programme effectively (up-take and completion of the programme).
    - Facilitators reported that the programme should be delivered in familiar facilities within close proximity to the target population. Examples included libraries and churches. Some men expressed concerns about the sessions being held at clinics or healthcare facilities.
    - In order to ensure sustainability some participants emphasised the importance of donor and government support so that MenCare+ can be delivered free-of-charge.
- Usage Characteristics:
    - All socio-cultural, contextual, physical and financial barriers were reported as issues that complicate ease of usage, often leading to participants having poor attendance or dropping out.
    - Most important were contextual barriers including issues relating to gangsterism, violence and prevalent drug and alcohol abuse (this was of particular concern in the coloured communities).

- The physical/financial barrier most often cited was the use of public transportation to access the programme.
- In terms of enabling factors participants cited personal commitment, social support from their family and other participants, and obtaining a certificate after completion as factors that encouraged and motivated participation.

Giovanni Nobre, Utrecht University, conducted a realistic evaluation entitled "Changing gender attitudes to reduce risky sexual behaviour" in 2015. Pre and Post questionnaires (Gender Equitable Men Scale, Attitude Towards condoms, Having Multiple Sex Partners, Alcohol and Substance Abuse) were used to collect quantitative data and focus group discussions were used to elicit qualitative data. The results found that gender attitudes and attitudes towards condoms increased significantly. The following recommendations were made:

- The administration of the pre and post questionnaires should be standardised – it was observed that trainers administer the questionnaires at different stages of the training.
- Some participants struggled with English and needed translation.
- Some participants were intimidated by the length of the questionnaire and experienced fatigue and sometimes resulted in the participants helping each other – the trainers should create a space in which participants are not able to work together or get distracted.

2014 Annual Report	
Result Area 1: Young men and caregivers are better informed	
1.1 Implementing organisations have established young men's SRH and caregiving groups	A total of 229 Young Men were reached in 2014 of which 190 attended all sessions.
1.2 Implementing organisations have established men's and couples fatherhood groups to engage men in SRH and MCH	A total of 252 Fathers were reached
1.3 Implementing organisations carry out community based campaigns around engaged family planning, fatherhood and caregiving	
○ National Positive Discipline media campaign	17,949,188
○ National Paternity Leave media campaign	4,945,606
○ Fatherhood dialogues on Father Involvement - Community outreach awareness raising dialogues – City of Cape Town Partnership	414
○ Material (pamphlet and posters) distribution	15,000
○ Door to Door Campaigns (6)	915
○ Father's Day Celebration	100

○ Community radio station media Campaign on the importance of father involvement	12,079,635
○ Public awareness raising presentations (163)	11,141
○ Half Day Awareness Raising Presentations (20)	412
○ New MenCare+ Film online views	12,000
○ Secondary school dialogues and events (3 school events) participants	653
○ Bill board campaign	450,000
Total number of men and women reached by MenCare+ campaign in 2014	*35,465,064*
Result Area 2 - Young men's and couples changed views on contraceptives	
2.1 Sociocultural barriers among men addressed with regard to contractive use, including male and female condoms	298 Men changed their view with regards to contraceptive use. MOSAIC facilitated 36 workshops with 450 adult men. Clinical SRH services were offered to 101 men at the MOSAIC SRH clinic located in Wynberg. *Preliminary results:* o Pre and post data suggest changed views on contraceptive use. o The percentage of participants that never used a condom, which decreased from 18% to 10% after the interventions.
Result Area 3 - Clinics provide sexual & reproductive healthcare services	
3.1 Health workers are trained to address SRH needs of young men to promote contraceptive use, safe sex, and promote their role as allies in family planning	176 healthcare workers were trained
3.2 Health workers are trained to engage fathers in prenatal care services	Training was combined with above training.
3.3 Counsellors are trained to counsel men to end intimate partner violence	Participants for the training workshop for Men counsellors (75 people) were strategically recruited from organisations that already had programmes in engaging men in issues of fatherhood, gender equality and/or domestic violence. A total of 328 new male clients entered the Toolkit for Men counselling programme in 2014.

	A further 361 male counselling follow-up sessions were facilitated (total number of sessions: 689).
Result Area 4 - Greater respect for SRH Rights	
4.1 Partners' organisations have strengthened their capacity to engage the local health sector to promote equal access to services to young men and fathers	136 social workers were trained on the importance of engaging men and boys in domestic violence services.
4.2 Greater awareness of policy gaps related to men's access to SRH, MCH and domestic violence services	The targets with regard to analysis of health and legal policies and laws concerning engaging men in SRH/MCH and violence services were met.

2015 Semi-Annual Report	
Result Area 1: Young men and caregivers are better informed	
1.1 Implementing organisations have established young men's SRH and caregiving groups	A total of 10 programme facilitators were trained (5 male; 5 female) A total of 227 young men participated in the young men's groups.
1.2 Implementing organisations have established men's and couples fatherhood groups to engage men in SRH and MCH	A total of 10 programme facilitators were trained (5 male; 5 female). A total of 551 participants (404 male; 147 female) participated in the Parenting groups. Retention has improved: 551 parents have participated in the groups and of those, 293 participants have attended 80 percent or more of the sessions.
1.3 Implementing organisations carry out community based campaigns around engaged family planning, fatherhood and caregiving	
○ Positive Parenting and Fatherhood	8 184 000
○ State of the World's Fathers/ State of Africa's Fathers	3 110 545
○ Parental leave	6 974 000
○ Positive Discipline	3 788 000
○ Public Presentations	15 960
○ Community Knock and Drop Campaigns	1 875

○ Community Mobilisation – Men's March	1 482
○ 2-day Male GBV awareness raising workshops	112
○ Half day awareness raising workshops	281
Total number of men and women reached by MenCare+ in 2015	*22 076 255*
Result Area 2 - Young men's and couples changed views on contraceptives	
2.1 Sociocultural barriers among men addressed with regard to contractive use, including male and female condoms	227 Men with changed views on contraceptive use.
Result Area 3 - Clinics provide sexual & reproductive healthcare services	
3.1 Health workers are trained to address SRH needs of young men to promote contraceptive use, safe sex, and promote their role as allies in family planning	34 Healthcare workers sensitised
3.2 Health workers are trained to engage fathers in prenatal care services	70 Healthcare workers trained (60 healthcare workers and10 social workers)
3.3 Counsellors are trained to counsel men to end intimate partner violence	46 counsellors were trained in domestic violence counselling training for men. A total of 110 men have been reached by counselling services.
Result Area 4 - Greater respect for SRH Rights	
4.1 Partners' organisations have strengthened their capacity to engage the local health sector to promote equal access to services to young men and fathers	52 staff of partner organisations have been trained and sensitised in how to advocate for young men's/ caregivers access to healthcare services.
4.2 Greater awareness of policy gaps related to men's access to SRH, MCH and domestic violence services	3 Health policies and laws were analysed in 2014. 11 training sessions for health sector staff/ legal sector staff on counselling programmes for men to stop domestic violence.

Overall, the research that has been conducted on MenCare+ South Africa indicated positive results and showed that participating in the programme had, in some ways, changed men's views and perceptions around gender roles and norms. The following summary of recommendations were made to improve the programme:

- The social community in which the participants live must be considered. While the programme has been successful in changing some men's attitude to gender roles – if they are still living in the same context, for example receiving criticism from the

community for engaging in caretaking or household activities, it will be difficult to affect behaviour change.

- Including community and church leaders in the programme is a possible way to affect greater societal change in the communities where they are working.
- The Programme should focus on exploring and overcoming fears related to attending healthcare facilities in order to affect health-seeking behaviour of men.
- The disclosure of HIV status to their partner should be an important part of the parenting group sessions.

METHODOLOGY AND RESULTS

Overview of Quantitative Methodology and Analysis

The quantitative data was obtained through pre and post questionnaires and the analysis was conducted using SPSS. Two separate questionnaires were used; one for Young Men (SRHR groups) and one for Parenting Groups.

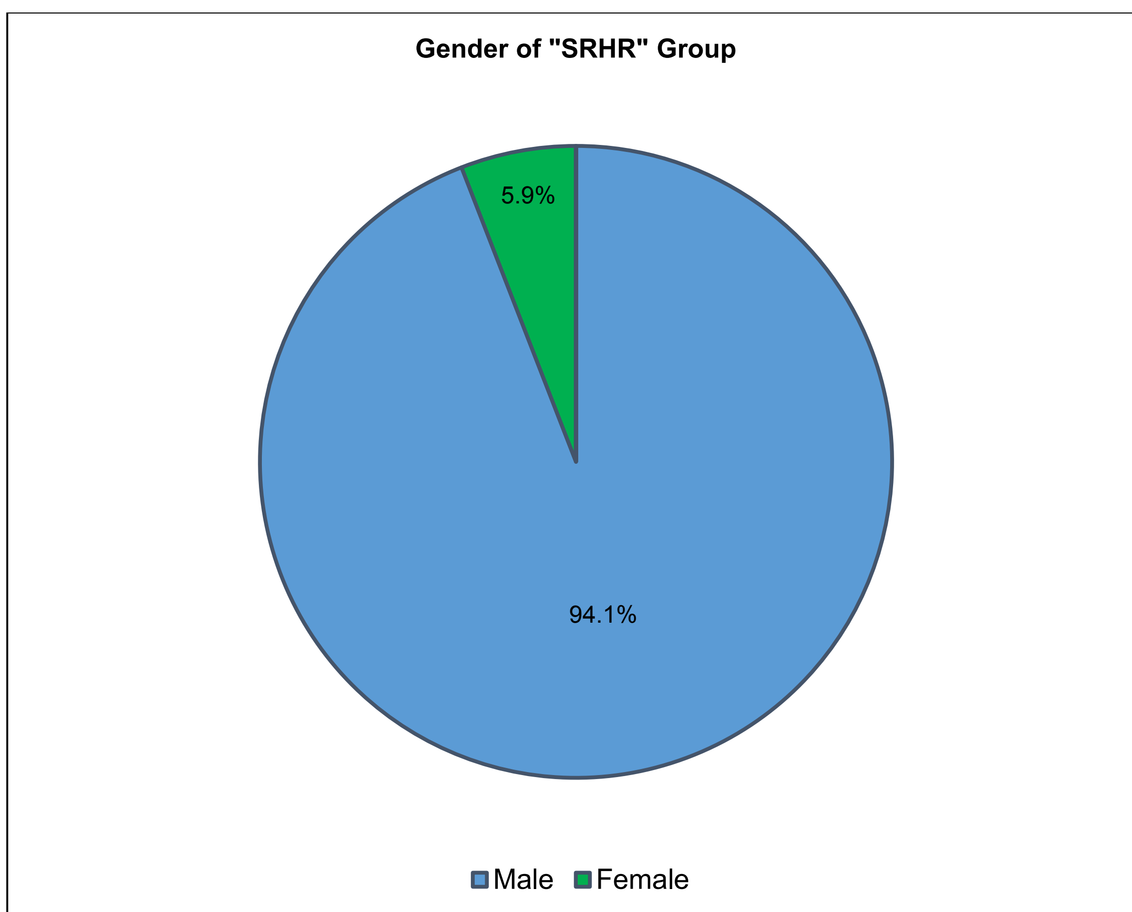
Both of these questionnaires were adapted and therefore different versions of the same questionnaires were used. The data capturing sheets for the different versions were similar yet different and prior to analysis the datasets were merged where possible. Each indicator was analysed using different analysis methods and more detail is provided about the methods used under each indicator.

Questionnaire Response Rate

	# Participating in MenCare+ Programme	# Completed at least one questionnaire	# Completed the PRE questionnaire	# Completed the POST questionnaire	# Completed both PRE and POST questionnaire
SRHR group	713	513	419	364	270
Parenting Group	1 550	863	757	543	444

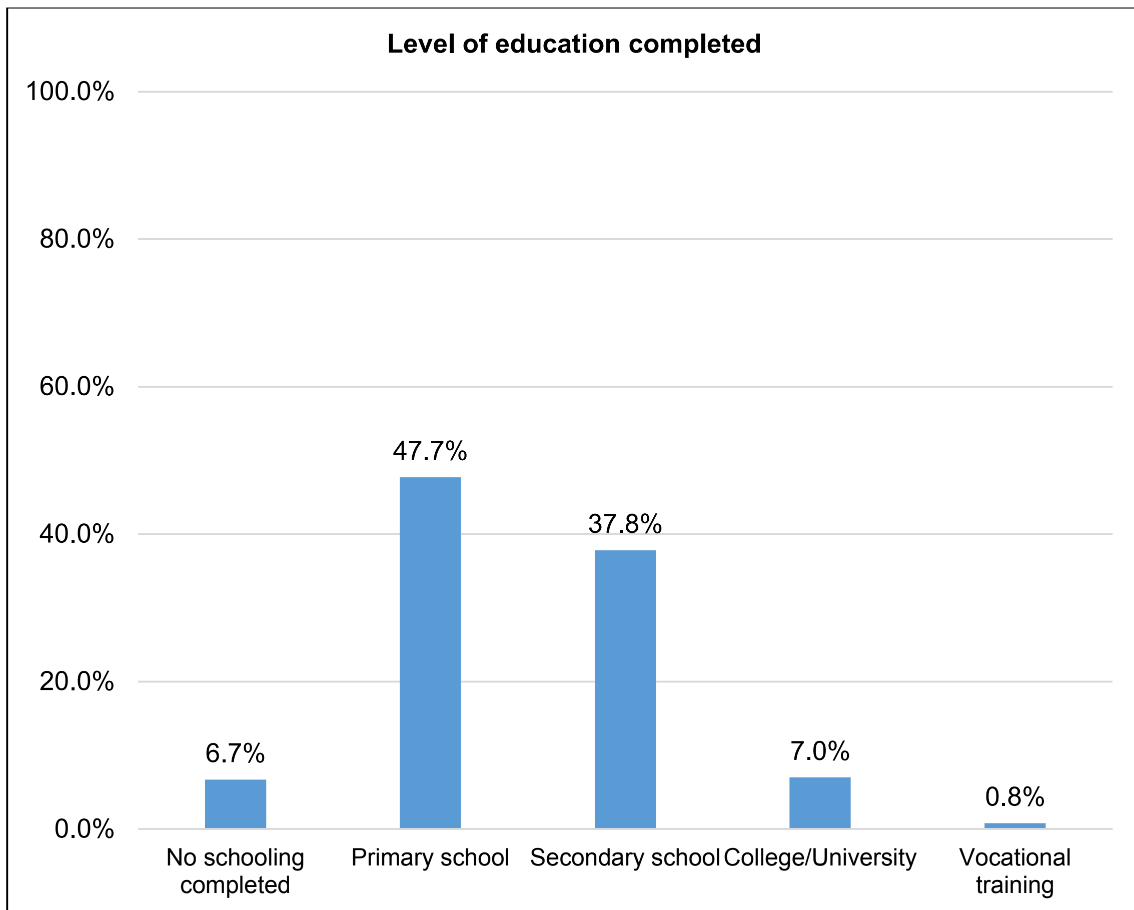
a. Demographics of Young Men Participants

Although the programme was aimed at young men, young females also attended the sessions and participated in the evaluation.

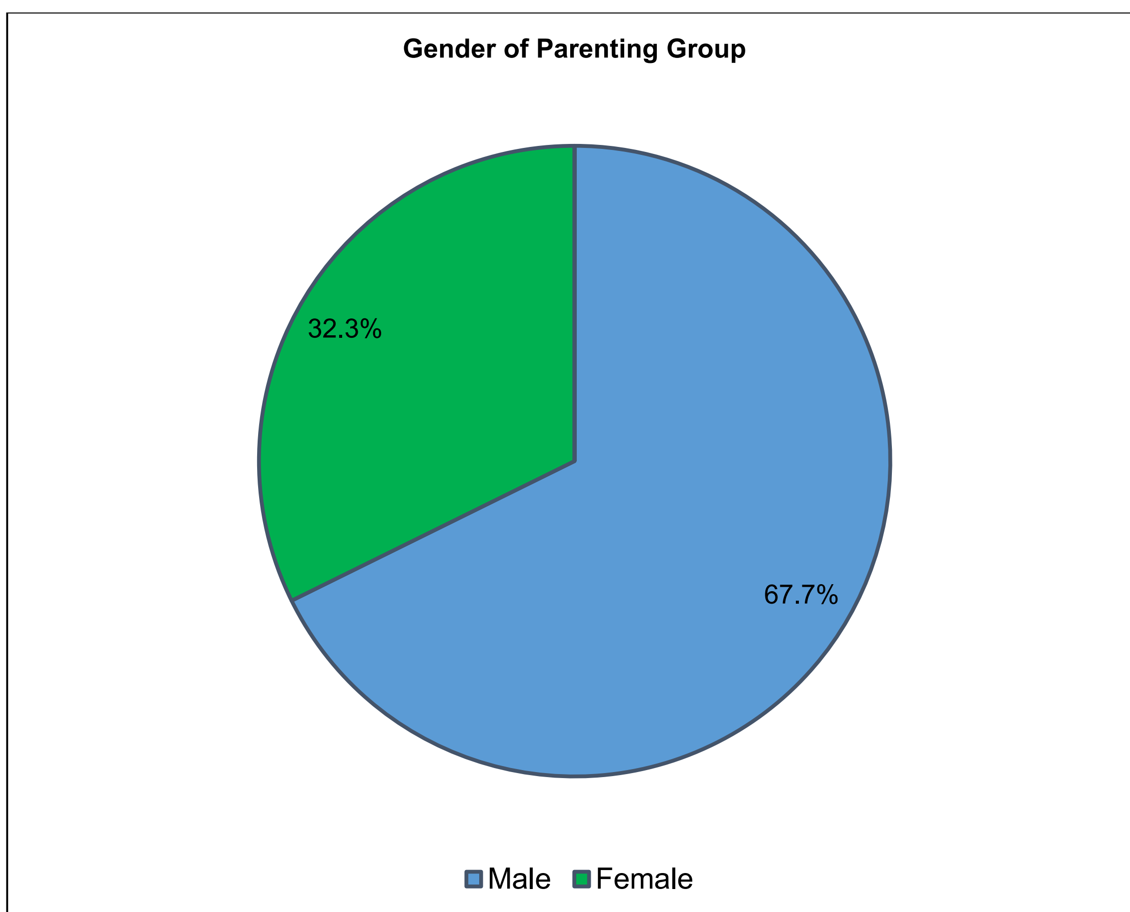


The ages of the participants ranged from 13 to 34 years and the average (mean) age of the participants were 18.5 years. The large majority (n = 475, 92.6%) were male. Only 30 (5.8%) were female. Eight participants did not indicate their sex.

69.8% were still enrolled at school when they completed the questionnaire, whereas only 68 (30.2%) stated that they were not enrolled in school. The table below presents the level of education the participants have completed.



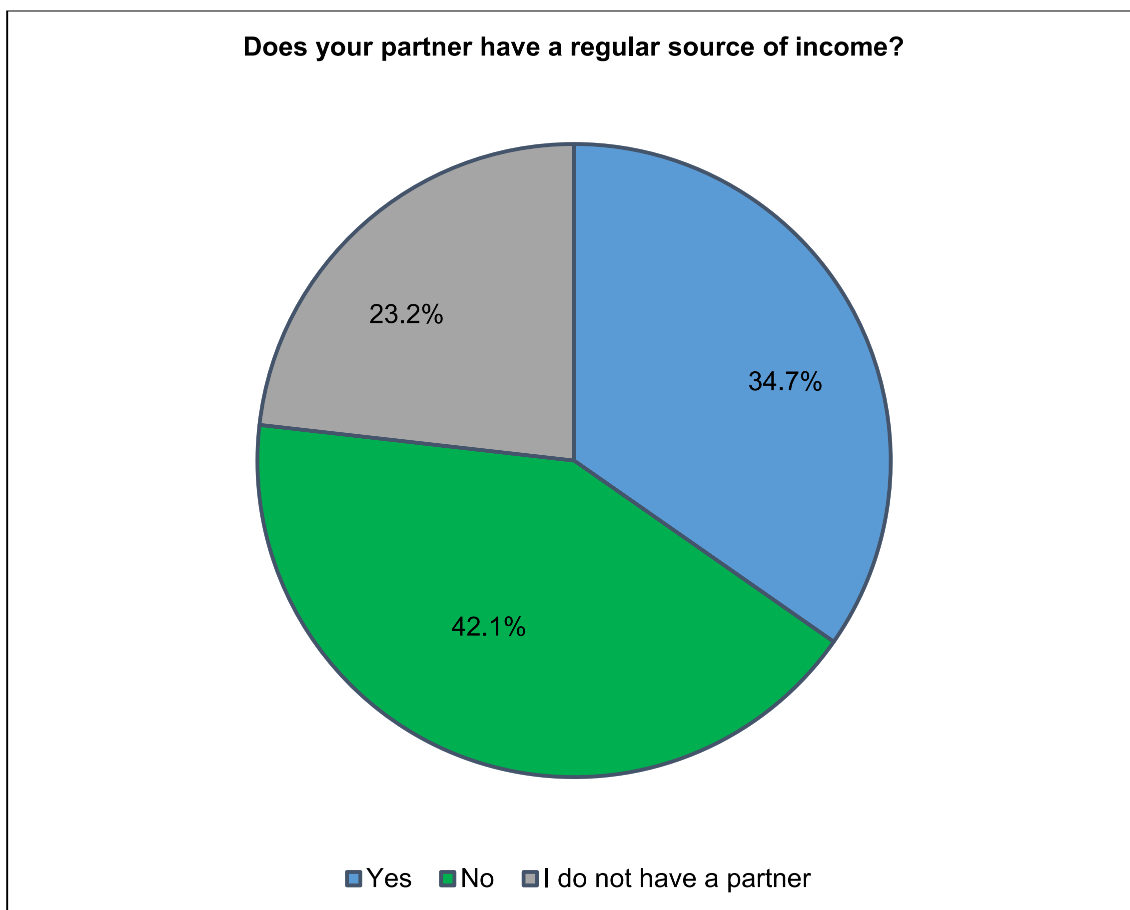
b. Demographics of Parenting Participants



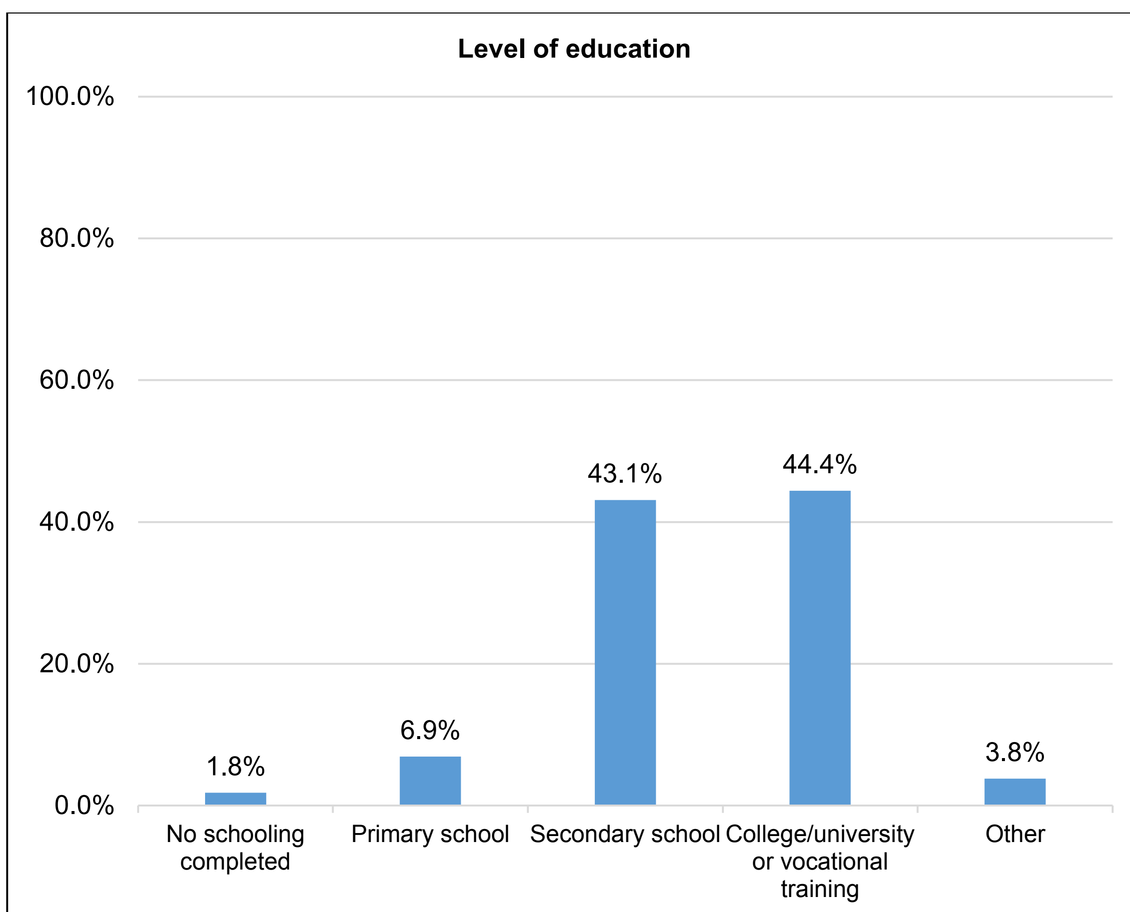
The age range of the participants is 17-72 years. The mean age for the total number of respondents (863) is 35.4 years. The mean age for all males are 34 and the mean age for all females are 37 years.

Cross tabulation			Do you have a regular source of income?		Total
			Yes	No	
Gender	Male	Count	246	254	500
		% of Total	49.2%	50.8%	100%
	Female	Count	140	79	219
		% of Total	63.9%	36.1%	100%

52.8% of the sample has a stable income while 47.2% do not. In terms of gender, 49.2% of males and 63.9% of females have a regular source of income and 50.8% of males and 36.1% of females do not.

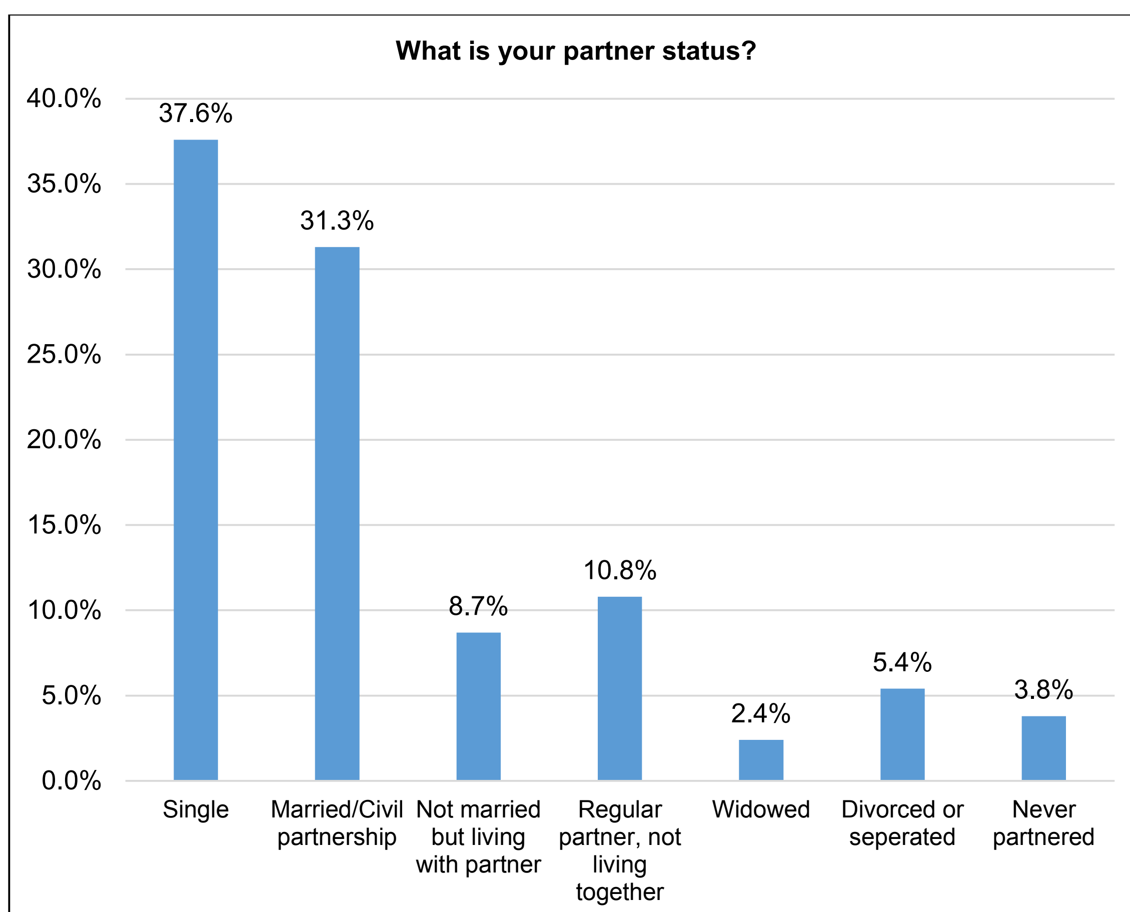


34.7% of the respondents' partners have a regular source of income. 42.1% of the respondents' partners do not have a regular income. 23.2% of the respondents do not have a partner.



Gender		What is the highest level of school you have completed?					Total
		No schooling completed	Primary school	Secondary school	College/university or vocational training	Other	
Male	Count	9	34	242	198	21	504
	% of Total	1.8%	6.8%	48.0%	39.3%	4.2%	
Female	Count	3	14	74	133	6	230
	% of Total	1.3%	6.1%	32.2%	57.8%	2.6%	100%

1.8% of the sample never completed schooling. 6.8% of the sample had only received education up to primary school level, while 43.1% of the sample received their education up to secondary school level. 44.4% of the sample has had some form of tertiary education and 3.8% indicated that they've received other forms of education. 33% of the male sample and 10.1% of the female sample had secondary school level education and 27% of males and 18.1% of females had a tertiary level education. Only a small percentage of males (1.2%) and females (0.4%) had no schooling.



37.6% of the sample indicated that they're single. 31.3% of the sample indicated that they're married or in a civil partnership. 8.7% of the sample aren't married, but living with their partner. 10.8% of the sample has a regular partner but doesn't live with them. 2.4% of the sample is widowed. 5.4% of the sample is divorced or separated. 3.8% of the sample never partnered.

Overview of Qualitative Methodology and Analysis

The qualitative component of the evaluation was guided by the indicators set in the reporting template; these indicators were more quantitative in nature. The Focus Group Discussions and Individual Interviews were conducted concurrently with the quantitative data analysis. Findings from the qualitative analysis were aimed at supporting each indicator.

a. Focus Group Discussions

Random sampling was initially chosen to select the beneficiaries of the MenCare+ program; however due to conditions beyond the control of the evaluation team, participants were

selected using a combination of random and non-random purposive and convenience sampling by the MenCare+ South Africa team. The MenCare+ beneficiaries were selected conveniently, meaning that they were selected based on ease of access and willingness to participate.

A total of 54 MenCare+ beneficiaries participated in the Focus Group Discussions (FGD), of which 33 were from the SRHR group and 21 were from the parenting group. The FGDs were conducted using semi-structured guides (please see Appendix B). One of the 21 parenting group participants was female; all the other FGD participants were males. The FGDs were conducted in English, Afrikaans or Xhosa depending on the participants' preference. Each FGD lasted approximately 1 to 2 hours and were audio-recorded. The researchers also made field notes, which they used in combination with the audio recordings to conduct a deductive qualitative analysis guided by the indicators set out in the template/indicators provided by Rutgers; the analysis set out to identify patterns across the data sets (audio recordings, transcripts and field notes) that are important to the description of the effectiveness of the programme and the process of change. The researchers listened to the audio recordings, read the transcripts and identified patterns in combination with their field notes.

b. Telephonic Individual Interviews

The telephonic individual interviews were conducted using lists sent by the MenCare+ team. The groups of people that were contacted are listed below:

- 7 Stakeholders, including:
  - Employees of the Department of Social Development
  - Employees of the Department of Correctional Services
  - Religious Leaders and pastors
  - Community mobilisers
  - Programme co-ordinators
  - MenCare+ facilitators
- 2 Media Stakeholders
  - A Bush Radio Representative
  - A Representative from Zibonele Radio Station
- 5 Health Care Workers
- 2 Teachers

- 5 Social Workers
- 9 Sonke Programme Staff
- 5 MOSAIC Programme Staff

A total of 35 telephonic individual interviews were conducted using semi-structured guides (please see appendix A). The same data analysis process was followed as the FGD analysis.

Result Area 1: Young men and caregivers are better informed and better able to make healthier choices regarding their sexuality, relationships, maternal health, and caregiving.

Outcome indicator 1.1.1a: 25% of participating young men have more gender equitable attitudes

1. Methodology

The pre and post questionnaires collected data about Gender Equitable Attitudes (GEA / GEM). Descriptive analyses was conducted to determine the frequency and percentage of respondents who disagreed prior to the programme and after attending the programme sessions. Paired sample T-test were utilised to determine whether there is a significant difference between pre and post scores.

Additionally, the GEM Scale was divided into three equal parts: high, moderate, and low support for equitable gender norms. The GEM scale consists of 13 items and a total score out of 39. The GEM scale was divided equally as follow:

Category	Score out of 39 on GEM
Low support for equitable gender norms	0 to 13
Moderate support for equitable gender norms	14 to 26
High support for equitable gender norms	27 to 39

2. Findings

Quantitative findings

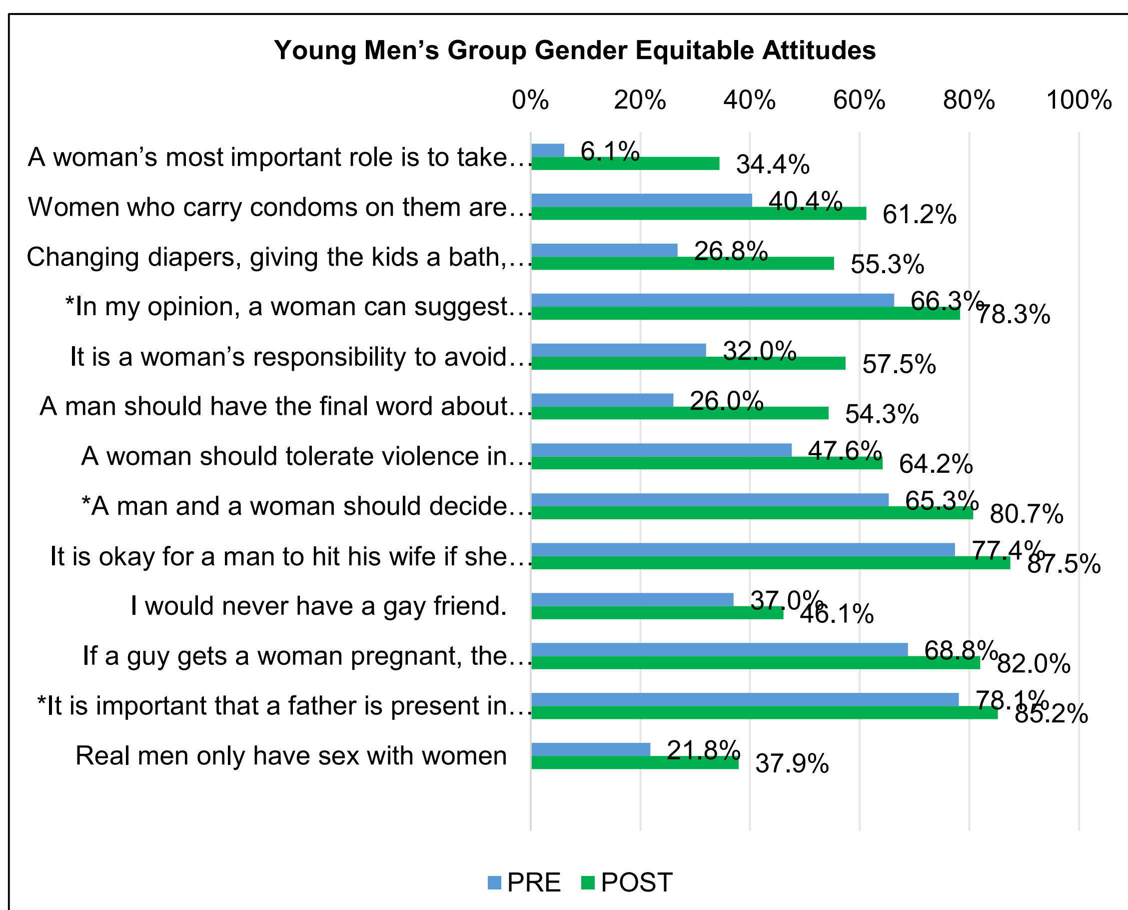
The table below presents the pre and post scores for each item on the GEM scale which includes only the respondents who completed both the pre and post GEM scale items. It was found that all the items on the GEM scale are significantly different when comparing pre and post scores.

Young Men – Gender Equitable Attitudes					
Questions	% agree pre-test	% agree post-test	% disagree pre-test	% disagree post-test	Is the change statistically significant?

					(95% confidence)	
A woman's most important role is to take care of her home and cook for her family.			N = 262		Yes	*p* = .000
			6.1%	34.4%		
Women who carry condoms on them are "easy".			N = 260		Yes	*p* = .000
			40.4%	61.2%		
Changing diapers, giving the kids a bath, and feeding the kids are the mother's responsibility.			N = 257		Yes	*p* = .000
			26.8%	55.3%		
*In my opinion, a woman can suggest using condoms like a man can. (*negative*)	N = 258				Yes	*p* = .004
	66.3%	78.3%				
It is a woman's responsibility to avoid getting pregnant.			N = 256		Yes	*p* = .000
			32.0%	57.4%		
A man should have the final word about decisions in his home.			N = 258		Yes	*p* = .000
			26.0%	54.3%		
A woman should tolerate violence in order to keep her family together.			N = 254		Yes	*p* = .000
			47.6%	64.2%		
*A man and a woman should decide together what type of contraceptive to use. (*negative*)	N = 259				Yes	*p* = .000
	65.3%	80.7%				
It is okay for a man to hit his wife if she won't have sex with him.			N = 257		Yes	*p* = .001
			77.4%	87.5%		

I would never have a gay friend.			N = 254		Yes	p = .020
			37.0%	46.1%		
*If a guy gets a woman pregnant, the child is the responsibility of both. (*negative*)	N = 256				Yes	p = .000
	68.8%	82.0%				
*It is important that a father is present in the lives of his children, even if he is no longer with the mother. (*negative*)	N = 256				Yes	p = .015
	78.1%	85.2%				
Real men only have sex with women			N = 261		Yes	p = .000
			21.8%	37.9%		

**Items are phrased in a different direction and the analysis recoded these items.*



The mean GEM scores were also significantly different increasing from 28.86 (pre) to a score of 31.51 (post) out of a possible 39 (maximum score on GEM).

Mean GEM Score (out of a possible 39). N = 200	Pre Score = 27.1	Post Score = 31.5	Yes	p = .000

To increase the sample size an additional paired sample T-test was done for all respondents who responded to at least 9 of the 13 questions. Therefore, the respondents who answered less than 9 of the 13 questions were not included in the paired sample T-test results below. This technique increased the sample size to 262. The mean GEM scores were significantly different increasing from 27.9 (pre) to a score of 28.2 (post) out of a possible 39 (maximum score on GEM).

Mean GEM Score (out of a possible 39). N = 262	Pre Score = 27.9	Post Score = 28.2	Yes	p = .003

Another coding option is to split the continuous GEM Scale into three equal parts: high, moderate, and low support for equitable gender norms:

Category	Score out of 39 on GEM
Low support for equitable gender norms	0 to 13
Moderate support for equitable gender norms	14 to 26
High support for equitable gender norms	27 to 39

The cross tabulation presents the number and percentage of respondents who fell into each of these categories prior to the MenCare+ sessions and after attending the sessions; it also presents the number and percentage of respondents who moved into a higher or lower category. No respondents' GEM scores fell into the low category. 8.5% of the respondents were in the moderate GEM category pre and post intervention. 27.5% of the respondents moved from the moderate category to the high category after the intervention; which means that they have more gender equitable attitudes/scores after attending the MenCare+ sessions. 7.0% of the respondents moved down, from the high to the moderate category. 57.0% of the respondents remained in the high category. In terms of outcome indicator 1.1.1a, 84.5% of the sample of participating young men have high equitable gender attitudes post intervention.

Young Men - PRE & POST Support for equitable gender norms

			POST Support for equitable gender norms		Total
			Moderate	High	
PRE Support for equitable gender norms	Moderate	N	17	55	72
		% of Total	8.5%	27.5%	36.0%
	High	Count	14	114	128
		% of Total	7.0%	57.0%	64.0%
Total		Count	31	169	200
		% of Total	15.5%	84.5%	100.0%

Additional analyses and inferential tests were conducted to determine if there are any differences between young females' and young males' GEA scores. Only five young females completed both pre and post GEA questions and conclusions could not be made about possible differences. However, descriptive analyses showed that a larger percentage of female respondents had more favourable GEA scores in the pre assessment. The young females' mean GEM Score (out of a possible 39) was 33.5 and the young men's score was 28.23.

Qualitative findings

In terms of Gender Equitable Attitudes, topics were discussed relating to the perceived definition and role of a young man, what was learnt about equality in the MenCare+ programme, how the MenCare+ programme has affected the young men's perceptions and the consequences thereof.

The participants reported that before participating in the MenCare+ sessions they thought that to be a young man was to smoke, drink, be a gangster and have many girlfriends. This form of male identification is described in the literature as 'indlavini' – a masculine identification characterised by violent behaviour, recklessness, and disrespect, especially towards elders (5).

"Yes, being umjita (cool guy), a gangster and having many girlfriends…things like that…that's a man."

"…as young men we drink and get drunk, once we are drunk some of us win girlfriends and have unprotected sex with them…"

Focus Group Discussion Participants

The participants in general reported that after the programme they now believe that being a young man means that you take responsibility for your actions, you support your partner and community, and you are a role model to other boys and young men in the community. It was also clear from the discussion that the young men see the roles of men and women as equal.

"Yes a lot has changed in my life…for an example the way I conduct myself, the way I treat other people in the community…respecting the elders and I've become more responsible in everything that I do."

Focus Group Discussion Participant

Some of the young men reported that the programme taught them that hitting and abusing their girlfriends was wrong.

"Yes a lot has changed, for me I grew up knowing from the way my father used to do things, that a woman do not have a right to say anything, I knew that the only way to resolve any issues with a woman is to hit her…..But now through the sessions, I know that it is important to listen to your girlfriend's facts instead of shutting her up. Most of the time I've realized that she has an important point which I was not going to hear if I shut her up."

"Most boys don't know how to resolve issues because the girls shout at them, the only thing that most boys knows is to hit them in order to shut them up. So this program has taught them that such thing is wrong. Now if my girlfriend shout at me I rather walk away than to hit her, I then come back when we are both calm to discuss the issues that caused problems but if she's still upset I leave her until she's calm."

Focus Group Discussion Participants

There were also reports of improved communication about contraceptive use between partners as well as the acceptance of gay men.

"The program has changed me, now I am able to communicate with my girlfriend about contraceptives, I even accompany her to the clinic."

Focus Group Discussion Participant

"We have learnt to respect and accept guys who have relationship with guys……I used to ignore them and we used to call them names…..now I respect their choices."

Focus Group Discussion Participant

In terms of self-reported needs and recommendations, participants were concerned that they would go back to their old ways without the ongoing support of the MenCare+ programme. Some of participants recommended that the programme should focus on women as well so that the women, or specifically the young men's partners, can inform the men of their mistakes and in turn help their male counterparts to change their behaviour.

"We need more sessions and support so that we don't get back to our old ways."

"Because if the sessions stop, the chances are that we are going to go back to what we used to do if there is no one to guide us."

Focus Group Discussion Participants

"*They said they were going to have because I told them that to have a few girls in this session, would give this session more something interesting. It will wake up ….."*

"…and the thing is that then there out there was supposed to make them come forwards and approach them so, so that you could have had an open discussion and that you could have knew where you stand really your wrong points and so on….."

Focus Group Discussion Participants

The Health Care Workers mentioned that they have noticed more of a change in the young fathers than in the older ones.

"Although this topic has been addressed in the community forums and radio stations, the older fathers still resist the change, but we do see the young fathers supporting their partners in maternal and child health"

Health Care Worker Interview

3. Conclusion

Outcome 1.1.1a can be confirmed as being a success as more than 25% of young men indicated a higher gender equitable attitude after the intervention. This positive change in gender equitable attitudes is statistically significant at the 95% level of confidence. The qualitative findings support the quantitative findings by showing a subjective change in attitudes towards gender roles and gender equity. We can deduct from the aforementioned results that the MenCare+ programme did improve the young men's attitudes toward gender equality. It was revealed in the FGDs with the young men that they learnt to respect not just women, but also all people in their communities including the youth, elders and people with different sexual orientations. The participants stressed their desire to continue with the programme and also their fear of reverting back to their unhealthy and irresponsible behaviours without the continued support of the programme. The participants also suggested that future programmes should include sessions with females since some of them feel that it will strengthen the impact of the programme. It is imperative that these self-identified needs of the young men should be considered when implementing a new programme or adapting the current programme.

Additional information: % of participating fathers/couples have more gender equitable attitudes

1. Methodology

The pre and post questionnaires collected data about gender equitable attitudes (GEA / GEM). Descriptive analyses were conducted to determine the frequency and percentage of respondents who disagreed prior to the programme and after attending the programme sessions. Paired sample T-test were utilised to determine whether there is a significant difference between pre and post scores.

2. Findings

<u>Quantitative findings</u>

The table below presents the pre and post scores for each item on the GEM scale for the parenting groups which includes only the respondents who completed both the pre and post GEM scale items. It was found that 12 of the 13 items on the GEM scale are significantly different when comparing the pre and post scores. The only item that did not change significantly was “A man and a woman should not decide together what type of contraceptive to use”.

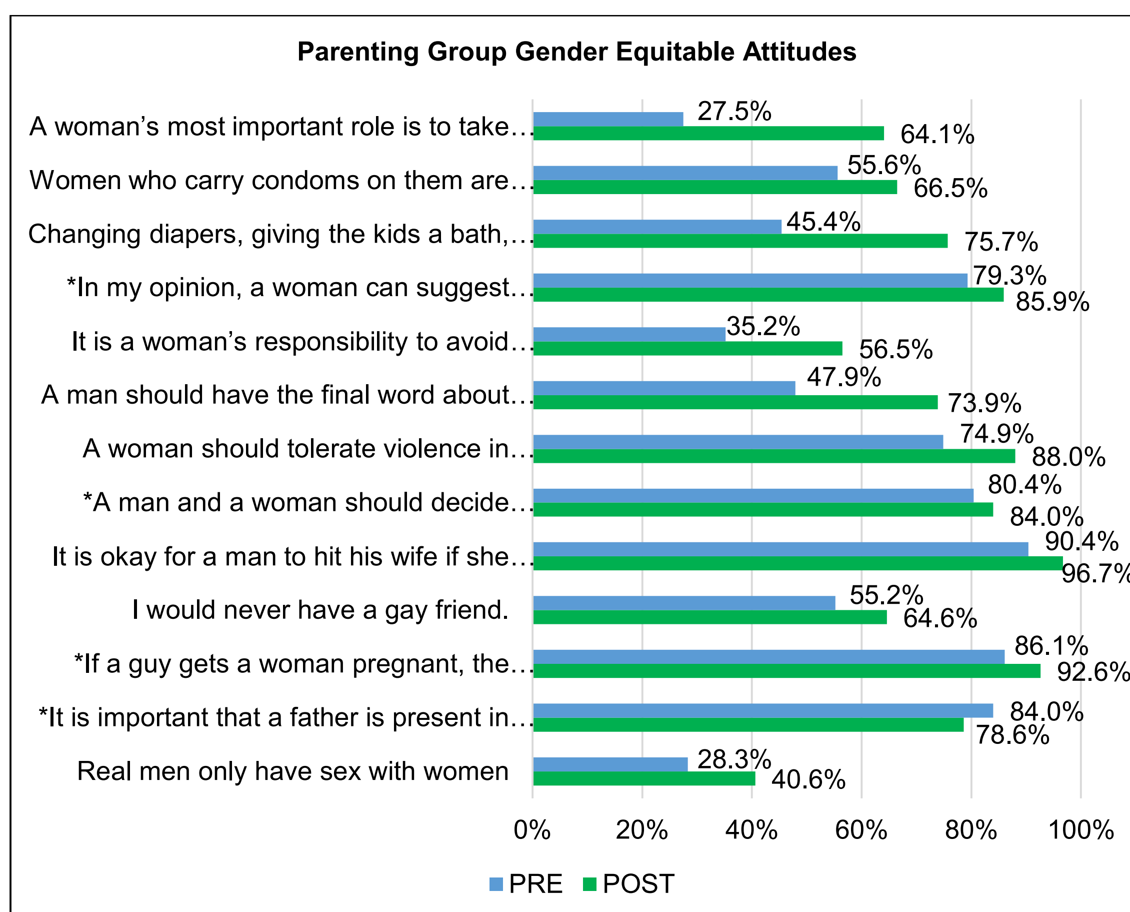
The results show that the item “It is not important that a father is present in the lives of his children, even if he is no longer with the mother” decreased significantly after the intervention from 84.0% to 78.6%.

<table>
<tr><th colspan="7">Parenting Group - Gender Equitable Attitudes</th></tr>
<tr><th>Questions</th><th>% agree pre-test</th><th>% agree post-test</th><th>% disagree pre-test</th><th>% disagree post-test</th><th colspan="2">Is the change statistically significant? (95% confidence)</th></tr>
<tr><td rowspan="2">A woman’s most important role is to take care of her home and cook for her family.</td><td rowspan="2" colspan="2"></td><td colspan="2">N = 429</td><td rowspan="2">Yes</td><td rowspan="2">p = .000</td></tr>
<tr><td>27.5%</td><td>64.1%</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="2">N = 421</td><td>Yes</td><td>p = .000</td></tr>
</table>

Women who carry condoms on them are “easy”.			55.6%	66.5%		
Changing diapers, giving the kids a bath, and feeding the kids are the mother’s responsibility.			N = 432		Yes	$p = .000$
			45.4%	75.7%		
*In my opinion, a woman can suggest using condoms like a man can. (*negative)*	N = 425				Yes	$p = .003$
	79.3%	85.9%				
It is a woman’s responsibility to avoid getting pregnant.			N = 423		Yes	$p = .000$
			35.2%	56.5%		
A man should have the final word about decisions in his home.			N = 422		Yes	$p = .000$
			47.9%	73.9%		
A woman should tolerate violence in order to keep her family together.			N = 426		Yes	$p = .000$
			74.9%	88.0%		
*A man and a woman should decide together what type of contraceptive to use. (*negative*)	N = 424				No	$p = .227$
	80.4%	84.0%				
It is okay for a man to hit his wife if she won’t have sex with him.			N = 425		Yes	$p = .000$
			90.4%	96.7%		
I would never have a gay friend.			N = 415		Yes	$p = .000$
			55.2%	64.6%		
*If a guy gets a woman pregnant, the child is the	N = 418				Yes	$p = .002$
	86.1%	92.6%				

responsibility of both. (*negative*)						
*It is important that a father is present in the lives of his children, even if he is no longer with the mother. (*negative*)	N = 425				Yes	$p = .000$
	84.0%	78.6%				
Real men only have sex with women			N = 424		Yes	$p = .000$
			28.3%	40.6%		

**Items are phrased in a different direction and the analysis recoded these items.*



The mean GEM scores were also significantly different increasing from 30.2 (pre) to a score of 33.2 (post) out of a possible 39 (maximum score on GEM).

Mean GEM Score (out of a possible 39). N = 437	Pre Score = 30.2	Post Score = 33.2	Yes	$p = .000$

The cross tabulation presents the number and percentage of respondents who fell into each of these categories prior to the MenCare+ sessions and after attending the sessions; it also presents the number and percentage of respondents who have moved into a higher or lower category. 4.8% of the respondents were in the moderate GEM category pre and post intervention. 18.1% of the respondents moved from the moderate category to the high category after the intervention; which means that they have more gender equitable attitudes/scores after they attended the MenCare+ sessions. 3.4% of the respondents moved down, from the high to the moderate category. 73.2% of the respondents remained in the high category. In terms of this additional outcome indicator, 91.5% of the sample indicated a high support for equitable gender norms post intervention.

Parenting Group - Support for equitable gender norms Cross tabulation						
			Post Support for equitable gender norms			Total
			Low	Moderate	High	
Pre Support for equitable gender norms	Low	Count	0	0	1	1
		% of Total	0.0%	0.0%	0.2%	0.2%
	Moderate	Count	0	21	79	100
		% of Total	0.0%	4.8%	18.1%	22.9%
	High	Count	1	15	320	336
		% of Total	0.2%	3.4%	73.2%	76.9%
Total		Count	1	36	400	437
		% of Total	0.2%	8.2%	91.5%	100.0%

Additional Chi-square and McNemar's Chi-square tests were completed to determine if there is a relationship between marital status and agreement with "A man and a woman should decide together what type of contraceptive to use"; and to determine if there is a relationship between marital status and agreement with "It is important that a father is present in the lives of his children, even if he is no longer with his mother". No relationship was found between the above mentioned variables.

Analyses and inferential tests were conducted to determine if there are any differences between female parents' and male parents' GEA scores. The mean GEA scores changed significantly ($p < 0.05$) for both females and males. Chi-square tests confirmed that there are significant differences between female and male parents on the following items:

- A man should have the final word about decisions in his home (Pre and Post)
  Female parents are more likely to disagree with this statement than male parents
- I would never have a gay friend (Pre)
  Female parents are more likely to disagree with this statement than male parents
- Real men only have sex with woman (Pre and Post)
  Female parents are more likely to disagree with this statement than male parents
- A man and a woman should decide together what type of contraceptive to use (Post)
  Female parents are more likely to agree with this statement than male parents

Qualitative findings

During the Parenting FGDs the participants were asked what they thought the role of the mother and father was. Only one participant reported that the role of the father is different to that of a mother, in his opinion a father should be married, go to work and provide for his family.

> *"For me…other people don't even want to do that – they still believe men should not do these things, a man is like a boss, and for us he is the one that is going to look for a job and that is his only responsibility. His job is to get a job, bring in food and money- that is his job as a parent – not to go to the kitchen."*
> *Focus Group Discussion Participant*

The other participants disagreed with this more traditional view of being a father - they thought that being a father meant you had to take responsibility for your actions and support your children and partner.

> *"It is not usual for African families and African men to do work at home. I remember one day a neighbour came to the house looking for my wife and she found me washing dishes, she was surprised and when my wife came she said to her 'I found your husband washing dishes, I pray to God to also give me a husband like him". (Laughter) But what I was doing*

> *is not common for other men to do, but mainly from what we are doing, other people learn from us and make it for them also.”*
> *Focus Group Discussion Participant*

The participants also mentioned that a father is a man who works together with his wife in resolving issues at home. In one of the success stories, it was mentioned that a man and his wife had marital problems. The programme motivated the man to reconcile with his wife and save their marriage.

> *“I would like to share this story about one of the guys who was here with us doing the workshop. He and his wife were on the verge of divorce, but the impact of the workshop was so great that he went back to his wife and they are now reconciling. He was one of those people that if he said something - it must be done that way and he apologised to his wife for his behaviour and he feels like he has a new lease on his marriage.”*
> *Focus Group Discussion Participant*

It was interesting to hear that some participants suggest that a single mother can also be called a ‘father’ because most of the time she plays all the roles by herself, she can provide financially, care for the health and education of her children and she can also protect her children.

> *“Traditionally is was believed that a mother should be a housewife and a father was the one who should go to work and provide for his children, but now it happens that a mother earns more than a father. I believe that nothing a mother does for her children that a father cannot do, even changing nappies and cooking…..for an example there are few women who can cook better than me. The only thing that a father cannot do that a mother can do is only delivering a baby and breastfeeding.” Focus Group Discussion Participant*

The participants still thought that a father should provide for his family, however this definition of providing broadened to include not only financial support, but emotional support, love, and support in household and care activities.

> *“…for me I will say this programme helped me because from the background that I grew up in, that was a very traditional background, where we believe a man can’t cook, a man cannot even look in the pot, bath children… But when I came to the programme I had to learn and*

cut those bounds, nowadays I can cook, I stay with the children at home, I can do everything and I am not ashamed of it." Focus Group Discussion Participant

It was also mentioned by the participants in this FGD and by some of the stakeholders, that the session about 'My father's legacy' had the biggest effect on participants. This session explores the participants' fathers and how they are remembered. A lot of the men in the sessions had abusive or absent fathers and this session motivated them to be different from their own fathers and they started to think about how they would like to be remembered by their children.

"I believe that the program has changed my life and my way of understanding. Being a father at a young age of 20 years was a challenge to me, I was not aware what was expected from me as a father, the program has made me a better father as compared to my peers who were not part of the program. I am involved in my child's life and I always support my girlfriend. I even sacrifice playing soccer to take care of my child and I sometimes allow my girlfriend go out to socialise with her friends while I care for the baby". Focus Group Discussion Participant

3. Conclusions

All the changes related to parents' gender equitable attitudes were statistically significant, except "A man and a woman should not decide together what type of contraceptive to use". Female parents were more likely to agree with the statement than male parents after the MenCare+ sessions. The item "It is not important that a father is present in the lives of his children, even if he is no longer with the mother" decreased significantly after the intervention from 84.0% to 78.6% that disagreed.

The attitudes that changed the most were "A woman's most important role is to take care of her home and cook for her family"; "Changing diapers, giving the kids a bath, and feeding the kids are the mother's responsibility"; "It is a woman's responsibility to avoid getting pregnant"; and "A man should have the final word about decisions in his home".

The qualitative findings suggest that fathers do have more gender equitable attitudes. The participants' views on the roles of mothers and fathers changed from a traditional perspective; where the man is the head of the household and the woman is expected to carry out all care and house work; to a more egalitarian view where the mother and the father are able to perform the same roles and both have equal power.

Outcome indicator 1.1.1b: 25% of participating young men use contraceptives, including condoms at latest high-risk sex

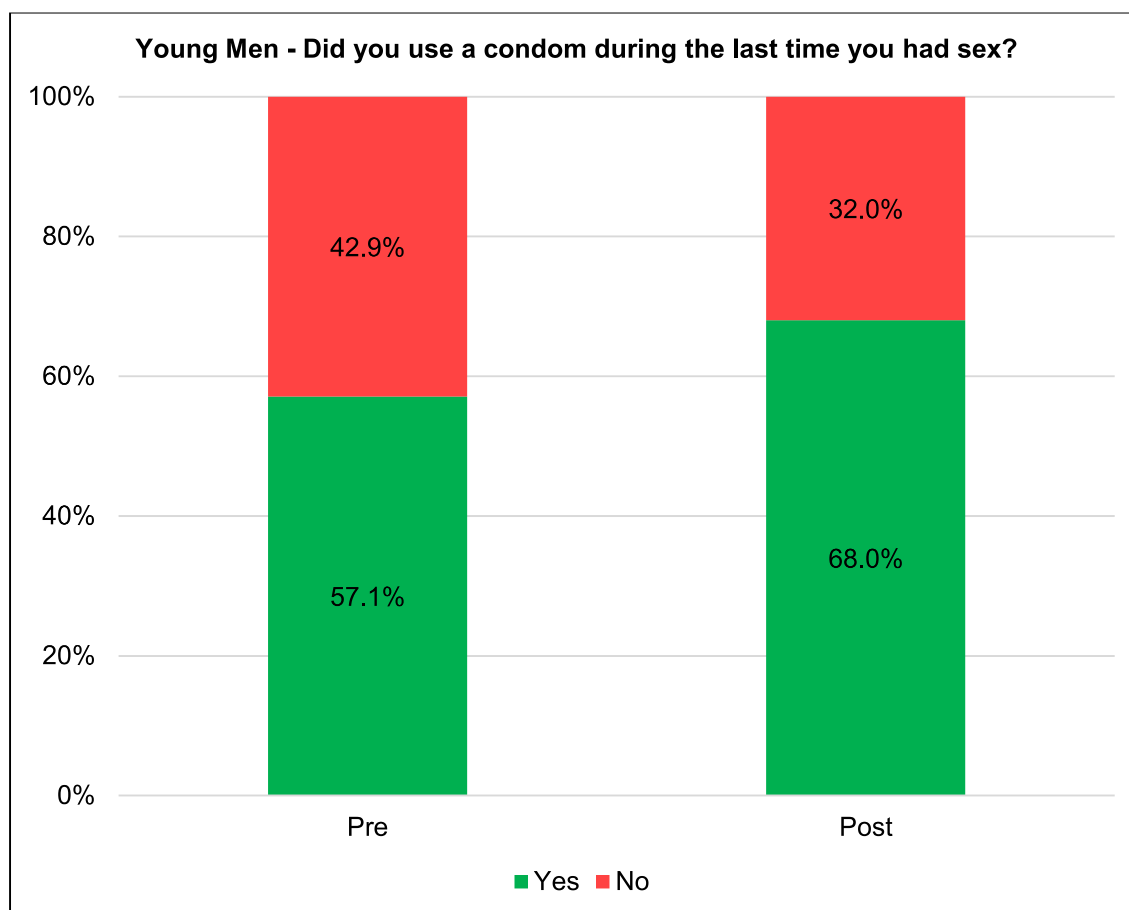
1. Methodology

Descriptive analysis methods were utilised to determine the frequency and percentage of participating young men who use contraceptives at latest high-risk sex. Cross tabulations also give insight into condom use and who made the decision to use a condom. The pre and post programme "attitude towards contraceptives" were also compared with each other; paired sample t-tests determined whether there was a significant difference between pre and post results for attitudes towards contraceptives.

2. Findings:

Quantitative findings

The respondents were asked "Did you use a condom during the last time you had sex?" When selecting only the participants who indicated that they do have sex – we find that 57.1% used condoms (last time of sex) prior to attending the MenCare+ sessions and 68.0% indicated that the used condoms after attending the sessions. The respondents who did not have sex are not included in the sample. A Fisher's Exact Test confirmed that there is a significant difference between pre and post condom use among young men ($p = .000$).



The revised version of the questionnaire also contained a question "Do you use a condom when you have sex?" The cross tabulation below presents the number of people the respondents had sex with in the past 3 months and whether they use condoms when they have sex (the tables below only include the respondents that made use of the revised questionnaire, the older questionnaire's question was phrased in a different way and cannot be presented together). Please see the table below for frequency and percentages of condom use per number of sexual partners.

The results show an increase in the percentage who always use condoms among those with "two" and "four or more" sexual partners. Decreases in condom use were found in the groups who have "one" ore "three" sexual partners. Chi-square tests (both pre and post) were conducted to determine whether there is a relationship between the number of sexual partners and condom use. The test confirmed that there is no relationship between the two mentioned

variables[1]. However, we do see an increase in condom use in total (from 38.9% to 45.7%) when comparing pre and post condom use; this supports the findings from above when the young men were asked "Did you use a condom the last time you had sex?"

Young Men - During the past 3 months, with how many people did you have sex? * Do you use a condom when you have sex? Cross tabulation					
		Do you use a condom when you have sex?			
		PRE		POST	
		Always	Sometimes/ No	Always	Sometimes/ No
During the past 3 months, with how many people did you have sex?	1	20	24	14	15
		45.5%	54.5%	48.3%	51.7%
	2	9	15	11	9
		37.5%	62.5%	55.0%	45.0%
	3	9	10	4	7
		47.4%	52.6%	36.4%	63.6%
	4 or more	6	20	13	19
		23.1%	76.9%	40.6%	59.4%
Total		113	69	42	50
		38.9%	61.1%	45.7%	54.3%

The questionnaires also contained questions/items to explore the type of condoms the young men use and what contraception methods they know. Both the older and revised version of the questionnaire contained these questions, but they were phrased differently as seen below:

- What type of contraception does your regular partner use? (Older questionnaire). Respondents could typically choose more than one answer.
- Which of the following contraception methods do you know? (Revised questionnaire). Respondents could typically choose more than one answer.
- What type of contraception does your partner use? (Revised questionnaire). Respondents could typically choose more than one answer.

The results of the two different questionnaires are therefore presented separately below.

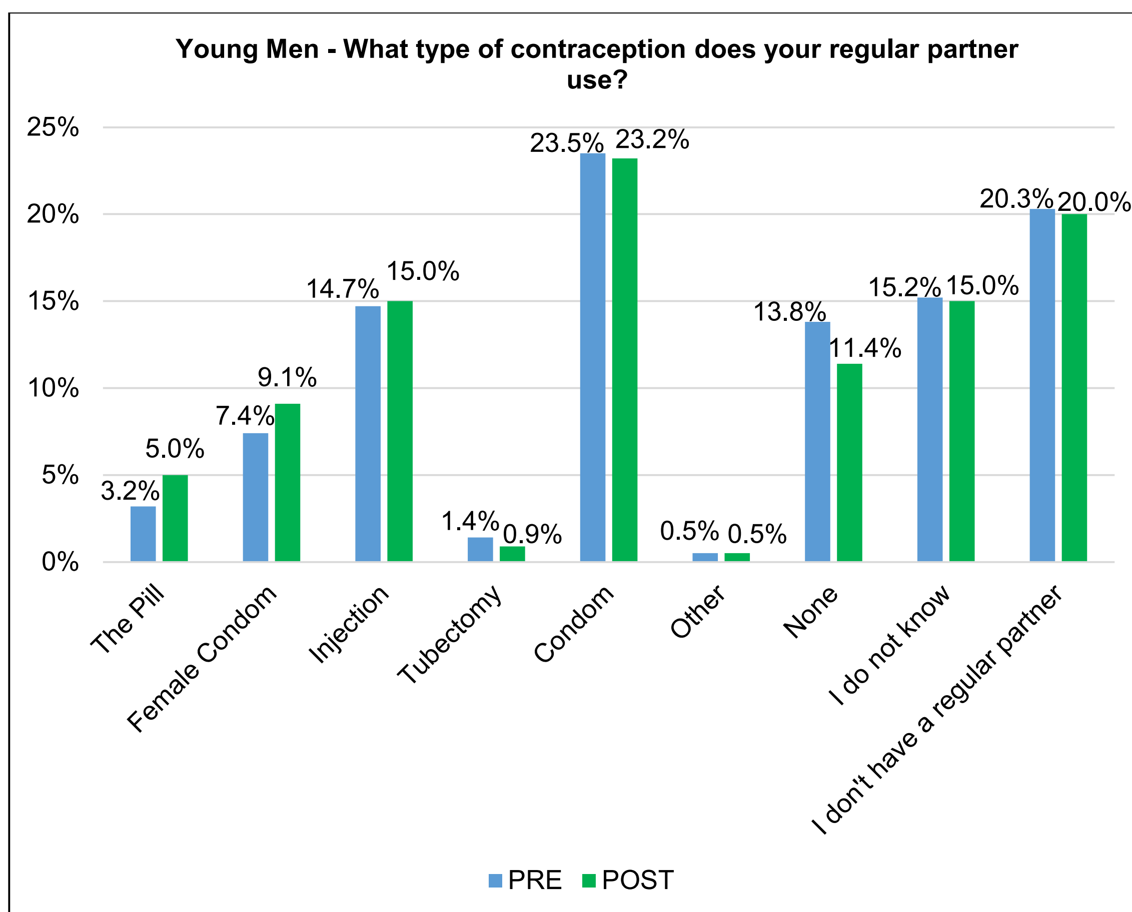
The results from the older questionnaire below display the type of contraception used by the young men's regular partners. "No contraception" decreased from 13.8% to 11.4%. As seen

[1] Respondents who reported having 4 or more partners in the last 3 months were grouped together to not violate the assumptions of the chi-square test. Zero cells had statistically significant residuals.

below, some types of contraception methods have increased and others have decreased. This could partially be explained by the fact that the respondents could choose only one answer.

[2]Young Men - What type of contraception does your regular partner use? Data collected using "older" version of questionnaire			
	PRE	POST	Change in %
The pill	7	11	1.8% increase
	3.2%	5.0%	
Female condom	16	20	1.7% increase
	7.4%	9.1%	
Injection	32	33	0.3% increase
	14.7%	15.0%	
Tubectomy	3	2	0.5% decrease
	1.4%	0.9%	
Condom	51	51	0.3% decrease
	23.5%	23.2%	
Other	1	1	No change
	0.5%	0.5%	
None	30	25	2.4% decrease
	13.8%	11.4%	
I do not know	33	33	0.2% decrease
	15.2%	15.0%	
I don't have a regular partner	44	44	0.3% decrease
	20.3%	20.0%	
Total	217	220	
	100%	100%	

[2] The pre and post columns of this table is not paired.



The results from the question 'Which of the following contraception methods do you know?" (From the revised questionnaire) are presented below. The total number of respondents who completed the revised version of the young men questionnaire were 179; and they could select as many answers as they liked (the sample was used as the denominator in the table below). The major increases and decreases were found under the percentage of respondents who knows about injection as contraception method, implants, condoms and IUD (Intra Uterine Devices).

Young Men – Which of the following contraception methods do you know? Data collected using revised version of questionnaire			
	PRE	POST	Change in %
The pill	72	76	2.3% increase
	40.2%	42.5%	
Female condom	80	73	3.9% decrease
	44.7%	40.8%	
Injection	24	83	33.0% increase
	13.4%	46.4%	
Tubectomy/Vasectomy	34	42	4.5% increase

	19.0%	23.5%	
Implant	104	59	25.1% decrease
	58.1%	33.0%	
Condom	13	89	42.4% increase
	7.3%	49.7%	
IUD	0	50	27.9% increase
	0.0%	27.9%	
Other	14	0	7.8% decrease
	7.8%	0.0%	
I do not know what contraception means	0	3	1.7% increase
	0.0%	1.7%	

The table below presents the frequency and percentages of who made the decision to use a condom. The respondents who indicated that they "do not have sex" and "do not use a condom" were excluded. The results are not paired and are purely describing the pre and post data. The majority of young men indicated that they made the decision to use a condom with their partners; the percentage of young men who made the decision with their partner to use a condom increased from 54.3% to 66.0% afterwards.

Young Men - Did you use a condom during the last time you had sex? * Who made the decision to use a condom? Cross tabulation

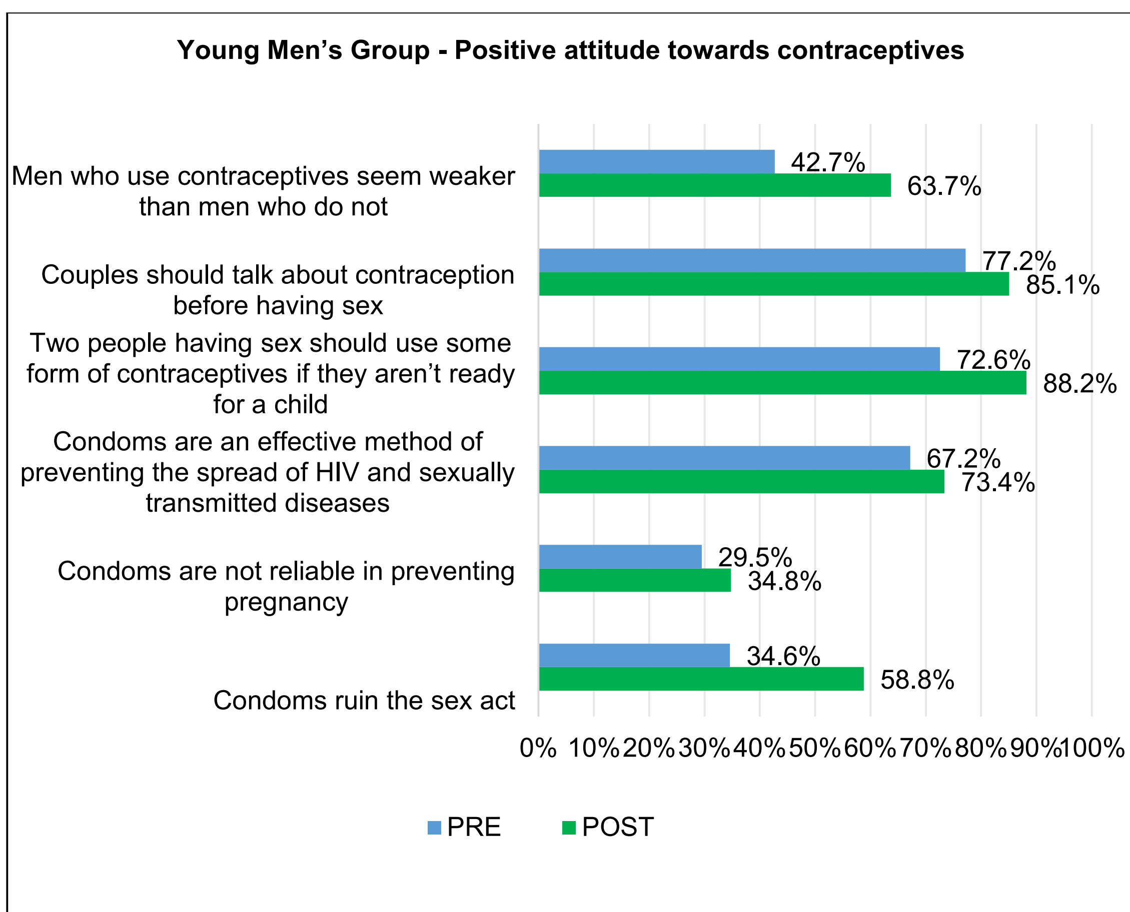
		Who made the decision to use a condom?			Total
		Me	My partner	Both	
Did you use a condom during the last time you had sex?	PRE - Yes	60 (32.6%)	24 (13.0%)	100 (54.3%)	184 (100%)
	POST - Yes	59 (30.4%)	7 (3.6%)	128 (66.0%)	194 (100.0%)

The table below displays the young men's attitude towards contraceptive use; the table compares the percentage of young men who had a positive attitude towards the individual items and also shows the difference in total scores (out of a maximum of 18) and whether the differences are statistically significant. The young men displayed a more positive attitude towards contraceptives for four of the six items on the scale except for "Condoms are an effective method of preventing the spread of HIV and sexually transmitted diseases" and "Condoms are not reliable in preventing pregnancy" where it was found that the young men's attitude stayed the same after attending the MenCare+ sessions. The way the question was phrased may have influenced the young men's responses. It is important to note that the difference between pre and post intervention is not significantly different for this item and that

the difference may be due to chance. The findings also show that the respondents' attitude towards condoms as a pregnancy prevention method remained unchanged.

Young Men - Attitude towards contraceptives						
Questions	**% agree pre-test**	**% agree post-test**	**% disagree pre-test**	**% disagree post-test**	**Is the change statistically significant? (95% confidence)**	
Question 1: Men who use contraceptives seem weaker than men who do not			N = 234		Yes	p = .000
			42.7%	63.7%		
*Question 2: Couples should talk about contraception before having sex	N = 241				Yes	p = .019
	77.2%	85.1%				
*Question 3: Two people having sex should use some form of contraceptives if they aren't ready for a child	N = 237				Yes	p = .000
	72.6%	88.2%				
*Question 4: Condoms are an effective method of preventing the spread of HIV and sexually transmitted diseases	N = 244				No	p = .994
	67.2%	73.4%				
Question 5: Condoms are not reliable in preventing pregnancy			N = 244		No	p = .320
			29.5%	34.8%		
Question 6: Condoms ruin the sex act			N = 243		Yes	p = .000
			34.6%	58.8%		

*The direction of these items are different and responses had to be recoded in order to calculate the mean score.



The paired sample t-test results show that there is a significant difference between the pre and post scores for attitude towards contraceptives. Sig. (2-tailed) .000. Therefore, we can conclude that the young men's attitudes toward contraceptives have changed significantly when comparing pre with post intervention scores.

	Mean score pre-test	Mean score post-test	Is the change statistically significant? (95% confidence)	
Mean score (Out of a possible score of 18). N = 201	13.8	15.1	Yes	*p* = .000

Additional McNemar's Tests were conducted to determine if there are any differences between young males' and young females' condom use. Significantly more young females indicated that they did not use a condom the last time they had sex when compared to young males (prior to the MenCare+ sessions). When the same test was conducted with the post data, the results showed that there were cells with a count of less than 5. Therefore, the results could not be used.

Did you use a condom during the last time you had sex?					
	Young Males		Young Females		Is their statistically significant difference?
	Yes	No	Yes	No	
PRE	188	137	5	8	Yes Exact Sig. (2-sided) = .000
	57.8%	42.2%	38.5%	61.5%	
POST	200	92	3	3	Violated assumption of McNemar Test. Results should not be used.
	68.5%	31.5%	50%	505	

Qualitative findings

Public Health studies of condom use often draw on the Health Belief Model, which emphasises a set of perceptions that are thought to influence health behaviours. These fall under the domains of the perceived seriousness of the outcome, the individual's perception of his/her susceptibility, the perceived benefits of a health behaviour, and perceived barriers to that behaviour (15). It also posits that a cue to action or stimulus must be present in order to trigger the health-promoting behaviour. Although the enabling factors and barriers to condom use was not discussed in the FGD with Young Men, the literature mentions that barriers to condom use include the following: the belief that condoms are inappropriate for committed or loving relationships, young people do not know how to use condoms effectively, belief that condom use signals mistrust of one's partner, and fear of sexual violence from a partner if a woman insists on condom use because it suggests that she has other partners (15).

However, the participants did indicate that after participating in the programme they take the responsibility to ensure that they have protected sex, they reported carrying condoms with them to ensure they are available and that they use a condom every time they have sex. The participants also discussed what the programme has taught them about sexually transmitted diseases and its symptoms.

"…sometimes my girlfriend do not like needle because she says it will make her fat…in that case I have to use condom because it's both our duty to use contraceptives not only hers….I always think that it will not be fair to make her pregnant at a young age because we both need to finish school….so I always make sure that we are having protected sex."

"We have learnt about the importance of going to the clinic if you notice any change in your private part, for an example if you have a lump or a sore."

Focus Group Participants

Some of the participants also mentioned that they have learned that you are at risk of contracting an STI if a condom has a hole through it.

> *"I learned that when using a condom you must first check if there is no hole on it, because you found that your partner can take a needle and put a hole through the condom which is invisible….any virus can pass through that hole and you can get infected…..it is therefore important that I always carry my own condoms that I'm sure about to ensure my safety."*
>
> *"The program has taught me the risks and dangers of unprotected sex, there was an example that was made during one of the session on contraceptives where we were told not to trust condoms brought by other people (partner) because it's impossible to see if the other person has put the needle through the sealed condom; as a result, since that time I always carry my own condoms".*
>
> *Focus Group Participants*

One participant stressed that a condom can still burst which would increase the chances of a girl falling pregnant.

> *"No I have not gained anything because the girls still get pregnant while using contraceptives and even if we use condoms, they still bursts."*
>
> *Focus Group Participant*

3. Conclusion

More young men used a condom during the last time they had sex after having finished with the programme. The young men's attitude towards contraceptive use did change positively after the programme, from 13.8 (out of a maximum score of 18) to 15.1 which was found to be significantly different. However, the items "Condoms are an effective method of preventing the spread of HIV and sexually transmitted diseases" and "Condoms are not reliable in preventing pregnancy" did not show any significant changes. The latter could possibly be better understood from what was spoken about in the FGDs since some of the participants still feel that condoms are unreliable as a contraceptive and a protective measure against HIV and STIs.

Otherwise, the qualitative data shows that the men reported higher use of condoms after the intervention. They also reported a better understanding of sexually transmitted infections and how this new understanding and knowledge led to them changing their behaviour.

Outcome indicator 1.2.1a: % of participating men (fathers) attend prenatal care visits

1. Methodology:

Descriptive analyses produced the frequencies and percentages of men attending prenatal care visits before and after attending the MenCare+ parenting sessions.

2. Findings

Quantitative findings

Please refer to Outcome indicator 3.2.1a: 75% increase in fathers attending prenatal care visits with partners below.

Qualitative findings

In the Formative Research for MenCare+ conducted by Rutgers (16) male participants indicated that they were reluctant to visit health facilities because they were scared, embarrassed, or worried about confidentiality. Furthermore, clinics were viewed as ‘places for women’ where there were ‘women’s pictures everywhere’, ‘all the nurses are female’, and staff were seen as disinterested and impersonal. Please see Outcome indicator 3.2.1a for a further discussion on Fathers attending prenatal care visits with their partners.

3. Conclusion

The percentage of young men attending prenatal care visits increased from 68.9% before the programme to 71.5% after the programme.

Outcome indicator 1.2.1b: % of participating couples communicate about family planning

1. Methodology

Data collected through the questionnaires for young men (SRHR groups) did not include items about couple's communication regarding family planning. The revised version of the parenting questionnaire had one item which asked the respondents "Do you talk about contraception with your partner?" Descriptive methods were utilised to explore the frequencies and percentages of pre and post programme communication about contraception.

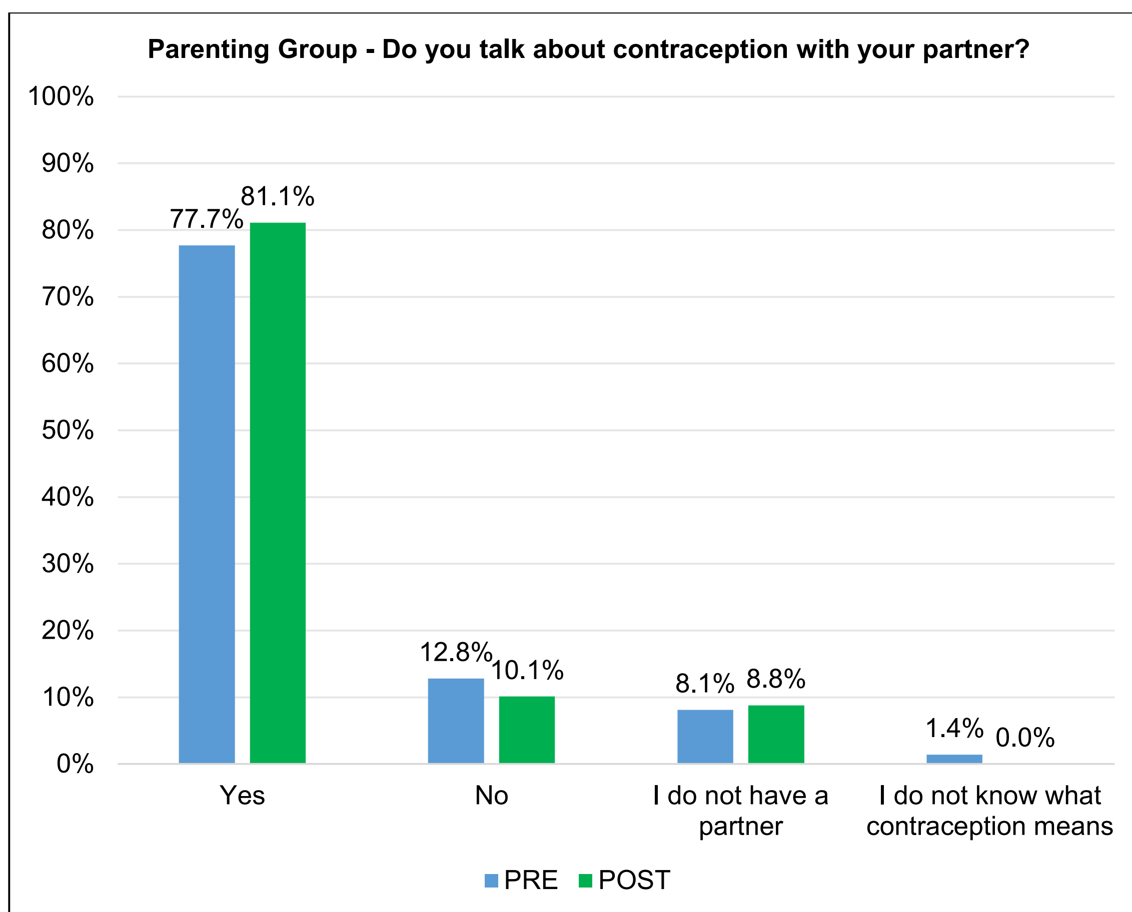
The topic was also discussed during the focus groups discussions with parents and young men. The information yielded through the focus group discussions are presented below.

2. Findings

Quantitative findings

The results show that there is a slight increase from 77.7% to 81.1% of participants who indicated that they do talk about contraception with their partners. The table below also includes those who do not have partners and the participants who do not know what contraception means.

Do you talk about contraception with your partner? (data from revised version only)	% pre-test	% post-test	Change in %
	N = 148		
Yes	77.7%	81.1%	3.4% increase
No	12.8%	10.1%	2.7% decrease
I do not have a partner	8.1%	8.8%	0.7% increase
I do not know what contraception means	1.4%	0.0%	1.4% decrease



The cross tabulation below excludes those who do not have partners and the participants who do not know what contraception means. Nine participants (7.0%) indicated that they did not previously communicate about contraception with their partners; but they do communicate with their partners after the intervention. But six participants (4.7%) communicated with their partners prior to the programme and they do not communicate with their partners about contraception afterwards.

Parenting Group: Pre_Do you talk about contraception with your partner? * Post_Do you talk about contraception with your partner? Cross tabulation				
		Post_Do you talk about contraception with your partner?		Total
		Yes	No	
Pre_Do you talk about contraception with your partner?	Yes	107	6	113
	No	9	7	16
Total		116	13	129

Chi-square tests confirmed that there are no significant difference between male and female parents in terms of them talking about contraception with their partners.

Qualitative findings

In the Formative Research for MenCare+ conducted by Rutgers (16) most participants indicated that family planning should be a shared decision, with mutual responsibility of both partners. However, when discussing contraceptive use, male participants indicated that contraceptive use was not a subject they would normally talk about with their partner and that decisions about contraception lay mainly with women (16). Gender inequality in reproductive decision-making is a key element of the social context of reproductive health, it has been reported that couples often disagree about the desirability of pregnancy and the use of contraceptives (17).

During the End of Programme Evaluation FGDs with parents, participants explained that they did begin to discuss issues regarding family planning with their partner after attending the parenting sessions; they also feel better enabled to support their partner in this regard.

"Our father did not have family planning, we were ten in my family and our parents did not have money to take us to school. I have learnt a lot from this program about family planning, now I do talk to my wife about these things".

"For me it was family planning, because for me, where I come from the father always has the word, the wife doesn't have a word – when he says it going to be like this that is how it will be. But when we talked about family planning I think it's a good thing because we have to share that experience. When you need something you have to talk to your partner in a good way- it is not like you are giving an obligation (you have to do this)."

Focus Group Participants

The evaluators noticed an overlap between this outcome indicator regarding family planning and outcome indicator 2.1.1 regarding contraceptive use. The World Health Organisation describes family planning as "Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility." It is clear from this definition that the concept of contraceptive use is an integral part of family planning.

3. Conclusion

The qualitative findings from the formative research conducted by Rutgers and the findings of the end-term evaluation concerning family planning were much the same. Both found that the men were enthusiastic in discussing family planning with their partners. This supports the

quantitative data, which shows a 3.4% increase in parents talking about contraception with their partners after the programme.

Outcome indicator 1.3.1: community members with a positive attitude towards men as caregivers and allies in family planning

1. Methodology

Data collection through the questionnaires from young men (SRHR groups) and parenting groups did not include items about other community members' attitude towards men as caregivers and allies in family planning.

The topic was however discussed during the focus groups discussions with Parents and Young men, and in interviews with key stakeholders, including Patrick Godana (MenCare+ Government and Media Manager).

The Ornico database was also used as a data source to determine the audience size of radio and television campaign activities.

2. Findings

Quantitative and Qualitative findings

The following MenCare+ media campaign activities were identified during the interviews and review of the MenCare+ South Africa Annual Reports. Table 6 provides an overview of the MenCare+ Media Campaign activities and their reach.

Table 5. Campaign Activities

<table>
<tr><th>Type of Campaign</th><th>2014 Annual Report</th><th>2015 Semi-Annual</th><th>2015 Evaluation</th></tr>
<tr><td>Positive Parenting and Fatherhood</td><td>N/A</td><td>8 184 000</td><td>N/A</td></tr>
<tr><td>State of the World's Fathers</td><td>N/A</td><td>3 110 545</td><td>N/A</td></tr>
<tr><td>National Positive Discipline Campaign</td><td>17 949 188</td><td colspan="2">3 788 000</td></tr>
<tr><td>National Paternity Leave Campaign</td><td>4 945 606</td><td colspan="2">N/A</td></tr>
<tr><td>Parental Leave</td><td>N/A</td><td>6 974 000</td><td>N/A</td></tr>
<tr><td>Door-to-Door Campaigns</td><td>915</td><td colspan="2">N/A</td></tr>
<tr><td>Community knock-and-drop campaigns</td><td>N/A</td><td>1 875</td><td>N/A</td></tr>
<tr><td>Father's Day Celebration</td><td>100</td><td colspan="2">N/A</td></tr>
</table>

Public Awareness Raising Interventions	163 presentations, 11 141 people	15 690	N/A
Half-day Awareness Raising Presentations	20 presentations, 412 people	281	N/A
Community Mobilisation - Men's March	N/A	1 482	N/A
MenCare+ online Films	12 000 views	N/A	
MenCare+ Material Distribution	15 000	N/A	
Father Dialogues	414	N/A	
Radio and television Programmes	12 079 653		
School visits	3 School events, 653 participants	10 School events (8 in the Eastern Cape; 2 in the Western Cape)	
Community Newspapers	38 Articles Published		
Facebook Page	2370 'likes'		
2 day male GBV awareness raising workshops	N/A	112	N/A
Information and Communication Talks	N/A		
16 Days of Activism Against Women and Child Abuse	N/A		
Sports Tournaments			25
Collaboration with Churches			+- 150 people
Men's Conference			300
Billboards	450 000		0
Total number of men and women reached by MenCare+	*35 465 064 (target: N/A)*	*22 076 255 (target: 59 771)*	*N/A*

A brief description of the 2015 campaign activities follows:

1) ***MenCare+ Material distribution***

   Included the distribution of MenCare+ pamphlets and posters. Below is an example of a South Africa MenCare+ poster.

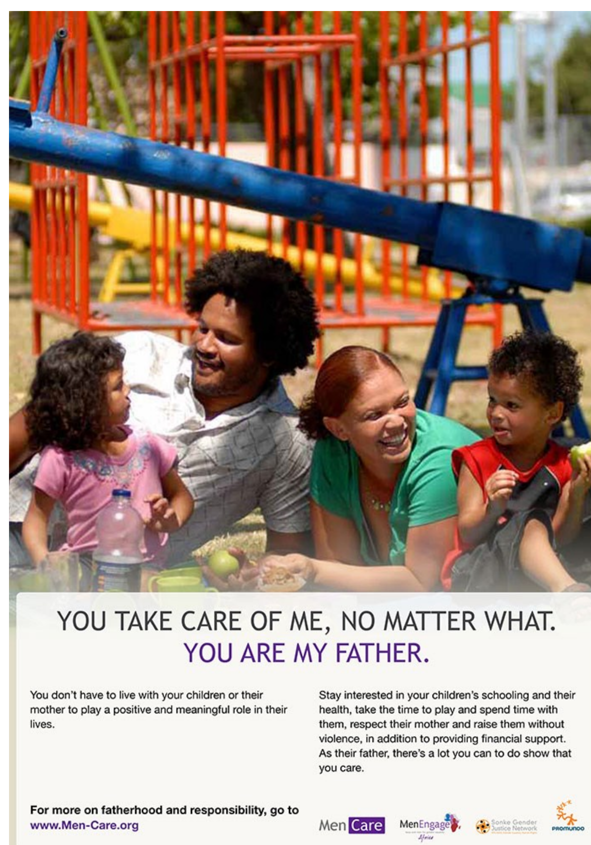


Figure 2. Example of a MenCare+ Poster

2) ***A community Imbizo (Father Dialogues) where fathers get together and discuss fatherhood issues.***

   Man Dialogues were held were men and fathers get together to discuss and debate issues around fatherhood. The themes that were discussed differed from one community to the next, but included topics such as violence and corporal punishment. Approximately 21 villages held Man dialogues and approximately 150 men attended per village.

3) ***Radio and Television Programmes***

The Radio Programmes are featured on various radio stations (please see table below for further details). The programmes centre on the issues pertinent to the MenCare+ programme, usually by a MenCare+ employee, and allows listeners to phone in to ask questions. Table 6 below shows the radio stations and television stations that broadcast programmes related to the MenCare+ programme, extracted from the Ornico Database. There are a few community radio stations that were not monitored by Ornico, and are therefore not included in the table below (Kanya FM–Butterworth, Vukani – Ikala, Zibonele Radio Station, Fort Hare University Radio, and University of Pretoria Radio – Tuks FM). The keyword “MenCare” was used to filter through all the data to identify radio and television sessions directly related to the programme. The search produced a total of 20 sessions (18 radio sessions and 2 television broadcasts).

Table 6. MenCare+ Radio and Television Programmes (Ornico Database)

	Date	Station	Programme	Region	Time	Duration	Ave (ZAR)	Audience
a)	2015/11/19	SAFM	Morning Talk	National	10:37 AM	22.06 min	90168	557 000
b)	2015/11/19	SAFM	Morning Talk	National	11:00 AM	3.20 min	13600	557 000
c)	2015/10/21	SAFM	The Talk Shop	National	8:07 PM	32.54 min	31584	557 000
d)	2015/07/22	SAFM	The talk shop	National	7:44 PM	32.17 min	30992	557 000
e)	2015/06/17	Radio 702	Talk at nine	Gauteng	10:20 PM	32.32 min	59211	665 000
f)	2015/06/17	Radio 702	Talk at nine	Gauteng	10:23 PM	33.12 min	60424	665 000
g)	2015/05/18	Cape Talk	Redi Tlhabi	Western Cape	9:41 AM	7.02 min	27346	108 000
h)	2015/05/18	Radio 702	Redi Tlhabi	Gauteng	9:41 AM	7.02 min	74891	665 000
i)	2015/04/22	SAFM	The talk shop	National	7:43 PM	0.17 min	255	557 000
j)	2015/04/22	SAFM	The talk shop	National	7:45 PM	14.46 min	13290	557 000
k)	2015/04/22	SAFM	The talk shop	National	8:01 PM	2.39 min	2385	557 000
l)	2015/04/17	SAFM	Afternoon Talk	National	2:09 PM	13.02 min	44574	557 000
m)	2015/04/17	SAFM	Afternoon Talk	National	2:25 PM	7.24 min	25308	557 000
n)	2015/03/16	Radio 702	Afternoon Drive	Gauteng	3:50 PM	3.55 min	45817	665 000
o)	2014/10/29	Bush Radio	Afternoon	Western Cape	1:10 PM	22.38 min	28382	63 000
p)	2014/07/23	Bush Radio	Bush Radio	Western Cape	1:35 PM	7.37 min	0	63 000
q)	2014/07/23	SAFM	SAFM Talkshop	National	7:12 PM	43.16 min	31152	557 000
r)	2014/06/09	SABC3	Expresso	National	6:18 AM	5.55 min	71000	2 726 000
s)	2014/06/04	SAFM	Talk Shop	National	7:42 PM	37.35 min	27060	557 000
t)	2014/04/04	ETV	Sunrise	National	7:15 AM	8.05 min	97000	3 064 000

A brief description of each radio and television session is supplied below (Ornico Database):

a) Part1 - Rowena Baird talks about why prohibiting corporal punishment is crucial to ending violence against children in South Africa. Patrick Godana, Head of Men-Care Fatherhood Campaign and Government and Media Liaison at Sonke Gender Justice is interviewed.
b) Part2 - Rowena Baird talks about why prohibiting corporal punishment is crucial to ending violence against children in South Africa. Patrick Godana, Head of Men-Care Fatherhood Campaign and Government and Media Liaison at Sonke Gender Justice is interviewed.
c) Mentor slot, talking to Thawanda Makhusha, senior research specialist in the human and social development division of the Human Sciences Research Council. Topics covered 10 years of research on fatherhood in Africa and some of the findings of the ground breaking studies on what we understand of fatherhood.
d) What's happening in the world of men today here in South Africa? Kevin Rather from Fathers in Africa talked about the State of the World's Fathers report - to give us a global view of state of men's contribution to parenting and caregiving.
e) Wessel van den Berg from Sonke Gender Justice joins Radio 702 to chat about the role of the fathers in parenting and elaborates about the report MenCare+ released called the State of the World's Fathers.
f) An interview conducted with Sonke Gender Justice Representative Mr Wessel van den Berg, where he talks about the State of the World's Fathers Report and that fathers should be more involved in their children's lives if greater gender equality is to be achieved. He also tells us more about paternity leave.
g) Denise Robinson from the DA commenting about the lack of response from the Ministry on the NGO's March such as the march held by Sonke Gender Justice last year in November calling on the Minister to accept a petition on a National Plan for Gender Based Violence.
h) Patrick Godana, the Government and Media Manager at Sonke Gender Justice's MenCare+ programme, talked about the extent to which migrant labour affects fatherhood in South Africa.
i) Afternoon Talk host, Ashraf Garda, was joined on the line by (INT) Chief Family Advocate at the Dept. of Justice and Constitutional Development, Adv. Petunia Seabi; and (INT) MenCare+ Government and Media Manager at Sonke Gender Justice,

Patrick Godana, to discuss whether divorced fathers are prejudiced when it comes to custody and visitation of their children. (Part 01)

j) Afternoon Talk host, Ashraf Garda, was joined on the line by (INT) Chief Family Advocate at the Dept. of Justice and Constitutional Development, Adv. Petunia Seabi; and (INT) MenCare+ Government and Media Manager at Sonke Gender Justice, Patrick Godana, to discuss whether divorced fathers are prejudiced when it comes to custody and visitation of their children. (Part 02)

k) Afternoon Drive presenter, Udo Carelse, is joined on the line by (INT) MenCare+ Global co-ordinator for Sonke Gender Justice, Wessel van den Berg, to discuss whether the imprisonment of parents who do not pay child maintenance is in the best interests of the child, who will then have an absent parent.

l) Thulani Velebayi from MenCare+ is in studio and has brought two men to share testament of being beneficiaries of the Father's Group.

m) Sonke Gender Justice Network, Global Co-ordinator Wessel van den Berg discusses the launch of the campaign by Financial Manager Hendrik Terblanche, advocating for ten days paternity leave.

n) (INT) Henrik Terblanche initiator of the #10 Days Paternity Leave campaign talks about the need for fathers to spend time with their children during their first days of life, forming a bond with the new born and supporting their partners. (INT) Manager for Sonke MenCare+ South Africa campaign, Andre Lewaks says they are extremely humbled by Hendrik's petition for paternity leave. He also expressed that he is talking on behalf of all fathers in South Africa. Paternity leave is very important for fathers, not only to be in their children's life, but to look at how they can provide better support for their couples.

o) This coming Sunday is Father's day and we all know how important it is to celebrate those days when we get the chance to be with family, but statistics in South Africa show that there are a large number of children that are living without the positive influence of their fathers. Sonke Gender Justice is an organisation that co-ordinates the global fatherhood campaign called MenCare+. To talk more about this campaign Wessel van den Berg who is the MenCare+ co-ordinator is in the studio.

p) Discussion topic: Men as disciplinarians. During Child Protection Week, Sonke Gender Justice is calling on parents and caregivers to stop spanking their children. Patrick Godana, MenCare+ Government and Media Manager at Sonke Gender Justice elaborates.

q) The Health Department remains concerned at declining condom use.

4) ***School visits to discuss Sexual and Reproductive Health with the young men and women.***

Visits to schools were conducted to discuss issues of Sexual and Reproductive Health with young men and women and corporal punishment.

They also respond to reports of corporal punishment in schools around the Western Cape. Community Action teams, who live in the community and are trained by Sonke, identify issues within their communities. They, along with Patrick, meet with the relevant people (e.g. the school's governing body) to discuss the matter and assist in finding a resolution.

5) ***Articles in Community, Provincial and National Newspapers and Magazines***

A total of 38 Newspaper articles were published regarding MenCare+ or issues that they advocate for. Please see Appendix C for a table describing the articles. Some readers contacted the Newspaper to get into contact with Sonke.

6) ***MenCare+ page on Facebook***

MenCare+ does have a Facebook page – however it is not specific to MenCare+ South Africa. There are currently 2370 'likes' for the page (as of the 26th of January 2016). If you search for #MenCare on Facebook it tells you that 87 717 people are talking about this topic on Facebook.

The MenCare+ South Africa team (Communication Unit) should consider developing their own page, specific to the MenCare+ programme. The administrator of that page can then access statistics about the page such as the number of times the page has been viewed, etc.

7) ***Information, Communication and Education talks in communities and heath care facilities***

IEC talks were conducted in MOUs, mainly to the mothers waiting for appointments and they were asked to pass the message on to their partners.

8) ***Involvement in 16 Days of Activism against Women and Child abuse.***

MenCare+ specifically target the issues of Child Abuse and corporal punishment.

9) ***Soccer and Netball tournament***

A sports tournament was organised by MenCare+ held in the Eastern Cape, Mbhashe Municipality. 25 people attended the event. The message that the event promoted was about engaging Young Men and Fathers to take positive responsibility in terms of emotional connectedness to their children and in terms of raising them in a positive way.

10) *Collaboration with Churches*

Patrick Godana, the MenCare+ Government and Media Manager was invited to address the Methodist Church of South Africa at the University of Stellenbosch where all the clergy in the Western Cape were gathered. He presented on aspects of the MenCare+ programme that the Church can draw on in terms of addressing social problems. One of the aims of his presentation was to challenge the Church to assist Sonke Gender Justice to bring about equitable parenting. The response from Bishop Andrew from the Methodist Church in the Western Cape was very positive, he described the 'journey' that the Methodist Church is beginning in terms of assisting various leagues and unions in the church (e.g. the men's league, the woman's league, etc.) to augment their gender language, particularly issues around parenting.

11) Men's Conference

MenCare+ approached men in the Lutheran, Anglican and other Churches to engage them and the Church in the MenCare+ programme and invite them to the Men's Conference. The Men's Conference was held in Gugulethu, and approximately 300 men attended. The response from the men was very encouraging, some men did contact Sonke after the conference to obtain more information on the Parenting/Fatherhood and SRHR Groups.

12) Billboards

Challenges with approval from the Department of Health resulted in a delay in the Billboards being erected in 2015.

During the interviews with the programme staff the following gaps in campaign activities were identified:

- Monitoring of campaign activities should be routinely carried out in order to determine the reach and impact on the community. It is important that the monitoring outcomes are documented and stored on an electronic database.

"The thing that we should have done better was to follow up with those participants and measure the impact that those campaigns had on them. We did not do enough in measuring the impact that our campaigns had on the community as a whole." MenCare+ South Africa Programme Staff Interviews

- There should be a stronger linkage to the services provided by NGOs in the different communities so that referrals may be made.

"When we do awareness or campaigns in different communities we need to know and be aware about NGOs near those communities that deal with such issues. These will help us in a way if we need to refer some of our clients for appropriate services to those NGOs. It also helps to track whether our clients received appropriate services needed or not." MenCare+ South Africa Programme Staff Interviews

- Government departments should be more involved during campaign activities, especially the Dep. Of Social Development.

"We need department of social development to support us during these campaigns, in most times you do not find government departments during campaign activities so we would really love to see them participating more often and having a good relationship with us in the future." MenCare+ South Africa Programme Staff Interviews

Additional information: Substance abuse

1. Methodology

Crosstabs were created to provide a paired summary of alcohol and substance abuse among the parenting group of respondents. A test for normality indicated that the pre and post responses were not normally distributed; therefore, a Friedman's ANOVA was conducted to test if the pre and post responses differed significantly.

2. Findings

Quantitative findings

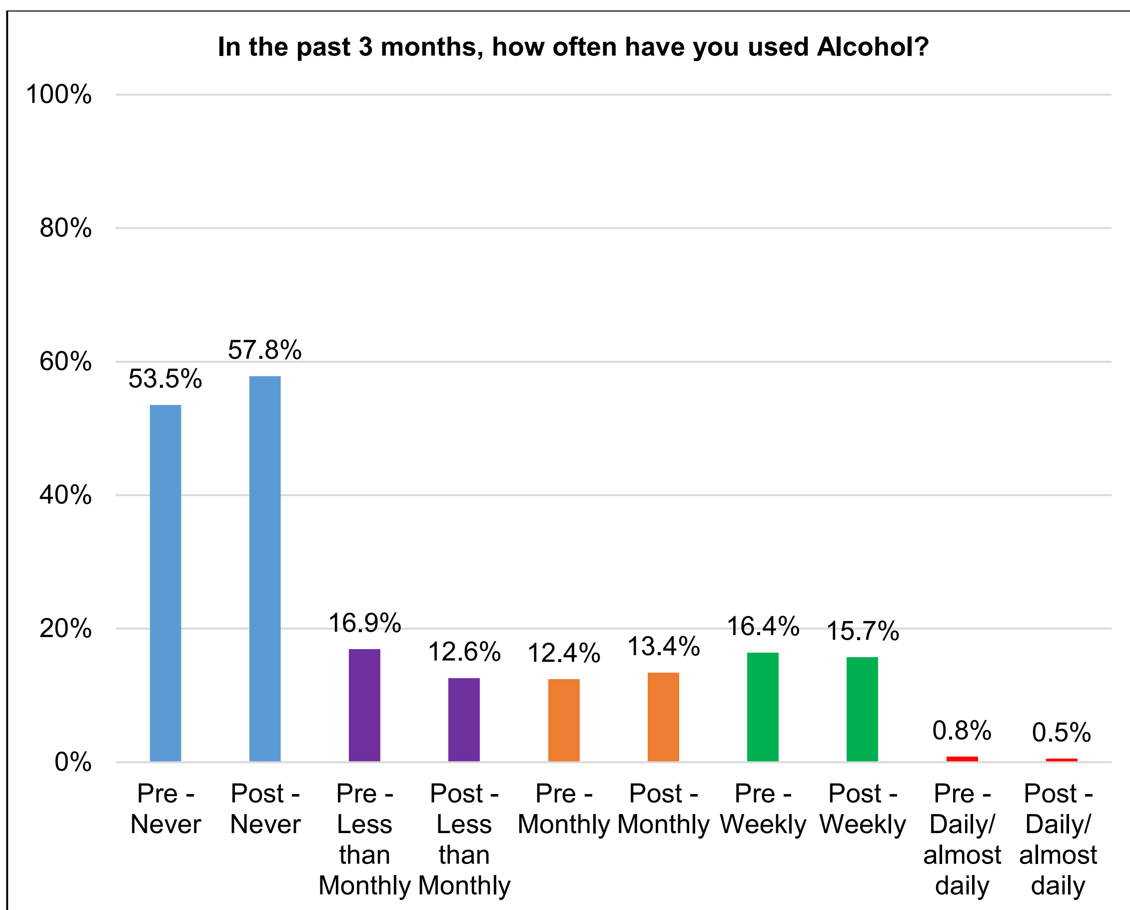
The majority of the respondents indicated that they never used drugs nor used alcohol within a period of three months dated when the questionnaires were administered. There was a slight

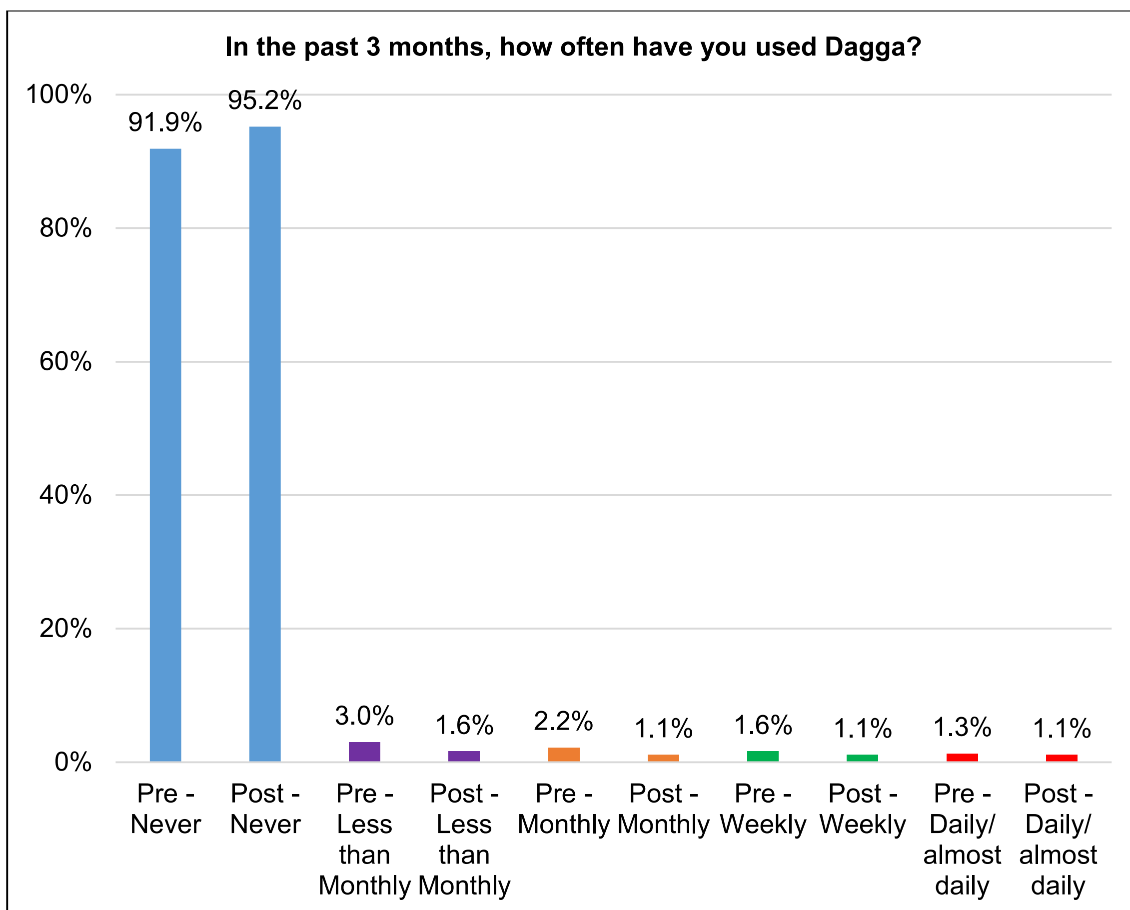
decrease in alcohol and substance abuse post intervention. With a confidence level of 99% the results are as follow:

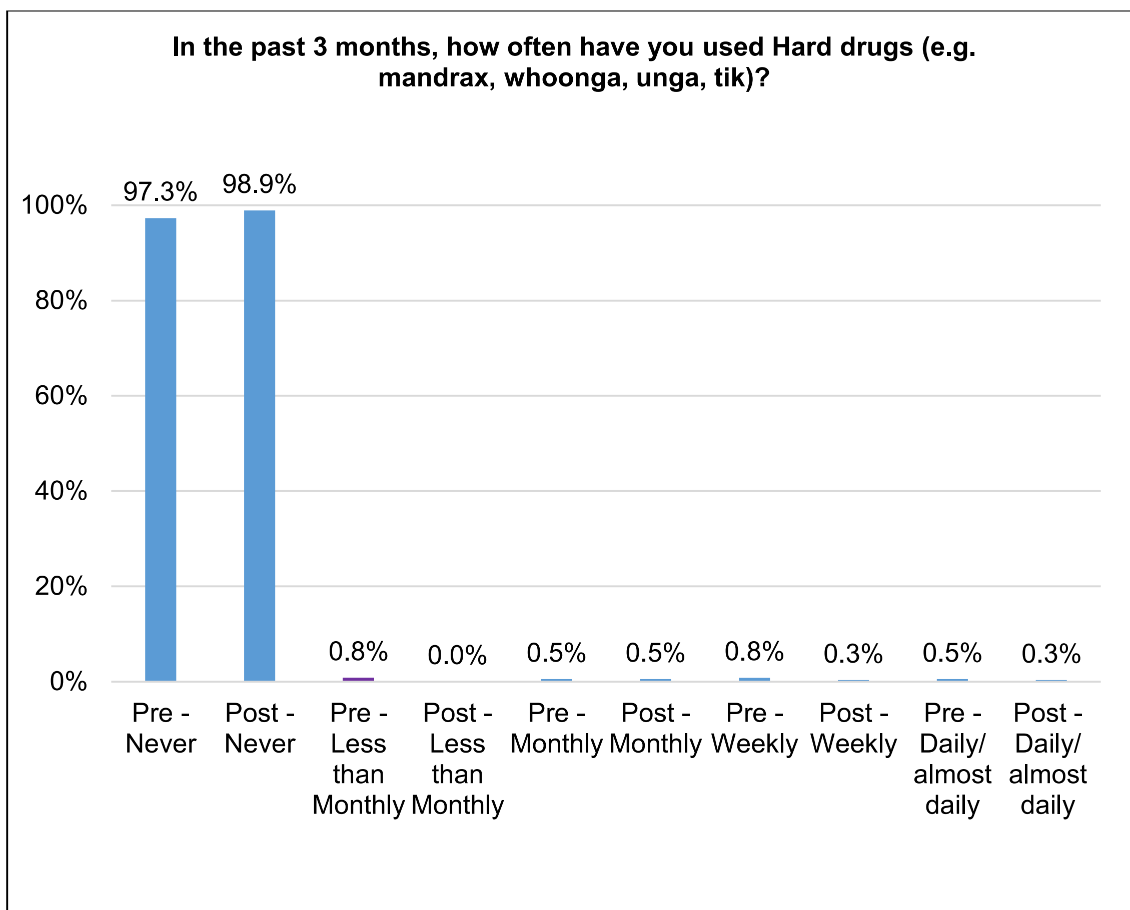
- For the question “In the past 3 months, how often have you used….Alcohol” no significant differences were found (overall $p > .01$).
- For the question “In the past 3 months, how often have you used….Dagga” significant differences were found (overall $p < .01$).
- For the question “In the past 3 months, how often have you used….Hard drugs (e.g. mandrax, whoonga, unga, tik)” no significant differences were found (overall $p > .01$).

Even with a confidence level of 95% both question 1 and question 3 (related to alcohol and hard drugs) indicated no significant changes, while question 2 (relating to Dagga use) did indicate a significant change.

Parenting Group – Alcohol and Substance Use										
Questions	**% Never pre-test**	**% Never post-test**	**% Less than monthly pre-test**	**% Less than monthly post-test**	**% Monthly pre-test**	**% Monthly post-test**	**% Weekly pre-test**	**% Weekly post-test**	**% Daily or almost daily pre-test**	**% Daily or almost daily post-test**
In the past 3 months, how often have you used….Alcohol	N = 396									
	53.5%	57.8%	16.9%	12.6%	12.4%	13.4%	16.4%	15.7%	0.8%	0.5%
In the past 3 months, how often have you used….Dagga	N = 372									
	91.9%	95.2%	3.0%	1.6%	2.2%	1.1%	1.6%	1.1%	1.3%	1.1%
In the past 3 months, how often have you used….Hard drugs (e.g. mandrax, whoonga, unga, tik)	N = 372									
	97.3%	98.9%	0.8%	0.0%	0.5%	0.5%	0.8%	0.3%	0.5%	0.3%


In the past 3 months, how often have you used Alcohol?
100%
80%
60%
40%
20%
0%
53.5%
57.8%
16.9%
12.6%
12.4%
13.4%
16.4%
15.7%
0.8%
0.5%
Pre - Never
Post - Never
Pre - Less than Monthly
Post - Less than Monthly
Pre - Monthly
Post - Monthly
Pre - Weekly
Post - Weekly
Pre - Daily/ almost daily
Post - Daily/ almost daily


In the past 3 months, how often have you used Dagga?
100%
80%
60%
40%
20%
0%
91.9%
95.2%
3.0%
1.6%
2.2%
1.1%
1.6%
1.1%
1.3%
1.1%
Pre - Never
Post - Never
Pre - Less than Monthly
Post - Less than Monthly
Pre - Monthly
Post - Monthly
Pre - Weekly
Post - Weekly
Pre - Daily/ almost daily
Post - Daily/ almost daily



Chi-square tests also confirmed that female parents less likely used alcohol and soft drugs (such as marijuana) prior to the sessions. The analysis of the hard drug use (pre) violated the assumptions for using the test results, no conclusions can be made. All of the post questionnaire substance abuse violated assumptions and therefore the results could not be used.

Additional information: Caregiving

1. Methodology

The questionnaire for the parenting group included a section about involvement in child caregiving. Crosstabs were created in order to provide a summary of paired responses (respondents who both completed this section on the pre and post questionnaire).

2. Findings

Quantitative findings

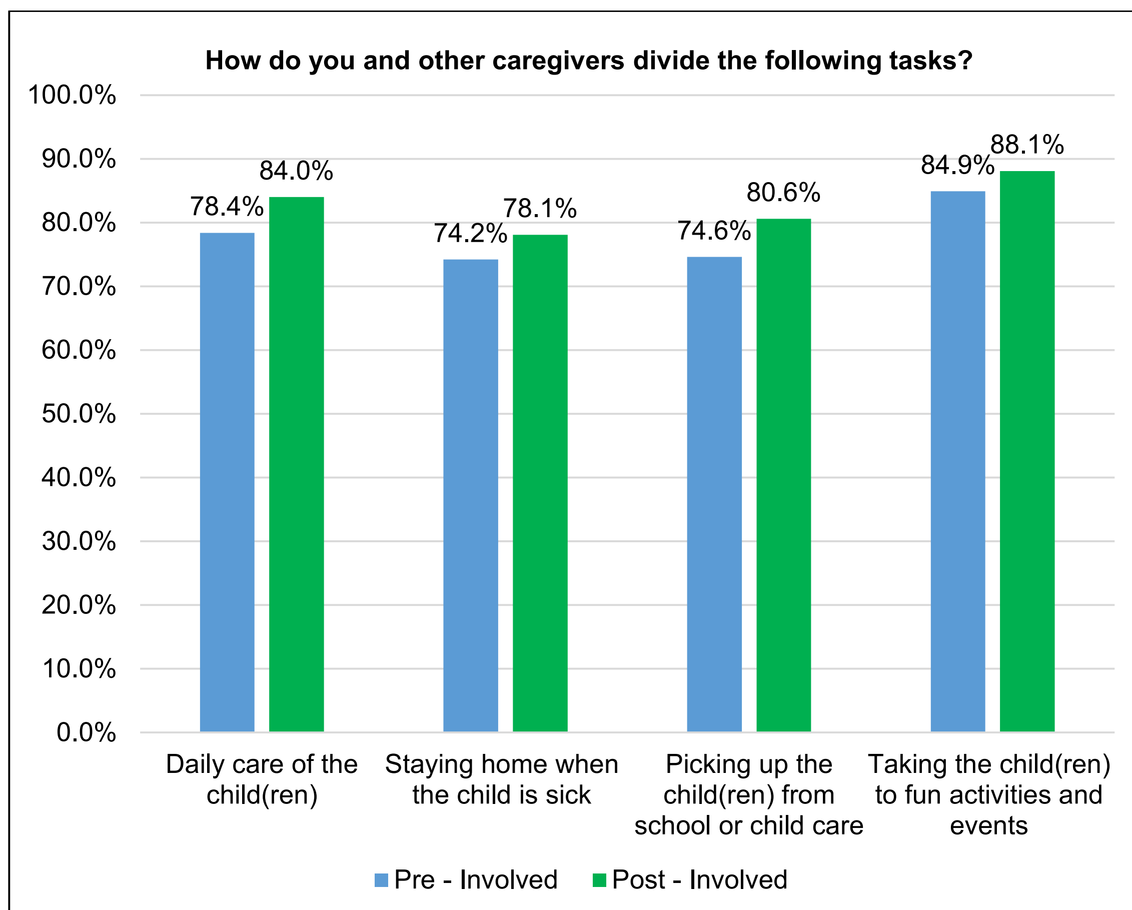
Under each statement the percentage of caregiving involvement increased post intervention and caregiving non-involvement decreased. A McNemar's test statistic was calculated due to the dependence of the pre and post variables. These results are as follow:

- For task 1 ["Daily care of the child(ren)"] caregiving involvement increased, but was not significant.
- For task 2 ("Staying home when the child is sick") caregiving involvement also showed a positive change, but was also not significant.
- For task 3 ["Picking up the child(ren) from school or child care"] the change in caregiving involvement significantly increased.
- For task 4 ["Taking the child(ren) to fun activities and events"] the change in caregiving involvement increased, but not significantly.

Parenting Group – Besides the help you receive from others, how do you and other caregiver(s) now divide the following tasks

Tasks	% Involved pre-test	% Involved post-test	Is the change significant? Confidence interval 95%	
Daily care of the child(ren)	N = 287		No	$p = .57$
	78.4%	84%		
Staying home when the child is sick	N = 283		No	$p = .208$
	74.2%	78.1%		
Picking up the child(ren) from school or child care	N = 279		Yes	$p = .031$
	74.6%	80.6%		

Taking the child(ren) to fun activities and events	N = 285		No	*p* = .233
	84.9%	88.1%		



Significant differences were found between female and male parents' involvement on the following items:

- *Daily care of the child(ren):* Woman reported being involved significantly more than males prior and after the sessions.
- *Staying home when the child(ren) are sick:* Woman reported being involved significantly more than males only in the post questionnaires.
- *Picking up the child(ren)* from school or childcare: Woman reported being involved significantly more than males prior and after the sessions.
- *Taking the child(ren)* to fun activities and events: Woman reported being involved significantly more than males prior to the sessions.

Result area 2: Increasing young men's/couples access to contraceptives, including male and female condoms, to promote good health

Outcome indicator 2.1.1: 75% increase in couples protected by contraceptives

1. Methodology

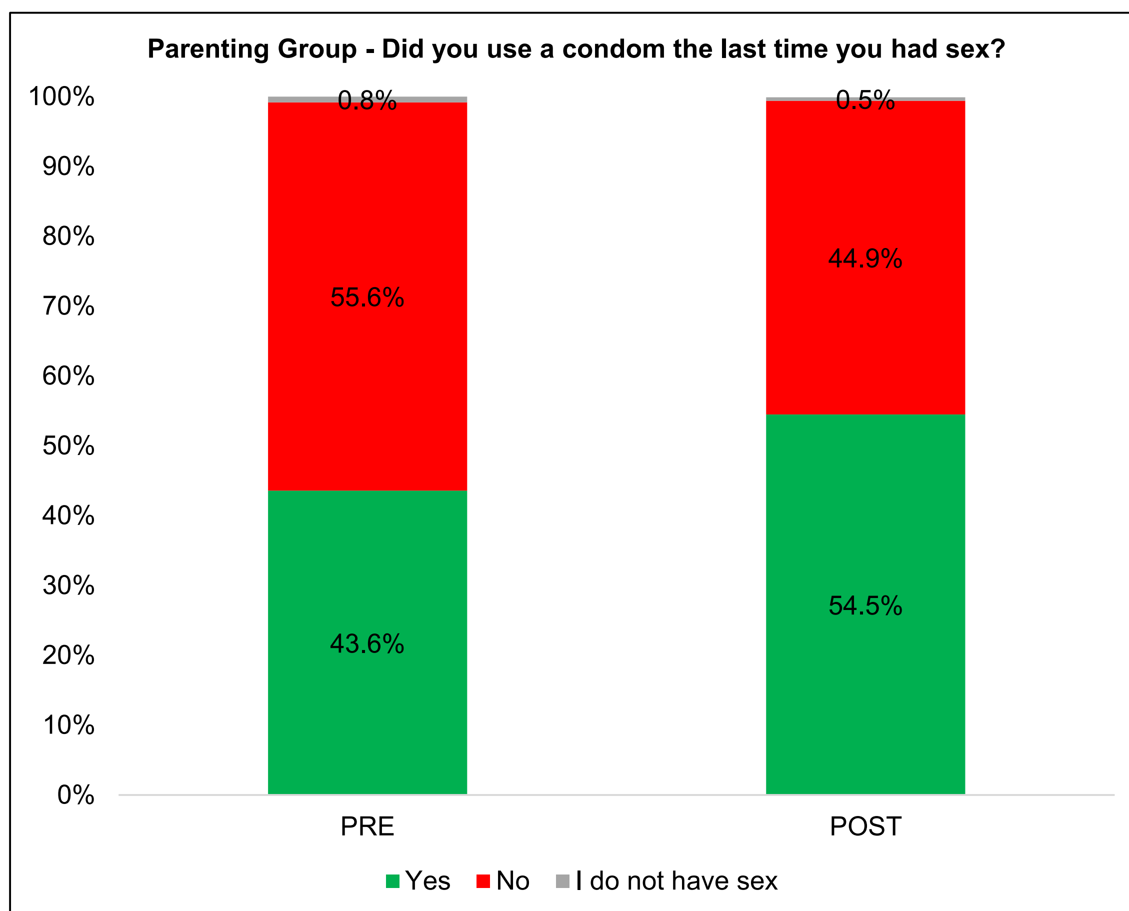
Descriptive methods were utilised to explore the frequencies and percentages of pre and post programme contraceptive use and the type of contraceptives used by couples.

2. Findings

Quantitative findings

The percentage of couples that used a condom the last time they had sex increased from 43.6% before the programme to 54.5% after the programme, indicating a positive change. It should be noted that an increase of 75.0% (as target) is very high. The percentage of couples are as high as 43.5% prior to the intervention. Before and after the intervention, the most common type of contraception used by the couples was the implant (pre: 41.1%; post: 42.0%). Unfortunately there was not a 75% increase in couples protected by contraceptives; however, the statistics indicate an overall increase in contraceptive use.

The results also show that the percentages of respondents whose partners do not use contraception has decreased by 6.0% as seen in the tables below.



Parenting Group - Couples protected by contraceptives
Paired – Cross tabulations

Condom - during the last time sex	% pre-test	% post-test	Change in %
	N = 365		
Yes	43.6%	54.5%	10.9% increase
No	55.6%	44.9%	10.7% decrease
I do not have sex	0.8%	0.5%	0.3% decrease

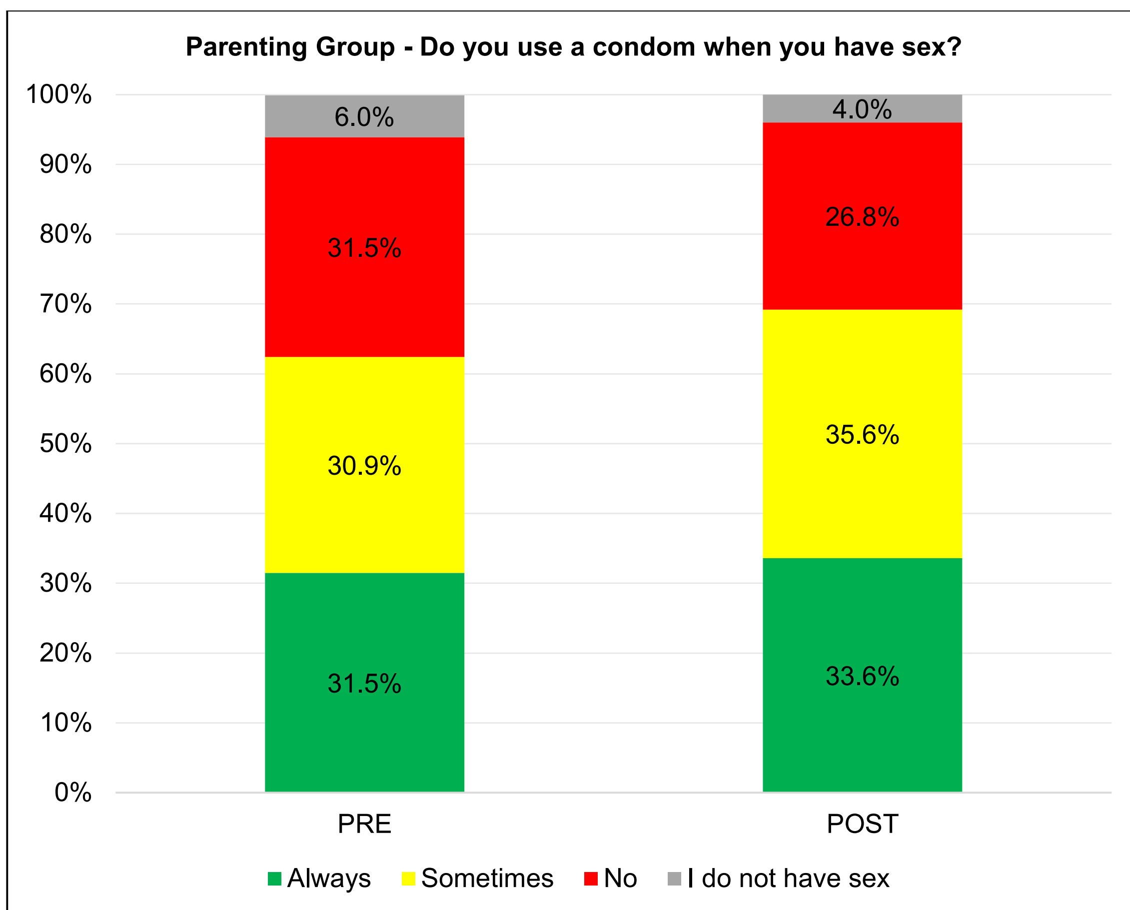
Do you use a condom when you have sex?	% pre-test	% post-test	Change in %

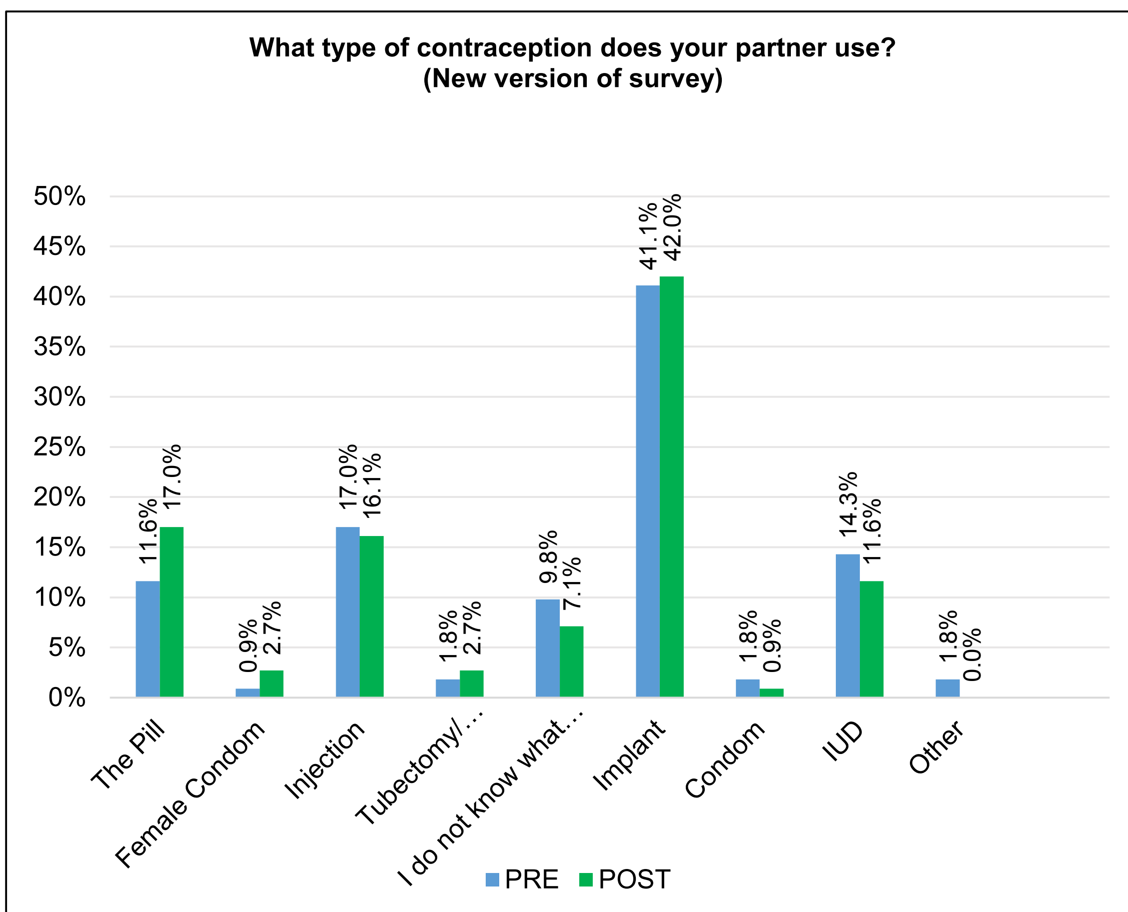
	N = 149		
Always	31.5%	33.6%	2.1% increase
Sometimes	30.9%	35.6%	4.7% increase
No	31.5%	26.8%	4.7% decrease
I do not have sex	6.0%	4.0%	2.0% decrease

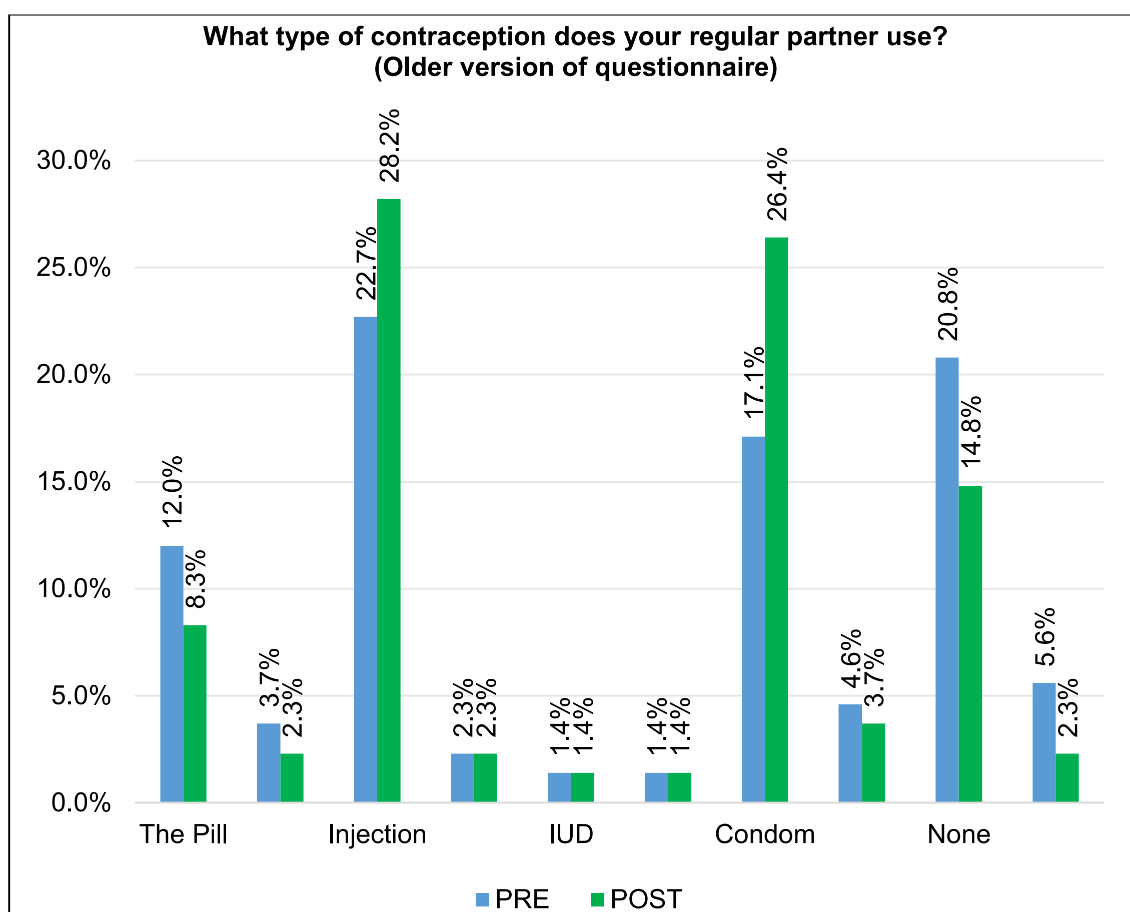
What type of contraception does your partner use?	**% pre-test**	**% post-test**	**Change in %**
	N = 112		
The Pill	11.6%	17.0%	5.4% increase
Female condom	0.9%	2.7%	1.8% increase
Injection	17.0%	16.1%	0.9% decrease
Tubectomy/Vasectomy	1.8%	2.7%	0.9% increase
I do not know what contraception means	9.8%	7.1%	2.7% decrease
Implant	41.1%	42.0%	0.9% increase
Condom	1.8%	0.9%	0.9% decrease
IUD	14.3%	11.6%	2.7% decrease
Other	1.8%	0.0%	1.8% decrease

Do you talk about contraception with your partner? (data from revised version only)	**% pre-test**	**% post-test**	**Change in %**
	N = 148		
Yes	77.7%	81.1	3.4% increase
No	12.8%	10.1	2.7% decrease
I do not have a partner	8.1%	8.8	0.7% increase
I do not know what contraception means	1.4%	0.0	1.4% decrease

What type of contraception does your regular partner use? (data from old version only)	% pre-test	% post-test	Change in %
	N = 216		
The Pill	12.0%	8.3%	3.7% decrease
Female condom	3.7%	2.3%	1.4% decrease
Injection	22.7%	28.2%	5.5% increase
Implant	2.3%	2.3%	No change
IUD	1.4%	1.4%	No change
Tubectomy	1.4%	1.4%	No change
Condom	17.1%	26.4%	9.3% increase
Other	4.6%	3.7%	0.9% decrease
None	20.8%	14.8%	6.0% decrease
I do not know	5.6%	2.3%	3.3% decrease
I don't have a regular partner	8.3%	8.8%	0.5% increase


Parenting Group - Do you use a condom when you have sex?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
6.0%
31.5%
30.9%
31.5%
4.0%
26.8%
35.6%
33.6%
PRE
POST
Always
Sometimes
No
I do not have sex


What type of contraception does your partner use?
(New version of survey)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
11.6%
17.0%
0.9%
2.7%
17.0%
16.1%
1.8%
2.7%
9.8%
7.1%
41.1%
42.0%
1.8%
0.9%
14.3%
11.6%
1.8%
0.0%
The Pill
Female Condom
Injection
Tubectomy/...
I do not know what...
Implant
Condom
IUD
Other
PRE
POST



Qualitative findings

Some young men discussed how they felt embarrassed to go to the clinic for contraceptives, especially when accompanied by their partners. They also mentioned that the MenCare+ programme encouraged them to support their partners and one participant specifically mentioned that he reminds his partner to get contraceptives to practice safer sex.

In the focus group discussions with fathers, the men discussed contraceptives in the light of family planning; and how they make use of contraceptives after attending the MenCare+ sessions. One father stated that he makes use of contraceptives (with his partner) after the programme taught him about the use of financial planning and how this is related to family planning. According to the participant, they were never taught the skills to use basic financial planning within family planning prior to attending the sessions. He now grasps the financial implications of having more children and therefore uses the skills he was taught to do family

planning with his wife; he is now able to discuss contraceptive use and family planning openly with his wife. He was motivated by the opportunity to relieve himself of additional financial burdens by doing family planning.

Please also see *outcome indicator 1.2.1b* above which is interlinked with access to contraceptives and use of contraceptives.

3. Conclusion

The percentage of couples that used a condom the last time they had sex increased from 43.6% before the programme to 54.5% after the programme, indicating a positive change. A 75% increase from 43.6% prior to the programme, which sets the target at 76.3% (after the programme). Before and after the intervention, the most common type of contraception used by the couples was the implant (pre: 41.1%; post: 42.0%).

Intermediate outcome indicator 2.1.1: % increase with changed views on contraceptive use

1. Methodology

Descriptive analysis methods were utilised to determine the frequency and percentage of attitude towards contraceptives. The pre and post programme "attitude towards contraceptives" are also compared with each other; paired sample t-tests determined whether there is a significant difference between pre and post results for attitudes towards contraceptives.

2. Findings

<u>Quantitative findings</u>

When comparing the overall mean score, we find that the participants significantly changed their attitude about contraceptive use. Items 1, 3, 5 and 6 showed a significant difference between the responses on the pre-test and the responses on the post-test. These differences indicated that the majority of participants had a more positive attitude towards contraceptives after the intervention. No significant change was found for Item 2 ("Couples should talk about contraception before having sex") and item 4 ("Condoms are an effective method of preventing the spread of HIV and sexually transmitted diseases"); however, it should be noted that the majority of participants had a more positive attitude before and after the intervention in terms of these two specific items.

Parenting Group - Attitude towards contraceptives						
Questions	**Paired**				**Is the change statistically significant? (95% confidence)**	
	% agree pre-test	**% agree post-test**	**% disagree pre-test**	**% disagree post-test**		
Question 1: Men who use contraceptives seem weaker than men who do not			N = 408		Yes	$p < .05$.
			64.5%	87.0%		
	N = 414				No	$p = .270$.

*Question 2: Couples should talk about contraception before having sex	91.1%	91.1%				
*Question 3: Two people having sex should use some form of contraceptives if they aren't ready for a child	N = 411				Yes	$p < .05$.
	89.1%	96.4%				
*Question 4: Condoms are an effective method of preventing the spread of HIV and sexually transmitted diseases	N = 413				No	$p = .093$.
	87.7%	91.0%				
Question 5: Condoms are not reliable in preventing pregnancy			N = 395		Yes	$p < .05$.
			39.2%	52.2%		
Question 6: Condoms ruin the sex act			N = 400		Yes	$p < .05$.
			53.3%	72.0%		
Mean Score (pre/post)			N = 424		Yes	$p < .05$.
			1.6825	1.80		

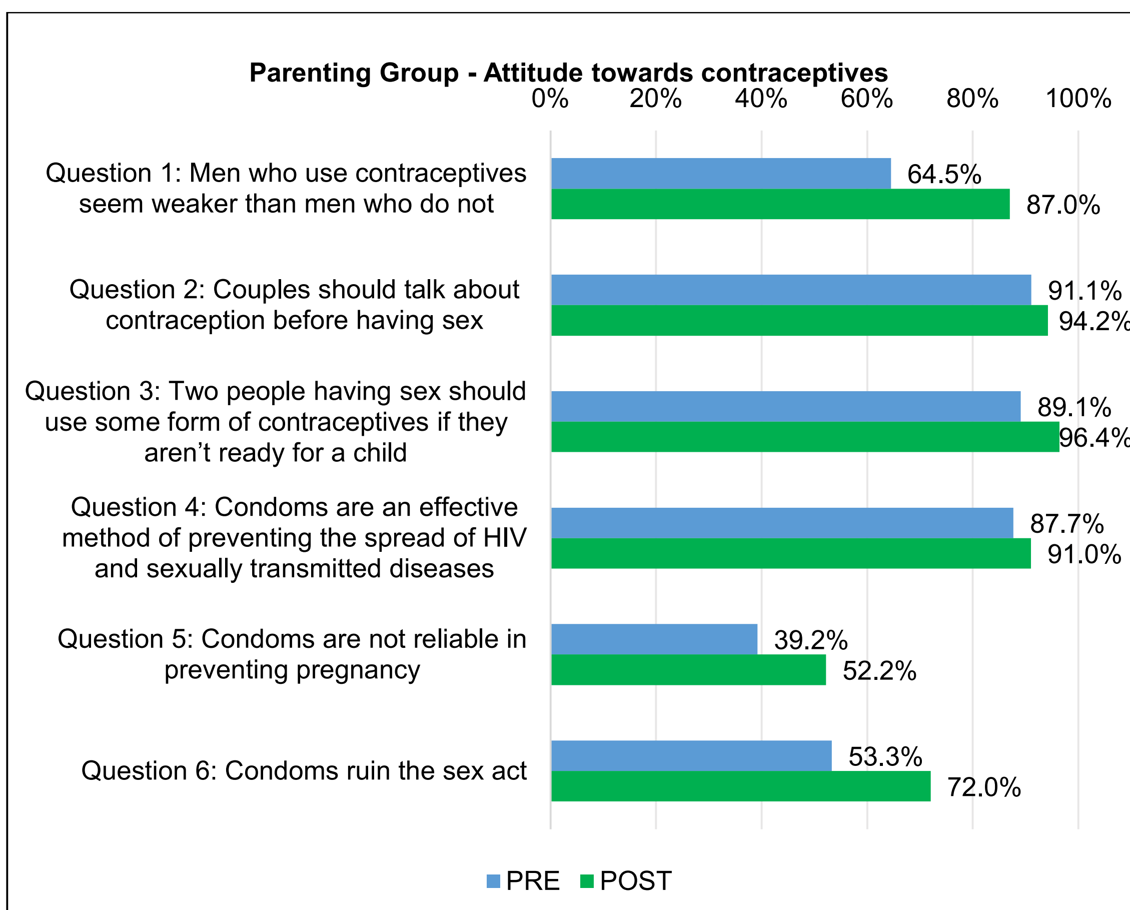
*The direction of these items are different and responses had to be recoded in order to calculate the mean score.

Significant differences between male and female parents were found on the following items related to contraceptives:

- "Men who use contraceptives seem weaker than men who do not"
  Woman are more likely than men to disagree with the statement (prior to attending the sessions). No significant difference was found between males and females after attending the sessions.
- "Two people having sex should use some form of contraceptives if they aren't ready for a child"

Woman are more likely than men to agree with the statement (prior to attending the sessions). No significant difference was found between males and females after attending the sessions.

- "Condoms ruin the sex act"
  Woman are more likely than men to disagree with the statement (prior to attending the sessions). No significant difference was found between males and females after attending the sessions.



Qualitative findings

Many of the FGD participants recommended that the MenCare+ programme should work in collaboration with the local churches and religious leaders to extend the reach of the programme. Not only can it extend its reach, but the programme may also be more effective because the general community members place a lot of trust in their churches and religious leaders.

"Pastors don't talk about these thing, they do nothing. They do not talk about contraception at church, we only learn from this programme and from each other." Focus Group Discussion Participant

"It is important to discuss these things at church, I am the pastor myself but we don't discuss such things. Sometimes the pastor himself is broken". Focus Group Discussion Participant

"In order to improve the program, it must be taken to churches because there is some opposition between the knowledge and the belief, so if it come from their worship place, it might be accepted". Focus Group Discussion Participant

Without probing about possible challenges when talking about religion, the participants started talking about the resistance the programme will most probably face when approaching the religious leaders. According to them the majority of churches preach a message of abstinence and that a message of "contraception use" might be in conflict with the religious leaders' views about sex. According to the message they receive from the church, non-married individuals should abstain from sex; some churches also preach that married couples should not use contraceptives and that deliberate acts of contraception are sinful.

Many of the participants expressed that religion forms an integral part of themselves and their communities. The same participants also mentioned how the MenCare+ programme taught them about the importance of family planning and contraception. They now believe that programmes such as the MenCare+ programme should approach religious leaders to discuss contraception and how the programme can collaborate with the churches.

Some of the FGD participants were religious leaders and they did not challenge the suggestions and views of the other participants about collaborating with the church. They also felt that it was a neglected topic within the church. The participants who were religious leaders agreed with the other participants; these individuals may serve as an access point to start a discussion with the church about contraception.

A study conducted in Kenya reported that the religious affiliation affects the use of contraceptives and plays a vital role in the reproductive behaviours of women (Abdulla, 2014).

Religion is widely known to affect the acceptance of modern contraception among people, thus affecting their reproductive behavioural outcomes in Sub-Saharan Africa. Religious leaders can therefore inhibit or promote family planning, which will affect the success of family planning programmes. Thus, they should be included in the development and promotion of family planning programmes (Karout and Altuwaijri, 2012).

Cultural values, beliefs and communication with partners affect women's use of contraceptives. SA's society, particularly in the rural areas, is still male-dominated and women feel pressured to prove their fertility. Better communication between women and their partners is reported to increase the likelihood of using contraception, as is high reported self-esteem among women (Sayem and Begum, 2008).

The evaluators noticed an overlap between this outcome indicator regarding contraceptive use and outcome indicator 1.2.1b regarding family planning (Please also see *outcome indicator 1.2.1b* above).

Participants also felt that learning about the menstrual cycle and the importance of communicating with their partner about contraception enabled them to support their partners.

3. Conclusions

The fathers/ couples attitudes towards contraceptives also changed positively after attending the sessions – the most significant change being in the number of respondents who disagreed that “Condoms ruin the sex act” (pre: 53.3%; post: 72.0%). Note that Question 2 & 4 showed no significant change in pre and post scores.

Result area 3: Public and private clinics provide better sexual and reproductive healthcare services, including domestic violence services, which more people are using

Outcome indicator 3.1.1a: 60% increase in young men making use of SRH services

1. Methodology

The questionnaires asked the respondents whether they make use of SRHR services, the types of services they utilise and if they feel comfortable making use of the services and reasons for discomfort if applicable. Descriptive analysis results provide the frequencies and percentages of the use of SRHR services are mentioned below.

2. Findings

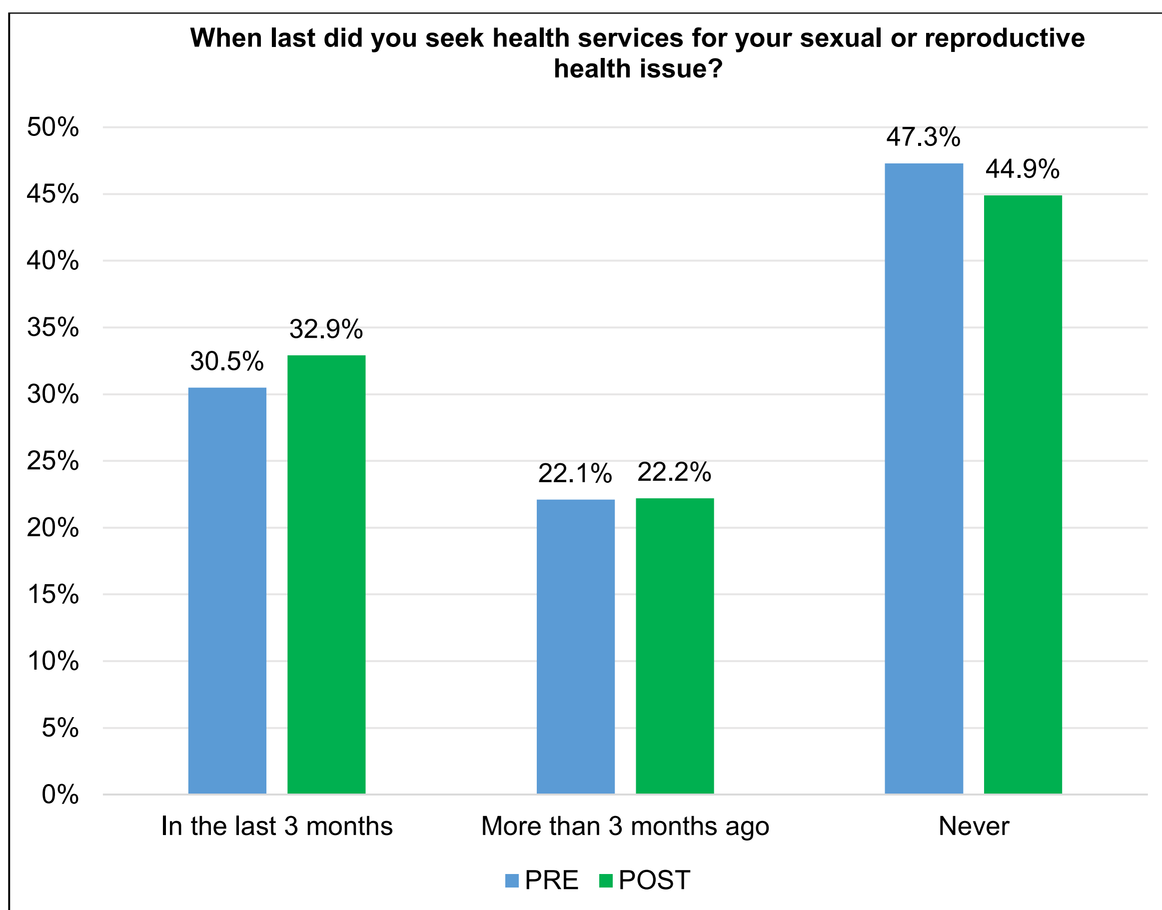
Quantitative findings

Age of Young Men		
	Frequency	Percent
15 - 20 years	288	81.4%
21 - 24 years	47	13.3%
25 - 35 years	19	5.4%
Total	354	100.0%

It was found that 32.9% of young men went to seek health services in the last 3 months at a clinic or hospital after the MenCare+ sessions; 2.4% more than before attending the sessions. When selecting the paired 112 respondents that did not seek any health services for sexual or reproductive health prior to the MenCare+ sessions, we find an increase of 28.6% of these young men accessing these services after attending the MenCare+ sessions. The percentage of young men who indicated that they have never accessed health care services for sexual or reproductive health decreased after the MenCare+ sessions (from 47.3% to 44.9%).

Young Men PRE - When last did you seek health services for your sexual or reproductive health issues?		
	Frequency	Percent
In the last 3 months	109	30.5%
More than 3 months ago	79	22.1%
Never	169	47.3%
Total	357	100.0%

Young Men POST - When last did you seek health services for your sexual or reproductive health issues?		
	Frequency	Percent
In the last 3 months	107	32.9%
More than 3 months ago	72	22.2%
Never	146	44.9%
Total	325	100.0%

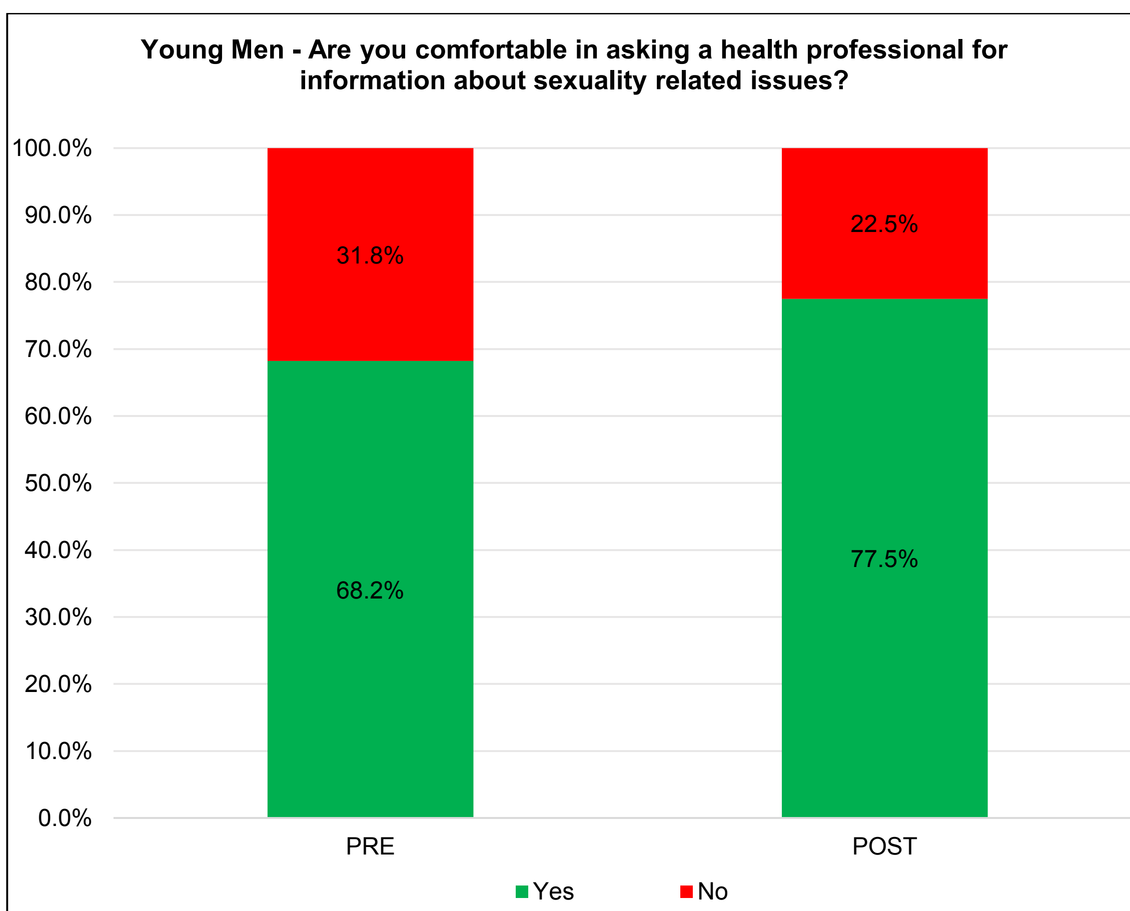


The percentage of males who feel comfortable asking health care professional's information about sexuality related issues has increased from 68.2% to 77.5% after attending the MenCare+ sessions.

Young Men PRE – Are you comfortable in asking a health professional for information about sexuality related issues?		
	Frequency	Percent
Yes	234	68.2%

No	109	31.8%
Total	343	100.0%

Young Men POST – Are you comfortable asking a health professional for information about sexuality related issues?		
	Frequency	Percent
Yes	251	77.5%
No	73	22.5%
Total	324	100.0%



The cross tabulation below shows that 86.4% of respondents who sought health services for sexual or reproductive health issues (in last 3 months) felt comfortable asking a health professional for information about sexuality related issues. The percentages for those feel comfortable asking and who sought health services for sexual or reproductive health issues are 73.4%.

Young Men - POST - When last did you seek health services for your sexual or reproductive health issues Are you comfortable asking a health professional for information about sexuality related issues? Cross tabulation				
		Are you comfortable asking a health professional for information about sexuality related issues?		
		Yes	No	Total
When last did you seek health services for your sexual or reproductive health issues?	In the last 3 months	95 (86.4%)	15 (13.6%)	110 (100%)
	More than 3 months ago	50 (73.5%)	18 (26.5%)	68 (100%)
	Never	107 (72.3%)	41 (27.2%)	148 (100%)
Total		252	74	326

Qualitative findings

The Young Men's group felt that the programme gave them a lot of knowledge regarding their own bodies and sexually transmitted diseases. They were also made aware of the importance of consulting a healthcare worker when they experience problems with their sexual health. They also became aware of the importance of completing the STD treatment prescribed to them. Additionally they feel more comfortable in advising others about STDs.

"We are able to advice our peers who are not part of the session about the things we've learnt from MenCare+ sessions, for an example, as young men we drink and get drunk, once we are drunk some of us win girlfriends and have unprotected sex with them……in the morning they don't know what happened and they get STI's, so we are able to advise them about what to do or where to go for help." Focus Group Participant

During the analysis of interviews with the key stakeholders three major challenges to involving men in Sexual and Reproductive Health and Maternal and Child Health were identified. They

were cultural and religious beliefs; men's reluctance to discuss issues relating to SRHR; and having a poor relationship with the mother of their child.

The Health Care Workers reported that men are seen attending the facility with their partners. They are seen collecting medication for their partners who are on ARV's. This is a sign that partners are disclosing their HIV status to each other. Men are also seen attending the support groups, and showing interest in supporting their partners.

3. Conclusion

With a suggested increase of 60%, the target was set at an ambitious 48.8% (percentage of percentage). It was found that 32.9% of young men went to seek health services in the last 3 months at a clinic or hospital after the MenCare+ sessions; 2.4% more than before attending the sessions.

More specifically, the paired 112 respondents that did not seek any health services for sexual or reproductive health prior to the MenCare+ sessions increased with 28.6%.

The percentage of males who feel comfortable asking health care professionals for information about sexuality-related issues has increased from 68.2% to 77.5% after attending the MenCare+ sessions. 86.4% of respondents who sought health services for sexual or reproductive health issues (in last 3 months) felt comfortable asking a health professional for information about sexuality related issues. The percentages for those who feel comfortable asking and who sought health services for sexual or reproductive health issues are 73.4%.

There were barriers to men accessing SRH services found during the qualitative analysis. The men mentioned that clinics need to be more 'friendly' towards men, in terms of the infrastructure and décor and in terms of the Health Care Workers' attitudes towards men.

Outcome indicator 3.2.1a: 75% increase in fathers attending prenatal care visits with partners

1. Methodology

The questionnaires provided quantitative data about fathers attending prenatal care; the focus groups discussions also addressed this topic. The quantitative data was descriptively analysed and the results below present frequencies and percentages of prenatal care visits by fathers. The tables compare pre and post programme results.

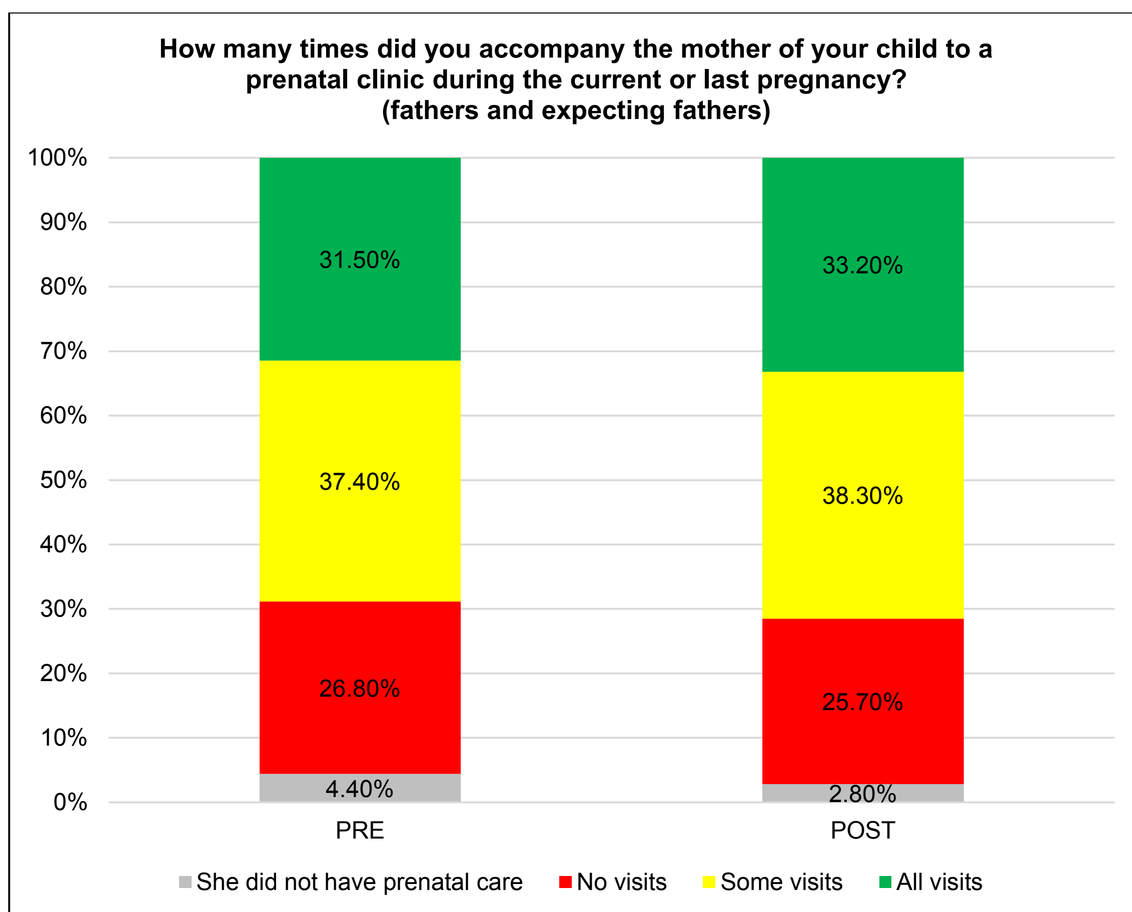
2. Findings

Quantitative Findings

The two tables below present all the fathers who responded; those who have children and those who are expecting children. We found that the percentages of 'number of visits' have remained similar, with only minor shifts in percentage when comparing pre and post results. This may be due to non-expecting fathers being included in the analysis.

PRE – How many times did you accompany the mother of your child to a prenatal clinic during the current or last pregnancy?		
	Frequency	Percent
No visits	91	26.8%
Some visits	127	37.4%
All visits	107	31.5%
She did not have prenatal care	15	4.4%
Total	340	100.0%

POST – How many times did you accompany the mother of your child to a prenatal clinic during the current or last pregnancy?		
	Frequency	Percent
No visits	55	25.7%
Some visits	82	38.3%
All visits	71	33.2%
She did not have prenatal care	6	2.8%
Total	214	100.0%



When selecting only the fathers/couples who were expecting a child when they completed the questionnaire; we found a 6.9% increase in those who went to all prenatal care visits. It should be noted that only 29 fathers indicated that they were expecting a child in both the pre and post questionnaire.

How many times did you accompany the mother of your child to a prenatal clinic during the current or last pregnancy? (Select cases if both pre and post indicated expecting a child)						
	Pre Count	Pre %	Post Count	Post %	Count change	% change
No visits	6	20.7%	4	13.8%	2 less	6.9% decrease
Some visits	13	44.8%	13	44.8%	-	-
All visits	10	34.5%	12	41.4%	2 more	6.9% increase
She did not have prenatal care	0	0.0%	0	0.0%	N/A	N/A
Total	29	100%	29	100%		

Qualitative findings

In the FGDs with the Fathers/Couples it was reported that they appreciate the importance of being involved in maternal and child healthcare, they feel more able to support their partners and accompany them to the pre- and post-natal care visits.

"One day she fell on her stomach while going for pre-natal visit alone….I was called, and felt bad….from that day I started supporting her when she goes for pre-natal visits although I was never part of what happened in the clinic….I was only accompanying her. Being part of this program has taught me a lot and as a result I have changed the way of doing things….now I am always part of everything when I take my partner to the clinic." Focus Group Discussion Participant

However, it was mentioned that fathers almost always experience problems in terms of access to maternal and child health care and are often not allowed to accompany their partner.

"Even the security officers in the clinics treats men bad….they deny us access. I think they need to be engaged and trained about the important of allowing men to support their partners in the clinics….some of these security officers are men and the will face the same situation in future. Sometimes the chase us away without even listening to the reason why we come to the clinic." Focus Group Discussion Participant

In an interview with a Volunteer Facilitator he mentioned the question of 'when do you become a father?' He reported that many of the fathers believed that you become a father 'when your son goes to the bush', pointing to certain cultural initiation ceremonies. This perspective of becoming a father, not when you impregnate someone, but when the child is initiated could shed light onto possible barriers to men's involvement in MCH.

The HCWs reported that as a result of the MenCare+ program, the numbers of couples attending antenatal and postnatal services or supporting their partners have increased.

"Before the collaboration with MenCare+, men were not accompanying their partners to the facility, but now there is a bit of change, we see some men coming even to labour ward and also during pre and post-natal visits". Health Care Worker interview

A big improvement in the community was observed by HCWs - men were previously not allowed in maternal and child healthcare services and the facilities were not partner friendly.

One participant reported that, *“culturally, childbirth was women’s thing not men, but now things have changed, the facilities are redesigned to be partner friendly in response to the program. At least now there are screens in place to ensure privacy” Health Care Worker interview*

The program has changed the minds of the security guards and staff to allow and involve the fathers in the maternal and child health – this perception was not shared by the Fathers (above), who reported that health care facility staff, including security guards, often do not allow them access.

3. Conclusion.

When selecting only the fathers/couples who are were expecting a child when they completed the questionnaire; we found a 6.9% increase in those who went to all prenatal care visits. With 34.5% of expecting fathers attending prenatal care prior to the sessions, the target was set at 60.4% (75% increase). The actual percentage of fathers attending prenatal care increased to 41.4%. It should be noted that only 29 fathers indicated that they were expecting a child in both the pre and post questionnaire.

Again, major barriers were found to men participating in pre and post-natal care visits. These include cultural beliefs such as it being a woman’s responsibility and not wanting to be perceived as ‘weak’, and the attitudes of health care workers.

Outcome indicator 3.2.1b: 75% increase in fathers present at birth of child (local laws permitting)

1. Methodology:

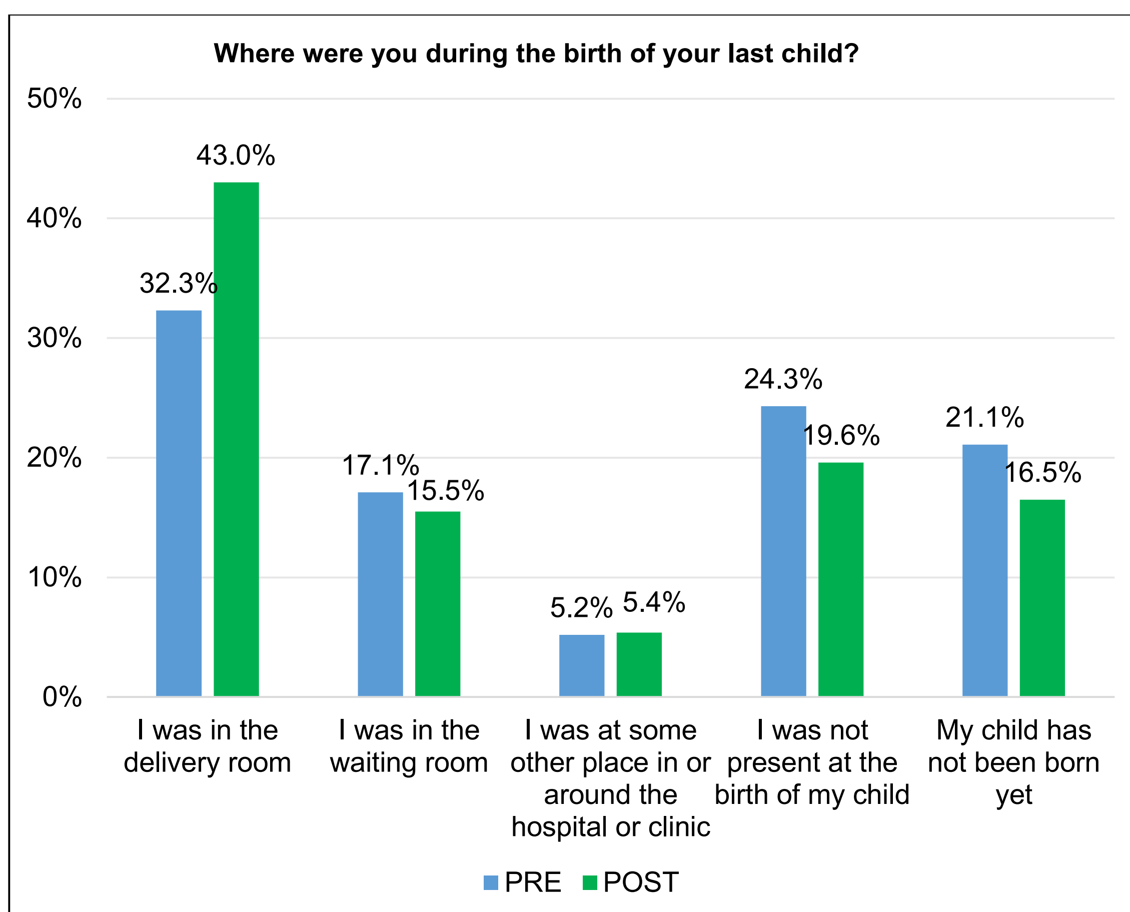
Descriptive analysis produced the frequency and percentages of the location of fathers during the birth of their last children.

2. Findings

Quantitative findings

PRE - Where were you during the birth of your last child?		
	Frequency	Percent
I was in the delivery room	161	32.3%
I was in the waiting room	85	17.1%
I was at some other place in or around the hospital or clinic	26	5.2%
I was not present at the birth of my child	121	24.3%
My child has not yet been born	105	21.1%
Total	498	100.0%

POST - Where were you during the birth of your last child?		
	Frequency	Percent
I was in the delivery room	136	43.0%
I was in the waiting room	49	15.5%
I was at some other place in or around the hospital or clinic	17	5.4%
I was not present at the birth of my child	62	19.6%
My child has not yet been born	52	16.5%
Total	316	100.0%



Qualitative findings

In the FGD with fathers, most of the participants expressed the desire to be more involved in maternal and child health care, including being present at the birth of the child. However, some participants were denied access to the maternity ward by security guards or nurses.

> *"For me, I have two kids, unfortunately during the birth of my first child who is 3years now I was denied access by the nurses and the security…….however I managed to see my child before my wife saw her because it was caesarean delivery……during the birth of my second child I was part of this program and I knew my rights……I demanded to be part of everything…I supported my wife all the way, I was there during her labour trying to calm her down because I could see that she was in pain. My wife told me afterwards that with me being there massaging her back and holding her hands has made a difference. I was there with her during pre-natal visits, delivery and post-natal visits…in fact, when she told me that her water broke…I knew what to do because we were taught what to do, then I took her to the hospital. Even at work they allowed me to be there for my wife. The feeling of being part of the whole process is unexplainable, it felt like I was a totally different person……you just forget about everything and be thankful to your woman for such a wonderful gift….your flesh and blood." Focus Group Discussion Participant*

In an article entitled 'What men don't know can hurt women's health' (17), the researchers describe the four main barriers to men's involvement in maternal and child health, while this study was conducted in Ghana – the results may shed light on the South African context. 1) perceptions that pregnancy is a female role while men are the providers; 2) cultural beliefs such as the belief that men who accompany their wives to receive antenatal services are being dominated by their wives; 3) health service factors such as unfavourable opening hours of service, poor attitude of health care workers and lack of space to accommodate male partners in health facilitates; and 4) the high cost associated with accompanying women to seek maternity care.

Fathers who were allowed to accompany their partner in ante- and post-natal care visits described the moment as being priceless.

"When my wife went in for delivery of our first child I wanted to go in but I was denied access by the security, he told me that men are not allowed in labour ward. I was very disappointed to be turned away by the security. When my wife went for delivery of our second child I was part of the program already and I insisted that I want to be involved but I was disappointed when the nurses tried to scare me, they told me that some men faints in the labour ward because of what they see, the asked me again is I was prepared for that, and I told them yes. Being part of my childbirth was a special moment for me, especially being the first person to hold our baby. I'd advise all the fathers out there to be part of childbirth of their babies" Focus Group Discussion Participant

"*Being involved during delivery was unforgettable experience to me, I got to see everything. Although the nurses told me to stand by the head, I insisted to stand where I can see everything and monitor even the machines that monitor heartbeat. I was the one who cut the umbilical cord, and I was happy to take it home with me because that (umbilical cord) is very important in my culture" Focus Group Discussion Participant*

The HCWs reported that having access to the fathers has helped them to reduce the number of complaints in labour ward, nurses no longer shout at patients because their partners are always there and are involved in the whole process.

Again, this contradicts with the information reported by some Fathers during the FGDs.

"We are involving the fathers in the labour ward during childbirth, we let the fathers cut the (Umbilical) cord since culturally, the (umbilical) cord is very important in terms of knowing your biological origin" Healthcare Worker interview

Participants reported that involving partners also helps when there is a complication during delivery.

"When there is complication with the mother during delivery and she has to be transferred to other units, the fathers hold the baby and put him/her on his chest while we are still attending to the mother". Healthcare Worker interview

3. Conclusion

Before the programme, 32.3% of fathers were in the delivery room when their child was born; with a 75% increase sets the target at 56.5%. After the programme, 43.0% were in the delivery room. Before the programme, 24.3% of fathers were not at the birth of their children, this decreased to 19.6% after the programme.

The qualitative data showed that while most men did want to be involved in the birth of their child, it is challenging for them. There were various barriers to being in the delivery room including cultural issues, or being at work. However the most significant barrier was Health Facility staff not allowing them access into the maternity ward. Not allowing access to fathers can be a result of many factors, including cultural and infrastructure issues. One hypothesis is that some public health facilities have communal maternity wards where more than one mother is in labour, in this case men are not allowed into the ward to provide some privacy for the women. The Health Care Workers did recognise that fathers should be allowed access to maternal and child healthcare and that this had been a problem. However, because of the MenCare++ programme, some of these problems are being mitigated – for example putting up privacy screens in communal wards.

Outcome indicator 3.3.1a: 80% increase in men's positive attitudes towards a respectful relationship

1. Methodology

Data regarding men's attitudes towards a positive relationship was not included in the SRHR or parenting groups, however, it was discussed in the FGDs. More detail about this indicator is available in the "Male Counselling Toolkit Evaluation".

2. Findings

Qualitative findings

Participants in the Young Men FGD found the session on the 'Human and the Thing' very interesting – they learnt that it is important to treat other people as human being, not objects. Participants also indicated that the programme taught them how to respect themselves; and they believe that respect for yourself leads to respect for others, especially women and children. It also taught them how to be respectful within relationships.

Teko* has realised that there should be a change in the way that daughter-in-law's are treated in his culture. After the program he was able to stand and protect them as he realised that these women are often being abused. He also educated his elders to ensure that they understand and see the importance of caring for women and not abusing them. *Focus Group Participant*

"Yes I can say my life has changed, there was a session about a human and a thing…… taking a person and making him/her a thing and making them do everything that you want, like bullying. That topic changed lot of things in me." Focus Group Participant

Outcome indicator 3.3.1b 80% increase in men's use of anger control strategies

1. Methodology

Data collected through the questionnaires from young men (SRHR groups) did not include items about men's use of anger control. The topic was however discussed during the focus groups discussions with parents and young men. The information yielded through the FGDs are presented below.

More detail about this indicator is also available in the "Male Counselling Toolkit Evaluation".

2. Findings

Qualitative Findings

Before their involvement in the programme some participants mentioned that they thought using violence towards their partner was normal as they had grown up seeing their father beat up their mother. Attending the sessions enabled them to communicate verbally when there is a misunderstanding or conflict with their partner.

> Fezile, who had just completed his 25 years jail sentence explained how the program has helped him to stay away from trouble. He was recently attacked by a mentally ill man and instead of fighting back - he thought about his recent training and decided to control his anger and walk away. For him the program has given him a second chance, even the community has accepted him and given him the second chance (All the participants clapped). *Focus Group Discussion*

Result Area 4: Greater respect for the sexual and reproductive health rights of people to whom these rights are denied

Outcome indicator 4.1.1: % increase in health sector staff showing positive support for engaging men and couples in integrated SRH/MCH/Domestic violence services

Health Care Workers reported that the MenCare+ program is very beneficial to patients, it has allowed them to form partnerships with the fathers and it has made it easy for the fathers to be available as companions to their partners. The program has played a big role in encouraging the involvement of the fathers supporting their partners in pre and post-natal care as well as in the life of their children.

Outcome indicator 4.2.1: # adapted or implemented policies at local or country level to promote engaging men in accessing SRH/MCH services.

Please see the table and timeline below describing the policy environment in South Africa and advocacy efforts by Sonke and MOSAIC over the past 3 years.

Table 7. Advocacy Efforts by Sonke and Mosaic

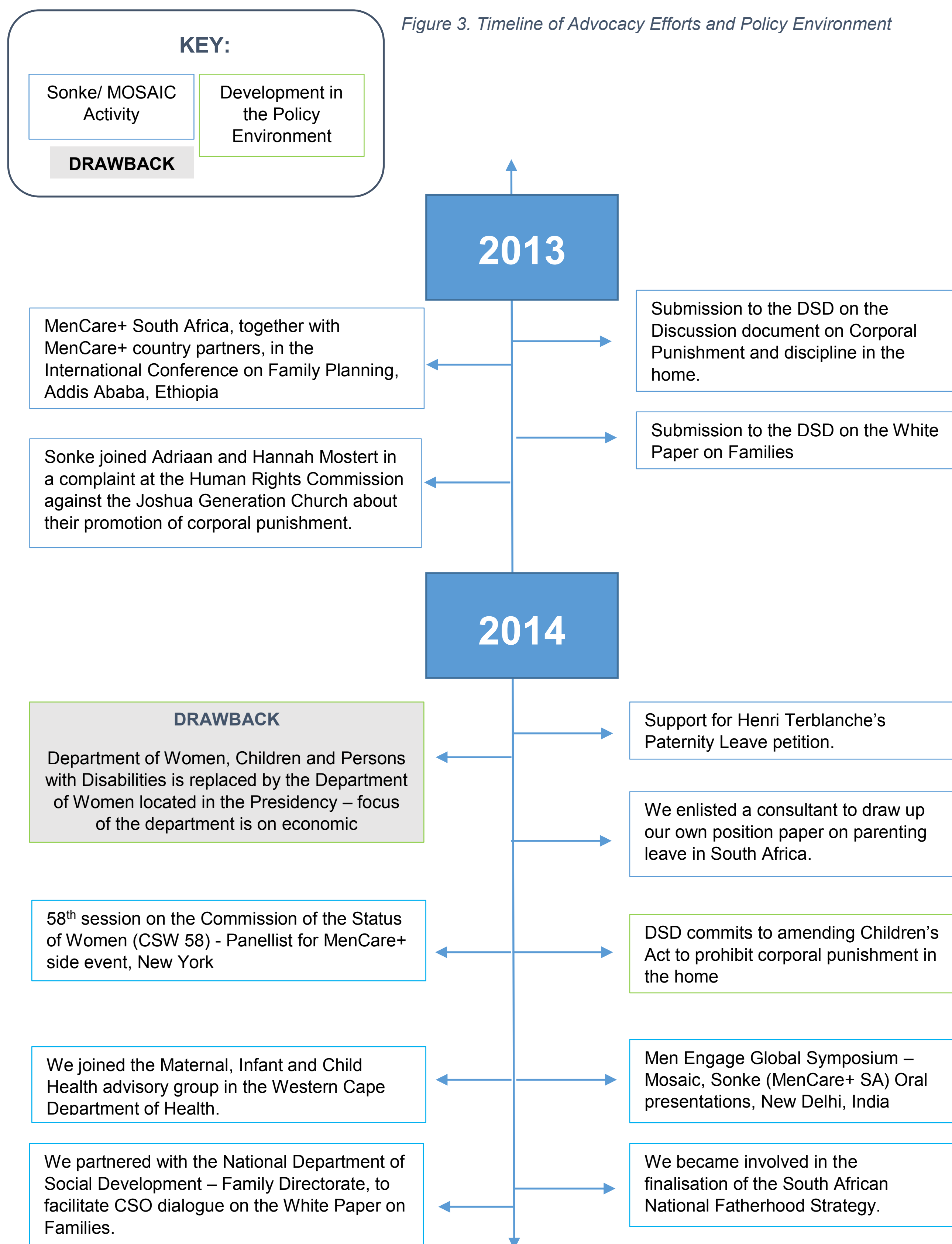
<table>
<tr><th>Goal & objectives:</th><th colspan="2">1. To ensure that corporal punishment is banned in all spaces including the home
2. To establish better leave for parenting, including leave for fathers and improved maternity leave
3. To improve health system policies to enhance men's contribution to maternal, infant and neonatal health.</th></tr>
<tr><td>Baseline status on advocacy issue:</td><td colspan="2">1. Corporal Punishment:
• Corporal punishment in schools was first outlawed by The Schools Act (1996), then by the National Education Policy Act (1996)
• In terms of Common Law corporal punishment by a parent is legal in South Africa.
2. Parental Leave:
• Maternal Leave
• Paternal Leave: Fathers are entitled to 3 days of Family Responsibility Leave.
3. Health System Policies</td></tr>
<tr><td>Year</td><td>Highlight/Drawback</td><td></td></tr>
<tr><td>2013</td><td>Sonke contributed significantly to the White Paper on Families in South Africa. Notably we ensured that the issue of parental leave was named and assigned to the Departments of Social Development and Labour to take on as an issue to explore.</td><td></td></tr>
<tr><td></td><td>Sonke joined Adriaan and Hannah Mostert in a complaint at the Human Rights Commission against the Joshua Generation Church about their promotion of corporal punishment. The complaint received significant media attention including a dedicated show on Carte Blanche, a national investigative journalism programme broadcast weekly, with a weekly viewership of 500 000 people.</td><td></td></tr>
<tr><td></td><td>Sonke and Mosaic established a relationship with the Health Impact Assessment unit at the Western Cape Department of Health, to facilitate a partnership relationship on MenCare+ in Cape Town.</td><td></td></tr>
<tr><td></td><td>MenCare+ South Africa participated, together with MenCare+ country partners, in the International Conference in Family Planning</td><td>Addis Ababa, Ethiopia</td></tr>
</table>

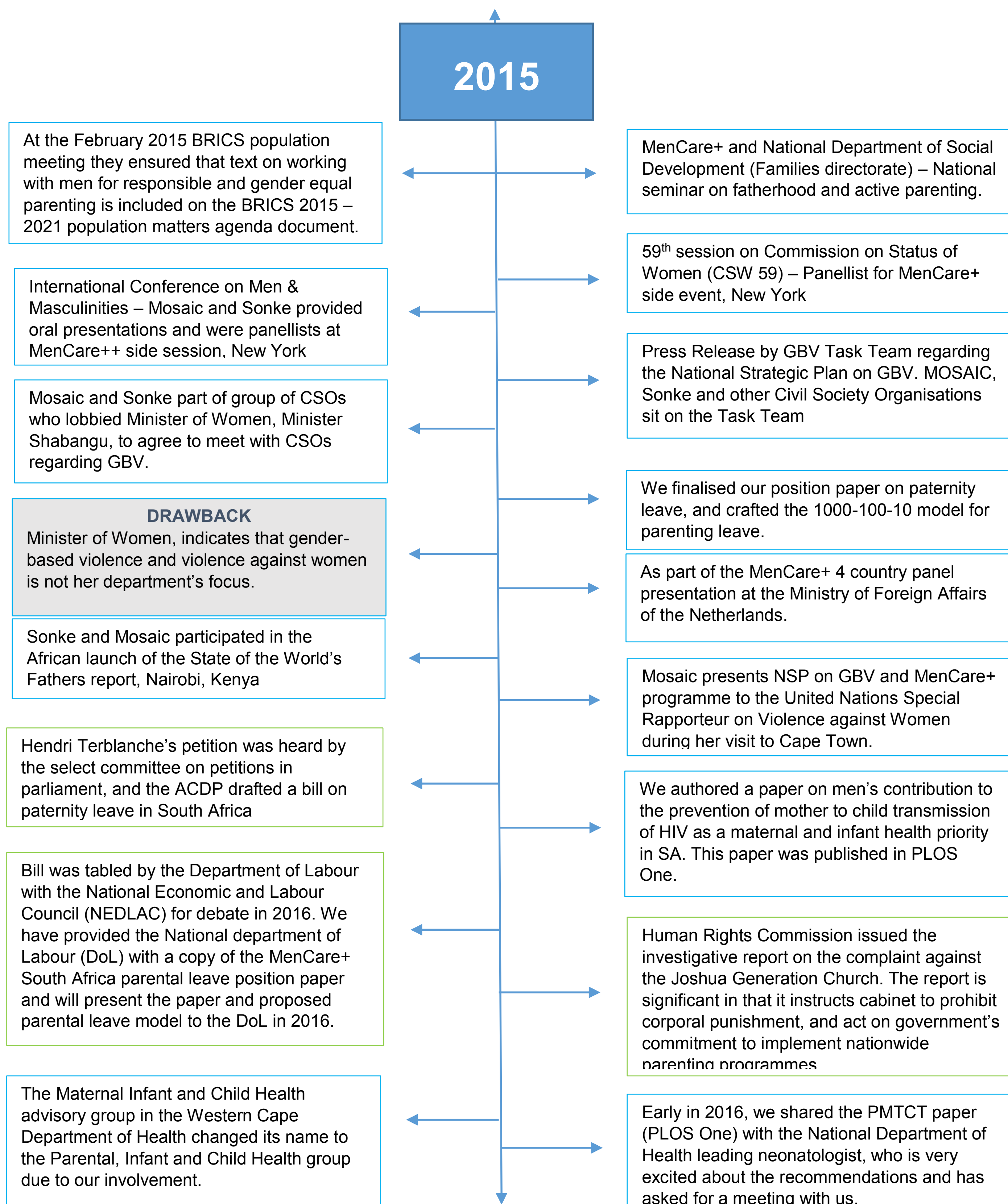
2014	We supported Hendri Terblanche's paternity leave petition.	
	We enlisted a consultant to draw up our own position paper on parenting leave in South Africa.	
	Panellist for MenCare+ side event at the 58th Session on the Commission on the Status of Women	New York
	MOSAIC and Sonke present oral presentations at the MenEngage Global Symposium	New Delhi, India
	We applied consistent media pressure to the SA Human Rights Commission to deliver the promised report regarding Joshua Generation Church.	
	We joined the Maternal, Infant and Child Health advisory group in the Western Cape Department of Health.	
	We became involved in the finalisation of the South African National Fatherhood Strategy.	
	We partnered with the National Department of Social Development – Family Directorate, to facilitate CSO dialogue on the White Paper on Families.	
2015	At the February 2015 BRICS population meeting we ensured text on working with men for responsible and gender equal parenting is included on the Brazil Russia India China South Africa (BRICS) 2015 – 2021 population matters agenda document. This document guides collaboration on population matters between the five countries and this text highlights this as a strategic issue in an influential programme.	
	MOSAIC and Sonke presented oral presentations and were panellists at the MenCare+ side session at the International Conference on Men & Masculinities	New York
	MenCare++ and National Dep. Of Social Development (Families Directorate) hold National Seminar on Fatherhood and active parenting.	
	Sonke and MOSAIC panellists for the MenCare+ side event at the 59th session on the Commission on the Status of Women.	New York
	Press Release by GBV Task Team regarding the NSP for GBV. Task Team consists of MOSAIC, Sonke and other CSOs	
	MenCare+ 4 country panel presentation at the Ministry of Foreign Affairs	Netherlands

	We finalised our position paper on paternity leave, and crafted the 1000-100-10 model for parenting leave. During the launch of the State of the World's Fathers report in the Netherlands, the same model of 1000-100-10 was used with an attached 40 000 signatures to lobby the Dutch parliament to improve paternity leave in the Netherlands, which was achieved.	
	MOSAIC presents NSP for GBV and MenCare+ Programme to the United Nations Special Rapporteur on Violence against women.	
	Hendri Terblanche's petition was heard by the select committee on petitions in parliament, and the ACDP drafted a bill on paternity leave in South Africa. Towards the end of 2015 the bill was tabled by the Department of Labour with the National Economic and Labour Council (NEDLAC) for debate in 2016. We have provided the National department of Labour (DoL) with a copy of the MenCare+ South Africa parental leave position paper and will present the paper and proposed parental leave model to the DoL in 2016.	
	We authored a paper on men's contribution to the prevention of mother to child transmission of HIV as a maternal and infant health priority in SA. This paper was published in PLOS One. In the paper we recommended that South African National and Provincial PMTCT guidelines and policies include concrete descriptions of how to achieve and measure the following three goals for male partner involvement: 1. Ensure that men are engaged as supportive partners in MNCH. 2. Expand MNCH service provision to link more effectively to the specific health needs of male clients. 3. Encourage men to challenge harmful gender-inequitable beliefs and behaviours.	
	Towards the end of 2015, the Human Rights Commission issued the investigative report on the complaint against the Joshua Generation Church. The report is significant in that it instructs cabinet to prohibit corporal punishment, and act on government's commitment to implement nationwide parenting programmes.	
	The Maternal Infant and Child Health advisory group in the Western Cape Department of Health changed its name to the Parental, Infant and Child Health group due to our involvement. In addition, we contributed to improving the introductory assessment tools for new mothers by ensuring that the mother is asked about the contribution to care that her partner provides as a standard entry level question for all new mothers.	

2016	Early in 2016, we shared this paper with the national department of health leading neonatologist, who is very excited about the recommendations and has asked for a meeting with us.	

Figure 3. Timeline of Advocacy Efforts and Policy Environment




2015
At the February 2015 BRICS population meeting they ensured that text on working with men for responsible and gender equal parenting is included on the BRICS 2015 – 2021 population matters agenda document.
MenCare+ and National Department of Social Development (Families directorate) – National seminar on fatherhood and active parenting.
59th session on Commission on Status of Women (CSW 59) – Panellist for MenCare+ side event, New York
International Conference on Men & Masculinities – Mosaic and Sonke provided oral presentations and were panellists at MenCare++ side session, New York
Press Release by GBV Task Team regarding the National Strategic Plan on GBV. MOSAIC, Sonke and other Civil Society Organisations sit on the Task Team
Mosaic and Sonke part of group of CSOs who lobbied Minister of Women, Minister Shabangu, to agree to meet with CSOs regarding GBV.
We finalised our position paper on paternity leave, and crafted the 1000-100-10 model for parenting leave.
DRAWBACK
Minister of Women, indicates that gender-based violence and violence against women is not her department's focus.
As part of the MenCare+ 4 country panel presentation at the Ministry of Foreign Affairs of the Netherlands.
Sonke and Mosaic participated in the African launch of the State of the World's Fathers report, Nairobi, Kenya
Mosaic presents NSP on GBV and MenCare+ programme to the United Nations Special Rapporteur on Violence against Women during her visit to Cape Town.
Hendri Terblanche's petition was heard by the select committee on petitions in parliament, and the ACDP drafted a bill on paternity leave in South Africa
We authored a paper on men's contribution to the prevention of mother to child transmission of HIV as a maternal and infant health priority in SA. This paper was published in PLOS One.
Bill was tabled by the Department of Labour with the National Economic and Labour Council (NEDLAC) for debate in 2016. We have provided the National department of Labour (DoL) with a copy of the MenCare+ South Africa parental leave position paper and will present the paper and proposed parental leave model to the DoL in 2016.
Human Rights Commission issued the investigative report on the complaint against the Joshua Generation Church. The report is significant in that it instructs cabinet to prohibit corporal punishment, and act on government's commitment to implement nationwide parenting programmes
The Maternal Infant and Child Health advisory group in the Western Cape Department of Health changed its name to the Parental, Infant and Child Health group due to our involvement.
Early in 2016, we shared the PMTCT paper (PLOS One) with the National Department of Health leading neonatologist, who is very excited about the recommendations and has asked for a meeting with us.

CONCLUSION

The MenCare+ South Africa Programme has shown positive results based on this end of term evaluation.

The overall scores for Gender Equitable Attitudes of both the Young men and Parenting Groups display an increase in Gender Equitable Attitudes post intervention. Qualitative data from the focus group discussions support these quantitative findings. Participants presented their personal experiences of the programme sessions as well as how these sessions have changed their perceptions of gender roles, stigma, abuse and communication with their partners regarding the use of contraceptives.

Young men's attitudes regarding contraception and contraceptive use (specifically condom use) changed positively after the programme. The young men displayed a more positive attitude towards contraceptives for four of the six items on the scale except for "condoms are an effective method of preventing the spread of HIV and sexually transmitted diseases" and "Condoms are not reliable in preventing pregnancy" where it was found that the young men's attitude stayed the same after attending the MenCare+ sessions. The issue of damaged condoms was voiced in some of the FGDs where the young men said that a condom with a hole through it can still place them at risk of contracting a STI or lead to pregnancy. The aforementioned may explain why the scores on the two items did not change significantly since the young men reported that they were taught of the danger of punctured condoms. The young men also reported that the programme has taught them about the role that contraceptives play in preventing STIs and also why contraceptives were important.

With regards to the Parenting Group, contraceptive use changed positively. The percentage of couples that used a condom the last time they had sex increased. The parents' attitudes towards contraceptives also changed positively after attending the sessions – the most significant change being in the number of respondents who disagreed that "Condoms ruin the sex act." It was clear from the FGDs that some of the parents feel more comfortable to talk about contraceptive use with their partners.

Young men still face several barriers to accessing SRH services, including cultural beliefs and the perception that health clinics are places for women only. However, despite this, the percentage of males who feel comfortable asking health care professionals for information

about sexuality-related issues has increased after attending the MenCare+ sessions. The FGDs revealed that some of the young men now know what the symptoms are of STIs and when to go to a clinic.

Fathers face similar barriers to being involved in maternal and child health care, participants in the focus group discussions reported often that while they would like to be involved in pre and post-natal care visits and be present at the birth of their child, it is often not possible. Their reasons include the perception that pregnancy related issues are a woman's concern only, so they have limited access to these services; infrastructure issues like communal wards; not being given time off from work; and health care facility staff' attitudes. The quantitative data shows a 6.9% increase in those fathers who went to all prenatal care visits and a 10.7% increase in fathers who were in the delivery room during the birth of their last child.

The quantitative data collected by the evaluation team provided valuable information regarding the programme's implementation and challenges (please see the recommendations below). Overall the programme beneficiaries, programme stakeholders, programme staff, healthcare workers and social workers were of the opinion that this programme has led to great improvements in their communities and that they can see these changes. Almost all of the participants in the qualitative data collection recommended that the programme should be expanded to the rest of South Africa, especially in rural areas, so that other young men and fathers may benefit.

The MenCare+ South Africa Programme has achieved a lot over the past three years, most notably the first of its kind 'State of the World's Fathers Report'; the short film 'Gift of Fatherhood'; training of Social Workers in 5 Provinces; the Paternity Leave position paper; and importantly, the majority of targets being reached. While these significant achievements should be celebrated, the implementation of programmes always comes with challenges and obstacles – these should also be given attention so that the programme may improve. The working relationship between Sonke and the Government (especially Health Dep.) was challenging and is an area that needs to be improved upon as it is a crucial element to improving the policy environment.

The evaluation team would like to end off this conclusion with a statement that describes the irreplaceable impact that the MenCare+ programme has had on individuals and communities.

*Mark, a father of two, who graduated from the programme in 2013 and subsequently became a facilitator for the programme had this to say about the impact of the programme on him:

Before he started attending the programme people in the community were asking *Mark how he was going to support his family financially, which used to cause a lot of anxiety for him because he was unemployed. This anxiety made him distance himself from his children and he did not have a strong relationship with them. However, after getting involved in the MenCare+ Programme he realised that there is more that he can offer his family, not only in terms of finances. As his relationship with his children grew stronger, he was able to relate to them better. This change he observed in his life motivated him to volunteer as a facilitator and subsequently his financial burden was alleviated.

Table 8. Summary of Results

Result Areas & Indicators	Target Achieved/ not achieved	Data Available
1. Young men and caregivers are better informed and better able to make healthier choices regarding their sexuality, relationships, maternal health and caregiving		
Outcome indicator 1.1.1a: 25% of participating young men have more gender equitable attitudes	Achieved 27.5%	Both Qualitative and Quantitative Findings
Outcome indicator 1.1.1b: 25% of participating young men use contraceptives, including condoms at latest high-risk sex	Achieved 68.0%	Both Qualitative and Quantitative Findings
Outcome indicator 1.2.1a: % of participating men (fathers) attend prenatal care visits	Please refer to Outcome indicator 3.2.1a	Qualitative Findings only
Outcome indicator 1.2.1b: % of participating couples communicate about family planning	Achieved 81.1%	Both Qualitative and Quantitative Findings
Outcome indicator 1.3.1: community members with a positive attitude towards men as caregivers and allies in family planning	N/A	Qualitative Findings only
2. Increasing young men's/ couples access to contraceptives, including male and female condoms, to promote good health		
Outcome indicator 2.1.1: 75% increase in couples protected by contraceptives	Not achieved	Both Quantitative and Qualitative data
Intermediate outcome indicator 2.1.1: % increase with changed views on contraceptive use	Achieved (statically significant change in mean score)	Both Quantitative and Qualitative data

3. Public and Private clinics provide better sexual and reproductive health care services, including domestic violence services, which more people are using.		
Outcome indicator 3.1.1a: 60% increase in young men making use of SRH services	Not Achieved 28.6% increase in paired cases	Quantitative data only
Outcome indicator 3.2.1a: 75% increase in fathers attending prenatal care visits with partners	Not Achieved 6.9% increase	Quantitative and Qualitative data
Outcome indicator 3.2.1b: 75% increase in fathers present at birth of child (local laws permitting)	Not Achieved 9.2% increase	Quantitative and Qualitative data
Outcome indicator 3.3.1a: 80% increase in men's positive attitudes towards a respectful relationship	N/A	Qualitative data only
Outcome indicator 3.3.1b 80% increase in men's use of anger control strategies	N/A	Qualitative data only
4. Greater respect for the sexual health and reproductive health rights of people to whom these rights are denied.		
Outcome indicator 4.1.1: % increase in health sector staff showing positive support for engaging men and couples in integrated SRH/MCH/Domestic violence services	N/A	Qualitative Data only
Outcome indicator 4.2.1: # adapted or implemented policies at local or country level to promote engaging men in accessing SRH/MCH services.	N/A	Qualitative Data only

RECOMMENDATIONS

The following list of recommendations was compiled from the findings of the desk review, the quantitative data analysis, the Focus Group Discussions with programme participants, interviews with programme stakeholders, programme staff, healthcare workers, social workers and the media.

Recommendations for Future Implementation

- *Continuing programme*
  - The majority of participants expressed the need for the MenCare+ programme to continue.

"I think that, that if we look at the work that, that Sonke came to do in the community…it is only taking off now. Our people are only getting used to the programme now. You see, the parents that, the parents who we worked with, are parents who, who use drugs, they drink, they (inaudible), but if you were to come to the sessions, you will see the things that the sessions do to them. Uhm, it makes you, it makes you, it takes you back."

"That is why I say that with this programme, the programme (sic) wants to take off. And it is different hear."

"And it is, it is really 'n great shame. If Sonke had to close their doors, then it is a great shame."

Focus Group Discussion Female Participant

- *Planning*
  - Questionnaires should be translated into local languages – some of the terms used would not be well-known to non-English participants (E.g. some people may not realise that condoms are a form of contraception).
  - Trainers and facilitators should use a projector and go through the questionnaire with participants before they fill it in.
  - Trainers should be involved in the design of the manual as they will have valuable insight into what the participants need and want.

- *Administration*
  - Administration of the Questionnaires should be closely monitored by facilitators and trainers. The participants should not be able to help each other or be

distracted, only those who participated in the programme should fill in the questionnaire.

- *MenCare+ Sessions and Participants*
    - MenCare+ should offer participants who have completed the sessions the opportunity for ongoing support and mentorship – participants mentioned that they feel they need more support once they have finished the MenCare+ sessions to stay connected with the programme and the people who were in the programme.
        - MenCare+ should consider providing participants with a manual or book that they can refer back to after completing the programme.
    - MenCare+ should be linked to other skills development programmes needed by the participants and in the communities, such as training and job opportunities.
    - Teenage parents are a group that were not well included in the last three years. Teenage parents may need the most support in terms of parenting and thus should be better included.
    - MenCare+ should consider combining some sessions with men and women – this was mentioned multiple times in the Focus Group Discussions and in previous recommendations made in other MenCare+ Reports. It could also be considered to create female groups (both SRHR and parenting) and only run certain sessions with the male participants.
    - The MenCare+ team should consider having sessions in the evenings and weekends for participants who work (both male and female) or are unable to attend weekday sessions – if such sessions already exists they should be promoted in the communities.
    - MenCare+ should consider arranging transport for participants who struggle to find their own transport to the venue, especially those who attend evening sessions.
    - The MenCare+ team should consider using participants who were particularly successful in completing the programme to start facilitating sessions or becoming community activists. Participants mentioned multiple times that they would like to continue being involved in MenCare+ and this may be useful in scaling up the programme.
    - MenCare+ Facilitators and Trainers should receive training on how to respond

to participants who reveal that they were abused as children or that they themselves abuse children. While there are referral mechanisms in place for this, the facilitators mentioned that they feel uneasy responding to that kind of situation in the group during the session.

- Counsellors/Social workers should undergo GBV training or refresher courses.
- MenCare+ should explore strategies to collaborate with the local church leaders as they have influence within the community. Some MenCare+ participants are religious leaders and can serve as an entry point to collaborate with the local churches.
- A discussion/ workshop should be held with local community and church leaders to try and align the messages (as far as possible) that they teach the community. For example, MenCare+ tries to teach and motivate young men to use contraceptives, however the church that they attend may say that to use contraception is a sin – these two conflicting messages will have a huge impact on behaviour change.
- A yearly event should be organised (depending on the budget) to get all the participants from different areas together

- *Advocacy Recommendations*
  - The policy and legal environment that discourages fathers from being actively involved in their child's life must be improved. For example the situation of paternity leave.
  - A portfolio of evidence with the results of this evaluation should be presented to the relevant Government Departments (such as the Dep. Of Health, Dep. Of Social Development, Dep. Of Justice) to provide evidence that the programme works and to motivate for their involvement in the continuation of the programme.

Recommendations for Future Measurement & Evaluation

- A baseline analysis should be conducted as soon as enough pre questionnaires have been collected. Not only will this serve as a benchmark, but it will also identify certain participant needs and will provide data to set programme indicator targets.

- Many of the targets were set using an "increase in percentage". It is suggested that the way targets are set are clearly defined and possibly revised after determining the "baseline" results (pre intervention outcome measures).
- Outcome indicators in the current reporting template were more quantitative of nature. A clear and specific qualitative evaluation question should be formulated to guide the qualitative component of future evaluations.
- There should be one central database for all the monitoring data (including campaign activities) to be stored, from both organisations. The quality, consistency and completeness of this data should also be monitored. The Success Stories should also be stored here.
- There should be one central database, that everyone has access to, for all Project Documents, Reports, IEC Material, etc. to be stored – such as Drop Box or Google Drive.
- Campaign activities should be documented – by this we mean going further than just the quantitative data describing the reach of the activity, but also describing the success or challenges that were experienced.
- Facilitators and Trainers should be motivated to document success stories that they come across in their groups. For instance a template should be drawn up for the format of a Success Story and every six months they should submit at least one to the Programme Manager.
- When conducting future evaluations of this Programme it would be advisable to elect one person from both organisations to be the contact person. Communication will be between the Evaluation Project Manager, Funder and this person to try and mitigate some of the challenges that come with having multiple contacts, opinions, and needs.
- Further exploratory research should be conducted about why many participants disagreed with statements such as "a man and a woman should decide together what type of contraceptive to use" and "it is important that a father is present in the lives of his children, even if he is no longer with the mother".
- The Outcome Measurement Report Format should be reconsidered. The way it is set out currently makes it difficult to discuss Qualitative Results effectively. The evaluators suggest that the Qualitative results should be discussed in a separate section to the Quantitative results. Thereafter, the correlations or differences between the two can be discussed.

LIMITATIONS

Although the evaluation obtained significant differences on many scores and behaviours before/after the MenCare+ programme, statistically we cannot say that the MenCare+ programme caused those changes; but this evaluation made use of routinely collected quantitative Monitoring and Evaluation data and did not set out to prove any causality.

Initially, a random stratified sampling strategy was used to recruit participants for the Focus Group Discussions. The stratification was to be done by main area. The MenCare+ programme reached beyond the three main areas to other smaller areas of major need and it was suggested that these groups should also be included in the evaluation. The existing sampling frame data was not adequate for stratifying per area. Therefore, a joint decision was taken to use a systematic random sampling strategy, and not to make use of stratified sampling. Sonke Gender Justice and Mosaic contacted the programme participants via telephone using systematic sampling. It was reported that there were some difficulties in the random sampling recruitment process; and in these cases a purposive nonprobability sampling technique was used to recruit participants for the FGDs. Difficulties were experienced to recruit employed FGD participants because the FPD sessions were scheduled during working hours; however, some participants were employed and managed to attend the FGD. These participants either worked night shifts or they managed to make an arrangement with their employers.

FPD also recruited individual interview participants via telephone. The contact details of each of the groups to be contacted were provided to FPD. Some contact details were missing, and these individuals did not have an equal chance to participate in the evaluation. The evaluation distinguished between various groups (stakeholders) and upon contacting certain groups it was found that they do not belong to the group (e.g. two teachers were reached when contacting health care workers). The interviewer continued with the interview by exploring how these people are related to the MenCare+ programme and used the interview guide (for other groups); more in-depth information were collected from these participants. Information obtained from these participants were discussed separately.

Some Focus Group Discussions did not take place at the scheduled time. Mitigation strategies were put in place and it was jointly decided to conduct additional individual interviews with the

groups that did not participate in the FGDs. It should be noted that the two data collection methods are similar, but also different. FGDs yield more information about consensus or debate (to explore disparate views); it generates opportunities for point/counterpoint discussion and resolutions and provides rich quality in-depth information of respondent interactions (to explore common trends). Individual interviews are also valuable for other reasons such as: more cost effective and it is easier to reach the participants.

The SRHR and Parenting questionnaires were revised/improved over a period of time. Some questions were removed and some were added to the newer versions. The response type/options of some questions also changed. This proved to cause difficulties in the merger and analysis of the quantitative data. Some of the data on the versions cannot be analysed together or be compared to draw conclusions for the group as a whole.

There are some limitations of making use of paper-based questionnaires. For an example, the 88 respondents (pre intervention) who indicated that they did not use a condom answered the question about “who made the decision to use a condom.” The answers from the respondents are contradictory.

Originally, the evaluation also set out to evaluate the MenCare+ campaigning activities using quantitative methods such as (1). Data collection at the launch of the bill boards, (2). Analysis of the transcribed radio discussion sound clips, (3). Paper-based surveys from the communities’ responses and (4). Social media surveys and real time responses tracked by the communication department. The four data sources mentioned above was not included in the evaluation. However, campaigning activities were explored qualitatively in the evaluation.

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APPENDIX A: COUNTRY SPECIFIC RESULT CHAIN

RESULT CHAIN MENCARE+ SOUTH AFRICA				
Result Area 1: Young men and caregivers are better informed and better able to make healthier choices regarding their sexuality, relationships, maternal health, and caregiving				
Outputs	**Output Indicators**	**Outcomes**	**Outcome Indicators (Target)**	**End of Term Evaluation Results**
(1.1.1) Implementing organisations have established young men's SRH and caregiving groups	* 53 trained young men's program facilitators	(1.1.1) Participating young men have a higher awareness of the importance of SRH and display more gender equitable attitudes and behaviours	* 25% of participating young men have more gender equitable attitudes	27.5% of participating young men have more gender equitable attitudes Participants' perception on the role of men and women have changed since the programme – they report that the roles of men and women are interchangeable and equal.
	* 417 young men (and women) participating in young men's groups (finished)		* 25% of participating young men use contraceptives, including condoms at latest high-risk sex	60.8% of young men used a condom during the last time they had sex. FGD Participants reported they now take the responsibility to ensure that they are protected every time they have sex since the programme.

(1.2.1) Implementing organisations have established men's and couples fatherhood groups to engage men in SRH and MCH	* 52 trained parenting groups facilitators	(1.2.1) Participating fathers become more involved in maternal health and in caregiving at home	* 25% of participating men attend prenatal care visits	71.5% of participating fathers attend prenatal care visits.
	* 1.536 people (previously couples) participated in the groups (finished)		* 25% of participating couples communicate about family planning	FGD (parenting group) participants discussed how they found the family planning sessions to have added value to their own lives and the lives of other community members. It assisted them with knowledge and influenced their behaviour in terms of family planning.
(1.3.1) Implementing organisations carry out community based campaigns around engaged family planning, fatherhood and caregiving	* 180.000 people (men and women) reached by the MenCare++ campaign	(1.3.1) Changed attitude towards men as caregivers and allies in family planning	30.000 community members with a positive attitude towards men as caregivers and allies in family planning	The community mobilisers made specific mention of the programme bringing communities together and making people realise the importance of caring for one another. They have noticed a change in their communities.

Result Area 2: Increasing young men's/couples access to contraceptives, including male and female condoms, to promote good health.				
Outputs	**Output Indicators**	**Outcomes**	**Outcome Indicators**	**End of Term Evaluation Results**
(2.1.1) Sociocultural barriers among men addressed with regard to contraceptive use, including male and female condoms	*750 men with changed views on contraceptive use.	(2.1.1) Increased use of contraceptives, including male and female condoms, by couples	*75% increase in couples protected by contraceptives. *Intermediate outcome indicator: 750 men with changed views on conceptive use.	7.9% increase in couples protected by contraceptives. * We can conclude that the respondents' attitudes toward the use of contraceptives did change positively.
Result Area 3: Public and private clinics provide better sexual and reproductive healthcare services, including domestic violence services, which more people are using				
Outputs	**Output Indicators**	**Outcomes**	**Outcome Indicators**	**End of Term Evaluation Results**
(3.1.1) Health workers are trained to address the SRH needs of young men to promote contraceptive use, safe sex, and promote	* 200 of health workers trained and sensitised to the needs of young men in the SRH clinic services setting	(3.1.1) More young men and women making use of higher quality SRH services	* 60% increase in young men making use of SRH services	2.4% increase in men making use of SRH services in the last three months

their role as allies in family planning			* 70% increase in young women making use of SRH services	18.2% increase in women making use of SRH services in the last three months
(3.2.1) Health workers are trained to engage fathers in prenatal care visits and other maternal health-related issues	* 200 of health workers trained and sensitised to the importance of engaging fathers in maternal health visits	(3.2.1) Increased engagement of fathers in maternal health related issues	* 75% increase in fathers attending prenatal care visits with partners	1.7% increase in fathers attending all the prenatal visits.
			* 75% increase in fathers present at birth of child (local laws permitting)	In delivery room: increased by 10.7%
3.3.1) Counsellors are trained to counselling men (Toolkit for men) to end violence in intimate partner relations	* 300 counsellors trained in domestic violence counselling	(3.3.1) Reduction of violence in intimate partner relationships	* 80% increase in men's positive attitudes towards respectful relationship	Participants indicated that the programme taught them how to respect themselves; and they believe that respect for yourself leads to respect for others, especially women and children. It also taught them how to be respectful within relationships.
	* 3.000 men reached in counselling		* 80% increase in men's use of anger control strategies	Before their involvement in the programme some participants mentioned that they thought using violence towards their partner was normal as they had grown up

				seeing their father beat up their mother. Attending the sessions enabled them to communicate verbally when there is a misunderstanding or conflict with their partner.
Result Area 4: Greater respect for the sexual and reproductive health rights of people to whom these rights are denied				
Outputs	**Output Indicators**	**Outcomes**	**Outcome Indicators**	**End of Term Evaluation Results**
(4.1.1) Partner organisations have strengthened their capacity to engage the local health sector in promoting equal access to SRH/MCH/DV services to young men/fathers	* 166 staff of partner organisations are trained and sensitised in how to advocate for young men's/caregivers access to SRH/MCH/DV services to young men/fathers	(4.1.1) A health sector environment that promotes young men's/father's rights to SRH/MCH/DV services, at district level	75% increase in health sector staff showing positive support for engaging men and couples in integrated SRH/MCH/Domestic violence services	Advocacy efforts of the past three years will be described in a timeline, including its contribution to political (and economical) changes in the environment. Please refer to Result Area 4, page 21.

(4.2.1) Greater awareness of the policy gaps related to men's access to SRH, MH and violence services	* 20 public health policies and laws analysed at the federal, state and municipal levels, related to access for men to quality of SRH/MCH services, and domestic violence services * 15 training sessions for health sector staff on counselling programmes for men to stop domestic violence	(4.2.1) More favourable policy environment for engaging men in SRH/MCH and stopping domestic violence	* At least 10 health posts and 1 municipal health sector (in a city with 7 million population) implements policies that promote engaging men in accessing SRH/MCH and DV services	

APPENDIX B: DATA COLLECTION TOOLS

Focus Group Guide: SRHR Group/ Young men

a. English

1. What is the role of a man?
   Probe: What does it mean to be a father in your view?
   Probe: Do any of you have children?
2. How many of you participated in the MenCare+ sessions?
   Probe: How many of you completed the programme?
   Probe: How is the graduation process?
3. If you can recall which sessions were your biggest highlight and why?
   Probe: How have you used the information gained from the sessions?
4. What has been the value of the sessions to your life?
   Probe: Benefits, Challenges, Gaps and Opportunities. Any story that stands out in your mind that illustrates your experience, positive or negative.
5. Have you observed any changes in your life since you have attended the sessions?
   Probe: Did you change the way you think after attending the sessions?
   Probe: Did your behaviour change after attending the sessions? How?
   Probe: When did you notice those changes?
   Probe: How did you feel or what did you do when you're experiencing those changes the first time?
6. Have anyone in your life observed any changes?
   Probe: How did other people respond to these changes?
   Probe: Are they supporting the changes, if yes, how
7. How are men in general involved in their children's health and education?
   Probe: If they are not, why not? What are the barriers?
8. Can anyone think of a man in their community that is involved in their children's health and education? What makes him different? How does he act? What is your view on this?
9. How do fathers support their boy or girl child in promoting health or education? Does promoting the health and education of sons differ from girls?
   Probe: How does it differ and why?
10. In your view, how can this program benefit other community members?
11. What support do you feel you need as men? What would you like to know?
12. Would you recommend MenCare+ to your peers and why?
13. Any suggestions that can help to improve the project?

We've come to the end of your discussion, Thank you for your time and for the fruitful discussion.

b. Afrikaans

1. Wat is die rol van 'n man?
   Probe: Uit julle oogpunt uit, wat is die rol van 'n pa?
   Probe: Het enige van julle kinders?
2. Gefokus op die MenCare+ sessies – hoeveel van julle het dit bygewoon?
   Probe: Hoeveel het die program klaar gemaak?
   Probe: Hoe was die proses om dit klaar te maak?
3. Watter sessies was die hoogtepunt en waarom?
   Probe: Hoe het jy die inligting wat uit die sessies gekom het gebruik?
4. Wat is die waarde van hierdie ouerskap of vaderskap sessies in jou lewe?
   Probe: Voordele, uitdagings, gapings en geleenthede. 'N storie wat uitstaan in jou gedagte wat jou ervaring illustreer, positief of negatief
5. Het jy enige veranderinge in jou lewe gesien omdat jy die sessies bygewoon het?
   Probe: Het die manier waarop jy dink verander agv. die sessies?
   Probe: Het jy jou gedrag verander agv. die sessies? Hoe?
   Probe: Wanneer het jy hierdie veranderinge waargeneem?
   Probe: Hoe het hierdie veranderinge jou maak voel? Of wat het jy gedoen?
6. Het enige-iemand anders hierdie veranderinge in jou lewe agter gekom?
   Probe: Wat was ander mense se reaksie op die veranderinge?
   Probe: Ondersteun hulle hierdie veranderinge?
7. Is mans in die algemeen betrokke by hulle kinders se gesondheid en opvoeding?
   Probe: Wat weerhou mans om betrokke te wees by hulle kinders se gesondheid en opvoeding?
8. Is daar 'n voorbeeld van 'n man in julle gemeenskap wat betrokke is by sy kinders se gesondheid en opvoeding? Wat maak hom anders? Hoe gedra hy homself? Wat is jou opinie hiervan?
9. Hoe ondersteun pa's hulle seuns en dogters om hulle gesondheid en opvoeding te verbeter? Hoe verskil dit tussen seuns en dogters?
   Probe: Hoekom verskil dit?
10. Hoe kan hierdie MenCare+ sessies die ander gemeenskapslede help?
11. Watter ondersteuning het julle as jong mans nodig? Is daar enige dinge waaroor julle meer wil weet?
12. Sal jy MenCare+ aan ander voorstel? Hoekom?
13. Is daar enige voorstelle oor hoe ons die projek kan verbeter?

Ons het nou aan die einde gekom. Dankie vir julle tyd – dit was baie waardevol.

c. Xhosa

1. Bangaphi abangootata phakathi kwenu?

    Probe: Kuthetha ukuthini ukubangutata ngokoluvo lwenu?

    Probe: Yohluke kanjani indima yokubangumama kweyokubangutata?

    Probe: Ukuba ungutata, zeziphi iindima zokubangutata ozonwabelayo?

    Probe: Zikhona iindima zokubangutata ongazonwabeliyo?

2. Ukhe wathatha inkxaxheba koluhlelo lwe MenCare++?

    Probe: Zeziphi iinkqubo othathe inkxaxheba kuzo?

    Probe: Ingaba niye nazigqiba zonke iinkqubo zoluhlelo? Bekunjani ngexesha lokuthweswa isidanga?

3. Xa ukhumbula kakuhle zeziphi zoluhlelo oye wazithanda kakhulu? Cacisa

    Probe: Ingaba uye walusebenzisa kanjani ulwazi olufumene kulenkqubo?

4. Ingaka ukuthabatha inkxaxheba kulenkqubo kuye kwenza galelo lini ebomini bakho?

    Probe: Iinzuzo, iingxaki, izikhewu, namathuba. Ingaba likhona ibali lempumelelo elicacisa ngamava akho, izinto ezintle okanye ezimbi?

5. Ingaba lukhona utshintsho ebomini bakho oko uthe wazibandakanya noluhlelo lootata okanye lwabazali?

    Probe: Loluphi utshintsho olubonayo ebomini bakho?

    Probe: Uqale nini ukulubona olutshintsho?

    Probe: Uye waziva njani okanye wenza njani xa uqala ukuliqaphela olutshintsho ebomini bakho?

6. Kukhona abanye abantu ebomini bakho ababone utshintsho kuwe?

    Probe: Umlingane wakho/abantwana bakho/iitshomi zakho okanye abantu basekuhlaleni ingaba baluthathe njani olutshintso?

    Probe: Ingaba bayakuxhasa ke kolutshintsho? Cacisa.

7. Ingaba amadoda asekuhlaleni azibandakanya kanjani kwimpilo nakwimfundo yabantwana babo? Cacisa. Yintoni eyenza kubenzima ukuzibandakanya?

8. Ingaba akhona amadoda eniwaziyo ekuhlaleni azibandakanyayo kwimpilo nakwimfundo yabantwana babo?

9. Ingaba ootata babaxhasa kanjani abantwana babo abangamakhwenkwe ukuqinisekisa ukuba banempilo nemfudo engcono? Le nkxaso ingaba iyohluka kubantwana abangamakhwenkwe kwabangamantombazana

    Probe: Yohluka kanjani? Cacisa

    Probe: Zeziphi izidingo ezibalulekileyo kakhulu kubantwana abangamantombazana nabangamakhwenkwe?

    Probe: Ingaba kuyatshintsha oku xa abantwana bakho abangamakhwenkwe nabangamantombazana befikisa?

10. Ingaba ukhona phakathi kwenu okhe wakhapha umlingane wakhe xa esiya kwezempilo ngexa akhulelwe naxa eyozala?

    Probe: Sixelele ukuba kwakunjani?

    Probe: Baniphatha njani oonompilo?

    Probe: Yintoni ocinga ukuba ingatshintshwa ukwenza ukube lo mba ubengcono?

11. Nikhe nabahambisa abantwana benu kwezempilo? Babenjani ngakuni abongikazi?

    Probe: Banithatha kanjani abanye abantu ekuhlaleni?

Probe: Ukuba ootata bebebandakanyeka kwimpilo nemfundo yabantwana babo, ingaba le nto ibozokwamkeleka kubongikazi nakwiititshala esikolweni?

12. Ngokombono wenu, lingabanzuzo yini oluhlelo ekuhlaleni?
13. Nkxaso yiphi abayidingayo ootata? Bangathanda ukwazi ntoni
14. Yintoni uloyiko olukhulu ngabantwana bakho? Athini wona amaphupha akho ngabo?
15. Ungabamema oogxa bakho koluhlelo? Cacisa.
16. Ingaba ungacebisa ntoni ukuphucula oluhlelo?

Sifikele esiphelweni salengxoxo, siyanibulela kahkulu ngexesha lenu nangegalelo lenu.

Focus Group Guide: Fathers and Couples

a. English

1. How many of you are fathers?
   Probe: what does it mean to be a father in your view?
   Probe: How is the role of being a father different from being a mother?
   Probe: if you are a father, which part of fatherhood do you enjoy the most?
   Probe: Are there any roles that you don't enjoy which are part of fatherhood?
2. Have you been part of the MenCare+ sessions?
   Probe: Which sessions did you attend?
   Probe: Did you graduate and how was the graduation process?
3. If you can recall which sessions were your biggest highlight and why?
   Probe: How have you used the information gained from the Parenting or SRHR sessions?
4. What has been the value of **parenting or fatherhood session** to your life?
   Probe: Benefits, Challenges, Gaps and Opportunities. Any story that stands out in your mind that illustrates your experience, positive or negative.
5. Have you observed any changes in your life since you have attended the parenting or fatherhood sessions?
   Probe: Which behavioural changes have you observed in your life?
   Probe: when did you notice those changes?
   Probe: how did you feel or what did you do when you're experiencing those changes the first time?
6. Have anyone in your life observed any changes?
   Probe: What is your partner's, your children's, your friend's and the community response to the changes observed in your life?
   Probe: Are they supporting the changes, if yes, how?
7. How are men in general involved in their children's health and education? If they are not, why not? What are the barriers?
8. Can anyone think of a man in their community that is involved in their children's health and education? What makes him different? How does he act? What is your view on this?
9. How do fathers support their boy or girl child in promoting health or education? Does promoting the health and education of sons differ from girls?
   Probe: how does it differ and why?
   Probe: How do girls or boys take priority over the other in difficult economic times?
   Probe: how does this change as sons and daughters age and go on to secondary school, or reach puberty?
10. Has any of the fathers been part of the Pre- and Post-natal sessions?
    Probe: how was the experience, please share?
    Probe: how was the treatment of the health care workers?
    Probe: Any observations or changes that you would like to see happening to make the experience better for fathers?
11. Have you taken your child to the clinic, if yes, how was the responses from the health care workers?

Probe: What was the community response?
Probe: If fathers were to get more involved in children's health and education, how well accepted would they be by nurses and school administrators and teachers?

12. In your view, how can this program benefit other community members?
13. What support do you feel you need as a father? What would you like to know?
14. What are your biggest fears for your children? What are your biggest future dreams?
15. Would you recommend MenCare+ to your peers and why?
16. Any suggestions that can help to improve the project?

We've come to the end of your discussion, Thank you for your time and for the fruitful discussion.

b. Afrikaans

1. Hoeveel van julle is pa's? Steek julle hande op...
   - **Probe:** Uit julle oogpunt uit, wat beteken dit om 'n pa te wees?
   - **Probe:** Hoe verskil die rol van 'n pa van die van 'n ma?
   - **Probe:** Watter deel van "pa wees" geniet jy die meeste?
   - **Probe:** Is daar enige rol van "pa wees" wat jy nie geniet nie?

17. Gefokus op die MenCare+ sessies – hoeveel van julle het dit bygewoon?
    - **Probe:** Hoeveel het die program klaar gemaak?
    - **Probe:** Hoe was die proses om klaar te maak?
18. Watter sessies was die hoogtepunt en waarom?
    - **Probe**: Hoe het jy die inligting wat uit die Ouerskap of SRHR sessies kom gebruik?
19. Wat is die waarde van hierdie ouerskap of vaderskap sessies in jou lewe?
    - **Probe**: Voordele, uitdagings, gapings en geleenthede. 'N storie wat uitstaan in jou gedagte wat jou ervaring illustreer, positief of negatief?
20. Het jy enige veranderinge in jou lewe gesien omdat jy die ouerskap/vaderskap sessies bygewoon het?
    - **Probe**: Het die manier waarop jy dink verander agv. die sessies?
    - **Probe**: Het jy jou gedrag verander agv vaderskap/ouerskap sessies? Hoe?
    - **Probe**: Wanneer het jy hierdie veranderinge waargeneem?
    - **Probe**: Hoe het hierdie veranderinge jou maak voel? Of wat het jy gedoen?
21. Het enige-iemand anders hierdie veranderinge in jou lewe agter gekom?
    - **Probe**: Wat was jou vrou, of kinders, vriende of die gemeenskap se reaksie op die veranderinge?
    - **Probe:** Ondersteun hulle hierdie veranderinge?
22. Is mans in die algemeen betrokke by hulle kinders se gesondheid en opvoeding?
    - **Probe:** Wat weerhou mans om betrokke te wees by hulle kinders se gesondheid en opvoeding?
23. Is daar 'n voorbeeld van 'n man in julle gemeenskap wat betrokke is by sy kinders se gesondheid en opvoeding? Wat maak hom anders? Hoe gedra hy homself? Wat is jou opinie hiervan?
24. Hoe ondersteun pa's hulle seuns en dogters om hulle gesondheid en opvoeding te verbeter? Hoe verskil dit tussen seuns en dogters?
    - **Probe**: Hoekom verskil dit?
    - **Probe**: Neem die dogters of seuns prioritieit in moeilike ekonomiese omstandighede? Hoe?
    - **Probe:** Hoe verander dit soos hulle ouer word? Laerskool na Hoërskool of puberteit?
25. Was enige van julle na voor of na-geboorte klasse toe?
    - **Probe**: Wat was julle ervaring van die klasse?
    - **Probe**: Hoe het die gesondheidswerkers julle hanteer?
    - **Probe:** Het julle enige-iets opgelet of is daar enige voorstell oor hoe dit beter gemaak kan word vir pa's?
26. Het enige van julle al julle kinders kliniek toe gevat? Wat was die gesondheidswerkers se reaksie?
    - **Probe**: Wat was die gemeenskap se reaksie?

Probe: Indien pa's meer betrokke sou raak by hulle kinders se gesondheid en opvoeding – hoe sal die susters by die klinieke, en die onderwysers en onderwyseresse reageer?

27. Hoe kan hierdie MenCare++ sessies die ander gemeenskapslede help?
28. Watter ondersteuning het julle as pa's nodig? Is daar enige dinge waaroor julle meer wil weet?
29. Wat is jou grootste wense vir jou kinders? En wat is jou grootste drome vir jou kinders?
30. Sal jy MenCare+ aan ander voorstel? Hoekom?
31. Is daar enige voorstelle oor hoe ons die projek kan verbeter?

Ons het nou aan die einde gekom. Dankie vir julle tyd – dit was baie waardevol.

c. Xhosa

1. Kuthetha ukuthini ukubayindoda?
   Probe: Yohluka kanjani indima kamama kwekatata?
   Probe: Kukhona umntu onomtwana phakathi kwenu?
2. Ingaba beniyiyo inxalenye yoluhlelo lwe MenCare+?
   Probe: Ingaba nithabat
   He inxaxheba kuzo zonke iinkqubo zoluhlelo?
   Probe: Niye naziva njani xa niyinxalenxe yoluhlelo?
3. Sesiphi esona sihloko eniye nasol; nwabela kakhulu kulenkqubo?
   Probe: Ingaba ulusebenzise kanjani ulwazi olufumene kulenkqubo?
4. Ingaka ukuthabatha inkxaxheba kulenkqubo kuye kwenza galelo lini ebomini bakho?
   Probe: Iinzuzo, iingxaki, izikhewu, namathuba. Ingaba likhona ibali lempumelelo elicacisa ngamava akho, izinto ezintle okanye ezimbi?
5. Ingaba lukhona utshintsho ebomini bakho oko uthe wazibandakanya noluhlelo lootata okanye lwabazali?
   Probe: Loluphi utshintsho olubonayo ebomini bakho?
   Probe: Uqale nini ukulubona olutshintsho?
   Probe: Uye waziva njani okanye wenza njani xa uqala ukubona olutshintsho ebomini bakho?
6. Kukhona abanye abantu ebomini bakho ababone utshintsho kuwe?
   Probe: Umlingane wakho/abantwana bakho/iitshomi zakho okanye abantu basekuhlaleni ingaba baluthathe njani olutshintso?
   Probe: Ingaba bayakuxhasa ke kolutshintsho? Cacisa.
7. Ingaba amadoda apha ekuhlaleni ayazibandakanya kwimpilo nemfundo yabantwana babo? Cacisa
   Probe: Yintoni eyenza kubenzima ukuba amadoda azibandakanye?
8. Ingaba akhona amadoda apha ekuhlaleni azibandakanyayo kwizinto ezimayelana nempilo kunye nemfundo yabantwana babo? Yintoni eyenza ukuba bohkuke kwamanye amadoda? Luthini uluvo lwakho kulomba?
9. Ingaba ootata babaxhasa kanjani abantwana babo abangamakhwenkwe ukuqinisekisa ukuba banempilo nemfudo engcono? Le nkxaso ingaba iyohluka kubantwana abangamakhwenkwe kwabangamantombazana
   Probe: Yohluka kanjani? Cacisa.
10. Oluhlelo lwe MenCare+ lungabanceda kanjani abanye abantu ekuhlaleni?
11. Yeyiphi inkxaso eniyidingayo njengamadoda, lwazi luni enisaludingayo?
12. Ingaba ungabamema oogxa bakho koluhlelo lweMenCare+? Cacisa.
13. Ingaba zikhona ingcebiso eninazo ekuphuculeni oluhlelo?

Sesifikele esiphelweni, siyanibulela ngobukho benu nangexesha nangegalelo lenu

Interview Guides

The following interview guides were all based on the Stakeholder Interview Guide provided by MenCare++ below. Questions were added or changed depending on the target group.

1. May you please tell us about the work that you do?
2. Have you heard about the project called MenCare+?

   Probe: What role do you think MenCare+ has played in your facility?
3. What value do you think MenCare+ brings to your work or clinic environment?

   Probe: have you observed any response towards MenCare+ from community members?
4. Do you allow partners to be part of the pre- and post-natal visits? Please share examples.

   Probe: Do you allow fathers to join their partners during labour?

   Probe: What has been your experience in dealing with fathers during the delivery process?
5. How does your clinic respond to fathers or male guardians, who are bringing children to the clinic?
6. Are there any issues that you have observed, which are affecting children in your community for an example maternal issues?

   Probe: How did you learn about these issues?

   Probe: How are you currently monitoring the issues?

   Probe: How are you addressing them?

   Probe: How are men and fathers involved in addressing issues affecting children?
7. What is your opinion of the role 1) mothers and 2) fathers play in children's health and education?

   Probe: Are there any economic or social barriers which prohibit men's involvement in children's life?

   Probe: how are those traditional gender norms around manhood affecting men's involvement?

   Probe: Have you ever engaged in efforts to create a more inclusive environment for fathers or men? If so, what were they?

   Probe: What is your personal opinion around engaging men as fathers and caregivers in supporting mothers and children?

8. What major actions have you taken to strengthen youth participation in child rights/fatherhood? What challenges did you face?
9. Do you have anything to add in relation to the discussion which I didn't ask you?
10. Would you recommend MenCare+ to your colleagues and why?
11. Any suggestions that can help to improve the project?

Thank you for your time and for the fruitful discussion.

Interview Guide: Social Workers

1. What is your role in the facility/ work you do?
2. What was the impact of the seminar you attended "Strengthening families: building capacity to engage men as caring and respectful fathers"?
3. What is your role in MenCare+?
4. What is the impact of MenCare+ programme?
5. What were some of the challenges you experienced in involving men and fathers in maternal and child care?
6. Do you have any recommendations?

Interview Guide: Healthcare Workers

1. What is your role in the facility?
2. What is the value of MenCare+ in your facility?
3. What impact has the MenCare+ programme had on the community?
4. Do you allow partners to be part of the pre and post-natal visits?
5. What impact has the MenCare+ programme had on traditional gender norms?
6. What impact has the MenCare+ programme had on the involvement of fathers during labour?

Interview Guide: Teachers

1. What is your role in MenCare+
2. What impact has the MenCare+ programme had on your school/ the learners involved?
3. Do you have any recommendations?

Interview Guide: Media

1. What is MenCare+?
2. What was your role?
3. Did you receive any responses from listeners after the MenCare+ broadcast?
4. What impact did MenCare+ have on the listeners or the community?
5. Do you think the programme needs to be improved?
6. Anything else you would like to add?

Interview Guide: Programme Staff

1. What is your role in the MenCare+ programme?
2. What value do you think the MenCare+ programme has added to the community?
3. What impact has the MenCare+ programme had on the beneficiaries?
4. Could you share success stories with us related to the MenCare+ programme?
5. Are there any challenges that you have come across during the MenCare+ programme?
6. Is there anything you would like to share or recommend for the MenCare+ programme?

APPENDIX C: NEWSPAPER ARTICLES

<table>
<tr><th colspan="4">Fatherhood</th></tr>
<tr><td></td><td>Newspaper</td><td>Author</td><td>Title</td></tr>
<tr><td rowspan="4">2013</td><td>Mail & Guardian</td><td>Mbuyiselo Botha</td><td>Fatherhood’s a struggle for the fatherless</td></tr>
<tr><td colspan="3">Fathers who have grown up without fathers of their own often do not have the opportunity to be appreciated, acknowledged and affirmed. The author emphasised how this made him aim to give his children that which he wasn’t given. However he also notes that much of the things he has done when it comes to his children was through trial and error because he did not have a point of reference to turn to.
Through his relationship with a father figure he has learnt that a father can be compassionate or cry in front of his children.
He acknowledges that there are many ways to be a father, whether one is able to provide financially or not.</td></tr>
<tr><td>Sunday Independent Dispatches</td><td>Hayley Thompson-de-Boor & Eddy Mavungu</td><td>Bringing the value of absent fathers home</td></tr>
<tr><td colspan="3">Findings of a study conducted by The Centre for Social Development in South Africa in partnership with Sonke Gender Justice highlighted the challenges men face in ensuring they stay connected with their children (“So we are ATM fathers?”).
Data from the National Income Dynamics Survey:
- 57% of fathers were not living with their children
- More than half of the fathers not living with their children had a low level of involvement with them
- 70% of fathers who saw their children either daily or several times a week contributed financially to their wellbeing.
From the in depth focus group discussions with absent fathers:
- When asked what it means to be a father, almost all participants responded that the father was the provider (financially). Being unable to provide seemingly left them with no other way of being a father.
- The participants were of the view that caregiving should be performed by women. However there was some disagreement about this with some participants stating that there is nothing stopping them from caregiving.
- Failure to pay Lobola and/or damages was often cited as the reason why they had been barred from their children.
- A key theme was their conflict-ridden relationships with the mothers of their children.
- The participants suggested that they should be allowed in the delivery room and that the harmful effects of certain cultural practices be addressed.
The authors conclude by recommending that more gender equitable attitudes and practices should be embraced in relationships, along with open and honest</td></tr>
</table>

	communication. Encouraging men to become loving and involved fathers will allow men to find a part of themselves that many have been told to hide.		
	Sunday Independent	Bailey, C.	The consequences of the absent father
	"So we are ATM fathers?" Only 4/10 black children under 15 live with their fathers. Of the remaining 6/10, 3 do not have regular contact with their fathers and 3 have absolutely no contact with their fathers. This can be because the fathers are unable to provide for them, are barred from seeing them, have a difficult relationship with the mother, the father is unable to pay damages, the mother is involved in a new relationship, or as a result of the pressure of not being able to provide fathers shy away from their children.		
2014	Destiny Man	Tshemese, M	In the name of the father
	The MenCare+ Global fatherhood campaign focuses on the three pillars of how fathers should be involved in their children's lives beyond the provision of financial support: - Presence - Partner Support - Preventing Violence When speaking of violence in apartheid SA, Hussein Abdilahi Bulhan said, "violence is any relation, process or condition by which an individual or group violates the physical, social and/or psychological integrity of another person or group. From this perspective, violence inhibits human growth, negates inherent potential and limits productive living." Bulhan's framing of violence is useful in understanding how relationships within families may have been affected by the apartheid system and how much impact that still has today.		
	Tygerburger – Ravensmead	No author	Men helped to care
	Tygerburger-Elsies Rivier	No author	Men urged to be positive role models for children
	Tygerburger-Elsies Rivier/ Bluedowns	No Author	Project gets men involved in family life
	The MenCare++ project is being run under the auspices of the directorate's vulnerable group's programme and focuses on education and awareness of gender-based violence in communities, as well as engaging men about fatherhood. The city formed a partnership with Mosaic and Sonke Gender Justice in July (2014). They facilitated three community based awareness raising events, designed specifically for men: - The first event in Rylands attracted more than 150 participants from Delft, Lavender Hill, Manenberg and Mitchell's Plain. Men participating in the MenCare+ project are referred via counsellors at NGOs facilitating the sessions and a follow up programme is in place to monitor the progress		

	of clients. In addition to improving gender and family relations, the project also tackles issues like HIV/AIDS.		
	Southern Mail	Oduwole, T. (Volunteer facilitator, MenCare+ Heathfield)	Father is a mirror
	"Father is a mirror" is an African adage that means we understand ourselves through our father – the father has a vital role to play in his child's life. Children with positively involved fathers have a higher chance of performing better at school and are less likely to engage in anti-social behaviour. Being a father is much more than being a financial provider, being present is important for building a positive relationship between child and father. South Africa has a high rate of absent fathers. Among the social factors that contribute to father's absenteeism are migrant labour, inability to pay maintenance, and gender based violence. Additionally the social expectations ascribed a status of ultimate providers and breadwinners on fathers. If they cannot meet these expectations they are sometimes denied access to their children		
	Your Baby	Bertelsmann, M	From good boys to better men: how we raise our boys helps them develop security in their masculinity, which our ultraviolent society desperately needs
	"Masculinity is inherently insecure, "asserts Thomas Burkhalter, a psychologist with a keen interest in masculinity research. Thomas says mothers hold a lot of power and if the process of separating from them is problematic, boys might grow up to be misogynistic, or rigidly self-reliant and angry. If a mother struggles to let her son go, a result in an adult man could be a manipulative man who expects his whim to be indulged. If a father is present - the separation from the mother can be less traumatic because the boy has a role model to emulate. If the mother is disdainful or angry with the father, a boy may internalise this feeling resulting in internal conflict. His advice to fathers of boys is to be conscious of what masculinity you are showing to your son.		
	Sowetan	Mohana, M	Fathers can give care just as much as mothers
	Studies have shown that men are primed for caregiving just as much as women. The hormones that get released when a woman breastfeeds (oxytocin and prolactin) are the same hormones released when men play with their children. Wessel van den Berg, child rights and positive parenting portfolio manager at Sonke Gender Justice, explains that men are not always supported enough to take on caregiving roles, particularly when it comes to early childhood learning.		
2015	Polokwane Observer	Franken, M	Fathers and father figures have new roles to play
	Research conducted by the Human Sciences Research Council and the South African Race Relations Institute found that 60% of children in South Africa have absent fathers and more than 40% of South African mothers are single parents.		

	The modern day father comes in various forms and today's father is no longer necessarily the breadwinner and disciplinarian. He can be single or married, employed or stay-at-home, adoptive or step parent, and a capable caregiver. Wessel van den Berg explains that there is a growing call for men to take up their place in society, "a leading factor in the use of violence by adults is childhood exposure to violence as shown in several studies." He also asserts that this should not be misinterpreted as the old call to bring back the 'head of the household'.

Paternity Leave			
	Newspaper	Author	Title
2014	Mail & Guardian	Peacock, D (Sonke Director) Van den Berg, W (Sonke child rights and positive parenting portfolio manager).	In the name of (all) the fathers
	A survey in 2013 by Statistics SA tells us that, on average, women spend three hours and 15 minutes a day on household activities whereas men only spend one hour and 28 minutes on the same activities. Women spend nearly eight times more of their time caring for the sick at home than men do. Research by Sonke Gender Justice in 2010 showed that there are woefully few maintenance officers and not nearly enough capacity in the maintenance courts to compel fathers to pay up. Women get four months maternity leave, while men get three days of 'family responsibility leave'. Paternity leave needs to be implemented alongside a strong focus on holding fathers more accountable for child support. When fathers connect with their children, they are more disposed to provide child support later on. When separated fathers contribute financially, they are more likely to remain involved in the child's life.		
	Cape Times	Jackman, R	White paper urges paternity leave for fathers
	The Mercury		Formal paternity leave up for discussion by govt
	The Star		White paper looks into paternity leave
	Pretoria News		Paternity leave likely to become part of Act
	A white paper on families, put together by the Department of Social Development with input from Sonke Gender Justice in 2013, recommends that paternity leave should be added to the Basic Conditions of Employment Act. The rights group has expressed its support for Henri Terblanche's petition for the law to be changed to grant fathers 10 days paternity leave. The white paper on families has been signed by the cabinet and in 2014 was understood to be up for discussion soon.		
	Business Brief	Arnold, F	Paternity Leave PAINS?
	The Mercury	Staff writer	Law may be introduced to grant paternity leave
	The Times- Career Times	Staff Writer	Father appeals for law to grant paternity leave

<table>
<tr><td rowspan="5"></td><td>Cape Argus</td><td>Van den Berg,W.</td><td>Paternity leave will give dads a chance to bond too</td></tr>
<tr><td>Rapport Sake 24</td><td>No author</td><td>Pa wil ook by nuwe baba wees ("Dad also wants to be with new baby")</td></tr>
<tr><td colspan="3">The law as it stands does not permit fathers to take paternity leave when their children are born. Henri Terblanche has petitioned the National Council of Provinces to amend the current law to grant fathers 10 days paternity leave.
Fathers may take 'family responsibility leave' according to the Basic Conditions of Employment Act, but it is limited to 3 days.
The non-profit organisation Sonke Gender Justice has come out in full support of amending the law.
Numerous African countries have already acknowledged the significant role of fathers in the early stages of childhood by offering paternity leave. Ghana, Kenya (up to 14 days) and Cameroon provide paternity leave.
Three years ago (2011) the University of Cape Town set the precedent for paternity leave when it granted its employee paternity leave in order to bond with his adoptive daughter. A white paper has been drafted by the Department of Social Development and has been signed by Cabinet.</td></tr>
<tr><td>Sowetan</td><td>Sidimba, L</td><td>10-day paternity leave a step closer</td></tr>
<tr><td colspan="3">The National Council of Provinces was scheduled to meet in November 2014 to discuss the 10-day paternity leave petition and other relevant issues.
Parliament also admits that South Africa pales in comparison to other countries such as Australia and Sweden who offer between 19 and 480 days of paternity leave.</td></tr>
<tr><td rowspan="2">2015</td><td>Mail & Guardian</td><td>Sosibo, K</td><td>One man fights for all fathers</td></tr>
<tr><td colspan="3">On May 22nd 2015 Henri Terblanche, frustrated by the silence of Parliament's selection committee, wrote to President Zuma and Deputy President Ramaphosa. On Father's day (21 June 2015) the MenCare+ Global Fatherhood Campaign will launch its position on paternity leave and get inputs from women's rights groups, to help obtain misgivings around how men might misuse their paternity leave.
Van den Burg says that they have proposed a 1000-100-10 model, which advocates that in the child's first 1000 days, parents must take at least 100 days leave per parent, 10 of those being non-transferable paternity leave at birth.
Male employees at Sonke are entitled to a month's paternity leave.</td></tr>
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<table>
<tr><th colspan="4">Violence and Corporal Punishment</th></tr>
<tr><td></td><td>Weekend Argus-Saturday Edition</td><td>Bower, C
Van den Berg, W (Sonke Gender Justice)</td><td>Banning corporal punishment will create a less violent society</td></tr>
<tr><td>2014</td><td colspan="3">In May 2014 the fourth amendment to the Children's Act commenced its journey through parliament.
It contains a clause prohibiting corporal punishment in the home. Thirty-seven countries have banned corporal punishment including Sweden, the Netherlands, New Zealand, and five African countries.
There are many reasons to prohibit corporal punishment: children are smaller and emotionally more vulnerable than adults and should at least be afforded the same protection as adults.
Beating children violates their right to physical integrity and freedom from fear, humiliation and degradation.</td></tr>
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	Five studies done since 1997 provide evidence that: - On average, the behaviour of the children of parents who spanked them got worse. - There was a strong association between corporal punishment and children's aggressive and anti-social behaviour. - In a landmark study, Elizabeth Gershoff found that parental corporal punishment was associated with: • Less self-discipline • Increased aggression • Increased delinquency and anti-social behaviour • A poorer relationship between parent and child • Decreased mental health • A higher risk of the child being physically abused • Increased adult criminal behaviour • Higher risk of becoming an abusive parent or partner.		
	Stellenbosch Gazette	No author	Tips for parenting in child protection month
	Mthatha Express	Reporter	Stand up and protect children
	Die Burger	Nienaber, M	Ouers gevra om lyfstraf vir maand te los ("Parents asked to not use physical punishment for a month")
	Die Burger	Nienaber, M	Bêre die roede n maand en vermy ook ligteklappie ("put away the rod for a month and avoid light smacks also")
2015	You	Sokopo, A	Before you spank: spare the rod, spoil the child – but there are better ways to discipline, experts say.
	Sowetan	Botha, M	Sparing the rod will not spoil the child
	Physical punishment of children is contrary to our own constitution as well as to several international treaties. Quality research in Africa shows that there are much better ways to discipline children that do not depend on physical punishment or spanking. The starting point for positive disciplines is for parents to think about the long-term goals for children, rather than short term ones. Using positive discipline is a smart way to prevent violence in the long term, as children grow up learning that problems are not solved through violence, but through thinking and negotiating. Sonke Gender Justice called all parents and caregivers during a week in June (child protection week) to avoid spanking their children and to then decide on the best method of managing their child's behaviour.		

Absent Fathers and 'ATM' dads			
2013	The Star	Grange, H	South Africa is a nation of deadbeat dads and the fallout hurts us all
	Cosmopolitan	Magwaza, K Twiggs, L	Is your baby daddy a baddy?
	The Times	Narsee, A	Grief of ATM fathers

<table>
<tr><td></td><td>Herald</td><td>Narsee, A</td><td>ATM dads blamed for dysfunctional kids</td></tr>
<tr><td rowspan="2">2015</td><td>The Independent on Saturday</td><td>Sanpath, A</td><td>Deadbeat dads making kids sad</td></tr>
<tr><td colspan="3">The absence of a father in a child's life, physical or emotional, can profoundly disadvantage the child in adulthood, and they also tend to be more vulnerable to many societal problems, including alcohol and drug abuse, promiscuity, teenage pregnancy, crime and violence.
Reasons for father absence include:
- Not having the ability to provide financially for the child
- Not having parenting skills due to the lack of father role models
- Women's empowerment which challenges the notion of men as heads of families
- Negative experiences of fatherhood
- A social attitude that men are not responsible for their dependents.
- Separation or divorce – and the mother won't allow the father access
Boys who grow up without a father tend to show 'hyper masculine' behaviours, including aggression. Girls who grow up without a father are more likely to have low self-esteem, engage in risky sexual behaviour and have difficulties forming and maintaining relationships.
The programmes and campaigns that tackle this issue look largely at popular notions of masculinity and the socialisation of boys and young men, as these issues are perceived to underlie not only the absent father phenomenon, but a number of other critical problems facing the country, including the spread of HIV/AIDS, violence and high incidence of rape.
Wessel van den Berg (Sonke Gender Justice) says that MenCare+ has found that if fathers learn that children need other things besides money, such as communication and emotional support, they remain involved more easily.
Reference to "So we are ATM fathers" (see Fatherhood section above)</td></tr>
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<table>
<tr><th colspan="4">Defaulting Maintenance</th></tr>
<tr><td rowspan="4">2015</td><td>Business Day</td><td>Narsee, A</td><td>Organisations oppose jail sentence for defaulting dads</td></tr>
<tr><td>The Times</td><td>Narsee, A</td><td>Don't jail Papgeld dads</td></tr>
<tr><td>Sowetan</td><td>Narsee, A</td><td>Jail for Papgeld dads not ideal</td></tr>
<tr><td colspan="3">Harsh prison sentences for fathers who default on maintenance will do more harm than good. Wessel van den Burg said that harsh penalties 'will have devastating effects' on those fathers who did not have the financial means to pay maintenance. Fathers would be unable to provide day-to-day support to their children. Instead of prison time other suggestions include withholding passports, visas, or driving licenses.</td></tr>
</table>

Appendix D: Extended Outcome Measurement Report

Please see the 'Extended Outcome Report' requested by Sonke Gender Justice and Mosaic in a separate document.