




Men's motivations, barriers to and aspirations for their families' health in the first 1000 days in sub-Saharan Africa: a secondary qualitative analysis

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ABSTRACT

Introduction The first 1000 days of life are a critical period of growth and development that have lasting implications for health, cognitive, educational and economic outcomes. In sub-Saharan Africa, gender and social norms are such that many men have little engagement with maternal and child health and nutrition during pregnancy and early childhood. This study explores how men perceive their role in three sites in sub-Saharan Africa.

Methods Secondary qualitative analysis of 10 focus group discussions with 76 men in Burkina Faso, Ghana and South Africa. Data were thematically analysed to explore men's perceptions of maternal and child health and nutrition.

Results Men considered themselves 'providers' and 'advisors' within their families, particularly of finances, food and medicines. They also indicated that this advice was out of care and concern for their families' health. There were similarities in how the men perceive their role. Differences between men living in rural and urban settings included health priorities, the advice and the manner in which it was provided. Across all settings, men wanted to be more involved with maternal and child health and nutrition. Challenges to doing so included stigma and proscribed social gender roles.

Conclusion Men want a greater engagement in improving maternal and child health and nutrition but felt that their ability to do so was limited by culture-specified gender roles, which are more focused on providing for and advising their families. Involving both men and women in intervention development alongside policymakers, health professionals and researchers is needed to improve maternal and child health and nutrition.

INTRODUCTION

The 2015 Sustainable Development Goal 5 (SDG5) to 'achieve gender equality and empower all women and girls' provides the global health community an opportunity

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Achieving gender equality is important to maternal and child health.

WHAT THIS STUDY ADDS

⇒ Men considered themselves 'providers' and 'advisors' within their families, potentially because society expects it, yet stigma prevents this.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Involving men in the development of maternal and child health support would be important in dismantling gender role norms.

to promote human rights, advance gender equality and achieve health for all.¹ Gender inequality and restrictive gender norms are powerful but separate determinants of health and well-being.² Achieving gender equality is particularly important in the context of maternal and child health and nutrition. We know that if women have independent access to resources, they and their children have better health and nutrition outcomes.³ This kind of access is unusual in countries in sub-Saharan Africa, where men are often the gatekeeper to resources. In addition, gender norms are currently such that many men across the globe have little engagement with antenatal and postnatal healthcare.^{2 4-7} Men's involvement during pregnancy and early childhood has been found to improve long-lasting health and developmental outcomes for both mother and child, including decreased prevalence of postnatal depression and improvements in height

and neurodevelopment of medically at risk infants.^{8–10} Potential mechanisms underlying the effectiveness of this involvement include improved couple communication and decision-making and increased male support of domestic practices.¹¹ These impact maternal and child health and nutrition outcomes via improvements in care-seeking health behaviours and attendance at healthcare facilities.

Gender norms are unspoken rules that shape what are considered appropriate and acceptable attributes and behaviours for men and women.² Patriarchal societies favour masculinity over femininity, leading to power and privilege favouring men and maintaining systemic gender inequality.^{2 4–7} Historically women, particularly poor women, are most affected by health-related consequences of gender inequality.^{2 6} There is, however, a new movement of men who support gender equality and highlight the impact of restrictive gender norms on their health and well-being.²

The 2019 Lancet series on gender equality highlights the paucity of qualitative research on gender norms over time and the links to health.^{4 6} One qualitative study found that many husbands in Ethiopia consider child rearing to be the mothers' responsibility.¹² Gender inequalities have been identified in our previous qualitative work exploring maternal and child nutrition in Burkina Faso, Ghana and South Africa.^{13–17} Women perceived men as absent from family life.¹⁶ Challenges were felt to be generated by socially and culturally determined gender roles, such as unequal food allocation.^{13–15} These findings reflect the women's perspective, with limited focus on the experiences of men and the challenges they face. We undertook a further analysis of only the men's focus group discussions (FGDs). This paper aims to provide an insight into men's motivations, barriers to and aspirations for their families' health in the first 1000 days through a secondary qualitative analysis of FGD data with men living in these communities, exploring how they perceive their roles within maternal and child health and nutrition.

The research question for this analysis was to understand how do men perceive their role in supporting their partner and children with health and nutrition in three sites in SSA?

METHODS

Settings

FGDs were conducted in Burkina Faso, Ghana and South Africa, selected to include rural and urban perspectives and countries at different stages of economic and nutritional transition. Rural participants were from Nanoro, Burkina Faso (from the Mossi ethnic group)¹⁸ and Navrongo, Ghana (with two ethno-linguistic groups Kasena and Nankani Navrongo).¹⁹ Urban participants from the urban township Soweto live in formal and informal settlements separated spatially from the economic hub of Johannesburg South Africa.²⁰ Data collection took place between January and March 2019.

These projects were conducted as part of the Improved Nutrition Preconception Pregnancy Post-Delivery study aimed at improving maternal and child nutrition in SSA through community engagement.²¹

Participants and recruitment

Purposive sampling techniques were used to recruit men age ≥ 18 years in the communities, described elsewhere.^{13–15} Sample size was guided by the principle of 'information power', an alternative to data saturation which emphasises the quality of information within the sample.²²

Data collection

FGDs were facilitated by men and women who were experienced local qualitative researchers in multiple languages (Moore in Nanoro; Kasem and Nankani in Navrongo; Xhosa, Zulu and English in Soweto) in community venues. Standardised semi-structured FGD guides were designed and adapted to explore health and nutrition issues for mothers and children (online supplemental appendix A). FGDs were audio-recorded and written or indicated consent was taken from all participants, including those with lower levels of literacy, who indicated consent with a thumbprint.

Secondary data analysis

Audio-recordings were transcribed from local languages to English by local research teams. The Burkina Faso research team transcribed to French and then English. Secondary data analysis was conducted on 10 FGDs; those that included only men from the communities in Nanoro (n=3), Navrongo (n=4) and Soweto (n=3) were selected (=76 men in total). Transcripts were inductively coded by two independent researchers using NVivo software V.12. Initial codes were generated, thematically analysed and themes were discussed in depth with the local research teams. Consolidated criteria for Reporting Qualitative Research guidance was used to structure reporting.²³ A reflection on how the study was conceptualised and conducted is found in online supplemental appendix B.

RESULTS

Participant characteristics are presented in [table 1](#). We identified two major themes underlying the men's experiences of, and concerns with maternal and child health and nutrition in their settings ([table 2](#)).

THEME 1. MEN AS THE ADVISOR

Men instructing women

In all sites, men reported supporting their families through instructing women on how they should improve health, nutrition and family life. Men in Soweto, focused on advising women to avoid harmful substances and unhealthy foods, and encouraged them to engage in exercise. In Nanoro and Navrongo, the discussions were



Table 1 Characteristics of participants

	Nanoro, Burkina Faso (N)	Navrongo, Ghana (N)	Soweto, South Africa (N)
Number	23	32	21
Number of FGDs	3	4	3
Marital status			
Single	3	6	14
Married	18	26	2
Divorced/widowed	0	0	3
Unknown	0	0	2
Educational status			
No education	9	9	0
Primary	5	8	15
Secondary	5	13	4
Higher than secondary	0	2	2
Other (non-formal)	4	0	0
Employment			
Employed	0	2	4
Unemployed	11	2	0
Self-employed	12†	28	14
Other	0	0	3

*Unknown (=2), caring for at least one child (n=18).
 †Self-employed/income generating activities.
 FGD, focus group discussion.

focused on how women’s hygiene practices could prevent ill health.

Also tell your wife and child that they must avoid things like alcohol, cigarettes, nyaope [street drug] and other drugs that will also impact on your life you know (FGD6_Soweto).

First, we give advice to our wives and children at home, if we see dirt in the house, we say that this should not be here, it has to be like this. If the child is playing naked, we ask the women to put clothes on him...This is how we live together, and how we manage to allow things to be well (FGD10_Nanoro).

As fathers, if there is refuse, we can ask them to clean. The mothers, when she prepares food, it is for the whole family. Wash your hands, do this....This is what

Table 2 Themes and subthemes from analysis

Theme	Subthemes
Men as the advisor	1.1 Men instructing women
	1.2 Men passing on their wisdom to children
Men as the provider	2.1 Difficulties providing support
	2.2 Men providing support to mothers
	2.3 Household well-being

I think, we can help, aside this, I don’t know what else we can do (FGD2_Navrongo).

Despite the importance placed on instructing women and children to engage in health behaviours, men felt that their advice was often not acceptable to women and that they ignored reminders about health and hygiene behaviours. Women were often considered ignorant about the consequences of their health behaviours for their children in all settings.

It is the advice as the daddy said, some women don’t take good care of children, they can let the child in the ground in the market, and the child is playing on the ground while it can make him sick (FGD9_Nanoro).

When we go to the health facilities, they tell the women to eat fruits, they don’t take this advice...That is one problem about the women, so after she has delivered, the child...how the baby is supposed to be, is it not like that. When they give her medicine, when she gets home, she won’t take them (FGD2_Navrongo).

Throughout the discussions, participants reported ways that they felt women’s health behaviour in relation to good nutrition and hygiene was not optimal. Some men considered women to be forgetful. They, therefore, felt it to be their responsibility to monitor women and remind them to engage in health behaviours:

It’s also our job just to remind them, you see, keep a watchful eye, because we also tend to ignore pregnant women and assume that she already knows what to do, so when you are able to as the father you need to remind her if she’s taken her medication, or this and that (FGD7, Soweto, South Africa).

I think that everything that they [pregnant women] eat, they need to reduce you know, perhaps when she’s used to drinking fizzy drinks, a 2 litre of that... She must stop (FGD7_Soweto).

Men passing on their health-related wisdom to children

Men in Soweto and Navrongo felt it was their role to pass their wisdom onto their children. This was not mentioned directly by men from Nanoro. A man in Navrongo spoke of advising his child on hygiene measures, which reduced the chances of catching disease:

After visiting the toilet or urinating you can wash your hands, tell the children to wash their hands to prevent fallen sick and to be healthy. In the future, when you are not there, and it is left with only the children they will remember that their father said that, after visiting the toilet or urinating we should wash our hands, because there are diseases. They too can teach the next generation, in that regard, we have kept our eyes on the ground and have seen that it is good to teach our children (FGD1_Navrongo).

You need to teach kids when they’re still young as well as exercise, that’s something that you need to

keep doing. Like walking with your child, all the time teaching him (FGD6_Soweto).

THEME 2. MEN AS THE PROVIDER

Men in all settings felt that their key role in the community was as a provider for their families. Men considered themselves responsible for financially supporting their families' health and nutrition. They were more motivated to support pregnant women and when they had their children, reflecting a perception of children as a priority (subtheme 1.2). Men across all settings felt responsible for keeping their family happy and supporting their well-being.

Difficulties providing support

Men across all settings provided food and medicine for their family but described difficulties due to poor access to healthcare and nutritious food and economic constraints. Men in Navrongo and Nanoro, spoke of providing food by farming and trading, but this was challenging due to limited agricultural output and trade opportunities. They discussed prioritising buying either food or medicine.

We are going to buy the liver. It does not cost as much as if she is not in good health and you will bring her for consultation and pay for drugs. You can have the liver at 500 CFA (0.93\$) but you cannot spend less than 2000 CFA (3.71\$) to pay for the drugs (FGD10_Nanoro).

The men emphasised the importance of providing financially for the health, safety and futures of their children, but some risks were taken. Some men in Soweto spoke about selling drugs to provide for their families.

Okay fine, to reduce actually this problem, I for one that's why I'm saying I'm selling dagga [...] I sell it and that's how we get money in this house, you understand, because these kids' mothers are all gone they left me with these kids because of this disease that's prevalent, HIV and AIDS (FGD5_Soweto).

They also acknowledged that some do not take responsibility in supporting their families by providing essential needs. One man from Navrongo expressed that these types of men were often selfish about money and forgot that they have a family to provide for when they receive the money:

Most men as soon as they get the money, money, they forget that they have women let alone say children (FGD3_Navrongo).

Men providing support to mothers

Across all sites, women were considered the primary caregivers. However, men in Soweto and Navrongo felt a greater responsibility to provide for their families when women became pregnant and for their child:

It is the duty of the husband to ensure that these foods they have mentioned she gets such food to eat. Sometimes a husband in a month they don't buy ingredients they don't buy anything, and we don't buy anything in respects to ingredients so when the woman becomes pregnant you now have to buy the ingredients (FGD4_Navrongo).

As fathers we must play the role of always being with our children and partners when they are going to visit the clinic (FGD5_Soweto).

In contrast, men in Nanoro did not express the desire to be involved in childcare in the same way

It is especially women that come in the sensitization discussion, men have their own business, it is an issue it is true, but it is women that take care of children, and they are responsible for the children than men (FGD9_Nanoro).

Stigma surrounding men's involvement in family life was a reoccurring topic in Navrongo and Soweto. This seemed to have a negative influence on the level of support that men felt they should provide:

When you see a man carrying a child to the clinic, or when you enter a home and see a man giving medicine to a sick child, when the woman is not at home or she is present and you the man is rather giving medicine to the sick child, when your friend comes to see this, oohh. This man, his wife has control over him, the wife doesn't have time for her children, it is the husband who has time for the children. Because of this reason, these little, little things are the things that make us the men to feel... The little things we are supposed to do, we withdraw, we don't support the women (FGD1_Navrongo).

Sometimes you want to go into the store and buy pads, and you're ashamed as a man, as a father, you don't know these things and you don't know what people will say when they see you buying pads, these are the things that we need to be exposed to, because what kind of father will I be if I don't know these things ... sometimes your partner sends you to the shops to buy all these things, milk, pads, and all that but you're dealing with your shame; there comes a time when we need to know feminine things you know, then we can be better father (FGD7_Soweto).

In Nanoro, stigma was not mentioned explicitly, but it was clear that the men's social roles were separate from women's:

R1: Otherwise maternity ward is not important for us (Laughs) ...

R2: Men don't know the maternity ward building, except those who take their wife to the maternity ward, some men have been asking what is this building for? (FGD8_Nanoro)

Household well-being

In all settings, men spoke about the importance of well-being and happiness within the family and how this contributes to overall health. Happiness and well-being were a universal priority across the different communities.

What we do to help is, when we wake up, and there is no work, we sit our wives and children together to converse. Your children and your wife, when you wake up, you all sit together to converse; I know after this, everyone goes out with a peaceful heart. So, I know that a peaceful heart is good health (FGD2_Navrongo).

To keep women happy with little, you can take a woman and take them to the park, or take your child and take them to the park, whatever you have in your pocket and give them that'll make them happy; money doesn't make women happy, it's not just about the money, everything that you have, in you, even from your heart, you understand, as long as you give it to her, keep her safe, give her, her own space, that's how they stay happy (FGD6_Soweto).

DISCUSSION

Overall main findings

This secondary qualitative analysis indicated that many of the men in our FGDs considered themselves as 'advisors' to and 'providers' for both women and children on health, nutrition and family life. In urban Soweto, priorities included the obesogenic food environment of unhealthy food and lack of physical activity, whereas in rural Navrongo and Nanoro, priorities included food insecurity and lack of access to medical care. The men felt that they needed to instruct women out of care and concern for their families' health as if they did not, women would not adhere to optimal health behaviour. Women were often described as forgetful, careless or unaware. The men in Soweto and Navrongo considered their role as passing on their wisdom to their children. Men in all settings felt responsible for providing well-being support. Although several reported a desire to support women with the domestic part of family life, there was a stigma attached to doing so.

Barriers to men's participation

Our previous qualitative work with women in these same communities showed that they perceived men to be absent and not to take responsibility for domestic family life.^{13–16 24} In contrast to these findings where men highlighted the importance of their role as both providers and advisers to their families, women expressed frustration that men 'controlled' them and that they preferred more autonomy and independence.^{13–16 24} Women felt that this could be achieved through opportunities to start their own businesses by making a greater financial contribution to their families' lives. These women's experiences align with the notion of 'good' and 'bad' fathers described by men in South Africa.²⁵ The men themselves considered 'bad'

fathers to be those who impacted their family in negative ways such as being absent.²⁵ To address the disparities in perceived gender roles in family life, previous studies have indicated that future interventions could focus on improving communication between partners to identify, together, what issues need to be addressed as well as mutually beneficial solutions in improving maternal and child health and nutrition.²⁶ A review of 28 qualitative and quantitative studies in SSA found additional barriers to men's involvement in maternal and child health linked to their perceived lack of time, money and had too many work commitments to be involved in family life.²⁷ In South Africa, high levels of unemployment impact their perceived masculinity and, therefore, the way they perceive their roles as father.²⁸ Men also perceived health professionals as unfriendly, felt that their community and family disapproved of their role in the family, and felt that the man's role in maternal and child health is unclear.

The men in this study perceived stigma to be a barrier to their involvement in maternal and child health and nutrition. These findings align with the 2019 Lancet series on Gender Equality, which advocated for a new movement of men who support gender equality, but who find themselves restricted by gender norms.^{2 4–7} This includes stigma of supporting women with domestic chores as seen in our work. Therefore, supporting men in engaging in domestic activities must first address the stigma, which is driven by gender role beliefs. Engaging men in maternal and child health and nutrition could both directly and indirectly impact women's health; women and children are those who are most affected by health-related consequences of gender inequality.^{2 6}

Strengths and limitations

This analysis involved many men from diverse settings. The original FGDs were not explicitly designed to explore men's perceptions of their roles in maternal and child health and nutrition. The FGDs with men provided opportunity to focus on men's perspective, usually neglected in maternal and child health and nutrition research. Discussion of the findings with local male researchers was key to mitigating the bias of having two female researchers from high-income countries, leading the analysis.

Implications

The 2019 Lancet series on Gender Equality calls on national governments, global health institutions, civil society organisations, academic settings and the corporate sector to actively promote gender equality to improve health.^{2 4–7} Improving maternal and child health and nutrition outcomes is more than simply involving men in healthcare, it is about changing social structures. For social structures to change, gender role beliefs need to be challenged. Future interventions could explore the possibility of men extending their role as 'advisors' to encourage and challenge each other to be actively involved in supporting women and addressing stigma associated with gender role beliefs. Other studies in SSA have explored the possibility of implementing couples counselling to improve communication.²⁶ Improved communication

could address and challenge beliefs about roles. The growing men's social movement on gender inequality calls for changes in beliefs about gender roles and in the division of labour, in the expectation that these will in turn change social structures.^{2 4-7} Future research should explore the perspectives of men and women, together and separately, in other settings, in order to establish ways in which gender role beliefs influence maternal and child health and nutrition outcomes and how these might be challenged.

CONCLUSIONS

Men in this study were motivated to improve maternal and child health and nutrition, yet their perceptions of the culturally determined gender roles impeded their engagement. This suggests that by challenging gender roles and gender health inequalities, we may be able to improve maternal and child health and nutrition outcomes in SSA. Future research could address our understanding of the challenges faced by men and what women want in terms of support. The most effective method of gaining this understanding is to ask men and women raising families and then to involve them in designing interventions to improve their communications and in developing community mobilisation programmes to identify both issues and solutions.

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Contributors AC, SC, MD, AE carried out data collection. DW, PHJ designed and analysed the secondary qualitative analysis (coding and development of initial themes), and RB, AC, SC, AE, GM supported the development of initial themes. All authors contributed to drafting and editing the article and approved the final manuscript. DW and PHJ are the guarantors of the paper and accept full responsibility.

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REFERENCES

- 1 United Nations. Goal 5: achieve gender equality and empower all women and girls, 2021. Available: <https://www.un.org/sustainabledevelopment/gender-equality/>. Access [Accessed 21 Dec 2021].
- 2 Heise L, Greene ME, Opper N, *et al*. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet* 2019;393:2440–54.
- 3 Briaux J, Martin-Prevel Y, Carles S, *et al*. Evaluation of an unconditional cash transfer program targeting children's first-1,000-days linear growth in rural Togo: a cluster-randomized controlled trial. *PLoS Med* 2020;17:e1003388.
- 4 Weber AM, Cislighi B, Meausoone V, *et al*. Gender norms and health: insights from global survey data. *Lancet* 2019;393:2455–68.
- 5 Heymann J, Levy JK, Bose B, *et al*. Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. *Lancet* 2019;393:2522–34.
- 6 Gupta GR, Oommen N, Grown C, *et al*. Gender equality and gender norms: framing the opportunities for health. *Lancet* 2019;393:2550–62.
- 7 Hay K, McDougal L, Percival V, *et al*. Disrupting gender norms in health systems: making the case for change. *Lancet* 2019;393:2535–49.
- 8 Jackson DB. The interplay between early father involvement and neonatal medical risk in the prediction of infant neurodevelopment. *Prev Sci* 2017;18:106–15.
- 9 McKee CL, Stapleton PB, Pidgeon AM. History of pre and perinatal (PPN) parenting education a literature review. *J Prenat Perinat Psychol Health* 2018;32:191–219.
- 10 Drysdale RE, Slemming W, Makusha T, *et al*. Father involvement, maternal depression and child nutritional outcomes in Soweto, South Africa. *Matern Child Nutr* 2021;17 Suppl 1:e13177.
- 11 Tokhi M, Comrie-Thomson L, Davis J, *et al*. Involving men to improve maternal and newborn health: a systematic review of the effectiveness of interventions. *PLoS One* 2018;13:e0191620.
- 12 Teklesilasie W, Deressa W. Barriers to husbands' involvement in maternal health care in Sidama zone, southern Ethiopia: a qualitative study. *BMC Pregnancy Childbirth* 2020;20:1–8.
- 13 Compaoré A, Ouedraogo K, Boua PR, *et al*. 'Men are not playing their roles', maternal and child nutrition in Nanoro, Burkina Faso. *Public Health Nutr* 2021;24:3780–90.
- 14 Debpuur C, Nonterah EA, Chatio ST, *et al*. Supporting maternal and child nutrition: views from community members in rural Northern Ghana. *Public Health Nutr* 2021;24:3719–26.
- 15 Erzse A, Goldstein S, Norris SA, *et al*. Double-duty solutions for optimising maternal and child nutrition in urban South Africa: a qualitative study. *Public Health Nutr* 2021;24:3674–84.
- 16 Watson D, Kehoe SH, Erzse A, *et al*. Community perspectives on maternal and child health during nutrition and economic transition in sub-Saharan Africa. *Public Health Nutr* 2021;24:3710–8.
- 17 Erzse A, Goldstein S, Tugendhaft A, *et al*. The roles of men and women in maternal and child nutrition in urban South Africa: a qualitative secondary analysis. *Matern Child Nutr* 2021;17:e13161.
- 18 Derra K, Rouamba E, Kazienga A, *et al*. Profile: Nanoro health and demographic surveillance system. *Int J Epidemiol* 2012;41:1293–301.
- 19 Oduro AR, Wak G, Azongo D, *et al*. Profile of the Navrongo health and demographic surveillance system. *Int J Epidemiol* 2012;41:968–76.
- 20 Mahajan S. *Economics of South African townships: special focus on Diepsloot*. Washington, US: The World Bank, 2014.
- 21 INPreP. Improved nutrition Pre-conception, pregnancy and Post-Delivery (INPreP), 2019. Available: www.inprep.soton.ac.uk [Accessed 21 Dec 2021].
- 22 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- 23 Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19:349–57.
- 24 Dalaba MA, Nonterah EA, Chatio ST, *et al*. Culture and community perceptions on diet for maternal and child health: a qualitative study in rural Northern Ghana. *BMC Nutr* 2021;7:36.
- 25 Makusha T, Richter L, Knight L, *et al*. "The Good and the Bad?" Childhood Experiences With Fathers and Their Influence on Women's Expectations and Men's Experiences of Fathering in Rural KwaZulu-Natal, South Africa. *Fathering* 2013;11:138–58.
- 26 Willcox ML, Mubangizi V, Natukunda S, *et al*. Couples' decision-making on post-partum family planning and antenatal counselling in Uganda: a qualitative study. *PLoS One* 2021;16:e0251190.
- 27 Manjate Cuco RM, Munguambe K, Bique Osman N, *et al*. Male partners' involvement in prevention of mother-to-child HIV transmission in sub-Saharan Africa: A systematic review. *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 2015;12:87–105.
- 28 Malinga M, Ratele K. *Fatherhood among marginalised Work-Seeking men in South Africa. engaged fatherhood for men, families and gender equality*. Springer, Cham, 2022: 265–78.