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"Someone Who Is Going to Preserve Your Surname and Clan Name": A Sesotho Cultural Perspective on Male Partner Involvement in Maternal and Newborn Care in the Free State, South Africa

Ngwi N. T. Mulu * and Michelle Engelbrecht

Centre for Health Systems Research & Development, University of the Free State, Bloemfontein 9301, South Africa; engelmc@ufs.ac.za
* Correspondence: 2022049064@ufs4life.ac.za

Abstract: In the global public health discourse, involving men in maternal and neonatal health is regarded as crucial for positive outcomes in both health and development. In South Africa, health interventions designed to promote male partner involvement among low-income indigenous populations have been framed within social constructivist notions of masculinities and have produced mixed outcomes. This has necessitated calls to explore alternative approaches, including the need to decolonise men and masculinities studies in Africa. As part of one phase of formative research for a mixed-method project aimed at adapting a male involvement intervention for the context of Sesotho-speaking men and women in the Free State, we applied a multi-site case study research design and collected qualitative data using focus group discussions and key informant interviews. Verbatim-recorded transcripts were translated, transcribed, and thematically analysed with NVIVO 14. The results indicate that customary practices in pregnancy, delivery, and newborn care are not static and vary between families based on belief systems, socioeconomic status, geographical setting (peri-urban/rural), and kinship networks of care. Therefore, these practices and beliefs should be understood, affirmed, and contested within the complex African-centred material and immaterial worldviews on personhood in which they were generated, transmitted, rejected, or adopted. It is recommended that a decolonised approach to male partner involvement in this context must be cognisant of the intersections of racial and gendered power relations, contestations in beliefs and practices, the resilient effect of colonialism on indigenous gender systems, as well as contemporary global entanglements that inform North–South power relations on the best practices in maternal and newborn health in the public health sector in South Africa.

Keywords: male partner involvement; maternal and newborn health; gender inequality; South African masculinities; decolonisation; gender-transformative interventions

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1. Introduction

The adoption of the Programme of Action at the International Conference on Population and Development (ICPD) in Cairo, 1994, signalled renewed interest among global health policymakers and health researchers for advocacy towards male partner involvement (MPI) as a strategy to improve maternal health and gender equity outcomes (McLean 2020; Daniele 2021; Kraft et al. 2014). In line with the recommendations of the World Health Organization, significant progress has been made in high-income countries (HICs) towards family-centred care in maternal and newborn health (Shaw et al. 2016). Health interventions on MPI in low- and middle-income countries (LMICs) have produced mixed outcomes, with significant promise towards improving healthcare utilisation (Suandi et al. 2020), despite potential risks such as inadvertently reinforcing health inequities by privileging the needs of mothers with male partners in maternity care or causing social stigma for

men who participate in what is perceived as the 'women's domain' (Roudsari et al. 2023). Some scholars have argued that variations in outcomes exist because of differences in the conceptualisation, design, implementation, and evaluation of health interventions on masculinities in Southern Africa (Morrell et al. 2012). This indicates that there are contestations in the extant literature on the best practices with regards to the conceptualisation, design, and implementation of MPI in different socioeconomic, geographical, and political contexts. Despite the ongoing debate, gender-transformative interventions have emerged as a dominant approach in health programming because unlike gender-neutral or gender-sensitive approaches, the goal is to reshape gender relations by dismantling inequitable gender and sexual norms (Dworkin et al. 2015; Kraft et al. 2014).

Key proponents of gender-transformative interventions have argued that the theoretical approaches that underpin health programming are varied, from social norm theories that inform individual behaviour change in psychology to social constructivism that undergirds interventions within the interdisciplinary field of critical men's studies (CMS) (Dworkin and Barker 2019). To address limitations to gender-transformative health programming, an intersectional approach has been proposed as a panacea based on the argument that the underlying principles of intersecting categories, gendered power relations, reflexivity, as well as social justice are important in understanding and dismantling inequalities in health (Ghasemi et al. 2021). An intersectional analysis draws our attention to how power relations within interventions are shaped by structural drivers, as well as individual perspectives on gender norms in contemporary society, often with little or no emphasis on the historical factors that shape 'North–South' power relations in global public health discourses that are intrinsic to postcolonial theories (Kerner 2017). What these diverse theoretical perspectives on health interventions in the context of MPI in Africa have in common is the fact that they were developed in the 'Global North'. Therefore, this article departs from poststructural approaches to the study of masculinities in South Africa by adopting a decolonial perspective on men and masculinities research in South Africa (Mfecane 2018, 2020; Ratele 2013). The authors argue that there is a need to include South African conceptualisations of masculinities within gender-transformative interventions designed to promote MPI among Sesotho-speaking communities in the Free State.

Literature Review and Conceptual Framework

Evidence-based research from health interventions in Mozambique, Kenya, Zambia, and South Africa have shown that MPI can be effective at preventing the vertical transmission of HIV from mother to child (Hampanda et al. 2020; Matseke et al. 2017b; Aluisio et al. 2016; Audet et al. 2016; van den Berg et al. 2015). Also, a scoping review on reproductive health interventions in Sub-Saharan Africa found that implementation strategies for MPI comprised various stakeholders, namely, community health workers, healthcare providers, peer role models, media campaigns, as well as community and religious leaders. The focus on multiple stakeholders lays emphasis on the need for not just a relational but also an inclusive and communal understanding of African masculinities in gender-transformative programmes in South Africa (Mfecane 2020). Despite evidence of positive health outcomes from health interventions with men in diverse African settings, outcomes on gender equity have been mixed, with one study from Tanzania reporting that pregnant women were turned away from healthcare facilities because they were not accompanied by their male partners (Peneza and Maluka 2018). In the context of South Africa, interventions to promote MPI, guided by gender-transformative approaches, have also produced mixed outcomes with limitations in promoting behaviour change beyond intervention groups to the broader communities (Dworkin et al. 2015). Perhaps these limitations can partly be attributed to a neglect of indigenous knowledge within health interventions. That is, uncritical perspectives on 'traditional masculinities' often ignore the experiences of marginalised men, such as gay men, men with disabilities, and men from diverse cultural backgrounds (Ratele 2013).

Several decades since the ICPD, it is still projected that LMICs will not attain Sustainable Development Goal (SDG) 3, reducing maternal mortality to below 70 per 100,000 live births and neonatal mortality to below 12 deaths per 1000 live births by 2030 (Kurjak et al. 2023). South Africa is no exception (Damian et al. 2019; National Department of Health 2020). While the causes of maternal and newborn mortality are often attributed to clinical factors, evidence from LMICs indicates that social, economic, and cultural factors also contribute to inequities that influence how people access resources, rights, and social and health services (Kraft et al. 2014). How gender inequality and gender norms impact health and well-being has been conceptualised in detail in a series of five papers in the Lancet (Hay et al. 2019; Weber et al. 2019; Heise et al. 2019; Heymann et al. 2019; Gupta et al. 2019). Framed around the concept of gender norms as distinct from social norms, this series provides compelling evidence in support of the argument that discrimination based on gender is embedded within formal and informal laws, policies, and institutions, with negative consequences for health, particularly for women and other gender and sexual minorities. Less attention is given to the implications of gender inequalities in health for men in this series.

Although the concept of MPI in the public health literature has been defined in different ways, within biomedical healthcare systems, it often refers specifically to male partner presence during antenatal care (ANC) visits, delivery, postnatal care (PNC) visits, or targeted outreach initiatives organised by maternal healthcare providers (Daniele 2021). Critiques have argued that such a narrow definition of MPI in health programming does not only exclude diverse representations and practices of MPI that exist in African contexts but can also lead to the conflation of 'traditional masculinities' with uncritical perspectives of hegemonic masculinity within health interventions (Everitt-Penhale and Ratele 2015). The representation of context-specific cultural norms in maternal and newborn care as barriers to MPI has the potential to generate a discursive backlash against gender-transformative approaches to MPI within communities in a post-apartheid South Africa that has legitimised 'traditional leadership' within a constitutional democracy (Ratele 2013). Furthermore, results from public health research on MPI is often framed in binary terms, with an overwhelming focus on the barriers and facilitators (Ongolly and Bukachi 2019; Roudsari et al. 2023) in varied socioeconomic and geographical contexts, which often ignore the nuances that interpretivist perspectives can bring to the fore.

On the one hand, results on barriers to male involvement in LMICs have identified factors such as patriarchal gender norms that stigmatise male involvement (Muheirwe and Nuhu 2019), structural barriers at public health facilities (Maluka and Peneza 2018), lack of knowledge regarding the role of fathers in MPI (Mfuh et al. 2016), and couple conflict (Mapunda et al. 2022). On the other hand, results on the facilitators of male involvement in MNH allude to individual factors such as level of education, occupation, standard of living, and exposure to electronic media (Gouda and Khan 2018; Bishwajit et al. 2017), as well as community- and policy-level factors, which include informal bylaws by traditional and community leaders, healthcare provider strategies, and NGO initiatives to promote MPI (Mullick et al. 2005; Manda-Taylor et al. 2017; Doyle et al. 2018). While these factors are important in identifying structural constraints to MPI at multiple levels, they do not fully explain the range of meanings and belief systems that underpin MPI in different geographical and cultural settings in Africa. To transcend a binary approach to MPI, which can lead to a reduction of 'traditional masculinities' to harmful individualised masculinities, this article adopts a decolonial, Africa-centred perspective on men and masculinities to tease out deeper understandings of the multiple meanings and belief systems that underpin community perspectives on MPI in pregnancy, delivery, and newborn care among Sesotho-speaking people in the Free State.

Social Science research, which has informed health programming on masculinities in South Africa since the 1990s, has been largely framed by social constructivist conceptualisations of gender. Inspired by a global movement, this interdisciplinary field is referred to as critical men's studies. A key conceptual framework in critical men's studies is hegemonic masculinities, which has significantly influenced gender activism and academic scholarship

in post-apartheid South Africa. Pioneered by the seminal work of R.W. Connell in the 1980s and initially theorised and operationalised in Australia, the UK, and the USA, hegemonic masculinities has evolved into a dominant conceptual framework in South African masculinities studies (Morrell et al. 2012). It refers to the multiple, context-specific forms of masculinity that vary across different cultures and periods, are constantly negotiated and performed, and maintain patriarchal power among men, as well as between men and women, while creating space for resistance and change (Connell and Messerschmidt 2005). Research on hegemonic masculinities in the South African context has revealed significant links between masculinities, violence, and health, specifically in a historical context that was characterised by a transition to democracy in the 1990s from decades of colonialism and apartheid policies of racial capitalism, which had divided the political and economic landscape along racial and class lines (Hunter 2005). This theoretical perspective evolved in South Africa along with a strong emphasis on the development of health interventions that do not only address symptoms, such as perceptions of a lack of MPI in maternal and newborn health, but that also target the underlying gender norms and gendered power relations that perpetuate them.

Proponents of decolonised, Africa-centred studies on men and masculinities have highlighted the limitations of social constructivist perspectives on gender while highlighting the benefits of a decolonised, African-centred scholarship for intervention programmes that are aimed at transforming gendered relations among indigenous populations in South Africa (Mfecane 2020). This theoretical perspective challenges the universality of Western notions of masculinities, emphasising historical context and indigenous understandings of personhood while promoting an inclusive, relational, and communal understanding of masculinity, with an emphasis on how intersecting categories of race, class, sexuality, and age shape African masculinities (Mfecane 2018). Overall, this perspective privileges African experiences in pregnancy, delivery, and newborn care within a specific time and space, while highlighting diversity and complexity.

2. Materials and Methods

Qualitative data were collected using focus group discussions (FGDs), community dialogues, and key informant interviews from September to November 2022 in a metropolitan municipality in the Free State Province, South Africa, comprising the following: seven cities/towns: (1) Mangaung, (2) Botshabelo, (3) Dewetsdorp, (4) Soutpan, (5) Thaba Nchu, (6) Van Stadensrus, and (7) Wepener, clustered into four sub-districts: (1) Bloemfontein, (2) Botshabelo, (3) Thaba Nchu, and (4) Naledi. Approximately 64 men and 64 women of reproductive age (18–49 years) were recruited through purposive and snowball sampling to participate in 16 FGDs. Two FGDs with men and two FGDs with women were conducted at each of the four study sites. Participants were recruited through NGOs, churches, and men's forums. Community leaders, including traditional leaders, religious leaders, representatives of men's groups, and traditional healers, were also purposively recruited with the assistance of men's and women's forums to participate in eight community dialogues across the four sub-districts. Purposive sampling was used to recruit key informants for interviews. Key informants comprised three persons from NGOs working in the field of gender justice and gender transformation in South Africa.

Separate data collection instruments (semi-structured interview guides) were designed for men, women, community leaders, and NGO staff to understand their perspectives on male involvement in maternal and newborn care. Interview guides for FGDs and community dialogues were translated into Sesotho through a back-translation process and piloted with a team of fieldworkers proficient in English and Sesotho. FGDs and community dialogues were conducted in Sesotho by trained facilitators who were recruited based on prior fieldwork experience in the selected communities. To ensure credibility, thick descriptions were generated in data collected by purposively recruiting participants willing to discuss male engagement in maternal and newborn care. Furthermore, the discussions took place in physical spaces where participants could safely share their experiences

in their home language. Two male facilitators conducted the FGDs with men, and the FGDs with women were conducted by two female facilitators. A religious leader and an assistant facilitator facilitated the community dialogues. Through the application of thematic analysis, all conclusions and interpretations presented in this paper can be traced back to the participants. Triangulation was used to further reduce potential biases by collecting data from different groups of participants (i.e., men and women of reproductive age, community leaders, and NGO staff). This helped to corroborate findings across the different groups during data analysis, which increased the overall trustworthiness of the study.

The FGDs and community dialogues were audio-recorded to ensure the dependability of the qualitative findings. The audio recordings were transcribed verbatim in Sesotho and then translated into English by skilled translators. Each verbatim transcript in Sesotho and the corresponding translation in the English language were compared and checked for consistency by the first author. Key informant interviews with NGO staff were conducted in English by the first and the second authors and transcribed verbatim by the first author to ensure confirmability. Sufficient data were collected to comprehensively address the topic and reach data saturation, where no new themes were generated. An audit trail of the research processes, including the data collection instruments and field notes, was recorded to ensure transferability.

Qualitative data from the FDGs, community dialogues, and interviews were processed using an inductive and descriptive approach. The researchers followed Tesch's eight steps of open coding as described in Creswell (2014) to develop themes. Transcripts were read and reread by the first and second authors for data familiarisation. This was followed by identifying patterns and interesting ideas in the data through peer debriefing between both researchers. The first author generated initial codes, and similar codes were grouped together based on relationships to create categories. This was followed by refining the codes and categories to ensure they captured the data accurately. Next, a code book defining the final set of categories and themes was developed using NVIVO 14, and the coding scheme was applied to the entire data set. Constant comparison was employed to ensure consistency and modify or add new relevant categories and themes. Finally, preliminary findings were presented to community stakeholders at a two-day workshop, which took place on 7 and 8 August 2023 in Bloemfontein, Free State. These stakeholders comprised community leaders, NGO representatives, and the Department of Social Development. This was important in checking for the accuracy and resonance of the findings with key stakeholders to enhance the credibility.

3. Results

Three main themes were generated, which comprised MPI during pregnancy, MPI during delivery, and MPI in newborn care. Two broad categories generated on MPI during pregnancy were customary marriage, or lenyalo and the acknowledgement of responsibility, or litsenyehelo. Specific codes identified were caregiving, which referred to the reduction in household chores that pregnant women are expected to perform as a direct form of practical and emotional MPI and the reliance on kin as an indirect form of support during pregnancy. The socioeconomic and historical context surrounding litsenyehelo produced contesting narratives of modernity versus customary practices as opposites. The second theme focused on MPI during delivery and highlights contradictions based on the preferences of young men, young women, and community leaders (who comprised both men and women), with regards to the physical presence of fathers in the delivery room as a form of MPI. The final theme focused on MPI in newborn care, with two broad categories that are again framed as contestations between 'tradition' and 'modernity'.

3.1. MPI during PregnancyLenyalo

Participants identified customary marriage as the most significant cultural practice that defines the nature of MPI during pregnancy. Practices of MPI in this contemporary cultural

and geographical context are shaped by the nature of the relationship in which the baby was conceived. Customary marriage is defined as a spiritual union rather than a physical or legal one by a traditional healer in a rural community. Therefore, pregnancies conceived within such spiritual unions are characterised by support for pregnant partners to adhere to a healthy lifestyle, both physically and emotionally, through increased participation in caregiving by male partners:

> *I think it is to do work that she was supposed to do in the house at that time. I think you are the one that has to do her workload because now she is carrying a lot, her load is heavy, that means her chores as well as mine are all mine and all the heavy lifting. She will do all the light work; she can be able to do the light work while I do the heavy one like washing clothes and everything, all have to be done by me until the time she delivers the baby. (220928FGD8MenBotshabelo)*

> *I think a woman should no longer do heavy household chores when pregnant. I mean chores that will require for me to stand for long because I will no longer be able to manage. My husband should be able to do them for me. He should fill the buckets with water, do laundry and hang it. A woman should not handle all those alone. Cooking is light but if it will require her to stand for a long time, the father must do it. (220923FGD3WomenDewetsdorp)*

Some participants represented the role of fathers during pregnancy as comprising increased participation in household chores that are considered physically demanding, like fetching water from outdoor taps, doing laundry by hand, and cooking. Pregnant women are perceived by both men and women of reproductive age as less capable of performing domestic tasks they could easily perform prior to pregnancy, particularly as the pregnancy advances. This demonstrates how gender relations during pregnancy are shaped by lower socioeconomic status, characterized by informal housing, where there is not necessarily running water in the house, washing is performed by hand, and the toilet facilities are located outside of the living quarters.

However, this perspective of increased male participation in caregiving during pregnancy was strongly contested by other participants based on representations of customary practices in caregiving during pregnancy as shaped by time and space. In this context, time refers to the ways in which the participants constructed the past and the present as fragmented, and space refers to the specific geographical location and socio-cultural contexts that shaped the experiences which they narrate:

> *Here we are still living in rural areas, we are still using that rural culture, ehh it's not all the time whereby when a woman is pregnant at home a man helps her because people will say he is under a spell. In other words, we are still living in old times, that mentality is still there, it hasn't changed because last weekend I had an argument with some men with the same thing and they said they would never do that. They told me that no! When you do such things, you are being bewitched so we are still on that old mentality. (221022CommunityLeaders8Dewetsdorp-Male)*

> *He would rather say let me go and find you my sister or my little sister, so that she can help you. Sometimes, some of the things need both of us to discuss but he will see it very important for him to be with his friends or rather go to the tavern, yes. (220922FGD5WomenThabaNchu)*

> *When I'm a guy accompanying my partner to the clinic, to be honest, I feel that we Black people, we feel like fools. You feel ashamed to accompany your partner to the clinic; you feel like a fool. As Black people, we are like that. To make an example, when we are standing there kissing a girl, the elders will say we are disrespectful. But for Whites, when they kiss, they are celebrating each other; it's a good thing. You see, that thing depends on where you were raised, that thing to accompany her you feel like an idiot. (220915FGD1MenBloemfontein)*

One male community leader contested MPI in caregiving during pregnancy based on narratives of time and space. For them, men do not participate in household chores as a form of support for their pregnant partners in that village, which he described as a rural setting. For a young woman in another rural setting, male partners would rather outsource caregiving during pregnancy to female relatives in favour of male bonding rituals such as drinking with other men in local bars. However, a young unmarried male participant relied on an alternative explanation to the nature of MPI in an urban, informal settlement in Bloemfontein by drawing on a racial hierarchy of cultures, with 'white' cultural norms depicted as ideal and 'black' cultural norms represented as problematic for MPI during pregnancy. For them, the biomedical practice of accompanying one's partner to antenatal care visits at the clinic was associated with 'Whites' and made them, 'Blacks', feel embarrassed. This perspective can be framed as narratives of 'us' and 'them'.

Traditional healers and ordinary community members also alluded to the spiritual aspects of Sotho culture that are implicit within the gendered relations that govern customary marriages, as well as customary practices during pregnancy:

> *When you marry someone, it's not just physical. It is also spiritual. Spiritually you are married. When she becomes pregnant, in other words, the two spirits have come together. (221013TraditionalHealers1Botshabelo)*

> *When you talk of culture there are some people that will tell you that after certain months of pregnancy, you should make sure that you don't be with the mother of your child at all until, she gives birth. When they are done dressing you up with that pink cloth, I forgot what it is called in Sesotho, yes you should no longer be with her, you should never be close to her, I don't know for how many months though. (220930FGD8WomenBotshabelo)*

> *There is one thing that we need to talk about without going around in circles. To tell the truth we can never be any other race. We are black people, having our own customs. In the olden days it was common knowledge and occurrence that during pregnancy the wife would know that the husband is rooster. No, we are not talking about a spreading pumpkin. We are talking about something that builds a man, which becomes a family thing that wife knows. It becomes an issue of not leaving your husband as he is, neglecting his sexual needs because of your cultural norms. Remember a man cannot wait for nine months without sex or three months. (221013TraditionalHealers1Botshabelo)*

Representations of Sotho cultural norms of dressing a pregnant woman in pink at a non-specified time during the pregnancy are juxtaposed with narratives of time and space which rely on representations of the past to explain a negotiated process whereby a husband was permitted to have sexual relations with another woman during the period of pregnancy when his wife was covered with the pink cloth. A review of all 16 FGDs and eight community dialogues indicates that participants were unsure of the exact period of separation, which is not surprising because customary practices are often transmitted by word of mouth and are therefore interpreted in different ways by different families. The metaphor of 'a husband is a rooster' by a traditional healer is immediately countered with the claim that he is not referring to a 'spreading pumpkin', which is a metaphor for a womaniser. This suggests that this participant is mindful of not providing a justification for sexual promiscuity but rather is romanticising the past, in search of solutions to contemporary problems that emerge from a specific customary practice that is often implemented at some stage during the third trimester of pregnancy, which they consider inconvenient for the sexual needs of men. Interestingly, the concept of Blackness is deployed as a rationale by the traditional healer instead of Sotho customary practices, again reinforcing the narrative of 'us' and 'them'.

For mothers, the separation during pregnancy serves a practical purpose, as parents and grandparents are considered knowledgeable on caregiving for pregnant women, particularly during the last few months when emergency preparedness is required. Another sub-theme that was generated by young men and women was the representation of elderly female relatives as the custodians of the knowledge in maternal and newborn health that

is required to provide adequate caregiving during pregnancy. It is important to note that this perspective contradicts earlier accounts of MPI in caregiving during pregnancy as a practical form of support:

> *I think it can be mothers and grandmothers because grandmothers have a lot of experience, and they also have information. Let's say for instance if I fall pregnant, my grandmother is the one that knows things I have to follow. She is the one that is going to help me to take care of my baby. (220930FGD8WomenBotshabelo)*

> *Yes, I agree with number five and number eight sir, that most of the times during her pregnancy, I will be sorting work things out there. It means then I will have to take her to my parents where I stay, where I know that my parents' day and night they are always there. Where my parent will help her with everything, she needs that I am unable to help her with. (220922FGD3MenDewetsdorp)*

Representations of the reliance on older relatives extend beyond parents and grandparents to include older neighbours, and this is indicative of the communal nature of life in the rural and urban informal settings where data were collected.

For younger men and women of reproductive age, their parents and grandparents are perceived as caregivers for pregnant women because pregnancy is regarded as a delicate period for mothers and babies. However, contradictions between the practices of pregnancy care provided by older female relatives and those provided by maternal healthcare providers were noted as an area of anxiety for young women:

> *I usually see people be in a hurry to help her when a woman is pregnant, more especially older people. They make sure they help her and give her what she needs such as advice. They keep on checking on her whether she is fine in that situation she is in. The problem starts when she gets to the hospital, they tell her this at home and when she arrives at the hospital, it changes. Nurses would say this and that to her so here at home, parents don't tell her same things as hospitals, things here at home are different from of hospitals. When you get there, they change they say this so you at home you were told to do things this way, you see? It is that things like "Portia do this" and when you get at the hospital you do not have to do that nurses say you will hurt the baby. (220930FGD8WomenBotshabelo)*

For this participant, conflicts arise between customary and biomedical practices on pregnancy care, which is a potential source of anxiety for young mothers. This can also be framed as a contestation between 'modernity' as represented by biomedical practices and 'tradition' as represented by customary practices that have been handed down from one generation to another within families in these communities.

This perspective on the reliance on elderly relatives for pregnancy was contested by one community leader by alluding to narratives of time and space, as well as by contrasting modernity and cultural norms in support of MPI in caregiving during pregnancy:

> *The gentlemen here are elders. They know that when the ladies were pregnant in the past, the grannies were called to come and guide them through that process. But currently, where we cannot live as extended families, you will hear people saying that the men in so and so's family is grannies, men there are just children. Now, in modern times, the father must be there to serve his wife. He must do what the grannies used to do. Supporting mothers during pregnancy; they need more support during that time to avoid the issue of stress. (221015CommunityLeaders3Bloemfontein)*

This argument provides a rationale for some of the changes to practices of MPI, from a past in which family structures were set up in a way that elderly relatives could always care for younger women during pregnancy, to a present where sometimes husbands are the only ones available to provide practical support, which leads to social stigma from community members.

Acknowledgment of Paternity: Litsenyehelo

Apart from MPI in pregnancy care within a customary union, participants also described challenges experienced with negotiating MPI in situations where pregnancies occur outside of a recognised union, particularly amongst young couples, including teenagers. On the one hand, young women described the customary practice of letter writing as a strategy to initiate MPI, and, on the other hand, young and older men used the word 'damages' to describe the process of 'taking responsibility' for a pregnancy when partners are not in a customary marriage:

> *Sometimes it may happen that when you are pregnant you tell your parents first before telling the father of your child. So, most of the times our parents send a letter to his home, the father of the baby so that his family and him know that the baby is now there. (220930FGD8WomenBotshabelo)*

> *Sometimes it is the influence of their families that makes them disappear because him and the family are denying the paternity of the child. You find that those who had disappeared only reappear with the very same family members a month after the child is born to claim that child. They come after 4 weeks because only then a baby has grown some physical features. To you as the mother, timing is wrong because it means you spent the entire pregnancy alone without his support. (220921FGD2WomenBloemfontein)*

> *I am gonna add on this issue, there's not much support to women when they are pregnant because lately these kids (referring to teenagers in the community) are the ones that are making babies so ehh it becomes very difficult for them to support pregnant partners. These kids don't even accompany their partners to the clinic, it is done by us older people. Here in our village, it's not there seriously. (221022CommunityLeaders8Dewetsdorp-Female)*

For these young women and one female community leader, male partners do not always get involved during pregnancy because of the perceived influence from their families and the perception of a high prevalence of teenage pregnancies in Dewetsdorp. The narrative above indicates that paternity is sometimes determined based on the physiological attributes of the child after birth, which significantly affects the MPI during pregnancy. This implies that paternal families might wait until after the birth of the child before initiating *litsenyehelo*.

Perspectives from NGO staff who have been involved in implementing gender-transformative interventions in diverse cultural settings in South Africa, including the Free State, argue that conflicts between extended families can influence MPI during pregnancy:

> *Acknowledging paternity by paying 'damages' can be a good thing if there is money and if all parties agree. It is a lovely way for two families to start to build a relationship. But if there is no consent, no willingness, no interest from either side, if there is no money, it becomes difficult to pay damages and then consequently not be recognised as the father of the child. I am quite clear that the challenge is not the customary practice, but the challenge is when conditions don't support that practice, conditions like financial availability, etc. (KeyinformantInterview1NGOStaff)*

However, some male participants, and particularly older men who were recruited as community leaders, constructed narratives that reify customary practices governing *litsenyehelo* as the solution to family disputes, which, for them, have emerged because of modernity:

> *Because culture is like, culture does not care about you have 'damaged' someone who has one eye or who has no teeth. They just write a letter at home and send it there that with that person this is what happened. They do not care whether she's ugly or not. We have taken modern ways you want to make a baby with the queen you understand (Laughs). (220922FGD3MenDewetsdorp)*

> *If I have done that, I must know that I must take responsibility and know that I must support this girl that I have impregnated. I say this because I am a father of boys, who I*

teach that once you make someone pregnant you must know that you are responsible. I tell them that in our culture you are expected to be there for your child and the woman you have impregnated. If you are working, you have a cell phone use it to connect and communicate with your partner, to calm her feelings. When you arrive at home you must know that the first thing you must do is to caress and touch and massage her in a particular way. Play with the child by touching the mother's tummy. We must teach our boys this. I do teach my boys this it's something I do. I was also taught this by my father. It is a very common teaching found in our communities and our traditional healers and leaders. (221013TraditionalHealers1Botshabelo-Male)

For these older male participants, customary practices provide solutions to the challenges that the families of young couples encounter while negotiating MPI during unplanned pregnancies. Although a traditional healer in Botshabelo described the practice of 'taking responsible' for all pregnancies as homogenous-based narratives of time and space, they are in fact contested by mostly female participants and some male participants mainly for socioeconomic reasons.

While the cultural expectation in these contexts is to write letters to the expectant father's family to invite them to 'take responsibility' for the pregnancy, socioeconomic factors also intersect with cultural norms in complex ways to influence MPI:

Another contributing factor is parents who want to choose partners for their children. Some would hate your pregnant partner because she is from a disadvantaged family or background. So, they want to choose for you who to have kids with forgetting that you love that other one they hate. For some men, they see it as an excuse to leave and run away from their responsibilities although we both conceived that child together without our parents involved. (221018CommuntyLeaders7Dewetsdorp-Female)

3.2. MPI during Delivery

Participants' representations of Sotho customary practices relevant to MPI during delivery are varied and highly contested by men, women, community leaders, and traditional healers. The dominant narrative that was generated from the group discussions was that, except for traditional healers, who are considered gender-neutral, fathers are not permitted to witness childbirth or stay in the same room with a newborn:

I agree with it because where I stay, there are women who come there, and we are helping the mothers together with my daughter to have their own children who are born in my house. (221013TraditionalHealers1Botshabelo-Male)

Representations of support for mothers during labour and delivery were understood as direct from male partners or indirect from the parents of young men and women. For some young men, the best form of support for young women during childbirth is that provided by older parents. Where pregnant partners cannot return to their parents because of changes to family structures in contemporary society, some expectant fathers see their role in practical terms, specifically referring to organising transportation for delivery in rural settings, where ambulances often arrive after the birth of a child due to delays:

I am going to speak on the issue of being supportive. I am going to speak of my si:e of the story. A woman that you are with, when she goes to deliver, she has to go home to her parents. She will then stay there and deliver there, after a month she will then come back. (220927FGD5MenThabaNchu)

When you live with the lady, when that time nears when she should give birth, I send her to her house (refering to her parents home). That is the thing I see happening (Uhm) yes (Uhm). Er unless there are men here who still live with their parents in the house. (220928FGD7MenBotshabelo)

If she needs an ambulance, you need to be there as you know how long an ambulance takes to arrive at the scene when you have called for it. And if you find that the mother cannot wait for the arrival of the ambulance, as a father you must make a plan so that the

she can be helped. That's the major role a father must play for the child to be born without complications and in good health. (221014CommuntyLeaders2Botshabelo)

This perspective of practical support as the main form of MPI was contested by others who either participated directly or as community leaders who encouraged younger people to be directly involved in childbirth:

My wife struggled to deliver when she was at the hospital; she wanted me. I was called, then I was at home and told that I must go in there (refering to the delivery room). When I got there, the baby was born. That was when she was able to deliver. That was when I was always with them, sir. (220928FGD8MenBotshabelo)

I teach them, yes, even my son-in-law, the time he went to the hospital, he went there with my daughter and the time she gave birth, he was also in the labour room with her; he wants nothing, he gave her all that support, and he came out holding his baby. (221022CommunityLeaders8Dewetsdorp)

This indicates that participants' representations of support during delivery vary from sending their partners to their parent's home, being summoned by healthcare professionals to the delivery room, and older parents who teach their adult children to be supportive by being physically present in the delivery room. This suggests that customary practices in delivery are not static but rather vary between families and communities in the context of the Free State.

However, the most heated debates were generated during the FGDs with young, unmarried women about MPI in the delivery room. While young, married women were supportive of the idea of MPI in the delivery room as a strategy to elicit empathy and more support in caregiving and family planning, young men wanted to be there for emotional support and practical reasons relevant to their perceptions of the poor quality of services provided to their partners during labour and delivery in public health facilities:

I think it is important for him to be there during childbirth. This is because by the time a child turns 2, a man would want to have another child. But if he was there when you delivered the first child and seen how horrific it is, he would even ask doctors for a permanent contraception so that one doesn't get pregnant again. In other cases, when you come back from the hospital weak after birth, he believes you are faking it. This is because he was not there during birth. (220923FGD3WomenDewetsdorp)

It is my responsibility to see my partner and support her when she goes to deliver. When we get there at hospitals or clinics, she may need water, toiletries. Even when she goes to the toilet you should go with her everywhere and let her lean on you then you give her that support. (220927FGD6MenThabaNchu)

On the contrary, most younger women who were unmarried were adamant that they would never allow their male partners in the delivery room, while older women in the group discussions were concerned about the lack of cooperation from younger women when male partners are involved in childbirth, again drawing a narrative of 'us' and 'them' and taking it a step further by making connections between race and social class with reference to inequities in the access to care between private versus public healthcare in South Africa:

I will never agree to give birth in the presence of my partner. The reason why I am saying that is because men are very brutal, heey!! They are very abusive verbally more especially when they are drunk, he will be insulting me saying I am a concubine. I was opening my legs widely blah blah, as for me, no. I don't want him I would rather open my legs for him in bed not in labour, no. (220922FGD5WomenThabaNchu)

I am saying no because women do not cooperate when they are with their boyfriends or family members. That happens to white people at private hospitals but at public hospitals, it's a problem. (220921FGD2WomenBloemfontein)

It is possible that the presence of male healthcare providers in delivery rooms at healthcare facilities could be a potential source of conflict for young couples in a cultural context where, historically, older women were responsible for caregiving from the third trimester of pregnancy and during delivery and newborn care.

Despite the diverse practices of MPI in delivery described in this section, a community leader in a rural setting made use of narratives of 'us' and 'them' to explain why 'black' men are not always allowed into the delivery room at some public healthcare facilities in the Free State. Interestingly, the participant also raised certain problems that may arise as a result of the separation of young couples in contemporary society:

> *We were raised in culture that when the baby is born, the father should not get near the baby too much, because a man's blood is too hot. That is why there at Moroka hospital they don't want the fathers to get in there when the woman delivers. Yes, white people can do what they want there is no problem. But we have started with the culture that when a woman gives birth the father must not get in there. That is why it is said that when you come back from the hospital as a new mom, the father must play far away from you and now he cannot get into the room, that is where men end up sleeping around. (221017CommunityLeaders6ThabaNchu-Male)*

3.3. MPI during Newborn Care

Community members also presented contrasting representations of MPI in newborn care. This refers to the first 28 days after the birth of a child from a biomedical lens, but it varies from as little as 10 days to as long as 6 months based on the perspectives of the participants in this study. Customary practices in newborn care were represented as spiritual practices that are not only intended to spiritually protect new parents but that also act as a rite of passage into personhood for a newborn in this cultural context. Male community leaders and traditional leaders presented themselves as custodians of these customary practices:

> *This is our culture. We were born into this; it is our way of life, as the gentleman has indicated. We know that when a baby has just been delivered, there will be a reed placed at the door, which indicates that men are not allowed to enter, only women. It was a known fact that in that house, we have a nursing mother, and you are not allowed to enter. You don't use that door; it is our culture from the past, and it still practised today. (221013TraditionalHealers1Botshabelo-Male)*

> *The last one when she has just delivered, that baby is not supposed to be seen, the baby will be seen after six months when she is grown. That will be when that family will be able to touch her; she is not supposed to be touched by just anybody. (220922FGD3MenDewetsdorp)*

> *On men we are black people right we are not like white people. White people after their babies are born they do babyshowers, for us our child initiates, after going through initiation that is when we will start having celebrations for her. After ten days, she must finish that ten days in the house. Because we are cultural people sometimes after a month she must come outside. (220922FGD4MenDewetsdorp)*

It is important to note that this isolation of newborns from the general public for varying periods of time does not only have spiritual but biomedical benefits, given that newborns are not fully immunised and the risk of contracting viral and bacterial infections are high if they are exposed to the public too soon:

> *When we do that, we are protecting your wife's and your own ancestral connection or spirit because, during the neobornl period, a woman is considered unclean. This is done so that the expected child must not have complications and enter our lives peacefully. (221013TraditionalHealers1Botshabelo)*

> *My mother will put on Kgwetsa (a traditional animal skin put on a baby's neck) when I enter traditional stuff because children will grow up with this tradition thing, yes. It is the parents that know how our baby is when she is like born, this is what should be done*

so that it does not end up being said that the baby needs a traditional ceremony. For an example, sir, a lot of time if you observe a child when he is little, there is no child that grows up without animal skin necklace on his neck (others in the group agree, yes). That thing called "Kgwetsa", a necklace for protection from evil spirits, is a thing that means a lot of things when we bring in clan names, yes. (220922FGD3MenDewetsdorp)

When you go out, let's say you are going to the tavern. You are going to make the baby sick at home, so you are not supposed to go there. Even speaking to some women at the tavern, you are going to make the baby sick, and that thing is gonna be dangerous for the baby; there are rules like that. What you must do as a new father is stay at home and take care of yourself because when you do wrong things, the baby will end up sick. (220930FGD8WomenBotshabelo)

While the explanations provided by traditional healers are framed within African cosmology, it does offer biomedical benefits by creating a safe space for new mothers to heal and nurse newborns while all their physiological needs are being provided for during this critical period. Again, the focus on fathers taking care of themselves lays emphasis on the need to avoid contracting any diseases or infections that can be passed on by the father to the mother and baby, both physically and spiritually.

While acknowledging the existence of the customary practices in newborn care that have been described above, some younger men are eager to be physically involved in all phases of pregnancy, delivery, and newborn care:

Those are the ones where things need to be changed, for our parents to let young fathers who already have babies and wives to be together during pregnancy and delivery. Yes, I think that it can enable fathers to be involved because for another person, if he has a baby and a wife and they are at her family home, he does not get the opportunity to be there for them. If it can change, the wives' parents, uhm, can allow fathers to come and do something. I think those are the things that will allow us to be involved in those things, my man. (220928FGD8MenBotshabelo)

When my wife called to tell me that the baby had arrived, I went straight to the baby, then I put him on my chest. In that way, I am forming a connection that here is your father. That is where we bonded, in hospital. When arriving at home, I change nappies. The mother teaches me how to do a T-hook to change a nappy. That is another way of bonding with the baby. We are not the same when it comes to bonding with our kids. (220927FGD5MenThabaNchu)

Despite the above narratives of MPI that involve male bonding with a newborn at a healthcare facility, community leaders and NGO experts caution against the implementation of health interventions that are aimed at promoting individual behaviour change in geographical and cultural contexts where conceptualisations of personhood are not simply individualistic but also communitarian. This could lead to a discursive backlash against interventions that seek to transform gendered relations in maternal and newborn care as privileging Western ways of being and doing over African cultural practices and belief systems:

It will start on the man's family side. When his sisters see it, they will say she has cast a spell on him. It becomes very difficult when they say she has cast a spell on you. When your brother-in-law see it, also they will say you are under her spell. They have forgotten that you are supporting and helping their sister. In your own family, they also have forgotten that you are helping to raise their grandchild. Someone who is going to preserve your surname and clan name. To make sure that he is healthy and is raised very well. (20221015CommunityLeaders3Bloemfontein)

Behaviour change takes various forms and shapes, but what matters the most is to have a kind of buy-in from the gatekeepers, whoever they are and wherever they find themselves. By that, I am talking about politicians. I am talking about your Ward Councillors. I am talking about traditional leaders. I am talking about religious leaders so that they are

able to affirm and confirm the impact that is positive that comes out of the programme. (KeyInformantInterview3NGOStaff)

4. Discussion

The main strength of this article lies in the fact that the authors did not begin with an a priori definition of MPI but rather sought to understand the meaning of MPI from the perspectives of men, women, and community leaders. The concept of social support emerged as the most common understanding of MPI in this cultural context. Social support varied from practical and emotional support that is provided directly by male partners to a network of support from kin, involving mainly older female relatives. Contrary to narrow biomedical definitions of MPI (Daniele 2021; McLean 2020), a qualitative case study on male partners' understanding of pregnancy-related care conducted in a rural community in South Africa found that men interpret their participation as comprising mainly practical and emotional support (Matseke et al. 2021). However, an earlier qualitative study that aimed at understanding the meaning of MPI in pregnancy and newborn care in the context of an intervention to promote MPI in PMTCT from the perspective of isiZulu-speaking women in Umlazi, the largest township in KwaZulu Natal, argued convincingly for the need to broaden the lens through which we define male involvement among diverse indigenous populations in South Africa (Maman et al. 2011). These authors argued in favour of the development of strategies to encourage MPI outside of the clinical setting, and to take cognisance of the importance of a support network that is not limited to male partners, which is characteristic of the communitarian nature of the geographical settings described in this study. This study therefore contributes to filling this gap in the research.

Through the application of an interpretive lens, this study has generated narratives of time and space, presented as contrasting representations of modernity and tradition in the context of MPI among Sesotho-speaking men and women in poor socioeconomic settings in the Free State. Space refers to diverse geographical settings that are inhabited by mostly Black South African populations in areas that were previously demarcated as Bantustans during the apartheid era (Ratele 2013). Although the term Black is contested and highly politicised, the authors have chosen to use it here mainly because this is how the participants referred to themselves. It is interesting that the participants made use of a racial identity more consistently than an ethnic identity when describing their cultural practices and beliefs in pregnancy, delivery, and newborn care. This could signal an awareness of more similarities than differences in the cultural practices of childbearing across different geographical locations, as well as in the apartheid and post-apartheid era spatial planning that makes up diverse indigenous populations in peri-urban areas known as townships (Chauke et al. 2015). For instance, the customary practice of pregnant women returning to their parents' homes at around the 7th month of pregnancy to give birth and receive newborn care for about a month has been described in research conducted among the Vhavenda, Vatsonga, amaZulu, Basotho, and Bapedi people (Nesane et al. 2016; Matseke et al. 2021; Mullick et al. 2005). Therefore, although these beliefs and practices are varied, they also share cultural norms that could be used as a unifier in mobilising collective action towards MPI, beyond the clinical setting in South Africa's rural and peri-urban communities.

Furthermore, it is important to note that the racial categories in South African public discourse are highly contested because their roots can be traced to a brutal history of colonialism and apartheid, which applied racialised hierarchies for the purposes of capitalists' accumulation and the political oppression of large sections of the population. These racial categories have been carried over into the post-apartheid era as part of a strategy for social, cultural, political, and economic redress. One of the consequences is the recognition of traditional authority and leadership within a constitutional democracy (Ratele 2013). By legislating tradition in modern South Africa, citizens that reside in traditional communities must constantly negotiate between customary law and constitutional rights. For Ratele (2013, p. 140), the implication of this dilemma is that customary gender and sex-

ual practices in rural communities cannot be understood and transformed outside of the '*eBandla*', '*Huva*', or '*inKantolo yeNdabuko*', effectively 'retribalizing' significant populations of Africans who are based in rural communities. These terms refer to the forum of traditional community leaders often constituted mostly of heterosexual men, in several South African indigenous languages.

Therefore, initiatives to promote MPI in diverse geographical (rural/per urban) and socio-cultural spaces that are characterised by conflicting discourses of modernity versus tradition must seek to mobilise some of the members of the '*eBandla*' as key stakeholders in health interventions. This attempt at community mobilisation must be informed by a definition of MPI that includes social support as defined by indigenous men and women, which comprises instrumental and emotional support, as well as kinship networks of care, which have been described above. Intervention material must also acknowledge the biomedical benefits of some of the cultural practices in maternal and newborn care that are prevalent in these settings. For instance, qualitative research conducted on cultural practices regarding childbearing in six different ethnic groups in Southern Africa identified several benefits, which could be integrated within biomedical health systems because of their congruence with modern healthcare practices (Chauke et al. 2015). In contrast, most empirical studies conducted among indigenous populations residing in peri-urban or rural communities in South Africa have been framed around the biomedical/positivist lens, which defines cultural beliefs as restricted to constraints of MPI (Nesane and Mulaudzi 2024; Matseke et al. 2017a), inadvertently depicting traditional masculinities that are multiple and contested as equivalent to hegemonic masculinity, which is perceived as singular, dominant, and oppressive (Everitt-Penhale and Ratele 2015). This leads to recommendations focused on the need to change social norms to address these 'negative cultural beliefs', thereby completely ignoring diversity in the understandings of MPI that were provided by the male participants. This demonstrates the dominance of Western epistemologies in studies on African masculinities, with a specific focus on MPIs in South Africa among indigenous populations (Mfecane 2018, 2020).

Adopting a Sesotho cultural perspective also draws our attention to the ways in which gender intersects with socioeconomic status, race, and age in MPI during pregnancy, delivery, and newborn care in these contexts. Intersections of race and class influenced gendered relations in caregiving during pregnancy and newborn care for some participants, as men indicated that, in the absence of support networks, they must engage in what was previously regarded as the elderly women's domain to support their pregnant partners. An intersectional lens sheds light on why this experience is different from the findings in an ethnographic study conducted among a diverse group of affluent fathers in Cape Town. Appling an ethics-of-care theoretical framework, the study argued that, apart from kinship networks, Black women also played an important role as caregivers and domestic workers in these affluent households, thereby shaping the ways in which fathers navigated practices of giving and receiving care in everyday life (van den Berg 2022). The privilege derived from a higher socioeconomic status fashioned different approaches to caregiving than those described by participants residing in poor socioeconomic settings where caregiving can only be provided by male partners or female family members. This presents a unique opportunity for engaging '*eBandla*s' in rural areas to counter narratives of love portion, which drives the social stigma against MPI in maternal and newborn care, with narratives of giving care to "Someone who is going to preserve your surname and clan name". Names and the meanings attached to them, as well as the rituals practiced around customary marriages, the acknowledgement of paternity, childbirth, and initiations into manhood (through initiation schools) hold significant value in indigenous South African conceptualisations of masculinity and fatherhood.

Finally, the limitations of this study comprise the fact that the results presented in this article are limited to the perspectives of participants who were purposively selected from low-income communities in peri-urban and rural areas within four sub-districts in the Free State. Therefore, the results cannot be generalised to all Sesotho-speaking people.

Furthermore, FGDs and key informant interviews were used as the primary method of data collection because the study was designed as part of a broader mixed-method project. Future research on this topic using a qualitative methodology would benefit from an ethnographic approach, as well as participatory action research.

5. Conclusions

The main argument in this article is that there is a need to include South African conceptualisations of masculinities within gender-transformative interventions designed to promote MPI among Sesotho-speaking communities in the Free State. Research on health interventions to promote MPI using different theoretical approaches in diverse social, economic, political, and cultural contexts has produced mixed outcomes. However, proponents of gender-transformative approaches contend that the paradigm is relatively young and offers potential for future research on health interventions with men, with an emphasis on integrating an intersectional perspective into gender-transformative health programming (Dworkin and Barker 2019). Following calls for decolonising men and masculinities studies in Africa, this article has shown the feasibility and potential benefits of a decolonised, African-centred perspective to interventions that are designed to promote MPI among indigenous African populations in South Africa.

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