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South African men's perceptions of breast cancer: impact of gender norms on health care accessibility

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Summary

Women in low- and middle-income countries (LMICs) often present to the health care system at advanced stages of breast cancer (BC), leading to poor outcomes. A lack of BC awareness and affordability issues are proposed as contributors to delayed presentation. In many areas of the world, however, women lack the autonomy to deal with their health needs due to restrictive gender norms. The role of gender norms has been relatively underexplored in the BC literature in LMICs and little is known about what men know about BC and how they are involved in women's access to care. To better understand these factors, we conducted a qualitative descriptive study in South Africa. We interviewed 20 low-income Black men with current woman partners who had not experienced BC. Interviewees had limited knowledge and held specific misconceptions about BC symptoms and treatment. Cancer is not commonly discussed within their community and multiple barriers prevent them from reaching care. Interviewees described themselves as having a facilitative role in their partner's access to health care, facets of which could inadvertently prevent their partners from autonomously seeking care. The findings point to the need to better consider the role of the male partner in BC awareness efforts in LMICs to facilitate prevention, earlier diagnosis and treatment.

Lay summary

Women in undeveloped countries are often not diagnosed with breast cancer until the disease is already very severe. Some of the reasons for this include a lack of awareness about breast cancer and difficulty affording the costs of health care or the costs of transportation to a hospital or clinic. In many areas of the world, women also do not have the freedom to respond to their own health needs without having a male family member involved. However, we do not know very much about how men may be involved in women's health care. To better understand this, we conducted a research study in which we talked to 20 South African men about what they knew about breast cancer and how they are involved in their partner's health care decisions. Through talking to them, we found out that many did not know about breast cancer or had inaccurate information about it. The men reported that people in their community do not often talk about cancer. The men described themselves as having a positive influence on their partner's health care decisions, but some of the things they reported doing might stop their partners from being able to access health care independently. Overall, we think that campaigns to raise awareness of breast cancer should consider how women's partners may be involved in their health care.

Keywords: cancer, gender, health care, South Africa, masculinity

INTRODUCTION

Breast cancer (BC) is frequently perceived as a problem affecting women in high-income countries, despite the fact that the majority of BC cases occur in low- and middle-income countries (LMICs) (Ferlay *et al.*, 2015). Moreover, the incidence of BC in LMICs is increasing as these areas experience increases in life expectancy and greater contributions from risk factors such as smoking, obesity and physical inactivity (Brinton *et al.*, 2014). Many LMICs are underprepared to deal

with the burden of BC in their populations due to a lack of routine mammography screening, poor health infrastructure and a historical prioritization of communicable diseases (Nugent and Feigl, 2010; Brinton *et al.*, 2014). As a result, women in LMICs are often diagnosed with the disease at advanced stages (Stage III or IV), when treatment is expensive and survival outcomes are poor (Groot *et al.*, 2006).

In South Africa, as in many LMICs, social and structural factors that lead to advanced diagnosis include a low awareness and misconceptions of BC, inaccessibility of the conventional health care system, preference for and the accessibility of traditional healers, fear of diagnosis and the unaffordability of health care (Coovadia *et al.*, 2009; Brinton *et al.*, 2014; Moodley *et al.*, 2016). As such, BC prevention and reduction interventions often strive to increase awareness of the disease and reduce the structural barriers women face in accessing the health care system (Brinton *et al.*, 2014). However, a relatively underexplored aspect of women's access to care in the context of BC is the role of gender norms surrounding women's autonomy. The concept of hegemonic masculinity describes how multiple forms of masculinity are hierarchically ordered to legitimize the subordination of women and less powerful men (Carrigan *et al.*, 1985; Connell, 1987), and has been extensively used to describe the impact of gender relations on the health and wellbeing of South African women (Jewkes and Morrell, 2010; Morrell *et al.*, 2013). In particular, hegemonic masculinity amongst Black South Africans is thought to be derived from experiences of extreme racial discrimination and material inequities that occurred in the context of colonialism and apartheid (Morrell, 2007; Morrell *et al.*, 2012). This masculinity is described as emphasizing men's physicality and control over women, which is contrasted with cultural ideals of femininity that encourage compliance and tolerance of male behaviour (Jewkes and Morrell, 2010). The result is that gender norms are often pitted against women's autonomy and independence, an issue that may extend to their ability to seek health care (Pronyk *et al.*, 2001). In their survey of 565 South African women, Maree and Wright (Maree and Wright, 2010) found that 21% required permission from their husbands or parents before seeking health care and 45% felt they should not spend money on their own health. Despite these findings, little appears to be known about how women's access to BC screening and treatment may be influenced by gender norms; ignoring these important social factors may be curtailing efforts to prevent and treat the disease. To ensure BC prevention interventions are tailored to the cultural context in which they are delivered, we require an understanding of what men's perceptions of BC are and how they perceive themselves to be involved in their partner's access to health care.

In this article, we aimed to examine the levels of awareness and knowledge of BC among Black South African men living in a peri-urban community. These findings could contribute to the development of tailored BC prevention programs and policies that take the role of women's partners and gender norms into account. In the following sections, we present our methods for obtaining men's perspectives on these issues and describe our key findings with respect to men's awareness, knowledge and perceptions of breast cancer, barriers to health care in their community, and the role of relevant gender norms. We follow this with a discussion of the findings and recommendations for policy and public health initiatives.

METHODOLOGY

We examined the following research questions: (i) What do Black South African men in long-term heterosexual relationships know about BC and how do they relate to their partners, provide (or do not provide) support, and what forms does this support take? And, (ii) What are the men's perceptions of their role in their partner's access to health care and how does this relate to broader societal considerations regarding gendered expectations of behaviour?

To answer these questions, we used a qualitative descriptive approach, which aims to provide a description of an experience whilst staying 'close to the data' and is well-suited for research questions that involve forms of quantification (Neergaard *et al.*, 2009). We drew on the concept of hegemonic masculinity described previously as a 'sensitizing concept' (Blumer, 1954), a 'background idea' (Charmaz, 2003) used to 'see, organize, and understand experience' (Blumer, 1954), to design the data collection instruments and provide general direction to the data analysis.

The study was approved by the Human Research Ethics Committee (Medical) at the University of the Witwatersrand in Johannesburg, Guateng, South Africa, and by the Hamilton Integrated Research Ethics Board (HIREB) in Hamilton, Ontario, Canada. Participants provided informed consent to participate in the study. Following the interview, they received educational resources about BC and had the opportunity to ask the investigator questions about BC. Participants also had the option to receive a summary of the study findings after their completion.

Study site

Health care in South Africa is provided by a mix of private and public entities (Coovadia *et al.*, 2009). Average out-of-pocket costs for health care in 2018

were $40.628 USD per capita compared to an average of $104.08 USD for middle-income countries (The World Bank, 2018b). In 2016, only 10.4% of Black South Africans were covered by medical aid (private health insurance) compared to 71.3% of white South Africans (Statistics South Africa, 2017, p. 25). Although this equates to only 17.4% of the total population having coverage (Statistics South Africa, 2017, p. 24), the private sector accounts for just under half (44.067%) of the total health expenditure (The World Bank, 2018a).

To narrow the gap between the public and private health care systems, SA is in the process of implementing a new National Health Insurance (NHI) plan that seeks to pool funds such that all South Africans have access to high-quality health care (South African Government, n.d.-a). The NHI has been put in place to address the racial inequities in access to high-quality health care and to unify the previously fragmented healthcare system (Naidoo, 2012). The government is implementing the NHI in stages, with full implementation scheduled for 2026 (South African Government, n.d.-b).

Breast cancer is the most common form of cancer among women in South Africa, representing 23.1% of all female cancer cases in the country (National Health Laboratory Service, 2017). Moreover, the incidence of BC in South Africa increased by 3–4% per year between the mid-1990s and mid-2010s (Joko-Fru *et al.*, 2020; Sung *et al.*, 2021). Mortality from BC in sub-Saharan Africa is high, in large part due to late presentation to the healthcare system (Sung *et al.*, 2021). A low socioeconomic position, low educational level and participating in unskilled work are associated with poorer BC awareness in sub-Saharan Africa (McKenzie *et al.*, 2018), and completing less than a high school education is associated with a more advanced stage of BC upon diagnosis in South Africa (Joffe *et al.*, 2018). The South African Breast Cancer Prevention and Control Policy (National Department of Health, 2017) provides standards of care that include a biannual clinical breast examination (CBE) for all women 40 years and older, printed educational materials in all clinics, and education on breast cancer self-examination (BSE) for all clinic attendees. Mammography was deemed too resource intensive as a BC strategy in SA and is only performed on symptomatic and high-risk patients (p. 28). There is a fairly well-established BC civil society of non-profit and advocacy organizations in the region that provide services such as education, mobile screening, policy advocacy and counselling (Burgess, 2017).

This study was conducted in a peri-urban township of approximately 250 000–500 000 people in the Gauteng province of South Africa. In the respective township, two public health clinics provide service to the entire area; the nearest public hospital is at least 30 km away. The majority of the individuals in this community experience multi-dimensional poverty, inadequate living conditions and poor levels of safety. They also lack access to basic government services such as water and electricity (Hatcher *et al.*, 2019). In a recent sample from this community ($n = 2454$), 71.6% of men reported engaging in one or more of the following: problem drinking, gender inequitable views and partner violence penetrations (Hatcher *et al.*, 2019).

Sampling strategy and inclusion/exclusion criteria

We recruited 20 Black men with the inclusion criteria that the participant was currently living with their woman partner for 2 years or longer and was sufficiently proficient in English to complete the interview. Since we desired to understand baseline perceptions of BC amongst a population with no prior experience with the disease, eligibility for inclusion also required that their partner had not previously received a BC diagnosis.

Though we were interested in exploring gender norms that may prevent women from seeking care, we similarly recognized the importance of identifying norms that may facilitate care. Moreover, we were equally aware of the risks of continuously portraying Black men as the 'problem' within academic research; doing so may reinforce and promote racism and alienate men who wish to join the movement toward a more gender-equitable order (Peacock *et al.*, 2009). Therefore, we included a subsample of men who were likely to espouse positive gender norms through conducting initial participant recruitment through a local gender advocacy organization. We recruited four men involved with the organization and used snowball and maximum variation sampling to recruit sixteen others. As a member of the community in which the study was conducted, the second author (B.L.) facilitated the latter sampling strategy through his existing connections.

Data collection

The first author conducted in-depth, face-to-face, semi-structured interviews with the men in June and July 2017. The interviews took between 14 and 51 (average of 29) min and were conducted in a private office of the local gender advocacy organization. The interview guide explored the men's knowledge of BC and cancer in general as well as their perceived role in their partner's access to health care. Saturation (Morse, 1995) was believed to have been obtained after 20 interviews based on the lack of newly emerging findings.

Data analysis

The recorded and transcribed interviews were manually coded by the first author and NVivo for Mac, Version 11.4.1 (QSR International, 2015) was used to organize the codes. Coding followed a three-cycle approach described by Aurini *et al.* (Aurini *et al.*, 2016, pp. 179–201) in which codes are assigned and progressively refined and integrated into larger overarching ideas. This coding strategy was both deductive and inductive in that the coding framework was established from a priori areas of interest (e.g., breast cancer knowledge) but also allowed for the emergence of posterior patterns. Frequency coding occurred with respect to quantifying pieces of the men's responses such as how many participants were aware of a particular symptom of BC. R.B. consulted with R.-S.M. and J.E., who have extensive experience conducting research with low-income communities in South Africa, to gain insight into the alignment of the findings with the social context.

RESULTS

Participant characteristics

Participant characteristics are provided in Table 1. The median age of participants was 41 years old (range 28–57), and the sample represented a mixture of individuals from eight different Southern African cultural/linguistic groups. The majority (75%) of the participants considered themselves to be religious. Less than half (35%) had completed matric (graduated from secondary school) or pursued higher education. Only four (20%) of the participants were formally employed, whereas thirteen (65%) of their partners were. Most (80%) received income through a mixture of piecework, selling small items, social grants or assistance from family members. The median combined monthly income of the participant and their partner was 4500 Rand, the equivalent of about $346 USD at the time of data collection (June and July, 2017). Nineteen participants (95%) were married or engaged and the median length of their relationships with their partners was 9.75 years. Just over half (55%) of the participants exclusively used the public health clinics for health care, which would cost them about 14 Rand ($1 USD) round trip to visit using the local transportation. For those who used the private clinics (45%), transportation cost an average of 30 Rand ($2.3 USD), or was sometimes provided by the clinic, and the consultation fee at the private clinics ranged from 30 to 280 Rand ($2.3–21.5 USD). Therefore, the total costs of transportation and consultation fees at private clinics represented roughly 1–7% of the median combined monthly income of the participant and his partner per visit. Only four participants (20%) indicated that they currently or have recently used a traditional or

Table 1: Aggregate demographic characteristics of study participants (n = 20)

Demographic characteristic	Number (%)
Age	Median: 41
	Range: 28–57
Ethnic/linguistic group Number of participants	Sotho: 2 (10)
	Sepedi: 5 (25)
	Venda: 2 (10)
	Tsonga: 1 (5)
	Xhosa: 2 (10)
	Zulu: 3 (15)
	Ndebele: 3 (15)
	Shona: 2 (10)
Religious affiliation Number of participants	Christian: 6 (30)
	Apostolic: 3 (15)
	Zion: 2 (10)
	Lutheran: 2 (10)
	Traditional culture: 2 (10)
	Unspecified: 2 (10)
	Not religious: 3 (15)
Educational attainment Number of participants	Less than secondary: 13 (65)
	Graduated secondary: 4 (20)
	Tertiary: 3 (15)
Employment status Number of participants	Formally employed: 4 (20)
	Piece work or vendor: 8 (40)
	Unemployed: 8 (40)
Partner's employment status Number	Formally employed: 13 (65)
	Piece work or vendor: 3 (15)
	Unemployed: 4 (20)
Monthly combined income Rand/USD	Median: 4500/346
	Mean: 5520/425
	Range: 0–20 000/0–1538
Marital status Number of participants	Married: 16 (80)
	Engaged: 3 (15)
	Not married: 1 (5)
Length of relationship with partner Years	Median: 9.5
	Mean: 12.75
	Range: 4–33
Public/private healthcare users Number of participants	Public: 11 (55)
	Private: 5 (25)
	Public or private: 4 (20)
Users of traditional healers Number of participants	Current traditional healer user: 3 (15)
	Current faith-based healer user: 1 (5)
	Past traditional healer user: 6 (30)
	Does not use: 10 (50)

Table 1. Continued

Demographic characteristic	Number (%)
Medical aid status (private health insurance) Number of participants	Has medical aid: 2 (10)
	No medical aid but partner does: 2 (10)
	No medical aid: 14 (70)
	Unspecified: 2 (10)
Affiliation with gender advocacy organization Number of participants	Affiliated: 4 (20)
	Participated in events: 2 (10)
	No affiliation: 14 (70)

faith-based healer, which were deemed to be very physically accessible. Only two participants (10%) had medical aid (health insurance), and two (20%) did not but indicated that their partner did.

Analytic themes

We describe the participants' knowledge of BC and cancer in general, (mis)conceptions about the disease, educational resources, barriers regarding their access to health care and relevant expressions of gender norms, roles and relations. The number of participants indicating a particular response is indicated in brackets. Pseudonyms are used to protect the participants' confidentiality.

Participants' knowledge of (breast) cancer

Many participants (11) had limited or no knowledge of cancer or offered only vague descriptions of the disease. The most commonly mentioned types were lung (6) and blood cancer (3). Commonly reported risk factors were smoking (13), drinking alcohol (10), familial history (9) and eating unhealthily (7). Inaccurate causes of cancer were cited such as putting objects (e.g. money and cell phones) in your bra (2), a shortage of enzymes (1) and using unfamiliar soaps (1). Four participants were unable to mention any risk factors or causes of cancer. Nine participants identified a lump as a sign of BC. Two further described this as a blood clot, and another as a 'bruise under your breast' (Rapula). Four participants also mentioned pain and itchiness in the breast as symptoms.

Eleven did not know any treatment options for cancer, though seven reported that the breast could be removed. Three participants identified chemotherapy as a treatment option but could not describe it in detail. When asked if they knew if their partner had ever checked herself for BC (completed breast self-examination), four indicated that she had, four reported that she had not and twelve were unsure.

Conceptions of cancer

Though ten participants believed that cancer could *not* be spread to others, three thought it could be passed to a baby through breastfeeding. Other reported forms of transmission were sexual intercourse (2), eating off the same plate (1) and using the same toothpaste (1), leading to beliefs such as 'She mustn't do or touch anything…she have to... stay on their own room.' (Banele). Some participants conflated the characteristics of cancer with that of HIV/AIDS, illustrated by reported transmission through breastfeeding (3) and sexual intercourse (2) and discourse such as 'Once you know your status, you can't spread [to] someone.' (Amogelang).

Though most participants (15) reported that BC could *not* be 'sent' to you by someone else, some described cultural beliefs about being cursed with a disease. They displayed fatalistic beliefs such as '[it's just] bad luck to be attacked by the disease' (Bonani) and '[these things] are meant to be' (Akhumzi). Many believed that 'cancer doesn't discriminate' (Lethabo) (12) by race. Despite this belief, some (6) believed that cancer is specifically dangerous to low-income Black South Africans because of financial instability, which can make it difficult to obtain treatment. For example, Khuselwa admits: 'Maybe I might just…let the cancer eat me up because I don't know…where I will go.' Some also believed that low-income Black South Africans have less awareness of BC, contributing to advanced presentation: '…so the time you see that you got cancer, there will be no time for you to live' (Mcebisi).

Participants were adamant about the need to visit the clinic if they or their partner suspected they had cancer and to do so early, 'before it grows' (Mcebisi). Most (11) believed that cancer was survivable if treatment was received.

Educational resources

Participants reported learning about cancer through television (i.e. health programs and soap operas) (11), famous figures (5), magazines and newspapers (5), conversation (4) and the radio (4). The majority (15) reported that cancer is not discussed in their community. According to Khuselwa: 'You, you come across someone who's sick, the first thing that comes to mind is, 'She's got AIDS, she's got HIV and stuff'... But I think… a lot of people might have it [cancer], but they already died but they didn't know it was cancer.' Participants expressed the need for more education about cancer in their community, stating 'Education can be…an *answer* to it' [italics reflect participant's emphasis] (Bonani), in terms of the lack of discussion of cancer in their community. A lack of knowledge was also a reason that a BC diagnosis would be feared: 'if you don't have information you are automatically thinking of death.' (Matsimela). Ten participants specifically expressed the desire to learn more about cancer,

but some admitted that they did not know where they could find further information.

Access to health care

Participants expressed multiple sources of dissatisfaction regarding the public clinics, including inconvenient clinic hours, long queues and disrespectful treatment. Sicelo adds: 'Just walking there and going there, you can get robbed, get shot or get killed… or get raped if you're a woman.' These issues generally led participants to prefer the services at private clinics, despite the consultation fee. There was a perception that private clinics are 'better than the public centers' (Matsimela) and should be sought when the health issue is serious. Other barriers to accessing health care were the cost of transport.

Expressions of relevant gender norms, roles and relations

A lack of employment appeared to be a significant source of discomfort for many of the men; they often expressed a feeling of responsibility for providing for their spouses and/or families. One participant expressed his frustration that his wife was the financial provider: 'So like, it frustrates me… she's the one who's doing a lot of things for our daughter… I feel like I should be the one providing for my daughter, and providing for her.' (Khuselwa)

In their partner's access to health care, the men played varied roles. With respect to finances, some expressed the belief that the man should provide the funds for his partner to access health care. For instance: '… I'm the one who's supposed give her money. No matter she got her money around… I'm the one who's supposed to do it because that is my house.' (Thuso) In contrast, some expressed that they shared the money equally, that she would use her own, or that they would need to borrow funds from others.

Many of the men (11) reported that they would go with their partner to the clinic if possible, though she could also go alone or with other family members. Seven indicated they would always go with her. Nine participants believed their partner should ask permission from him to receive health care and ten indicated that she does not require his permission. As Lubanzi asserted: 'She just go, she must go. She's a woman, she's my wife. Yeah, her health comes first…There's no need to ask permission from me.' The participants often described the openness they had with their partner, for example: '…this one is going to be my friend, forever. We can share everything.' (Thuso). Most (18) believed she would tell him if she had an issue with her breast, and two did not specify.

The participants also described changes in gender roles that occurred in times of illness or underemployment. For example, one participant described taking on parenting duties while his partner was employed and he was not. Though he described this new role to be challenging, he asserted: 'I'm a responsible father… Even she [the child] couldn't give, realize the mother is not here because I'm there, I was there for her.' (Lubanzi)

Most of the men (14) also reported that a breast cancer diagnosis would not affect their relationship, they would stay together, and/or he would need to provide more support to her during that time. As Lethabo explained: 'Because I can't reject her at that moment. Because that's when she needs me more than before'. Of the remaining participants, four did not understand the question and one thought that a BC diagnosis would affect their relationship, though did not specify how. Two of the participants also specifically mentioned that, after learning about BC through participation in the study, they would start talking about it with their partner and if she had BC they would 'push her to get treatment, so she get(s) better' (Rapula).

DISCUSSION

Scholars in numerous contexts have advocated for the need to better understand men's role in women's access to care for BC (Asobayire and Barley, 2015; Rwamugira *et al.*, 2019). Building on this research, this study sought to identify men's understanding of BC and their perceived role in their partner's access to BC in a low-income setting in which social and structural barriers to care are substantial (Coovadia *et al.*, 2009).

Similar to other LMIC populations (Brinton *et al.*, 2014), our findings indicate that participants had limited knowledge of cancer (in general) and BC. Promisingly, almost half of the participants were able to identify a lump as a sign of BC, yet participants lack of knowledge of cancer treatments may produce fear of diagnosis, a documented barrier to seeking BC care (Moodley *et al.*, 2016). Potentially harmful beliefs that cancer is contagious were reported which appear to reflect general confusion regarding the differences between cancer and HIV. This could result in stigmatization of the individual with cancer (Oystacher *et al.*, 2018), yet it is possible that it positively facilitated the participants' understanding of the importance of being tested and treated (i.e. 'knowing one's status'). Participants generally seemed to believe that an individual will survive cancer as long as they receive treatment: the transition of HIV/AIDS from a deadly disease to a chronic illness in SA (Deeks *et al.*, 2013) may have contributed to this perspective.

Furthermore, many participants in our study believed that cancer affects individuals of all racial groups equally, a belief that may be the product of

South Africa's efforts to promote racial equality following the end of apartheid. Despite this, participants demonstrated awareness of their own vulnerable social and financial positions due to their social status, specifically their lack of access to health care, inability to afford treatment and lack of knowledge and awareness of cancer. Safety concerns when accessing health clinics were also described by participants and may be an important barrier to care especially for women; this may also be a reason for many of the participants reporting that they accompany their partners to the clinic. Self-awareness of these barriers in their community may reduce individuals' self-efficacy towards completing treatment (Sheeran *et al.*, 2016). Moreover, the lack of discussion about cancer in their community could be contributing to stigma and misconceptions about the risk that also acts as barriers to BC prevention (McFarland, 2003). Despite the lack of current discussion, participants expressed a desire to learn more about cancer and to educate others in their community, suggesting that BC prevention campaigns would be well-received in this community.

Overall, many of the men in this study described themselves as playing a primarily facilitative role in their partner's access to care. This perceived role does not align well with hegemonic masculinity, which broadly endorses and legitimizes the control of women (Jewkes and Morrell, 2010). More specifically, South African hegemonic masculinity is thought to be associated with attitudes that include: sexual control, emotional detachment, toughness, male independence, violence, domestic irresponsibility and provision of resources (Luyt, 2005). In contrast, the men in this study described emotional openness with their partner, which many portrayed to be an integral aspect of their relationship. They affirmed that they would encourage her to receive treatment for BC and described their beliefs that they would stay together in the event of illness and provide more support to her during this time. These responses align with Maree and Wright's findings (Maree and Wright, 2010) that male partners may play an important role in encouraging women to seek care for BC. The men also described examples of taking on domestic tasks when their partner became the financial provider and some indicated that resources within their partnership are shared and equally divided. Importantly, these positive findings were not only portrayed by the men that were involved in gender advocacy work: all of the participants portrayed attitudes along different dimensions that could be considered gender-equitable.

Despite this, some of the men also displayed attitudes that were aligned with conceptions of hegemonic masculinity. These were expressed with respect to some of the men controlling their partner's access to health care by requiring them to seek permission and/or through the provision of resources. These views were communicated in the same conversations in which the men portrayed the gender equitable attitudes described above. These 'seemingly contradictory' attitudes are congruent with gender ideology which emphasizes the 'independence and multidimensionality of masculinity and femininity constructs' and suggests that this construct independence allows for individuals to adopt both progressive and traditional attitudes simultaneously (Luyt, 2005). In South Africa, women's rights are actively promoted but norms of traditional masculinity still abound and are promoted by high-level political figures (Morrell *et al.*, 2012), which could be contributing to the simultaneous endorsement of both gender-equitable and traditional attitudes towards gendered behaviour. Groes-Green (Groes-Green, 2012) presents a similar argument when examining masculinity amongst boys in Mozambique, arguing that the multiplicity of masculine performances observed may be a product of the muddled entanglement of traditional male roles and modern egalitarian values that have emerged in this context.

It is important to note that the findings observed may be a product of both social desirability and selection bias. Though only four men in our sample were directly involved in gender advocacy work, recruitment of men via snowballing methods and through a member of the gender advocacy organization likely biased the sample towards those with more gender-equitable attitudes. Moreover, heterosexual men in long-term relationships in South Africa may present different conceptualizations of masculinity than other groups of South African men. Importantly, we point the reader to large datasets demonstrating the endemic nature of intimate-partner violence in South Africa (Jewkes *et al.*, 2009) to suggest that the overarching picture may not be as optimistic as our findings suggest. Moreover, the interviews in this study were conducted by the first author, a young, white, Canadian woman. The incongruence between her identity and the interviewee's identity may have resulted in different performances of masculinity than would have occurred if the interviews were conducted by a Black South African man or woman. Though challenging, this outsider perspective can have benefits with respect to allowing interviewers to remain critical while examining the data as well as the potential for less concern from participants about being judged by a member of their community (Tinker and Armstrong, 2008).

Recommendations and conclusions

Awareness and prevention efforts for BC in LMICs have the potential to significantly impede the effect

of the disease on the population (Yip *et al.*, 2011). Strategic public health messaging in written and verbal form and in all local languages should be implemented to encourage earlier symptom recognition and presentation to the health care system. It will be important to distinguish cancer from other common afflictions such as HIV/AIDS, to target specific misconceptions about the disease and to tailor messages to marginalized and low-income groups. Educational efforts should be accompanied by a corresponding increase in health care resources for at-risk communities with a commitment to mitigating difficult barriers to care such as the costs of transportation and safety issues encountered when accessing health clinics. Initiatives that aim to include men in BC awareness interventions and to empower women to be more in control of their health needs are necessary. Moreover, efforts to encourage gender-equitable norms surrounding women's autonomy, in general and specifically with respect to access to health care, should be initiated and supported by the government, civil society and the media.

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ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study received ethical approval from the Hamilton Integrated Research Ethics Board in Hamilton, Ontario, Canada, and the University of the Witwatersrand Research Ethics Committee (Medical) in Johannesburg, Gauteng, South Africa.

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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