The fear of social stigma experienced by men: A barrier to male involvement in maternal services in Misungwi District, rural Tanzania

Maendeleo Boniphace

Catholic University of Health and Allied Sciences

Dismas Matovelo (✉ magonza77@yahoo.co.uk)

Catholic University of Health and Allied Sciences

Rose Laisser

Catholic University of Health and Allied Sciences

Victoria Yohani

Catholic University of Health and Allied Sciences

Hadija Swai

Bugando Medical Centre

Leonard Subi

Ministry of Health, Community Development, Gender, Elderly and Children

Zabroni Masatu

Ministry of Health, Community Development, Gender, Elderly and Children

Sylvia Tinka

Catholic University of Health and Allied Sciences

Hannah Faye G. Mercader

University of Calgary

Jennifer L. Brenner

University of Calgary

Jennifer L. Mitchell

University of Calgary

Research Article

Keywords: Fear, social stigma, maternal health, rural-Tanzania

Posted Date: March 16th, 2021

DOI: <https://doi.org/10.21203/rs.3.rs-289853/v1>

Abstract

Background: Evidence have shown that male involvement is associated with improved maternal health outcomes. In rural Tanzania, men are the main decision makers and may determine women's access to health services and ultimately their health outcomes. Despite efforts geared towards enhancing male participation in maternal health care, participation remains low; one barrier that impacts men's participation is the fear and experience of social stigma. This study, built on previous findings about men's perspectives in attending antenatal care appointments in Misungwi district in Tanzania, more closely examines the fear of social stigma among men attending maternal health services.

Methods: A secondary analysis was conducted on data collected for a broader research study on male involvement in maternal services. We conducted twelve focus group discussions with males of reproductive age, and six in depth interviews with health care workers and village leaders. Interviews were audiotaped and transcripts were transcribed and translated to English. Transcripts were organized in NVivo V.12 then analyzed using thematic approach.

Results: Three main themes were found to create fear of social stigma for men: 1. Fear of HIV testing; 2. Traditional Gender Norms and 3. Financial and material insecurity.

Conclusion: Respondent's experiences reveal that fear of social stigma is a major barrier to attend maternal services with their partners. Attention must be given to the complex sociocultural norms and social context that underly this issue at the community level. Strategies to address fear of social stigma require an understanding of the real reasons some men do not attend maternal services and require community engagement of community health workers (CHWs), government officials and other stakeholders who understand the local context.

Introduction

Maternal mortality is a critical health issue in Low- and Middle-income countries (LMICs) such as Tanzania. In Tanzania, maternal mortality ratio has remained high, at about 566 per 100,000 live births [1], despite several interventions at the health facility and community levels. Over the decades, research has shown that addressing gender equity issues in LMICs is an integral part of the efforts to reduce maternal and perinatal mortality and morbidities [2, 3]. Men are often decision makers at family level in terms of when and how women access and utilize antenatal care (ANC) & delivery services and ultimately maternal and child health outcomes [4, 5].

Enhanced male participation in ANC and delivery services, can increase shared decision making in impactful health choices such as parenting, health care-seeking for delivery and illness, contraception, and family planning. Increased male involvement during pregnancy has several advantages such as in reducing maternal stress through emotional, logistical, and financial support. Furthermore, male participation during maternal services is associated with increased use of health facility delivery and use of postnatal health services and reduced postpartum complications [3, 6]. Although men play a key role

as the main decision makers in the family, interventions and programs to improve access and utilization of maternal services, often target women, and despite efforts to include and encourage men's attendance, their involvement in maternal health matters remains low [5].

Studies in Nigeria and Gambia, patriarchal countries similar to Tanzania, revealed that social stigma is one factor that contributes to men's low attendance to maternal services. In many communities, community members look down on men who escort their wives to ANC and delivery services [5, 7, 8]. In a study in Kenya, men reported that they would be perceived as being "ruled" by their wives, "ridiculed" and not seen as "men" if seen taking part in maternal services [9]. Further, economics and material insecurity have been found in other studies to be a barrier to male attendance. A study in Geita region of Tanzania found that community members may feel stigmatized for not having good attire at the health facility and is a barrier for ANC and delivery seeking [10].

The social stigma related with HIV infection and testing at health facilities can prevent male attendance for maternal services [11, 12]. While men fear being tested, they also fear that their results will not be kept confidential; healthcare worker's (HCWs) who broke confidentiality has been found in South Africa [13]. Such experiences can create mistrust, fear and resistance for men to attend maternal services [8, 10, 14, 15].

Men are clearly impacted by various cultural practices and gender roles and these may negatively impact seeking maternal services. In our recent study [2] we examined perceptions of males in Misungwi district that impact attendance to ANC services and described two themes: 1. Perceived exclusion during ANC visits among men and 2) Traditional gender norms resulting to low attendance among men, with subthemes of (a) shame and (b) secrecy. In this study, we sought to more closely examine and better understand the genesis of social stigma, which appeared in our subtheme of shame, and how the fear of social stigma impacts male attendance to ANC and delivery services.

Methods

This study was a secondary analysis of qualitative data collected for a broader research study of perceptions of male involvement in maternal services in Misungwi District located in Tanzania. The full methods for the broader research study are outlined in detail elsewhere <https://doi.org/10.1186/s12884-021-03585-z> [2]. Upon completion of our study [2], we returned to the data to more fully examine the data for stories of shame, stigma or fear, which was touched upon in our broader study.

Data analysis:

Data collected were in Swahili language, then transcribed and translated in English. The transcripts were reviewed by the technical team from CUHAS and BMC to ensure accuracy of participant interviews. The secondary thematic analysis was influenced by our analysis and findings of our first paper <https://doi.org/10.1186/s12884-021-03585-z> [2] and we used sensitizing concepts such as fear, social stigma and gender norms to more fully explore the experience of social stigma. We used NVivo version

12 to organize qualitative data. Transcripts were read line by line and chunks of data were assigned a code. The codes were organized in NVivo and code books were generated and reviewed and agreed upon by external mentors from University of Calgary (UoC) and CUHAS. Codes were organized and collapsed into themes.

Results

The table below shows demographic characteristics of respondents whose age ranged from 25–60 years and the majority were above 35 years and were married (80%) as described in the Table 1 below.

Table 1
Demographics of study participants (N = 50)

Characteristics	N	%
Age (years)		
25–34	15	30
≥35 years	35	70
Marital status		
Married	40	80
Common law relationship	10	20
Education		
Primary	41	82
Secondary	9	18
Occupation		
Peasant	42	84
Community Health Workers	2	4
Healthcare Workers	2	4
Village Leaders	3	6
Driver	1	2

The three themes found in this study include: 1. Fear of HIV testing, 2. Gendered male norms and roles and 3. Financial and material insecurity.

Theme 1: Fear of HIV testing

Respondents revealed that men fear taking the HIV test and the social stigma that accompanies having a test, testing positive and compromised confidentiality about test results. The fear of HIV is a collective fear, accompanied by social stigma in the community; however, respondents share that women may be disproportionately bearing the responsibility of being tested. Respondents shared that men may prefer their partner to attend ANC, take the HIV test and as a result many men will assume that their result is the same.

One respondent explains, *“Men are unwilling to be tested for HIV. They just tell their women, you go alone, if you are HIV negative, I am also negative”* (Father with one child). Given that HIV testing is mandatory during ANC visits, male involvement in this portion of maternal care is subsequently impacted more than other aspects of maternal and newborn care.

The fear of HIV testing is augmented by the fear that others will overhear their diagnosis or that healthcare workers breach confidentiality and may reveal a positive HIV test in front of others or share it with others without consent. Several respondents shared experiences that increase their fear of being stigmatized. One participant noted that confidentiality was not honored in the clinic:

“Some community members noticed that I was seated somewhere privately with a healthcare worker. To my surprise they asked the nurse about the conversation and this nurse revealed to him about my result. Next time I will not tell her a thing” (Father with more than one child).

“Help us with the treatment we receive from our healthcare providers, health providers should not reveal the secrets of the patients because when they do that, that person won’t tell them a thing when they meet her/him again, even if she has some illnesses, she/he won’t tell them because they are not trustworthy” (Father with one child).

Another respondent shared that community members may know the results of a man’s HIV test, and they assert that healthcare workers are sharing this information and breaching confidentiality. Some individuals noted that the physical space is often not conducive to private conversations, increasing the risk of men experiencing discomfort in taking the HIV test and desire better spaces at health facilities. One respondent explained:

“The Government should create more privacy so that there can be space to accommodate people to talk freely with a health provider so that what you tell her remains there and you do not hear about it elsewhere.” (Expectant father).

Theme 2. Gendered male norms and roles

Participants shared several impacts of the locally held beliefs about male and female roles in the community that can create a fear of social stigma for men. Attending and being part of ANC is often considered a ‘woman’s issue’ and many men report feeling shame and a fear of being laughed by their fellow men if they escort their partners to the health facility.

A father shared, *“we have a shame, shame is upon us we men to attend clinic. The shame comes when we escort our wives, other men will laugh at you...”* (Father with more than one child).

The act of men walking together with their partner and attending health facility visits is impacted by cultural beliefs. Sukuma tribe members hold the belief that men are being controlled or charmed by their partners, which conflicts with their roles as a man. A man explained:

“The community believes that if you’re with your wife all the time people will say (heeee) this man has been whipped, set under control of a woman that’s why we are not going” (Father of one child).

When couples arrive at the clinic, there are further discomforts for men and women. Culturally, it is not common for men and women to sit together in most gatherings. The father report that.

“sitting together in the waiting spaces or on the same bench is “uncomfortable to sit with many pregnant women...while there are no other men.” (Expectant father).

Having multiple sexual partners among men is an accepted norm in the study site. Yet, there is perception among men that while having a concubine is common, it is still done in secrecy. This results in men not attending appointments with women to avoid being seen by others with someone who is not their wife.

You find most of men have more than one family, so if he escorts a concubine and that man is seen by other people at the clinic, it will be revealed that he escorted another woman, that will become a barrier to escort a woman to ANC. Because men fear family conflict which may arise if he is seen with a concubine at the health facility (Father of one child).

“You find someone went out of his marriage then the woman faces challenge to come with him to clinic as others will know, that’s why they pick other men such as “boda bodas drivers” to satisfy health providers that they came with their husband” (Health care provider).

Theme 3. Financial and material insecurity

Respondents reported several experiences that contribute to insecurity, shame, and fear of being judged by health facility workers or community members. Some respondents disclosed that for Sukuma speakers, not being able to understand or speak Swahili contributed to insecurity and resistance to attend the health facility. One participant described:

“In my opinion some men do not escort their partners because they are afraid of being asked questions at the health facility, so they are shy and unconfident of expressing themselves in Swahili language if the HCW does not communicate tribe language (Sukuma)” (Father with more than one child).

“... other men are afraid to come to our facility because they have not prepared their wives with the requirements for individual birth preparedness, others are afraid to come because of economic status, so mostly those are the reasons” (Healthcare provider).

In the Sukuma community, the family is expected to bring clothes (Khanga) and other materials for the delivery of the baby. For some families who lack the economic means to provide materials or who lack the proper attire, reported shame for being unable to provide the clothes and materials. One of the respondents shared a story about a man who escorted his wife without the required clothes to support the woman after delivery:

“Some men do not escort their pregnant woman because first of all they do not take good care of them in terms of buying nice clothes, so they feel ashamed when they go together with a woman who has no proper attires” (Village Leader).

“I observed in one facility there was one man who came with his wife with one pair of cloth (khanga), and when that woman gave birth that man was asked to give his shirt in order to clean his wife’s blood, that man was embarrassed, and he said he will not attend the facility unless he has clothes for her wife” (Community Health Worker).

In Sukuma culture, it is important for men to be the provider and are considered the ‘head of the household’ and being perceived as unable to provide for their wife and baby is a large barrier in attendance to ANC and delivery services.

Discussion

We found several experiences about the fear of social stigma that serve as a barrier to men’s attendance and involvement to maternal services in rural Tanzania. There is a social stigma surrounding HIV testing and testing positive for HIV, which is augmented by fears of a lack of confidentiality around test results. Engrained gender norms impact men’s attendance, such as gendered roles (e.g., pregnancy is a woman’s issue; sitting with women at the clinic), social stigma related to appearing “charmed” by one’s partner or shame about being judged as being of a lower economic status (e.g., being unable to provide clothes/materials for their partner). While extramarital affairs are culturally common among men, they likewise are done in secret and men fear being seen by others should they escort a woman who is not their wife to the health facility. To maximize male attendance, efforts must work with communities to understand and address deep-rooted cultural and gender-based norms that create fears for men and seek local solutions to encourage meaningful participation during pregnancy in locally appropriate ways.

While men attending maternal services with their pregnant partners is increasingly being endorsed as a standard to promote optimal family-centered care, its achievement in many communities in rural Sub-Saharan Africa, has been hard to accomplish [2, 6]. While our study presents fears of social stigma which may be unique to the Sukuma tribe, our themes are consistent with other countries which have identified similar barriers to maternal services [10, 16]. Similar to other traditional gender normed communities, pregnancy is perceived as a woman’s issue [14, 17] and the social stigma against men who partake in “women’s work,” such as ANC visits, or who appear controlled by their partner [17] hinders male engagement in maternal health in Misungwi district. Moreover, in Misungwi culture, it is not common for men and women to sit together at gathering, and as such there is discomfort in sharing physical spaces

and benches with women at the health facilities. Similar experiences men's discomfort are found in Uganda [8], and in South Africa, men were sometimes told by health care workers to go outside because the space is only for women [18].

Our study echoes other studies where locally held beliefs about gender result in embedded and rigid masculine norms [12, 19, 20]. In Sukuma tribe, men are the providers for the family; our study found that fear of social stigma among community members in Misungwi was attributed to the lack of appropriate clothing during delivery and being perceived as a poor provider. Issues of poverty impacting the uptake of ANC services have likewise been found in Geita in Northern Tanzania [10]. While having multiple sex partners in Tanzania is perceived as normal practice by men, for women it is perceived as prostitution [21] and can create conflict within the family if discovered. As such men keep their affairs secret and refrain from attending appointments with women with whom they are having affairs; similar to the study in Uganda, they fear being seen, found out, judged by HCWs and want to avoid conflict with their wife or family members [22].

The social stigma associated with HIV and HIV testing at health facilities, has been identified as a barrier for male attendance to maternal services [8, 10, 12]. Men in our study fear being tested, but also fear that their results will be disclosed without their consent. Lack of confidentiality and trust among HCW's has, likewise has been found in South Africa [13]. The social stigma of HIV and HIV testing combined with the lack of confidentiality experienced by community members has strong implication on the uptake of maternal and newborn child health services. It impairs dignified respectful maternity care to the clients [8, 10]. This may in turn form mistrust for HCWs competencies, as a result the community members may decide not to seek health care services to their facility and may lead to malpractices which has legal implication to HCWs at the health facility [14, 15].

This study involved perspectives of a variety albeit relatively small sample of men and health workers from a narrow demographic group (rural communities; over 25 years old). Our sample may have missed men who may have characteristics and logistics that make it difficult for them to attend ANC and delivery services, such as those working full time, working away from the community, or men anxious about their personal situations and disclosure (i.e., polygamy, age difference, casual partner relationship). The strength of our study is that it has considered rural population where maternal service seeking for men is not favorable [23]. Qualitative data collection allowed us to explore men's perspectives on a topic which is culturally not considered to be their role and to explore the sensitive topic of their fears of social stigma.

Recommendations And Conclusion

This study is important for policymakers, government, and development partner maternal program implementers who strive to integrate men into visits to enhance family-centered care. In rural settings in Tanzania, increased male attendance at ANC and delivery will not increase solely because of policy or encouragement. Real change in male engagement in maternal issues will occur when there are clearer understandings of the local source of stigma that might inhibit men's attendance, and strategies that are

respectful of cultural and gender norms. This study suggests incorporating locally relevant strategies to encourage men's attendance, such as local government meetings that incorporate an agenda to discourage unfavorable gender norms through community-based education and role modeling at various levels of local government and community. Community health care workers (CHWs) and "male champions" can help to educate men and model for men, the importance of attending ANC services with their partners, while also specifically addressing and validating their fear of social stigma. The health facility management can consider health facility environment which supports men's needs during ANC and delivery, such as adherence to confidentiality, sensitivity and strategies that address language barriers and programs that provide supplies to those who cannot afford them.

Addressing uptake of maternal and newborn services in culturally bound communities requires understanding of the social stigma experienced by men, as stipulated in this study, to help in formulating interventions that are tailed to community needs in rural settings in Tanzania. While social stigma may vary from one community to another, men must be heard and understood within their local context, with community solutions developed to acknowledge and challenge sources of stigma.

Abbreviations

ANC: Antenatal Care; BMC: Bugando Medical Centre; CHW: Community Health Workers; CUHAS: Catholic University of Health and Allied Sciences; FGD: Focus Group Discussion; HCW: Health care workers; HIV: Human Immunodeficiency Virus; IDI: In-depth Interviews; KII: Key Informant Interviews; MoHCDGEC: Ministry of Health Community Development Gender Elderly and Children; UoC: University of Calgary.

Declarations

The following were adhered during the period of this study sites in Misungwi.

Ethics approval and consent to participate

Ethical clearance for this study was given by the Catholic University of Health and Allied Sciences Research & Ethical Committee (CREC/201/2017), National Institute for Medical Research Lake Zone Institutional Review Board (MR/53/100/493), Mbarara University of Science and Technology Research Ethics Committee (MUREC #04/06-17), Uganda National Council for Science and Technology (SS #4386), and the University of Calgary Conjoint Health Research Ethics Board (REB17-1741). Prior to data collection in the field, we obtained permission from the District Medical Officer in Misungwi and respective village leaders. The respondent signed consent forms and confidentiality of their information was observed during the research study. To ensure confidentiality, respondents were given numbers and asked to mention it instead of names during the interview and all information collected were kept confidential in the research unit.

Consent for publication

The respondents gave permission to the researchers to publish the findings in different academic forums such as conferences and public it in peer review journal but keeping in mind not exposing their names in the quotes as was signed in the consent forms.

Availability of data and Materials

For data and materials used in this study can be requested from the project principal investigator through this contact: Dr. Dismas Matovelo at magonza77@yahoo.co.uk.

Competing interests

All authors in this study do declare that we do not have any competing interest.

Funding

This work was carried out with the aid of a grant from the Innovating for Maternal and Child Health in Africa (IMCHA) initiative, a partnership of Global Affairs Canada (GAC), the Canadian Institutes of Health Research (CIHR), and Canada's International Development Research Centre (IDRC). The views expressed herein do not necessarily represent those of IDRC or its Board of Governors. The funder had no competing influence in the entire research study proposal, and development manuscript. The fund provided was used to carry out all research study duties such field activities, transport, and personnel.

Authors' contributions

BM: Wrote the first draft of manuscript and lead the team. DM, JB, JM: reviewed several drafts of the manuscript, designed the protocol, and provided technical inputs to the study. RL: reviewed the study protocol, interview guide and supported the team with data analysis. ST, HS: Supported the team with data analysis. VY: Reviewed the interview guide tool, coordinated the team in data collection & analysis and reviewed the manuscript. HM: involved in the initial design of the study and reviewed the manuscript. LS and ZM: provided technical inputs to the study and involved in the design of the protocol. All authors read, agreed, and approved manuscript to be send in peer review journal for publication consideration.

Acknowledgements

The authors of this study would like to thank all who made this study take place including the funders of this study, Misungwi District and village leaders, research assistants, and Community members within Misungwi District in Tanzania.

References

1. United Republic of Tanzania: Ministry of Health, Community Development, Gender, Elderly and Children. *The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016–2020): One plan II. Dar es Salaam*. 2016.

2. Boniphace M., Matovelo D., Laisser R., Swai H., Yohani V., Tinka S., et al., *Men perspectives on attending antenatal care visits with their pregnant partners in Misungwi district, rural Tanzania: a qualitative study*. BMC Pregnancy and Childbirth, 2021. **21**(1): p. 1–8.
<https://doi.org/10.1186/s12884-021-03585-z>.
3. Yargawa J. and Leonardi-Bee J., *Male involvement and maternal health outcomes: systematic review and meta-analysis*. J Epidemiol Community Health, 2015. **69**(6): p. 604–612.
<http://dx.doi.org/10.1136/jech-2014-204784>.
4. Ahmed A., Hossain, S., Quaiyum, A., Reichenbach, L., Mamun, A., Huq, N. *Husbands' knowledge on maternal health care in rural Bangladesh: an untapped resource?: 2.1–016*. Tropical Medicine & International Health, 2011. **16**.
5. Falade-Fatila O. and Adebayo AM. *Male partners' involvement in pregnancy related care among married men in Ibadan, Nigeria*. Reproductive health, 2020. **17**(1): p. 14.
<https://doi.org/10.1186/s12978-020-0850-2>.
6. Kaye DK., Kakaire O., Nakimuli A., Osinde MO., Mbalinda SN., Kakande N. *Male involvement during pregnancy and childbirth: men's perceptions, practices and experiences during the care for women who developed childbirth complications in Mulago Hospital, Uganda*. BMC pregnancy and childbirth, 2014. **14**(1): p. 1–8. <https://doi.org/10.1186/1471-2393-14-54>.
7. Lowe M., *Social and cultural barriers to husbands' involvement in maternal health in rural Gambia*. The Pan African medical journal, 2017. **27**. doi: 10.11604/pamj.2017.27.255.11378.
8. Byamugisha R., Tumwine JK., Semiyaga N., Tylleskär T. *Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: a cross-sectional survey*. Reproductive health, 2010. **7**(1): p. 1–9. <https://doi.org/10.1186/1742-4755-7-12>.
9. Nanjala M. and Wamalwa D., *Determinants of male partner involvement in promoting deliveries by skilled attendants in Busia, Kenya*. Global journal of health science, 2012. **4**(2): p. 60. doi: 10.5539/gjhs.v4n2p60.
10. Konje ET., Hatfield J., Kuhn S., Sauve RS., Magoma M., Dewey D. *Is it home delivery or health facility? Community perceptions on place of childbirth in rural Northwest Tanzania using a qualitative approach*. BMC pregnancy and childbirth, 2020. **20**: p. 1–11. <https://doi.org/10.1186/s12884-020-02967-z>.
11. Chibwae A., Kapesa A., Jahanpour OL., Seni J., Basinda N., Kadelya E., et al., *Attendance of male partners to different reproductive health services in Shinyanga District, North western Tanzania*. Tanzania Journal of Health Research, 2018. **20**(2). <https://doi.org/10.4314/thrb.v20i2>.
12. Maluka SO. and Peneza AK, *Perceptions on male involvement in pregnancy and childbirth in Masasi District, Tanzania: a qualitative study*. Reproductive health, 2018. **15**(1): p. 1–7.
<https://doi.org/10.1186/s12978-018-0512-9>.
13. Grant M., Wilford A., Haskins L., Phakathi S., Mntambo N., Horwood CM. *Trust of community health workers influences the acceptance of community-based maternal and child health services*. African

- journal of primary health care & family medicine, 2017. **9**(1): p. 1–8.
<http://dx.doi.org/10.4102/phcfm.v9i1.1281>.
14. Ganle J.K., Ganle JK., Dery I., Manu AA., Obeng B. *'If I go with him, I can't talk with other women': Understanding women's resistance to, and acceptance of, men's involvement in maternal and child healthcare in northern Ghana*. Social science & medicine, 2016. **166**: p. 195–204.
<https://doi.org/10.1016/j.socscimed.2016.08.030>.
 15. Mrisho M., Schellenberg JA., Mushi AK., Obrist B., Mshinda H., Tanner M., et al. *Factors affecting home delivery in rural Tanzania*. Tropical medicine & international health, 2007. **12**(7): p. 862–872.
<https://doi.org/10.1111/j.1365-3156.2007.01855.x>.
 16. Aborigo R.A., Reidpath DD., Oduro AR., Allotey P. *Male involvement in maternal health: perspectives of opinion leaders*. BMC pregnancy and childbirth, 2018. **18**(1): p. 1–10.
<https://doi.org/10.1186/s12884-017-1641-9>.
 17. Ganle J.K. and Dery I. *'What men don't know can hurt women's health': a qualitative study of the barriers to and opportunities for men's involvement in maternal healthcare in Ghana*. Reproductive health, 2015. **12**(1): p. 1–13. <https://doi.org/10.1186/s12978-015-0083-y>.
 18. Ladur AN., Colvin CJ., and Stinson K. *Perceptions of community members and healthcare workers on male involvement in prevention of mother-to-child transmission services in Khayelitsha, Cape Town, South Africa*. PloS one, 2015. **10**(7): p. e0133239. • <https://doi.org/10.1371/journal.pone.0133239>.
 19. Kwambai TK., Dellicour S., Desai M., Ameh CA., Person B., Achieng F., et al. *Perspectives of men on antenatal and delivery care service utilisation in rural western Kenya: a qualitative study*. BMC pregnancy and childbirth, 2013. **13**(1): p. 1–10. <https://doi.org/10.1186/1471-2393-13-134>.
 20. Morfaw F., Mbuagbaw L., Thabane L., Rodrigues C., Wunderlich AP., Nana P., et al. *Male involvement in prevention programs of mother to child transmission of HIV: a systematic review to identify barriers and facilitators*. Systematic reviews, 2013. **2**(1): p. 1–13. <https://doi.org/10.1186/2046-4053-2-5>.
 21. Nyblade L., Stockton M., Nyato D., Wamoyi J. *Perceived, anticipated and experienced stigma: exploring manifestations and implications for young people's sexual and reproductive health and access to care in North-Western Tanzania*. Culture, health & sexuality, 2017. **19**(10): p. 1092–1107.
<https://doi.org/10.1080/13691058.2017.1293844>.
 22. Larsson EC., Thorson A., Nsabagasani X., Namusoko S., Popenoe R., Ekström AM. *Mistrust in marriage-Reasons why men do not accept couple HIV testing during antenatal care-a qualitative study in eastern Uganda*. BMC public health, 2010. **10**(1): p. 1–9. <https://doi.org/10.1186/1471-2458-10-769>.
 23. Fotso J.C., Higgins-Steele A., and Mohanty S. *Male engagement as a strategy to improve utilization and community-based delivery of maternal, newborn and child health services: evidence from an intervention in Odisha, India*. BMC health services research, 2015. **15**(1): p. 1–10.
<https://doi.org/10.1186/1472-6963-15-S1-S5>.