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Men's Health Days in southern Malawi: service uptake and implementation barriers and enablers

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Abstract

Background

Men in sub-Saharan Africa often experience lower uptake of preventive and outpatient health services than women. In Malawi, previous research suggests that routine health services do not always respond well to men's needs and preferences. This study assessed the implementation of Men's Health Days (MHDs), a free, male-focused Saturday morning service model introduced in four health facilities in southern Malawi.

Methods

We conducted a mixed-methods study. Quantitative data were obtained from routine programme records on participation and services delivered between August 2022 and January 2024. Qualitative data were collected from women, healthcare workers, stakeholders, and programme documentation to identify barriers and enablers to implementation. Quantitative data were analysed descriptively, and qualitative data thematically.

Results

A total of 3,636 men attended MHDs across the four participating facilities, with average attendance ranging from 42 to 57 men per centre per day. Qualitative data included focus group discussions with 40 women, debriefing meetings with 30 healthcare workers, stakeholder meetings with 14 participants, and programme documentation. Key enablers were Saturday delivery, free services, a male-focused space, integrated screening and treatment, and community mobilisation. Participants reported that men felt more comfortable, recognized, and included in the service. Main barriers were shortages of medicines and supplies, reduced participation after incentives were withdrawn, uneven communication in remote areas, transport challenges for staff, and concerns about financial sustainability. Women, providers, and stakeholders also described perceived improvements in household communication and community health awareness.

Conclusions

MHD appeared to be a feasible and acceptable male-friendly service model for engaging men in health pathway. MHDs may help address barriers to men's access to care. In the longer term, the integration of the most effective elements into routine services may contribute to more inclusive, gender-sensitive care and more equitable access for both men and women.

Introduction

Across sub-Saharan Africa (SSA), men's engagement along the health pathway is often limited. A recent global review found that, in many settings, men had lower rates of healthcare seeking, diagnosis, and treatment adherence to HIV/AIDS, diabetes, and hypertension [1]. More broadly, the evidence base on men's health literacy and health-seeking remains uneven and is heavily concentrated on HIV and sexual and reproductive health, as sex-disaggregated data is often not available for other conditions [2]. Existing literature suggests that men's lower use of services is shaped not only by socio-economic factors, social-cultural beliefs, traditional masculinity norms, stigma and men's knowledge [3,4], but also by the way services are organized and delivered. Reported barriers include inconvenient clinic hours, long waiting times, direct and indirect costs, limited privacy, and the perception that health facilities are primarily designed for women and children [2,5–7].

Evidence from Malawi showed that main factors associated with men's attendance are related to limited responsiveness of facility-based services to their needs. In a community-representative survey, most men reported at least one health facility visit in the previous year, either as clients or caregivers, suggesting that men have contact with services [8]. However, this contact does not necessarily translate into uptake of preventive or screening services [9]. This pattern is consistent with the Gendered Health Pathways Programme analysis, which shows that men have lower rates of diagnosis and treatment adherence than women for HIV/AIDS, diabetes, and hypertension. In addition, negative service experiences—particularly those related to cleanliness, medicine availability, waiting time, provider attitudes toward men and not offered screening—have been associated with lower HIV testing among men. Studies from Malawi also found that men living with HIV often preferred workplace (markets and other casual employment sites), social (football pitches, bars, churches, traditional Malawian board game spaces), and outreach-based services (mobile clinics and weekend door-to-door services), while health facilities were the least preferred option [10,11]. Our previous systematic review further showed that interventions specifically designed to engage men can improve male partner attendance and strengthen male involvement in antenatal and HIV care, particularly when they include multiple integrated components such as health education and provider-supported strategies [12]. However, current evidence also indicates that person-centred approaches tailored to men may improve clinical outcomes, as men tend to value positive interactions with providers and tailored counselling more than the specific delivery model itself, such as community-based ART distribution [13,14]. Together, these findings suggest that improving men's engagement may requires services that are not only more accessible, but also more acceptable, person-centred, and responsive to their preferences.

While the literature has described many barriers to men's care-seeking and preferences, there is still limited evidence on how male-friendly service models can be organized and delivered in SSA, particularly within facility-based services. Our literature research on existing implementation studies suggest that male-friendly approaches may improve men's engagement when they combine features such as male-only staff, integrated services that address multiple health needs in a single visit [15], and flexible delivery models (workplace- or mobile-based clinics and weekend services) [2,10,16–18]. However, many of these models have been delivered as stand-alone or specially organized services rather than as part

of standard weekday care [7,15,18]. As a result, there is still limited evidence on how male-friendly, facility-based models can be delivered in ways that are feasible and acceptable in SSA.

To address this gap, Men's Health Days (MHD) were introduced in four health facilities in southern Malawi as a free, male-focused Saturday morning service. MHD were previously piloted in our implementation study in the same area, entitled WeMen [19], with the aim of improving male partner involvement in women's care. In the same setting, our previous qualitative work also showed that male support is complex and shaped by gendered power relations, and that what is framed as support may also involve control over women's access to care[20]. The intervention offered health education, screening, counselling, outpatient consultations, and medication dispensing; it was designed to reduce barriers related to work schedules, direct costs, long waiting times, and men's discomfort with conventional services. This study assesses the implementation of MHD by: (1) describing the intervention and services delivered; (2) reporting service uptake during the implementation period; and (3) identifying key barriers and enablers to implementation from the perspectives of female partners, healthcare workers, and stakeholders.

Methodology

Study design

This study employed a mixed-methods design. The quantitative component described participation in MHD and the volume of services delivered during the implementation period. The qualitative component explored barriers and enablers to implementation using multiple data sources: focus group discussions (FGDs) with women, debriefing meetings with healthcare providers, stakeholder meetings, and programme manager reports (Fig. 1).

Study setting

The study was conducted as part of the wider project entitled "Bridge the Gap: reducing gender disparity in the fight against HIV/TB in Malawi," funded by the Italian Agency for Development Cooperation (2022–2024). The broader project combined health worker mentorship with a gender-responsive strategy. This analysis is rolled out in selected facilities located in three rural districts of southern Malawi: Balaka, Machinga, and Mangochi. These facilities are either public or CHAM-affiliated hospitals (Christian Health Association of Malawi). They are part of DREAM, a public health initiative focused on ART, PMTCT, TB, and the prevention and treatment of non-communicable diseases [21].

Description of the intervention

MHDs were organized as Saturday morning clinics exclusively for men aged 18 years and above. Service was offered free of charge. Each facility deployed a team including a coordinator, clinical officers, nurses, community health workers, and HIV testing services staff. The intervention combined group health education, individual counselling, clinical screening, outpatient consultations, and medication

dispensing. Topics addressed during health education included HIV, TB, malaria, non-communicable diseases, general health concerns, sexual and reproductive health, and the influence of gender norms on health-seeking behaviour.

To promote attendance, several communication strategies were used before and during implementation. These included meetings with traditional authorities, van-based campaigns with sound systems, awareness campaigns in public spaces led by male champions, and posters and flyers distributed at health centres. Each of the four centres conducted monthly community campaigns from August 2022 to January 2024, avoiding rainy and harvest seasons. In addition, during the early phase of implementation, snacks and drinks (incentive) were provided to men participating in a separate research activity conducted alongside MHDs, as specified in the research protocol and approved by the ethics committee. Although this was not part of the MHD service model and the related findings have been reported elsewhere [22]. The research activity ended in November 2022, while MHD implementation continued beyond that date.

Quantitative component

The quantitative component used routine programme records to describe participation in MHD and the services delivered between August 2022 and January 2024. The indicators extracted included the total number of men attending MHD, average attendance per facility, HIV tests performed, glucose tests, TB tests, medical check-ups, and the number of men treated or dispensed medication.

Qualitative component

Focus group discussions with female patients

Eligible participants were women aged over 18 years who were receiving HIV treatment in the same healthcare centres during the week. They were invited to participate by trained healthcare workers. The FGD guide explored gender roles, men’s roles within the household and community, women’s views on male-targeted services, and perceived changes in men’s access to care and in household or community dynamics following the introduction of MHD.FGDs were conducted between August and November 2023 in Chichewa by a Malawian social science researcher (co-author), with simultaneous translation into English to allow participation of the researcher in note-taking and moderation. Discussions were recorded, transcribed, translated, and checked locally. The guide used for the focus group discussions with women is available in Supplementary File 1.

Debriefing meetings with healthcare professionals

The debriefing meetings were attended by healthcare professionals who managed, organized and provided the services of the MHD initiative. The meetings started with a presentation and discussion of

the preliminary study results on a survey conducted with men participating the MHD on gender norms, health decision-making and access to care. The findings are described elsewhere [22]. This was followed by a discussion focused on what worked, what did not work and what could be improved during the MHD, as indicated by the After-Action Review guide [23,24]. The aim of this approach is to gather feedback from workers regarding their experiences and insights into planning and performing this service. These discussions were used to evaluate the management process, and to identify areas for improvement. The after-action review guide used for the debriefing meetings with healthcare workers is available in Supplementary File 2.

Meetings with the stakeholders

Two meetings with the directors of health districts and key regional health representatives were organized to share the MHD impact. During the first meeting, we shared the preliminary results on men participation, and service usage.

At the end of the project, a final meeting was organized to update stakeholders on the results of the project and to inform for future interventions and policy. Notes were taken during the meeting with stakeholders and integrated in our analysis.

Data Analysis

Quantitative data were summarized using descriptive statistics. To compare attendance during and after the provision of the incentive (December 2022 to January 2024), we monthly attendance was summarised by center and by period, then plotted as grouped means and as total attendance over time.

Qualitative data from FGDs, provider debriefings, stakeholder meetings, and programme reports were analysed thematically and organized around the main implementation enablers, implementation barriers, and perceived secondary effects of the intervention. An inductive approach was adopted. The transcripts and notes were read several times to identify emerging themes and a codebook was developed. The first phase of coding followed an open-ended approach using a constant comparative method [25]. The codebook was then tested on two transcripts, reviewed, and refined. Given the available data sources, the qualitative findings were interpreted as reflecting the perspectives of women, providers, stakeholders, and programme documentation. The data were then imported into Nvivo 14, a qualitative software that supports coding and data management.

Ethics

The study received ethical approval from the National Health Sciences Research Committee (AID 012349/01/4). The Director of Health and Social Services (DHSS) for Balaka, Namandanje, Mangochi, and Machinga District Council provided institutional support. Before the start of the study, all participants were required to sign or thumbprint an informed consent form. Relevant guidelines and

regulations were strictly adhered to throughout the study, ensuring that all methods were conducted in accordance with the approved protocol. The data were handled by the authors from the Scuola Superiore Sant'Anna. Personal data were used in accordance with the General Data Protection Regulation (GDPR) 2016 and Data Protection Act (DPA) 2018. Participants were informed about how their data would be used and shared, and data were anonymized and placed in secure data storage.

Results

Men's participation in the Men's Health Days initiative

An overall participation of 3,636 men across the four health centres was recorded from August 2022 to January 2024, with ranging from 42 to 57 men per center per day. Across the four health centres, the following service were recorded: 844 tests for HIV, 178 glucose tests and 181 TB tests were performed. 2,566 medical check-ups followed by 1,394 men treatment dispensation.

Men's Health Days Attendance Before and After the End of the Incentive

Figure 2. Total monthly attendance over time from the period in which snacks and drinks were provided (as part of other research activities; August 2022- November 2022) to the subsequent period in which they were not provided (December 2022- January 2024).

Participants in the qualitative component

A total of five FGDs were held with 40 women. Three FGDs were conducted in Balaka, one in Namandanje, and one in Kapire. In addition, three debriefing meetings were organized in Balaka, Namandanje, and Kapire, involving a total of 30 healthcare workers, while the two stakeholder meetings involved 14 participants (Table 1).

Table 1
Participants at meetings: center, role and number

Type	*Location of the Health centers*	*Participants*	*Total number of participants*
FGDs	Balaka	HIV-positive women	7
	Balaka	HIV-positive women	8
	Balaka	HIV-positive women	9
	Namandanje	HIV-positive women	8
	Kapire	HIV-positive women	8
Debriefing Meetings	Balaka	Nurses (2), Coordinator, CHW (2), Clinical Officer, HTS counsellor, HAS	9
	Kapire	Nurses (2), Coordinator, CHW (2), Clinical Officer, HTS counsellor, HAS	8
	Namandanje	Coordinator, CHW (4), HAS (2), HAS (2), Disease and Control Surveillance Assistance, Clinical Officer (2), Nurse	13
Stakeholder meetings	Balaka	MDs (4) Clinical officers (4) Nurses (4) Expert client (1) Administrative staff (1)	14

CHW: Community Health Worker, HTS: HIV Testing Services, HAS: Health Assistance Surveillance, MDs: Medical doctors

We analyzed the findings from these different qualitative sources by focusing on the main facilitators and barriers to the implementation of the MHD initiative.

Facilitators of the Men's Health Days initiative

The key strengths of the MHD included the offer of exclusive, male-centred services in a supportive environment where men could feel comfortable discussing their concerns. The initiative was deliberately implemented on Saturdays, delivered free of charge, and organized within existing health facilities, which made the service more accessible and familiar to participants. According to providers and stakeholders, the scheduling of the services on Saturdays accommodated men who were working during the week, while the free screenings and medication helped remove financial obstacles to participation.

A further strength of the intervention was the creation of a dedicated space for men. Providers noted that, in contrast to routine services that are often perceived as oriented toward women and children, the

MHD created an environment in which men felt more at ease and more willing to express themselves. As one participant explained:

"Men open up when they are together, and women are not around. They are engaged in the discussions, and they feel free to express themselves." (FGD with female patient, Balaka)

Another provider emphasized that men appreciated having a day that explicitly acknowledged their right to healthcare and their role as clients within the health system.

"Men were happy to come and saw this day as recognition of their role as men and their right to healthcare. Hospitals are often dominated by women, so this opened doors for them". (Debriefing meeting, Coordinator, Balaka)

The integrated nature of the services was also perceived as important. In addition to health education activities, the MHD offered clinical screening, counselling, outpatient consultations, and medication dispensing. This combination of services enabled men to address multiple health needs in a single visit and created opportunities for dialogue on HIV, TB, malaria, diabetes, and sexual and reproductive health. According to providers, these health education sessions also helped staff better understand men's views and misconceptions regarding health and care-seeking.

Finally, implementation was supported by the communication strategies used before and during the intervention. These included meetings with village chiefs, campaigns using a van equipped with a sound system, awareness activities in public spaces organized by male champions, and posters and flyers distributed in the health centres. According to participants, these multiple channels helped raise awareness of the initiative and contributed to participation.

Barriers to implementation of the Men's Health Days initiative

Despite men's participation in the initiative, several barriers to implementation were identified.

One of the main challenges during the initial months of the MHD was the shortage of essential medical supplies, including medications, glucose testing strips, analgesics, and antibiotics. These shortages affected the healthcare centres' ability to provide all the services that had been communicated in advance and, in some cases, created disappointment among participants.

A second important barrier concerned the role of incentives. During the first days of the programme, the staff provided snacks and drinks. According to providers and programme reports, participation declined after these incentives were discontinued, suggesting that incentives may have played a role in encouraging attendance, at least in the early stages of implementation.

Participants highlighted communication challenges, particularly in reaching more remote areas. Vehicles used for community sensitization were not always able to access rural locations, and information was

not consistently delivered immediately before each clinic day. According to respondents, this reduced the reach and timeliness of communication activities and may have limited participation among men living farther from the facilities.

The economic and organizational sustainability of the MHD model emerged as a further concern. Stakeholders noted that offering services exclusively for men on Saturdays requires additional resources and logistical arrangements, including staff availability, transport, and continued financing. Healthcare workers reported that working on Saturdays added to their workload and created transport difficulties, especially for staff living far from the health facilities. Stakeholders therefore questioned how such a model could be sustained and integrated on a wider scale within the national health system.

Perceived secondary effects on household communication and community health awareness

Women, and providers described perceived secondary effects of the intervention beyond service uptake. According to women's accounts, participation in the MHD appeared to stimulate discussions within the household about health, prevention, and men's roles in family health matters. As one woman explained:

"I have seen changes in my family. Before, he was not open with the children, but after he started coming here, he began talking to them about the benefits of attending and encouraged them to come with him. I think the counselling helped bring this change." (FDG1 with women, Balaka)

Participants also suggested that men who attended the MHD became more active in sharing health information with other community members and friends. Healthcare workers similarly reported that the health education component encouraged more open conversations around health, prevention, and gender dynamics within the household. However, these findings should be interpreted cautiously. In this study, the qualitative evidence on household and community effects was derived from the perspectives of women, healthcare providers, stakeholders, and programme reports, rather than from direct interviews with men. For this reason, these findings are better understood as perceived spillover effects of the initiative rather than as direct evidence of behavioural change among male participants.

Discussion

This study suggests that Men's Health Days were a feasible and acceptable male-friendly service model within four health facilities in southern Malawi. Over the 18-month implementation period, 3,636 men attended the initiative, and a substantial number of medical check-ups, HIV tests, glucose tests, TB tests, and treatments were provided. These findings indicate that MHDs were able to attract men to preventive and outpatient care when services were organized in a way that responded to their practical needs and preferences. This is particularly relevant in Malawi, where previous research has shown that routine services often fail to convert men's contact with the health system into effective opportunities for screening and care uptake [9,26].

Several features of the intervention appeared to support participation and implementation. The initiative was delivered on Saturdays, offered free services, and created a male-focused space within existing health facilities, thereby reducing some of the barriers that men commonly face when accessing care. The integrated package of health education, screening, counselling, and treatment may have increased the attractiveness of the model by allowing men to address multiple health needs in a single visit. The findings also suggest that men felt more comfortable, recognized, and part of the service in a setting that was explicitly designed for them. These findings are in line with the broader literature, which suggests that convenient timing, male-friendly environments, integrated service delivery, and respectful provider attitudes can facilitate men's engagement with health services [2,6,7,15,18]. In this respect, the dedicated space offered by MHD may have helped reduce the perception that health facilities are primarily designed for women and children.

Community mobilisation appeared to play an important role in implementation. Meetings with village chiefs, van-based announcements, male champions, posters, and flyers helped create visibility and legitimacy for the initiative. These strategies likely contributed to awareness and initial uptake. Findings show that communication remained uneven, especially in more remote areas, suggesting that the reach of the intervention depended not only on the design of the service itself but also on the strength and continuity of its outreach mechanisms. This is consistent with previous work showing that male-friendly models are more effective when service delivery is combined with active outreach and communication strategies [7,15].

A central finding of this study is that the main challenges were not related to men's willingness to attend, but rather to the practical conditions required to sustain the intervention over time. Shortages of medicines and medical supplies limited facilities' capacity to provide the services that had been advertised. Providers and stakeholders also raised concerns about Saturday staffing, transport difficulties, and the broader financial sustainability of delivering men-only services outside routine schedules. Attendance declined after the withdrawal of snacks and drinks provided during an earlier, separate research activity conducted alongside MHDs. As noted above, these were not part of the MHD service model itself, but may nonetheless have supported early uptake. From a public health perspective, even a small incentive may help increase participation; however, such measures are unlikely to represent a sustainable long-term strategy. Importantly, MHDs continued to operate after these research-related incentives ended, although with lower attendance, suggesting that the intervention remained feasible even in their absence. An important next question is whether the men who continued to attend without incentives were those with greater health needs. If so, post-incentive attendance may still represent an important route to reach those most in need of care. All these findings suggest that the main implementation question is not only whether male-friendly services attract men, but how such services can be adapted and embedded within routine service delivery to remain sustainable over time.

The study identified possible secondary social effects of the intervention. Women, providers, and stakeholders described perceived improvements in household communication, greater openness around health issues, and instances in which men shared health information with others in the community.

These observations suggest that a male-targeted service may have effects beyond the first encounter. However, these findings should be interpreted cautiously (as we did not interview men), and confirmed with further studies.

This study has several limitations. Firstly, social desirability bias may have affected the FGDs and debriefing meetings. Secondly, men were not directly involved in this qualitative research; however, our group has already published a related study based on a survey conducted with men during the MHD, as mentioned in the introduction of this paper [22]. Thirdly, the FGDs and meetings were conducted within the DREAM programme, which is a non-public healthcare setting. The results may therefore not be fully generalizable to public-sector contexts, where additional constraints may emerge. Finally, as this was an 18-months initiative, we were unable to monitor subsequent phases of diagnosis, treatment, and adherence to monitor men's behaviours and collect more information on impacts of MHD. Further research is needed in at least one area. Research should examine how the most effective elements of this model can be adapted within health systems over time. While dedicated male-focused services may help address barriers in the short term, the longer-term goal should not be the creation of separate services for men, but the development of more inclusive and gender-sensitive services in which both women and men feel recognized, welcomed, and able to access care without structural or social barriers.

This paper adds to the literature by shifting attention from whether men face barriers to care — which is already well established — to how a male-friendly model can be implemented within routine service delivery in Malawi. This study provides lessons on the characteristics that may support implementation, as well as the barriers that may undermine long-term sustainability. MHD can be understood as a promising "transitional service delivery approach". Its longer-term value may lie not in maintaining separate services for men, but in informing the design of more inclusive health services that are responsive to the needs of both men and women. Overall, MHD long-term contribution will depend on whether male-friendly service models can be adapted and integrated within broader health systems.

Conclusions

This study suggests that Men's Health Days were a feasible and acceptable male-friendly service model within health facilities in southern Malawi. By offering services on Saturdays, free of charge, the initiative appeared to reduce barriers to men's access to care. Men's Health Days represents a promising approach for engaging men in preventive and outpatient care, but further research is needed to guide the development of more inclusive and gender-sensitive services within broader health systems.

Declarations

Ethics approval and consent to participate

The study was approved by the National Health Sciences Research Committee (AID 012349/01/4). The Director of Health and Social Services (DHSS) for Balaka, Mangochi, and Machinga District Council also

provided institutional support for the study. Prior to participating in the study, all participants were required to sign or thumbprint an informed consent form. Relevant guidelines and regulations were strictly adhered to throughout the study, ensuring that all methods were conducted in accordance with the approved protocol.

All interviewees provided written informed consent prior to participation.

Consent for publication

Not applicable

Availability of data and materials

Available upon request to the first author

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

The study was conceptualized by IT. Research design and implementation were carried out by IT, IP, and SO. Data were collected by IT, SO and SHM and analysed by IT. IT, IP, CS, ALN, SHM interpreted the results. The initial draft of the manuscript was written by IT and revised by all authors. All authors approved the submitted version and agreed both to be both to be personally accountable for the author's own contributions.

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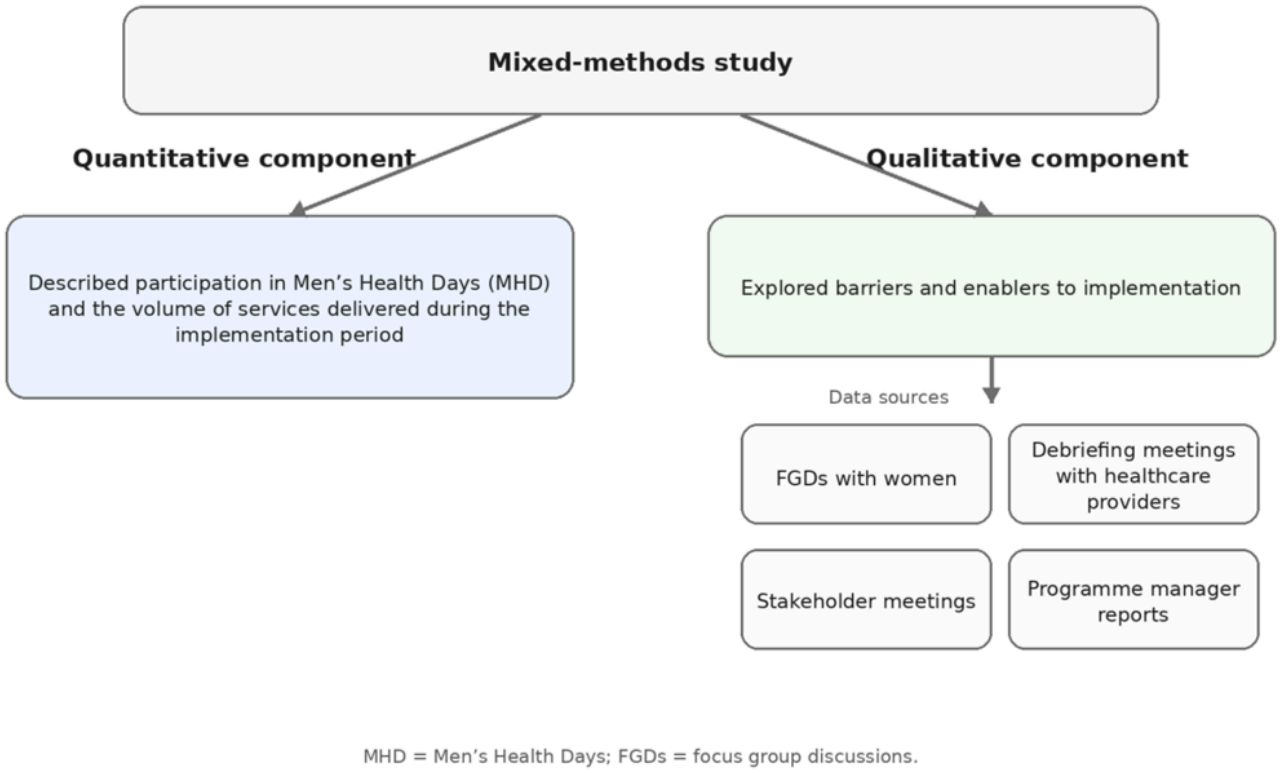
Figures



MHD = Men's Health Days; FGDs = focus group discussions.

Figure 1

Overview of the study methodology

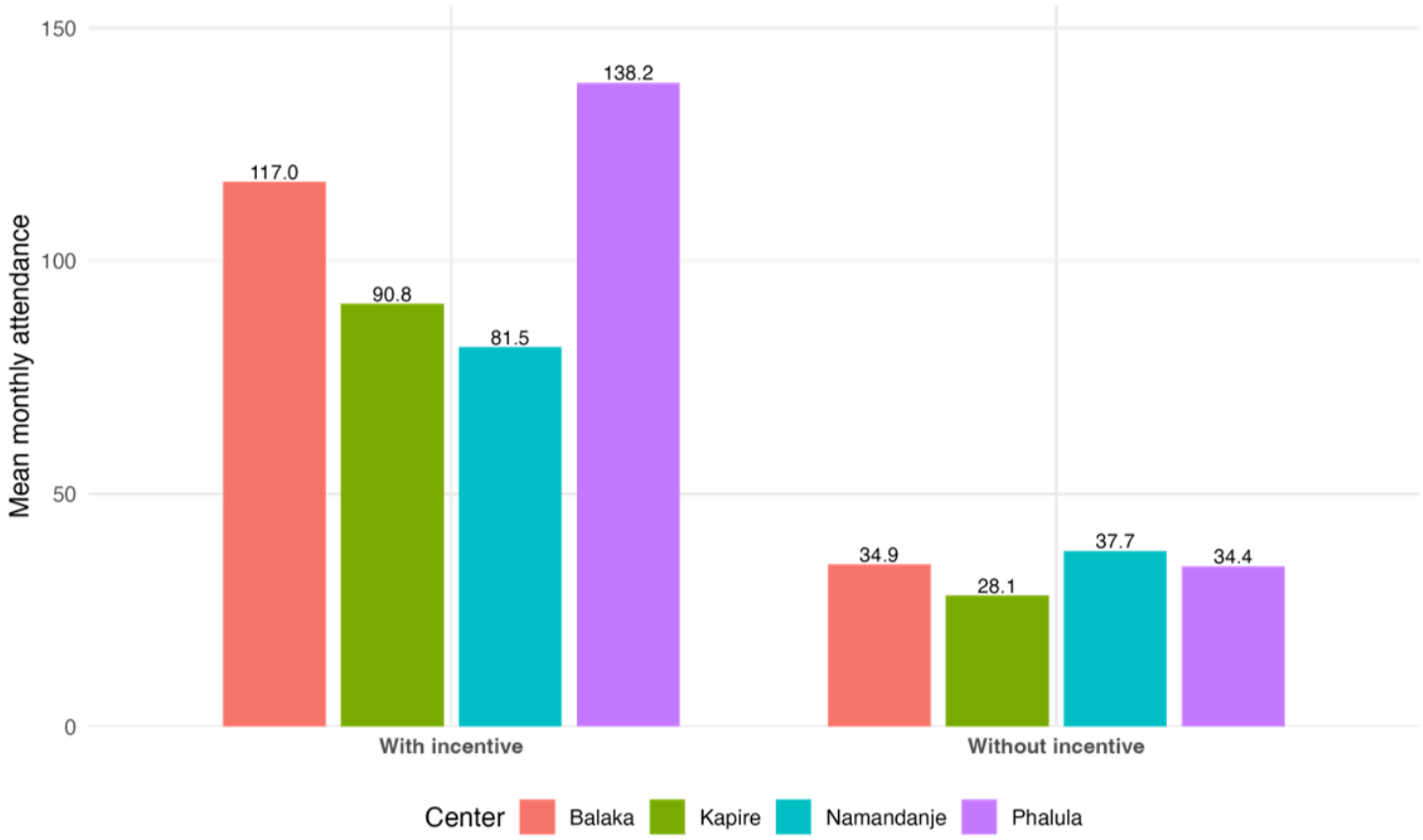


Figure 2

Figure 1. Comparison of mean monthly attendance by center between the period in which snacks and drinks were provided (as part of other research activities) and the subsequent period in which they were not provided.

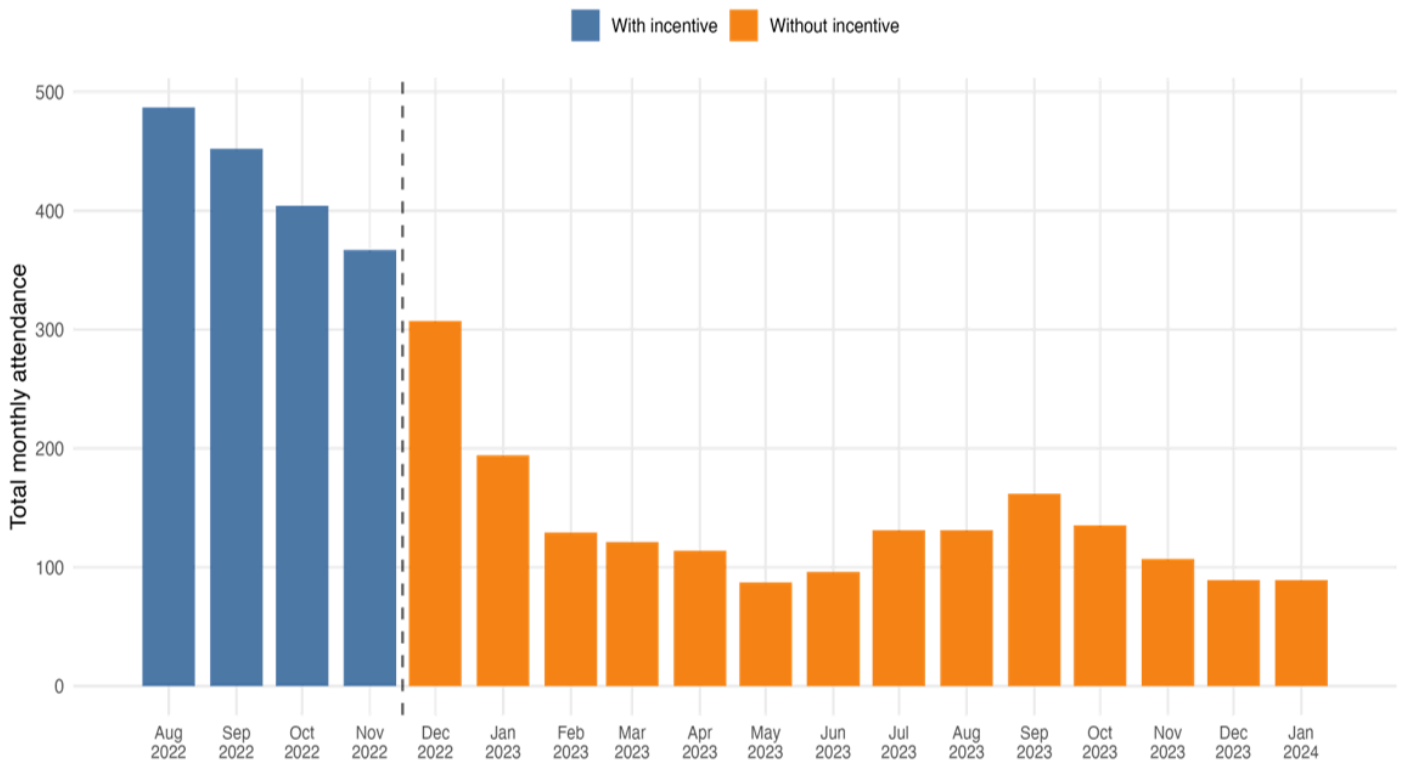


Figure 3

Figure 2. Total monthly attendance over time from the period in which snacks and drinks were provided (as part of other research activities; August 2022- November 2022) to the subsequent period in which they were not provided (December 2022- January 2024).

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SupplementaryFile1FGDsGuide.docx
- SupplementaryFile2DebriefingMeetingGuide.docx