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MEN'S HEALTH IN SUB-SAHARAN AFRICAN COUNTRIES WITH SPECIAL FOCUS ON SIERRA LEONE: CHALLENGES, STRUCTURAL DETERMINANTS AND EMERGING OPPORTUNITIES FOR GENDER-RESPONSIVE HEALTHCARE SYSTEMS.

Ibrahim Sahr Momoh

Independent Researcher, Peterborough, Cambridgeshire, UK.

Email: momohis@live.com

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ABSTRACT: ***Introduction:*** *Men in Sub-Saharan African (SSA) countries, including Sierra Leone, experience disproportionately high mortality and morbidity from infectious and chronic diseases. Despite this persistent evidence, men's health remains insufficiently prioritised in policy, research, and health system planning. This review examines the social, structural, and health system factors shaping men's health outcomes, focusing on how gender norms, labour conditions, and systemic gaps contribute to preventable illness and premature death.* ***Methodology:*** *A narrative synthesis of peer reviewed literature, regional health reports, and global health frameworks was conducted. Sources were analysed to identify themes related to masculinity norms, occupational exposures, economic instability, mental health, and health system responsiveness. Evidence was integrated across disciplines to develop a comprehensive understanding of determinants influencing men's health.* ***Findings:*** *Four intersecting determinants emerged: (1) socio-culturally constructed masculinity norms that discourage preventive care and promote risk taking; (2) hazardous labour conditions and economic precarity that heighten exposure to injury, stress, and poor health outcomes; (3) healthcare delivery systems that inadequately engage men resulting in delayed help seeking; and (4) mental health challenges obscured by stigma and limited service availability. Evidence indicates that inclusive male- and female- gender responsive policies with targeted interventions can improve men's engagement with care and other supportive services.* ***Conclusion:*** *Improving men's health in SSA is a critical public health priority and essential for advancing gender equity and strengthening health systems. A clearer, evidence-based focus on men's and boys' health, supported by gender inclusive and context specific strategies, is vital for achieving equitable and sustainable health outcomes.*

KEYWORDS: Africa, Challenges, Determinants Health, Men's, Opportunities, Sierra Leone, Sub-Saharan.

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INTRODUCTION

Human health discourse has increasingly incorporated gender-specific considerations, recognising that an individual's gender significantly influences both health outcomes and illness experiences. However, global health research remains notably asymmetric, with a long-standing focus on women's health and the inadvertent neglect of equally critical aspects of men's health. Globally, traditional gender norms significantly shape health-seeking behavior, often resulting in compromised care for men. This is particularly evident in Sub-Saharan African (SSA) countries, where rigid masculine norms often discourage men from engaging with healthcare services, resulting in delayed diagnoses and poorer health outcomes. This oversight has been aptly termed the "missing men" in global health statistics and programs (Leon & Colvin, 2024), underscoring a critical gap in current understanding and in the formulation of programs to address the health challenges faced by men, not just in SSA countries but globally (Beia et al., 2021). As a result, men in SSA countries face unnecessary barriers to accessing, engaging with, or using appropriate healthcare services, a situation exacerbated by sociocultural factors inherent to masculinities, institutional deficiencies, and problematic relational dynamics with healthcare professionals (Borges et al., 2021). In this paper, the aim is to examine the multifaceted challenges and structural determinants affecting men's and boys' health in SSA countries and identify emerging opportunities to strengthen men's health through gender-transformative interventions, targeted health screening, health education and promotion, male-friendly service design, workplace-based programs, digital health innovations, and policy integration within universal health coverage frameworks. This exploration will highlight how prevailing constructs of masculinity, coupled with economic constraints and systemic inadequacies, contribute to a disconnect between men's health needs and available healthcare services. It will also emphasise the imperative of a relational gender approach in public health to comprehensively address health inequalities.

Life expectancy and gendered health in Africa

Life expectancy in SSA appears strongly correlated with gender, with females having higher life expectancy than males across all regions. Gendered health disparities reflect the interaction of biological, social, and structural determinants that shape distinct patterns of vulnerability for women and men. Consistently, the burden of reproductive and maternal health challenges is highlighted and prioritised. The World Health Organisation (WHO, 2025) reports that, though significant progress is being made, an estimated 178,000 maternal deaths were recorded in the African region in 2025, representing about 70% of global maternal mortality. Similarly, UNAIDS (2025) reported that women and girls account for 63% of new HIV infections in sub-Saharan Africa in 2025. In situations where available resources are scarce, headline statistics like these provide a compelling rationale for prioritising women's health needs at the expense of other equally important priorities, including men's health issues. However, as shown in Fig. 1, women generally live longer than men in Africa, with a 4-year life expectancy advantage, though two regions (Eastern Africa and Southern Africa) recorded even larger differences of 6 years in 2024 (Saifaddin on Statista, 2026). Africa recorded an estimated 11,522,895 deaths in 2024, including 6,173,088 male deaths and 5,349,807 female deaths, based on UN DESA and WHO-aligned demographic modelling (United Nations Department of Economic and Social Affairs, 2024). In 2025, total deaths are projected to rise to approximately 11.7 million, with the male–female mortality ratio remaining stable at roughly 115 male deaths for every 100 female deaths (United Nations Department of Economic and Social Affairs, 2025). Hence,

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in 2024, there were **823,281** more male deaths than females, a figure equivalent to the combined population of Ndola and Mufulira Districts in the Copperbelt province of Zambia using the 2022 census figures (Zambia Statistics Agency, 2022). In Sierra Leone, for the period January – December 2025, the Sierra Leone National Civil Registration Authority (2026) recorded 10,280 male deaths and 7,625 female deaths, representing a percentage ratio of 57:43. Men continue to record higher mortality from injuries, violence, and non-communicable diseases, patterns linked to higher rates of tobacco, illegal drug, and alcohol use, and to delayed health-seeking behavior. Current population and health statistics demonstrate a gendered pattern, with men continuing to experience lower life expectancy and higher premature deaths attributable to external and behavioral causes. By comparison, women are heavily burdened by high maternal mortality rates and morbidity from chronic infectious, reproductive, and socially mediated health challenges (Naghavi et al., 2025).

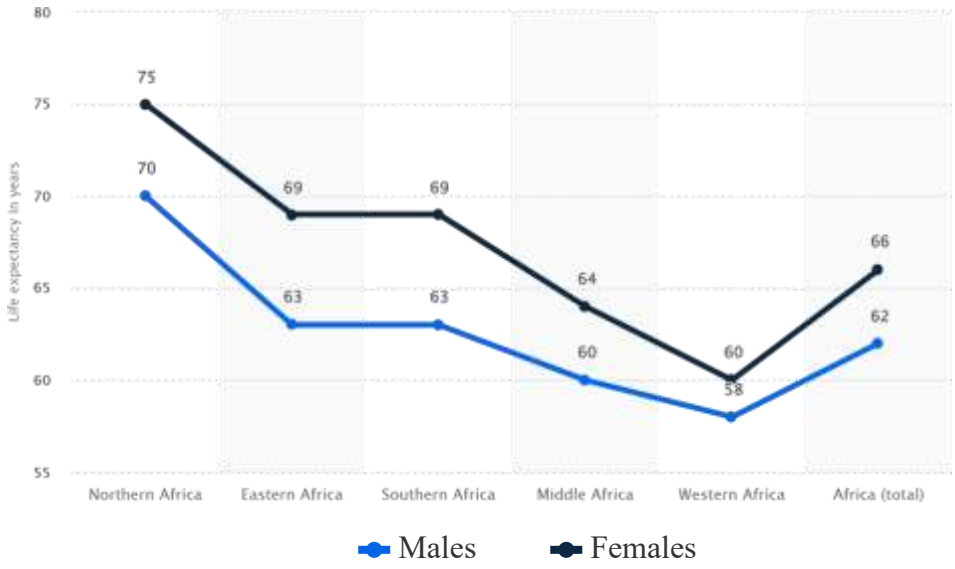

Fig. 1: 2024 Africa life expectancy at birth (Saifaddin, *Statista, 2026*).

Gender Norms, Masculinity, and Health-Seeking Behaviour

Researchers, critical observers, and advocacy groups, including Prof Alan White, Prof Derek Griffith, Prof Paul Galdas, Dr Noel Richardson, and Global Action on Men's Health (GAMH), have highlighted the role of gender norms, particularly dominant ideas of masculinity, as a key influence on men's health behaviour. They have consistently reported that norms which promote toughness, emotional restraint, risk-taking, and independence are closely linked to men delaying seeking help, avoiding preventive healthcare, and engaging in health-harming activities such as heavy drinking, unsafe sex, and risky occupational or recreational pursuits. These expectations are reinforced through socialisation and cultural norms that ascribe to men the roles of breadwinners, protectors, family heads, and decision-makers. Socio-cultural expectations have resulted in men being considered to have acquired a privileged patriarchal position in society, with all its much-discussed negative characteristics.

Globally, it is known that men view seeking healthcare as inconsistent with the ideals of masculinity. Regular medical check-ups, screenings, or prompt attention to symptoms can be

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viewed by men as signs of weakness or vulnerability (Palmer et al., 2024). As a result, men frequently delay seeking care until their symptoms become unbearably severe, leading to late diagnoses of chronic illnesses, advanced stages of infectious diseases, and less favorable health outcomes. This behavior is seen in severe communicable or infectious conditions such as malaria, tuberculosis (TB), and HIV/AIDS, as well as in non-communicable diseases such as cancer, diabetes, and cardiovascular complications, including hypertension and strokes, where early intervention is crucial to initiate or optimise care, address complications, and improve outcomes (Sathar et al., 2024).

Men, especially those living in rural areas, often perceive health clinics/hospitals as spaces primarily for women and children . Elements such as the clinic/hospital environment, staff members' communication styles, and service priorities reinforce the notion that healthcare facilities are "not for men" (Leichliter et al., 2011). This symbolic exclusion, combined with practical barriers such as long wait times, a lack of privacy, and clinic hours that clash with men's work schedules, can further discourage men from attending hospital or clinic appointments.

Cultural norms around masculinity strongly affect men's mental health. In many SSA cultures, the expectation that men remain stoic and emotionally controlled is reinforced through the enculturation process and the rite of passage for boys into manhood. Masculinity significantly contributes to the underdiagnosis of mental health conditions such as depression, anxiety, and psychological distress (Banks & Collier, 2025). Men also internalize pressures from unemployment, financial strain, or other social expectations, which can increase their risk of substance abuse and suicide (Mathieu et al., 2022). In many SSA countries, mental health services are limited, located in urban areas, and poorly integrated into primary care, offering few support options.

Epidemiological Burden and Structural Factors

The burden of both infectious and non-infectious diseases remains high in SSA. Country-specific population census data and annual health statistics data show that men have greater mortality rates, and where disaggregated statistics are reported, record very high incidence of conditions, including heart disease, diabetes, liver cirrhosis, road traffic accidents or occupational injuries, and infections, including sexually transmitted infections and tuberculosis (TB) (Schumacher et al., 2023). A mix of behavioral choices, environmental exposures, and systemic factors drives these trends, and masculinity (hegemonic or toxic) is identified as a strong influence, particularly in young, mobile male populations.

Workplace and Environmental Hazards.

The types of occupation and work environment can adversely affect employees' physical and mental health due to exposure to environmental hazards, machines, accidents, or toxic workplaces, which cause anxiety, stress, and depression. Generally, men in SSA countries are more likely to be employed in occupations such as mining, construction, fishing, transportation, and agriculture.

Figures derived from International Labour Organisation (2025, 2023, and 2024) indicate that 78% of men in Sub Saharan Africa participate in the labour market, yet a disproportionate share is concentrated in hazardous forms of work. Modelling based on sectoral risk profiles shows

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that approximately 68% of employed men which is equivalent to 53 out of every 100 working age men are engaged in high-risk occupations, particularly in agriculture, construction, transport, mining, and security services. This pattern demonstrates a pronounced gendered exposure to occupational hazards, with men substantially overrepresented in sectors characterised by physical risk, informality, and limited regulatory oversight. Such workplaces often lack adequate safety regulations, protective equipment, or effective enforcement. As a result, men face increased risks of respiratory illnesses, muscle and joint problems, and serious injuries.

In many SSA countries unstable employment, long hours, and limited social protection or access to social service benefits make it difficult to access medical care. Taking time off work for treatment can mean losing crucial income not only for the working man but also for the whole family (immediate and extended) who depend on his wages, thereby further discouraging men from taking time off to access health services. The opportunity cost of men attending a hospital clinic or working is a difficult trade-off that primary breadwinners often face. The decision between attending a hospital or clinic appointment and going to work involves weighing the opportunity cost of time and resources. Attending a hospital clinic may provide access to medical, nursing, and other allied healthcare professionals, potentially leading to more rapid investigation, diagnosis, and initiation or monitoring of treatment. However, it can also entail a significant time commitment, which the potential for improved health outcomes may offset. Conversely, going to work can provide a day's wage, vital financial support for maintaining the family, job security, and opportunities for personal growth and advancement. The decision is difficult to make in a region with very high unemployment, intense competition for available jobs, and a very limited universal social safety net.

Road Traffic Injuries

Accidents from road traffic injuries are a leading cause of disability and death among men. Traffic regulations are poorly enforced across Africa, and motorcycle accidents remain a significant challenge. Two-wheeled motorcycles and three-wheeled kekes are now very popular modes of transportation, especially among the working class, thereby exposing passengers to risk-taking behaviors prevalent among motorbike/keke riders (predominantly young men). Speeding, alcohol or drug misuse, and the non-use of protective helmets are often normalized within the masculine peer cultures of motorcycle riders, resulting in accidents that cause significant injuries and deaths.

Rapid urbanisation and inadequate transport infrastructure have led to high passenger use of two-wheeled motorcycles and tricycles (locally known as Keke), which are contributory factors in this context. Prior to the end of the civil war in Sierra Leone in 2002, comparatively few commercial motorcycles and kekes operated on routes in both rural and urban areas of the country. After the war ended, as part of the drive to reintegrate ex-combatants and child soldiers into society, there was a massive introduction of commercial motorcycles and kekes (Buccitelli & Denov, 2017). Most motorcycle riders (bike-men as they are known locally) and keke drivers are mostly young men who are often not adequately trained before being entrusted with these deadly machines. This has resulted in a reported noticeable spike in motorbike and keke accidents, which persists to this day. Similar trends in motorbike accidents, injuries, and deaths are reported in West Africa and across SSA. In all these countries, masculine peer culture dynamics, non-compliance with head helmet use, alcohol, and the use of illegal recreational

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substances have been cited as aggravating reasons for bike accidents and the resultant injuries and deaths (Ntramah et al., 2023).

Non-Communicable Diseases

Non-communicable diseases (NCDs), including cardiovascular conditions (hypertension/cardiac arrest/stroke), diabetes, cancers (prostate, testicular, or lung for men), chronic respiratory disease, chronic kidney disease, liver cirrhosis, and mental health conditions, are rising rapidly across SSA countries. According to the Africa CDC (2022), this region also experiences very high levels of neglected tropical diseases. Currently, the African Region is endemic for 20 of the 21 priority neglected tropical diseases, affecting over 565 million people and accounting for 35 per cent of the global disease burden. Reported statistics frequently show men as having a high prevalence of these conditions. Contributing factors for NCDs include diet (many SSA countries rely on increased importation and consumption of processed foods), high salt intake, tobacco use, alcohol and recreational drug use, and a growing sedentary lifestyle, particularly among affluent urban populations (Casari et al., 2022). The Sierra Leone 10-year-long civil war resulted in a massive internal displacement of its people, with men, women, and children fleeing from their homes in rural villages and seeking sanctuary and protection in the country's larger cities of Freetown, Bo, Makeni, Kenema, Kono, and Port Loko. This forced internal migration resulted in a significant increase in the populations of these cities (Statistics Sierra Leone, 2016). When the civil war ended through a United Nations- and African Union-negotiated peace deal, many of the displaced people decided to make the cities their new permanent homes. The facilities in these cities were not initially planned to accommodate such a sudden influx of people. Hence, health services are inadequate, not free, and often basic. Screening for early detection of NCDs and adherence to agreed treatment plans are vital for managing population health in resource-constrained settings. Men are less likely to present for regular screening or adhere to long-term treatment, leading to higher rates of complications and premature mortality.

Infectious Diseases

Infectious diseases caused by bacteria, viruses, fungi, and parasites are a major healthcare challenge in SSAs, with frequent outbreaks and major emergencies, as seen with COVID-19 and Ebola. Diseases like TB, HIV/AIDS, malaria, cholera, Hepatitis, Dengue, and pneumonia require prompt treatment and hence engagement with the available healthcare services. Engaging with healthcare services is a crucial determinant of health. Men's lower engagement with health services contributes to delays in diagnosing and treating infectious diseases. In HIV programmes, for example, Gaumer et al. (2026) reported that men are less likely to test, initiate antiretroviral therapy, or remain in care. Similar patterns are observed for tuberculosis, with men often presenting with advanced disease, resulting in poorer outcomes (Fiorentino et al., 2024). The consequences of suboptimal management of these infectious diseases not only affect individual men; they also endanger the lives of their intimate partners, direct contacts, and the community at large, while making it difficult to manage these communicable diseases, prevent their spread within the community, and reduce the effectiveness of available antimicrobial drugs.

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Mental Health, Stigma, and Under-Recognition

Mental health is still one of the most neglected areas of men's health in SSA countries. Widespread stigma around mental illness, combined with gender expectations, prevents many men from admitting to emotional struggles they may be experiencing. Conditions like depression, anxiety, and substance abuse often manifest as irritability, anger, or withdrawal, which leads to these conditions being overlooked or misdiagnosed (Atewologun et al, 2025).

Recent estimates indicate that male suicide mortality in several African countries is 2 – 4 times higher than that of females. According to the International Africa Health Observatory (2022), Lesotho reported male suicide rates of 35.44 deaths per 100,000, compared with 6.91 female deaths per 100,000, while South Africa shows rates of 25.68 versus 5.86. However, although female rates are lower, suicide remains a significant cause of premature mortality among young women aged 15 – 29 (World Population Review, 2026). These figures are thought to reflect substantial underreporting across the African continent due to stigma, legal restrictions, and weak civil registration systems, suggesting that the true gender burden of suicide in sub-Saharan Africa may be even greater than current data indicate.

Mental health services are typically under-resourced and historically located in cities, which makes it difficult for those residing in rural areas to access mental health support. In The Gambia, the only psychiatric hospital in the country, the Tanka Tanka Psychiatric Hospital, is located in Banjul (The Borgen Project, 2025). Similarly, in Sierra Leone, Kissi Mental Hospital, opened in 1820 and now known as the Sierra Leone Psychiatric Teaching Hospital, is the country's main hospital for mental health care, located in Freetown (Partners in Health, Sierra Leone, 2020). Many primary care workers, employed as Community Healthcare Officers (CHOs) at rural outposts in Sierra Leone and in larger towns, have limited skills to assess, diagnose, and/or manage mental health problems as they appear in men, and mental health is rarely included as part of standard health care. This creates a largely unrecognised crisis in male mental health and remains generally not prominent in most national health plans or strategies addressing men's health.

Health Systems, Policy Gaps, and Gender-Blind Approaches

Although evidence of health disparities affecting men is being highlighted, it remains a low-priority area in national policies of most SSA countries, where the focus is on women's health, especially in the area of maternal and child health. The primary concern is a drive to reduce the unacceptably high maternal mortality rates, control infectious diseases like cholera, HIV/AIDS, malaria, TB, Covid-19, Ebola, Mpox, and expand universal health coverage (Tegomoh & Titanji, 2024; WHO, 2025). While maternal mortality remains a critical priority, the overwhelming focus on women's reproductive health has inadvertently marginalised men's health needs. This gender imbalance contributes to late diagnosis, higher mortality rates, and chronic/untreated infectious diseases among men. This ultimately undermines the government's broader public health goals. Hence, men's health advocacy organisations such as the Global Action on Men's Health, African Men's Health Forum, and MenEngage Africa Alliance continue to urge national governments and international partners/non-governmental organisations to prioritise men's health and to address generic developed/agreed national/local strategies that inadvertently overlook the specific health needs of men and boys.

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Lack of Male-Focused Strategies

Health strategies are important because they provide the framework and agreed funding necessary to address the issues required to achieve health outcomes. Presently, few countries have developed explicit men's health strategies, resulting in a fragmented and inconsistent approach to addressing men's and boys' health needs (Richardson et al., 2019). National health promotion campaigns overwhelmingly prioritise women and children, reflecting long-standing public health traditions but inadvertently leaving men underrepresented in outreach, education, and community-based engagement efforts. As a result, men often receive limited exposure to preventive messaging or early detection initiatives. In SSA screening programmes for hypertension, diabetes, and cancers such as colorectal, lung, oral, and retinoblastoma rarely incorporate male-specific strategies, tailored communication, or targeted mobilisation campaigns, despite substantial evidence demonstrating lower male participation and delayed health-seeking behaviour. This gap is further compounded by structural and sociocultural barriers that discourage men from engaging with routine care. Collectively, these omissions contribute to persistent inequities in health outcomes and highlight the urgent need for gender responsive public health planning across the region (Seidler et al., 2023).

Data Gaps

Data plays a significant role in our understanding of health and in its planning. Hence, data-driven services are the new way forward. Most SSA health information systems do not consistently collect or report disaggregated data by sex and age, making it difficult to understand how patterns of healthcare service use and health outcomes differ across gender groups. Without this level of detail, policymakers struggle to identify inequities, allocate resources efficiently, and design interventions to address the specific needs of men, women, boys, and girls. This persistent gap in routine data collection continues to constrain gender-responsive health planning across many low- and middle-income settings. Encouragingly, recent developments in Sierra Leone signal progress. In January 2026, the Minister of Health commissioned a new integrated national health data hub to capture relevant gender-specific data, thereby strengthening evidence-based decision-making and guiding future policy directions (MOH, Sierra Leone, 2026).

There also appears to be a notable shortage of research on men's health across sub-Saharan Africa, particularly qualitative or mixed-methods studies that explore men's lived experiences of illness and healthcare. A Google Scholar search illustrates this imbalance. A search using the keywords *'Africa, lived, experience, illness, health, care, qualitative and quantitative research'* yielded 137,000 fewer results for men, demonstrating that health research remains uneven across the region. Universities that play key roles in higher education and healthcare research need to attract greater interest in men's and boys' health issues. Currently, there are few universities with dedicated men's health faculties or departments, or male-specific standalone study programs, although some departments clearly advertise gender studies. However, a detailed review of these programs indicates that they tend to focus more on scholarship and research relating to women's empowerment, inequalities affecting women, and women's health disparities.

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Service Design and Accessibility.

Presently, many healthcare services are often organised in ways that do not align with men's daily realities. Clinic hours overlap with working hours, waiting times are long, and services may not offer privacy or confidentiality. Due to colonial constructs, the healthcare workforce remains predominantly female, especially at lower cadres, who serve as gatekeepers to the healthcare system. Additionally, there are local taboos and traditions that men must contend with. For example, in Sierra Leone, rigid cultural norms, patriarchal household structures, and gender-segregated traditions create strong taboos that discourage men from disclosing their personal health problems to women, including their own wives. As Oosterhoff & Mills (2012) observed, these norms frame illness as weakness, reinforce male stoicism, and restrict open communication about sensitive health issues, thus contributing to delayed care-seeking and poorer health outcomes among men. There is an acute shortage of specialised mental health practitioners relative to general nurses, midwives, or doctors. Mental health training is limited in some SSA as there are no standalone Mental Health Nurse or Specialist Psychiatry training programmes. Generic curricula allocate limited time to mental health within generic nursing, midwifery, or medical training programmes.

Healthcare staff communication and interpersonal skills are another challenge. Healthcare workers who complete their generic training may require additional and/or ongoing continuous professional development (CPD) to engage men effectively. In Sierra Leone, CPD is encouraged by professional regulators, such as the Sierra Leone Nursing and Midwifery Council, but it remains non-mandatory for employment and non-statutory for license renewal. National workforce assessments have highlighted the absence of compulsory CPD systems to support registered staff (MOH, Sierra Leone, 2025). Consequently, fewer appropriately qualified staff with the requisite training and experience are available to support men's mental health issues, fostering suspicion among men, which can lead to gendered assumptions that men are disinterested or noncompliant patients. In such a system of unmet mental health needs, alternative informal healthcare services, including faith healers, diviners, traditional herbalists, or 'native doctors', are consulted instead. These unregulated practitioners can pose various negative consequences, including reported human rights abuses such as beating or chaining of the patient, locking in a dark room, restricting food or fasting or starving patients, and administering unlicensed concoctions that are potentially toxic (Berhe et al, 2024).

Emerging Opportunities for Improving Men's Health

Although many of the challenges recounted above persist, research also identifies several promising approaches to improving men's health in SSA. Examples include community-based programs, changes in health systems, and new policy approaches.

Gender-Transformative Health Promotion

Health promotion, the process of enabling people to increase their control over and improve their health, is vital. According to the WHO (2016), the basic strategies for health promotion identified in the Ottawa Charter were: advocate (to strengthen factors that promote health), enable (to allow all people to achieve health equity), and mediate (through collaboration across all sectors). In many SSA countries, donor-driven health promotion strategies have not reached the critical mass of the male population. This is because the focus has remained on maternal health, child health, and communicable diseases; an understandable approach has produced

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some measurable results. This gendered approach also shapes how health issues are reported in local media to attract public attention. Ugwu et al. (2025) analysed men's health coverage in 2 popular Nigerian newspapers. Over 1 year, they observed that only 30 men-related articles were published, an insufficient volume to sustain public and policy attention. Greaves (2025) highlights the importance of gender-transformative strategies to challenge harmful ideas about masculinity and promote healthier, more equitable behaviours. Gottert et al. (2025) provide evidence that healthcare programs that involve men in conversations about gender, relationships, and health issues affecting them, their families, and their communities reduce aggression and violence, improve sexual and reproductive health, and increase preventive or curative healthcare-seeking behavior. These methods can also be used to prevent or better manage both communicable and non-communicable diseases, support mental health, and improve workplace safety.

Men's help-seeking behavior continues to be strongly shaped by masculine norms that discourage vulnerability. However, recent evidence shows that exposure to positive male role models, peer educators, and trusted community leaders can significantly shift these attitudes. Contemporary studies show that when men observe other men modeling emotional openness and proactive health behaviors, they are more likely to reinterpret help-seeking as acceptable and socially legitimate (O'Neil & Denke, 2024). Peer-led interventions have been particularly effective, with systematic reviews showing that men engage more readily with mental health and well-being services when support is delivered by relatable male peers who normalise emotional expression and reduce stigma (King & Smith, 2023). Community-based programs further highlight the influence of local male champions, such as coaches, faith leaders, and workplace mentors, in reshaping norms around masculinity and encouraging men to seek help earlier (Robertson & White, 2023). Collectively, this emerging evidence underscores the critical role of male-led, peer-driven, and community-anchored approaches in improving men's willingness to seek support and express emotions more freely.

- **Creating male-friendly Health Services**

The way healthcare is organised will affect how the intended patient users access services. Men engage more effectively with healthcare systems when services are made more accessible and appealing to them (Galdas et al., 2025). Various strategies such as extending clinic hours to evenings and weekends, providing workplace screenings, mobile clinics, and expanded use of telemedicine through online tools/Applications have been employed in developed countries, including the UK, the USA, and the EU. Some of these strategies could be adapted and easily implemented in SSA countries, even with resource constraints. Positive benefits have also been achieved by organising special men's health clinic days, creating male-focused services, ensuring clean clinic spaces or hospital wards, investing in training healthcare staff in gender-sensitive communication, and ensuring privacy and confidentiality. Where such improvements and service redesigns have been implemented and evaluated, men report feeling welcome, thereby helping to remove practical obstacles to accessing care (Mashilo et al., 2025; Mokua, 2024).

- **Digital Health and Mobile Health Innovations**

A quiet evolution is underway in SSA countries, where younger populations are growing. The availability and use of mobile technology are reaching even into more remote areas (Vailshery,

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2026). The widespread use of mobile phones in SSA countries makes digital health a powerful means of reaching men. Mobile health (mHealth) tools can deliver health education, appointment reminders, support medication adherence, and provide mental health support. Digital platforms also offer privacy, making it easier for men to seek care without fear of stigma (Segun-Omosehin et al., 2025). Additionally, Hampshire et al. (2024) reported using data from Ghana, Ethiopia, and Malawi to document the reach, nature, and perceived impacts of community health workers' (CHWs) informal mHealth practices, as well as the equity of their distribution. They concluded that informal mhealth is already happening at scale, far outstripping its formal equivalent. They recommended that policymakers engage seriously with this emergent health system and work closely with those on the ground to address sources of inequity, without undermining existing good practice.

- **Workplace-Based Interventions**

Workers' productivity depends on their health and ability to work. Hence, the importance of occupational health departments within many employment organisations, especially in developed countries, where organised unions protect workers and promote their health. Workplaces provide a practical and accessible setting for reaching men who may rarely engage with formal health services. Employers can integrate health education, routine screenings, and safety training into the workplace, which is especially valuable in high-risk sectors such as mining, construction, manufacturing, and transportation (Hulls et al., 2022). Delivering services directly at job sites reduces common barriers such as time constraints, travel costs, and the stigma associated with visiting clinics. It also normalises preventive care as part of everyday working life, helping men adopt healthier behaviours, identify health issues earlier, and contribute to a stronger culture of wellbeing within their organisations.

- **Community and Faith-Based Engagement**

In many communities, there is an easily accessible resource in community leaders, religious groups, and traditional authorities who wield significant influence over daily life and collective decision-making. However, their services are often left untapped, especially in the implementation of donor-sponsored health-related projects, despite their authority shaping social norms, gender expectations, and attitudes toward health-seeking behavior among men (Adeniran et al., 2024). When men's health initiatives intentionally involve these key stakeholders, healthcare programs become more culturally grounded, trusted, and acceptable to local communities. Religious organisations maintain extensive, well-established networks that reach men across both rural and urban settings. These networks can serve as powerful platforms for sharing accurate health information, challenging harmful stereotypes, and countering the stigma associated with mental health, HIV testing, or chronic disease management. By partnering with respected leaders and faith-based institutions, health interventions gain legitimacy and are better positioned to shift norms, encourage early care-seeking, and promote healthier behaviors among men (Tchouaket et al., 2025).

- **Policy Integration and Health-System Reform**

There is growing recognition that men's health must be visible part of national health strategies, universal health coverage, and non-communicable disease (NCD) plans, as men have been underrepresented in these areas. In a related paper, Momoh (2025) reported that only one sub-

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Saharan country currently has a specific men's health strategy. The South African Men's Health Strategy (South Africa National Department of Health, 2021), though specific to South Africa, can serve as a useful starting point. Other SSA countries can develop their own men's health strategies, or a regional body like the African Union can commission a men's health strategy for member countries to adopt. The World Health Organisation, in collaboration with the European Union (WHO, 2018), developed an EU-wide strategy that was adopted by member countries. Men's and boys' advocacy groups and international health bodies emphasise that men's health improves when policymakers establish gender-specific goals and indicators, collect and analyse sex-disaggregated data, allocate resources to both female- and male-focused initiatives, and integrate gender analysis into health planning. These reforms strengthen equity and create health systems that are more responsive to the needs of all population groups (Men & Boys Coalition, 2026; Movember, 2026).

Identified Gap	Proposed Intervention	Policy Rationale
Lack of a specific national men's health strategy	Government and international partners to collaborate to develop a Sierra Leone men's health strategy	Improve men's health outcomes throughout their life course.
Unsafe artisanal and small-scale mining (ASM)	Formalise ASM practices; provide safety training and protective equipment	Reduces injury, toxic exposure, and long-term health risks in high-risk rural sectors
Insufficient occupational health services	Deploy mobile clinics and workplace outreach teams	Expands access to screening, injury care, and mental health support for men in remote or informal jobs
Inadequate data on men's occupational health	Invest in injury surveillance and gender-disaggregated labour statistics	Enables evidence-based policymaking and monitoring of health outcomes.
Barriers to males seeking care including mental health support due to cost, stigma or masculine norms.	Launch male gender-sensitive health campaigns and peer-led education programmes Investing in mental health training, services and integrating mental health into primary care.	Encourages early care-seeking and reframes health as strength and responsibility
Large number of youths in precarious informal jobs	Provide skills training, job placement, and livelihood support	Reduces entry into hazardous work and improves long-term health and economic outcomes

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Absence of appropriate injury or disability protection	Expand social protection schemes to cover informal male workers	Ensures financial resilience and access to care following work-related injury or illness
Weak enforcement of labour safety standards	Strengthen regulatory capacity and inspection systems	Improves compliance and reduces occupational risk in high-risk sectors

Table 1. Linking gaps to proposed interventions for men's health in Sierra Leone.

CONCLUSION

Globally, men's health, though widely recognised as an important area in need of improvement, is often treated as a secondary service and neglected in resource allocation and global health equity strategies. The obstacles men face, from restrictive masculinity norms and job-related hazards to shortcomings in health systems and policies, are significant but surmountable. New evidence highlights opportunities for gender-transformative, community-driven, and systemic solutions to improve men's health and advance gender equality. To make the most of these opportunities, those involved in developing and/or agreeing on healthcare policies and strategies (governmental and non-governmental organisations or institutions), healthcare practitioners, and researchers (local and international) need to place greater emphasis on men's health, drawing on robust data, cultural awareness, and a commitment to gender justice. Improving men's health is not a distraction from national or global health goals; it is a key part of building inclusive, adaptive, and fair health systems for everyone in Sierra Leone and across sub-Saharan Africa.

IMPLICATIONS FOR POPULATION HEALTH

Targeted support has been shown to significantly improve identified health issues. For example, between 2000 and 2023, Sierra Leone reduced the maternal mortality rate from 1506 to 354 per 100,000 live births (World Bank Group, 2026), with the government setting and implementing clear policies and targets and working collaboratively with development partners. In January 2026, the Minister of Health disclosed on national television that they aim to further reduce this number to fewer than 70 maternal deaths per 100,000 by 2030, in line with the UN Sustainable Development Goal. Targeted support for men's health issues has the potential to similarly deliver significant improvements, as evidenced by the publication of England's first men's health strategy (Gov.UK, 2025), which details the UK Government's 10-year vision for men's health and the actions they are taking to improve the health and well-being of all men and boys in England.

Enhancing men's health in SSA countries goes beyond reducing men's vulnerabilities. It opens the door to broader social and economic improvements. When men are healthier, family units are more stable, economies are stronger, and communities thrive. Efforts that challenge harmful gender norms benefit everyone by fostering fairer relationships and reducing the transmission of infections and violence. A growing body of research shows that men's poorer health outcomes are not biologically inevitable. Leading scholars on men's health, including Dr. Will Courtenay, Dr. Ian Banks, and Peter Baker, indicate that men's excess morbidity and mortality

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arise from modifiable social, economic, and structural determinants, including gender norms, occupational exposures, and inequitable health systems. There is ample evidence that men's health inequalities are socially produced and can be reduced through targeted policy and system reforms. These proponents of fairer men's health services argue that addressing the underlying causes of men/boys' ill health and mortality, while being mindful of gender and cultural differences, can undoubtedly lead to better health for men. For healthcare service provision, gender should be viewed as a relational concept, and improving men's health should not happen in isolation from women's health, nor should it detract from other health priorities. Rather, men's health should be organised, commissioned, and provided in a comprehensive, equity-focused approach that strengthens health systems for all.

Suggestions for future research on men's health in Sierra Leone and Sub-Saharan Africa.

- **Map structural drivers of risk:** Examine how informality, labour segmentation, weak enforcement, and economic precarity shape men's exposure to hazardous work.
- **Interrogate male gender norms:** Undertake qualitative and mixed-methods research to understand how masculine identities, risk perception, and social expectations influence men's health behaviours.
- **Quantify cumulative health impacts:** Conduct longitudinal and sector-specific studies on injuries, chronic conditions, mental health, and multi-hazard exposures across the life course.
- **Strengthen evidence on male health-seeking:** Investigate barriers to preventive care, early treatment, and engagement with health systems among men in high-risk occupations.
- **Evaluate male gender-responsive interventions:** Test workplace safety programmes, protective-equipment access, and community-based health initiatives tailored to men's needs.
- **Integrate policy and systems research:** Assess how labour, health, and social-protection policies can be aligned to reduce occupational risk and improve men's health outcomes.

Informed Consent Statement

No human subjects were involved in writing this article. Hence, informed consent is not applicable.

Conflict of Interest Declaration

I declare no competing financial or personal relationships that would appear to influence the work reported in this article.

The views expressed in this article are those of the author only and do not in any way reflect those of anyone else.

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