Frequency of visits to health facilities and HIV services offered to men, Malawi

Kathryn Dovel, Kelvin Balakasi, Sundeep Gupta, Misheck Mphande, Isabella Robson, Shaukat Khan, Alemayehu Amberbir, Christian Stilson, Joep J van Oosterhout, Naoko Doi & Brooke E Nichols

Objective To determine how often men in Malawi attend health facilities and if testing for human immunodeficiency virus (HIV) is offered during facility visits.

Methods We conducted a cross-sectional, community-representative survey of men (15–64 years) from 36 villages in Malawi. We excluded men who ever tested HIV-positive. Primary outcomes were: health facility visits in the past 12 months (for their own health (client visit) or to support the health services of others (guardian visit)); being offered HIV testing during facility visits; and being tested that same day. We disaggregated all results by HIV testing history: tested ≤ 12 months ago, or in need of testing (never tested or tested > 12 months before).

Findings We included 1116 men in the analysis. Mean age was 34 years (standard deviation: 13.2) and 55% (617/1116) of men needed HIV testing. Regarding facility visits, 82% (920/1116) of all men and 70% (429/617) of men in need of testing made at least one facility visit in the past 12 months. Men made a total of 1973 visits (mean two visits): 39% (765/1973) were as guardians and 84% (1657/1973) were to outpatient departments. Among men needing HIV testing, only 7% (30/429) were offered testing during any visit. The most common reason for not testing was not being offered services (37%; 179/487).

Conclusion Men in Malawi attend health facilities regularly, but few of those in need of HIV testing are offered testing services. Health screening services should capitalize on men's routine visits to outpatient departments as clients and guardians.

Introduction

Men throughout sub-Saharan Africa have a lower life expectancy than women. One contributing factor is men's underrepresentation in early disease detection, for example, timely diagnosis of life-threatening conditions such as tuberculosis, human immunodeficiency virus (HIV) infection, and hypertension. Low uptake of routine screening services is concerning because delayed diagnosis can result in advanced stages of illness and increased risk of onward HIV or tuberculosis transmission. Effective strategies are needed to reach men with routine screening services.

Facility-based interventions for routine screening services can increase men's engagement in care and may be more scalable and sustainable than community-based approaches, particularly in resource-constrained settings where human resources are limited. Yet, most interventions for men prioritize community-based approaches in part due to assumptions that men do not attend health facilities and intentionally avoid health facilities altogether. A common belief is that community services are required to find so-called missing men who otherwise cannot be reached. Little is known, however, about how often men actually attend health facilities, either as clients or in support of the health care of others (i.e. as guardians). Facility-based strategies during routine facility visits may be a feasible way to reach most men if men frequent health facilities.

While men in sub-Saharan Africa are less likely than women to access testing and treatment services for HIV and tuberculosis, these services likely comprise only a minority of men's facility visits. Men may attend outpatient departments for acute care, or attend a variety of other departments as guardians to aid others seeking care, such as spouses or children. A study in Malawi found that 22% (90/401) of rural men had accessed health services for their own health in the previous 2 months. However, the proportion of men attending health facilities over time is still unclear because findings were limited to visits for men's own health care (not as guardians) and only visits within the previous 2 months.

It is also unclear if men who attend health facilities for reasons other than HIV and tuberculosis services are offered screening services (such as HIV, tuberculosis or hypertension screening) during their facility visits. Research suggests that screening coverage during routine care may be low for a range of diseases, especially among individuals attending outpatient departments that are often busy and overburdened. Low screening coverage could indicate missed opportunities to engage men already attending health facilities. Examining the frequency with which men attend health facilities, and whether screening services are offered when they do attend, is important to understand the potential role of facility-based interventions for men.

We used HIV testing as a case study to explore the potential role of facility-based screening strategies for men. We focused on HIV testing because Malawian national guidelines indicate that sexually active men should be tested for HIV every 12 months, regardless of symptoms or age. HIV testing is also decentralized and widely available in nearly every

---

Abstract in العربية، 中文，Français，Русский和Español at the end of each article.
We conducted a cross-sectional, community-representative survey of men in 36 villages in the central and southern regions of Malawi. We used a multistage sampling design to select study villages and potential respondents. We purposively selected two districts in central and southern regions (Likonde and Chikwawa) and three mid-size health facilities per district (six facilities in total). We then randomly selected six villages within each facility’s catchment area by using a computer-generated sequence of random numbers (36 villages in total), and used household census listings to randomly select men within each village. Villages were a mean of 5.14 km (standard deviation, SD: 3.46 km) from facilities, had a mean of 72.8 (SD: 27.7) households per village, and the main occupations were farming, fishing and informal employment (further details available in the data repository). 19

Eligibility criteria for inclusion in the survey were: (i) age 15–64 years; (ii) current resident of the participating village; and (iii) spent > 15 nights in the village in the previous 30 days. We excluded men who did not meet eligibility criteria from the final household listing before randomization. For this paper, we also excluded men who self-reported ever testing HIV-positive. We stratified the random selection of men by village (about 45 men per village, although some villages had fewer than 45 men due to small village size) and age category: young men (15–24 years), middle-aged men (25–39 years) and older men (≥ 40 years). We used computerized random number generation to select strata.

Data collection and measurement

Male research assistants recruited randomly selected individuals with the assistance of community health workers and village chiefs. We categorized individuals as not found after three failed tracing attempts. We conducted surveys wherever convenient for respondents, which was usually at the respondent's home, the village chief’s residence (a typical gathering place in villages) or the respondent's place of work.

We collected the following data: (i) demographic data, such as age, marital status and education; (ii) self-reported HIV testing history, defined as tested recently (testing HIV-negative in the past 12 months) or in need of testing (never tested positive or tested > 12 months ago), as per national guidelines; 20 (iii) number of health facility visits made in the previous 24 months; (iv) services received during the last four health facility visits, including who received the services (i.e. client or guardian visit type); and (v) if HIV testing was offered and received during each facility visit. We defined client visits as any visit where the primary service received was for the respondent's own health. We defined guardian visits as any visit where the primary service was received by another person and the respondent attended the facility to support that person's use of health services – we did not categorize providing transportation and immediately leaving the facility as a guardian visit. We defined being offered HIV testing as being told about HIV testing by a health-care worker at the facility on the same day as a facility visit, and actual HIV testing as completing an HIV test the same day as a facility visit. We conducted surveys in the local language (Chichewa) and they lasted about 55 minutes on average.

Analysis and sample size

Our primary outcome was health facility attendance in the past 12 months – we excluded any health visits made more than 12 months before the survey. Secondary outcomes included being offered HIV testing during facility visits in the past 12 months and completing an HIV test at any facility visit in the same period. Our study included 1116 men (HIV-negative or with an unknown HIV status), which meant that it had had over 80% power to estimate population-level frequency of health-facility visits within the past 12 months, assuming 5% precision, 0.05 level of confidence and about 10,000 men and male adolescents in each facility catchment area.

We used descriptive statistics to examine how often men attend health facilities and the reason for facility visits (client or guardian), disaggregated by history of HIV testing (tested in the past 12 months or in need of testing). We conducted sensitivity analyses using assigned weights to account for variation in village size. The results from sensitivity analyses did not change findings and are available in the data repository. 24 No data were missing.

Ethical considerations

The National Health Sciences Review Committee of Malawi (number 2338) and the University of California Los Angeles Institutional Review Board (number 20–001606) approved study activities. All eligible individuals completed a written informed consent form immediately following screening procedures. For individuals between 15 and 18 years of age, guardians provided written consents.

Results

We recruited 1473 men between 15 August and 18 October 2019. Of these men, we screened 1293 (88%) men for eligibility – we were unable to screen 180 (12%) men (Fig. 1). Of the 1293 men screened, 1117 (86%) were eligible for inclusion in the study. One man declined to participate in the study and thus we included 1116 men in the analysis (Fig. 1).

Table 1 shows the demographic data of the respondents according to history of HIV testing. The mean age of men was 34 years (SD: 13.2), 84% (941/1116) felt healthy and 82% (910/1116) were married or living with a partner. Most men (69%; 767/1116) had worked in the previous 30 days and 27% (299/1116) had spent three nights or more away from their home in the same period.

Participants commonly reported risky sexual behaviour, with 31% (345/1116) reporting having two sexual partners or more in the past 12 months.
and 18% (198/1116) reporting not using a condom with at least one non-married or live-in partner in the same period. At the time of the study, 55% (617/1116) of the men needed HIV testing (defined as never tested or tested > 12 months ago) – 26% (294/1116) had never been tested.

Of the total number of men included in the study, 82% (920/1116) had made at least one facility visit as either a client or guardian in the past 12 months, and 70% (429/617) of men in need of HIV testing had made at least one facility visit (Fig. 2). Secondary analyses show a similar frequency of facility visits among men who had never been tested (data repository).24 We found 10% (109/1116) of all men and 11% (68/617) of men in need of HIV testing only attended facilities as a guardian (i.e. made no visits as a client).

A total of 1973 health facility visits were made by 920 men, with a mean two visits (SD 1–3) per participant, in the past 12 months (Table 2). Of all health visits made, 39% (765/1973) were made as guardians. Among men in need of testing, 48% (373/771) of visits were guardian visits. Most visits were to outpatient department clinics (84%; 1653/1973), regardless of visit type (client or guardian). Very few men attended a facility to support women’s

---

**Table 1. Characteristics of men participating in the community survey, by HIV testing history, Malawi, 2019**

| Characteristic                              | All men (n = 1116) | Men recently tested (n = 499) | Men in need of testinga (n = 617) | Pb |
|---------------------------------------------|-------------------|------------------------------|-----------------------------------|----|
| **Demographic data**                        |                   |                              |                                   |    |
| Age in years, mean (SD)                     | 34 (13.2)         | 35 (12.2)                    | 34 (14.0)                         | 0.16 |
| Education completed in years, mean (SD)     | 6 (3.4)           | 6 (3.5)                      | 6 (3.3)                           | < 0.001 |
| Household wealth quintile, no. (%)          |                   |                              |                                   | 0.14 |
| Poor                                        | 372 (33)          | 152 (30)                     | 220 (36)                          |    |
| Middle income                               | 372 (33)          | 179 (36)                     | 193 (31)                          |    |
| Wealthy                                     | 372 (33)          | 168 (34)                     | 204 (33)                          |    |
| Number of children living in household, mean (SD) | 3 (2.4)          | 3 (2.3)                      | 3 (2.4)                           | < 0.001 |
| Self-rated health (good or very good), no. (%) | 941 (84)          | 415 (83)                     | 526 (85)                          | 0.341 |
| **School, work and travel, no. (%)**        |                   |                              |                                   |    |
| Currently attending school (secondary or above) | 49 (4)            | 28 (6)                       | 21 (3)                            | 0.07 |
| Worked for pay in previous month (formal or informal) | 767 (69)         | 365 (73)                     | 402 (65)                          | < 0.001 |
| Slept ≥ 3 nights away from home in past 30 days | 299 (27)          | 149 (30)                     | 150 (24)                          | 0.03 |
| **Sexual partnerships**                     |                   |                              |                                   |    |
| Married or living together, no. (%)         | 910 (82)          | 443 (89)                     | 467 (76)                          | < 0.001 |
| Length of current relationship, in years, mean (SD) | 13 (10)          | 12 (10)                      | 14 (11)                           | 0.05 |
| **Sexual risk behaviour, no. (%)**          |                   |                              |                                   |    |
| Two or more sexual partner in past 12 months | 345 (31)          | 174 (35)                     | 171 (28)                          | 0.01 |
| Had sex with a non-married or live-in partner without using a condom | 198 (18)         | 91 (18)                      | 107 (17)                          | 0.70 |
| Partner known to be HIV-positive             | 14 (1)            | 8 (2)                        | 6 (1)                             | 0.54 |
| **HIV testing, no. (%)**                    |                   |                              |                                   |    |
| Tested ≤ 12 months before                    | 499 (45)          | 499 (100)                    | 0 (0)                             | NA |
| In need of HIV testing                       | 617 (55)          | 0 (0)                        | 617 (100)                         | NA |
| Never tested                                | 294 (26)          | NA                           | 294 (48)                          |    |
| Tested > 12 months ago                       | 323 (29)          | NA                           | 323 (52)                          |    |

HIV: human immunodeficiency virus; NA: not applicable; SD: standard deviation.
a Defined as never been tested or tested more than 12 months before.
b χ2 test, t-test or Kruskal–Wallis test.
reproductive health services or preventive services for children younger than 5 years. Among guardian visits, 42% (318/765) of men were accompanying children, 26% (199/765) were accompanying friends and 24% (182/765) were accompanying their sexual partner. Men in need of testing made significantly fewer facility visits, were more likely to attend a facility as a guardian (not a client), and were more likely to attend the outpatient department than men who had recently been tested for HIV (P < 0.001 for all visit characteristics). Men in need of testing were also significantly less likely than recently tested men to accompany their sexual partners during guardian visits (P < 0.001) – those in need of testing primarily accompanied children, friends or other relatives.

Table 3 shows HIV testing services offered and used among men who attended a health facility. Among all men who attended a facility in the past 12 months, 25% (233/920) were offered provider-initiated HIV testing and counselling during at least one facility visit and 48% (441/920) were tested for HIV. A higher proportion were tested than offered testing because some men only attended facilities for HIV testing services or actively sought out HIV testing during their facility visit (without being prompted by a health-care worker). When excluding men who only attended facilities for HIV testing services (defined as only attended the HIV testing and counselling department, 143 men), 38% (298/777) of men were tested for HIV during a facility visit outside an HIV testing and counselling department.

Fig. 3 depicts missed opportunities for reaching men with HIV testing. Among all men, the biggest gap in the cascade for facility-based testing was being offered HIV testing. While 82% (920/1116) of men had made at least one facility visit in the past 12 months, only 25% (233/920) were offered provider-initiated HIV testing and counselling (Fig. 3). Of those offered these services, 198 (85%) accepted them and were tested for HIV that same day. Among men in need of testing, 70% (429/617) had made at least one facility visit in the past 12 months, but only 30 (7%) were offered provider-initiated HIV testing and counselling, none of whom accepted testing.

The most commonly reported reasons for not testing during their most recent facility visit were: not offered testing (37%; 179/484); perceived low risk of infection (23%; 113/484); and not ready to test (17%; 81/484). Reasons reported were similar for client and guardian visits (data repository). Among men making guardian visits, only 13% (35/268) were not willing to test because of lack of privacy because they were accompanying someone else.

Discussion

Few studies have examined men’s general health-seeking behaviour in sub-Saharan Africa, or the role of men as guardians. Using data from a community-representative survey of 36 villages in Malawi, we show that more than three quarters of men with an HIV-negative or unknown HIV status had attended a health facility in the past 12 months. Over 80% of all visits to health facilities were to an outpatient department for acute, curative services; 39% of all visits were as a guardian to support the health care of others. Among men in need of HIV testing, 70% had attended a health facility in the past 12 months. Over 90% of their facility visits were to an outpatient department and 48% of visits were as guardians.

Our findings challenge the common belief that men do not attend health facilities, which has important implications for programmes targeting men. If facility-based services can be scaled up, most men may be reached during routine outpatient department visits. Targeted community-based strategies could then focus on the small proportion of high-risk men who do not regularly attend facilities, which could improve the efficiency and overall sustainability of HIV and other health screening programmes. However, facility-based services should capitalize on every visit made by men. Men in our study made a median of two facility visits in the past 12 months, far fewer than other studies have documented for women of similar ages. Therefore, there may be relatively fewer opportunities to reach men at health facilities as compared with women, and every opportunity should be taken to engage men.

We found extensive missed opportunities to reach men who were already engaged with the health system. Among men in need of HIV testing who had attended a health facility, only 7% were offered HIV testing. Other research suggests that similar missed opportunities also exist for other routine screening services. Given the multiple barriers to testing (such as long wait times, lack of privacy and unfriendly staff), men may benefit from being offered testing during every facility visit, including at outpatient departments and during guardian visits. Being offered testing may substantially increase overall testing coverage. Of all the men in our sample, 85% of those offered testing ac-
Men’s attendance at health facilities, Malawi

Kathryn Dovel et al.

A large proportion of men’s facility visits were as guardians, where men supported the health care of others. Deliberate efforts to offer screening services to male guardians should be prioritized. Our findings differ from other studies that report that men are not involved in the health care of their families, although recent literature recognizes that traditional gender roles for caregiving are changing. Additional research is needed to understand men as guardians and how guardian visits can be best used as an entry point for men’s own health.

How can interventions best capitalize on men’s frequent facility visits? Opt-out services are key to improved uptake of a range of health services. Screening services could be offered in outpatient department waiting areas while men wait for acute care, thus taking advantage of time already spent at the facility. Self-testing in outpatient department settings can also improve efficiency and minimize the human resources required to administer tests. HIV self-testing at health facilities has been shown to reduce staff time required for testing, increase testing coverage and is acceptable among men. Investment in adequate infrastructure and staffing may also be needed for longer-term solutions for screening efforts in outpatient departments.

Our study has several limitations. First, we used HIV testing as a case study to understand the potential reach of facility-based screening services among men. Missed opportunities for facility-based screening among men may represent missed opportunities to reach men earlier in the HIV care cascade.

**Table 2. Facility visits made by men in the past 12 months, by visit type and HIV testing history, Malawi, 2019**

| Type of visit | All men | Men recently tested | Men in need of testing | \( P^a \) |
|---------------|---------|---------------------|------------------------|----------|
| **All visits, n** | 1973 | 1202 | 771 | < 0.001 |
| Among men who made any visit in the past 12-months, median no. of all visits (IQR) | 2.0 (1.0–3.0) | 2.0 (2.0–3.0) | 2.0 (1.0–2.0) | < 0.001 |
| Visit type, no. (%) | | | | < 0.001 |
| Guardian visit | 765 (39) | 392 (33) | 373 (48) | |
| Client visit | 1208 (61) | 810 (67) | 398 (52) | |
| **Guardian visits, n** | 765 | 392 | 373 | |
| Among men who made any visit in the previous 12 months, median no. of visits in that time (IQR) | 2.0 (1.0–2.0) | 2.0 (1.0–3.0) | 2.0 (1.0–2.0) | < 0.001 |
| Client relationship with male, no. (%) | | | | < 0.001 |
| Child | 318 (42) | 155 (40) | 163 (44) | |
| Partner | 182 (24) | 122 (31) | 60 (16) | |
| Friend or other relative | 199 (26) | 84 (21) | 115 (31) | |
| Other | 66 (9) | 31 (8) | 35 (9) | |
| Main department where services were accessed, no. (%) | | | | < 0.001 |
| Outpatient | 646 (84) | 310 (79) | 336 (90) | |
| HIV testing and counselling | 3 (< 1) | 2 (1) | 1 (< 1) | |
| Antiretroviral therapy | 8 (1) | 6 (1) | 2 (< 1) | |
| Female reproductive health | 89 (12) | 64 (16) | 25 (7) | |
| Services for children younger than 5 years | 5 (1) | 4 (1) | 1 (< 1) | |
| Dentist | 3 (< 1) | 1 (< 1) | 2 (< 1) | |
| Other | 11 (1) | 5 (1) | 6 (2) | |
| **Client visits, n** | 1208 | 810 | 398 | |
| Among men who made any visit in the past 12 months, median no. of client visits in that time (IQR) | 2.0 (1.0–3.0) | 2.0 (2.0–3.0) | 1.0 (1.0–2.0) | < 0.001 |
| Main department services were accessed, no. (%) | | | | < 0.001 |
| Outpatient department | 1007 (83) | 623 (77) | 384 (96) | |
| HIV testing and counselling | 171 (14) | 169 (21) | 2 (< 1) | |
| Female reproductive health | 2 (< 1) | 2 (< 1) | 0 (0) | |
| Dentist | 17 (1) | 7 (1) | 10 (3) | |
| Other | 11 (1) | 9 (1) | 2 (< 1) | |

HIV: human immunodeficiency virus; IQR: interquartile range.

\( a \) Defined as never been tested or tested more than 12 months before.

\( b \) \( \chi^2 \) test, t-test or Kruskal–Wallis test.

\( c \) Facility visits where HIV testing and counselling was the main reason for men attending the facility.

\( d \) For antenatal care, family planning or delivery.
services may be higher for less prioritized health concerns, such as tuberculosis and hypertension. Second, our findings may not be generalizable outside Malawi as health-care-seeking behaviour may differ in countries with higher rates of formal employment and health insurance coverage, such as South Africa. Third, survey data rely on self-reporting and may be susceptible to social desirability bias if men believe they should engage in health services or HIV testing specifically. Fourth, we may have underestimated the proportion of men in need of HIV testing because we did not account for risk factors that increase the recommended frequency of testing—such as known HIV exposure or seeking services for sexually transmitted infections. Finally, our sampling frame did not account for variation in village size or the number of men within each age category in the general population. Sensitivity analyses assigned weights to adjust for these potential biases and found no differences in study results.

Contrary to common beliefs about men, the majority of Malawian men made a health facility visit in the past 12 months, with outpatient departments as the primary entry point for both clients and guardians. Despite frequent facility visits, men were rarely offered HIV testing services, highlighting missed opportunities to engage men already present at health facilities. Increased coverage of routine screening services at outpatient departments and for male guardians could improve programmatic efficiencies by taking advantage of men’s presence at health facilities.

Acknowledgements
We thank the community health-care workers and community leaders who facilitated household census and individual-level recruitment and the men who participated in the study. We also thank Vania Wang and Elijah Chikuse.

Table 3. Offer and use of HIV testing among men visiting health facilities in the past 12 months, by HIV testing history, Malawi, 2019

| Variable | All men, no. (%) (n = 920) | Men recently tested, no. (%) (n = 491) | Men in need of testing, no. (%) (n = 429) | \( p ^ \) |
|----------|---------------------------|--------------------------------------|----------------------------------------|------|
| Testing services | | | | |
| Offered provider-initiated testing and counselling at least once | 233 (25) | 203 (41) | 30 (7) | \(< 0.001\) |
| Tested for HIV at least once | 441 (48) | 442 (90) | 0 (0) | \(< 0.001\) |
| Tested for HIV, excluding at visits to HIV testing and counselling department | 298/777 (38) | 296/344 (86) | 0 (0) | \(< 0.001\) |
| Reason for not testing during most recent visit (n = 484) | | | | |
| Not offered testing | NA | NA | 179 (37) | NA |
| Perceived low risk of infection | NA | NA | 113 (23) | NA |
| Not ready to test | NA | NA | 81 (17) | NA |
| Other | NA | NA | 84 (17) | NA |
| Requires too much time | NA | NA | 23 (5) | NA |
| Lack of privacy | NA | NA | 4 (1) | NA |

HIV: human immunodeficiency virus; NA: not applicable.
\( ^{a} \) Defined as never been tested or tested more than 12 months before.
\( ^{b} \) \( \chi^2 \) test, \( t \)-test or Kruskal–Wallis test.
\( ^{c} \) Respondents were allowed to give more than one reason.

Funding: The Foreign, Commonwealth and Development Office of the United Kingdom of Great Britain and Northern Ireland funded the study (grant number: 300380). KD receives funding from the Fogarty International Center (K01-TW011484-01, UCLA CFAR grant AI028697), and the Bill & Melinda Gates Foundation (grant number: 001423).

Competing interests: None declared.

Fig. 3. Proportion of men visiting a health facility in the past 12 months, offered HIV testing and accepted HIV testing, Malawi, 2019

Study population
Made a facility visit
Offered HIV test during a facility visit
Tested for HIV during a facility visit

HIV: human immunodeficiency virus.

Note: Absolute numbers are presented in Table 3.

Kathryn Dovel et al.

Men’s attendance at health facilities, Malawi

Bull World Health Organ 2021;99:618–626 doi: http://dx.doi.org/10.2471/BLT.20.278994

623
为了自己的健康（本人就诊）或为了照顾他人健康（作

目的 旨在确定马拉维男子前往卫生机构就诊的频率，以及就诊期间是否接受人体免疫缺陷病毒 (HIV) 检测。方法 我们面向马拉维 36 个村庄的男子 (15 至 64 岁) 开展了一项具有社区代表性的横断面调查。我们排除了曾经检测过 HIV，且检测结果呈阳性者的男子。调查结果主要包括：在过去 12 个月内前往过卫生机构就诊【为了自己的健康（本人就诊）或为了照顾他人健康（作为监护人代为就诊）】，就诊期间接受过 HIV 检测；就诊和检测是在同一天。我们按照 HIV 检测情况对所有结果进行分类：12 个月内检测过，或需要检测（从未检测或超过 12 月以前检测过）。结果 我们在分析中纳入了 1,116 名男子。这些人的平均年龄是 34 岁（标准差：13.2），且 55% (617/1116) 的

根据结果表明，马拉维男子经常前往卫生机构就诊，但需要 HIV 检测的男子很少能够接受这项检测服务。应该充分利用男子本人和作为监护人定期前往门诊就诊的机会来提供健康筛查服务。

Резюме
Частота посещений медицинских учреждений и предоставление услуг, связанных с ВИЧ, которые предлагаются мужчинам в Малави

Методы Мы провели поперечный репрезентативный опрос среди мужчин (от 15 до 64 лет) из 36 деревень Малави. Мы исключили мужчин, которые ранее имели положительный результат тестирования на ВИЧ-инфекцию. Первыми данными для анализа были посещения медицинского учреждения
за последние 12 месяцев (в связи со своим собственным здоровьем (посещение в роли пациента) или для оказания поддержки в получении услуг здравоохранения другим лицам (посещение в роли опекуна)), предложение пройти тестирование на ВИЧ во время посещения медицинского учреждения, а также прохождение тестирования в тот же день. Мы разделили все результаты по анализу тестирования на ВИЧ: проходили тестирование ≤ 12 месяцев назад или нуждаются в тестировании (не проходили тестирования никогда или > 12 месяцев назад).

Результаты В анализ были включены 1116 мужчин. Средний возраст составлял 34 года (стандартное отклонение: 13,2); 55% (617/1116) мужчин нуждались в тестировании на ВИЧ. Что касается посещений медицинских учреждений, 82% (920/1116) всех мужчин и 70% (429/617) мужчин, которые нуждались в тестируемых, посетили медицинское учреждение по крайней мере один раз за последние 12 месяцев. Мужчины соверили в общей сложности 1973 посещения (в среднем два посещения): 39% (765/1973) были опекунами и 84% (1657/1973) посещали амбулаторные отделения. Среди мужчин, которые нуждались в тестировании на ВИЧ, только 7% (30/429) было предложено вернуться для повторного тестирования во время посещения. Наиболее частой причиной непереносимости был тот факт, что такую услугу просто не предлагали (37%: 179/487).

Вывод Мужчины в Малави регулярно посещают медицинские учреждения, но немногим мужчинам, которые нуждаются в тестировании на ВИЧ, предлагают такую услугу. Медицинские службы должны наилучшим образом воспользоваться фактом регулярного посещения мужчинами амбулаторных отделений как в качестве пациентов, так и в качестве опекунов.

Resumen

Frecuencia de visitas a los centros de salud y servicios de VIH ofrecidos a los hombres en Malawi

Objetivo Determinar la frecuencia con la que los hombres de Malawi acuden a los centros de salud y si se ofrecen pruebas del virus de la inmunodeficiencia humana (VIH) durante las visitas a dichos centros.

Métodos Se realizó una encuesta transversal, representativa de la comunidad, de hombres (de 15 a 64 años) de 36 pueblos de Malawi. Se excluyeron los hombres que alguna vez dieron positivo en la prueba del VIH. Los resultados primarios fueron: visitas a centros de salud en los últimos 12 meses (para su propia salud (visita del paciente) o para apoyar los servicios de salud de otros (visita de cuidador)); que se les ofreciera la prueba del VIH durante las visitas a los centros; y que se les hiciera la prueba ese mismo día. Desglosamos todos los resultados según el historial de pruebas del VIH: se hicieron la prueba hace ≤12 meses, o necesitan la prueba (nunca se hicieron la prueba o se hicieron la prueba hace >12 meses antes).

Resultados Se incluyeron 1116 hombres en el análisis. La edad media fue de 34 años (desviación estándar: 13,2) y el 55 % (617/1116) de los hombres necesitaban la prueba del VIH. En cuanto a las visitas a los centros, el 82 % (920/1116) de todos los hombres y el 70 % (429/617) de los hombres que necesitaban la prueba realizaron al menos una visita a un centro en los últimos 12 meses. Hubo un total de 1973 visitas (con una media de dos visitas): el 39 % (765/1973) fueron como cuidadores y el 84 % (1657/1973) fueron a departamentos ambulatorios. Entre los hombres que necesitaban someterse a la prueba del VIH, solo al 7% (30/429) se les ofreció la prueba durante cualquier visita. La razón más común para no hacerse la prueba fue que no se les ofrecieron servicios (un 37 %; 179/487).

Conclusión Los hombres de Malawi acuden a los centros de salud con regularidad, pero a pocas de los que necesitan someterse a la prueba del VIH se les ofrecen los servicios. Los servicios de detección sanitaria deberían aprovechar las visitas rutinarias de los hombres a los departamentos ambulatorios como pacientes y cuidadores.

References

1. Wang H, Dwyer-Lindgren L, Ogden KT, Rajaratnam JK, Marcus JR, Levin-Rector A, et al. Age-specific and sex-specific mortality in 187 countries, 1970–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet. 2012 Dec 22;380(9859):2071–94. doi: http://dx.doi.org/10.1016/S0140-6736(12)61719-X PMID: 23246603
2. Raising the profile of men's health. Lancet. 2019 Nov 16;394(10211):1779.
3. Teo CH, Ng CJ, Booth A, White A. Barriers and facilitators to health screening in men: a systematic review. Soc Sci Med. 2016 Sep;165:168–76. doi: http://dx.doi.org/10.1016/j.socscimed.2016.07.023 PMID: 27511617
4. Carmona S, Bor J, Nattey C, Maughan-Brown B, Maskew M, Fox MP, et al. Persistent high burden of advanced HIV disease among patients seeking care in South Africa's national HIV program: data from a nationwide laboratory cohort. Clin Infect Dis. 2018 Mar;66 suppl_2: S111–7. doi: http://dx.doi.org/10.1093/cid/ciy045 PMID: 29514238
5. Mensah GA. Epidemicology of stroke and high blood pressure in Africa. Neurology. 2008 Jun;50(5):1385–401. doi: http://dx.doi.org/10.1002/0022-1237(1978)35:5<577::AID-NEN1402>3.0.CO;2-N PMID: 63365
6. Sharma M, Barnabas R, Celum C. Community-based strategies to strengthen men’s engagement in the HIV cascade in sub-Saharan Africa. PLoS Med. 2017 Apr 11;14(4):e1002262. doi: http://dx.doi.org/10.1371/journal.pmed.1002262 PMID: 28399122
7. Connell RW, Messerschmidt JW. Hegemonic masculinity: rethinking the concept. Gend Soc. 2005;19(6):829–59. doi: http://dx.doi.org/10.1177/0891243205278639
8. Havlir DV, Balzer LB, Charlebois ED, Clark TD, Kwarisima D, Ayieko J, et al. HIV testing and treatment with the use of a community health approach in rural Africa. N Engl J Med. 2019 Jul 18;381(3):219–29. doi: http://dx.doi.org/10.1056/NEJMoai1809666 PMID: 31314966
9. Njuga B, Vorkopen S, Patel P, Reid MJ, Vedanthan R, Piff C, et al. Models of integration of HIV and noncommunicable disease care in sub-Saharan Africa: lessons learned and evidence gaps. AIDS. 2018 Jul;1;32 Suppl 15:33–42. doi: http://dx.doi.org/10.1097/QAD.0000000000001887 PMID: 29952788
10. Connell RW, Messerschmidt JW. Hegemonic masculinity: rethinking the concept. Gend Soc. 2005;19(6):829–59. doi: http://dx.doi.org/10.1177/0891243205278639
11. Spot B. Reaching out to men and boys. Addressing a blind spot in the response to HIV [Internet]. Geneva: Joint United Nations Programme on HIV and AIDS; 2017. Available from: https://www.unaids.org/en/resources/documents/2017/blank_spot (cited 2020 Sep 20).
14. Horton KC, MacPherson P, Houben RM, White RG, Corbett EL. Sex differences in tuberculosis burden and notifications in low- and middle-income countries: a systematic review and meta-analysis. PLoS Med. 2016 Sep;13(9):e1002119. doi: http://dx.doi.org/10.1371/journal.pmed.1002119 PMID: 27598345

15. Hensen B, Taoka S, Lewis JJ, Weiss HA, Hargreaves J. Systematic review of strategies to increase men's HIV-testing in sub-Saharan Africa. AIDS. 2014 Sep 10;28(14):2133–45. doi: http://dx.doi.org/10.1097/QAD.0000000000000395 PMID: 25062091

16. Yeatman S, Chamberlin S, Dovel K. Women's (health) work: a population-based, cross-sectional study of gender differences in time spent seeking health care in Malawi. PLoS One. 2018 Dec 21;13(12):e0209586. doi: http://dx.doi.org/10.1371/journal.pone.0209586 PMID: 30576388

17. Mair L, Corbett EL, Feasey NRA, Kamchedzera W, Khundi M, Lalloo DG, et al. Provider-initiated HIV testing and TB screening in the era of universal coverage: are the right people being reached? A cohort study in Blantyre, Malawi. PLoS One. 2020 Aug 13;15(8):e0236407. doi: http://dx.doi.org/10.1371/journal.pone.0236407 PMID: 32790669

18. Addo J, Smeeth L, Leon DA. Hypertension in sub-Saharan Africa: a systematic review. Hypertension. 2007 Dec;50(6):1012–18. doi: http://dx.doi.org/10.1161/ HYPERTENSIONAHA.107.093336 PMID: 17954720

19. HIV testing services guidelines. Lilongwe: Malawi Ministry of Health, 2016.

20. People living with HIV receiving ART [internet]. Geneva: UNAIDS; 2020. Available from: http://aidsinfo.unaids.org [cited 2021 May 16].

21. Malawi antiretroviral treatment program quarterly report. Results up to December 30, 2020. Lilongwe: Malawi Ministry of Health, 2021.

22. Dovel K, Shaba F, Offorjebe OA, Balakasi K, Nyirenda M, Phiri K, et al. Effect of facility-based HIV self-testing on uptake of testing among outpatients in Malawi: a cluster-randomised trial. Lancet Glob Health. 2020 Feb;8(2):e276–87. doi: http://dx.doi.org/10.1016/S2214-109X(19)30534-0 PMID: 31961557

23. Mabuto T, Hansoti S, Charalambous S, Hoffmann C. Understanding the dynamics of HIV testing services in South African primary care facilities: project SOAR results brief. Washington, DC: Population Council; 2018. doi: http://dx.doi.org/10.31899/hiv5.1022

24. Dovel K, Balakasi K, Gupta S, Mphande M, Robson I, Khan S, et al. Missing men or missed opportunity: supplemental file. London: figshare; 2021. doi: http://dx.doi.org/10.1016/j.hsag.2015.11.001

25. Malawi guidelines for clinical management of HIV in children and adults. 4th edition. Lilongwe: Malawi Ministry of Health, 2018.

26. Yeatman S, Chamberlin S, Dovel K. Women's (health) work: a population-based, cross-sectional study of gender differences in time spent seeking health care in Malawi. PLoS One. 2018 Dec 21;13(12):e0209586. doi: http://dx.doi.org/10.1371/journal.pone.0209586 PMID: 30576388

27. Dovel K, Dworkin SL, Cornell M, Coates TL, Yeatman S. Gendered health institutions: examining the organization of health services and men's use of HIV testing in Malawi. J Int AIDS Soc. 2020 Jun;23(52) Suppl 2 e25517. doi: http://dx.doi.org/10.1002/jia2.25517 PMID: 32589346

28. Schell ES, Geoffroy E, Phiri M, Brumbwe A, Weinstein J, Jere JM. Cracking the code: getting men tested in rural Africa. AIDS. 2016 Jan 30;30(2):331–2. doi: http://dx.doi.org/10.1097/QAD.0000000000000913 PMID: 26684825

29. Mohlabane N, Tushana B, Pelzer K, Mwiroongo A. Barriers and facilitators associated with HIV testing uptake in South African health facilities offering HIV counselling and testing. Health SA Gesondheid. 2016;21(1):86–95. doi: http://dx.doi.org/10.1002/j.hsag.2015.11.001

30. Quinn C, Kadenguje DT, Johnson CC, Baggaley R, Dalal S. Who are the missing men? Characterising men who never tested for HIV from population-based surveys in six sub-Saharan African countries. J Int AIDS Soc. 2019 Oct;22(10):e25398. doi: http://dx.doi.org/10.1002/jia2.25398 PMID: 31631576

31. Pascoe L,Peacock D. Addressing the health needs of men and boys: an analysis of 14 eastern and southern African countries' national policies on health, HIV, sexuality and reproductive health, and mental health [Internet]. Cape Town: Sonke Gender Justice, 2017. Available from: https://www.malecircumcision.org/resource/addressing-health-needs-men-and-boys-progress-analysis-14-eastern-southern-african [cited 2020 Sep 20].

32. Manderson L, Block E. Relatedness and care in southern Africa and beyond. Soc Dyn. 2016;42(2):205–17. doi: http://dx.doi.org/10.1080/02533952.2016.1218139

33. Block E. Reconsidering the orphan problem: the emergence of male caregivers in Lesotho. AIDS Care. 2016;28 Suppl 4:3–40. doi: http://dx.doi.org/10.1080/09540121.2016.1195480 PMID: 27297796

34. Mehus CJ, Wieling E, Achan L, Oloya OT. Identifying the roles of fathers in post-war northern Uganda: groundwork for a parenting intervention. Afr Stud. 2018;77(4):526–48. doi: http://dx.doi.org/10.1080/00020184.2018.1496593

35. McLean KE. Caregiving in crisis: fatherhood refashioned by Sierra Leone's Ebola Epidemic. Med Anthropol Q. 2020 Jun;34(2):227–42. doi: http://dx.doi.org/10.1111/maq.12556 PMID: 31651046

36. Dzudile A, Rayner B, Oji D, Schutte AE, Twagurumukiza M, Damasceno A, et al; PASCAR task force on hypertension. Roadmap to achieve 25% hypertension control in Africa by 2025. Cardiovasc J Afr. 2017 Jul/Aug;28(4):261–72. doi: http://dx.doi.org/10.1080/09359066.2017-809138 PMID: 28906541

37. Kwasiromma D, Atukunda M, Owagumisita A, Chamie G, Clark T, Kabami J, et al. Hypertension control in integrated HIV and chonic disease clinics in Uganda in the study. BMC Public Health. 2019 May 6;19(1):511. doi: http://dx.doi.org/10.1186/s12889-019-6838-6 PMID: 31060545

38. Musheke M, Nakalisa H, Gari S, McKenzie O, Bond V, Martin-Hilber A, et al. A systematic review of qualitative findings on factors enabling and deterring uptake of HIV testing in sub-Saharan Africa. BMC Public Health. 2018 Mar 11;18(1):220. doi: http://dx.doi.org/10.1186/s12889-017-4258-13-220 PMID: 32497196

39. Ingold H, Mwiwerinde O, Ross AL, Leach R, Corbett EL, Hatzoikl Z, et al. The Self-Testing Africa (STARA) Initiative: accelerating global access and scale-up of HIV self-testing. J Int AIDS Soc. 2019 Mar 22(51) Suppl 1 e25249. doi: http://dx.doi.org/10.1002/jia2.25249 PMID: 30007517

40. Yared N, Horvath K, Fashanu O, Zhao R, Baker J, Kulasingam S. Optimizing screening for sexually transmitted infections in men using self-collected swabs: a systematic review. Sex Transm Dis. 2018 May;45(5):294–300. doi: http://dx.doi.org/10.1097/OLQ.0000000000000739 PMID: 29465701

41. Dovel K, Gupta S, Stillison C, Mphande M, Balakasi K, Robson I, et al. HIV self-testing to optimize facility testing: a cluster randomized trial in Malawi [internet]. Virtual Conference on Retroviruses and Opportunistic Infections (CROI), 6–10 March 2021. Available from: https://www.croiconference.org/abstract/hiv-self-testing-to-optimize-facility-testing-a-cluster-randomized-trial-in-malawi/ [cited 2021 May 16].