

SYSTEMATIC REVIEW

Strategies to promote men's health-seeking behaviour: a systematic review

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Abstract

Background: Men's underutilisation of healthcare services remains a public health challenge, contributing to delayed diagnosis, low uptake of preventive services, avoidable complications, and poor health outcomes. Although barriers to men's health-seeking behaviour have been widely documented, less attention has been given to synthesising evidence on strategies to address this challenge. This systematic review synthesised evidence on interventions and strategies to promote health-seeking behaviour among adult men. **Methods:** Systematic searches of PubMed, EBSCOhost, ScienceDirect, and Google Scholar were conducted to identify studies published between January 2000 and February 2026. Grey literature was searched through repositories and relevant organisational websites. Primary studies involving men aged ≥ 18 years that evaluated interventions to improve health-seeking behaviour or healthcare utilisation were included. Records were managed using Rayyan, independently screened by three reviewers, and appraised using the Joanna Briggs Institute (JBI) Critical Appraisal Tools and the Mixed Methods Appraisal Tool (MMAT). Owing to heterogeneity in study designs, settings, interventions, and outcomes, findings were synthesised narratively using thematic analysis. Eight studies met the inclusion criteria. **Results:** Six strategy categories were identified: peer-led male engagement, Men's Sheds programmes, human immunodeficiency virus (HIV) self-testing, digital health interventions, facility-based health education programmes, and male-friendly dedicated spaces within health facilities. These strategies were associated with increased willingness to seek healthcare, greater healthcare utilisation, improved knowledge, enhanced uptake of preventive services, and stronger engagement in health-seeking behaviours. However, evidence was limited by the small number of studies, methodological heterogeneity, and the predominance of descriptive and observational studies conducted in sub-Saharan Africa. **Conclusions:** Multi-component interventions integrating community-based approaches, digital health technologies, and health system adaptations are more likely to improve men's engagement with healthcare services than single-component interventions. Rigorous, context-specific intervention studies are needed to determine which strategies are most effective, for whom, and under what circumstances. **The PROSPERO Registration:** CRD42024548211.

Keywords

Health; Health seeking behaviour; Interventions; Men; Strategies

1. Introduction

Developing effective strategies to improve men's utilisation of healthcare services is essential for enhancing men's health and wellbeing [1]. In this review, strategies are defined as planned actions and interventions designed to encourage men to utilise healthcare services and adopt behaviours that promote and maintain their health [2]. Health-seeking behaviour is conceptualised as the process through which men recognise health needs, seek health-related information, communicate about health concerns, engage in preventive and diagnostic ser-

vices, access healthcare when needed, and undertake actions aimed at maintaining or improving their health [3]. Therefore, outcomes such as health knowledge, intentions to seek care, communication about health concerns, uptake of testing and screening services, and healthcare utilisation were considered relevant indicators of health-seeking behaviour in this review. Health knowledge and intentions were regarded as enabling factors that may facilitate future engagement with healthcare services, whereas testing behaviour, screening uptake, and healthcare utilisation were considered observable manifestations of health-seeking behaviour. Despite considerable ad-

vances in healthcare delivery, men continue to underutilise primary healthcare services in many countries, making this an ongoing public health concern [4]. For example, a study conducted in Spain found important gender differences in healthcare utilisation among older adults. Women were more likely than men to seek medical attention after developing a lump in the armpit following recovery from a cold, whereas men were less likely to seek care for the same condition [5]. This finding illustrates that men often delay seeking healthcare even when symptoms may warrant medical evaluation.

Importantly, low healthcare utilisation among men has been reported even in countries where healthcare services are provided free of charge [1]. Numerous studies have, therefore, explored the barriers that discourage men from accessing healthcare services. Commonly reported barriers include lack of time to attend health facilities, fear of being seen seeking healthcare, fear of receiving a serious diagnosis, long waiting times, self-medication, and reliance on traditional medicine [6, 7]. In some African settings, cultural beliefs and masculine norms that emphasise self-reliance and toughness have also been identified as barriers to healthcare utilisation. However, these sociocultural factors are context-specific and should not be assumed to apply universally across different populations. The consequences of poor healthcare utilisation among men are substantial. Men who underutilise healthcare services experience a greater burden of chronic diseases and have higher mortality rates than women from many leading causes of death [8]. Furthermore, evidence from the World Health Organization (WHO) indicates that men experience higher mortality rates than women for most non-communicable diseases across all WHO regions [9, 10]. Recognising these challenges, various interventions have been introduced to improve men's engagement with healthcare services. One such intervention is the establishment of male-friendly clinics that provide healthcare services specifically tailored to men's needs [11]. These clinics were developed to create more welcoming environments and encourage men to access preventive and curative healthcare services. Nevertheless, evidence suggests that men remain less likely than women to utilise healthcare services and often seek medical attention only when their illnesses have become severe [12].

Delayed healthcare seeking also contributes to late diagnosis, delayed initiation of treatment, avoidable complications, and poorer health outcomes [13]. This systematic review

aimed to synthesise evidence on strategies and interventions used to promote health-seeking behaviour among adult men aged 18 years and older. Specifically, the review sought to identify the types of strategies implemented, describe their reported outcomes, and assess their potential to improve men's engagement with health services. Identifying and evaluating these strategies may help reveal gaps and inform actions to improve men's health-seeking behaviour. However, studies focusing exclusively on specific subpopulations of men were excluded because these groups have unique factors that influence their health-seeking behaviour.

2. Methods

2.1 Search strategy

A systematic search was conducted in PubMed, EBSCOhost, ScienceDirect, and Google Scholar to identify studies published between January 2000 and February 2026. Grey literature was also searched through institutional repositories and relevant organisational websites. The search strategy combined terms related to men, health-seeking behaviour, and strategies or interventions using the Boolean operators AND and OR, as outlined in Table 1. The complete search strategies for each database are presented in Table 2 to ensure transparency and reproducibility. All retrieved records were imported into Rayyan for duplicate removal and screening. Three reviewers independently screened the titles and abstracts of all identified records, followed by full-text assessment of potentially eligible studies. Any disagreements regarding study eligibility were resolved through discussion and consensus. The review included primary studies involving men aged 18 years and older that evaluated strategies or interventions aimed at improving health-seeking behaviour or healthcare utilisation. Systematic reviews were excluded because this review focused on primary evidence. This review was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines. The completed PRISMA 2020 checklist is presented in **Supplementary material 1**.

2.2 Study selection

Records retrieved from the electronic databases were imported into Rayyan, a web-based platform designed to facilitate systematic reviews. Duplicate records were removed before the

TABLE 1. Search terms.

Search concepts and eligibility criteria

Population: Men OR Males OR Adult men

Exposure: Strategies OR interventions OR actions OR "Proposed actions" OR measures

Outcome: "Health Seeking Behaviour" OR "Health seeking" OR "Help seeking" OR "Health service use" OR "Healthcare use" OR "Health Services"

Inclusion criteria:

- English language
- Studies involving adult men aged 18 or older
- Published between January 2000 and February 2026

Search terms were combined using Boolean operators (AND/OR) and adapted to the syntax of each database.

TABLE 2. Database search strategy.

Database	Search query
PubMed	((("Health Services Accessibility"[MeSH Terms] OR "health seeking behaviour"[All Fields] OR "health-seeking behavior"[All Fields] OR "help-seeking behavior"[All Fields] OR "health service utilization"[All Fields] OR "healthcare utilization"[All Fields]) AND ("Men"[MeSH Terms] OR ("Men"[MeSH Terms] OR "Men"[All Fields]) OR ("male"[MeSH Terms] OR "male"[All Fields]) OR ("male"[MeSH Terms] OR "male"[All Fields] OR "males"[All Fields] OR "male s"[All Fields] OR "maleness"[All Fields])) AND ("Health Promotion"[MeSH Terms] OR "intervention*" [All Fields] OR "strateg*" [All Fields] OR "program*" [All Fields] OR "peer education"[All Fields] OR "digital health"[All Fields] OR "self testing"[All Fields] OR ("male friendly"[All Fields] AND ("service"[All Fields] OR "service s"[All Fields] OR "serviced"[All Fields] OR "services"[All Fields] OR "services s"[All Fields] OR "servicing"[All Fields]))) AND ((ffrft[Filter]) AND (fha[Filter]) AND (comparative study[Filter] OR introductory journal article[Filter] OR observational study[Filter] OR randomized controlled trial[Filter]) AND (fft[Filter]) AND (2000/1/1:2026/2/28[pdat]) AND (english[Filter]))
ScienceDirect	males OR men AND strategies OR interventions AND "health seeking behaviour" OR "health service use" OR "health services"
EBSCOHost	((males OR men)) AND ((strategies OR methods OR techniques OR interventions OR measures OR actions)) AND ((health seeking behaviour OR health seeking OR help seeking OR health service use OR health services OR health services))
Google scholar	males OR boys OR men AND strategies OR methods OR techniques OR interventions OR measures OR actions AND health seeking behaviour OR health seeking OR help seeking OR health service use OR health services OR health services

MeSH: Medical Subject Headings.

screening process. Three reviewers independently screened the titles and abstracts to identify potentially eligible studies. Any disagreements regarding study inclusion or exclusion were resolved through discussion and consensus. The full texts of potentially eligible studies were then independently assessed by the three reviewers for final eligibility. The study selection process is summarised in the PRISMA flow diagram in Fig. 1.

2.3 Inclusion and exclusion criteria

This review included studies that reported strategies or interventions aimed at promoting men's health-seeking behaviour among adults aged 18 years and older. Eligible studies were published in English between January 2000 and February 2026. Studies focusing exclusively on highly specific subpopulations of men with distinct healthcare contexts were excluded to enhance conceptual comparability across the included studies.

2.4 Quality assessment

The methodological quality of the included studies was independently assessed by all three reviewers using validated critical appraisal tools appropriate for each study design. Qualitative studies were appraised using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research [14]. Quantitative cross-sectional studies were critically appraised using the "JBI 8 Checklist for Analytic Cross-sectional Studies" [15]. The Mixed Methods Appraisal Tool (MMAT) was used to appraise mixed-methods studies [16]. The certainty of evidence for each included study was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach [17]. The included stud-

ies, as presented in Table 3 (Ref. [11, 18–24]), were classified as having a low, moderate, or high risk of bias. Studies that met all applicable appraisal criteria were classified as having a low risk of bias, whereas those with minor methodological limitations in non-critical domains were classified as having a moderate risk of bias. Studies with substantial methodological limitations in one or more critical domains were classified as having a high risk of bias. The detailed quality assessment results are presented in the **Supplementary material 2**. To enhance methodological transparency and minimise the risk of reporting bias, the review protocol was prospectively registered with the International Prospective Register of Systematic Reviews (PROSPERO; Registration No. CRD42024548211) before the review was undertaken.

2.5 Data extraction and synthesis

All three reviewers used a standard data extraction tool in Microsoft Excel format. Owing to heterogeneity in study designs, interventions, populations, and outcomes, a meta-analysis was not appropriate. Findings were, therefore, synthesised narratively, with intervention strategies organised into thematic categories. The data on intervention strategies were analysed inductively to generate themes. Reviewers conducted line-by-line coding and grouped codes according to similarities. Themes were then developed from these grouped code categories. One overarching theme and six sub-themes were identified.

2.6 Certainty of evidence assessment

The certainty of evidence for each intervention category was assessed using the GRADE approach [17]. The body of

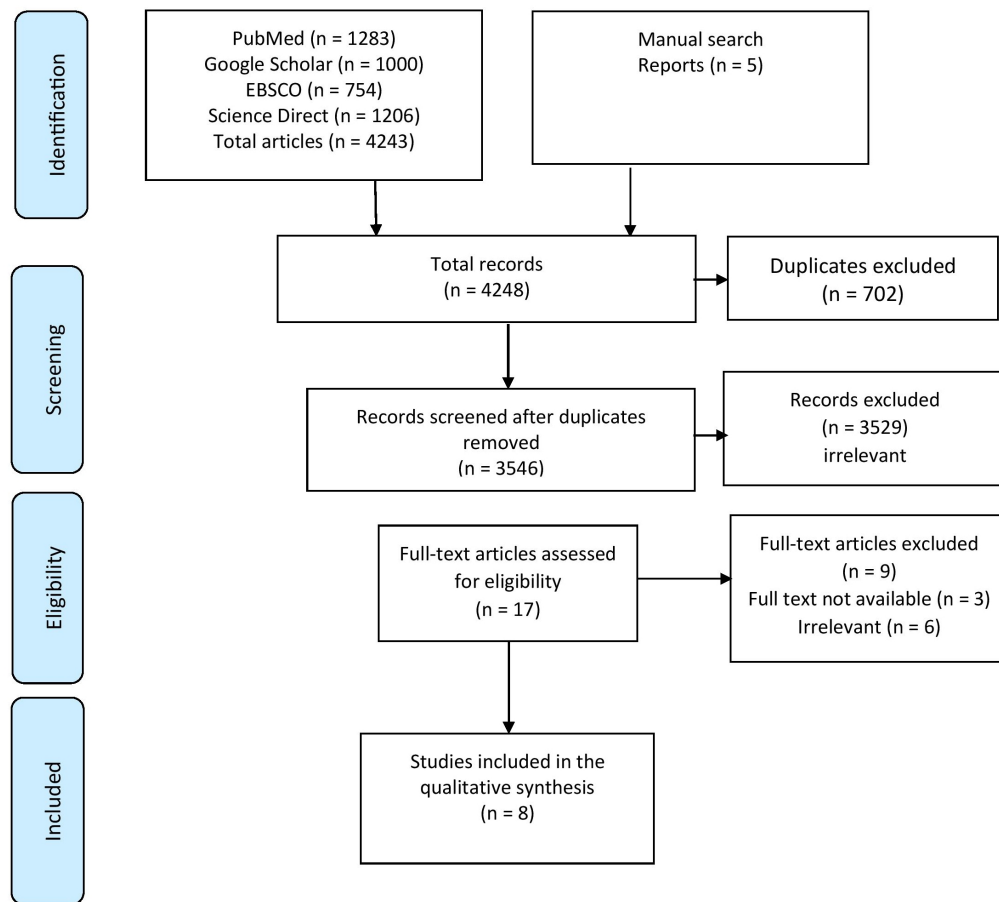


FIGURE 1. PRISMA flow diagram for the identification and screening of included studies.

evidence was evaluated across the following domains: risk of bias, inconsistency, indirectness, imprecision, and publication bias. Because most included studies were qualitative, cross-sectional, or mixed-methods in design, the certainty of the evidence was initially considered low. It was further downgraded when there were important methodological limitations, substantial heterogeneity in interventions and outcomes, small sample sizes, or when only one study contributed to an intervention category.

3. Results

Electronic database searches yielded 4243 records, while a manual search produced 5 reports. After duplicate removal, 3546 studies and four reports were screened by the three reviewers. Consequently, 17 records were screened in full to determine eligibility against the inclusion criteria. After a thorough assessment, eight studies met the inclusion criteria and were included in the review. The PRISMA flow diagram in Fig. 1 summarises these findings.

3.1 Strategies used to promote men's health-seeking behaviour

3.1.1 Male engagement through peer education

Of the eight included studies, two reported the use of peer education to encourage men to attend health services. Men

who supported their partners in vaccinating their children, accompanying them to health facilities, participating in Human Immunodeficiency Virus (HIV) testing with their female partners, and refraining from intimate partner violence were identified as role models in the community. These men were trained to challenge harmful gender norms, improve their knowledge of personal and family health protection, and promote the utilisation of health services. Following completion of the training, they recruited other men through community leaders and existing male groups to participate in workshops, where they were further trained on these aspects to promote health-seeking behaviour [18, 19]. This intervention resulted in improved health-seeking behaviours, including increased visits to health facilities, condom use among main partners, HIV testing, and improved communication between partners regarding pregnancy prevention [18].

3.1.2 Men's sheds

One study reported that men were encouraged to improve their health-seeking behaviours through participation in men's sheds. Health professionals engaged men in discussions on conditions such as bowel cancer, stroke, and male-specific conditions, including prostate and testicular cancer. Participation in the programme increased men's willingness to engage in positive health-seeking behaviours [20].

TABLE 3. Characteristics of included studies.

Author	Year	Aim/Objectives	Population and sample size	Study design	Main findings	Study setting	Quality assessment
Stern <i>et al.</i> [19]	2015	Examined the impact of a three-year intervention project conducted in the Hoima district of Uganda, which sought to engage men in sexual and reproductive health as clients.	Men, 170	Mixed methods	The intervention increased men's knowledge of condom use. Peer education was also used and led to increased sexual and reproductive knowledge, offered Sexual couple counselling and testing, and improved gender equality.	Uganda	Moderate Risk
Choko <i>et al.</i> [21]	2017	Describe the views of pregnant women and their male partners on HIV self-test kits that are woman-delivered.	Men, pregnant women, 20	Qualitative	The findings indicate that men preferred HIV self-testing alone before they could go for testing with partners together.	Malawi	Low Risk
Ghanotakis <i>et al.</i> [18]	2017	Evaluate male engagement intervention to transform gender norms and improve family planning and HIV Service uptake in Kabale, Uganda.	Men, 2373	Cross-sectional Study	The intervention improved men's health-seeking behaviours, specifically in visiting health facilities, HIV testing, and condom use.	Uganda	Moderate Risk
Dowden <i>et al.</i> [11]	2019	Determine how the introduction of male-friendly clinics impacted male care-seeking behaviour and to describe the reasons for accessing services among men in rural Kenya.	Men, 124	Cross-sectional survey	The intervention increased the number of men visiting health facilities. Most men were diagnosed with upper respiratory tract infections, malaria, and injuries.	Kenya	Low Risk
Kelly <i>et al.</i> [20]	2021	Explore the impacts of Sheds on male health improvement and their potential role as a preventative gendered public health measure.	Men, 62	Qualitative	The Men's Shed programme was used to promote men's engagement with healthcare services. The findings show an increase in men's health-seeking behaviours and improved management of personal health.	Scotland	Low Risk
Oliffe <i>et al.</i> [22]	2021	Describe associations between men's usage levels of the e-health program Don't Change Much (DCM) and their recent and intended health behaviour changes, and report an exploratory analysis of the moderating effects of demographic variables on the associations between DCM users and their recent and intended health behaviour changes.	Men, 1766	Cross-sectional study	The Don't Change Much (DCM) e-health program was used to encourage men to adopt healthy behaviours. There were improvements in health behaviour change, and more men committed to intended future behaviour changes.	Canada	Low Risk
Hildon <i>et al.</i> [23]	2022	Describe dormitory contexts and explore behaviour change related to both prevention of transmission as well as healthcare seeking for COVID-19 among male migrant workers.	Men, 23	Qualitative	Digital tools (apps, online platforms, e-learning) were used to provide health education and deliver test results. Peer-sharing and communication strategies were used, where men encouraged each other to engage in testing and treatment and to use healthcare services.	Singapore	Low Risk
Ooi <i>et al.</i> [24]	2024	Assess patient uptake and healthcare providers' acceptability and feasibility of implementing Screen Men, emphasising the importance of Implementation science research in healthcare innovation.	Healthcare providers, 26; Men, 75	Mixed-method explanatory sequential design	A web-based app was used to encourage men to participate in screening. 75 patients accessed the Screen Men app over 5 months, and Only 20% completed it.	Malaysia	Low Risk

HIV: Human Immunodeficiency Virus.

3.1.3 HIV self-testing

Among the eight included studies, one reported that HIV self-test kits were provided to women attending antenatal clinics for distribution to their male partners. This strategy was widely accepted by men and was preferred over standard facility-based testing. It also resulted in an increased number of men participating in HIV testing [21].

3.1.4 Use of digital platforms

Three studies reported the use of digital interventions, including an e-health programme, a web-based screening application, and digital communication tools designed to support health education and engagement with care. Reported benefits included improved access to health information, intended behaviour change, increased screening uptake, and peer encouragement to use health services [22–24]. However, uptake and completion varied across platforms, suggesting that acceptability and sustained engagement may depend on context, user interface design, and access to digital technologies.

3.1.5 Facility-based health education programmes

One of the eight studies reported that trained health professionals and peer educators provided hands-on health education to men attending health facilities either alone or with their partners. The intervention primarily targeted men who had presented for medical male circumcision. In addition to health education, men were offered free HIV testing and treatment for sexually transmitted infections (STIs), including HIV. Furthermore, men were given the option to choose between a male or female service provider [19].

3.1.6 Establishment of a male-dedicated section in existing health facilities

One study indicated that men were encouraged to utilise health services through male-only clinics. These clinics provided free services exclusively to male patients on designated days of the month and employed dedicated male health workers stationed within specific areas of existing health facilities. The services offered included blood pressure monitoring, sexual and reproductive health examinations, and HIV testing. Men attended these male clinics more frequently than general health facilities. The study also identified several factors that may contribute to men's reluctance to utilise routine health facilities [11].

3.2 Certainty of evidence across intervention categories

The GRADE assessment indicated that the certainty of evidence across the identified intervention categories ranged from low to very low, as shown in Table 4 (Ref. [11, 18–24]). The evidence for peer-led male engagement, Men's Sheds, HIV self-testing, facility-based health education programmes, and male-friendly dedicated clinic spaces was rated as very low, primarily because these categories were supported by only one or two studies with observational, qualitative, or mixed-methods designs and heterogeneous outcomes. The evidence for digital platforms was rated as low, despite being

supported by multiple studies, due to substantial heterogeneity in intervention design, implementation, and outcome reporting. Overall, the identified strategies should be interpreted as promising approaches rather than interventions supported by high-certainty evidence.

4. Discussion

This review identified six broad intervention categories that may improve men's engagement with health services. Across the included studies, strategies that reduced stigma, improved convenience, enhanced privacy, or created male-tailored points of contact appeared most promising. However, the evidence should be interpreted cautiously because the included studies varied substantially in design, setting, intervention content, and outcome measurement. As a result, the review is better positioned to map promising approaches than to establish comparative effectiveness.

Two included studies reported increased utilisation of health facilities among men [11, 18]. The effectiveness of this strategy suggests that male role models serving as peer educators can help challenge harmful masculine norms, and men may be more receptive to health messages delivered by trusted male peers. These results align with those of a systematic review by He *et al.* [25], which reported that peer education improved HIV testing, condom use, and other health behaviours. Community-based interventions, such as Men's Sheds, also emerged as an important strategy for addressing men's poor health-seeking behaviour. These platforms provide men with a safe space to discuss health issues and receive education without stigma in formal clinic settings. The findings concur with Cordier and Wilson [26], who found that Men's Sheds supported men's mental health needs, as well as health promotion and health literacy.

HIV self-testing was also identified as a strategy to improve men's engagement in health services. Evidence suggests that HIV self-testing is acceptable to men because of its convenience, privacy, and confidentiality, which help to overcome barriers such as stigma and fear of discrimination in health facilities [27]. However, challenges have been observed regarding linkage to care following HIV self-testing among individuals who receive a positive test result. Some men find it difficult to refer themselves for treatment. Clear policies are needed to facilitate linkage to care following self-testing. Digital health interventions, including e-Health programmes and web-based platforms, were also associated with improvements in health-seeking behaviour. These platforms provide flexible, private, and user-friendly access to health information and services, making them particularly appealing to men who may avoid traditional healthcare settings. Research suggests that digital interventions can improve health behaviours, increase knowledge, and support engagement in preventive services [28]. A systematic review conducted by Sharif *et al.* [29] highlights the growing role of digital health technologies in enhancing HIV prevention, testing, and treatment adherence, especially among hard-to-reach populations. However, their effectiveness may be limited in settings with low digital literacy and limited access to digital technologies.

TABLE 4. GRADE assessment of certainty of evidence for strategies promoting men's health-seeking behaviour.

Intervention category		Included studies	Study designs	Main reported outcomes	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty
Peer-led male engagement		Ghanotakis <i>et al.</i> [18]; Stern <i>et al.</i> [19]	Cross-sectional; mixed-methods	Increased clinic attendance, HIV testing, condom use, partner communication, and sexual and reproductive health knowledge	Serious	Serious	Not serious	Serious	Suspected	Very low
Men's programmes	Sheds	Kelly <i>et al.</i> [20]	Qualitative	Improved willingness to discuss health, better self-management, and greater readiness to seek care	Serious	Serious	Serious	Serious	Suspected	Very low
HIV self-testing		Choko <i>et al.</i> [21]	Qualitative	High acceptability, preference for self-testing, and increased male participation in HIV testing	Serious	Serious	Serious	Serious	Suspected	Very low
Digital platforms		Oliffe <i>et al.</i> [22]; Hildon <i>et al.</i> [23]; Ooi <i>et al.</i> [24]	Cross-sectional; qualitative; mixed-methods	Improved access to health information, intended behaviour change, screening uptake, and peer encouragement to use health services	Serious	Serious	Not serious	Serious	Suspected	Low
Facility-based health education programmes		Stern <i>et al.</i> [19]	Mixed-methods	Improved health knowledge, counselling uptake, STI/HIV testing, and service engagement	Serious	Serious	Not serious	Serious	Suspected	Very low
Male-friendly dedicated sections in existing health facilities		Dowden <i>et al.</i> [11]	Cross-sectional survey	Increased male attendance and improved acceptability of male-oriented services	Serious	Serious	Not serious	Serious	Suspected	Very low

The certainty of evidence was downgraded mainly because most included studies were observational, qualitative, or mixed-methods, with substantial heterogeneity in intervention content, implementation context, and outcome measures. In several intervention categories, only one study contributed evidence, limiting consistency and precision. Therefore, confidence in the estimated effects remains limited. HIV: Human Immunodeficiency Virus; STI: sexually transmitted infections.

Facility-based health education programmes and male-friendly services, such as male clinics, were identified as key strategies to increase men's use of healthcare services and improve health-seeking behaviour. These strategies highlight the importance of health system re-engineering to improve men's utilisation of healthcare services. Providing an opportunity to choose a provider and creating male-dedicated spaces can reduce discomfort and perceived stigma associated with using health facilities. These findings are consistent with those of Hlongwa and Nicol [30], who found that men's lower engagement with healthcare services is often linked to structural barriers and perceptions of healthcare systems as being unresponsive to men's needs. Overall, this review highlights that men's health-seeking behaviour is influenced by multiple factors, including gender norms, stigma associated with healthcare utilisation, and health system constraints. Therefore, a single intervention is unlikely to be sufficient. A comprehensive, multi-component approach combining community-based strategies, digital interventions, and health system strengthening is likely to be more effective.

The GRADE assessment indicated that the certainty of evidence for the identified strategies was generally low to very low. This reflects methodological limitations in the available literature rather than evidence of ineffectiveness. Most intervention categories were supported by a small number of studies, many of which were qualitative or observational and used heterogeneous outcome measures. Accordingly, this review should be interpreted as identifying promising, contextually relevant strategies to enhance men's healthcare engagement, while also highlighting the need for more rigorous comparative research.

This review has several limitations. First, only English-language studies were included, potentially excluding relevant evidence from non-English-speaking contexts. Second, the included studies were heterogeneous in design, settings, and outcome measures, limiting comparability across interventions. Third, much of the evidence came from qualitative or cross-sectional studies, limiting causal inference regarding effectiveness. Fourth, some intervention categories were represented by only one study, reducing confidence in generalisability. Fifth, publication bias cannot be excluded, particularly as studies with null findings may be underreported. Moreover, the included studies were geographically concentrated, with most conducted in sub-Saharan Africa and focusing primarily on HIV-related or sexual and reproductive health interventions. As a result, the identified strategies were evaluated within specific healthcare systems, disease burdens, gender norms, and community contexts, which may not be representative of other regions. While the findings provide valuable insights into approaches for improving men's health-seeking behaviour, their transferability to other settings should be interpreted with caution. Despite these limitations, this review provides a useful synthesis of intervention types and highlights promising directions for future men's health programming and research.

5. Conclusions

This review identified six broad categories of strategies that may support men's health-seeking behaviour: peer-led

engagement, Men's Sheds, HIV self-testing, digital platforms, facility-based health education, and male-friendly service spaces. The included studies suggest that these approaches are acceptable and show promise in enhancing men's engagement with health services; however, the evidence base remains heterogeneous and methodologically limited. Consequently, more robust, comparative, and context-sensitive research is needed to determine which strategies are most effective, for whom, and under what conditions.

ABBREVIATIONS

HIV, Human Immunodeficiency Virus; JBI, Joanna Briggs Institute; MMAT, Mixed Methods Appraisal Tool; PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses; STI, Sexually Transmitted Infection; NCDs, Non-Communicable Diseases; WHO, World Health Organization; PROSPERO, International Prospective Register of Systematic Reviews; GRADE, Grading of Recommendations Assessment, Development and Evaluation.

AVAILABILITY OF DATA AND MATERIALS

This study is a systematic review of published literature. All studies included in the review are cited in the manuscript and are publicly accessible through the databases and sources described in the Methods section. Data extracted from the included studies are presented in this study.

AUTHOR CONTRIBUTIONS

LC, TRL and LM—conceptualized the review; conducted the literature search, screening, quality appraisal, and data extraction. LC—drafted the manuscript. TRL and LM—critically revised the manuscript for important intellectual content. All authors read and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable. This study is a systematic review of the published literature and did not involve direct human participants.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found, in the online version, at <https://oss.jomh.org/files/article/2105120005374787584/attachment/Supplementary%20material.zip>.

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