BARRIERS AND FACILITATORS TO USE OF MALE FRIENDLY CLINICAL SERVICES IN QUELIMANE, ZAMBÉZIA PROVINCE, MOZAMBIQUE: RESULTS OF A QUALITATIVE STUDY, 2021

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Background

- Programmatic data in Mozambique have shown that access to health services, chronic disease treatment outcomes, and antiretroviral treatment coverage are higher among women than men living with HIV, and male-focused interventions are needed.
- In 2018, the Ministry of Health launched a National Strategy for Male Engagement in Health Care, including guidelines on the provision of male-friendly services (MFS). MFS were provided through male-friendly clinics, dedicated to male patients only, where predominantly male healthcare workers provided care through a one-stop model outside of normal clinic hours.
- The Provincial Health Authorities of Zambézia Province, in collaboration with Friends in Global Health, piloted the MFS in Quelimane City, the capital of Zambézia, to increase the number of men tested for HIV, enrolled and retained in ART services.
- This evaluation aimed to identify facilitators and barriers influencing uptake to men-friendly services.

Methods

Study design

- A qualitative study, with in-depth interviews (IDI) and focus group discussions (FGD), was conducted between February to April 2021.

Study sites

- 3 health facilities (HF) in Quelimane City (Coalane HF, Maquival Sede HF, and 24 de Julho HF) providing MFS;
- 2 companies: one with regular (i.e., day shift) working hours and the other with varying work shifts;
- 3 communities surrounding the selected health facilities.

Study population

- Male patients;
- Health care providers (both male and female);
- Male employees (from selected companies);
- Males from the surrounding communities; and
- Female patients; While males were the target population, some women were included for IDI, as their opinions regarding these services may be influential in males' uptake.

Data collection and analysis

- All participants were selected via convenience sampling. FGD and IDI sessions were conducted in Portuguese or Chuabo (local language). Recordings were transcribed in Portuguese and coded by two independent investigators. Thematic analysis was performed.

Results

- Eighty-three IDI and five FGD (n=40) were conducted. Sociodemographic data are presented (Table 1) and primary facilitators and barriers are summarized (Table 2) below.

Table 1. Sociodemographic data (n=123)

	Patients (IDI) (n=65)	Health Care Providers (IDI) (n=18)	Employees (FGD) (n=14)	Community Members (FGD) (n=26)
Sex				
Female	24 (37%)	10 (56%)	NA	NA
Male	41 (63%)	8 (44%)	14 (100%)	26 (100%)
Educational Level				
No education level	17 (26%)	0	1 (7%)	3 (12%)
Basic Level	18 (28%)	0	1 (7%)	3 (12%)
Medium level	13 (20%)	3 (17%)	3 (21%)	6 (23%)
Pre-university level	13 (20%)	9 (50%)	5 (36%)	11 (41%)
Higher Level	4 (6%)	4 (22%)	4 (29%)	3 (12%)

NA - Not Applicable

Table 2. Primary barriers and facilitators identified by participants

BARRIERS	FACILITATORS
Male and female patients, employees and males in community highlighted: ❖ **Perception that poor quality care would be received by health care providers** ❖ **Not knowing such services were available** *"Today is the first day that I am hearing of this, this project. Yes yes." (Male patient, Interview, Coalane HF)* ❖ **Competing priorities (e.g., work responsibilities)** *"If I have headaches, we take paracetamol… at dawn, you have to look for life to support the family" (Male from community, FGD, Community near Maquivale HF)* ❖ **Prolonged wait time at regular, non-EWH sectors** ❖ **Men have a low predisposition to seek health services** **Healthcare providers highlighted barriers such as:** ❖ **Limited human resources, limited equipment and long distances (for patients and providers) from home to the health facility, and male health care seeking behavior/ attitudes.**	**All participant groups mentioned:** ❖ **Good quality care offered by health care providers** ❖ **Extended Working Hours (EWH)** *"Because… because of, the schedule established here, usually doesn't coincide with the work schedule… So, we are more available to go to the hospital when it is not time of work." (Male patient, Interview, 24 de Julho HF)."* ❖ **One Stop Model** *"…So I would advise because you don't have that situation of going to the queue on the other side, on the other side there is the queue, so you go there, … finish there, so that's it, go home." (Male patient, Interview, 24 de Julho HF)."* ❖ **Care/Attendance by male providers** *"I would look for it because knowing that I am making an appointment with a man just like me is, I take all my secret to him and also to ask for an idea what I can do in my life." (Male from community, FGD, Community near Maquivale HF)* ❖ **Short waiting time**

Conclusions

- ❖ MFS are an acceptable model to offering male-centered care, especially for patients who are not able to go to health facility during routine hours;
- ❖ Demand creation messaging is needed to improve awareness of MFS in communities;
- ❖ There is a need to improve care, good communication and attention given to patients;
- ❖ Advocacy with employers is needed to improve male engagement into healthcare;
- ❖ Given the acceptance of the model, MFS could cover screening and management of infectious disease (e.g., HIV/AIDS) as well as non-communicable disease.

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