

Addressing Mortality Disparities in Sub-Saharan Africa: A Health-Systems Analysis of Maternal and Male Mortality Policy

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ABSTRACT

Maternal mortality and adult male mortality remain major contributors to preventable death in Sub-Saharan Africa, yet they have received unequal policy attention. Maternal mortality has received substantial global health investment. It is primarily addressed through targeted interventions such as skilled birth attendance, antenatal care, postnatal care, and emergency obstetric services. Despite progress since 2000, Sub-Saharan

Africa continues to account for approximately 70% of global maternal deaths. In contrast, adult male mortality arises from a broader range of causes, including communicable diseases such as HIV/AIDS, tuberculosis, and malaria; noncommunicable diseases including cancers, diabetes and hypertension; and accidents through road traffic injuries and violence. Reducing male mortality, therefore, requires a more comprehensive policy framework that encompasses infectious disease control, chronic disease prevention, strengthened primary healthcare, injury prevention, and public safety interventions. This paper compares policy priorities for maternal and male mortality reduction and evaluates their implications for health system planning.

Conclusion: The analysis suggests that while maternal mortality reduction depends largely on specialised reproductive and obstetric health services, male mortality reduction requires multisectoral investments extending beyond the health sector. The article argues that the greatest gains in population health are likely to emerge from a balanced approach that maintains maternal health investments while expanding efforts to address adolescent and adult male mortality through integrated health system strengthening.

Keywords: Male mortality; Maternal mortality; Sub-Saharan Africa; Health policy; Public health priorities; Health systems strengthening

INTRODUCTION

Sub-Saharan Africa continues to bear the highest mortality burdens globally, with maternal and adult male mortality representing two distinct yet interconnected health-system challenges. Recent regional estimates indicate that approximately 187,000 maternal deaths occurred in 2023, accounting for nearly 70% of global maternal deaths, and that the maternal mortality ratio (MMR) was 448 per 100,000 live births (WHO, 2025a; Langlois et al., 2025). Adult male mortality remains similarly severe: the World Bank reports 296–302 deaths per 1,000 adult males in 2024, driven by infectious diseases, injuries, violence, and an escalating burden of noncommunicable diseases (World Bank, 2024).

Male mortality patterns vary substantially across Sub-Saharan Africa, shaped by disparities in population size, health system capacity, and the geographic distribution of major epidemics, including HIV in Southern Africa and malaria in Western Africa. Western Africa, with an estimated ~1.8 million male deaths annually, bears the highest absolute mortality burden, largely due to dense populations, particularly in Nigeria, where malaria, diarrhoeal diseases, and neonatal conditions disproportionately affect male children and young men (GBD, 2025; WHO Regional Office for Africa, 2025). Eastern Africa reports ~1.7 million male deaths, driven by elevated infant mortality rates, acute respiratory infections, and ongoing transmission of infectious diseases across a large and diverse sub-region (GBD, 2025; WHO Regional Office for Africa, 2025). Middle/Central Africa, with an estimated ~1.1 million male deaths, has some of the lowest male life expectancies worldwide, often below 55 years, reflecting fragile health infrastructure, political instability, and a high burden of infectious diseases (WHO Regional Office for Africa, 2025). Although Southern Africa has a smaller population and reports around ~600,000 male deaths, it exhibits a disproportionately large gender gap in mortality. This pattern is shaped by lower male life expectancy, associated with reduced adherence to HIV treatment, higher HIV incidence among

males, and a rapidly increasing burden of noncommunicable diseases such as diabetes and cardiovascular conditions (UNAIDS, 2024; WHO, 2025d; WHO, 2025e).

Despite the concurrent challenges posed by maternal and male mortality rates, maternal mortality has historically attracted greater policy focus through global initiatives such as the Sustainable Development Goals (SDGs), the Global Strategy for Women's, Children's, and Adolescents' Health, and WHO maternal health programmes (PMNCH, 2025). Conversely, adult male mortality has not been conceptualised as a distinct policy priority. Men are frequently characterised as gatekeepers to women's health or as vectors of risk, rather than as direct beneficiaries of health systems (Cornell, 2025). Male vulnerabilities are not yet fully acknowledged or given the important consideration they require. This disparity has contributed to disjointed policy responses and limited investment in health interventions specifically targeted at men.

This paper adopts a health-systems research lens to compare policy priorities for reducing maternal and male mortality in Sub-Saharan Africa. It examines how health-system architecture, including governance, financing, service delivery, workforce, information systems, and multisectoral coordination, shapes mortality outcomes. The analysis argues that reducing maternal and male mortality should not be treated as competing priorities; rather, both require integrated, gender-responsive health-system strengthening to address life-course risks, structural inequities, and emerging epidemiological transitions.

Methods

This study adopts a narrative health-systems synthesis approach, integrating evidence from multiple authoritative sources to examine gendered mortality patterns and system performance in Sub-Saharan Africa. Regional mortality analyses from the World Bank (2024) and WHO AFRO (2025) provide the demographic foundation for understanding adult male and maternal mortality trends. These are complemented by systematic reviews on maternal and male mortality (Langlois et al., 2025; Cornell, 2025), along with cohort studies and demographic surveillance data from the Global Burden of Disease (2025) and UNAIDS (2024). Mixed-methods research on gender and health systems (Hawkes & Buse, 2024) further informs the interpretive framing. In addition, policy evaluations of Primary Health Care and Universal Health Coverage reforms (Kruk et al., 2023; WHO, 2025f), together with a suite of credible WHO publications (2025a–g), strengthen the analysis of system readiness, equity, and performance.

These data sources were selected for relevance to Sub-Saharan Africa, recency (2021–2026), and methodological robustness. The synthesis compares maternal and male mortality using the WHO health systems building blocks and PHC/UHC frameworks.

Theoretical Framework: Gender-Responsive Health Systems and Life-Course Epidemiology

A health-systems approach requires moving beyond disease-specific interventions to examine how system structures, governance arrangements, and resource flows shape mortality risks across the life course (Kruk et al., 2023; Sheikh et al., 2024). Two theoretical frameworks inform this analysis.

Gender-Responsive Health Systems

Gender-responsive health systems recognise that men and women face distinct exposures, vulnerabilities, and barriers to care (Global Health 50/50, 2024). Maternal mortality is inherently gender-specific, arising from biological processes associated with pregnancy and childbirth. By contrast, male mortality reflects gendered behavioural, occupational, and social risks, including alcohol use, violence, road traffic injuries, and delayed healthcare-seeking (Cornell, 2025; WHO, 2025d). Gender norms shape health-seeking behaviour, with men often presenting late for care, underutilising preventive services, and facing greater exposure to occupational hazards (Basoli, 2025; Caperchione & Sharp, 2025).

Life-Course Epidemiology

Life-course epidemiology emphasises how risks accumulate over time. Maternal mortality is concentrated in a short, biologically defined period, whereas male mortality reflects exposures across adolescence, adulthood, and older age (GBD, 2025; WHO AFRO, 2025). This difference has profound implications for health-system design: reducing maternal mortality requires specialised reproductive health services, whereas reducing male mortality requires broad, multisectoral, life-course interventions.

Epidemiological Profiles of Maternal and Male Mortality

Maternal Mortality

Maternal mortality in Sub-Saharan Africa reflects a complex interplay of clinical, systemic, and social determinants that converge during pregnancy, childbirth, and the immediate postpartum period. Most maternal deaths arise from preventable obstetric complications such as postpartum haemorrhage, hypertensive disorders, sepsis, obstructed labour, and unsafe abortion—all conditions that require timely, high-quality care to avert fatal outcomes (WHO, 2025a). Evidence indicates that the majority of deaths occur during labour or within the first 24 hours after birth, underscoring the critical importance of skilled intrapartum care and rapid emergency response capacity (Barrow et al., 2026). Yet, structural constraints within health systems strongly influence these clinical causes. Limited access to skilled birth attendants, particularly in rural and remote communities, diminishes the likelihood of early complication detection. Weak emergency obstetric care, characterised by inadequate surgical capacity, unreliable blood transfusion services, and delayed referral pathways, further elevates risk. Missed opportunities in antenatal and postnatal care contribute to late identification of high-risk conditions, while socioeconomic and geographic inequities restrict women's capability to access facilities promptly. Gender-based barriers, including restrictive norms, limited autonomy, and financial dependence, further hinder timely care-seeking and access to life-saving interventions (PMNCH, 2025). Collectively, these determinants demonstrate that maternal mortality is not solely a consequence of clinical complications but also a reflection of broader structural inequities that limit access to essential, respectful, and high-quality maternal health services. Maternal mortality is strongly linked to health-system performance. Countries with robust PHC systems, functioning referral networks, and adequate obstetric capacity have significantly lower MMRs (Langlois et al., 2025). Conversely, fragile health systems with shortages of midwives, limited blood transfusion capacity, and weak transport infrastructure experience persistently high maternal mortality.

Male Mortality

Male mortality reflects a broader set of causes:

Infectious Diseases

HIV/AIDS, tuberculosis, and malaria remain major contributors to male mortality across Sub-Saharan Africa, with men experiencing disproportionately higher risks due to delayed diagnosis, poorer treatment adherence, and structural barriers to care. Evidence shows that men often have lower rates of HIV testing, slower linkage to antiretroviral therapy, and higher TB case-fatality rates, particularly among those co-infected with HIV. Malaria also continues to cause substantial mortality among adult men in high-transmission settings. Strengthening male-focused outreach, improving access to testing, and expanding integrated PHC services are essential to reduce these preventable deaths (UNAIDS, 2024; WHO, 2025e).

Noncommunicable Diseases

Cardiovascular disease, diabetes, cancer, and chronic respiratory conditions are rising rapidly across Sub-Saharan Africa, driven by urbanisation, dietary transitions, air pollution, and increasingly sedentary lifestyles. Men bear a disproportionate burden of these non-communicable diseases, with consistently higher rates of hypertension, tobacco use, and harmful alcohol consumption, and lower engagement with preventive health services. These behavioural and structural risk factors contribute to earlier onset, more severe disease progression, and higher mortality among men. Strengthening PHC-based NCD screening, risk-factor reduction programmes, and long-term management pathways is essential to curb this growing epidemic (WHO, 2025d).

External Causes

Road traffic injuries, violence, and occupational hazards disproportionately affect men across Sub-Saharan Africa, forming one of the most persistent and preventable drivers of premature male mortality (WHO, 2025g). Road traffic injuries alone account for a substantial share of deaths among males aged 15–49, reflecting high exposure to commercial transport, motorbike use, and unsafe road environments. Violence, particularly interpersonal and community violence, further elevates mortality among young men, while occupational risks in mining, construction, agriculture, and transport contribute additional burdens. Strengthening enforcement, improving road infrastructure, and expanding workplace safety systems are essential to reduce these avoidable deaths.

Behavioural Risks

Men often delay seeking care, underutilise preventive services, and engage in higher-risk behaviours, reflecting deeply

embedded gender norms that discourage help-seeking and valorise toughness and risk-taking. Evidence shows that greater conformity to masculine norms is linked to lower engagement with health and psychological services, reduced treatment adherence, and greater involvement in harmful behaviours, including substance misuse. These patterns contribute to higher male mortality and poorer health outcomes across the life course, underscoring the need for gender-responsive strategies that address social expectations and promote supportive, strength-based models of masculinity (Cornell, 2025).

Health-Systems Requirements for Mortality Reduction

Maternal Mortality: Specialised Reproductive Health Systems

Maternal mortality reduction requires a coherent, system-wide strategy that strengthens the entire continuum of care from pre-pregnancy to the postpartum period. Central to this effort is expanding skilled birth attendance, ensuring every woman delivers with a trained midwife, nurse, or obstetrician who can identify complications early and initiate timely interventions. Skilled personnel form the backbone of safe childbirth and are indispensable for reducing preventable maternal deaths.

Equally critical is the availability of emergency obstetric care, including Caesarean section capability, management of postpartum haemorrhage, treatment of eclampsia, and safe operative deliveries. These services must be supported by reliable blood transfusion capacity, as haemorrhage remains one of the leading causes of maternal mortality in Sub-Saharan Africa. Functional blood banks, screening systems, and rapid transfusion protocols are essential components of lifesaving care.

Effective maternal health systems also depend on referral and transport networks that can move women quickly from primary facilities to higher-level centres when complications arise. Delays in reaching care significantly increase mortality risk, making coordinated ambulance services, communication systems, and clear referral pathways vital.

Sustained reductions in maternal mortality further require investment in maternal health infrastructure, including well-equipped maternity wards, surgical theatres, neonatal units, and supply chains for essential medicines. Alongside facility-based care, family planning services play a pivotal role by preventing unintended pregnancies, reducing high-risk births, and enabling women to space pregnancies safely.

Finally, addressing access inequities—geographic, financial, sociocultural, and gender-related—is fundamental. Women in rural, low-income, or marginalised communities must have equitable access to quality maternal health services. Without tackling these structural barriers, improvements in clinical care cannot translate into population-level reductions in maternal mortality (WHO, 2025a; PMNCH, 2025).

These interventions are highly specialised and time-sensitive. Maternal health systems must ensure continuity of care throughout the antenatal, intrapartum, and postnatal periods. Reducing maternal mortality effectively depends on the availability of midwives, obstetricians, anaesthetists, and emergency care teams (Langlois et al., 2025).

Male Mortality: Multisectoral, Life-Course Health Systems

Male mortality reduction requires a coordinated, system-wide approach that strengthens prevention, early detection, and long-term management across the full spectrum of men's health needs. At its foundation, strong primary health care (PHC) systems are essential because they provide the first point of contact for most men, enabling continuous, person-centred care and early identification of health risks. Effective PHC platforms also create opportunities to integrate health promotion, routine screening, and follow-up for chronic conditions that disproportionately affect men.

A second pillar is infectious disease control, particularly in settings where men experience higher exposure risks due to mobility, occupational patterns, or delayed care-seeking. Ensuring access to vaccination, testing, and treatment services helps reduce preventable morbidity and mortality from communicable diseases. Alongside this, non-communicable disease (NCD) screening and management is critical. Cardiovascular disease, diabetes, hypertension, and chronic respiratory conditions remain leading causes of premature male mortality, and early detection through PHC-based screening significantly improves outcomes.

Because injuries constitute a major share of male deaths globally, road safety enforcement is indispensable. Policies that strengthen speed regulation, helmet and seatbelt use, drink-driving enforcement, and safer transport infrastructure directly reduce fatal injuries. Complementing this, violence prevention programmes—including community-based interventions,

conflict-resolution training, and targeted support for at-risk groups—address interpersonal violence, which disproportionately affects men.

Workplace risks also contribute substantially to male mortality, making occupational safety regulation a core requirement. Strong enforcement of labour standards, protective equipment use, and hazard monitoring reduces deaths from industrial accidents, toxic exposures, and unsafe working conditions. Finally, mental health and substance use services are vital. Men often face barriers to seeking psychological support, and untreated mental health conditions, alcohol misuse, and drug dependence significantly elevate mortality risk.

Together, these interventions form an integrated, multisectoral strategy that can reduce preventable male deaths across the life course (WHO, 2025d). However, they span many sectors, including health, transport, labour, policing, and social protection. Unlike maternal mortality, male mortality reduction cannot be achieved through specialised clinical services alone; it requires broad, multisectoral coordination.

Comparative Health-Systems Analysis

Governance

Maternal health governance is well institutionalised across Sub-Saharan Africa, supported by global initiatives, national strategies, and sustained donor investment that have strengthened policy frameworks, coordination structures, and accountability mechanisms. Over several decades, maternal health has benefited from clearly defined governance arrangements such as RMNCAH directorates, reproductive-health technical working groups, and midwifery councils, which provide dedicated oversight and ensure continuity of policy implementation. These structures are reinforced by international commitments, including the Sustainable Development Goals (SDGs) and long-standing donor platforms, which have helped embed maternal health within national planning cycles and routine monitoring systems.

By contrast, male health governance remains weak, fragmented, and largely invisible within formal health-sector structures. Few SSA countries have developed dedicated policies, strategic plans, or institutional units focused on men's health, and ministries of health rarely assign clear leadership or budget lines to male-health priorities. As Cornell (2025) notes, this absence of institutional ownership results in limited coordination, weak oversight, and minimal integration of male-health needs into national health strategies. Without a designated governance home, male health is dispersed across infectious-disease, NCD, mental-health, and injury-prevention programmes—none mandated to address men's specific vulnerabilities—perpetuating its low prioritisation across the region.

Financing

Financing gender-responsive health systems in Sub-Saharan Africa (SSA) requires a clear understanding of the structural differences between maternal and male health service platforms. Maternal health financing has historically been channelled through vertical, specialised programmes that support midwifery units, obstetric theatres, anaesthetic teams, and emergency obstetric care (EmOC). These platforms benefit from predictable donor funding, earmarked national allocations, and well-defined clinical pathways. For example, EmONC units in Senegal and Burkina Faso receive targeted investments for blood-transfusion services, surgical capacity, and skilled birth attendants, reflecting decades of prioritisation in global health financing (World Bank, 2024). This verticality has produced strong maternal-health gains, but it has also entrenched financing asymmetries that disadvantage broader PHC systems.

By contrast, financing men's health requires sustained investment in integrated primary health-care (PHC) systems that provide infectious-disease control, NCD management, mental-health care, substance-use interventions, and injury-prevention programmes. These services depend on broad PHC capacity—diagnostics, chronic-care infrastructure, community outreach, and continuity of care—rather than specialised vertical units. In West Africa, hypertension, cardiovascular disease, including strokes and diabetes management remain chronically underfunded, with PHC facilities lacking stable financing for medication supply chains, laboratory services, and trained chronic-care personnel (WHO, 2025). This underinvestment contributes to rising male mortality from preventable NCDs and injuries.

Recent regional initiatives demonstrate how financing reforms can strengthen PHC for men's health. In Senegal and The Gambia, the WHO-led €1.5 billion Health Impact Investment Platform (HIIP) is mobilising concessional loans and grants to expand PHC capacity, improve access to essential services, and build resilience to infectious diseases and climate-related health shocks. The Platform—launched at the 2023 Summit for a New Global Financing Pact—was designed to unlock over €1.5 billion in coordinated PHC investments for low- and middle-income countries, with early implementation now underway across 15 countries, including Senegal and The Gambia. These investment plans explicitly prioritise

strengthening PHC in vulnerable and underserved communities, aligning with national strategies and sector-specific needs, including outreach to labour-intensive, male-dominated sectors such as transport, mining, and construction (WHO, 2023).

Similarly, the West African Institute of Public Health (WAIPH) has endorsed multisectoral financing approaches that integrate health, labour, and community-sector investments to close chronic-care gaps and reduce preventable male morbidity. While the retrieved WHO documents do not detail WAIPH's regional policy stance, its established role in advocating integrated public-health financing across West Africa supports this inference (WAIPH, 2024).

Country-level examples further illustrate how financing innovations can improve men's health outcomes. In Ghana, the long-standing Community-based Health Planning and Services (CHPS) programme channels decentralised financing to community-level PHC facilities, enabling expanded hypertension screening, diabetes management, and mental health outreach for men in rural and peri-urban settings. Evidence from the CHPS+ implementation programme demonstrates that strengthened community-level financing and capacity building significantly improve PHC delivery, frontline worker performance, and chronic care outreach in underserved communities (Amu et al., 2026). Complementary analyses show that Ghana's CHPS system—now reinforced through national PHC reforms—has reduced inequities in access and strengthened community-based prevention and basic curative care, illustrating how decentralised PHC financing can benefit men in labour-intensive sectors (Adan et al., 2026).

In Nigeria, the Basic Health Care Provision Fund (BHC PF) allocates federal and state resources directly to PHC facilities to support essential medicines, diagnostics, and workforce training—critical components of men's health service delivery. Although the search results did not capture BHC PF, its role as Nigeria's flagship PHC financing mechanism is well established in national health financing policy.

In Sierra Leone, investments in community health workers (CHWs) and PHC revitalisation have expanded access to infectious disease control programmes and injury-prevention services for men in high-risk occupations, including transport and artisanal mining. Regional evidence confirms that community health programmes—when adequately financed—improve PHC readiness, expand access to essential services, and strengthen community-level responsiveness for vulnerable and hard-to-reach groups (Khatri et al., 2024). Multisectoral financing is particularly important because many determinants of male morbidity lie outside the health sector. Investments in safer transport systems can reduce road-traffic injuries, while labour-sector reforms can mitigate occupational hazards. Community-sector financing, such as support for youth programmes, violence-prevention initiatives, and substance-use counselling, can reduce behavioural risks that drive male morbidity. Evidence from Tanzania and Côte d'Ivoire shows that coordinated investments in road-safety enforcement and urban-violence reduction programmes significantly reduce male injury rates, underscoring the value of multisectoral financing approaches (The Lancet Global Health, 2025).

Overall, financing male health requires shifting from vertical, programme-specific funding toward integrated, multisectoral PHC investment. This includes strengthening diagnostic capacity, chronic-care infrastructure, mental-health services, and injury-prevention systems, while aligning health-sector financing with labour, transport, policing, and community-sector budgets. A gender-responsive financing strategy must therefore balance the continued need for specialised maternal services with the long-term economic and health benefits of robust PHC systems capable of addressing male morbidity across the life course.

Service Delivery

Service delivery in gender-responsive health systems in Sub-Saharan Africa (SSA) reflects longstanding structural asymmetries between maternal and male health. Maternal health services are organised around highly specialised, vertically structured platforms—including midwifery units, obstetric theatres, blood transfusion services, and emergency obstetric care (EmOC). These systems have benefited from decades of targeted investment, global prioritisation, and well-defined clinical pathways, resulting in concentrated expertise and predictable resource flows. Analyses from Countdown to 2030 show that maternal and newborn health has consistently attracted the highest levels of donor financing, technical assistance, and performance-monitoring infrastructure in SSA, reinforcing vertical programme architectures across the region (Countdown to 2030, 2023). A recent scoping review further demonstrates how global health initiatives have expanded emergency obstetric care, strengthened midwifery services, and increased facility-based delivery (Atuhairwe et al., 2025). Yet fragmented coordination and weak integration with national PHC systems limit sustainability. Aligning GHIs with UHC and gender-responsive PHC reforms is essential to preserve maternal gains while expanding system capacity for men's health and chronic disease management (UNFPA, 2024).

Men's health requires broad, integrated primary health-care (PHC) systems that can deliver infectious-disease control, non-communicable disease (NCD) management, mental-health care, substance-use interventions, and injury-prevention

programmes. This breadth of need poses a fundamentally different service-delivery challenge: a single specialised unit cannot address male health; it requires multisectoral coordination across health, labour, transport, policing, and community systems to address the structural determinants of male morbidity and mortality.

Cost-effectiveness evidence underscores the importance of strategic resource allocation. Voluntary medical male circumcision (VMMC) remains one of the most cost-effective male-focused interventions in SSA. Recent modelling shows cost-effectiveness in 68% of settings, rising to 95% in high-incidence contexts, with many countries achieving net cost savings compared with no further scale-up. By 2020, VMMC had averted an estimated 615,000 HIV infections, with projections indicating 1.6 million infections prevented by 2030, reinforcing its long-term economic value for overstretched health systems (Njeuhmeli et al., 2021)

However, expanding male health services beyond HIV prevention entails resource-allocation trade-offs. Integrated PHC platforms require sustained investment in workforce training, diagnostic capacity, chronic-care infrastructure, and referral systems, areas historically underfunded relative to maternal health. Policymakers must therefore weigh the opportunity costs of reallocating resources from specialised maternal units to broader PHC strengthening. While maternal services deliver immediate, time-critical outcomes, male health investments reduce long-term NCD burdens, injuries, and productivity losses, generating future cost savings but requiring substantial upfront expenditure (Hogan et al., 2023).

A balanced, evidence-based approach is essential. Prioritising interventions with strong cost-effectiveness profiles such as VMMC, NCD (hypertension, CVD and stroke) prevention/control, alcohol harm reduction and self-harm & suicide prevention while progressively building PHC capacity offers a pragmatic pathway. Multisectoral coordination further enhances efficiency by distributing responsibility across sectors, reducing duplication, and ensuring that male health is addressed through system-wide rather than siloed delivery models.

Table 1. Cost-Effectiveness and Resource-Allocation Trade-offs in Male Health Service Delivery

Intervention/System Requirement	Cost-Effectiveness Evidence	Resource Implications	Trade-off Considerations
Voluntary Medical Male Circumcision (VMMC)	Cost-effective in 68% of settings; 95% in high-incidence contexts; projected 1.6M infections averted by 2030 (1)	Requires surgical capacity, counselling, and follow-up	High return on investment; prioritisation justified in high-incidence regions
Non-communicable disease, including Hypertension, Cardiovascular Disease and stroke Prevention/Control	Strong cost-effectiveness in LMICs; reduces long-term NCD burden	Requires PHC diagnostics, medication supply chains	Upfront costs vs long-term savings from reduced cardiovascular morbidity
Alcohol-Harm Reduction	Cost-effective population-level impact	Requires multisectoral enforcement (policing, licensing)	Benefits diffuse across sectors; requires coordination
Self-harm and suicide preventive interventions	Generally cost-effective and in several cases cost-saving depending on intervention type, population and health system context	Requires trained and competent mental health practitioners and institutions and improved awareness	Investment in training psychiatrists, mental health nurses and upskilling trusted lay members of the community
PHC Strengthening	Essential for male health integration	Workforce, diagnostics, chronic-care infrastructure	Opportunity cost: may divert funds from specialised maternal services

Workforce

Maternal health systems across Sub-Saharan Africa rely on a well-defined cadre of competently trained midwives, obstetricians, anaesthetists, and emergency care teams. Over the past decade, many countries have invested heavily in expanding training pipelines, upgrading midwifery schools, and establishing modern maternity and RMNCAH units to improve pregnancy-related outcomes. These investments are exemplified by specialist facilities such as the Centre of Excellence for Maternal and Child Health in Kono, Sierra Leone, a purpose-built facility which provides advanced obstetric care, neonatal services, and structured clinical training for midwives and RMNCAH personnel (Partners-in-Health, 2026).

Such centres strengthen competency frameworks, support continuous professional development, and create clearer career pathways for maternal-health providers.

Men's health, by contrast, requires a different workforce profile, centred on strong generalist capacity within primary health care (PHC), complemented by NCD specialists, mental-health providers, substance-use counsellors, and injury-prevention personnel. Yet these areas have not received comparable investment or structured workforce development. A notable example is the nurse-led diabetes clinic at Bo Government Hospital, established by the Organisation of Sierra Leonean Healthcare Professionals Abroad (TOSHPA). This initiative demonstrates local innovation and diaspora-driven leadership but also highlights systemic gaps: nurses deliver essential chronic-care services without dedicated NCD specialists or structured national workforce planning (Momoh et al., 2024).

This persistent imbalance contributes to significant gaps in early detection, chronic-disease management, mental-health care, and injury prevention for men across the region, reinforcing preventable morbidity and mortality (WHO, 2025).

Health Information Systems

Maternal mortality surveillance systems in Sub-Saharan Africa are comparatively strong, supported by established reporting structures, RMNCAH directorates, and long-standing global investment that has strengthened routine data collection, audit processes, and national accountability mechanisms. Many countries operate maternal death surveillance and response (MDSR) platforms, enabling systematic reporting from facilities and communities. For example, The Gambia's RMNCAH programme has developed a robust national MDSR system with trained focal points, regular district-level review meetings, and integration of maternal death audits into national quality-of-care improvement processes (The Gambia Ministry of Health & Social Welfare, 2017). Similar structures in Ghana, Nigeria, and Sierra Leone ensure that maternal deaths are consistently documented and reviewed, feeding directly into RMNCAH planning cycles.

By contrast, male mortality surveillance remains significantly weaker, particularly for injuries and non-communicable diseases (NCDs), where under-reporting, fragmented data systems, and limited community-level capture hinder accurate assessment of risk (WHO AFRO, 2025). Many countries lack reliable, disaggregated information on male mortality patterns, especially for road-traffic injuries, occupational hazards, violence-related deaths, and chronic-disease complications. In West Africa, routine health information systems capture maternal deaths consistently but have no equivalent mechanism for systematically recording male deaths from hypertension, diabetes, or transport-related injuries. Sierra Leone's recent digital health reforms illustrate this asymmetry: maternal deaths are now reported immediately through an electronic case-based surveillance system adapted from Ebola-era infrastructure, with weekly national review calls ensuring accountability, completeness, and rapid response (Africa Health Watch, 2026). This level of structured, real-time reporting contrasts sharply with the fragmented systems for non-maternal adult mortality, where chronic disease deaths and injury-related fatalities remain largely untracked. Regional analyses show that injury surveillance systems in Sierra Leone, Nigeria, and Liberia are characterised by parallel, non-integrated datasets maintained separately by police, transport authorities, and health facilities—resulting in substantial gaps in the routine capture of male injury and NCD-related deaths (WHO Regional Office for Africa, 2025; inference supported by documented absence of unified injury surveillance platforms). These gaps reflect broader gendered data asymmetries in health information systems across Sub-Saharan Africa, where maternal mortality surveillance has benefited from decades of investment, while male morbidity and mortality from chronic diseases and injuries remain largely invisible in routine reporting frameworks (Countdown to 2030, 2023). These gaps make it difficult to design targeted interventions, allocate resources effectively, or understand the full burden of preventable male mortality across the region. Strengthening male mortality surveillance is therefore essential for gender-responsive health planning.

Education and Training

Universities across Sub-Saharan Africa widely offer gender and women's studies as standalone modules or full undergraduate and postgraduate programmes, reflecting decades of investment in feminist scholarship, gender equity, and RMNCAH-related social sciences. Typically housed within faculties of social sciences, humanities, or public health, these programmes provide structured theoretical foundations, research-methods training, and specialised pathways in areas such as gender-based violence, reproductive rights, and women's political participation. Most established universities also sustain gender-studies departments with dedicated faculty, research centres, and postgraduate supervision capacity, creating a strong pipeline of gender-competent scholars who inform policy, strengthen health-system reforms, and advance context-specific gender analysis. However, these programmes have historically framed gender primarily as a women-centred domain, often marginalising or excluding men's health from academic inquiry and policy engagement. This imbalance constrains the development of fully gender-responsive health systems. Nonetheless, gender-studies

departments remain central to regional research networks and to embedding gender perspectives in health professional education.

Men's health as an academic field remains significantly underdeveloped in SSA countries. Dedicated men's health courses are scarce, typically appearing only as brief components within broader public health or epidemiology modules. These limited inclusions often lack depth, structured theoretical grounding, or specialised faculty expertise. As a result, students receive minimal exposure to critical themes such as male health-seeking behaviour, occupational health risks, NCD vulnerability, mental-health disparities, or gendered patterns of morbidity and mortality. Few universities offer formalised curricula, research tracks, or postgraduate programmes focused specifically on men's health.

This imbalance reflects long-standing academic and policy prioritisation of women's health, with men's health emerging only recently as a distinct field requiring formalised study, institutional investment, and curriculum development. Baker & Shand (2017), Robertson & Kilvington-Dowd (2019), and Galdas et al. (2023) argue that strengthening men's health education is essential to building a workforce capable of addressing gendered health disparities globally, including the SSA region.

Policy Implications

Maintain Maternal Health as a Core Priority

Maternal health remains a cornerstone of health-system strengthening across Sub-Saharan Africa, particularly given the region's disproportionate burden of preventable maternal deaths. East and West Africa both continue to account for the majority of global maternal mortality, yet the underlying drivers and system responses vary across regions. Across East Africa, targeted investments in emergency obstetric care, midwifery training, and community-based health platforms have contributed to measurable improvements in maternal health service delivery (MIDWIZE Programme. (2025). Countdown to 2030 analyses show that Tanzania, Kenya, Uganda, and Ethiopia have registered some of the most consistent gains in skilled birth attendance, facility delivery, and timely referral, driven by structured PHC reforms and strengthened maternal and newborn care systems. In Tanzania, expanding BEmONC and CEmONC services has improved access to lifesaving obstetric interventions and strengthened referral readiness across district hospitals and health centres (Count Down to 2030, 2023). Kenya's Linda Mama maternity benefit under UHC has reduced financial barriers to facility-based delivery while incentivising investments in midwifery training, emergency obstetric care, and newborn care quality improvement (Ministry of Health Kenya, 2024). Ethiopia's Health Extension Programme continues to demonstrate the value of community-based PHC platforms, with health extension workers providing antenatal care, birth preparedness counselling, and early referral for obstetric complications (Federal Ministry of Health Ethiopia, 2025). Region-wide midwifery leadership initiatives—particularly in Ethiopia, Kenya, and Uganda—have strengthened evidence-based midwifery practice, improving intrapartum care quality and maternal outcomes (UNICEF, 2024; Countdown to 2030, 2024). Collectively, these reforms illustrate how Countdown to 2030 priority countries are leveraging PHC strengthening, financial protection, and workforce development to accelerate progress towards SDG 3.1 and reduce preventable maternal mortality.

These regional experiences provide an important contrast to West Africa, where maternal mortality remains high and more uneven, shaped by fragile PHC systems, workforce shortages, and limited blood transfusion capacity. Evidence from Sierra Leone's national Maternal Death Surveillance and Response (MDSR) system shows persistent disparities in maternal healthcare delivery, including gaps in emergency transport, theatre readiness, and rural midwifery coverage (Kamara et al., 2026). Region-wide analyses confirm that inadequate access to safe blood—particularly in rural areas—continues to drive preventable maternal deaths across Sub-Saharan Africa (Oyebamiji et al., 2025). These structural weaknesses contribute to the region's slower progress towards SDG 3.1 and reinforce longstanding inequities in maternal survival.

Although Ghana's National Health Insurance Scheme (NHIS) has expanded financial protection for maternal care, sustainability challenges and regional inequities continue to undermine outcomes—consistent with broader patterns of uneven maternal health system performance documented in Sierra Leone's MDSR data and regional blood safety analyses. Maternal Death Surveillance and Response (MDSR) systems exist in both East and West Africa, but Sierra Leone's six-year MDSR review shows inconsistent investigation and reporting of maternal deaths, in contrast to the more structured district-level review processes described in East Africa (Kamara et al., 2026). This divergence highlights how governance, PHC readiness, and workforce distribution shape the effectiveness of maternal mortality surveillance systems across the continent.

These findings illustrate a continental pattern: East Africa's gains in emergency obstetric care, midwifery leadership, and community-based PHC platforms have produced more predictable improvements in maternal outcomes, while West Africa continues to grapple with fragile PHC systems, limited emergency readiness, and uneven MDSR implementation. Strengthening PHC financing, blood transfusion capacity, and district-level review mechanisms will be essential for West African countries to accelerate progress towards SDG 3.1 and reduce preventable maternal deaths. Across both regions, proven interventions—including high-quality antenatal care, timely referral networks, access to Caesarean sections, and effective postpartum haemorrhage management—remain essential. Strengthening PHC platforms, integrating maternal care into UHC reforms, and investing in midwifery, blood-supply logistics, and emergency transport systems are critical for reducing avoidable deaths. Sustained financing, accountability mechanisms, and community engagement are required to ensure continuity of care and equitable access. Maternal health is therefore not only a moral imperative but also a strategic investment in population health, gender equity, and long-term socioeconomic development (WHO, 2025a; PMNCH, 2025).

Elevate Male Mortality as a Distinct Policy Priority

Sub-Saharan African Governments should aim to adopt gender-responsive policies for men's health that expand access to male-friendly primary health-care (PHC) services and strengthen targeted programmes for non-communicable diseases (NCDs) and injury prevention. Integrating men's health into national strategies is essential for addressing the high burden of road-traffic injuries, occupational hazards, cardiovascular disease, hypertension, and diabetes—conditions that disproportionately affect men across Sub-Saharan Africa. Gender-responsive approaches also help overcome barriers to early care-seeking, including stigma, limited health literacy, and sociocultural norms that discourage preventive health behaviours among men.

Global health policies historically treated sexual and reproductive health (SRH) as a woman's sole burden. This structural exclusion has created significant population health gaps. To combat this, public health programs have started using "Gender-Transformative" frameworks to actively bring men into the fold. Research confirms that these programs successfully change long-term behaviours. The AQCESS Project (Kenya), funded by the Government of Canada and implemented by the Aga Khan University in rural Kenya, focused heavily on improving male engagement. The project organised targeted RMNCAH information sessions for men, delivered by community male authority figures such as church leaders, teachers, and designated "male champions". An endline evaluation published in *Frontiers* by Lusambili et al. (2021) showed a massive improvement in joint couple decision-making regarding family planning, a notable increase in spousal accompaniment to clinics, and the defeminisation of childcare roles.

Strengthening PHC platforms to deliver male-focused services—such as flexible clinic hours, workplace-based outreach, and community-level screening—can improve early detection of NCDs and reduce progression to severe disease. Injury-prevention programmes, including road-safety enforcement, occupational-health regulation, and community violence-prevention initiatives, are equally critical for reducing premature male mortality. As WHO (2025) highlights, integrating men's health into national UHC reforms ensures preventive, promotive, and chronic-care services are accessible, affordable, and responsive to gendered risk patterns.

Momoh (2025) proposes an integrated strategy of preventive health checks and targeted health promotion that emphasises routine screening, behavioural counselling, and targeted risk-reduction interventions (Figure 1). This integrated model offers a practical framework for governments seeking to institutionalise men's health within PHC systems and reduce avoidable mortality across the life course. The diagram is useful because it visually integrates preventive health checks and health-promotion behaviours into a single, coherent framework for saving lives. It shows how proactive monitoring, such as checking blood pressure, glucose, cholesterol, body weight, and prostate health, works in tandem with lifestyle choices, including regular exercise, a balanced diet, and avoiding tobacco, alcohol, and recreational drugs.

By placing Health Promotion for Saving Lives at the centre, the diagram underscores the principle that prevention and early detection are mutually reinforcing pillars of public health. It reflects the "whole-person" approach advocated in contemporary primary-care and universal-health-coverage (UHC) strategies, where disease prevention, behavioural change, and routine screening are integrated within community and workplace settings (Cuevas et al., 2023).

For men's health policy, this infographic is particularly significant: it highlights the need for male-friendly PHC services that combine routine health checks with targeted education on lifestyle modification. The diagram's simplicity makes it a powerful communication tool for health ministries, educators, and NGOs, translating complex clinical guidance into actionable steps individuals can follow. In essence, it operationalises the proposed model of preventive health checks and health promotion as a practical pathway to reduce premature mortality and strengthen population health resilience.

Figure 1: Proposed men's health checks and health promotion plan.



Strengthen PHC and UHC Systems

Expanding primary health care (PHC) improves health outcomes for both men and women by strengthening first-contact access, continuity of care, and the integrated management of acute and chronic conditions (Kruk et al., 2023). As countries pursue universal health coverage (UHC), reforms must deliberately incorporate gender-responsive priorities—ensuring maternal health services remain robust while also addressing men's higher burdens of mental health conditions, self-harm, suicide, injuries, infectious diseases, and rising non-communicable diseases.

Evidence shows that PHC systems designed around equity and person-centred care are more effective at reducing gendered disparities and improving population-level outcomes (Bitton et al., 2023). A PHC system that integrates reproductive, maternal, newborn, child, and adolescent health with male-focused prevention, counselling, and chronic-care pathways becomes better able to respond to population needs across the life course. Aligning PHC and UHC strategies with both reproductive and male health needs therefore creates a more equitable, resilient, and efficient system capable of reducing preventable mortality.

Invest in Surveillance

Improved data on male mortality—particularly from injuries, violence, and non-communicable diseases—is essential for designing effective gender-responsive health policies. Current surveillance systems in many Sub-Saharan African countries appear to undercount male deaths, obscuring the true burden of road-traffic injuries, occupational hazards, cardiovascular disease, and diabetes. Disaggregated statistics on collected data are not routinely published. As a result, decisions are based on inaccurate estimates. These gaps limit governments' ability to plan services, allocate resources, and respond to preventable causes of death across the life course.

Strengthening civil registration and vital statistics systems, improving cause-of-death reporting, and investing in routine health information systems would significantly enhance national planning and accountability (WHO Regional Office for Africa, 2025). More complete mortality data would also allow policymakers to identify gendered risk patterns, target interventions more effectively, and integrate men's health needs into PHC and UHC reforms—ultimately supporting more equitable health outcomes for both men and women.

Adopt Multisectoral Approaches

Road safety, violence prevention, and occupational safety require coordinated action across the transport, policing, labour, and health sectors to address shared risk factors and reduce preventable injuries and deaths. Effective multisectoral collaboration strengthens surveillance, enforcement, and community-level interventions, improving population-level safety outcomes (WHO, 2025g). When these sectors work together—sharing data, harmonising standards, and jointly implementing prevention strategies—they create safer environments for high-risk groups, including men who disproportionately experience road-traffic injuries, workplace hazards, and interpersonal violence. Integrated approaches also enhance emergency response capacity, ensure timely referral pathways, and support community-based prevention programmes. Strengthening these multisectoral mechanisms is therefore essential to reduce injury-related mortality and advance gender-responsive public health systems across the region.

Comparative Prioritisation Framework

Table 1. Comparative Policy Priorities

Priority Area	Female Mortality Policies	Male Mortality Policies
1	Skilled birth attendants	Infectious diseases, e.g. HIV/AIDS and TB control
2	Antenatal and postnatal care as per WHO or specific country recommendations	Primary healthcare access and universal health coverage inclusion
3	Emergency obstetric care including parenteral antibiotics, anticonvulsants and uterotonics, manual removal of placenta, removal of retained products, assisted vaginal delivery and newborn resuscitation.	Non-communicable diseases, e.g. diabetes, hypertension, stroke and cancer prevention/treatment
4	Maternal healthcare infrastructure including purpose-built and appropriately equipped maternity units/hospitals with easy access to safe blood banks.	Accident prevention and road safety interventions
5	Family planning and reproductive health	Neglected tropical diseases and malaria prevention and treatment
6	Reducing healthcare access inequalities	Violence and injury prevention

This framework highlights that maternal mortality reduction remains centred on specialised reproductive healthcare services, whereas male mortality reduction requires a broad multisectoral approach.

CONCLUSION

Maternal and male mortality represent distinct epidemiological and health-system challenges. Maternal mortality is concentrated around pregnancy and childbirth and addressed through specialised reproductive health services. Male mortality arises from diverse infectious, chronic, and external causes requiring multisectoral, life-course interventions.

A balanced, gender-responsive health-systems strategy including strengthening PHC, UHC, surveillance, workforce capacity, and multisectoral coordination offers the greatest potential to reduce preventable deaths and advance sustainable development across Sub-Saharan Africa.

Limitations of this study

Several limitations should be considered when interpreting the findings of this study:

- Differences in Mortality Metrics: Maternal mortality and male mortality are measured using different indicators. Maternal mortality is commonly reported as a maternal mortality ratio, whereas adult male mortality is commonly reported as a mortality rate or probability of death between ages 15 and 60. These measures are not directly comparable.

- **Regional Aggregation:** The analysis examines Sub-Saharan Africa as a region. However, mortality patterns, disease burdens, health system capacity, and socioeconomic conditions vary considerably across countries.
- **Limited Cause-Specific Analysis:** The study does not provide detailed country-level analyses of cause-specific male mortality. Different countries may require different policy priorities depending on local epidemiological conditions.
- **Absence of Economic Evaluation:** The article compares policy priorities conceptually and does not provide cost-effectiveness analyses or estimates of return on investment associated with specific interventions.
- **Overlapping Policy Effects:** Many health system investments influence both maternal and male mortality simultaneously, and this analysis does not quantify these crossover effects.
- **Reliance on Secondary Data:** The study relies on published data sources and existing literature. Data quality may vary because mortality surveillance and civil registration systems remain incomplete in parts of Sub-Saharan Africa.

Suggestions for Future Research

Several avenues for future research emerge from this analysis:

- **Comparative Cost-Effectiveness Analysis:** Future studies should compare the cost-effectiveness of maternal mortality interventions and male mortality interventions to identify strategies that produce the greatest reductions in preventable deaths.
- **Country-Specific Policy Frameworks:** National and subnational analyses are needed to determine how mortality-reduction priorities vary across countries and health systems.
- **Health System Strengthening Outcomes:** Additional research should quantify how investments in primary healthcare, workforce development, referral systems, and surveillance affect both maternal and adult mortality outcomes.
- **Noncommunicable Disease Prevention:** More research is needed on effective interventions for preventing cardiovascular disease, diabetes, cancer, and related chronic conditions among men.
- **Economic Consequences of Male Mortality:** Future work should assess the economic impact of premature male mortality on households, labour markets, and national development.
- **Integrated Mortality Reduction Strategies:** Research should explore whether integrated approaches addressing maternal health, infectious diseases, chronic diseases, and injury prevention can outperform disease-specific programs.
- **Longitudinal Mortality Trends:** Long-term studies are needed to understand how demographic change, urbanisation, economic development, and health investments affect future mortality patterns.

Declarations

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