# MASCULINITY AND UTILISATION OF SEXUAL REPRODUCTIVE HEALTH SERVICES AMONG MALE YOUTHS AGED 18-24 IN HARARE, ZIMBABWE

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## Abstract

***This study explores the relationship between masculinity and the utilisation of sexual reproductive health (SRH) services among male youths aged 18-24 in Harare, Zimbabwe. Grounded in Courtenay's Relational Theory of Gender and Men's Health, the research aims to ascertain the masculinity norms that impede access to SRH services and elucidate their impact on the acceptability and accessibility of these services. Using a qualitative case study approach, in-depth interviews were conducted with 12 male youth participants from four districts in Harare. The findings reveal that dominant masculine identities, shaped by socially constructed norms, encourage risky health behaviours such as heavy drinking, multiple sexual partners, and the underutilisation of SRH services. Additionally, the preference for alternative health-seeking methods, like traditional medicine, further contributes to the underutilisation of SRH services. The study highlights the need for explicit and targeted educational campaigns,***

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***policy advocacy, and user-friendly healthcare facilities to address the masculinity-related barriers to SRH service utilisation among male youths. Improving men's SRH knowledge and creating a supportive environment is crucial for enhancing their engagement with SRH services and ultimately improving their overall health outcomes.***

**Keywords:** *sexual health, gender, service provision*

## INTRODUCTION

The Human Immune Deficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) remain significant global health challenges, with developed countries making progress in curbing the epidemic, while developing and resource-limited countries continue to be affected (Klionsky *et al*., 2021; Seyed Alinaghi *et al*., 2021). The relationship between masculinity and the utilisation of Sexual Reproductive Health (SRH) services among men is a complex global issue that has elucidated various aspects. Nevertheless, masculinity beliefs and norms continue to influence men's attitudes towards the utilisation of SRH services and their health in general (Skovdal *et al*., 2011).

Taken together, HIV&AIDS prevention and control remains a significant global health challenge (Klionsky *et al*., 2021). The pandemic continues to disproportionately affect Sub-Saharan Africa. According to the Joint United Nations Programme on HIV&AIDS (UNAIDS), in 2021, approximately 38.4 million people were living with HIV globally, with sub-Saharan Africa accounting for 67% of the global total (UNAIDS, 2022). In the same period, a total of 1.5 million new HIV infections were recorded, thus representing 64% of the global total. However, most countries in the region have made substantial progress in curbing the disease from spreading.

In Zimbabwe, the HIV prevalence rate among adults aged 15-49 years was estimated at 12.9 % in 2021 (ZIMPHIA, 2020). This translates to that at least one-third of new HIV infections in Zimbabwe occur among adolescents and young people (15-24 years). This persists despite concerted efforts to normalise HIV&AIDS. Stigma impedes adolescents from accessing HIV sexual reproductive health services (Gottert *et al*., 2017), notwithstanding the government's identification of the need to focus on curbing HIV incidences among young men and women. HIV prevalence was found to be higher among women than men in the survey (15.3% and 10.2%, respectively) (ZIMPHIA, 2020). Differences in HIV service uptake have been identified, with a growing number of studies highlighting that men are significantly less likely to get tested for HIV or to enrol and adhere to antiretroviral treatment (ART) services (Skovdal *et al*., 2011; Treves-Kagan *et al*., 2017).

The above findings give credence to the existence of hegemonic masculinity. Thus, hegemonic masculinity, defined as the pattern of practice that allows men's dominance over women to continue, influences men's social character and health-seeking behaviours (Lewis *et al*., 2020). Certain behaviours associated with this type of masculinity have been linked to an increased risk of poor health (Courtney, 2005). Studies indicate that men are less likely to get tested for HIV or enrol in and adhere to antiretroviral treatment (ART) services (Chikutsa *et al*., 2015).

In support of the above submission, a survey in South Africa reveals that only 20% of those tested for HIV were male (Lesedi *et al*., 2015). A study of HIV testing in Sub-Saharan Africa found that male workers (22%) were less likely to take advantage of testing programmes than female workers (28%), while male spouses (6%) were less likely to get tested than female spouses (18%) (*ibid*.). Even when the number of men

and women using HIV testing services is equal, men tend to get tested only when they are critically ill.

These revelations are not coincidental as they can be attributed to societal norms of masculinity, which discourages men from seeking HIV services (Olanrewaju *et al*., 2019. Several recent studies highlight the impact of these social constructions and their role in men's low HIV service uptake and participation studies such as Treves-Kagan *et al*. (2017), Muchabaiwa and Mbonigaba (2018) and Ninsiima *et al*. (2021). Undie *et al*. (2011) found that young male adolescents in Malawi and Uganda resisted getting tested for HIV, as they felt it signalled a lack of self-confidence and vulnerability, traits that conflicted with their male youth identity. Similarly, Fitzgerald, Collumbien and Hosegood (2010) highlight challenges facing South African men in participating in ART programmes, arguing that gendered expectations and local constructions of masculinity discouraged some men from disclosing their HIV status and seeking treatment, for fear of being perceived as failing in their roles as sons, husbands or breadwinners. Many men coped with the stresses of HIV and treatment by resorting to alcohol, further undermining their treatment regimens (*ibid*.).

Lindegger *et al*. (2016) allude to traits that men in certain cultural contexts in South Africa are expected to possess, such as being tough, unemotional, aggressive, denying weakness, sexually unstoppable, and physically strong. However, as Courtenay (2009) highlights, men are not only conditioned by social representations of manhood, but also actively construct and enact these representations in their own lives. Disengagement with health services and careless health behaviours may be ways for men to demonstrate hegemonic masculinity (*ibid*.). Health-risk behaviours, such as unprotected sex and multiple partners, may be directly associated with virility and a way to assert manliness (Lindegger *et al*., 2016). In Malawi, men were

found to even view HIV as a symbol of their manhood (Landa and Fushai, 2018).

There is generally low uptake and utilisation of SRH services by men globally and regionally, including low uptake of HIV testing and screening, voluntary medical male circumcision, condom use, and use of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) (*ibid.*; Xuebin, 2023). Scholars have asserted that the nexus between masculinity and health-seeking behaviour is evident in men's lower utilisation of primary health services compared to women (Craig *et al*., 2008; Amoo *et al*., 2018). In Zimbabwe, the disparity in the utilisation of SRH services is evident. For example, the Multiple Indicator Cluster Surveys (MICS) of 2019 reports that only 47% of men were tested for HIV and knew their results in the last 12 months, compared to 62% of women. This gap is often attributed to societal norms of masculinity. Furthermore, data show a significant gender disparity: the proportion of men who were tested for HIV and received their results in the past 12 months rose from 21% in 2010-11 to 36% in 2015, according to the Zimbabwe Demographic and Health Survey (ZDHS.2015).

In Zimbabwe, the underutilisation of SRH services among men is prevalent. This is demonstrated by the low condom usage in young men aged 15-24, with a 14.3% prevalence reported in the ZDHS 2015, and a significant drop in male condom use from 135 million to 95 million in 2019, according to the 2020 Global AIDS Response Progress Report. Despite Zimbabwe's high HIV prevalence rate, currently estimated at 12.9% among adults aged 15-49 (ZIMPHIA, 2020), services like medical male circumcision remain underused. Voluntary medical male circumcision (VMMC) is a key strategy to achieve the UNAIDS goal of a 90% reduction in HIV prevalence by 2030 (UNAIDS, 2018).
In addition to the previously mentioned methods, other strategies have been implemented for HIV prevention, such as oral pre-exposure

prophylaxis (PrEP) and post-exposure prophylaxis (PEP), initially targeting high-risk individuals. For example, PrEP has been linked with men who have sex with men and transgender women (Parmley *et al*., 2022). PEP is applicable for both non-occupational use and sexual exposure (PEPSE) (Sultan *et al*., 2014). The adoption of PEP following sexual exposure could be advantageous for young males engaged in high-risk sexual behaviours in less developed countries (Berhan and Berhan, 2015).

Research has explored the perceived barriers and facilitators to PrEP uptake among the youth (Mahumuza *et al*., 2021). Masculine norms are linked to reduced condom use, multiple sexual partnerships (Olanrewaju *et al*., 2019), intimate partner violence (Willie *et al*., 2018; Fleming *et al*., 2019), lower HIV testing rates (Sileo *et al*., 2018), and decreased engagement in HIV care (Sileo *et al*., 2019). It is crucial to investigate how masculine norms impede the uptake of SRH services by male youths in Zimbabwe.

## THEORETICAL FRAMEWORK

The study utilises Courtenay's (2000) Relational Theory of Gender and Men's Health, which suggests that men's health-seeking behaviours and beliefs are expressions of their masculine identity and conformity to dominant masculine norms. Masculinity is often defined in contrast to healthcare, perceived as a feminine sphere (Seidler *et al*., 2016). Nonetheless, men can validate their masculinity through various means, such as educational background, ethnicity, age, sexual orientation, economic status, and religion (Courtenay, 2000). Masculinity influences how men view and engage in health-seeking behaviour. Prior research shows that men and boys are pressured to adopt robust health-related beliefs, emphasising independence, toughness, and self-reliance, unlike women and girls (Myburg, 2011; Nzama, 2013; Obure *et al*., 2016; Olanrewaju *et al*., 2019). Sociologists contend that traditional masculinity, marked by risk-taking, emotional

restraint, and the rejection of weakness, may negatively impact men's health (Gottert *et al*., 2017; Barros *et al*., 2021). This study employs the Relational Theory to investigate the adoption of HIV Testing and Counselling, VMMC, PrEP, and PEP as HIV prevention strategies among young men in Harare.

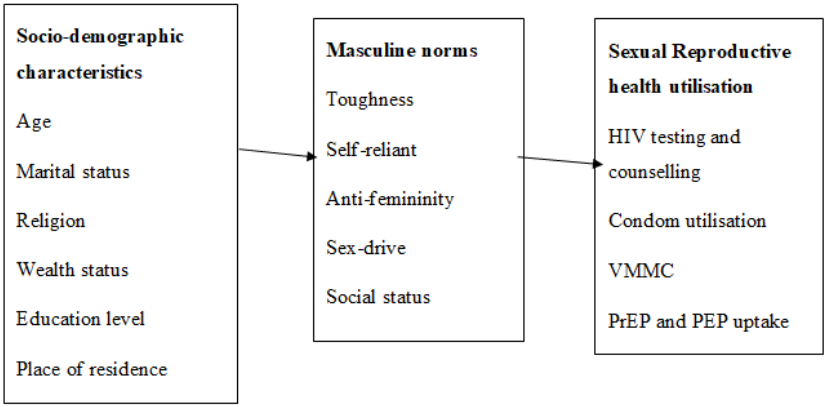


**Figure 1:** Conceptual framework showing utilisation of SRH services among youth aged 18-24 in Harare, Zimbabwe

The framework emphasises that socio-demographic backgrounds can affect the use of SRH services (Figure 1). It suggests that masculine beliefs and norms, such as expectations for men to exhibit toughness, independence, and invulnerability, may impact the acceptability of SRH services among male youths in Harare. These beliefs and norms could act as either barriers or facilitators to accessing SRH services in Zimbabwe. They may also interact with other factors to influence the overall use of SRH services by male youth in Harare.

## METHODS

The study utilises a case study qualitative research approach to gain deeper insight into the effects of masculinity norms on the utilisation of SRH services by male youths aged 18-24. A key benefit of this approach is the ability to conduct a thorough examination of a

particular phenomenon or context (Yin, 2017). Harare province was chosen for convenience sampling due to its four socio-economically diverse districts: Harare Rural, Epworth, Harare Urban, and Chitungwiza. Through purposive sampling, 12 individuals were selected for the study, three participants from each district. This aligns with previous research that also opted for a manageable number of participants (Amoo *et al*., 2017; Olanrewaju *et al*., 2019). The recruitment and interview process took place from the start of October until October 15, 2023, with informed consent obtained from all participants.

### DATA ANALYSIS PROCEDURES

The interviews were recorded, transcribed, and analysed using thematic analysis with Atlas.ti. The transcripts were coded, and themes were identified based on the research objectives and the conceptual framework. The thematic analysis allowed underlying themes and patterns to be identified (Clarke, 2006).

## FINDINGS

### HIV TESTING AND COUNSELLING

The participants expressed a fear of judgment and loss of societal dignity if they were to seek HIV testing. They believed that being seen queuing at a clinic or visiting HIV testing clinics would subject them to ridicule and assumptions of being HIV positive. Participants expressed concerns about being seen at HIV testing clinics, fearing they would be laughed at and labelled as HIV-positive.

> "Imagine being seen in a queue at a clinic or hospital, l would feel not man enough. Boys rangu rikandiona rinotondiseka, zvinomakisa saying ane muzvezve (If my boys see me they will laugh at me because it's embarrassing and they will say I have AIDS )." (R4)

Participants also mentioned the judgmental attitudes of healthcare workers at community clinics, who they believed would judge them for visiting HIV testing clinics. The respondents revealed that the judgmental attitudes of healthcare workers, particularly nurses, further discouraged them from seeking HIV testing and counselling services.

> "In our community clinics, we usually meet community members there and they judge you for visiting HIV testing clinics as they know that we doing raw sex or unprotected sex (laughs)." (R10)

> "Nurses don't care even if you are ill. I saw them shouting at a man who had an STI at the clinic saying muchinyanya (you are reckless.)" (R6)

Male youths also expressed discomfort in discussing their sexuality with female healthcare providers, preferring to consult male-dominated traditional healers instead. Most respondents in the study indicated that they would normally consult traditional healers before they would seek health care in clinics, especially if they suspected that they had contracted a sexually transmitted disease. In instances, where Western medicine is required, participants would consult traditional healers first. The delay in seeking healthcare in this case is, therefore, a direct result of the unsuccessful preferred initial consultation. Masculinity norms delayed seeking medical attention promptly.

> "I went for HIV testing to get tested but there were too many female nurses and girls in the clinic and l left because l was the only guy." (R12)

> "Before I can go to the clinic, I consult my aunt's traditional healers (herbalist). He can mix some herbs for me so I don't have to go to the clinic and he once cured my STI infection." (R7)

**CONDOM UTILISATION**

Condoms remain one of the most effective strategies for preventing the spread of HIV, yet significant barriers persist in ensuring their

consistent use among male youth. One major barrier is the perceived reduction in sexual pleasure associated with condom use.

> "Sweet harinake kana richidyirwa mubepa" (sex is not satisfying and not fun with a condom on.)Wakambogeza mushower wakapfeka raincoat here ukachena?" ("Have you ever taken a shower with your raincoat on and expect to get clean?" (R9)

This perception can undermine motivation to use condoms, especially in the event of unplanned sexual encounters.

> "Sometimes you just meet a beautiful girl and do a one-night stand or it could happen at a party apa ndinenge ndisina bepa (without condom) so I would just have to do without a condom" (R1).

The judgmental attitudes and behaviours of health workers present a significant obstacle. Respondents reported harsh lectures, disapproving glances, and an overall absence of privacy and comfort when trying to obtain condoms at local clinics. R4 recounted:

> "I remember this other day trying to pick condoms at a local clinic. The nurse just gave me a side eye. I had to drop the packet and go because l knew she was going to give me a harsh lecture."

Such experiences may discourage young individuals from obtaining condoms in the future. Perceptions of a sexual partner's character also play a role in decisions about condom use. Some respondents expressed the belief that "good girls" could be trusted to not require a condom, whereas "girls who associate with sugar daddies" were deemed to need protection.

> "There are good girls and the girls who move with the sugar's daddy. Those types of girls you have to use a condom with because you don't know where they have been." (R2)

This gender double standard can lead to inconsistent condom use and promotes visual assessments as a screening tool.

> "*Unongona kuti nyama yakanka inoutatura yoga* (citing the old College Storage Commission advert, 'Good meat speaks for itself'".

Alcohol and impaired judgment also emerge as significant barriers.

> "When you are having drinks and then you see a girl that you want, a condom is always the last thing you think of as it kills the mood" (R5).

The sense of urgency and the fear of losing the opportunity for sex further compound the challenge, as described by another participant:

> "It is difficult to use a condom after you have been drinking. Everything just goes so fast and there is no time to be looking for a condom. Imagine if the girl wants to have sex and you are busy looking for a condom, what if she changes her mind? (laughs). You know things are moving fast" (R12).

In conclusion, the entrenched barriers to consistent condom use among male youths are deeply rooted in societal constructs of masculinity, particularly in the context of hegemonic masculinities that prescribe rigid roles and expectations for men. This notion often portrays men as powerful, dominant, and invulnerable, reinforcing the belief that only those who are weak or less masculine would prioritise protection and fear the consequences of risky behaviour.

These ingrained ideas around masculinity not only shape individual perceptions of manhood, but also influence social norms and behaviours related to sexual health practices. The pressure to conform to these ideals can lead young men to prioritise notions of strength and invincibility over their well-being and that of their partners, often at the expense of practising safe sex.

### VOLUNTARY MEDICAL MALE CIRCUMCISION UPTAKE

The adoption of voluntary medical male circumcision (VMMC) remains a complex issue, with mixed perspectives emerging from the

respondents. Some participants indicated a perceived loss of sexual pleasure and sensitivity following circumcision. R8 noted:

> "If I want to protect myself from HIV, I would use a condom instead of relying on circumcision, as circumcision is perceived to reduce sexual pleasure."

Another respondent stated:

> "The circumcision gave me endurance in bed and it is cleaner, but it reduces penis sensitivity, so sex is less pleasurable for me than before, but to my wife, it's the best." (R3).

However, most respondents did not believe that VMMC would necessarily lower their risk of HIV infection. Instead, they cited other motivations for undergoing the procedure, such as partner preference and perceived improvements in sexual performance.

> "I believe getting circumcised can lessen the chances of getting STI, that is why l got circumcised but it cannot prevent HIV whatsoever, and I heard it increased sexual enjoyment for the ladies, so l got circumcised and the difference is slightly better." (R8)

Another respondent stated:

> "My wife wanted me circumcised because she said it was cleaner that way and l would not pass cancer to her because of dirt on my foreskin and it also improved my endurance in bed." (R7).

The underutilisation of VMMC services was associated with significant barriers, including fear of pain and the mandatory HIV testing requirement. Many respondents who had undergone VMMC also reported severe anxiety due to concerns about poor treatment and the fear of being diagnosed with HIV.

> "The only problem is that I have to take an HIV test. The test is frightening, and I am scared of it. It's better not knowing because if you know, you get stressed." (R12).

Interestingly, some respondents revealed that they had accessed VMMC services primarily due to the financial compensation offered,

and to prove that they were man enough rather than for health-related reasons.

> "I needed money, and I was so broke so l heard they give USD10 after circumcision by a friend who got his 10 bucks so l went, and l got mine and l even referred my guy so that he could also get some for himself." (R1)
> "I wanted to prove to my friends that I was tough not a woman and can withstand the perceived pain associated with VMMC." ( R5)

The attitudes and perceptions surrounding) reflect a complex landscape, where individuals report a mix of positive and negative experiences. While some respondents highlight the benefits of VMMC, such as reduced risk of HIV transmission, improved hygiene, and cultural or religious significance, others express concerns and reservations about the procedure. Positive experiences often stem from the perceived health benefits associated with VMMC, including lower susceptibility to certain sexually transmitted infections and improved reproductive health outcomes. Additionally, cultural or religious motivations may play a significant role in shaping positive attitudes towards circumcision among certain communities.

Conversely, negative perceptions of VMMC may arise from fears surrounding the procedure itself, including pain, complications, and potential changes in sexual function. Cultural beliefs, misinformation, and social stigma can also contribute to negative attitudes towards circumcision, leading to reluctance or resistance among certain individuals or communities.

**PREP AND PEP USAGE**

Respondents believed that PrEP and PEP were not common or widely used in Zimbabwe, except among sex workers, healthcare providers, and other key populations.

> "Youths were not knowledgeable on how to access and when to use these two HIV-preventing methods, the surface information about PrEP and PEP and they are arrogant. Most men do not believe that they are reliable, and

> they prefer other preventative measures such as condoms." (Student Nurse, 24 years)

The low awareness, misconceptions, and resistance to using PrEP and PEP among male respondents reveal a concerning trend in the perception of these vital HIV prevention methods. Many individuals harbour misconceptions that these medications are burdensome, associated with promiscuity, and carry social stigma, leading to hesitancy or outright rejection of these effective preventive measures.

> "Us men cannot even wear condoms at all times (laughs), *kokuzoti zvenyu zve* PrEP and PEP *izvo,* it's too much." (R12)

> "I will never take PEP again, it is good but many men do not know how it works like l do but it is just too many pills for about a month and we men don't want that." (R2)

The lack of awareness about PrEP and PEP among male respondents underscores the urgent need for targeted education and outreach initiatives to disseminate accurate information about the benefits and mechanisms of these medications. Addressing misconceptions through comprehensive and culturally sensitive campaigns can help dispel myths and increase understanding among at-risk populations.

Resistance to PrEP and PEP often stems from deep-seated societal attitudes and stereotypes surrounding sexual behaviour and health practices. The association of these medications with promiscuity reflects a broader issue of judgment and discrimination that hinders individuals from accessing potentially life-saving interventions.

In general, there was low awareness, misconceptions, and resistance to using PrEP and PEP among the male respondents, who felt the medications were too burdensome and associated with promiscuity.

**MASCULINITY BELIEFS AND NORMS AND UTILISATION OF SRH SERVICES**

The study sheds light on how hegemonic masculinity shapes men's attitudes towards seeking medical attention, particularly in the context of HIV testing and healthcare utilisation. The societal construct of masculinity, which emphasises traits like strength, independence, and stoicism, can create barriers that discourage men from proactively seeking healthcare services or knowing their HIV status until they are severely ill.

> "What made me go for HIV testing is an STI that I had for two weeks, and I was scared to death thinking it was AIDS after a week of increasing pain." (R4)

For many men, the act of seeking help or undergoing HIV testing is perceived as a threat to their self-image of strength and self-reliance. Admitting vulnerability or acknowledging the need for medical assistance is often equated with weakness or emasculation, leading to a reluctance to engage with healthcare systems for preventive care or early intervention. This reluctance to seek medical attention until faced with a severe health crisis can have detrimental consequences, particularly in the case of HIV where early diagnosis and treatment are critical for improving health outcomes and preventing transmission to others. The stigma and shame associated with HIV testing further exacerbate the challenges faced by men in acknowledging their risk and taking proactive steps towards knowing their status.

The masculinity norms were further highlighted by the discomfort male youths expressed about the female-dominated healthcare environment. They were uncomfortable disclosing personal health issues to female nurses, as indicated by this response:

> "I am not comfortable telling a female nurse about my STI condition and the clinics and hospital are filled with many female nurses." (R8)

Male youths also described norms around having multiple sexual partners, which was viewed as expected and desirable.

> "I mean you know the girls here. There are good girls and the girls who move with the sugar daddy. Those types of girls you have to use a condom with because you don't know where they have been." (R7)

However, they also believed they could assess a woman's HIV status based on visual cues, as expressed by this respondent:

> "If I have sex with someone then I think I won't get sick if she is beautiful. I can tell the difference between a sickly person and one who is not sick." (R10)

The study underscores the detrimental effects of rigid adherence to masculinity norms on health-seeking behaviours among male youths in Zimbabwe, particularly in the context of HIV transmission risk. The societal expectations surrounding masculinity, which often emphasise traits such as stoicism, toughness, and self-reliance, create significant barriers that hinder young men from accessing essential healthcare services and engaging in preventive behaviours.

The pressure to conform to traditional notions of masculinity can lead to a reluctance to seek medical help or engage in behaviours that are perceived as signs of weakness or vulnerability. This aversion to health-seeking behaviours not only delays early diagnosis and treatment but also perpetuates the cycle of HIV transmission by limiting access to crucial prevention strategies such as testing, counselling, and adherence to ART.

Moreover, the stigma associated with HIV and the fear of being perceived as less masculine or promiscuous further compound the challenges faced by young men in Zimbabwe. The reluctance to confront their health needs or acknowledge their risk of HIV infection due to societal expectations of masculinity contributes to a heightened vulnerability to the virus and limits opportunities for timely intervention and support.

**FACTORS INFLUENCING MALE YOUTH'S UTILISATION OF SRH SERVICES**

The study findings reveal a complex interplay between socioeconomic status, masculine identity, and the willingness of male youth to undergo HIV testing. The perception that testing positive for HIV would tarnish masculine identity, to a greater extent among individuals who consider themselves poor, sheds light on the multifaceted challenges faced by disadvantaged populations in accessing and engaging with healthcare services. For male youths from lower socio-economic backgrounds, the fear of being stigmatised and the potential repercussions on their masculine identity can act as significant barriers to seeking HIV testing. The association of poverty with increased vulnerability to social judgment and diminished self-worth exacerbates the reluctance to confront one's HIV status and seek necessary medical care.

Additionally, the belief that the mental stress of an HIV-positive result would be amplified by existing struggles with poverty underscores the intersecting challenges faced by marginalised individuals. The perception that wealthier individuals would be better equipped to cope with an HIV diagnosis due to their financial resources highlights the unequal burdens borne by those living in poverty. The notion that wealth can provide a buffer against the emotional and social impacts of an HIV-positive diagnosis reflects broader societal disparities in access to resources and support systems. This disparity not only affects health-seeking behaviours, but also perpetuates inequalities in health outcomes and quality of life among different socio-economic groups.

> "Money makes things easier, as poor as l am, l struggle to get a balanced diet meal. If am diagnosed with HIV, I will struggle to get better because I cannot have proper meals every day, but wealthy people can get well easily." (R6)

The study findings underscore the pervasive influence of HIV&AIDS stigma on the healthcare-seeking behaviour of male youths,

particularly in the context of HIV testing and counselling services. The fear of visiting healthcare facilities due to the associated stigma within the community reflects deep-seated societal attitudes and misconceptions that perpetuate discrimination and hinder individuals from accessing essential health services.

The conflation of HIV&AIDS stigma with threats to masculinity further complicates the healthcare-seeking behaviour of male youths. The perception that seeking HIV testing services may compromise one's masculine identity reflects the harmful gender norms and stereotypes that permeate communities, reinforcing the notion that vulnerability and illness are antithetical to traditional notions of strength and resilience.

> "I do not like going to the clinic because people will start questioning and saying what is wrong with this guy. Maybe he has muzvezve (slang for HIV&AIDS). People can talk and they see." (R5)

**FACTORS AFFECTING ACCESSIBILITY TO SRH SERVICES BY MALE YOUTH**

The study findings shed light on the multifaceted reasons underlying the lack of participation of male youth in SRH) programmes, revealing a complex interplay of knowledge gaps, gender beliefs, and concerns about confidentiality that collectively impede engagement with essential health services.

Many male youths view the fact that women make up most of the staff in SRH facilities and certain programmes as problematic, leading to challenges that prevent them from utilising these services. One of the common masculine perceptions of women is that they are incapable of "keeping secrets" and "talking too much", which would compromise the confidentiality of their results.

> "These clinics and hospitals are staffed by women and young women. So, imagine if you have a disease (STI) and you have to show the female nurse

your private parts… we don't want to be insulted, women talk too much!" (R2)

The issue of privacy in public health facilities is a major concern, as the distinct rooms for those with HIV&AIDS separate them from other healthcare users, further perpetuating the stigmatisation of people living with HIV&AIDS. This contradicts the common masculinity norm, as fear is seen as a sign of weakness. Most young males expressed their discomfort with seeking healthcare, as they are often asked to do a blood test, which reveals their status.

> "At clinics and especially hospitals *unotoziva kuti uku ndokune vanhu vane chirwere* (you know that this is the section with people living with HIV) because those seeking testing and HIV treatment will be at the same section, and it demotivates you to get tested *unobva watongobuda haudzokere.*" (you immediately leave and do not come back). (R8)

Additionally, most participants in the study indicated a lack of knowledge about PrEP and PEP and how they could access these services, as confessed by one respondent:

> "I only heard about PrEP and PEP from people and l don't know much of how they can prevent HIV I would just stick to condoms." (R3)

## DISCUSSION

The study examines the impact of masculinity on the uptake of SRH services among male youth aged 18-24 in Harare. It reveals that masculinity norms significantly influence service utilisation, consistent with previous research (Olanrewaju, 2019). Key masculine traits, such as toughness and self-reliance, act as barriers that prevent young men from seeking essential reproductive health services, adversely affecting their well-being (*ibid.*).

Previous studies, including those by Nzama (2013), Lesedi *et al*. (2015), and Barros *et al*. (2021), corroborate the findings of the current study,

highlighting the pervasive influence of masculinity norms on male youths' attitudes and behaviours regarding SRH services. The collective body of research underscores the need to address harmful gender stereotypes and promote a more inclusive and supportive environment that encourages young men to prioritise their sexual and reproductive health without fear of judgment or stigma.

Participants reported reluctance to access SRH services due to stigma associated with STIs and HIV, fearing loss of social status and being perceived as 'weak' or 'ill' (Myburg, 2011; Nzama, 2013; Olanrewaju, 2019). Many delayed seeking care until severely ill, often opting to consult peers or traditional healers first, reflecting a strong self-reliance mentality. These findings are explained by the theoretical framework of the Relational Theory of Gender, which states that health-related behaviours and opinions are identifiable strategies for validating masculinity and promoting unhealthy behaviour (Nzama, 2013; Lesedi *et al*., 2015; Barros *et al*., 2021).

It was further found that male youths expressed a negative attitude towards disclosing and utilising SRH services (Kennedy *et al*., 2013; Das *et al*., 2018; Rhead *et al*., 2019). Most of the participants in the study revealed that SRH care facilities were staffed with female health workers and faced challenges in discussing SRH issues with them. Similar studies agree with the present study's findings which found that most men are socialised to be self-reliant, and not to openly display their sexual reproductive health challenges (*ibid.*).

It was not surprising to find that some study participants viewed the use of SRH services, such as HIV counselling, VMMC, PrEP, and PEP, as inappropriate and unnecessary. This could be explained by how males associate those visiting hospitals to be women (Lubega *et al*., 2015; Olanrewaju *et al*., 2019). Several participants displayed ignorance,

showing indifference towards not knowing their HIV status, undergoing circumcision, or using PrEP and PEP. These attitudes are consistent with the Relational Theory of Gender, which posits that masculinity is often expressed through the avoidance or neglect of healthcare and the endorsement of unhealthy behaviours (Lubega *et al*., 2015; Olanrewaju *et al*., 2019).

The study uncovered a significant finding that transcends educational and employment statuses: participants' perceptions and utilisation of SRH) services were not influenced by their educational or professional backgrounds. This key insight, supported by Lubega *et al*. (2015) and Olanrewaju *et al*. (2019), underscores the overarching impact of masculinity norms and beliefs on the underutilisation of SRH services among male youths, irrespective of their educational or occupational achievements.

The study's results reveal that despite differences in educational attainment or employment status, masculinity norms and beliefs played a pivotal role in shaping male youths' attitudes towards accessing and utilising SRH services. This suggests that cultural expectations and societal constructs of masculinity can act as significant barriers that impede young men from seeking essential reproductive health care, regardless of their socioeconomic standing or educational background. The convergence of findings from studies by Lubega *et al*. (2015) and Olanrewaju *et al*. (2019) reinforces the notion that masculinity is a multifaceted construct that extends beyond demographic factors such as educational background, age, ethnicity, economic status, or religion. The Relational Theory of Gender, as highlighted in these studies, emphasises that masculinity is deeply ingrained in societal norms and expectations, influencing behaviours and attitudes across diverse populations.

The study's findings resonate with existing research that underscores the critical role of knowledge as a barrier to accessing SRH services. Myburg (2011), Nzama (2013), Obure *et al*. (2016) and Olanrewaju *et al*. (2019) have previously highlighted the impact of knowledge gaps on SRH service utilisation, a trend that is also evident in the current study. Participants in this study demonstrated a lack of knowledge as a significant hindrance to accessing and utilising SRH services, including preventive measures such as PrEP) and (PEP). The absence of information and awareness about these preventive methods emerges as a key factor limiting male youths' engagement with these critical healthcare services.

The study reveals that most male youths had never accessed or utilised PrEP and PEP services, with only one participant reporting some level of engagement. This lack of utilisation was directly attributed to the participants' limited understanding of these preventive measures, highlighting the pivotal role of education and awareness in promoting access to essential SRH services.

By corroborating the findings of previous studies, the current research underscores the urgent need to prioritise information dissemination, education, and awareness-raising initiatives that empower male youths with the knowledge needed to make informed decisions about their sexual and reproductive health. Enhancing understanding of preventive strategies like PrEP and PEP is crucial in equipping young men with the tools to protect themselves and make proactive choices regarding their health and well-being.

The study's exploration of male youths' perceptions and attitudes towards SRH care centres reveals a nuanced perspective that challenges conventional stereotypes about masculinity. Despite the prevailing societal image of men as strong and fearless, the youth in the study expressed apprehension about visiting SRH care centres due

to fears of probably being diagnosed with HIV, highlighting underlying concerns and vulnerabilities that diverge from traditional masculine ideals. This finding aligns with Nzama (2013) and Olanrewaju *et al*. (2019), who also emphasise the impact of fear and stigma on men's engagement with SRH services. In contrast, the study's results diverge from the classification proposed by Ajayi and Soyinka-Airewele (2018), who characterise African men, and potentially men in other societies, as tough, fearless, bold, and natural leaders. This disparity underscores the complexity and variability of masculine identities and challenges the homogeneity of traditional gender norms.

Moreover, the study sheds light on another significant barrier to accessing SRH services: the fear of pain. Participants expressed concerns about the physical discomfort associated with procedures such as circumcision, reflecting a divergence from the expectation of stoicism and strength typically associated with masculinity. This opposition to masculine beliefs and norms underscores the multifaceted nature of gender identities and how individuals navigate and negotiate societal expectations.

The study's findings regarding the accessibility of SRH services among participants from various economic backgrounds resonate with existing research that emphasises the importance of free healthcare services in public facilities to improve healthcare affordability. Gottert *et al*. (2017), Amoo *et al*. (2018) and Olanrewaju (2019) highlight the impact of accessible and cost-effective healthcare on service utilisation. Despite the availability of free healthcare services in public facilities, participants in this study disclosed that they did not utilise these services, even though they were readily accessible and affordable. This observation aligns with the Relational Theory of Gender, which posits that men's beliefs and behaviours regarding health are influenced by societal constructs of masculinity.

The reluctance of male participants to access public health services, despite their affordability and accessibility, underscores the significant role of masculinity norms in shaping healthcare-seeking behaviours. The societal expectations surrounding masculinity, which often emphasise self-reliance, toughness, and stoicism, may act as barriers that deter men from seeking healthcare services, even when they are readily available.

The study's investigation into male youths' experiences with healthcare facilities reveals significant barriers that hinder their access to SRH services in public healthcare settings. Challenges such as a lack of privacy and negative attitudes from healthcare providers were identified as key factors that deterred male youths from seeking SRH services, reflecting a broader trend observed by Landa *et al*. (2018). The findings of the study align with .(*ibid.*), who also underscored the impact of inadequate privacy and unfavourable attitudes of healthcare workers on the underutilisation of SRH services. The lack of privacy in SRH centres can compromise individuals' comfort and confidentiality, limiting their willingness to seek out and engage with essential healthcare services. Similarly, negative attitudes displayed by healthcare providers can create a hostile or unwelcoming environment that further discourages individuals from accessing care.

These shared experiences highlight systemic issues within healthcare facilities which must be addressed to improve service delivery and promote greater utilisation of SRH services among male youths. Ensuring privacy and fostering a supportive, non-judgmental attitude among healthcare providers are essential steps in creating a conducive environment that encourages individuals to seek the care they need without fear of stigma or discomfort.

In summary, the study finds that masculinity impacts on the utilisation of SRH services among male youths in Harare, Zimbabwe. Cultural

expectations and societal constructs of masculinity seem to negatively impede young men from seeking essential reproductive health care, regardless of socioeconomic standing or educational background of the participants. Knowledge gaps regarding SRH services among male youths are also prevalent, and other key factors that impede their access to healthcare as well fear of being stigmatised if tested HIV positive and feminisation of health care facilities.

**RECOMMENDATIONS**

The study identified several barriers that male youth face in accessing SRH services and recommended a multifaceted approach to enhance their participation. Key recommendations include advocating for policy changes that prioritise men's health concerns and allocate resources to improve male access to SRH services. It is essential to develop gender-sensitive policies that address the unique challenges male youth encounter when seeking SRH care, emphasising confidentiality, privacy, and cultural sensitivity in service delivery.

Additionally, targeted SRH programmes tailored to the needs of male youth should be developed and implemented, focusing on confidentiality and perceptions of masculinity. Incorporating behavioural change components into these programmes can encourage healthier attitudes and practices regarding sexual and reproductive health. Collaborating with community organisations to provide youth-friendly SRH services that are accessible and culturally appropriate is crucial.

Capacity-building is also vital. Healthcare providers should receive training on gender-sensitive care and effective communication strategies when interacting with male youth. Furthermore, community health workers should be empowered to engage with male youth,

providing information and promoting SRH services within their communities. Lastly, advocacy and awareness efforts should aim to highlight the importance of SRH services for male youth, the barriers they face, and the economic and health benefits of investing in their sexual and reproductive health. Engaging policymakers, stakeholders, and the community in discussions on improving male participation in SRH programmes is essential.

**REFERENCES**


Barker, G., & Ricardo, C. (2005). Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV&AIDS, Conflict, and Violence. *Social Development Papers, No. 26*. Washington, D.C.: World Bank.

Chikutsa, A., Ncube, A. C. and Mutsau, S. (2015). Association between Wanting Circumcision and Risky Sexual Behaviour in Zimbabwe: Evidence from the 2010-11 Zimbabwe Demographic and Health Survey. *Reproductive Health, 12*(1). https://doi.org/10.1186/S12978-015-0001-3

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine, 50*(10), 1385–1401. https://doi.org/10.1016/S0277-9536(99)00390-1

Courtenay, W. H. (2009). Dying to be men: Gender-related differences in morbidity and mortality. *Folia Geographica Series Geographia Humana, 41*(2), 7–27.

Courtenay, W. H. (2005). Dying to be men: Socioeconomic status, masculinity, and male health. *International Journal of Men's Health, 4*(2), 173–193.

Fleming, P. J., Lee, J. G. L. and Dworkin, S. L. (2014). "Real Men Don't": Constructions of Masculinity and Inadvertent Harm in Public Health Interventions. *Public Health, 104*, 1029-1035. https://doi.org/10.2105/ajph.2013

Indicators, K. (2016a). Zimbabwe Demographic and Health Survey 2015. www.dhsprogram.com.

Indicators, K. (2016b). Zimbabwe Demographic and Health Survey 2015. www.dhsprogram.com.

Kalichman, S., Mathews, C., Kalichman, M., Eaton, L. A., & Nkoko, K. (2018). Male circumcision for HIV prevention: Awareness, risk compensation, and risk perceptions among South African women. *Global Public Health*, *13*(11), 1682–1690

Kaufman, M. R. *et. al.* (2016a). Adolescent Sexual and Reproductive Health Services and Implications for the Provision of Voluntary Medical Male Circumcision: Results of A Systematic Literature Review. *Plos ONE, 11*(3). https://doi.org/10.1371/journal.pone.0149892

Kibira, S. P. *et al.* (2014). Differences in Risky Sexual Behaviours and HIV Prevalence of Circumcised and Uncircumcised Men in Uganda: Evidence from a 2011 Cross-sectional National Survey. *Reproductive Health, 11*(1). https://doi.org/10.1186/1742-4755-11-25

Landa, N. M. and Fushai, K. (2018). Exploring Discourses of Sexual and Reproductive Health Taboos/Silences among Youth in Zimbabwe. *Cogent Medicine, 5*(1), 1501188. https://doi.org/10.1080/2331205x.2018.1501188

Lesedi, C., Hoque, M. E., & Ntuli-Ngcobo, B. (2011). Youth's Perception towards Sexual and Reproductive Health Services at Family Welfare Association Centres in Botswana. *Journal of Social Sciences*, *28*(2), 137–143.

Matyanga, C. M. J., Khoza, S. and Gavi, A. S. (2014). HIV Pre-Exposure Prophylaxis: Pharmacists Knowledge, Perception and Willingness to Adopt Future Implementation in a Zimbabwean Urban Setting. *East and Central African Journal of Pharmaceutical Sciences, 17*.

Mcgillen, J. B. *et al.* (2018). The Emerging Health Impact of Voluntary Medical Male Circumcision in Zimbabwe: An Evaluation Using Three Epidemiological Models. *Plos ONE, 13*(7). https://doi.org/10.1371/journal.pone.0199453

Ministry of Health and Child Care. (n.d. A). Implementation Plan for HIV Pre-Exposure Prophylaxis in Zimbabwe 2018-2020.

Ministry of Health and Child Care. (n.d. B). Implementation Plan for HIV Pre-Exposure Prophylaxis in Zimbabwe 2018-2020.

Ministry of Health and Child Care. (2016). *National Adolescent and Youth Sexual and Reproductive Health Strategy (ASRH) II: 2016-2020: Stepping up for good sexual and reproductive health outcomes for adolescents and youth in Zimbabwe*. Government of Zimbabwe.

Muchabaiwa, L. and Mbonigaba, J. (2018). Impact of the Adolescent and Youth Sexual and Reproductive Health Strategy on Service Utilisation and Health Outcomes in Zimbabwe. *Plos ONE, 14*(6). https://doi.org/10.1371/journal.pone.0218588

Nhemachena, A. and Mlambo, N. (2020). Reimagining Higher Education for National Development: Perspectives on Education 5.0 in Zimbabwe. *Journal of Education and Development, 5*(4), 22-37.

Ninsiima, L. R., Chiumia, I. K. and Ndejjo, R. (2021). Factors Influencing Access to and Utilisation of Youth-Friendly Sexual and Reproductive Health Services in Sub-Saharan Africa: A Systematic Review. *Reproductive Health, 18*(1), 135. NLM (Medline). https://doi.org/10.1186/S12978-021-01183-Y

Nyoni, K. (2023). S*ocial Work Ethics in an Innovation-Driven Economy*. Harare: Zimbabwe Professional Studies.

*Nzama, N. (2013). Masculinity and Men's Health Seeking Behaviours amongst Black/African Men: The Case of Durban, Kwazulu-Natal, South Africa [Master's thesis, University of KwaZulu-Natal]. ResearchSpace@UKZN.*

Olanrewaju, F. O. *et al.* (2019). Masculinity and Men's Health-Seeking Behaviour in Nigerian Academia. *Cogent Social Sciences, 5*(1). https://doi.org/10.1080/23311886.2019.1682111

Rhead, R. *et al*. (2019). The Multidimensionality of Masculine Norms in East Zimbabwe: Implications for HIV Prevention, *Testing and Treatment. AIDS, 33*(3), 537-546.

Skovdal, M. *et al.* (2011). Masculinity as a Barrier to Men's Use of HIV Services in Zimbabwe. *Globalization and Health,* 7. https://doi.org/10.1186/1744-8603-7-13

Treves-Kagan, S. *et al.* (2017). Gender, HIV Testing and Stigma: The Association of HIV Testing Behaviours and Community-Level and Individual-Level Stigma in Rural South Africa Differ for Men and Women. *AIDS and Behaviour, 21*(9), 2579-2588. https://doi.org/10.1007/s10461-016-1671-8

UNAIDS. (n.d.). UNAIDS Targets: Engaging Men and Boys [Presentation/Internal Document]. Somse.

UNAIDS_targets_engaging_men_boys_Somse, n.d.; Zimbabwe Population-Based HIV Impact Assessment 2020, n.d.-a; Zimbabwe Population-Based HIV Impact Assessment 2020, n.d.-b;

Zimbabwe Demographic and Health Survey (ZDHS). Zimbabwe National Statistics Agency (ZIMSTAT) and ICF. (2017). Zimbabwe Demographic and Health Survey 2015. ZIMSTAT and ICF.

Zimbabwe Population-based HIV Impact Assessment 2020. (n.d.-a). http://phia.icap.columbia.edu

Zimbabwe Population-based HIV Impact Assessment 2020. (n.d.-b). http://phia.icap.columbia.edu

ZIMPHIA. (2021). Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2020: Summary report. ICAP at Columbia University