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Original Article

Unpacking The Intersection of Masculinity, Gender Roles and VMMC in Chirumhanzu District, Zimbabwe

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Abstract - *This study explored the intersection of masculinities, gender and Voluntary Medical Male Circumcision (VMMC) among men aged 18-49 years in Chirumhanzu District, Zimbabwe, where HIV is 11.0% nationally, and 14.5% in Chirumhanzu, yet VMMC uptake remains 35.0% against an 80.0% target. Using a pragmatism paradigm and explanatory sequential mixed methods design (QUAN → qual), inclusion was males aged 18-49 years (delimited from WHO 15-49 to allow independent adult consent, as 15-17 are minors requiring parental signed consent plus assent), uncircumcised, resident ≥6 months and willing. Ethical clearance was obtained from MRCZ, JREC and DMO-Chirumhanzu district, with independent written consent for all 18-49 adults. Quantitative data were collected via simple random sampling, N=80 (Cochran formula + FPC + 10% = minimum 54, achieved 80 = 100.0% response) and analyzed in SPSS v25 with percentages to 1 decimal point. Qualitative data were from purposive sampling of 20 participants in 6 FGDs (3-4 per group) until saturation, with a male moderator in private Shona sessions, analyzed using Braun and Clarke's 6 steps and ensured through trustworthiness, not reliability. Results showed masculinity as contested at the intersection: 43.8% viewed VMMC as affirming masculinity through cleanliness and sexual performance, while 56.2% viewed it as undermining manhood through pain, loss of foreskin identity and shame with female providers. The gender intersection was evident as 85.0% reported VMMC affects women, with wives and girlfriends influencing decisions, while 82.5% discussed VMMC with peers, and 47.0% sought courage from peers, showing masculinity is negotiated relationally. Culture intersected strongly as 90.0% reported cultural barriers where traditional norms, chieftaincy and church teachings prohibit circumcision. Health system intersection emerged as a paradox of 100.0% access versus 90.0% dissatisfaction, with 43.8% citing target-driven rather than education-driven services, fear of mandatory HIV testing and lack of youth-friendly male providers. Young age (52.5% were 18-20 years), rurality (67.5% rural) and student status (60.0%) further intersected with masculinity and gender. The study concludes that VMMC is not an individual uptake issue but an intersectional negotiation where masculinities, gender, age, culture and health system quality intersect, producing a service that is available but not acceptable.*

Keywords - *Masculinity, VMMC, Gender roles, Intersection.*

1. Background

Zimbabwe has an adult HIV prevalence of 11.0%, with Chirumhanzu District in Midlands Province recording 14.5%. Voluntary Medical Male Circumcision reduces heterosexual HIV acquisition by 60% according to WHO, yet the national target of 80% coverage remains unmet, with Midlands at 14% and Chirumhanzu uptake estimated at 35%. Despite 100.0% reported access to VMMC services at Mvuma District Hospital, uptake remains low, raising the question of why men do not utilise available services.

1.1. Problem Statement and Justification

Low VMMC uptake persists in Chirumhanzu despite service availability. Existing literature exhibits urban bias and focuses on women only, leaving masculinity and gender influences in rural Karanga settings poorly understood. Findings will inform gender-transformative demand creation strategies critical for achieving 95-95-95 HIV targets.

1.2. Aim and Objectives

The aim was to explore how masculinities and gender influence VMMC uptake among men aged 15-49 years in Chirumhanzu District. Four objectives were set to assess perceptions of masculinity, explore gender roles in decision-making, determine health system and cultural barriers, and recommend gender-transformative strategies. Research questions were aligned to objectives using an explanatory sequential mixed-methods approach.

2. Literature and Theoretical Framework

The study was anchored on Connell's Theory of Masculinities, which describes hegemonic, subordinate,

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marginalized and plural masculinities, Gender Relational Theory, which positions gender as relational, including women in men's health decisions, and Intersectionality by Crenshaw. Gaps identified include Rice 2024, McGraw 2021 and Mangenah 2021 whose work is urban-biased and focuses on women only, lacking rural male perspectives.

3. Methodology

A pragmatic paradigm and explanatory sequential mixed-methods design QUAN → QUAL was used. The study site was Chirumhanzu District Midlands Province covering Mvuma urban and Charandura communal areas. The population was men aged 15-49 years per the WHO reproductive age definition.

3.1. Inclusion and Exclusion Criteria

Inclusion criteria were male sex, age 15-49 years, resident in Chirumhanzu for at least six months, uncircumcised, willing to provide consent and conversant in Shona or English. Uncircumcised men were included deliberately to generate demand-side evidence on barriers to uptake. Exclusion criteria were circumcised men, either medical or traditional, non-residents, those unable to consent and acutely ill persons. Age clarification is critical. The WHO standard 15-49 years includes minors 15-17 years who require parental written consent plus adolescent assent per MRCZ and MoHCC VMMC policy 10-49 years. The study also delimited analysis to 18-49 years for independent adult consent to avoid child protection complexities. Therefore, the final sample includes both with appropriate ethics.

3.2. Sampling and Sample Size

Sample size was determined using the Cochran formula $n0=Z^2pq/e^2$ where Z=1.96 at 95% confidence, p=0.14 Midlands VMMC prevalence, q=0.86, e=0.05, giving 185, with finite population correction $n=n_0/[1+(n_0-1)/N]$ where N∼1500, yielding 164, reduced to a feasible minimum 54 plus 10% non-response, final achieved N=80. Quantitative sampling was multistage stratified reflecting Chirumhanzu population rural 67.5% n=54 urban 32.5% n=26, random selection of four wards, systematic sampling of every fourth household and lottery method for one eligible male per household. Qualitative sampling was purposive maximum variation N=20 in six focus group discussions of three to four participants each, selected from quantitative participants who reported cultural barriers and peer influence, with saturation reached at the fourth FGD.

3.3. FGD Details

Six FGDs totalling 20 participants, composed mainly of young men 18-20 years who constituted 52.5% n=42 of the quantitative sample, rural and uncircumcised, were conducted to explain quantitative results. Venues were private rooms at clinics with a male moderator using the Shona language and audio recording.

3.4. Ethical Considerations and Consent Clarification

Ethical clearance was obtained from MRCZ, JREC, Midlands Provincial Medical Director and Chirumhanzu District Medical Officer. For participants aged 15-17 years, written informed consent was obtained from parents or guardians, plus written assent from adolescents, and interviews were conducted privately with the right to withdraw and refusal respected. For 18-49 years, independent written informed consent was obtained. Confidentiality, anonymity, voluntariness and non-maleficence were maintained.

3.5. Data Analysis and Rigour

Quantitative data were analysed in SPSS v25 using descriptive statistics, frequencies, percentages rounded to one decimal point, such as 43.8%, 56.2%, 90.0% and mean age 22.3±5.1 years, and inferential statistics Chi-square and Fisher exact with significance predetermined at $p<0.05$ at 95% confidence interval. Quantitative rigour was ensured through content validity expert review and pretest, construct validity, reliability Cronbach's alpha 0.79, trained assistants, standardised Shona translation and double data entry. Qualitative analysis used Braun and Clarke's six steps of familiarisation, coding, theme searching, reviewing, defining and reporting with manual coding and NVivo. Qualitative rigour ensured trustworthiness per Lincoln and Guba credibility through prolonged engagement, triangulation and member checking, transferability through thick description of Chirumhanzu Karanga context, dependability through audit trail and independent co-coding agreement 87% and confirmability through reflexivity journal and bracketing of researcher male bias.

3.6. Major Quantitative Findings

Demographics N=80 showed 52.5% aged 15-20 years, 67.5% rural, 60.0% students. Masculinity was contested with 43.8% n=35 perceiving VMMC as undermining masculinity due to pain intolerance seen as weakness and loss of sexual prowess, while 56.2% n=45 perceived it as enhancing masculinity through cleanliness and modern manhood. Cultural barriers were reported by 90.0%, n=72, 95% CI 81.3-95.2. Peer discussion was reported by 82.5%, with 47.0% seeking courage. While 100.0% reported access, 90.0% were dissatisfied with services, citing lack of male providers, privacy breaches, long waits and target-driven education.

3.7. Major Qualitative Findings

Six themes emerged. Fear of pain, injection and mandatory HIV testing. Parental concerns for minors 15-17 years. Need for youth-friendly male provider services with privacy. The role of traditional and community leaders, including chiefs and churches, influences decisions. Peer support as a source of courage is captured as kuchecheudzwa. The role of women, wives and girlfriends is

pressured but excluded from formal decision-making due to patriarchal norms.

3.8. Integration QUAN plus QUAL

Integration showed QUAN 90.0% cultural barrier is explained by QUAL themes of chiefs and religion. QUAN 82.5% peer discussion is explained by the QUAL theme of courage. The QUAN paradox of 100% access versus 90% dissatisfaction is explained by QUAL themes of poor education and a target-driven approach.

4. Discussion

Masculinity contested finding aligns with Connell's plural masculinities and Rice 2024 Zambia. The 90% cultural barrier aligns with (Skolnik 2020) in rural Zimbabwe. Peer influence aligns with Mangenah's 2021 peer-led models. Access versus acceptability gap aligns with the WHO 2023 quality framework.

5. Conclusion

Masculinity is both a barrier and a facilitator. VMMC uptake is gender-relational, not male-only, as women influence decisions. Services are available but not acceptable, indicating a quality gap.

Recommendations

Programme level peer-led demand creation, male providers, youth-friendly hours and privacy screens. Policy level shift from target-driven to an education-driven approach, and involves women and leaders. Community-level engagement of chiefs and churches. Research-level study of the satisfaction of circumcised men and longitudinal uptake.

Limitations and Strengths

Limitations include a small N=80, inclusion of only uncircumcised men, self-report bias and the Chirumhanzu-only setting limiting generalisability. Strengths include the first mixed-methods study in Chirumhanzu, 100% response rate, explanatory depth and alignment with WHO indicators with rigorous Cochran sampling.

Contribution to Knowledge

Empirically first mixed study in Chirumhanzu, 15-49 years. Theoretically applies Connell's plural masculinity and intersectionality to the rural VMMC context. Practically identifies the acceptability gap and provides a model for gender-transformative programming.

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