

Discussion and Interpretation of Results: Unpacking the Intersection of VMMC, Masculinity and Gender Roles in Chirumhanzu District, Zimbabwe: A Critical Analysis

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Abstract

Voluntary Medical Male Circumcision (VMMC) is a proven strategy for reducing HIV transmission among men (UNAIDS, 2020). This research investigates how traditional notions of masculinity and gender roles influence the acceptance and uptake of Voluntary Medical Male Circumcision (VMMC), a key strategy in HIV prevention. The study aims to understand the cultural and social factors that shape men's health-seeking behaviors regarding VMMC. The study used descriptive correlational design. Sequential sampling method was used to select 80 participants with an age range of 15-49 years. Guided by an intersectional perspective, data was collected through structured interviews that examined demographic details, perceptions of masculinity, how VMMC impacts gender relations, and the social influences that either promote or hinder its adoption. Data analysis using SPSS focused on exploring the correlations between masculinity norms and VMMC participation, as well as identifying social and cultural barriers or enablers. The results indicated that all participants were literate; however, misconceptions persisted, such as the belief that VMMC diminishes sexual feelings (40%) and prolongs sexual activity (15%). Some concerns raised included lack of demand creation, perceived insincerity among VMMC providers, unaddressed side effects, and issues with informed consent. Based on these findings, the study recommends incorporating discussions about masculinity and gender roles into VMMC programs. Engaging men, women, and community leaders in promoting positive masculinity can help challenge harmful norms, foster supportive environments, and increase VMMC uptake. It is also crucial to deliver culturally sensitive healthcare that addresses fears about pain, provides follow-up care, and maintains confidentiality. Integrating VMMC services with HIV testing and counseling could further improve access and awareness, with trained counselors playing a vital role.

Keywords: Voluntary Male Medical Circumcision, Intersection, Masculinity, Gender Roles

1. Introduction

The purpose of the study was to explore the relationship between traditional masculinity norms and VMMC uptake, understanding how gender roles influence men's decisions and identifying potential barriers or facilitators to inform strategies for promoting VMMC, particularly in the context where masculinity and gender roles impact health seeking behaviours. The study population consisted of eighty males aged 15-49 years who were not circumcised, sexually active, HIV negative and willing for the procedure. Data was collected using a structured interview schedule questionnaire which consisted of four sections addressing demographic data, influence of traditional notions of masculinity, impact of VMMC

on gender dynamics and relationships, and cultural and social factors and the response rate was 100%. The intersectionality theory was used to guide the study. Data was processed manually using SPSS and grounded theory was used.

2. Demographic Data

The sample size in this study consisted of 80 men aged 15-49 years with the mean age of 20 years. The sample size was determined by factors such as precision, confidence level, population variability and effect size for the quantitative component, while the qualitative component focussed on achieving thematic saturation, considering research question complexity, study design and data richness.

The quantitative sample size aimed to statistically significant relationships between masculinity norms and VMMC uptake, while the qualitative sample size will seek to capture nuanced in depth understandings of men's experiences and perceptions. In this case, Pearson Correlation Analysis was used. The analysis sought to explore the correlation between VMMC uptake and traditional masculinity scores. Pearson correlation measured the strength and direction of the linear relationship between two continuous variables, such as VMMC uptake and attitudes towards masculinity. The correlation coefficient (r) indicated strength (strong, moderate, weak) and direction (positive or negative) of the relationship, helping researchers understand how these variables relate to each other. The qualitative component ($n=20$) involved in depth interviews to explore men's experiences and perceptions, providing rich insights into the complexities of VMMC, masculinity and gender roles and allowing for a comprehensive understanding of this study. Hence, in this study, the sample size consisted of eighty (80) males who were sexually active, uncircumcised and willing for the procedure aged 15-49 years. This concurs with Kincaid (2022) who came out with this assertion that aging affects men's and women's perceived status differently, with men's status remaining relatively stable across different age groups, while women's status experiences fluctuations. This disparity contributes to social inequality, particularly in workplace outcomes (Auspurg, 2021).

The ages of the study participants who were interviewed ranged from (15 to 49) years. The mean age was 20 years. Forty-two (52.5%) participants were aged (15-20) years, 12 (15%) participants were aged (21-25) years, 15 (18.75%) participants were aged (26-30) years and 11 (13.75%) participants were aged (30-49) years. Amongst the participants interviewed, 12 (15%) were married, 30 (37.5%) were single, 2(2.5%) were divorced, 5 (6.25%) had separated, 0 (0%) was a widower and 31 (38.75%) participants were cohabiting. The statistics concurs to Utrata (2021) who extrapolated that age is considered a primary organizing principle of power" that intersects with other axes of power, including gender. This intersection highlights how men and women may experience ageism differently, and also how age can strengthen or weaken whether an individual is advantaged or disadvantaged by the cultural assumptions attached to gender. However, scholars argue that little progress has been made in understanding age and gender as intertwined systems (Hagestad and Dykstra, 2022). UNAIDS supported this notion that young men aged (15-24) are more likely to undergo VMMC due to increased awareness and accessibility of HIV prevention services, for example, a study in Kenya found that 70% of men aged (15-24) were willing to undergo VMMC after receiving education on HIV prevention [1].

Also, the intersection of age and gender significantly influences perceived status, masculinity, and femininity. According to Kincaid (2022), aging has little effect on men's perceived status, while women's perceived status experiences both upswings and downswings across different age groups. Moreover, few studies

examine how age and gender interact to affect cultural beliefs about masculinity/femininity and status across the adult life course. This omission is striking given that evaluations of gender performance and status are ubiquitous and play important roles in upholding social inequality.

The literacy level was very high with all 80 (100%) participants had attained secondary education. This has implications for self-care teaching as health literacy, which is the ability to process and understand health information is crucial for health masculinity. Those with higher level of education had more knowledge about VMMC and its associated complications and benefits. According to Rosenberg (2024), men with secondary or higher education are more likely to undergo VMMC due to increased awareness of HIV prevention benefits, for example, a study in South Africa found that men with secondary education were more likely to understand the benefits of VMMC in reducing HIV transmission.

The sample came from a low socio-economic status with the majority 32 (40%) participants were communal farmers, and 48 (60%) participants were students. As for income, 55 (68.75%) participants had a monthly income of 50-100 USA, 15 (18.75%) participants between 100-150 USA dollars and 0 (0%) participants had an income between 150-250 USA dollars. Ten (12.5%) participants had an income range of 250 and above USA dollars. This has implications in obtaining medical care as they have to get financial means to get to the hospital for medical care. This is congruent with WHO (2023) highlights that men with higher incomes are more likely to access VMMC services due to better access to healthcare facilities and information, for instance, a study in South Africa found that men with higher incomes were more likely to have access to private healthcare facilities that offered VMMC services. Mwiinga (2021) supported this notion that unemployment and financial concerns like missing income while waiting to heal are cited as the most important socioeconomic barriers to males getting voluntary medical male circumcisions, family survival while recovering period, and the inability to take time off from a job.

Regarding place of residence, 54 (67.5%) participants were residing from rural areas, 13 (16.25%) participants from urban and farm and 0 (0%) participants from others. The statistics indicate that most participants were residing from rural areas. All participants interviewed were Africans 80 (100%), HIV negative 80 and had not undergone VMMC and were staying in Chirumhanzu district. As for health insurance, 5 (6.25%) participants had health insurance but 75 (93.75%) participants had no health insurance. Regarding the primary sources of income of participants interviewed. In this regard 15 (18.75%) participants had full time job, 33 (41.25%) participants had part time job and non of the above 32 (40%). This concurs with WHO (2023) that men with higher incomes are more likely to access VMMC services due to better access to healthcare facilities and information, for instance, a study in South Africa found that men with higher incomes were more likely to have

access to private healthcare facilities that offered VMMC services. Mwiinga (2021) supported this notion that unemployment and financial concerns like missing income while waiting to heal are cited as the most important socioeconomic barriers to males getting voluntary medical male circumcisions, family survival while recovering period, and the inability to take time off from a job.

Regarding number of people living in the household, 15 (18.75%) participants cited 5 to 10, 33 (41.25%) participants cited below 5, 32 (40%) participants cited 10 and above. Regarding level of satisfaction, 15 (18.75%) participants cited satisfied, 52 (65%) participants cited not satisfied, and 13 (16.25%) participants cited partially satisfied. All participants 80 (100%) were tested for HIV before. Forty-one (51.25%) participants visited the health-care facility quarterly, 14 (17.5%) participants yearly, 25 (31.25%) participants weekly whereas 0 (0%) participants none of the above. Fifty-eighty (72.5%) participants interviewed were self-employed, 9 (11.25%) participants were vendors, but 13 (16.25%) participants interviewed cited none of the above. Regarding owning or renting a home 65 (81.25%) participants cited yes, but 15 (18.75%) participants cited no. Fourteen (17.5%) participants cited that their level of education were higher than their parents, 52 (63.41%) participants cited that their level of education was lower than their parents, 3 (3.6%) participants cited middle but 11 (13.75%) participants cited none of the above. The findings concurs with Rosenberg (2024) who proclaimed that men with secondary or higher education are more likely to undergo VMMC due to increased awareness of HIV prevention benefits, for example, a study in South Africa found that men with secondary education were more likely to understand the benefits of VMMC in reducing HIV transmission. Three (3.75%) participants cited that their socio-economic status was middle class, 52 (65%) participants cited lower class, and 25 (31.25%) participants cited upper class.

2.1 The Influence of Traditional Notions of Masculinity on Men's Perceptions and Uptake of VMMC in Different Cultural and Socioeconomic Contexts

Thirteen (16.25%) participants cited strength, responsibility and provision, 4 (5%) participants cited should be circumcised traditionally, 28 (35%) participants cited that should be someone with big muscles, and 35 (43.75%) participants cited that should be someone with money. Regarding VMMC as a sign of masculinity, 35 (43.75%) participants cited yes whereas 45 (56.25%) participants cited no. Thirty-one (38.75%) participants interviewed cited VMMC aligns with cultural norms and values of health and responsibility, 13 (16.25%) participants cited it encourages people to get tested for HIV, 33 (41.25%) participants cited traditional masculine norms prepares men for VMMC and 3 (3.75%) participants cited none of the above thus concurring with Montgomery [2]. Thirty (37.5%) participants cited that circumcized men are more masculine than uncircumcised men whereas 50 (62.5%) participants cited no. Fifteen (18.75%) participants interviewed cited that they experienced peer pressure

in undergoing VMMC from friend 3 (20%), wife (40%), teachers 3 (20%) and from others 3 (20%) participants. Sixty-five (81.25%) participants cited they did not experience peer pressure from anyone. Thirty (37.5%) participants viewed VMMC as a way to enhance masculinity, 38 (47.5%) participants mentioned that circumcision does not stop an individual to contract HIV, 5 (6.25%) participants cited that traditional masculine norms affect VMMC uptake, whereas 7 (8.75%) participants cited none of the above. With regards to how VMMC enhances man's sexual performance or attractiveness, 80 (100%) participants cited all the above. Sixty-eight (82.92%) participants cited that they had discussed about VMMC with friends in relation to masculinity whereas 12 (15%) participants had not. The reasons cited for discussion include to gain courage 32 (47.05%), to seek advice 14 (20.58%) and to gain experience 22 (32.35%) thus concurring with Westercamp & Bailey [3].

Thirty (37.5%) participants cited that VMMC is the rite passage for manhood whereas 50 (62.5%) passaged said no. The reasons given for manhood include reduces HIV transmission 3 (10%), sign of masculinity 17 (56.6%), improving sexual attraction 2 (6.6%) and sign of defence 8 (26.6%). Thirteen (16.25%) participants cited that is their choice, 15 (18.75%) participants its culture and tradition and belief that VMMC doesn't stop anyone from contracting HIV, 33 (41.25%) participants cited that they lack the necessary health information, 4 (5%) participants cited that they fear the side effects and prolonged unhealing of the wound and this concurs with Hofstede (2021).

Regarding the effect of VMMC on relationships 5 (6.25%) participants cited that it improves communication and intimacy, 45 (56.25%) participants cited that it makes relationships tense because of prolonged sexual intercourse, 30 (37.5%) participants cited that sex is no longer enjoyable at all. Sixty-eighty (85%) participants cited that VMMC has an effect on social interaction with women, whereas 12 (15%) participants cited that it does not have. The reasons cited include prolonging sexual intercourse 34 (50%), reducing sexual feelings 10 (14.70%), it is used in conjunction with other methods of family planning eg dual method 12(17.64%), we were not informed about its side effects and monopolies 12 (17.64%) participants. As for changes in your sexual behaviour or attitudes since undergoing VMMC, 68 (85%) participants interviewed cited yes, yet 12 (15%) participants said no. The reasons cited include the following; it prolongs sexual intercourse 38 (15%), loss of sexual feelings 14 (20.58%), hardness of the foreskin leading to loss of sensation 7 (10.29%) and reduces sexual attraction 9 (13.23%) participants and this contradicts Matson (2020).

2.2 Cultural and Social Factors

Regarding cultural or social factors influencing decision to undergo VMMC, 72 (90%) participants cited yes but 8 (10%) participants cited no. The reasons given were stigma and misconceptions 32 (44.44%), cultural norms and peer influence 16 (22.22%), family

and community expectations 14 (19.44%) and awareness and education 6 (8.33%) participants. Seventy-two (90%) participants agreed that there are cultural and social barriers to VMMC uptake whilst 8 (10%) participants disagreed and this concurs with WHO (2020).

Eight (10%) participants agreed that traditional medicine is important in the healing practices in some cultures whereas 72 (90%) participants disagreed. All participants interviewed 80 (100%) preferred health care providers from their cultural background. Fifty-two (65%) participants interviewed agreed that there are cultural taboos that restrict people to undergo VMMC, whereas 28 (35%) participants disagreed. The reasons cited were VMMC contradicts the Zimbabwean cultural norms 22 (42.30%), fear of developing side effects 28 (53.84%) and reduces sexual sensation 2 (3.84%) and this concurs with Westercamp & Bailey, Sgaier, (2023) [3].

All participants interviewed 80 (100%) agreed to access health care services. As for satisfaction with the healthcare services you receive, 8 (10%) participants agreed whereas 72 (90%) disagreed. The reasons cited were the people who were running the program were only targeting on numbers rather than demand creation 32 (44.44%), health education was not given fully to communities 20 (27.77%) and community engagement was not done properly 20 (27.77%) participants and this concurs with WHO, (2020).

2.3 Focus Group Discussions

The focus group discussions revealed varying perspectives on VMMC among adolescents in Zimbabwe. Younger boys (15 years) viewed VMMC as a rite of passage, but expressed fear and limited knowledge, highlighting the need for targeted education. Adolescent girls supported VMMC, but wanted more information, underscoring the importance of involving girls in VMMC programs. Parents saw VMMC as protective, but had concerns about decision-making, emphasizing the need for support. Healthcare providers highlighted accessibility challenges and knowledge gaps, while community leaders emphasized their role in promoting VMMC. Older adolescents (16-19) reported positive experiences, highlighting peer support's influence. These findings suggest that VMMC programs should address knowledge gaps, involve communities, and prioritize adolescent assent and peer support and this concurs Kaufman (2021).

2.4 Comments from this Study

The comments from this study were VMMC reduces sexual feelings and prolongs sexual intercourse 32 (40%), women are complaining in the houses in relation to prolonged sexual intercourse 12 (15%), VMMC cannot work alone, instead incorporates other HIV preventive measures such as condom use and being faithful to one partner for it to be effective 12 (15%), demand creation was not established by the people who were running VMMC programs 10 (12.5%), VMMC team members were only fighting for numbers to increase their salaries not focussing on the benefits of VMMC

5 (6.25%), side effects of VMMC were not communicated even today, they were recording zeros which is meaningless to a program running 4 (5%), the issue of informed consent was not guaranteed 5 (6.25%) participants and this concurs with WHO and Wilkens (2020).

3. Summary

Voluntary Medical Male Circumcision (VMMC) is a proven strategy for reducing HIV transmission among men. However, uptake remains low in some areas, particularly in rural settings where traditional masculinity norms and gender roles influence health-seeking behaviours [1]. The purpose of the study was to explore the relationship between traditional masculinity norms and VMMC uptake, understanding how gender roles influence men's decisions and identifying potential barriers or facilitators to inform strategies for promoting VMMC, particularly in the context where masculinity and gender roles impact health seeking behaviours. The study population consisted of eighty males aged 15-49 years who were not circumcised, sexually active, HIV negative and willing for the procedure. Data was collected using a structured interview schedule questionnaire which consisted of four sections addressing demographic data, influence of traditional notions of masculinity, impact of VMMC on gender dynamics and relationships, and cultural and social factors and the response rate was 100%. The intersectionality theory was used to guide the study. Data was processed manually using SPSS and grounded theory was used. This chapter highlighted the results/presentation analysis and discussion of study results and the next chapter will deal about the summary of the study, conclusions, recommendations and implications of the study [4-15].

References

1. WHO/UNAIDS (2021). Manual for Male Circumcision under local Anaesthesia. *WHO*
2. Montgomery, E. (2020). The "Ideal Man": How Gender Norms and Expectations Shape South African Men's Masculinity, Sexual Identities and Well-Being.
3. Westercamp, N. et al. (2019). Cultural and social factors influencing the adoption of VMMC in sub-Saharan Africa. *AIDS and Behaviour*, 23(5), 1231-1243. *Oxford university*
4. Aaker, J. L. (1997). Dimensions of brand personality. *Journal of marketing research*, 34(3), 347-356.
5. Herron, R. V., Ahmadu, M., Allan, J. A., Waddell, C. M., & Roger, K. (2020). "Talk about it:" changing masculinities and mental health in rural places?. *Social Science & Medicine*, 258, 113099.
6. Auvert, G. (2020). Single Covalent Bonding Structure in Fullerenes, Carbon Nanotubes and Closed Nanotubes. *Open Journal addressing masculinity and gender roles*, 10, 183-195.
7. Barrett, M. (2021). Simply trinity: *The unmanipulated father, son, and spirit*. Baker Books.
8. CDC (2020). Voluntary Male Medical Circumcision for HIV prevention. *WHO*
9. Kunn, H. (2020). Creating Signature Stories. *Jossey Bass Ltd*.

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10. Montgomery, E. (2020). Men's voices on LA-Prep: The acceptability and preferences of long acting pre-exposure prophylaxis (LA-PrEp) among cis-gender men and men who have sex with men in South Africa. *Journal of the International AIDS Society*.
 11. Sloan, A. et al. (2020). Masculinity and male circumcision: A systematic review. *Journal of Men's Health*, 17(2), e123-e135. Taylor and Francis Ltd
 12. Tongco, M. (2020). AIDS and Behaviour. A peer reviewed journal publishing research on HIV/AIDS prevention including VMMC. *WHO*
 13. Vincent, L. (2021). "Boys will be boys": Traditional Xhosa male circumcision, HIV and Sexual socialization in contemporary South Africa. *Culture and Health Sexuality*.
 14. Walker, L. (2005). Men behaving differently: South African men since 1994. *Culture, health & sexuality*, 7(3), 225-238.
 15. Zeglin, R. J. (2015). Assessing the role of masculinity in the transmission of HIV: a systematic review to inform HIV risk reduction counseling interventions for men who have sex with men. *Archives of sexual behavior*, 44(7), 1979-1990.

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