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2gether 4SRHR

A Rapid Situational Assessment of
Sexual and Reproductive Health and Rights Needs Among Men and Boys in:

ZIMBABWE

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Background:

Men and boys have diverse sexual and reproductive health and rights (SRHR) needs, that often remain unfulfilled due to a number of barriers, such as male stoicism, a reluctance to admit ill health, restrictive access to health facilities, negative stereotypes of male clients among providers and services that do not cater for their needs, and a lack of agreed-upon standards for delivering sexual and reproductive health (SRH)sexual clinical and preventative services to men and boys.

Key global, continental and regional commitments have called for greater engagement of men and boys on SRHR. Only in recent years has a concerted effort been made in East and Southern Africa to consider the needs of men and boys more intentionally.

At the country level, there have been several initiatives to engage adolescent boys and young men in community programmes on SRHR, such as the Brotha2Brotha programme, but the main focus is directed towards adolescent girls and young women. This focus is also observed in much of the recent peer-reviewed literature reporting on SRH programme interventions in Zimbabwe and corresponds with conventional health programming in the region, targeting women of reproductive age in response to the high number of maternal and child deaths. Often men have been included in these programmes to support their partners thereby neglecting the role of men as end-users themselves as well as little acknowledgment of their potential as agents of normative change. Community perception also has a bearing on the uptake of, and the urgency with which adolescent boys and young men SRHR issues are addressed.

Rationale for the rapid situational assessment:

Men have a shared responsibility, as partners and parents, for decisions around the health and well-being of their families including decision making about when, whether and how many children they wish to have, to preventing sexually transmitted infections (STIs) and HIV and promoting SRHR in their communities. However, little is known of the extent to which:

- National policies and strategies incorporate male engagement or have dedicated male engagement strategies.

- Male social and gender norms and behaviours determine SHR outcomes of men and boys; and men and boys are accessing SRHR services.

- Men and boys are accessing SRHR services.

Global, continental and regional commitments on male engagement

The International Conference on Population and Development (ICPD) Programme of Action, Chapter 4 C aims to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.

African Union Initiative on Positive Masculinity

is a commitment by Heads of State and Government; the private sector; religious and traditional leaders; academia; civil societies; women and youth to accelerate the prevention and elimination of violence against women and girls in Africa at all levels. It includes a commitment to ensure that the necessary policies and measures are put in place by Member States to address any form of impunity.

The Southern African Development Community (SADC) Regional Strategy for SRHR (2019-2030)

calls for Member States to engage men and boys as partners, and as individuals with their own SRHR needs. It also urges Member States to ensure that services meet the specific SRHR needs of men and boys.

To respond to these questions, the 2gether 4 SRHR Programme, a Joint United Nations Regional Programme that aims to improve the SRHR of all people in East and Southern Africa, commissioned the Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal to undertake a rapid situational assessment of the SRHR needs of men and boys in five countries in the region, including Zimbabwe.

The purpose of the assessment was to examine the extent to which national laws, policies and strategies integrate issues relating to men and boys and to assess the structural, social and behavioural drivers that facilitate or impede the uptake of SRHR services by adolescent boys and young men aged 18 to 34 years. This was followed by a validation meeting convened with representatives of the countries who reviewed the findings. This brief summarises the key findings of the rapid assessment, the policy review and inputs received during the validation meeting.

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Methodology:

2gether 4 SRHR is a regional programme with applied learning in countries. Zimbabwe was included in the assessment as it was a focus country in the first phase of the 2gether 4 SRHR Programme.

Study site and Sampling: The assessment was conducted in Mashonaland-East, a rural district and Harare, an urban district in Zimbabwe. These were purposively selected to ensure that the assessment captured the SRHR realities of adolescent boys and young men in diverse environments. Samples were drawn from adolescent boys and young men who had been involved in SRHR programmes and those who had not.

Recruitment:

For in-programme recruitment in Mashonaland East, participants were recruited through the existing National AIDS Council (NAC) structures in the wards during the Bortha2Brotha (B2B) intervention that the NAC implements. In Hopley, a Harare suburb, participants were recruited through Zimbabwe Health Intervention Community Research (ZiCHIRe) i.e. B2B programme. Initial connection with study participants was established through community mobilizers for SRH programmes.

For out-of-programme recruitment, eligible participants presented themselves at sites where data was being collected, possibly because they had heard of the incentive that was linked to completing the survey. In Mashonaland East, the research team innovatively recruited at some of the centres where adolescent boys and young men met i.e. at pool/snooker tables. In Hopley, the team was also assisted by community members to recruit.

Focus group participants were recruited at various places in the community such as taxi and bus ranks, business centres, marketplaces or at clinics. Researchers were supported by local administrators, chiefs, civil society programme managers, and health service providers during the recruitment process. These participants were not the same adolescent boys and young men who had completed the survey.

Providers of (adolescent) SRH services and SRH programme implementers, national-level government officials and policymakers were identified through snowball sampling.

Data Collection:

The assessment used various data collection methods including:

A quantitative face-to-face survey:

Self-administered to 200 adolescent boys and young men drawn from the two districts using digital tablets. A total of 100 of the sampled adolescent boys and young men were involved in selected SRHR programmes, 50 from each district while the other 100 were selected from outside the SRHR programme in the two districts. 50 were selected from each district. The survey included questions on participants' socio-demographic information, most recent sexual experiences, experience of intimate partner violence, experience with HIV and SRHR programmes, mental health, masculinity norms, and stigma among others.

Focus group discussions:

Five focus groups discussions were conducted each having 5 to 10 adolescent boys and young men. During participant selection, there was an attempt to balance the focus groups between younger groups (younger than 26) and older groups of men (27 to 34 years). The focus groups discussions were facilitated by two researchers. Questions focused on social norms and expectations of being a man, participants' experiences with sexuality education, and SRH services and programmes, and the contextual challenges (including the impact of COVID-19) that supported or hindered participants (or their peers) to meet their own needs and the needs of their partner in SRH and to be a 'change agent' on SRHR in their community.

Key informant interviews:

Three health-care providers were interviewed using semi-structured questionnaire and focused on the provision of clinical and non-clinical services in accordance with the global package for men and boys, challenges and successes of serving adolescent boys and young men, the use of evidence-based approaches, guidelines and innovations to inform programme interventions and approaches, and the impact of COVID-19 on SRH services and programmes. At national level, six government officials and policymakers were interviewed on the current SRHR policy context, the use of data to inform policy, budgeting implications, innovations and challenges around scaling up approaches for adolescent boys and young men. Respondents included the Ministries of Health and Education, as well as large civil society organizations working on SRHR and operating on a national scale.

Ethical clearance was obtained from the University of KwaZulu-Natal (BREC/00003894/2022) and the Medical Research Council in Zimbabwe (MRCZ/A/2906).

Key Findings:

Sample characteristics:

The median age for the sample of adolescent boys and young men was 22 years old, just under half had completed secondary schooling (48.3 per cent). Approximately half of adolescent boys and young men were rural based (51.0 per cent). Fifty-five per cent of the households had sufficient food in the previous 12 months.

Men as clients:

Most adolescent boys and young men had access to HIV testing and counselling services (82.7 per cent), male circumcision services (82.2 per cent) and STI testing services (81.7 per cent) in their community. Fewer adolescent boys and young men indicated they had information and counselling on sexual myths and cultural barriers to SRH in their community (31.2 per cent). Just over one fifth (21.8 per cent) indicated they have access to vasectomy services in their community and a similar proportion (20.8 per cent) had access to information and counselling and treatment for cancers of the male reproductive organs available in their community.

Men as partners:

The majority (82.7 per cent) of adolescent boys and young men indicated they would support their partner to access HIV services, while approximately three quarters (75.7 per cent) would support their partners to access prenatal care services. Just over a quarter (27.2 per cent) indicated they would support their partner to access safe abortion services.

Men as change agents:

A quarter (26.1 per cent) of adolescent boys and young men were involved in a health-focused programme or activities implemented by a non-governmental organization (NGO) in their community.

Psychosocial characteristics:

One fifth (20 per cent) of adolescent boys and young men indicated they had perpetrated at least one form of intimate partner violence. The median gender equitable scale score is 31 (range: 17–45), where a higher score means more equitable scores. The majority (77 per cent) of adolescent boys and young men agreed with the statement that most people with HIV are supported by their families when they disclose their HIV status. A minority (3 per cent) indicated they felt sad all of the time (5 to 7 days per week) in the previous month and 3 per cent felt lonely all of the time in the previous month. Nearly one fifth (18.7 per cent) of adolescent boys and young men also indicated that they occasionally felt lonely (3 to 4 days per week) in the previous month. Over one quarter (27.6 per cent) indicated that they occasionally (3 to 4 days per week) felt hopeful about the future in the previous month.

Table 1: Indicators from the quantitative survey for adolescent boys and young men in Zimbabwe, 2023 (n=200)

Men as clients:	Median/ %
Per cent indicating HIV testing and counselling available in community	82.7
Per cent indicating voluntary medical male circumcision is available in community	82.2
Per cent indicating STI testing is available in community	81.7
Per cent indicating information and counselling on sexual myths and cultural barriers available	31.2
Per cent indicating vasectomy services are available	21.8
Per cent indicating information and counselling and treatment for male cancers of the reproductive organs available	20.8
Men as partners:	
Per cent indicating they would support partner to access HIV services	82.7
Per cent indicating they would support partner to access pregnancy services	75.7
Per cent indicating they would support partner to access a medically safe abortion	27.2
Men as change agents:	
Per cent indicating they were involved in health-focused NGO	26.1
Psychosocial variables	
Per cent perpetrated intimate partner violence	20.0
Median score on Gender Equitable Men Scale (Range)	31 (17-45)
Per cent agree that most people are supported by their families when they disclose their HIV status	77.0
Per cent that felt sad all the time (5–7 days per week) in the previous month.	3.0
Per cent that felt lonely all the time (5–7 days per week) in the previous month	3.0
Per cent indicated they occasionally felt lonely (3–4 days per week) in the previous month	18.7
Per cent indicated they occasionally felt hopeful about the future (3–4 days per week) in the previous month	27.6

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Key findings from the policy review

Policy attention to male SRH needs in Zimbabwe is narrowly focused on the prevention and treatment of HIV and other STIs, and a substantial part of the globally defined SRH service package for men and adolescent boys is missing from key guiding documents. This may be because SRH was not defined as one of the country's priority areas within the previous National Health Strategy (2016–2020). In the current National Health Strategy (2021–2025), there is no emphasis given on improving the SRHR needs of males, especially older men. Boys are covered under children and adolescents since one of the health sector priorities in this strategy is improved reproductive, maternal, newborn, child and adolescent health and nutrition. Conditions such as infertility, the provision of contraceptive services or the issue of sexual and gender-based violence (SGBV) as they relate to men are not prioritized in this document. However, the strategies speak of cancers (including prostate), ending tuberculosis (TB) and nutritional status as particular concerns in men, and provide disaggregated epidemiological data to this end, but subsequent strategies remain gender neutral.

There is also minimal reference to male involvement within the strategies proposed under the Strategy's Maternal, Neonatal and Child Health priority area, as is seen in other countries in the region.

Highlights of key policies where men and boys are addressed:

- **The Zimbabwe National HIV and AIDS Strategic Plan (2015–2020**): Men are specifically mentioned as a target group for promoting the uptake of HIV testing services, receiving HIV information in their places of leisure, and as partners in the provision of care to HIV-positive women, and as partners in the provision of pre-exposure prophylaxis (PrEP) for women from high-risk groups. Strategies to address discrimination and SGBV against (male) key populations are proposed by this policy document.

- **The Anti-Retroviral Treatment guidelines (2016)** speak of the provision of PrEP to high-risk men as part of a broader package of STI screening, condom provision, contraception or safer conception services.

- **The National HIV Communication Strategy (2019–2025**) is also explicit on the need for male-specific interventions and targets adolescent boys and young men as one of 11 priority groups.

- **The National Gender Policy (2013–2017)** is one of the few, if not the only, policy document which speaks to the role of men as change agents in SRHR. The policy assigns a key role to men in the elimination of SGBV and proposes male forums for discussions on gender-based violence and integration of the topic in the educational curriculum.

- **The National Adolescent SRH Policy (2016–2020)** also alludes to SGBV being prevalent among boys and young men under the age of 18 but contains no interventions in response to this problem.

Broader health and gender-related policies make no mention of men who have sex with men and men with trans or non-binary identities.

Addressing male health-seeking barriers and service gaps

Multiple barriers impede the uptake of SRH services by men and boys in Zimbabwe. Distance to a facility and out-of-pocket payments for extra checks, medicine, and medical supplies, like IV fluids, were among the reasons provided in focus groups that dissuaded them from considering a health facility as their first port of call. Gender role expectations also formed an important barrier in timely health-seeking among men, whereby facility visits were generally viewed as a sign of weakness. As men feared exposure and subsequent ridicule from the community, many indicated to prefer traditional medicine. Most adolescent boys and young men said that they find hospitals intimidating and were expecting questions while waiting in line for free condoms.

> ***Our definition of masculinity is that the man will be pronounced dead once the intestines are out, so men sort of push on before they go to the facility to access all these services.***
>
> *-(A Shona proverb: Kufa Kwemurume Kubuda hura) Policymaker Health, Zimbabwe*

There were clear on-the-ground challenges to bring men into maternal health programmes as supportive partners. Key informants shared how these programmes struggle to shift the perception among men from thinking women are just there for childbearing, to being open to the challenges of women and viewing these as challenges that also concern them. During the focus group discussions, the following challenges were highlighted:

• Adolescent boys and young men shared the perception that girls do not want to go to the facility with them (though no one ever tried), and there was also a sense that couple visits are welcomed only when one is married. Among the ones who were married, experiences were shared of joining their wives once pregnant and a consensus that one cannot stay away as the partner needs to do the HIV test too.

• Abortion care was particularly sensitive; several adolescent boys and young men indicated they would not support their partner in undertaking an abortion, because they perceived it to be a sin. Adolescent boys and young men cited minimal exposure to programmes where gender roles and SGBV are discussed as another challenge. There was a perception that only adults are invited for this, including for the informal court hearings where such cases are resolved at the community level.

• Some of the adolescent boys and young men felt that physical violence is permissible if a girlfriend is caught cheating (“they have to be told the hard way”). In focus groups with participants who were already married, discussions on gender roles appeared to be more progressive and modern, with examples of men who were sharing household responsibilities and discussing when to have sex with their wife. A recurrent topic in the discussions with adolescent boys and young men was the considerable risks peers are taking in their engagement with sex workers. Some said this was out of naivety and lack of SRH knowledge in younger men, whereas others blamed alcohol and peer pressure for such behaviour.

Probing into the implementation of the Communication Strategy on HIV (2019–2025) in which these risk behaviours were problematized, key informants indicated that resource constraints impeded the provision of information, education and communication materials at facility and community levels. Various informants also voiced the concern that even if good policies and strategies are in place and have been costed, it does not imply that there are funds to implement them.

Highlights and supporting promising practices

New efforts to remove barriers in access to SRH services for adolescent boys and young men are underway, according to key informants. The Ministry of Health is considering giving priority to young people in school uniforms at its health facilities, which may make a difference. Sectoral collaboration is, according to the Ministry of Education, stipulated clearly in the Education Act section 64, and enacted through information provision and psychosocial support to pupils in the education system, and clinical services under the purview of the Health Ministry.

> ***Health facilities are being educated now to be quick and have systems, for example, that help accommodate serving adolescents who come in uniform, so that they can go back to school early.***
>
> *-Policymaker health, Zimbabwe*

Other promising practices[1] include the following:

- **Soccer clubs,** which combined sports with teachings on SRH seemed very popular and also drew the attention of adolescent boys and young men who had not been exposed to such programmes. Programmes for adolescent boys and young men in sites selected for the study draw on a range of sports, such as soccer, volleyball, darts and snooker.

- **Health promotion and encouragement of clinic visits** takes place during sports activities and health-seeking behaviour is facilitated by the clinic's proximity to the sport fields and extended opening hours.

- Programmes are promoted more widely through so called **birthday bashes**, through which current sportsmen are asked to bring their network of friends who then receive information and education on SRH during these events. There is also an **initiative of 'male mobilizers'** by the Ministry of Health and PADARE in 14 districts to encourage men to accompany their wives to the facility. However, as the study did not take place in one of these districts, there is no further information on this practice.

- **Adoption of integrated packages for SRH** at health centres which are accessible and age appropriate.

- **Community sensitization on SRH** issues using a multistakeholder approach or the whole-of-government approach.

- **Strengthening of guidance and counselling** in schools as safety nets for adolescents.

- Adoption of problem boxes to address issues to do with challenges associated with adolescents.

- **Twinning SRH programmes with mental health and gender-based violence** issues to build emotional resilience in adolescents.

[1] Note promising practices here refers to both those included in the study as well as those that were discussed and agreed upon at the validation meeting.

Key recommendations:

The following recommendations are informed by the rapid assessment, the policy review and the validation meeting:

• Conduct a national baseline study to identify and measure harmful gender and social norms.

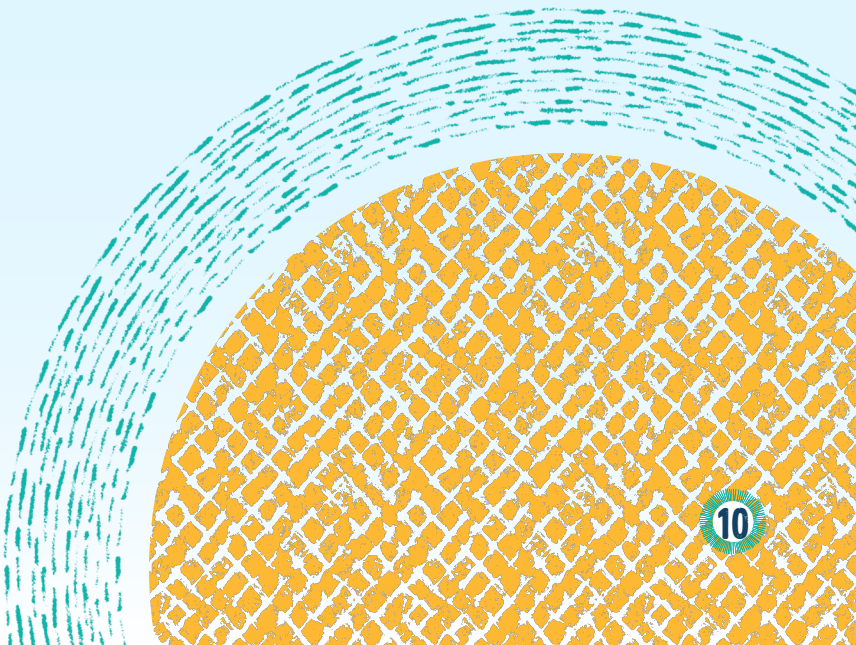
• Develop and implement a costed national male engagement strategy for SRHR.

• Allocate resources for implementation of male engagement activities.

• Strengthen the capacity of health-care providers in delivering comprehensive and integrated SRHR package for men and boys in their diversity.

• Develop a monitoring and evaluation framework on male engagement for SRHR with shared data collection tools for tracking progress.

• Document innovations and best practices on male engagement for learning and scaling up.



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