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Masculinity and access to reproductive health services in men in Peru

Masculinidad y acceso a servicios de salud reproductiva en varones en Perú

Masculinidade e acesso a serviços de saúde reprodutiva para homens no Peru

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ABSTRACT

Objective: To determine the relationship between masculinity and access to reproductive health services among men in Peru. **Method:** This was a quantitative, non-experimental study with a descriptive, cross-sectional relational design. The research was conducted between March and May 2024 in the rural district of San Jacinto, Tumbes Region. Structured anonymous questionnaires were administered to a probabilistic stratified sample of 337 men aged 18 to 49 years. Inclusion criteria were male residents of San Jacinto between 18 and 49 years of age who voluntarily agreed to participate and signed the informed consent form. Exclusion criteria included cognitive or communication difficulties that prevented proper completion of the questionnaire as well as individuals temporarily residing in the area. Descriptive and inferential analyses were performed using SPSS® v.23. **Results:** Most participants (86.6%; n = 292) exhibited negative masculinity, while only 13.4% (n = 45) demonstrated positive masculinity. Regarding access to health services, a significant proportion (83.7%; n = 282) had not received sexual and reproductive health care in the past six months, whereas only 16.3% (n = 55) had accessed such services. **Conclusion:** No statistically significant relationship was found between masculinity and access to primary sexual and reproductive health services among rural men in Tumbes.

Descriptors: Reproductive Health Services; Health Services Accessibility; Access to Primary Care; Masculinity.

RESUMEN

Objetivo: *Determinar la relación entre la masculinidad y el acceso a los servicios de salud reproductiva en varones en Perú.* ***Método:*** *Estudio cuantitativo, no experimental, con diseño descriptivo relacional de corte transversal. La investigación se llevó a cabo entre los meses de marzo y mayo de 2024, en el distrito rural de San Jacinto, Región de Tumbes. Se aplicaron cuestionarios anónimos estructurados a una muestra de 337 varones, entre 18 y 49 años, seleccionados mediante muestreo probabilístico estratificado. Los criterios de inclusión fueron: varones residentes en el distrito de San Jacinto, con edad comprendida entre 18 y 49 años, que aceptaron participar voluntariamente en el estudio y firmaron el consentimiento informado. Se excluyeron aquellos que presentaban dificultades cognitivas o de comunicación que impidieran contestar adecuadamente al cuestionario, así como quienes se encontraban de manera transitoria en la localidad. Se realizó un análisis descriptivo e inferencial con el programa SPSS® v.23.* ***Resultados:*** *La mayoría de los participantes (86.6%; n= 292) presentaron una masculinidad negativa, mientras que solo el 13.4% (n=45) manifiestaron una masculinidad positiva. Respecto al acceso a los servicios de salud, la gran mayoría de los participantes (83.7%; n=282) no ha recibido atención en salud sexual y reproductiva en los últimos seis meses, mientras que solo el 16.3% (n=55) sí ha accedido a algún servicio.* ***Conclusión:*** *No se evidenció una relación estadísticamente significativa entre la masculinidad y el acceso a los servicios primarios de salud sexual reproductiva en varones rurales de Tumbes.*

Descriptores: *Servicios de Salud Reproductiva; Accesibilidad a los Servicios de Salud; Acceso a Atención Primaria; Masculinidad.*

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RESUMO

Objetivo: *Determinar a relação entre a masculinidade e o acesso aos serviços de saúde reprodutiva entre homens no Peru.* ***Método:*** *Estudo quantitativo, não experimental con desenho descritivo relacional de corte transversal. A pesquisa foi realizada entre março e maio de 2024, no distrito rural de San Jacinto, região de Tumbes. Foram aplicados questionários estruturados anônimos a uma amostra de 337 homens, com idades entre 18 e 49 anos, selecionados por amostragem probabilística estratificada. Os critérios de inclusão foram: homens residentes no distrito de San Jacinto, com idade entre 18 e 49 anos, que concordaram em participar voluntariamente do estudo e assinaram o termo de consentimento livre e esclarecido. Foram excluídos aqueles com dificuldades cognitivas ou de comunicação que os impediram de responder adequadamente ao questionário, bem como aqueles que estavam temporariamente na localidade. Foi realizada uma análise descritiva e inferencial usando o SPSS® v.23.* ***Resultados:*** *A maioria dos participantes (86,6%; n=292) apresentou masculinidade negativa, enquanto apenas 13,4% (n=45) apresentou masculinidade positiva. Com relação ao acesso a serviços de saúde, a grande maioria dos participantes (83,7%; n=282) não recebeu atendimento de saúde sexual e reprodutiva nos últimos seis meses, enquanto apenas 16,3% (n=55) tiveram acesso a esses serviços.* ***Conclusão****: Não houve relação estatisticamente significativa entre a masculinidade e o acesso aos serviços primários de saúde sexual e reprodutiva entre homens da zona rural de Tumbes.*

Descritores: *Serviços de saúde reprodutiva; Acessibilidade aos serviços de saúde; Acesso à atenção primária; Masculinidade.*

INTRODUCTION

Due to the structural discrimination established by society between men and women — assigning them different roles and expectations — sexual and reproductive health issues have traditionally been regarded as the sole responsibility of women. As a result, women have become the primary target group and beneficiaries of both local and international reproductive health and family planning programs.[1]

This situation is reinforced by the underestimation of the role men play in the sexual and reproductive health of their families, particularly their partners.[2] Public policies and healthcare providers often overlook the fact that men also have needs in this area and that their behavior directly affects sexual and reproductive health outcomes. Meanwhile, women's needs remain primarily focused on the safe use of contraceptive methods and satisfaction with the services they receive.[3]

Male reproductive behavior is crucial, as men are central decision-makers regarding sexual relationships, contraceptive use, and the prevention of sexually transmitted infections (STIs) and HIV.[4] However, information about men's attitudes, perceptions, and behaviors related to sexual and reproductive health remains limited.[5]

Adolescent males' access to sexual and reproductive health (SRH) services is constrained by a historically female-centered perspective.[6] Moreover, many adolescent boys are exposed to cultural norms that encourage risky behaviors, such as pressure to conform to hegemonic masculinity, having multiple sexual partners, using alcohol or drugs, and resisting condom use.[7] While youth-focused health services do exist, their presence alone does not guarantee active male participation.[8]

Overall, access to primary sexual and reproductive health services is a key component of well-being and, from a health promotion perspective, represents an opportunity to transform attitudes, behaviors, and social environments that restrict such access. In rural areas, where these barriers are intensified by geographic and cultural factors, health promotion efforts must focus on developing educational, community-based, and social communication interventions that challenge gender stereotypes, strengthen male autonomy in self-care, and facilitate their connection with health services.[9]

The social construction of masculinity — rooted in self-sufficiency, risk minimization, and resistance to seeking medical care — can hinder the use of these essential services.[10] Some studies[11,12] have shown that traditional gender norms discourage male participation in sexual and reproductive health programs, with negative consequences for STI prevention, family planning, and emotional well-being.

In this context, it is essential to analyze the relationship between masculinity and access to primary sexual and reproductive health services among men in rural areas. This approach can help identify the sociocultural and structural barriers that limit access and guide the design of health promotion strategies aimed at reducing inequalities, promoting gender equity, and strengthening men's involvement in the care of their sexual and reproductive health.

Accordingly, this study aims to determine the relationship between masculinity and access to reproductive health services among men in Peru.

METHOD

This was a quantitative, relational descriptive study with inferential analysis. Inclusion criteria were: male residents of the district of San Jacinto, aged between 18 and 49 years, who voluntarily agreed to participate in the study and signed the informed consent form. Individuals with cognitive or communication difficulties that prevented them from completing the questionnaire adequately, as well as those temporarily residing in the area, were excluded.

A total of 2 structured questionnaires were administered to 337 men aged 18 to 49 years who were in some form of marital or cohabiting relationship. Participants were distributed across the villages (caseríos) of the district of San Jacinto, Tumbes, Peru, and data collection took place between March and May 2024. The first questionnaire was adapted from a study conducted by the Association of Men for Equality of Castilla La Mancha (AHIGE CLM). It consists of 37 items, with scoring ranges classified as follows: Negative Masculinity: 37 to 74; Positive Masculinity: 75 to 185. For the purposes of this study, masculinity encompassed dimensions related to attitudes, behaviors, and beliefs about gender roles, emotional expression, self-care, decision-making in sexual and reproductive health, and relationships with partners.

Positive masculinity was defined as being characterized by gender equity, shared responsibility in sexual and reproductive health, emotional openness, respect for partner's rights, and a favorable attitude toward the use of health services. Conversely, negative masculinity was defined as being based on dominance, machismo, risk minimization, resistance to emotional expression, and reluctance to seek medical care.[11] Classification was based on the scores obtained from the previously validated instrument, with participants categorized as exhibiting either positive or negative masculinity according to the established cutoff points.

The second questionnaire, designed by the authors, assessed access to health services and consisted of eight questions with dichotomous and multiple-choice responses.

Descriptive and inferential analyses were performed using IBM SPSS Statistics for Windows, version 23 (IBM Corp., Armonk, N.Y., USA). Descriptive statistics were used for univariate analysis of absolute and relative frequencies of each variable. Contingency tables were constructed to examine the relationship between masculinity and access to sexual and reproductive health services. Bivariate analysis was conducted using the chi-square (χ^2) test, with statistical significance set at $p < 0.05$.

The ethical integrity of the study was ensured through the collection of informed consent from all participants. Additionally, the project was approved by the evaluation committee under Dean's Resolution No. 018-2025/UNTUMBES–FCS, issued on January 20, 2025.

RESULTS

The analysis of masculinity within the sample revealed that most participants (86.6%; n = 292) exhibited negative masculinity, while only 13.4% (n = 45) demonstrated positive masculinity.

Most participants (n = 282; 83.7%) had not received any sexual and reproductive health care in the past 6 months, whereas only 16.3% (n = 55) accessed some type of service during that period. Among those who received care, the most commonly reported service was condom distribution (n = 29; 8.6%), followed by sexual health counseling (n = 11; 3.3%), HIV testing (n = 7; 2.1%), and treatment for STIs (n = 2; 0.6%). Despite these figures, 288 participants (85.5%) stated that they had not received any form of sexual and reproductive health care.

Among participants classified with negative masculinity, 14.8% (n = 50) reported having received sexual and reproductive health services, while 71.8% (n = 242) did not access such services. In contrast, among those with positive masculinity, only 1.5% (n = 5) received care, whereas 11.9% (n = 40) did not. Pearson's chi-square test yielded a value of 1.032 with a significance level of 0.310. This indicates that no statistically significant association was found between the type of masculinity and receipt of sexual and reproductive health services in this study. (Table I)

Table I. Relationship between masculinity and access to primary sexual and reproductive health services in rural areas of northern Peru, 2024.

Masculinity		Have you received any sexual and reproductive health care in the past 6 months?			Pearson's chi-square	
	N	Si	No	Total		
Negative masculinity	n	50	242	292		
	%	14.8	71.8	86.6		
Positive masculinity	n	5	40	45	1.032a	0.310
	%	1.5	11.9	13.4		
Total	n	55	282	337		
	%	16.3	83.7	100.0		

a. 0 cells (0.0%) had an expected count less than 5. The minimum expected count was 7.34.

DISCUSSION

The analysis of the social construction of masculinity in the sample reveals that 86.6% (n = 292) of participants fall within a profile of negative masculinity, while only 13.4% (n = 45) demonstrate positive masculinity. This finding reflects the predominance of traditional models of masculinity, characterized by traits such as self-sufficiency, dominance, avoidance of vulnerability, and resistance to behaviors associated with self-care and health-seeking. These traits, rooted in rigid sociocultural norms, limit men's willingness to adopt healthy behaviors and use available health services.[13]

In contrast, positive masculinity — although a minority in the sample — represents a more flexible model oriented toward gender equity, empathy, and active participation in personal care. Despite various initiatives aimed at promoting alternative models of masculinity, these remain scarcely adopted, especially in rural settings where traditional norms are deeply entrenched.[14] This imbalance in the distribution of masculinity types reflects not only the persistence of conventional ideals but also a broader social resistance to change, possibly linked to a lack of positive role models or fear of social stigma.

This configuration has important implications for health promotion, as behaviors associated with negative masculinity tend to obscure the perceived need for medical care, particularly in the domain of sexual and reproductive health. Among participants with negative masculinity, 14.8% (n = 50) reported having received sexual and reproductive health care, while 71.8% (n = 242) did not access such services. In the group with positive masculinity, 1.5% (n = 5) received care, while 11.9% (n = 40) did not. Despite these differences, the Chi-square test did not reveal a statistically significant association between masculinity type and receipt of care ($\chi^2 = 1.032$; $p = 0.310$).

These results are consistent with previous research suggesting that while masculinity influences health attitudes, it is not always a decisive factor in health service utilization.[15] Structural factors such as education level, economic environment, geographic accessibility, and perceived quality of care may carry equal or even greater weight in the decision to seek medical attention.[16]

From a health promotion perspective, these findings highlight the need for comprehensive strategies that not only aim to transform hegemonic masculinity models but also address the multiple barriers that hinder equitable access to services.[17] Health promotion efforts in this context must go beyond information dissemination, incorporating participatory processes that empower men, recognize their specific needs, and actively involve them in decision-making related to their sexual and reproductive health.[18]

Furthermore, it is essential for these interventions to consider the specificities of rural contexts, where living conditions, available resources, and cultural norms demand tailored approaches.[19] Promoting a more inclusive masculinity does not merely involve challenging stereotypes; it also requires ensuring safe spaces, accessible services, and well-trained professionals who can support these processes without judgment or stigma.[20]

In summary, although no statistically significant relationship was found between masculinity and access to primary sexual and reproductive health services in the studied sample, the results underscore the urgency of advancing health promotion strategies that target not only individual perceptions but also the broader social determinants that shape health behaviors. This calls for an intersectoral and intercultural approach that integrates educational, community, and healthcare efforts to promote greater equity and well-being in sexual and reproductive health for men in rural areas.

CONCLUSION

No statistically significant relationship was found between masculinity and access to primary sexual and reproductive health services among rural men in Tumbes. This absence of a direct association suggests the need to explore other underlying factors that may influence access, such as sociocultural norms, educational level, perceived need, and the actual availability of services.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

CONTRIBUTIONS

Jhon Edwin Ypanaque Ancajima contributed to the development and planning of the study, as well as to the writing and/or revision of the manuscript. **Aura Puican Pachob** contributed to the data collection, analysis, and interpretation. **Gabriela Cordova Silva** contributed to the writing and/or revision of the manuscript.

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