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Masculinity and health-seeking for human immunodeficiency virus and other sexually transmitted infections in poor urban settlements in sub-Saharan Africa: a scoping review

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Abstract

In sub-Saharan Africa, boys' and men's health-seeking behaviours are shaped by societal attributes associated with being a man. This scoping review examines how masculinity influences health-seeking regarding Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs), among boys and men in poor urban settlements**.** A systematic search was conducted across Google Scholar, African Journals Online, PubMed, and ProQuest for studies published between 2015 and 2024. Across the 18 papers reviewed, HIV/STI testing is hindered by masculine norms that equate manhood with invulnerability and physical strength, due to fears of appearing weak, losing income, and testing positive. Masculinity norms that link strength with silence, independence, and social respect also discourage men from seeking or adhering to HIV/STI treatment, due to fears of stigma, loss of reputation, or perceived weakness. Healthcare systems, with limited male-friendly services and provider attitudes perceived as emasculating, further reinforce these barriers. Finally, the review also identified protective expressions of masculinity, as financially stable young men were more likely to adopt safer behaviours and invest in committed partnerships. In conclusion, addressing masculinity-driven barriers to HIV/STI care in poor urban settlements is critical. Future research should explore approaches that reframe HIV/STI care as responsible and masculine, as well as promote male-friendly healthcare facilities.

Keywords: Masculinity, Health-seeking behaviour, HIV/STI, sub-Saharan Africa, poor urban settlements.

SDG Keywords: SDG 3: Good health and well-being; SDG 5: Gender equality; SDG 10: Reduced inequalities

Background

Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs) are prevalent in sub-Saharan Africa (UNAIDS, 2024). The challenges in the management and spread may stall progress toward several sustainable development goals, particularly target 3.3, which aims to end the acquired immunodeficiency syndrome epidemic and other communicable diseases by 2030. The risk of HIV is exacerbated by STIs, which increase the viral load, susceptibility, and disease progression (Cohen et al., 2019).

Women bear a disproportionate burden of HIV/STIs, but boys and men face unique challenges of poor access to care and increased risky behaviours. Available evidence indicates that men are more reluctant to seek sexual and reproductive health care than women, except when an illness becomes life-threatening or severe (Dowden et al., 2019; Nyalela & Dlungwane, 2023). In many countries across sub-Saharan Africa, men, including those who are high risk, are less likely to access treatment and know their HIV status (Gottert et al., 2020; UNAIDS, 2017). This also means that even when sexual and reproductive health services, including prevention and management of HIV and other STIs, are available, uptake of these services remain suboptimal for boys and men (Nyalela & Dlungwane, 2023).

Boys and men's health-seeking behaviour is shaped by cultural and gender norms, with masculinity – understood as the socially constructed set of behaviours, roles, and expectations associated with boys and men, playing a central role in influencing service uptake (Etienne, 2018). Traditional constructs of masculinity, such as exhibiting physical and emotional strength, self-reliance, risk-taking, and independence, may play roles in the reluctance of boys and men to seek timely medical care (Courtenay, 2010; Fleming et al., 2016). These norms and societal expectations may affect the perception of vulnerability by boys and men and invariably make them unwilling or ashamed of preventive and curative sexual and reproductive health services in a bid to keep up the appearances of masculinity. This reluctance also stems from concerns about being perceived as weak or dependent on medical support (Chavalala et al., 2025; Olanrewaju et al., 2019).

These gendered dynamics become particularly pronounced in poor urban settlements, where masculine norms intersect with poverty, structural exclusion and environmental marginalisation (Kabiru et al., 2011; Madise et al., 2012). In these contexts, Africa continues to bear a high burden of HIV, with urban slums contributing disproportionately to prevalence rates (Behzadifar et al., 2024). Moreover, HIV/STI co-infection rates are also high among those who reside in these settings (Culbreth et al., 2020). This is partly due to patterns such as early sexual debut, multiple partnerships, and low condom use (Madise et al., 2012). Despite this heightened vulnerability, access to HIV/STI services remains constrained for boys and men in poor urban settlements.

Despite a growing body of research on HIV/STIs in sub-Saharan Africa, significant gaps remain that justify this scoping review. Previous reviews highlight men's reluctance to test, delayed treatment initiation, and perceptions of clinics as "female spaces," but much of this evidence is drawn from general urban and rural populations (see Sileo et al., 2018; Witzel et al., 2017;

Ahmed et al., 2018). Poor urban settlements, where structural and social vulnerabilities may amplify these dynamics, remain absent in existing reviews. Moreover, while some reviews have considered masculine norms in relation to HIV health-seeking behaviour, their treatment has been fragmented. They often focused on single points along the HIV continuum (testing or treatment) and rarely integrated evidence across prevention, diagnosis, and longer-term management, or extending the lens to STIs more broadly (e.g., Sileo et al., 2019; Eshun-Wilson et al., 2019; Hlongwa et al., 2020). This scoping review addresses these gaps by synthesising evidence on how masculinities influence boys' and men's HIV/STI health-seeking within poor urban settlements in sub-Saharan Africa across prevention, diagnosis/testing, and treatment/management.

Notably, there is a lack of synthesised evidence from sub-Saharan Africa that specifically examines how masculine norms shape boys' and men's health-seeking behaviours for HIV/STIs within the context of poor urban settlements. Given that these settings are marked by poverty, weak health infrastructure, and increased sexual health risks, it is necessary to synthesise evidence to inform researchers and policymakers. In doing so, it seeks to contribute towards fulfilling the sustainable development goals commitment to "leave no one behind" (Baker, 2016; Lancet, 2019) by contributing towards the design of male gender-transformative interventions tailored to urban poor communities in the region.

Methodology

The scoping review followed the first five steps of *Arksey and O'Malley framework*, along with the *Joanna Briggs Institute Manual for Evidence Synthesis*. This process includes identifying research questions, selecting relevant studies, charting the data, and collating, summarizing, and reporting the results (Arksey & O'Malley, 2005).

Step 1: Identifying research questions

The review was conducted to summarise the existing research findings on masculinity and health-seeking behaviours for STI and HIV in poor urban settlements in sub-Saharan Africa, and through the analysis of the existing research, identify gaps and guide future research. The focus on HIV and other STIs is because of their overlapping routes and risk factors. Both are transmitted primarily through unprotected sexual contact and are influenced by similar behavioural factors. The focus on poor urban settlements is because men in these contexts experience compounded vulnerabilities that interact with restrictive masculine norms to influence HIV/STI testing and treatment. Addressing this gap is essential for developing gender-responsive and context-specific interventions in this setting.

Therefore, the research question was, "how does masculinity affect health-seeking behaviours in the context of HIV/STI among boys and men living in poor urban settlements in sub-Saharan Africa?" This question extends prior syntheses by centring poor urban settlements as a distinct social and service-delivery context and by considering HIV and STIs across prevention, diagnosis/testing, and treatment/management.

Sub-questions

1. What masculine norms shape boys' and men's HIV/STI prevention, testing, and treatment behaviours in poor urban settlements in sub-Saharan Africa?
2. Through what mechanisms do these norms hinder or facilitate health-seeking?
3. How do settlement conditions (i.e. poverty and weak infrastructure) influence these relationships?
4. What intervention or service delivery strategies are identified, and where are the evidence gaps?

Step 2: Identifying relevant studies

Eligibility criteria

The eligibility criteria were guided by Population, Concept, and Context (PCC), developed by the Joanna Briggs Institute (Peters et al., 2020). The "Population" included boys and men, the concepts included masculinity and health-seeking behaviours concerning HIV/STIs, while the context is poor urban settlements in sub-Saharan Africa.

We included all study designs in peer-reviewed articles, books, and book chapters, historical literature, and reviews that have been published in the English language between 2015–2024. This period is marked by the notable intensification of research and programmes that are gender focused. We excluded studies that were exclusively on populations of women and children, focused on urban or rural areas in general but not specific to poor urban settlements, conducted outside sub-Saharan Africa, as well as research focusing on general health behaviours or non-sexual health topics (e.g., general well-being, mental health, or chronic diseases not related to HIV/STI).

Search strategy

The literature search was conducted in four databases (PubMed, ProQuest, Google Scholar and African Journals Online). The search was conducted between 2015 to 2024. The search strategy (see box 1) was developed using a combination of keywords and Boolean operators, which reflected the Population, Concept, and Context. The keywords included "masculinity", "masculine identity", "gender norms", "health behaviour", "health-seeking behaviour", "health utilisation", "urban slum", "informal urban settlements", "slum communities", and "poor urban settlements".

Box 1: Search strategy
("Masculinity" OR "masculine identity" OR "gender norms" OR "masculine norms" OR "gender identity" OR "masculine roles" OR "boys" OR "men") AND ("health-seeking behaviour" OR "health practices" OR "treatment-seeking" OR "care-seeking" OR "health utilisation" OR "health behaviour") AND ("HIV" OR "human immunodeficiency virus" OR "AIDS" OR "acquired immunodeficiency syndrome" OR "sexually transmitted infections" OR "STI" OR "sexually transmitted diseases" OR "STD") AND ("slum" OR "urban slum" OR "informal settlements" OR "shanty towns" OR "low-resource settings" OR "low-income settlements" OR "unplanned settlements" OR "Underserved communities")

Step 3: Study Selection

Six reviewers independently screened the studies identified from the search based on the predefined eligibility criteria. The six reviewers working independently helped minimise bias and ensure a comprehensive evaluation of the literature. The titles and abstracts were initially screened to identify eligible studies with the aid of Zotero. The full text of the studies that met some criteria was further screened for eligibility. Disagreements over articles that met or did not meet the criteria were resolved through discussions based on the inclusion and exclusion criteria, with each reviewer justifying their decision based on the study's relevance to the research question. However, when the reviewers could not reach an agreement, a senior member of the team intervened to make the final inclusion decision.

Step 4: Data extraction and charting

A data charting form was developed using an Excel spreadsheet to systematically capture the following information from the included studies: Study characteristics: author(s), year, country, study design, and population. Masculinity constructs: definitions, dimensions, and representations of masculinity. Health-seeking behaviours: prevention, diagnosis, and treatment of HIV/STIs. Theoretical frameworks used (if any) and key findings and conclusions.

Step 5: Summary and synthesis of data

The framework for synthesis was guided by the WHO-prioritised areas for research on STIs to address the global public health need (Gottlieb et al., 2024). Although the process identified 40 priority STI research needs, it was organised into four main domains (diagnosis, prevention, management, and epidemiology) for clarity and ease of presentation. This study focused on prevention, management, and diagnosis, as these domains directly relate to individual health-seeking behaviours (see Table 1). Epidemiology was not included to maintain a focus on personal healthcare interactions rather than broader population-level disease patterns.

This scoping review adopted a combined approach using the Best Fit Framework Synthesis and Narrative synthesis to present the data. The Best Fit Framework Synthesis allows the researchers to use an existing theoretical or conceptual framework to structure the analysis, while also allowing modifications or expansions if new themes emerge. In this study, findings are organized around the themes of prevention, diagnosis, and management. The narrative synthesis identifies patterns, trends, and variations across the included studies. Overall, both syntheses highlight both demand-side (e.g., stigma, gender norms) and supply-side (e.g., health worker attitudes, service availability) barriers and facilitators to HIV/STIs health-seeking behaviours.

Table 1: Types of Literature on Masculinity and HIV/STIs Health-Seeking Behaviours

Domain	**Explanations**

Prevention	Masculinity-related factors influencing condom use, risk perception, and condom negotiation; engagement with community outreach programs, HIV/STIs education, and other risk-reduction strategies.
Diagnosis (testing)	Barriers and facilitators to HIV/STIs testing, including self-diagnosis practices, willingness to seek testing, fear of stigma; access to diagnostic services and perceptions of HIV screening programs.
Management (treatment)	The role of masculinity in adherence to HIV/STIs treatment regimens, use of formal healthcare services, healthcare provider interactions, and reliance on alternative or traditional medicine.

Findings

Description of papers

Three hundred and forty (340) papers were identified from the databases. We screened the articles and discovered 47 duplicates, which were removed. We then proceeded with screening by abstract, leading to the removal of 251 abstracts that were not focused on masculinity, HIV/STIs, and poor urban settlements. Out of the remaining 42 articles assessed for eligibility, 24 articles were removed because they did not specifically address prevention, management, or diagnosis of HIV/STIs. Therefore, the final review included 18 studies (see Figure 1).

The body of literature reviewed shows a strong emphasis on HIV research across diverse African settings, with fewer studies addressing STIs more broadly (see Table 2). Also, the distribution shows that while masculinity and HIV research are robust in East and Southern Africa, West and Central Africa remain underrepresented, despite high disease burden and diverse masculinity norms that may influence health-seeking behaviour.

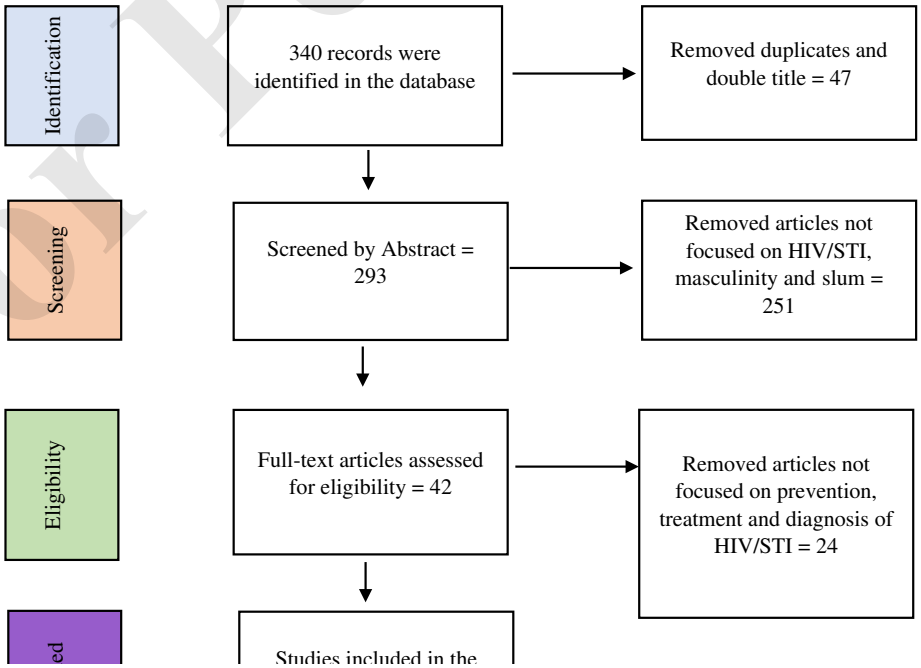

Figure 1: Flowchart showing included literature
Figure 1 Alt Text: Flowchart showing study selection: 340 records identified, 47 duplicates removed, 251 excluded by abstract, 24 removed after full-text review, and 18 studies included in the final review.

Table 2: Summary of studies included in the review

S/n	Cite	Method	Population characteristics	Country	Focus
1	Psaki et al., 2022	Mixed method	Adult men (18–35)	South Africa	HIV
2	Logie et al., 2020	Quantitative	Youth aged 16–24 years	Uganda	STI
3	Logie et al., 2021a	Qualitative	urban refugee and displaced youth aged 16-24 living in informal settlements	Uganda	HIV
4	Logie, et al., 2021b	Qualitative	Refugee cisgender youth aged 16 to 24.	Uganda	HIV
5	Logie, et al., 2021c	Quantitative	Includes boys and young men aged 16-24 living in informal settlements.	Uganda	HIV
6	Izugbara, 2015	Qualitative	Men aged 25-64	Kenya	HIV
7	Odii et al., 2024	Qualitative	Boys (18 - 24) and Men (25 - 50)	Nigeria, DR Congo and Rwanda	HIV/STI
8	Jennings et al., 2017	Qualitative	Includes boys aged 15 to 17, and young adults	Kenya	HIV
9	Zigah et al., 2023	Qualitative	Gays, bisexuals, and all other men who have sex with men	Ghana	HIV
10	Caminada et al., 2023	cross-sectional mixed-methods study	Youths aged 13-40 years	Kenya	HIV/STI
11	Abu-Ba'are et al., 2024	Qualitative	18 years old cisgender man who self-identifies as gay, bisexual, or pansexual	Ghana	HIV

			or engages in sexual intercourse with another cis-gender man		
12	Muhia, 2023	Mixed method cross-sectional study	Adolescents (10-19) living in informal settlements including boys and girls.	Kenya	HIV
13	Oloo, 2024	Mixed Method	Adolescents and youth students within the ages of 15 and 24	Kenya	HIV/STI
14	Renzaho et al., 2017	Quantitative	Participants were aged 13 - 24,	Uganda	HIV/STDs
15	Renzaho et al., 2022		Young people	Uganda	HIV/STI
16	Gibbs et al., 2020	Mixed method	Boys and Men (18-30 years)	South Africa	HIV
17	Okumu et al., 2023	Quantitative	Displaced youth aged 16–24 years	Uganda	HIV/STI
18	Closson et al., 2020	Quantitative	Young men	South Africa	HIV

Diagnostics and testing

Papers included in the review reported that masculinity is a key factor driving reluctance to undergo HIV/STI testing in poor urban settlements (see Table 3 for a summary of findings). One study reported that young men refuse testing for HIV/STIs because of the likelihood of testing positive as well as the need to preserve their identity (Logie et al., 2021a). Testing positive is not only a health concern for men but a direct threat to their masculine identity because it reveals their vulnerability.

Available evidence also suggests that there are monetary and time-related concerns of HIV/STIs testing. In poor urban settlements where poverty and informal economies are prevalent, financial stability is a key marker of masculinity (Izugbara, 2015). As a result, it was reported that boys and men often prioritise work and income generation over testing for HIV/STI (Psaki et al., 2022). Additionally, because testing facilities are often located outside poor urban settlements, the time spent traveling to the sites and waiting to be attended to by healthcare providers is a concern, as boys and men value financial independence, and being present at testing sites could result in lost income. On the other hand, two studies show that financial independence increases the likelihood of testing (Jennings et al., 2017; Zigah et al., 2023). Thus, while financial independence may facilitate testing, the pressure to sustain income and avoid financial disruption simultaneously constrains boys' and men's engagement with HIV/STI services.

Multiple studies on gay, bisexual, and men who have sex with men and boys reported that embarrassment, stigma, and fear of diagnosis present significant barriers to HIV testing (Caminada et al., 2023; Logie et al., 2020; Zigah et al., 2023; Abu-Ba'are et al., 2024). This stigma could be a result of negative attitudes among healthcare providers, including their lack of confidentiality regarding the status of their clients (Caminada et al., 2023; Logie et al., 2020). For gays, bisexuals, and all other men who have sex with men, masculinity-related stigma operates at the intersection of sexual orientation, gender norms, and health, creating multiple barriers to HIV/STI testing. As captured in one study, gays, bisexuals, and all other men who have sex with men fear testing due to the double stigma associated with testing positive, which could

jeopardise their reputation (Zigah et al., 2023). This fear is borne out of the question of what is next for their health? status and sexual orientation are discovered (Abu-Ba'are et al., 2024).

While gay, bisexuals, and all other men who have sex with men face stigma rooted in sexual orientation and masculinity norms, young boys experience barriers related to embarrassment and concerns about community perception (Muhia, 2023). A study in Uganda revealed that young boys often avoid going to hospitals due to fears of losing respect in the community, stemming from the intrusive questions posed by healthcare providers (Logie et al., 2021a). Also, to avoid being seen by friends and to avoid being stigmatised, one study reported that some boys prefer travelling to communities outside their own to test for HIV/STI (Logie et al., 2021b).

Finally, it was suggested that reframing HIV/STIs testing as an act of strength and responsibility could encourage uptake. However, the evidence on this is limited since it was reported in one study (Abu-Ba'are et al., 2024). However, available interventions that are about strengthening relationships and communication on HIV/STIs testing for men may not always conform due to traditional masculine norms. For example, a study in South Africa found that even when testing opportunities were made available through targeted programming, some men remained resistant to testing due to entrenched masculine norms (Psaki et al., 2022). This is based on the fear that testing positive could dissolve relationships and prevent them from continuing their work.

Table 3: Summary of findings

Testing				**Treatment and management**				**Prevention**			
Authors	Thematic areas	Intersection with Masculine norms	Health-seeking behaviour	Authors	Thematic areas	Intersection with Masculine norms	Health-seeking behaviour	Authors	Thematic areas	Intersection with Masculine norms	Health-seeking behaviour
Logie et al., 2021a	The likelihood of testing positive and the need to preserve identity	Testing positive reveals vulnerability; the lack of privacy in the testing process threatens masculine identity	Refuse testing to preserve identity	Oloo, 2024; Caminada et al., 2023; Logie et al., 2021a	Treatment increases fear of being publicly identified as having HIV	Being publicly identified as HIV positive could signal vulnerability, lead to the loss of respect, loss of social standing	Refuse to disclose status and refuse treatment	Oloo, 2024: Renzaho et al., 2017	Deflecting Responsibility for Sexual Health to Partners	Men deflect responsibility to appear in control, since admitting fault signals weakness, but this shift can also make them feel a loss of control.	Reluctant to use condom but blame partners when they contract HIV/STIs rather than prevent
Izugbara, 2015; Psaki et al., 2022;	Economic and time-related barriers to HIV/STI testing	The testing process interferes with men's time for work, disrupting their provider role and thereby challenging masculine ideals of productivity and provision.	Delay or reject testing for HIV/STI	(Jennings et al., 2017)	Financial independence	Financial independence influence men to make health-related decisions, signalling autonomy and self-direction.	Regular treatment	Gibbs et al., 2020; Okumu et al., 2023	Do not know how to use condom	Showing this could portray men as weak and inexperienced	Engage in sex without condoms

Jennings et al., 2017; Zigah et al., 2023	Financial independence	Financial independence influence men to make health-related decisions, signalling autonomy and self-direction.	Test for HIV	Oloo, 2024; Muhia, 2023	Lack of privacy and confidentiality in treatment sites	This could lead to the loss of reputation in society.	Discouraged from seeking treatment and/or seek treatment from informal health providers	Jennings et al., 2017	Financial stability	Financially stable men can fulfil socially accepted roles	Invest in committed relationship and protects oneself from risk taking
Caminada et al., 2023; Logie et al., 2020; Zigah et al., 2023; Abu-Ba'are et al., 2024	Importance of privacy and confidentiality to gays, bisexuals, and all other men who have sex with men	Testing could reveal one's sexual orientation, and this is a problem where masculinity is defined by heterosexuality and conformity to social norms.	Testing is avoided to protect one's masculine image and avoid social exclusion, ridicule, or violence.	Caminada et al., 2023	Opening time of facilities	Adjust opening time to accommodate men reduced loss of work hour	Encouraged treatment seeking	Caminada et al., 2023; Closson et al., 2020; Logie, et al., 2021c	Lack of financial stability	Lacks the power or authority to negotiate safe sex	Have sex without protection.
Muhia, 2023; Logie et al., 2021a	Embarrassment and Stigma from Health Provider Interactions	Intrusive questions generate concerns of losing respect, which undermines masculine ideals of dignity, control, and social standing.	Delay or reject testing for HIV/STI;	Renzaho et al., 2022	women seeking treatment without partners permission	undermining his role as a "man" and decision maker	may jeopardise their social and financial support from partners				

Logie et al., 2021b	Preference for Testing Facilities Outside the Community	Test outside one's community maintain social status	Go for testing	Odii et al (2024)	Positive masculinity programme	Reposition "being a man" as protecting others and exercising restraint.	Encourage treatment and responsibility
Psaki et al., 2022	Availability of testing site in community	Visibility can signal suspicion of infection, which threatens masculine identity	Resist testing				

Treatment and management

Across different contexts, multiple studies show that being infected with HIV/STIs is associated with stigma, which often results in diminished respect for those affected (Oloo, 2024; Caminada et al., 2023; Logie et al., 2021a). Therefore, boys would rather suffer in silence than talk about their status, as doing so could signal vulnerability, dependency, and the loss of respect (Oloo, 2024). Fear of being publicly identified as HIV-positive discourages boys from seeking care, particularly in health centres with designated HIV/AIDS clinics. Rather than seek treatment if infected with HIV/STIs, some young participants in a Kenyan study indicated they would consider suicide (Caminada et al., 2023). In another study, displaced youths reported that it was best to keep their HIV status to themselves because it could be a threat to their path to autonomy and stability (Logie et al., 2021a). In other words, they believe that disclosing their status and seeking treatment will threaten their social standing and limit their chances of surviving in an already precarious environment.

Since most poor urban settlements are characterised by poverty, the lack of finance could influence adherence to HIV treatment and overall STI management for boys and men. One study conducted among boys and young adults in Kenya reported that those financially stable were more likely to seek care and adhere to antiretroviral therapy (ART) due to their ability to afford treatment and maintain a nutritious diet (Jennings et al., 2017).

At the institutional level, healthcare settings reinforce masculine norms that discourage HIV/STI treatment, particularly through a lack of male-friendly services. Most treatment outlets are in the open, and boys often avoid seeking HIV/STI treatment or management in these outlets due to the fear of losing their reputation (Oloo, 2024). Additionally, there were concerns that teachers and health workers may know their status (Muhia, 2023). This draws attention to the importance of respect for boys and men and how the healthcare setting may be perceived as emasculating. This perception contributes to boys and men seeking treatment outside formal health institutions. One study reported that some seek care in herbal clinics, where they are better respected and do not lose their privacy and respect (Oloo, 2024).

Additionally, for boys and men in poor urban settlements who depend on daily work to survive, the operating hours of health facilities may conflict with their work schedules. But one study reported that some public health centres have adapted by opening on weekends and public holidays to accommodate men who otherwise might avoid seeking treatment due to work obligations (Caminada et al., 2023).

Beyond influencing men's treatment behaviour, masculinity also shapes power dynamics in relationships, particularly regarding women's agency in seeking HIV/STI treatment. Specifically, the framing of masculinity can diminish women's autonomy, as asserting independence (such as seeking treatment without their partner's consent) may jeopardise their social and financial support from partners (Renzaho et al., 2022). At the same time, evidence from Congo, Nigeria, and Rwanda shows that positive masculinity programmes can reframe male responsibility, encouraging infected boys and men to abstain from sexual intercourse with their partners until they have completed treatment (Odii et al., 2024).

Prevention

The relationship between masculinity and the use of condoms is complex and nuanced. In Kenya, one study reported that young men believe that their partners are trustworthy but blame them when infected and may even beat them up (Oloo, 2024). This may be to deflect responsibility and reassert control since admitting fault could clash with the idea that men must remain emotionally composed. The study further reveals that while some boys and men carry condoms, they are often reluctant to use them. There are instances when condoms are not available, and the urge takes over the desire for self-control. This suggests that other contexts may influence the masculine ideal of self-control and restraint. However, in another study, awkwardness and embarrassment during sexual encounters discouraged condom use, as boys and men do not want to appear weak and inexperienced (Gibbs et al., 2020). Therefore, while some of them carry condoms as a sign of readiness, others struggle with using them due to perceptions of weakness.

Furthermore, in one study, young men expressed the view that young women should confidently request condom use (Renzaho et al., 2017). However, this assertive behaviour from women can be perceived by some men as being pressured, leading them to reject the request as a means of asserting dominance. These individual-level dynamics are further shaped by broader community-level inequitable gender norms that uphold male dominance. For example, in one study, while women are pressured to be submissive, boys and men are expected not to use condoms to avoid being considered unmasculine (Okumu et al., 2023).

Social and economic factors, including financial stability, perceptions of masculinity, and access to prevention services, often influence the extent to which men engage in preventive behaviours. In some contexts (e.g., Kenya), economic hardship may limit sexual risk-taking, as reported in a study on young men (Jennings et al., 2017). Therefore, financial stability is a protective factor because it encourages men to invest in committed partnerships and focus on material acquisitions. Additionally, long-term financial stability promotes partner loyalty among young men by encouraging them to marry one wife or remain with one married sexual partner.

However, multiple studies reported that transactional sex remains a significant factor in HIV/STIs transmission, with power imbalances affecting condom negotiation and risk perception (Caminada et al., 2023; Closson et al., 2020; Logie, et al., 2021c). Masculinity encourages power and dominance among men, but boys and men in poor urban settlements who are financially unstable may lack the power to negotiate safe sex (Caminada et al., 2023; Closson et al., 2020). For example, in Uganda, young men engaging in relationships with older, wealthier partners report limited control over safer sex practices, thereby placing them at risk of HIV/STIs (Logie et al., 2021c).

Discussion

The objective of this paper was to synthesise existing evidence on the influences of masculine norms on boys' and men's health-seeking behaviours regarding HIV/STIs in poor urban

settlements. The findings indicate that masculinity reinforces vulnerability, financial concerns, dominance, and autonomy, all of which contribute to delayed or avoided HIV/STIs testing, treatment, and prevention. However, the reviewed literature also suggests that masculinity is not uniformly harmful. In some contexts, financially stable young men in committed relationships were more likely to adopt safer sexual practices, indicating that masculine ideals can be reframed around responsibility and care to promote positive health-seeking.

Across literature, boys and men were shown to avoid testing or treatment because admitting illness is perceived as incompatible with socially constructed ideals of strength and stoicism. This avoidance behaviour is particularly pronounced where boys and men fear that accessing services could affect how they are perceived. Boys and men are raised to fix things for others, but not themselves (Macdonald et al., 2022). The situation is no different from gays, bisexuals, and all other men who have sex with men, who fear that it might inadvertently disclose their sexual orientation, thereby exposing them to social exclusion in contexts where heteronormative masculinity dominates (Caminada et al., 2023; Muhia, 2023). Multiple studies on MSM illustrate that refusal to use condom are often framed as markers of masculinity, whereas using protection is seen as less masculine (Zeglin, 2019).

Masculinity also intersects with boys' and men's economic roles, shaping decisions around HIV/STIs testing, treatment, and prevention. In poor urban settlements, where livelihoods are often informal and income is earned daily, health-seeking can be experienced as a direct threat to men's provider role and to the masculine ideal of productivity and independence (Izugbara, 2015; Psaki et al., 2022). This trade-off is a response to broader cultural expectations that men must be providers (Naugle et al., 2019). In such contexts, even free or subsidised services may be rejected if they threaten men's role as economic providers.

At the same time, the review showed that financial stability was an enabler of positive health-seeking behaviours, particularly because it gave young adults the autonomy to choose facilities that guaranteed privacy while attending to their needs (Jennings et al., 2017; Zigah et al., 2023). These findings suggest that money plays a dual role in the health of boys and men in poor urban settlements: while the lack of money creates economic pressures resulting in discouraging care-seeking behaviours, financial independence facilitates access to care.

The review further shows that boys' and men's decisions around prevention, particularly condom use, are shaped by expectations of male dominance and sexual control. Condom refusal was linked to fears of appearing inexperienced or mistrustful, especially in long-term relationships (Gibbs et al., 2020). Admitting uncertainty about how to use condoms or agreeing to a partner's request for protection was sometimes perceived as emasculating or a sign of weakness. These dynamics were particularly pronounced among adolescent boys and young men, who are still negotiating their masculine identity in the context of peer pressure and social performance. However, the literature also suggests that when young men are in committed relationships and feel economically secure, they are more likely to adopt safer sexual practices (Jennings et al., 2017). This indicates that certain expressions of masculinity (i.e., such as responsibility and care) can be reframed to support prevention efforts.

Interactions with health workers and the design of service delivery also emerged as important cross-cutting influences on boys' and men's health-seeking behaviour. They often delayed or rejected HIV/STI services because providers were perceived as judgmental or intrusive, asking personal questions in ways that felt demeaning or emasculating (Logie et al., 2021b). Health facilities are often located far from poor urban settlements, and additional barriers include the cost of services and men's limited ability to influence facility hours or access (Caminada et al., 2023). This aligns with previous research showing that boys and men often view health centres as a feminine domain and may avoid them to affirm their masculinity (Ganle & Dery, 2015). This refusal to visit health facilities is further reinforced by evidence from a systematic review showing that some men seeking HIV treatment rely on women to collect antiretroviral therapy on their behalf (Jacques-Aviñó et al. 2019).

While the review does not explicitly explain why disrespect from health workers is perceived as a threat to masculine identity, existing studies highlight that many primary health care providers are women (Odii et al., 2022). In this context, boys' and men's refusal to tolerate perceived disrespect may reflect an attempt to preserve masculine pride and avoid perceived emasculation.

Notably, this was problematic in community-based clinics where patients feared being recognised or gossiped about. In contrast, facilities that were perceived as male-friendly, those offering discretion, flexible hours, and respectful engagement, were associated with increased uptake of testing and treatment services (Fleming & Dworkin, 2016). These findings reinforce the importance of health system responsiveness not just to medical need, but to gendered experiences of stigma, shame, and social visibility.

There is a growing need for positive masculinity programs to evolve in response to the diverse needs of boys and men, particularly concerning HIV/STI prevention (Odii et al., 2024). It needs to move from being gender-sensitive to being gender-transformative (Izugbara et al., 2022). Also, interventions may need to consider the age of young people when engaging them in HIV/STIs prevention (Logie et al., 2021c). Furthermore, there is a need for increased investment in the provision of condoms and in how they are used, as young men reported embarrassment at not knowing how. Also, coupling HIV prevention programs with male-focused savings, goal setting, and commitment incentives can provide more protective goals and alternative pursuits during periods of financial stability (Jennings et al., 2017).

Overall, the review demonstrates that a complex interplay of identity, economy, and social expectation shapes boys' and men's engagement with HIV/STIs services. Masculine norms, rooted in early socialization and reinforced through peer, community, and institutional interactions, can discourage health-seeking behaviours by framing illness and prevention as weaknesses. Yet, these same norms can also be reframed to promote health when aligned with values of autonomy, protection, and responsibility. Thus, more evidence showcasing this must be emphasised in future studies. Likewise, interventions must therefore go beyond generic male-targeted messaging and instead address the underlying gender dynamics that influence men's decisions across the HIV/STI care continuum. Finally, a key consideration for future research is whether the perceived confidentiality of testing and treatment sites, and their physical location within or outside poor urban settlements, influences boys' and men's willingness to use these services.

Strengths and Limitations

A key strength of this scoping review is that it covers all countries in sub-Saharan Africa, and this contributes to the robustness of the findings. Additionally, the decision to include literature on both HIV and other STIs provides a more comprehensive understanding of the barriers and challenges to testing, treatment, and prevention.

However, some limitations should be acknowledged. First, the available literature on masculinity and health-seeking behaviours among boys and men, particularly in the context of STIs other than HIV, is limited. This limited the depth of analysis and suggests that key relationships and constructs remain underexplored. Second, the uneven distribution of studies across sub-Saharan Africa, with noticeable gaps in West and Central Africa, limits the generalizability of findings. As such, conclusions should be interpreted with caution, particularly where regional disparities exist. Fourth, while both boys and men were included, the literature disproportionately focused on adolescents and young men, with fewer studies addressing adult men, thereby limiting our understanding of masculinity's influence across the life course. Finally, the review was limited to studies published in English due to feasibility constraints. As a result, relevant evidence published in French or Portuguese, including studies from Francophone and Lusophone sub-Saharan Africa, may not have been included. This may under-represent findings from non-Anglophone settings and should be considered when interpreting the transferability of the results across the region.

Conclusion

This scoping review maps the range of evidence available on health-seeking behaviours of boys and men in poor urban settlements in sub-Saharan Africa are strongly shaped by prevailing masculine norms. Expectations of dominance, control, and emotional self-reliance discourage engagement with HIV/STI prevention, testing, and treatment services. Financial insecurity and economic pressures further deter help-seeking behaviours, particularly where healthcare incurs direct or opportunity costs. In addition, distrust of formal healthcare systems, often fuelled by stigma, embarrassment, and perceived judgment, drives some men to seek care in informal or alternative settings such as herbal clinics. These findings highlight the urgent need for gender-responsive strategies that address both structural and masculine-driven barriers to HIV/STIs treatment, testing, and prevention. Inclusive interventions, together with research that actively reframes health-seeking as an affirmation of masculine strength and responsibility, are essential to improving the sexual and reproductive health outcomes of boys and men in poor urban settlements.

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The authors report there are no competing interests to declare.

Author contributions statement

Conception and design: AO; analysis and interpretation of the data: AO, OOZ, USA, PO, EJE, CNE, CKA, NTSF, CU, and CI; the drafting of the paper: AO, OOZ, USA, PO, EJE, and CNE; revising it critically for intellectual content: AO, OOZ, USA, PO, EJE, CNE, CKA, NTSF, CU, CI, and OO; and the final approval of the version to be published: AO, CU, CI, and OO; all authors agree to be accountable for all aspects of the work.

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