

Rethinking Masculinity and Mental Health in Zimbabwe

Tanaka John Marindire

Psychology Department, Chitungwiza Central Hospital, Harare, Zimbabwe

DOI: <https://doi.org/10.47772/IJRISS.2026.100800879>

Received: 19 June 2026; Accepted: 24 June 2026; Published: 19 September 2026

ABSTRACT

Men's mental health remains a critically under-addressed aspect of the health sector worldwide. Many men in Zimbabwe are particularly unlikely to seek psychological support despite mounting evidence of distress including elevated suicide rates. This conceptual paper examines the intersection of hegemonic masculinity and mental health help-seeking among Zimbabwean men, synthesizing empirical and theoretical literature from Zimbabwe, the wider African context and global research. Adopting a critical review design, the paper integrates Connell's theory of hegemonic masculinity with an Afrocentric Framework (Asante, 1998) to explain both the structural enforcement of masculine norms that suppress help-seeking and their specific cultural expression in the Zimbabwean context. The review identifies three key gaps in the existing literature: a scarcity of empirical research on Zimbabwean men's help-seeking pathways, an absence of evaluated and culturally grounded interventions and insufficient operationalization of Afrocentric principles within formal practice. In response, the paper proposes the *Unhu* Men's Mental Health Framework, a multi-level intervention model addressing individual masculine identity reconstruction, community-level shifts in social norms and structural improvements aimed at increasing the accessibility and cultural responsiveness of mental health services. The paper concludes that reframing help-seeking as an expression of courage and communal responsibility, rather than weakness, offers a theoretically grounded and culturally resonant direction for future research and intervention in Zimbabwe. The proposed framework is conceptual and requires empirical validation.

Keywords: masculinity, mental health, help-seeking, hegemonic masculinity, Afrocentricity, *Unhu*, Zimbabwe

1. INTRODUCTION

Men's mental health remains a critically under-addressed aspect of the health sector worldwide, despite growing research-based evidence of significant psychological distress among men. According to World Health Organization (WHO) (2021), men die by suicide at more than double the rate of women globally (2.3 times), with the gap exceeding threefold in high-income countries. In Africa, male suicide rate is reported as 18 per 100,000, considerably higher compared to the global average of 12.6 per 100,000 (World Health Organization, 2021). Help-seeking behavior is consistently constrained by culturally reinforced masculine ideas that emphasize emotional control, self-reliance and the suppression of vulnerability (Addis & Mahalik, 2003). According to Ezeugwu and Ojedokun (2020), traditional masculine norms among men have been reported to make them more susceptible to mental health issues. In addition, societal expectations and stigma discourage men from seeking help, resulting in a significant number of untreated conditions.

Regionally, this pattern is clearly evident across Southern Africa, where men account for the majority of suicide deaths and mental health services remain under-resourced. Mogano et al. (2025) reported that in South Africa, approximately 79% of the 13,774 mental health related deaths were men, tallying to 10,861 deaths.

Locally, in Zimbabwe, men also tend not to seek mental health services, similar to men in regional and global contexts, largely due to cultural reasons. According to Mhlanga and Chidarikire (2025), suicide has become the third leading cause of death among youths with the data indicating that more males compared to females die by suicide. Men most often seek counselling when their situations have escalated or when seeking

counselling is mandatory. Mhlanga and Chidarikire (2025) reported that many Zimbabwean men do not seek psychological support as they fear being labelled as weak within their community.

Understanding how cultural norms operate and how they can be thoughtfully challenged is essential for improving psychological outcomes among Zimbabwean men. This conceptual paper examines how hegemonic masculine norms shape psychological and help-seeking among Zimbabwean men, synthesizes Zimbabwean, African and international evidence to identify research gaps and propose culturally grounded directions for future interventions.

2. LITERATURE REVIEW

2.1 Hegemonic Masculinity

Connell's (1995) concept of hegemonic masculinity remains foundational to understanding men's mental health. Hegemonic masculinity describes the dominant cultural ideal of manhood, characterized by expectations that men should be strong, self-reliant, providers and protectors. According to Connell (1995), hegemonic masculinity refers to culturally endorsed norms that reinforce male power.

Recent research has extended and refined this framework. Mhlanga and Chidarikire (2025) adapted Thomas Joiner's Interpersonal Theory of Suicide together with the concept of hegemonic masculinity to contextualize suicidality among male university students in Zimbabwe. The Afrocentric framework, which calls for examining phenomena from the standpoint of Africans as subjects rather than objects (Asante, 1998), is particularly valuable for exploring masculinity in Zimbabwe. As a corrective and critique, Afrocentricity challenges Africans to express their agency through seeking home-grown solutions tailored to the mental health needs of the continent (Mhlanga & Chidarikire, 2025).

2.2 Masculinity and Mental Health in African Contexts

Research on masculinity and mental health in the African context has been growing significantly in recent years. Ezeugwu and Ojedokun (2020) explored norms and mental health of African men, examining how internalization of masculine norms among men has been reported to make them more susceptible to mental health problems.

Mogano et al. (2025) indicated that in South Africa, research on Northern Sotho male youth found that masculine culture is centered on the intersectionality of social processes and cultural ideologies underpinned by a strong male value ethos. On the downside, failure to meet these expectations may lead to gender role conflict and mental health difficulties with maladaptive coping mechanisms frequently adopted. The study by Mogano et al. (2025) underscored the need for culturally sensitive, context-specific awareness campaigns and to help educate men on the long-term negative implications that masculine culture may have on their mental health.

Mhlanga and Chidarikire (2025), studying male university students at Midlands State University (MSU) in Zimbabwe, identified that masculinity emphasizing stoicism, resilience and emotional restraint significantly increases susceptibility to mental health challenges. The findings indicate that male students felt compelled to conform to culturally rigid masculine ideals and gender norms in the face of a challenging socio-economic environment. Furthermore, social and self-stigmatization surrounding mental health reduced their help-seeking behaviors, thereby compromising their ability to cope effectively. According to Mhlanga and Chidarikire (2025), key factors that were identified as exacerbating mental health struggles included failure of romantic relationships, sexual orientation, drug and substance abuse and social expectations. These findings highlight the role of cultural narratives in trivializing the psychosocial well-being of young male adults and underscore the urgent need for adaptation of inclusive male-responsive mental health strategies that challenge harmful gender norms and masculine ideologies. Complementing this, Jani and Piroro (2025), in a qualitative study of boys and men in Sanyati District found that adherence to toughness and stoicism as masculine ideals led to systematic underreporting of both physical injuries and mental health difficulties, with participants

explicitly linking help-seeking to weakness and describing substance use as a means of demonstrating resilience and dominance. Their findings extend the urban university-based evidence above into a rural setting, suggesting that these dynamics are not confined to a single demographic within Zimbabwe.

A further empirical study conducted in Goromonzi, a peri-urban area in Mashonaland East, offers additional support to these patterns. Banda and Mlambo (2023), drawing on Courtenay's relational theory of gender and men's health, interviewed and held focus group discussions with 50 participants, including men, women, boys, girls and health workers, to examine the relationship between masculinity and men's mental health in the area. The study found that despite the physical availability of health centers, men in Goromonzi continued to resent or avoid consulting on health issues, with cultural norms of masculinity identified as major influence on this reluctance. This finding is notable because it isolates cultural and identity-based barriers from purely structural ones: where a Zimbabwean study like Skovdal et al. (2011) shows masculinity conflicting with patient role, Banda and Mlambo's findings suggest this conflict persists even where services are locally accessible, reinforcing that expanding services alone is unlikely to resolve Zimbabwean men's underutilization of mental health care.

2.3 Men's Mental Health and Presentation of Distress

Depression in men does not always present in its classical form. Instead of overt sadness, men may exhibit irritability, aggression, emotional numbing, substance use, risk-taking behavior or social withdrawal (Seidler et al., 2016). This masked or externalized presentation of depression is clinically significant because it is frequently misidentified or overlooked by health professionals, family members and the men themselves (Cochran and Rabinowitz, 2000)

In Zimbabwe, the picture is further complicated by socioeconomic stressors. High rates of unemployment, economic instability and rapid social change have eroded traditional male roles centered on provision and household leadership (Mhlanga & Chidarikire, 2025). According to the above scholars, when men can no longer fulfill these socially expected roles, the psychological cost can be profound, manifesting as shame, hopelessness, substance misuse and interpersonal conflict. Research has shown that men struggle with depression and anxiety, which has been linked to financial and relational challenges (Mhlanga & Chidarikire, 2025).

2.4 Help-Seeking Behavior and Barriers

2.4.1 Individual Barriers

Help-seeking behavior refers to a process in which a person recognizes distress, decides help is needed, identifies a source of support and then engages with that source (Rickwood et al., 2005). Among men, this process is often disrupted by internalized masculine norms that prioritize toughness, control and self-reliance over emotional disclosure (Addis & Mahalik, 2003). Traditional masculinity discourages acknowledging vulnerability and reduces the willingness to seek mental health support (Staiger et al., 2020). Men often downplay symptoms to preserve identities tied to strength, work and family responsibility (Staiger et al., 2020).

According to Vogel et al. (2006), Self-stigma of Seeking Help is defined as the reduction in self-esteem that occurs when an individual labels himself or herself as weak, unacceptable or inadequate for seeking psychological help. Self-stigma has been linked to help-seeking attitudes (Hammer et al., 2013), and it has been linked to Gender Role Conflict (Pederson and Vogel, 2007).

2.4.2 Social Barriers

At the social level, hegemonic masculinity frames depression and help-seeking as potentially unmanly, which exposes men to ridicule, marginalization and social withdrawal (Staiger et al., 2020). Fear of stigma and limited emotional competence are each identified as barriers that inhibit men's transition from private distress

toward public help-seeking (Rickwood et al., 2005). Fear of being seen as weak or non-masculine by others and by themselves discourages emotional disclosure among men (Rice et al., 2020). A recent qualitative study by Mushonga et al. (2026) reinforces this pattern with direct evidence from Zimbabwean youth: participants described being “raised to be strong” and not permitted to show emotion, with help-seeking itself equated with weakness. The study found that gender norms, family reputation concerns, stigma and institutional distrust operate not as separate barriers but as mutually reinforcing forces, producing what the authors term a “layered ecology of silence” around men’s and boys’ emotional disclosure.

2.4.3 Structural Barriers

In Zimbabwe, help-seeking is also constrained by a large treatment gap and severe workforce shortages in mental health care (Chibanda, 2017). The Friendship Bench initiative addressed this gap by integrating brief psychological care into primary health care through trained lay health workers, illustrating both the depth of the access problem and one practical response to it (Chibanda, 2017). A related dynamic operates even where services exist. Skovdal et al. (2011), studying men’s use of HIV services in rural Zimbabwe, found that hegemonic masculine identity requiring men to appear strong, in control and disease-free, directly conflicted with the expectations of the patient role which demands accepting a diagnosis, following instructions and attending appointments. This suggests that structural barriers to help-seeking in Zimbabwe are not purely about service availability but a deeper incompatibility between masculine identity and the act of formally engaging with a health system, a dynamic likely to extend to mental health services as well. This pattern is echoed in quantitative research by Rhead et al. (2019), surveying over 3,000 men in eastern Zimbabwe, found that men scoring highly on masculine norms of toughness and antifemininity had lower rates of HIV testing, providing large-sample confirmation that masculine identity measurable predicts reduced health-service engagement, not merely a pattern observed in smaller qualitative studies.

3. METHODOLOGY

3.1 Research Design

This study adopts a conceptual review design rather than an empirical research design, consistent with its aim of synthesizing existing theory and evidence to build a new argumentative framework rather than generating primary data. According to Grant and Booth’s (2009) typology of review types, a critical review goes beyond mere description of the literature to demonstrate a significant degree of analysis and conceptual innovation, typically resulting in a hypothesis, model, or, as in this case, an integrated conceptual framework. This approach enables the study to synthesize the literature on men’s mental health, identify a specific knowledge gap concerning the underexamined intersection of hegemonic masculinity, coping and help-seeking among Zimbabwean men and propose directions for future research and intervention.

3.2 Literature Search Strategy

A structured, though non-systematic, search strategy was employed to identify relevant sources, drawing on the general principles for enhancing rigour in narrative and conceptual reviews outlined by Xiao and Watson (2019). Literature was retrieved from PubMed, PsycINFO, Scopus, Google Scholar and African Journals Online (AJOL), covering publications from 1995 to 2025. Search terms included “masculinity”, “hegemonic masculinity”, “help-seeking”, “men’s mental health”, “Zimbabwe”. “Afrocentric” and “*unhu*”. The search initially identified 52 potentially relevant publications. Sources were retained for full-text consideration when they were peer-reviewed and directly relevant to Zimbabwean men’s mental health, masculinity, help-seeking behavior or culturally grounded mental-health practice. Studies from other African contexts were included only when they offered a significant theoretical or comparative contribution to the Zimbabwean discussion.

Inclusion criteria

- Peer-reviewed journal articles and literature from recognized bodies

- Publications addressing masculinity, men's mental health, or help-seeking behavior
- English-language sources
- Priority given to African and where available, Zimbabwean contexts

Exclusion criteria:

- Non-peer-reviewed opinion pieces or media commentary without empirical or theoretical grounding
- Studies focused exclusively on populations or contexts with limited conceptual transferability to the Zimbabwean setting, unless offering significant theoretical contribution
- Duplicate or superseded versions of the same study

4. DISCUSSION AND SYNTHESIS

Having reviewed the empirical and theoretical literature on masculinity and men's mental health in the preceding sections, this section synthesizes these findings into an integrated explanation of why some Zimbabwean men underuse mental health services and also identifies where the literature's current gaps lie. The synthesis is organized around two complementary theoretical lenses: Connell's (1995) hegemonic masculinity, which explains the structural origins of the norms that suppress help-seeking and the Afrocentric framework (Asante, 1998), which explains both the cultural specificity of norms and the pathway through which these norms can be reconstructed.

4.1 Hegemonic Masculinity as a Structural Explanation

Connell's (1995) concept of hegemonic masculinity offers the structural starting point for this synthesis, with the idea that a dominant cultural idea of manhood characterized by stoicism, self-reliance and provision is not simply a personality trait held by individual men but a socially enforced standard against which all men are measured.

The Zimbabwean studies reviewed above show that that conformity to rigid masculine ideals can intensify self-stigma and reduce willingness to seek psychological support. These findings demonstrate how hegemonic masculinity operates through social expectations and the fear of losing status within one's community. The study by Mogano et al. (2025) on Northern Sotho male youth in South Africa reinforces this structural explanation, showing that masculine culture is centered on the intersectionality of social processes and cultural ideologies and failure to meet societal expectations may lead to gender role conflict and mental health difficulties.

4.2 The Role of Culture and Afrocentricity

While Connell's framework is valuable, it was developed primarily in the Western context and does not fully account for cultural specificity of masculine norms in Zimbabwe. The Afrocentric framework (Asante, 1998) addresses this limitation by calling for examining phenomena from the standpoint of Africans as subjects and by challenging Africans to express their agency through seeking home-grown solutions tailored to the continent (Mhlana & Chidarikire, 2025)

In the Zimbabwean context, cultural frameworks such as *unhu* (the Shona expression of ubuntu, meaning personhood through relationship with others) offer resources for a more expansive masculinity. Values such as communal responsibility, interdependence and emotional depth have historically been framed as part of manhood (Mhlana & Chidarikire, 2025). However, these values have been overshadowed by more rigid masculine ideals that emphasize emotional restraint encapsulated in phrases such as *murume haacheme* (*a man does not cry*), which equate emotional restraint with maturity and strength (Mhlana & Chidarikire, 2025).

The Afrocentric lens also helps explain the role of traditional healers and faith communities in men's mental health pathways. However, integration with clinical services remains limited, representing a missed opportunity for culturally congruent mental health care.

4.3 Integrated Synthesis: Understanding the Mechanism

The two frameworks are complementary. Hegemonic masculinity explains how socially enforced expectation of toughness, self-reliance and emotional control can suppress disclosure and help-seeking. Afrocentricity provides a culturally grounded basis for responding to these pressures by drawing on relational values as *unhu*, communal responsibility and interdependence. Together, they inform an approach that challenges harmful norms without requiring men to reject culturally meaningful identities (Asante, 1998; Connell, 1995).

4.4 Research Gap

The existing literature on men's mental health in Zimbabwe, while growing, is characterized by significant gaps that limit the development of effective, culturally grounded interventions. This review identifies three primary areas where evidence is insufficient:

- **Scarcity of Empirical Research on Help-Seeking Pathways**

This review identified few Zimbabwe-specific studies that solely focus on men's mental health (Mhlanga & Chidarikire, 2025). This leaves a critical gap in understanding the help-seeking behaviors of the broader male population across different age groups, socio-economic strata and geographical locations (rural vs urban). The pathways men take before reaching crisis point, such as their interactions with informal support networks (friends and family) and why men choose specific sources of help (traditional vs formal) remain largely unexamined.

- **Absence of Evaluated, Culturally-Grounded Interventions**

While the literature robustly identifies barriers to help-seeking (stigma, masculine norms, structural constraints) it falls short on providing an evidence base for interventions that have been designed, implemented and evaluated in the Zimbabwean context. No published studies were identified in this review that systematically tested interventions that intentionally incorporate Afrocentric values like *unhu* to reconstruct harmful masculine norms. Without such research, the development of scalable, evidence-based programs is severely hampered.

- **Limited Operationalization of Afrocentric Frameworks in Mental Health Practice**

The conceptual value of the Afrocentric framework is highlighted (Asante, 1998; Mhlanga & Chidarikire, 2025), particularly in identifying culturally grounded resources like *unhu*. However, the literature does not adequately explore how this framework can be operationalized within formal mental health systems. Research is needed to systematically investigate how principles of communal responsibility and interdependence can be mobilised to counteract stigma and to design services that are not just accessible, but also culturally resonant and acceptable to some Zimbabwean men. These gaps mean the framework proposed in Section 5 rests on theoretical inference from adjacent literature, not on direct empirical testing in this population.

5. Proposed Intervention Model: The *Unhu* Men's Mental Health Framework

The components below are conceptual proposals derived from the preceding theoretical synthesis. None have yet been implemented or tested in Zimbabwe. Their inclusion here is intended to guide future empirical piloting rather than to represent an established program of intervention. Based on the integrated synthesis of hegemonic masculinity and Afrocentricity, this paper proposes a multi-level intervention model designed to address the identified gaps. The model operates at three interconnected levels: Individual, Community and Structural.

5.1 Individual- Level Intervention: Reconstructing Masculine Identity

Goal: To help men develop a more expansive and healthier understanding of masculinity that does not equate emotional expression with weakness.

Components:

- **Men's Healing Circles (Male-Only Support Groups):** Facilitated by mental health experts, these groups provide a safe, culturally acceptable space aimed at discussing men's emotional struggles, financial pressures and relationship challenges. The facilitator actively challenges the notion that *murume haacheme* (a man does not cry) by reframing emotional disclosure as a form of *kushinga* (courage) and responsibility to one's family.
- **Masculinity Re-education Modules:** Psychoeducational content delivered in community settings (workplaces, churches, community halls) that normalise mental health struggles, teach emotional literacy and model alternative masculine identities that value interdependence over hyper-individualism. Content is anchored in the principles of *unhu*, framing help-seeking as an act of communal responsibility rather than individual failure.
- **Coping Skills Training:** Practical workshops teaching adaptive coping strategies to replace maladaptive behaviors such as alcohol misuse, substance use or even aggression. The training will incorporate stress management, conflict resolution and problem-solving skills tailored to common socio-economic stressors.

5.2 Community- Level Intervention: Shifting Social Norms

Goal: To modify the social environment that enforces harmful masculine norms and stigmatizes help-seeking.

Components

- **Community Men's Dialogue Forums:** Regular facilitated discussions involving men, community leaders, churches, workplaces and other trusted community structures. The forums will create opportunities to discuss help-seeking behavior as strength rather than weakness when facing mental health challenges.
- **Male Mental Health Champions:** Train selected men and respected community members to recognize signs of psychological distress, provide basic psychological support, challenge harmful stereotypes and facilitate referral to appropriate services.
- **Family and Peer Engagement:** Strengthen supportive relationships by educating families and peers on how men experience distress. The emphasis will be on listening, practical support and early referral rather than judgment or ridicule.
- **Community Awareness Campaigns:** Develop culturally relevant messages in English and local languages that present help-seeking as an expression of responsibility, courage and *unhu*. Campaigns should make use of settings and communication channels that are accessible to men.

5.3 Structural- Level Intervention: Making Mental Health Services Male-Responsive

Goal: To address systemic barriers by making mental health services more accessible, affordable and culturally congruent

Components:

- **Integration with Primary Health Care:** Strengthen the integration of brief psychological interventions into primary health-care settings so that men can access support without having to enter highly specialized mental health services at the point of first contact.

- **Culturally Responsive Design:** Mental health services should incorporate locally meaningful concepts such as *unhu*, communal responsibility and culturally familiar pathways of support while maintaining appropriate clinical standards.
- **Referral Partners:** Develop stronger referral pathways between formal mental health professionals, religious communities and community-based organizations, with clear boundaries, confidentiality and appropriate referral procedures.
- **Male-Friendly Access Points:** Explore flexible service delivery approaches, including community outreaches, workplace-based programs and non-clinical community settings, subject to ethical, safeguarding and confidentiality requirements. These approaches may reduce the visibility and stigma associated with attending a dedicated mental health facility.

5.4 Proposed Pathway of Change

The *Unhu* Men's Mental Health Framework proposes that harmful masculine norms contribute to emotional suppression, self-stigma and reluctance to seek professional assistance. These processes interact with socioeconomic pressures, relationship difficulties and limited services. This increases the likelihood of psychological distress remaining untreated or being expressed through maladaptive coping. The framework therefore proposes simultaneous action at the individual, community and structural levels.

At the individual level, men are supported to reconstruct masculinity and develop healthier coping skills. At the community level, social norms are challenged and supportive networks are strengthened. At the structural level, mental health services are made more accessible and culturally responsive. Together, these levels are expected to increase mental health literacy, reduce stigma, strengthen adaptive coping and improve timely help-seeking.

5.5 Proposed Outcomes and Indicators

The following outcomes and indicators are proposed to guide future empirical piloting of the framework. They have not yet been validated and not presented as established findings.

LEVEL	OUTCOMES	INDICATOR
Individual	Reduced self-stigma of help-seeking	Pre and post scores on the Self-Stigma of Seeking Help Scale (Vogel et al., 2006)
Individual	Improved emotional literacy	Facilitator-rated participation and self-report measures in Healing Circles
Community	Reduced perceived social sanction for help-seeking	Community survey on attitudes toward men's help-seeking, pre/post campaign
Community	Increased referrals by Male Mental Health Champions	Number of documented referrals to formal, community-based and culturally relevant traditional support services
Structural	Increased service utilization by men	Clinic-level sex-disaggregated attendance

		data before and after integration
Structural	Reduced treatment gap	Ratio of estimated need to service contacts, tracked longitudinally

5.6 Feasibility and Implementation Considerations

The proposed *Unhu* Men's Mental Health Framework is intended to be developed and evaluated through a phased approach rather than implemented immediately as an established intervention. Initial development should involve structured consultation with Zimbabwean men, mental health professionals, community leaders, religious leaders and other relevant stakeholders. Such consultation is essential to assess the cultural appropriateness, acceptability and practical feasibility of the proposed components and to identify locally meaningful ways of discussing masculinity, emotional well-being and help-seeking.

Implementation faces practical constraints that must be considered alongside the conceptual design of the framework. Resource limitations in Zimbabwe include a shortage of trained mental health professionals and constrained health budgets. These limitations can mean that individual-level and community-level components, such as Men's Healing Circles and Male Mental Health Champions, are likely to be more immediately feasible than structural-level integration into primary health care, because structural integration depends on broader health-system reform. Community-level components could draw on existing infrastructure, such as the lay health worker model already used by Friendship Bench (Chibanda, 2017), rather than requiring entirely new service structures. Implementation would also depend on the genuine buy-in of traditional and religious leaders, given their established role in men's help-seeking pathways. Without their engagement, culturally framed messaging risks being perceived as externally imposed rather than community-owned.

A phased approach is therefore recommended. Small-scale pilot programs could first test Men's Healing Circles, psychoeducational activities and community dialogue forums alongside existing mental health promotion services. Male Mental Health Champions could be integrated into existing community networks, provided that they receive appropriate training, ongoing supervision and clearly defined referral responsibilities. Structural integration into primary health care could follow as capacity allows. This sequencing is itself a proposition that requires empirical testing rather than a validated implementation pathway. Partnerships between formal mental health services, community organizations, religious structures and other trusted support networks could further support referral and continuity of care.

Feasibility evaluation should examine the recruitment and retention of participants, the acceptability of the intervention, attendance and completion rates, referral uptake, the availability of trained facilitators and the resources required for implementation. Pilot studies should also assess whether the proposed outcome indicators are culturally appropriate, reliable and practical to measure. Findings from these initial studies could be used to refine the framework before larger-scale effectiveness evaluations. All implementation must adhere to ethical, safeguarding and confidentiality requirements, particularly where community-based and culturally embedded forms of support are involved. Collaboration with traditional and faith-based structures should operate within clearly defined referral boundaries and should complement rather than replace appropriate professional mental health care. This phased approach would allow the framework to be evaluated for feasibility and acceptability before claims about its effectiveness or scalability are made.

6. Implications for Mental Health Practice in Zimbabwe

The proposed framework has several implications for mental health practice. First, practitioners should avoid treating men's reluctance to seek help simply as an individual deficit. Second, interventions should recognize

the diversity of Zimbabwean men rather than assuming that one model of masculinity applies across age, socioeconomic status, geographical location and cultural background.

Third, mental health promotion should move beyond crisis-oriented responses towards prevention and early intervention. Community-based approaches can provide opportunities to engage men before distress becomes severe. Finally, culturally grounded approaches should identify cultural resources that promote well-being while critically addressing norms that discourage emotional expression and appropriate help-seeking.

7. RECOMMENDATIONS

- Conduct Zimbabwean empirical studies examining how masculine norms influence recognition of distress, coping and help-seeking of different male populations.
- Develop and evaluate culturally grounded interventions based on *unhu* and other locally meaningful values.
- Investigate collaboration between formal mental health services, religious leaders and community-based organizations, with particular attention to safe referral pathways.
- Train mental health professionals and community workers in gender-sensitive approaches that recognize masked or externalized presentations of psychological stress.
- Evaluate whether community-based primary-care approaches improve early-seeking and continuity of care among men.
- Ensure that the future research includes rural and urban populations and men from different socioeconomic and age groups so that findings are not limited to a specific population.

8. LIMITATIONS OF THE CONCEPTUAL PAPER

This paper is conceptual and does not present primary empirical data. Its arguments therefore depend on the quality, availability and contextual relevance of the literature identified through the structured but non-systematic search strategy. Evidence from other African settings may not transfer directly to Zimbabwe because masculine norms and mental health pathways vary across communities. The proposed *Unhu* Men's Mental Health Framework should therefore be regarded as a theoretically informed model requiring empirical validation rather than as an established intervention.

9. CONCLUSION

Men's mental health and help-seeking in Zimbabwe are shaped by the interaction between masculine norms, social stigma, socioeconomic pressures and limited access to culturally responsive care. Integrating hegemonic masculinity with Afrocentric principles, particularly *unhu*, provides a basis for reframing help-seeking as responsible and relational rather than weak. The proposed *Unhu* Men's Mental Health Framework offers a direction for future research and intervention, but its acceptability, feasibility and effectiveness must be tested with Zimbabwean communities.

REFERENCES

1. Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, 58(1), 5–14. <https://doi.org/10.1037/0003-066X.58.1.5>
2. Asante, M. K. (1998). *The Afrocentric idea* (Rev. and expanded ed.). Temple University Press.
3. Banda, R., & Mlambo, N. (2023). Exploring the nexus between masculinity and men's mental health: Case of Goromonzi Peri Urban Mashonaland East Zimbabwe. *International Journal of Research and Innovation in Social Science*, 7(9), 963–967. <https://dx.doi.org/10.47772/IJRISS.2023.70983>
4. Chibanda, D. (2017). Reducing the treatment gap for mental, neurological and substance use disorders in Africa: Lessons from the Friendship Bench in Zimbabwe. *Epidemiology and Psychiatric Sciences*, 26(4), 342–347. <https://doi.org/10.1017/S2045796016001128>

5. Cochran, S. V., & Rabinowitz, F. E. (2000). *Men and depression: Clinical and empirical perspectives: Practical resources for the mental health professional*. San Diego, CA: Academic Press
6. Connell, R. W. (1995). *Masculinities*. University of California Press.
7. Ezeugwu, C. R., & Ojedokun, O. (2020). Masculine norms and mental health of African men: What can psychology do? *Heliyon*, 6(12), Article e05650. <https://doi.org/10.1016/j.heliyon.2020.e05650>
8. Grant, M. J., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, 26(2), 91–108. <https://doi.org/10.1111/j.1471-1842.2009.00848.x>
9. Hammer, J. H., Vogel, D. L., & Heimerdinger-Edwards, S. R. (2013). Men's help seeking: Examination of differences across community size, education, and income. *Psychology of Men & Masculinity*, 14(1), 65–75. <https://doi.org/10.1037/a0026813>
10. Jani, C., & Piroro, C. A. (2025). Traditional masculine norms and health disparities among boys and men in Sanyati District, Zimbabwe. *International Journal of Research and Innovation in Social Science*, 9(4), 522–530. <https://dx.doi.org/10.47772/IJRISS.2025.90400041>
11. Mhlanga, S., & Chidarikire, M. (2025). Masculinity and gender norms as risk factors in suicide and suicide ideation among male university students in Zimbabwe. *Psychology, Health & Medicine*. Advance online publication. <https://doi.org/10.1080/13548506.2025.2601064>
12. Mushonga, R. H., Bere, C. T., Mtisi, T. J., Dambi, J., Nyamwanza, O., Maramba, A., & January, J. (2026). Hidden distress: A qualitative study of sociocultural barriers to mental health help-seeking among young people in Zimbabwe. *Frontiers in Public Health*, 14, 1816545. <https://doi.org/10.3389/fpubh.2026.1816545>
13. Mogano, N. T. H., Letsoalo, D. L., & Oduaran, C. A. (2025). Effects of masculine culture on the mental health of Northern Sotho male youth. *BMC Psychology*, 13, Article 605. <https://doi.org/10.1186/s40359-025-02934-3>
14. Pederson, E. L., & Vogel, D. L. (2007). Male gender role conflict and willingness to seek counseling: Testing a mediation model on college-aged men. *Journal of Counseling Psychology*, 54(4), 373–384. <https://doi.org/10.1037/0022-0167.54.4.373>
15. Rhead, R., Skovdal, M., Takaruzza, A., Maswera, R., Nyamukapa, C., & Gregson, S. (2019). The multidimensionality of masculine norms in east Zimbabwe: Implications for HIV prevention, testing and treatment. *AIDS*, 33(3), 537–546. <https://doi.org/10.1097/QAD.0000000000002041>
16. Rice, S. M., Oliffe, J. L., Kealy, D., Seidler, Z. E., & Ogrodniczuk, J. S. (2020). Men's help-seeking for depression: Attitudinal and structural barriers in symptomatic men. *Journal of Primary Care & Community Health*, 11, 2150132720921686. <https://doi.org/10.1177/2150132720921686>
17. Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health*, 4(3), 218–251. <https://doi.org/10.5172/jamh.4.3.218>
18. Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, 49, 106–118. <https://doi.org/10.1016/j.cpr.2016.08.002>
19. Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., & Gregson, S. (2011). Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Globalization and Health*, 7(1), 13. <https://doi.org/10.1186/1744-8603-7-13>
20. Staiger, T., Stiawa, M., Mueller-Stierlin, A. S., Kilian, R., Beschoner, P., Gündel, H., Becker, T., Frasch, K., Panzirsch, M., Schmauß, M., & Krumm, S. (2020). Masculinity and help-seeking among men with depression: A qualitative study. *Frontiers in Psychiatry*, 11, Article 599039. <https://doi.org/10.3389/fpsy.2020.599039>
21. Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, 53(3), 325–337. <https://doi.org/10.1037/0022-0167.53.3.325>
22. World Health Organization. (2021). *Suicide worldwide in 2019: Global health estimates*. World Health Organization. <https://www.who.int/publications/i/item/9789240026643>
23. Xiao, Y., & Watson, M. (2019). Guidance on conducting a systematic literature review. *Journal of Planning Education and Research*, 39(1), 93–112. <https://doi.org/10.1177/0739456X17723971>