How Men in Harare Perceive and Engage with Mental Health Support Systems: Insights from an Organisation in Harare, Zimbabwe

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Abstract

Men's engagement with mental health services remains disproportionately low, particularly in Zimbabwe, where cultural norms, societal expectations, and stigma often discourage help-seeking behaviours. This study explored the perceptions and engagement of men in Harare, Zimbabwe, regarding mental health support systems, with a focus on identifying the barriers that hinder their willingness to seek psychological support. Results from the research revealed that many men perceived mental illness as a sign of personal weakness, leading them to self-medicate with alcohol, pursue traditional healing practices, or seek religious counselling instead of accessing professional mental health services. Structural challenges, including long waiting times, financial constraints, and dissatisfaction with the quality of formal mental health care, further deterred engagement. However, community-based interventions, such as the Friendship Bench, emerged as effective, accessible, and culturally sensitive alternatives. The study recommends integrating mental health services into primary healthcare, expanding community-led mental health programmes, and implementing targeted awareness campaigns to challenge stigma and normalize help-seeking among men. Addressing these barriers is essential to fostering a more inclusive mental health system that encourages greater male participation in Zimbabwe's mental healthcare landscape.

Keywords: men's mental health, stigma, masculinity norms, help-seeking behaviour, Zimbabwe, mental health services, cultural perceptions, community-based interventions

Introduction

Mental health is a crucial component of overall well-being, influencing emotional resilience, cognitive functioning, and social relationships. However, men's reluctance to seek psychological support remains a significant global concern, particularly in Zimbabwe, where cultural, societal, and structural factors discourage help-seeking behaviour (Seidler, 2019). Traditional masculinity norms often promote stoicism, self-reliance, and emotional restraint, discouraging men from acknowledging mental health challenges or seeking professional support (Mahalik, 2019). Consequently, men are less likely than women to access mental health services, even when experiencing severe conditions such as depression, anxiety, or post-

traumatic stress disorder (PTSD) (WHO, 2020). This reluctance has contributed to higher rates of undiagnosed mental illnesses, increased substance abuse, and rising male suicide rates worldwide.

In Zimbabwe, mental health services have historically been underfunded and deprioritised, with greater focus directed towards other public health concerns like HIV/AIDS, tuberculosis, and maternal health (Mufunda & Mebrahtu, 2022). Limited awareness and accessibility further discourage men from seeking mental health care, as societal norms often equate help-seeking with weakness rather than strength (Chibanda, 2016). As a result, many men resort to self-medicating through alcohol or drug use, compounding their psychological distress rather than addressing its root causes. A lack of mental health education exacerbates the problem, leaving many Zimbabwean men unaware of symptoms or available services within their communities.

The World Health Organisation (WHO, 2020) notes that cultural expectations across African societies often pressure men to internalise their emotional struggles, making it challenging to acknowledge mental health issues or pursue professional support. In Zimbabwe, stigma surrounding mental illness extends to families and communities, discouraging open discussions. Consequently, many men suffer in silence, leading to severe consequences, including chronic depression, social isolation, and an increased risk of suicide. Studies indicate that for every female suicide in Zimbabwe, there are at least three male suicides, underscoring the urgent need to address men's mental health challenges (Chibanda, 2019).

Despite the growing demand for mental health interventions, Zimbabwe faces significant barriers in service provision. Limited funding, a shortage of trained professionals, and inadequate mental health infrastructure restrict access to timely and effective care (Matare, 2017). Most mental health services are concentrated in urban areas like Harare, leaving rural populations underserved (Mafa & Chigangaidze, 2020). Additionally, the high cost of private therapy sessions and under-resourced public services further deter men from seeking support.

In response, non-governmental organisations (NGOs) and community-based initiatives, such as the Friendship Bench programme, have introduced accessible, low-cost mental health support by training lay health workers to provide psychological assistance in informal settings (Chibanda et al., 2016). While these interventions have shown success in reducing depression and anxiety symptoms, men's participation remains disproportionately low, indicating that cultural beliefs and stigma continue to hinder access to care (Nyoni, 2020).

This study aims to explore men's perceptions and engagement of mental health services in Harare, Zimbabwe, identify key barriers to help-seeking, and assess potential interventions to increase male participation in mental health care. By addressing stigma, raising awareness, and tackling systemic challenges, stakeholders in Zimbabwe's health sector can work toward a more inclusive mental health framework that prioritises accessibility, affordability, and culturally sensitive interventions.

Literature review

Global perspective

The global discourse on mental health service utilisation consistently reveals that men engage with mental health services at lower rates than women, despite experiencing similar or higher levels of psychological distress. Research from Western countries, such as the United States and the United Kingdom, indicates that men are significantly less likely to seek professional mental health support due to concerns about social stigma, financial constraints, and a lack of culturally sensitive services (Mahalik et al., 2013). This belief is further reinforced by social norms that equate emotional vulnerability with weakness, making it challenging for men to openly discuss their mental health struggles. In Australia, similar findings demonstrate that dominant masculine ideologies contribute to men's reluctance to engage in conversations about mental health. Seidler et al. (2019) highlight that this reluctance reduces the effectiveness of mental health interventions, as men may resist therapy or fail to adhere to treatment plans.

The issue of low male engagement in mental health services is not limited to high-income countries. In many Asian cultures, particularly in Japan and China, societal expectations for men to embody strength, rationality, and self-sufficiency serve as additional barriers to seeking professional help. In Japan, mental health challenges are often perceived as personal failures, prompting many men to conceal their distress rather than seek external support (Yamawaki et al., 2012). Similarly, in China, there is a cultural emphasis on endurance and perseverance, discouraging open discussions about emotional struggles. These patterns underscore the influential role that gender norms play in shaping men's perceptions and utilisation of mental health services across different cultural contexts.

Regional context (sub-Saharan Africa)

In sub-Saharan Africa, mental health care remains significantly underdeveloped due to limited resources, inadequate policy implementation, and deeply ingrained cultural beliefs. Mental illness is often attributed to supernatural forces, witchcraft, or divine punishment, resulting in

widespread stigmatisation (Nyamhanga & Frumence, 2014). These prevailing societal attitudes discourage individuals from seeking professional medical interventions, as mental disorders are frequently perceived as spiritual afflictions rather than medical conditions. Studies in South Africa reveal that men facing mental health challenges often resort to harmful coping mechanisms, such as excessive alcohol consumption, rather than seeking professional support (Petersen et al., 2016). Within many African communities, alcohol abuse is normalised, with substance use often seen as an acceptable means of escaping emotional distress. The World Health Organisation (2021) reports that many African nations allocate less than 1% of their health budgets to mental health services, severely limiting access to care and reinforcing the stigma associated with mental illness.

Additionally, the lack of mental health infrastructure and trained professionals in sub-Saharan Africa presents a significant challenge. Many countries in the region have an alarmingly low number of psychiatrists and psychologists, rendering mental health services inaccessible to large segments of the population. Even in urban areas where mental health facilities are available, cultural beliefs and societal expectations often prevent men from seeking professional intervention. Furthermore, mental health campaigns and awareness programmes remain insufficient, with few initiatives specifically addressing men's unique concerns and perceptions. As a result, many African men continue to suffer in silence, further perpetuating the neglect of mental health as a crucial aspect of public health (Nyamhanga & Frumence, 2014).

National and local insights (Harare, Zimbabwe)

In Zimbabwe, mental health has historically received limited attention due to competing health priorities, including HIV/AIDS, tuberculosis, and maternal health (Mufunda & Mebrahtu, 2022). Mental health services in the country remain severely underfunded and are often a low priority in national health policies. Religious and traditional healing practices play a central role in Zimbabwe's approach to mental health. Many Zimbabweans turn to spiritual healers and religious institutions as their first point of contact for mental health issues rather than seeking assistance from psychologists or psychiatrists (Matare, 2012). The widespread belief in supernatural causes of mental illness further deters the use of formal mental health services. However, initiatives such as the Friendship Bench in Harare have made significant strides in addressing the mental health service gap. The Friendship Bench is a community-based programme that offers psychological support through trained lay health workers who conduct therapy sessions in informal, non-clinical settings. This model has demonstrated success in

improving mental health outcomes, particularly for individuals experiencing anxiety and depression (Chibanda et al., 2016).

Overall, the literature suggests that men's reluctance to seek mental health support in Zimbabwe is deeply rooted in cultural norms, societal expectations, and structural limitations within the healthcare system. Addressing these barriers requires targeted interventions that promote mental health awareness among men, challenge harmful gender norms, and integrate mental health services into accessible and non-stigmatizing environments. By understanding the unique challenges faced by men in Harare, mental health professionals and policymakers can develop more effective strategies to encourage help-seeking behaviours and improve mental health outcomes for men in Zimbabwe.

Objectives of the study

i) To explore men's attitudes and perceptions toward mental health and their willingness to utilise mental health services.
ii) To identify the primary barriers preventing men from seeking professional mental health support, with a focus on cultural, societal, and structural factors.
iii) To evaluate the effectiveness of existing mental health interventions in engaging men and addressing their mental health needs; and to propose evidence-based recommendations for enhancing men's engagement with mental health services

Methodology

Research design and approach

This study employs a qualitative research approach, focusing on in-depth exploration of men's perceptions towards mental health services in Harare, Zimbabwe. A qualitative approach is particularly effective in understanding complex social phenomena, such as cultural attitudes and behavioural patterns, which influence mental health help-seeking behaviours (Bryman, 2012). Unlike quantitative research, which emphasises numerical data, qualitative research prioritises subjective experiences and lived realities, making it ideal for this study's objective of examining men's attitudes, beliefs, and barriers to mental health care.

The research is grounded in a phenomenological framework, which aims to capture the lived experiences of participants as they relate to mental health services (Smith et al., 2009). Phenomenology allows researchers to understand how individuals perceive and interpret their interactions with mental health care providers and the broader health system. Given that men's

reluctance to seek mental health services is influenced by deep-seated social norms, stigma, and structural factors, this framework provided an opportunity to explore these factors in a holistic manner. Through phenomenology, the study delved into participants' personal narratives, shedding light on how cultural expectations and masculinity norms shaped their mental health decisions.

These interviews encouraged in-depth discussions and enabled the researcher to probe further into the reasons behind certain perceptions and behaviours societal norms and peer influences on mental health. This methodological approach ensured that the study captured both individual and collective perspectives, making it well-suited for understanding the multi-layered barriers that prevent men from seeking professional mental health support.

Participants and sampling

The study engaged 30 men aged 18 to 65 from diverse socio-economic backgrounds in Harare to capture generational differences in perceptions of mental health. Participants were purposively selected to ensure diversity in age, education, employment, and social experiences. Recruitment was conducted through community networks, mental health organisations, local clinics, and NGOs, with additional participants identified through snowball sampling. This approach helped include individuals who might typically be hesitant to discuss mental health due to stigma or lack of awareness.

To ensure a balanced and representative sample, participants were selected based on three key criteria:

Table 1: Three key criteria used to select participants

Demographic Category	Subgroups	Purpose/Focus
Age group	Young adults (18 – 30) Middle Aged Men (31-50) Older Men (51-65)	To analyse generational differences in perception of mental health
Socio Economic Background	Low Income Middle Income High Income	To capture how economic status influences mental health help seeking behaviour
Education and Employment Status	Unemployed Students	To explore the impact of employment stability and education on mental health perceptions

By utilising purposive and snowball sampling methods, the study ensured that the participants' experiences provide a comprehensive representation of how different socio-economic factors influence men's perceptions of mental health services in Harare. This approach enhances the credibility and transferability of the findings, allowing them to inform policies and interventions that aim to increase male engagement with mental health care in Zimbabwe.

Data collection methods

The study employed face-to-face semi-structured interviews and focus group discussions (FGDs) as primary data collection methods. These methods were chosen to allow participants to express their views freely while enabling researchers to explore underlying themes influencing men's perceptions of mental health services in Harare.

The semi-structured interviews were conducted in a one-on-one setting, allowing participants to share their personal experiences and perspectives without external influences. This approach was particularly useful in understanding individual barriers to mental health help-seeking, including stigma, masculinity norms, and personal beliefs about mental illness (Krueger & Casey, 2015). Each interview lasted between 45 to 60 minutes, covering key topics such as men's understanding of mental health, their awareness of available services, and their perceived challenges in accessing psychological support. The interview questions were open-ended, allowing for a natural flow of conversation and enabling participants to discuss aspects they found most relevant. Interviews were conducted in both English and Shona, depending on the participant's preference, to ensure clarity and comfort during the discussions.

In addition to the interviews, focus group discussions (FGDs) were conducted to capture collective attitudes towards mental health services and explore how peer influences shape men's perceptions of mental health help-seeking behaviours. Each focus group consisted of 5-7 participants and lasted approximately 90 minutes. The discussions were moderated using a structured guide, but participants were encouraged to engage in free-flowing dialogue, sharing their opinions and experiences regarding mental health. FGDs provided an interactive environment, allowing researchers to observe how societal norms are reinforced within peer groups. This method was particularly valuable in understanding how masculinity expectations shape men's reluctance to seek professional psychological support.

All interviews were audio-recorded with participant consent, ensuring that data was accurately captured for later transcription and analysis. Field notes were also taken to document non-verbal cues, emotional expressions, and notable interactions that could provide additional

context to the responses. The combination of personal interviews and group discussions ensured that the study captured both individual perspectives and collective social attitudes, offering a comprehensive understanding of the factors influencing men's engagement with mental health services.

Appointments for the FGD were arranged using multiple methods to maximise participant convenience and attendance. Potential participants fitting the target demographics were contacted via phone, WhatsApp, and in-person outreach. Various date and time options were offered to accommodate schedules, and participants confirmed their preferred slots. Venue details and reminders were sent prior to the sessions, with follow-up reminders a day before. Flexibility was maintained by offering alternative sessions or one-on-one interviews for those unable to attend the initial groups.

Data analysis and interpretation

This research utilised reflexive thematic analysis, as described by Braun and Clarke (2006, 2019). This method is particularly well-suited for analysing qualitative data such as focus group discussions (FGDs), where the aim is to explore participants' perceptions, experiences, and meaning-making processes in depth. Reflexive thematic analysis was selected because it prioritises the researcher's active role in theme development and interpretation. It allows for rich, detailed exploration of participants' perceptions and experiences and it also works well with data derived from varied demographic groups. The analysis followed Braun and Clarke's six phase process: familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and producing the report.

The following key themes emerged from the data analysis:

1) Cultural norms and masculinity: Many participants emphasised that societal expectations of strength and emotional control discouraged them from seeking mental health support. There was a strong perception that men should "handle their own problems" without external help.

2) Stigma and fear of judgment: A significant number of participants expressed concerns about being labelled as weak or mentally unstable if they sought professional help. Some feared that their peers or employers would view them differently if they were known to have mental health concerns.

3) Lack of awareness and accessibility: Several participants were unaware of the available mental health services in Harare. Others reported difficulties in accessing psychological support due to financial constraints, long waiting times, and the lack of male-friendly mental health services.

Ethical considerations

Given the sensitive nature of mental health discussions, ethical considerations were strictly adhered to throughout the research process. Ethical guidelines were followed to ensure participant safety, respect, and well-being throughout the study (Orb et al., 2001).

Before participating, all respondents were provided with detailed information about the study's objectives, procedures, potential risks, and benefits. Informed consent was obtained from each participant, ensuring that their involvement was voluntary and based on full understanding of the research process. Participants were also assured that they had the right to withdraw from the study at any point without any negative consequences.

Confidentiality and anonymity were strictly maintained to protect participants' identities. Personal details such as names, addresses, and any identifiable information were excluded from the final research documents. Each participant was assigned a unique code, which was used for data storage and analysis instead of their real names. All audio recordings, transcripts, and written notes were securely stored, accessible only to the research team.

Considering the emotional sensitivity of discussing mental health issues, psychological support was made available for any participant who felt distressed or uncomfortable during the interview or focus group discussions. Participants were informed of available mental health support services, including community-based organisations and helplines, in case they required further assistance. Special attention was given to ensuring a safe and non-judgmental environment where men could freely express their views without fear of stigma or discrimination.

Findings

Table 2: Thematic analysis outline

Objectives	Major Theme	Sub-Theme	Key Insights
1. To explore men's attitudes and perceptions toward mental health and their willingness to utilize mental health services	Negative Perceptions of Mental Health Masculinity and Internalization	• Mental illness as weakness • Therapy seen as ineffective • Resistance to seeking help	• From the findings, many men view illness as a sign of personal failure and perceive professional help as unnecessary or untrustworthy. • Cultural expectations discourage men from acknowledging emotional struggles ore expressing vulnerability
2. To identify the primary barriers preventing men from seeking professional mental health support	Stigma and societal judgement Culture and religion	• Fear • Loss of respect • Alcohol and substance use	• From the findings, stigma around mental health leads to shame, fear of social exclusion, and avoidance of therapy. Men worry about being seen as weak or unfit • In the absence of trusted health services, men self-medicate or turn to culturally accepted coping strategies that are often harmful or ineffective
3. To evaluate the effectiveness of existing interventions and propose recommendations	Alternative coping mechanisms Community-based models	• Peer support approach • Friendship bench success	• The friendship Bench is widely appreciated for its culturally appropriate, non-judgemental and accessible format. It reduces barriers by normalizing mental health talk and offering peer support

Men's attitudes and perceptions toward mental health and their willingness to utilise mental health services

Most participants held negative perceptions of mental health services, viewing them as ineffective or unnecessary. Mental illness was seen as a sign of weakness, especially among older and traditionally minded men. Many believed that men should handle problems internally, discouraging help-seeking behaviour. Some participants expressed a lack of trust in mental health professionals, feeling that their concerns were not well understood or adequately addressed. The prevailing belief among participants was that mental illness is a sign of personal weakness, leading many men to resist acknowledging psychological distress or seeking professional assistance. A significant proportion of participants reported avoiding professional mental health services due to the societal stigma attached to seeking psychological support. Many believed that admitting to mental distress could lead to social ridicule, discrimination, or even loss of respect within their communities. Some participants feared that seeking therapy

would lead others to question their competence at work, as mental illness is often associated with diminished masculinity and vulnerability.

> "We, men, are always secretive and we don't want to expose our issues to other people. We pretend to be strong in every situation" (Participant C)

> "I believe society and our upbringing play a big role. We believe that we should not show emotions as it is a sign of weakness and with such phrases as *shingirirai semurume* (persevere as a man). As a sign of strength man avoid seeking help and try to solve the problem on their own" (Participant A)

Participants expressed widespread scepticism toward formal mental health care. Many viewed therapies as unnecessary, ineffective, or a sign of personal weakness. This belief was especially common among older men and those from traditional backgrounds. Such attitudes significantly limit men's willingness to engage with mental health services.

Barriers preventing men from seeking professional mental health support, with a focus on cultural, societal, and structural factors

The study revealed that the perception of mental health services among men in Harare is largely negative, with stigma and cultural beliefs playing a significant role in discouraging help-seeking behaviours. Many participants preferred traditional healers or religious leaders over mental health professionals. Structural barriers included high costs of private therapy, long waiting times, and lack of resources in public health facilities. There was also a general distrust in formal systems, with services perceived as inaccessible or irrelevant to men lived realities. Instead of engaging with formal mental health services, many participants relied on self-medication, traditional remedies, or religious counselling as alternative coping mechanisms. Others turned to traditional healers, believing that mental illnesses were caused by supernatural forces, witchcraft, or ancestral spirits rather than medical conditions. Religious counselling was also frequently cited, with several participants stating that they preferred seeking guidance from church leaders or prophets rather than mental health professionals. Many men viewed prayer and religious intervention as more socially acceptable ways of addressing mental struggles, reinforcing the idea that mental health treatment should be spiritual rather than medical.

> "I believe culture and religious beliefs have created an accepted perception that mental issues are a result of either spiritual attacks or demonic manifestations" (Participant E)

> "We fear having our problems being divulged to others in the same circles with the effect, thereafter, being that one who becomes a laughingstock of the community" (Participant D)

Stigma emerged as a powerful barrier. Participants feared being labelled as weak or unfit for work. This fear led many to avoid professional help and instead suffer in silence. The pressure to maintain a strong, unemotional image prevented open discussions about mental health.

The effectiveness of existing mental health interventions in engaging men and addressing their mental health needs, and to propose evidence-based recommendations for enhancing men's engagement with mental health services

For those who had engaged with formal mental health services, dissatisfaction was a recurring theme. Many participants criticised the inefficiency of mental health services, citing long waiting times, inadequate attention from professionals, and the perceived ineffectiveness of therapy. Some men felt that mental health professionals did not fully understand their concerns or offer practical solutions, leading to a lack of trust in the system. Additionally, the cost of mental health services was noted as a barrier, with some participants highlighting that private therapy sessions were too expensive, while public mental health services lacked sufficient resources and personnel. Alcohol and substance use emerged as common self-treatment methods, particularly among younger men and those from economically disadvantaged backgrounds. Some participants reported using excessive alcohol consumption to "numb" their emotional pain and escape societal pressures.

> "I have always been told that seeking help from a professional requires money. So, I just left it. The government clinics are always full, and you wait for hours. Sometimes there's no one even available."

> "In the absence of trusted health services, men self-medicate or turn to culturally accepted coping strategies that are often harmful or ineffective" (Participant F)

In place of professional care, many men turned to alcohol, religious counselling, or traditional remedies. These coping mechanisms were seen as more accessible and socially acceptable but often worsened their mental health. This underscores the need for better formal services that are culturally and socially aligned with men's preferences.

Despite these negative perceptions, the Friendship Bench emerged as a promising community-based model that effectively engages men by providing informal, non-judgmental, and culturally sensitive support. Its peer-led approach was especially valued for building trust and breaking down stigma.

> "Talking to someone from the community is different. They understand us better. Doctors just ask questions, but these people really listen."

While alternative coping mechanisms such as alcohol use, traditional healing, and religious counselling remain prevalent, initiatives like the Friendship Bench demonstrate promising solutions for improving men's access to mental health care.

Discussion of findings

This study set out to explore men's perceptions and attitudes toward mental health, the barriers they face in seeking professional support, and the effectiveness of current interventions. The findings indicate that societal norms around masculinity, cultural beliefs, and stigma remain significant obstacles to help-seeking among men in Harare. Many participants reported that expressing vulnerability or seeking psychological help is perceived as a weakness, a view deeply rooted in how men are socialised.

Additionally, structural barriers such as the cost and inaccessibility of services further limit men's engagement with formal mental health care. Instead, many rely on alternative coping mechanisms, including alcohol use, traditional healing, or religious counselling. Despite these challenges, community-based models like the Friendship Bench were found to be more acceptable and effective due to their informal, peer-led approach.

These findings are consistent with global and regional literature on men's mental health and suggest the need for more inclusive, culturally sensitive, and male-friendly mental health strategies. Future interventions must address both the cultural and structural barriers while promoting models that resonate with men's lived experiences and social realities.

Conclusion

The findings of this study underscore the significant influence of cultural norms, stigma, and lack of awareness on men's perceptions of mental health services in Harare, Zimbabwe. Many men continue to view mental health struggles as a personal weakness, preventing them from seeking professional support. Deeply embedded masculinity norms that emphasise self-reliance and emotional restraint further discourage men from openly discussing their mental health concerns. As a result, a large proportion of men preferred self-medication, traditional remedies, or religious counselling over engaging with formal mental health services. This reluctance to seek help has contributed to worsening mental health conditions, increased substance abuse, and in extreme cases, a rise in male suicide rates. The study also reveals systemic challenges in the provision of mental health care, including long waiting times, financial constraints, and the perceived ineffectiveness of therapy, which further deter men from utilizing available services.

One of the most critical findings of this study is the role of stigma and fear of judgment in shaping men's attitudes toward mental health services. Many participants expressed concern about being labelled as weak, unstable, or incompetent if they sought professional help. This stigma is not only reinforced by social circles, workplaces, and religious institutions, but also by the healthcare system itself, which is often perceived as being ill-equipped to handle men's mental health concerns effectively. Even among those who were aware of mental health services, distrust and dissatisfaction were common, with complaints about the lack of male-specific interventions, inadequate counselling, and dismissive attitudes from healthcare providers. These barriers create an environment where men suffer in silence, choosing to endure psychological distress rather than seek professional help.

Despite these challenges, the study identified opportunities for improving mental health service accessibility and engagement among men. One promising intervention is community-based mental health programmes, such as the Friendship Bench, which has been well-received for its non-judgmental, informal, and easily accessible approach. Unlike traditional clinical settings, the Friendship Bench provides a comfortable environment where men can receive psychological support without fear of stigma. The success of this model suggests that mental health interventions must be tailored to fit within the cultural and social frameworks that shape men's perceptions of help-seeking behaviours.

Recommendations for future interventions

To address the barriers identified in this study, future interventions must focus on:

1. Expand community-based mental health support

Scaling up initiatives like the Friendship Bench: Stakeholders ought to establish similar peer-led, community-based mental health programmes in underserved areas. These could expand their presence in workplaces, schools, and religious institutions to improve accessibility.

Train and support lay health workers: Interested organisations could provide ongoing training to lay counsellors to enhance their capacity in providing mental health support. They could also equip them with knowledge about men's mental health concerns and stigma management.

Introduce mobile mental health units: Mobile network providers could deploy mobile clinics or pop-up mental health services to reach men in rural and economically disadvantaged areas. These units could offer confidential consultations and mental health screenings.

2. Reduce stigma and promote help-seeking

Implement culturally relevant anti-stigma campaigns: Community organisations ought to develop campaigns that challenge harmful masculinity norms and emphasize the strength in seeking help. They could utilise storytelling, testimonials, and positive male role models to normalise mental health discussions.

Engage local leaders and influencers: Stakeholders could collaborate with respected community leaders, religious figures, and public personalities to advocate for mental health support and reduce stigma.

Leverage media and digital platforms: Media organisations ought to produce radio shows, podcasts, and short films discussing men's mental health challenges. They could also use social media to share real-life stories and resources.

3. Develop male-centred mental health services

Establish men's support groups: Stakeholders ought to create safe spaces where men can openly discuss mental health challenges without fear of judgment. Peer-led discussions can be effective in reducing stigma and fostering mutual support.

Offer specialised counselling programmes: Psychological services organisations could develop counselling initiatives that address issues commonly faced by men, such as financial stress, relationship challenges, substance use, and trauma.

Provide flexible and anonymous services: Stakeholders and psychological services organisations could implement telehealth and online counselling platforms that ensure confidentiality, catering to men who may fear public exposure or stigma.

4. Integrate mental health into existing services

Incorporate mental health into primary care: Training institutions could offer training to general practitioners and healthcare providers to conduct routine mental health screenings and offer basic mental health support. This normalisation can reduce stigma.

Partner with workplaces and educational institutions: Various educational institutions and employers could offer on-site mental health counselling and workshops to address workplace stress and academic pressures. These could assist to implement employee assistance programmes (EAPs) with mental health resources.

Strengthen collaboration with traditional healers and religious leaders: Stakeholders could provide mental health literacy training to traditional healers and clergy, encouraging appropriate referrals to mental health services when needed.

5. Address structural and financial barriers

Advocate for increased funding: Mental health institutions ought to work with policymakers to allocate greater resources for mental health services, especially in public health facilities.

Provide affordable and accessible services: Mental health institutions ought to establish subsidised mental health programmes or sliding-scale fee models to ensure affordability for low-income individuals.

Expand mental health infrastructure: Local authorities and government ought to develop more community mental health centres with trained professionals in both urban and rural areas.

6. Build capacity through training and research

Train mental health professionals in gender-sensitive approaches: Educational institutions ought to ensure psychologists, counsellors, and social workers receive training on addressing men's mental health challenges in a non-judgmental and supportive manner.

Incorporate cultural competency training: Educational institutions ought to equip professionals with knowledge on cultural beliefs surrounding mental health and masculinity to provide respectful and effective care.

Encourage community-based research: Educational institutions ought to conduct participatory research that involves men in shaping mental health interventions. Establish feedback mechanisms to continually improve programmes.

7. Promote early intervention and preventive measures

Introduce mental health education programmes in schools: The curriculum ought to educate boys and young men on emotional intelligence, coping strategies, and stress management. It should also encourage open discussions about mental health from an early age.

Develop peer mentorship programmes: Communities ought to establish peer support networks where older, experienced men mentor younger men on mental health and emotional resilience

Provide psycho-education to families: Stakeholders ought to offer workshops and resources to families on recognising signs of mental distress and providing support to male relatives.

8. Monitor and evaluate intervention effectiveness

Establish monitoring systems: Mental health providers ought to track the outcomes and impact of mental health interventions through surveys, focus groups, and interviews.

Utilise data for continuous improvement: Mental health providers ought to analyse findings to refine programmes, ensuring they remain responsive to the needs of men in Harare.

Promote collaboration: Mental health providers ought to foster partnerships between government agencies, NGOs, and academic institutions for large-scale implementation and evaluation of mental health initiatives.

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