

BARRIERS TO ACCESS: AN ANALYSIS OF MALE PARTICIPATION RATES AND OUTCOMES IN COMMUNITY-LED MENTAL HEALTH INTERVENTIONS IN HARARE

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Abstract

Male participation in community-led mental health interventions remains disproportionately low in many low- and middle-income countries, including Zimbabwe. This study examines barriers to male engagement and associated psychosocial outcomes within community mental health interventions in Harare. Guided by the Social Role Theory, the Health Belief Model and Ecological Systems Theory, the study adopts a qualitative-dominant mixed-methods approach, drawing on programme records, key informant interviews and Zimbabwean case-study evidence. Findings reveal that hegemonic masculinity norms, mental health stigma, economic precarity and gender-insensitive programme designs significantly limit male participation. However, empirical and case-study evidence demonstrates that gender-responsive adaptations, such as male peer facilitation, flexible scheduling and targeted outreach, substantially improve engagement and mental health outcomes. The study concludes that addressing male under-representation requires culturally grounded, structurally adaptive and policy-supported community mental health programming.

Keywords: *gender norms; stigma; community mental health; help-seeking behaviour; masculinity; service accessibility*

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INTRODUCTION

Community-led mental health interventions have increasingly been adopted as key strategies for addressing mental health treatment gaps in low and middle-income countries. In contexts where formal psychiatric services are limited, decentralised and task-shifted models of care offer accessible and culturally responsive alternatives. In Zimbabwe, community-based mental health programmes have been promoted to enhance early identification, psychosocial support and continuity of care at grassroots level. Despite these developments, utilisation of such interventions remains uneven, with men consistently under-represented among service users.

Low male participation in community mental health interventions represents a significant public health concern. Men in Zimbabwe experience a substantial burden of untreated mental health conditions, often manifested through substance misuse, interpersonal violence and elevated suicide risk. However, prevailing gender norms emphasizing self-reliance, emotional control and resilience discourage men from acknowledging psychological distress or seeking help. These socio-cultural barriers are further compounded by economic pressures and structural limitations that restrict men's ability to engage with community-based psychosocial services.

The aim of this study is to analyze barriers to male participation in community-led mental health interventions in Harare and to examine psychosocial outcomes associated with male engagement. The study is guided by three research questions: (1) What socio-cultural, economic and structural factors influence male participation in community mental health interventions? (2) What

outcomes are associated with male engagement in these interventions? and (3) What strategies can enhance male inclusivity and effectiveness of community mental health programmes? The study is organised as follows: the next sections present the conceptual and theoretical frameworks underpinning the study, followed by a review of relevant literature, research methodology, findings, discussion and conclusions with recommendations.

CONCEPTUAL FRAMEWORK

The conceptual framework guiding this study positions male participation in community-led mental health interventions as the central outcome variable influenced by multiple interacting factors operating at individual, community and structural levels. At the individual level, socio-cultural constructions of masculinity, mental health literacy and perceived stigma shape men's attitudes towards help-seeking and psychosocial support. Mokhwelepa and Sumbane (2025) aver that dominant masculine norms that aggrandise emotional strength, self-reliance and control, often discourage men from acknowledging psychological distress or engaging in mental health programmes.

At the community level, social expectations, peer influence and prevailing attitudes toward mental illness further mediate male participation. Fear of social judgement and labelling within community spaces discourages visible engagement with mental health services. At the structural level, economic precarity, informal employment, programme design characteristics (such as session timing, location and facilitator gender) and policy commitment significantly influence access and sustained engagement. These factors interact dynamically to determine not

only participation rates but also the quality of engagement and psychosocial outcomes achieved by male participants.

THEORETICAL FRAMEWORK

This study is underpinned by an integrated theoretical framework drawing on the Social Role Theory, the Health Belief Model and the Ecological Systems Theory. These theories collectively provide a multidimensional lens for understanding male participation in community-led mental health interventions within the Zimbabwean context.

The Social Role Theory explains how socially constructed gender roles influence behaviour and expectations (Eisend and Rößner, 2022). In many societies, including Zimbabwe, men are socialised into roles that emphasize emotional control, independence and resilience. Eisend and Rößner (*ibid.*) further propose that these norms discourage expressions of vulnerability and reliance on psychosocial support, positioning mental health help-seeking as incompatible with dominant masculine identities. Consequently, men may avoid participation in community mental health interventions to maintain social status and conformity to societal gender expectations.

The Health Belief Model further elucidates individual decision-making processes related to health service utilisation (Hagger, 2025). According to this model, men's engagement with mental health interventions is influenced by perceived susceptibility to mental health problems, perceived severity of symptoms, perceived benefits of intervention and perceived barriers to participation. In the context of community mental health programmes, stigma, fear of labelling, time constraints and

economic costs often outweigh perceived benefits, thereby reducing participation.

The Ecological Systems Theory situates male participation within broader social, economic and policy environments. This perspective highlights how individual behaviours are shaped by interactions across multiple systems, including family, community, institutions and national policy frameworks (Nartey *et al.*, 2023). Economic instability, programme accessibility and policy prioritisation of mental health services interact with socio-cultural norms to either enable or constrain male engagement. Together, these theories underscore the need for multi-level, gender-responsive approaches to improving male participation in community-led mental health interventions.

LITERATURE REVIEW

Globally, gender disparities in mental health service utilisation have been consistently documented, with men demonstrating significantly lower rates of help-seeking compared to women. The World Health Organisation (WHO, 2021) reports that men are less likely to access preventive, diagnostic and therapeutic mental health services despite experiencing comparable or higher levels of certain mental health risks, including substance use disorders and suicide. This disparity has been attributed largely to socio-cultural constructions of masculinity that discourage emotional expression and reliance on professional support.

Connell's (2020) Theory of Hegemonic Masculinity provides a useful lens for understanding these patterns. Dominant masculine norms emphasize strength, autonomy and emotional restraint, framing mental illness as a personal failure rather than a health

condition. As a result, men may delay or avoid seeking help until symptoms become severe. This phenomenon has been observed across diverse cultural contexts, suggesting that masculinity operates as a global yet locally mediated barrier to mental health service utilisation.

In low- and middle-income countries, gendered barriers to mental health care are compounded by structural constraints such as poverty, limited service availability and under-resourced health systems. Patel *et al.* (2018), through the Lancet Commission on Global Mental Health, highlight that while community-based and task-shifted mental health interventions offer promising solutions to service gaps, they do not automatically address gender inequities. Without deliberate attention to gender dynamics, community mental health programmes may inadvertently reproduce existing patterns of exclusion.

Across sub-Saharan Africa, research indicates that men's mental health help-seeking behaviours are shaped by intersections of masculinity, economic roles and social expectations. Studies from Southern Africa show that men's identity as primary economic providers often takes precedence over health-seeking, particularly in contexts characterised by high unemployment and informal labour markets (Andrade *et al.*, 2014). Time poverty and fear of income loss discourage attendance at scheduled community interventions, especially those delivered during standard working hours.

As Sweeney *et al* (2024) point out, stigma remains a central barrier to male participation in mental health interventions across the region. Mental illness is frequently associated with weakness,

spiritual failure, or social deviance, leading men to conceal psychological distress. Fear of being labelled “mentally ill” or perceived as incapable undermines willingness to participate in visible community-based programmes. This stigma is often reinforced by peers, family members and community leaders, creating a social environment that discourages help-seeking.

Within Zimbabwe, mental health service delivery has historically been institutional, urban-centred and heavily reliant on tertiary psychiatric facilities. For decades, services were concentrated at Ingutsheni Central Hospital in Bnlawayo, limiting access for the majority of the population. Recognising these challenges, Zimbabwe has increasingly embraced decentralised and community-based approaches to mental health care. Policy reforms and strategic frameworks have emphasized task-shifting, integration of mental health into primary health care and community participation.

The National Mental Health Strategy (2019-2023) outlines Zimbabwe’s commitment to strengthening community mental health systems through capacity building of lay health workers, integration of mental health into primary care and promotion of psychosocial interventions at community level. The strategy acknowledges the importance of equity and access. However, gender-specific considerations are only implicitly addressed. As a result, practical implementation of gender-responsive mental health programming remains limited.

One of the most prominent community mental health interventions in Zimbabwe is the Friendship Bench programme. Developed to address common mental disorders through

problem-solving therapy delivered by trained lay health workers, the Friendship Bench has demonstrated significant effectiveness in reducing symptoms of depression and anxiety (Chibanda *et al.*, 2016). The programme has been scaled up nationally and internationally, positioning Zimbabwe as a global leader in community mental health innovation.

Despite its success, utilisation data from the Friendship Bench consistently show that women constitute the majority of service users. Chibanda *et al.* (2021) note that men are under-represented, particularly in urban settings such as Harare. Several explanations have been proposed, including men's reluctance to discuss emotional problems in public spaces, discomfort with predominantly female facilitators and perceptions that the intervention is "not designed for men."

Zimbabwean studies examining gendered access to mental health services reinforce these findings. Elliason (2025) reports that men in urban setups often associate mental health services with severe mental illness, institutionalisation and social disgrace. Consequently, men prefer informal coping mechanisms such as alcohol use, withdrawal, or reliance on spiritual explanations rather than engaging with formal or semi-formal mental health services.

Economic factors further constrain male participation. Zimbabwe's prolonged economic challenges have resulted in widespread informal employment, forcing many men to prioritise daily income-generating activities over health care (Kidia *et al.*, 2024). Community mental health interventions that require regular attendance or operate during working hours inadvertently

exclude men whose livelihoods depend on daily presence in informal markets or casual labour. This structural barrier highlights the importance of aligning programme design with men's economic realities.

Programme design and delivery models also influence male engagement. Research suggests that gender-neutral approaches may fail to resonate with men whose help-seeking preferences differ from those of women. Interventions that lack male facilitators, male-focused outreach, or engagement with male-dominated social spaces, such as workplaces, sports clubs and community leadership structures, are less likely to attract sustained male participation.

Policy and funding constraints further shape the landscape of community mental health in Zimbabwe. While mental health is recognised as a public health priority, it remains underfunded relative to other health sectors (Kidia *et al.*, 2017). Limited resources restrict programme expansion, training of male facilitators and development of targeted outreach strategies. Additionally, weak integration between mental health policy and broader gender and social development policies undermines coordinated responses to male mental health needs.

Taken together, the literature highlights that low male participation in community-led mental health interventions is not solely a matter of individual choice but the outcome of intersecting socio-cultural, economic, institutional and policy-level factors. While Zimbabwe has made significant strides in expanding community mental health services, persistent gender disparities underscore the need for deliberate, evidence-based strategies that

address male-specific barriers. This study contributes to the literature by examining these dynamics within the context of Harare and by exploring outcomes associated with male engagement in community mental health interventions.

RESEARCH METHODOLOGY

This study adopted a qualitative-dominant mixed-methods research design to examine barriers to male participation and associated outcomes in community-led mental health interventions in Harare. The mixed-methods approach enabled triangulation of data sources, strengthening the credibility and depth of analysis by combining descriptive quantitative trends with rich qualitative insights.

Data were drawn from three primary sources: (1) programme records from selected community mental health initiatives operating in Harare, (2) semi-structured interviews with male participants and community mental health service providers and (3) purposively selected case studies of community-based psychosocial interventions. Purposive sampling was employed to ensure inclusion of adult men who had either participated in or disengaged from community mental health programmes, as well as key informants involved in programme implementation.

Qualitative data were analyzed thematically following a systematic process of familiarisation, coding, theme development and interpretation. Quantitative programme data were analyzed descriptively to identify participation patterns and trends. Ethical considerations included informed consent, voluntary participation, confidentiality and anonymity. Ethical approval was

obtained through appropriate institutional and community-level procedures.

FINDINGS

Analysis of data reveals four interrelated themes that shape male participation and outcomes in community-led mental health interventions in Harare.

THEME 1: MASCULINITY NORMS AND MENTAL HEALTH STIGMA

Participants consistently identified dominant masculine norms as a major barrier to engagement. Men reported that seeking mental health support was often perceived as a sign of weakness or personal failure. Fear of social judgement and loss of respect within families and communities discouraged men from openly participating in community mental health programmes. This stigma was particularly pronounced in public or semi-public intervention settings.

THEME 2: ECONOMIC PRECARITY AND TIME POVERTY

Economic pressures emerged as a significant structural barrier. Many participants were engaged in informal employment or casual labour, making it difficult to attend scheduled sessions without compromising income. Programmes operating during standard working hours unintentionally excluded men whose livelihoods depended on daily presence in informal markets or workplaces.

THEME 3: PROGRAMME DESIGN AND GENDER RESPONSIVENESS

Programme design characteristics strongly influenced male participation. Interventions that were perceived as gender-neutral

or female-oriented attracted fewer men. In contrast, programmes that incorporated male peer facilitators, flexible scheduling and targeted outreach reported improved male engagement. Case-study evidence indicated that introducing male-focused components resulted in measurable increases in attendance.

THEME 4: PSYCHOSOCIAL OUTCOMES OF MALE ENGAGEMENT

Men who engaged consistently in community mental health interventions reported positive psychosocial outcomes. These included reduced psychological distress, improved emotional regulation, enhanced coping strategies and strengthened family and interpersonal relationships. Participants also reported increased awareness of mental health and reduced reliance on maladaptive coping mechanisms such as substance use.

DISCUSSION

The findings of this study demonstrate that low male participation in community-led mental health interventions is shaped by a complex interaction of socio-cultural, economic and structural factors. Consistent with the Social Role Theory, dominant constructions of masculinity discourage emotional vulnerability and formal help-seeking, positioning mental health engagement as incompatible with masculine identity.

The Health Belief Model provides further explanatory insight, as men perceived the social and economic costs of participation, such as stigma, time loss and income disruption, to outweigh perceived benefits. This imbalance significantly reduced motivation to engage, particularly in interventions that lacked male-specific adaptations.

The Ecological Systems Theory underscores how individual attitudes are embedded within broader social and policy environments. Economic instability, programme accessibility and limited policy integration reinforced barriers at multiple levels. Importantly, the findings also demonstrate that when interventions are adapted to address these barriers through flexible delivery models, male peer facilitation and targeted outreach, male engagement and outcomes improve significantly. These findings align with Zimbabwean and regional literature highlighting the need for gender-responsive mental health programming. However, this study extends existing knowledge by illustrating how structural adaptations can translate into tangible psychosocial benefits for men in community settings.

CONCLUSION

This study concludes that male participation in community-led mental health interventions in Harare is constrained by intersecting socio-cultural, economic and institutional barriers. Masculinity norms, stigma, economic precarity and gender-insensitive programme designs collectively limit men's engagement with community mental health services. Despite these challenges, evidence from empirical data and case studies demonstrates that gender-responsive adaptations significantly enhance male participation and psychosocial outcomes.

RECOMMENDATIONS

Based on the findings, the study recommends the following:

Gender-responsive Programme Design: Community mental health interventions should incorporate male-focused components, including male peer facilitators and tailored outreach strategies.

Flexible Service Delivery: Programmes should adopt flexible scheduling and delivery models that accommodate men engaged in informal employment.

Community Sensitisation: Targeted community education initiatives should address stigma and harmful masculinity norms that discourage help-seeking.

Policy Integration: Mental health policies should explicitly mainstream gender considerations and align with broader social and economic development frameworks.

Sustainable Funding: Increased investment in community mental health services is essential to support programme adaptation, scale-up and sustainability.

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