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Male youth suicide in urban Zimbabwe: Implications for social work

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ABSTRACT

Suicide among male youths is a global public health and societal problem that needs to be addressed by the social work profession. This study explores factors around the recurrence of suicide among male youths in Bindura urban, Zimbabwe, and possible social work interventions. The paper is pertinent as previous studies mostly focused on economic factors. The study adopted a qualitative approach through a descriptive phenomenology design, using semi-structured, in-depth interviews with five male youths aged 17 to 35 who had attempted suicide; it also included seven parents, seven relatives, seven friends of youths who had committed or attempted suicide, four witnesses of youth suicides, and seven professionals. Thematic data analysis was used. Results indicate that failed romantic relationships, socio-economic challenges and evil spirits played central roles leading to male suicide from a human factor perspective. These findings have implications for social work education, practice and research. Social workers must connect male youths with employment, social protection and livelihood programmes to alleviate lost dignity and moral distress linked with economic hardships. The article reaffirms that social workers must engage with belief systems and work with families, traditional leaders and religious actors to question fatalistic understandings of distress. Spirituality-informed community teaching could provide effective intervention. The study recommends that social work curricula be strengthened with culturally and spiritually-based theory.

Keywords: human factor; male youth; mental health; suicide; urban Zimbabwe

INTRODUCTION

Suicide is a community, family and individual social and public health issue worldwide (World Health Organization [WHO], 2021a). On the global level, it is described as death as a result of self-inflicted homicidal/self-harmful action to end life (National Institute of Mental Health, n/d; WHO, 2025a). This implies that suicide is intentional and self-inflicted, as a conscious, deliberate and voluntary action whereby one takes one's own life (WHO, 2025a; Kerkhof, 1994). Smith et al. (2020) indicate that suicide accounts for 1.4% of all deaths in the world, and it was the third leading cause of death among 15- to 29-year-olds in the world in 2021. Suicide Collaborators (2025) point out that these deaths included about 519,000 male deaths. This study explored the issues around the suicide cases amongst male youths in Bindura town in Zimbabwe and proffers possible social work interventions. The study adopts the human factor perspective as a theoretical lens that explains human behaviour through the interconnected dimensions of social relationships, agency, spiritual beliefs and cultural values (Adjibolosoo et al., 2020; Mararike, 1998). It does not posit biological or inherent differences between human groups; rather, it highlights that human experiences are contextually situated and must be understood within the specific cultural and social frameworks that give them meaning (Adjibolosoo, 1998). The article is arranged as follows: an introduction and background to the study; theoretical literature review and research methods; a discussion of the research results and implications of the findings.

BACKGROUND

Globally, suicide trends in the last decade were characterised by a complicated picture of the long-term decline in age-standardised suicide rates compared with disastrous growth rates in certain regions and in some groups of people. Although overall global mortality related to suicide fell to about 717,000 (as compared to 762,000 in 2000), there are a considerable number of deaths linked to suicide that can be attributed to the differences and variations in regions that are worth investigating (WHO, 2021c, 2025b). The age-standardised mortality rate has declined over time, from 14.9 deaths per 100,000 population in 1990 to 9.0 per 100,000 in 2021 (Suicide Collaborators, 2025). Notably, men continue to die by suicide at rates over twice as high as those for women globally (12.3 males versus 5.6 females per 100,000 people), with the gender gap particularly pronounced in high-income countries (National Institute of Mental Health, n/d; Centres for Disease Control and Prevention, 2025). The WHO (2025b) reveals that suicide is the third leading cause of death among young men who are between the ages of 15 and 29 years. Garnett et al. (2022) add that the rates of male suicide among young people between the ages of 10 and 19 rose during the years 1999 to 2020 (from 7.4 to 9.7 per 100,000 population). While women in middle adolescence to emerging adulthood (ages 15-24) have suicidal ideation and attempt suicide at higher rates, males in this age group more commonly die by suicide.

According to the Centres for Disease Control and Prevention (2025), the trend of suicide rates going up until 2021 was observed in the younger generation in the global population. In South America, from 1990 to 2009, the rates rose by 56 and 43 per cent among males and females aged

15-19, respectively, and in Japan the rates were 37 and 63 per cent, respectively (WHO, 2022; National Institute of Mental Health, n/d; American Centres for Disease Control and Prevention, 2025). This information reflects a major gender and age imbalance, with higher suicide rates more prevalent among men globally (National Institute of Mental Health, n/d; American Centres for Disease Control and Prevention, 2025). According to Sareen et al. (2005), suicide is mostly prevalent among male youths who experience long-term emotional issues, including depression, among others. Tasfi and Mostofa (2024) also identify poor relationships and alcohol and drug issues as contributory causes of suicide, as well as unemployment, loneliness, guilt and related problems. The Centres for Disease Control and Prevention (2025) identify suicide risk factors at individual (such as depression, substance use and hopelessness), relationship, community and societal levels, which are in turn influenced by cultural and environmental factors. The WHO (2025a) further indicates that many male youth suicide cases occur impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship disputes, or chronic pain and illness. In addition, experiencing conflict, disaster, violence, abuse or loss and a sense of isolation are strongly associated with suicidal behaviour among male youths (WHO, 2021c, 2025a). Suicide rates are also high among vulnerable groups who experience discrimination, such as migrant male youths and gays (Naghavi, 2019; WHO, 2025a). The situation of males with respect to suicide is also worsened because they are more difficult to reach psychologically and emotionally for suicide prevention interventions, and warning signs and deterioration in mental health are often not recognised by those in their environments (Hofmann & Wagner, 2023). Many men express their distress before suicide through externalising symptoms such as aggressiveness, antisocial and risk-taking behaviour, irritability and increased addictive behaviour (Hofmann & Wagner, 2023).

Generally, the literature reveals a gender paradox regarding suicidal behaviour among men and women in the world (Shelef, 2021). Hofmann and Wagner (2023) found that women attempt suicide more often than men, but men die by suicide more often. This is explained by men's tendency to avoid sharing their distress and, consequently, often do not receive adequate support from their social or professional environment (Hofmann & Wagner, 2023). Men also evince a significantly lower willingness to make use of support services than women, although the number of men who seek professional support in crises has risen in recent years (Richardson et al., 2021). In addition, men use alcohol or other drugs for self-medication significantly more often than women do (Kolves et al., 2020). Acute intoxication promotes disinhibition effects and reduces impulse control, which in turn facilitates suicidal behaviour among male youths (Kolves et al., 2020). At the same time, however, there are global efforts to address suicidal behaviour by the World Health Organization (WHO) and the International Association for Suicide Prevention (IASP) that focus on multisector public health approaches (WHO, 2025). With an estimated 727,000 to 800,000 people dying by suicide annually, the focus is on implementing evidence-based interventions to reach the UN Sustainable Development Goal 3.4.2 of reducing the global suicide rate by one third by 2030 (Pirkis et al., 2024). However, Babajani et al. (2024) argues that

suicide-related situations for men remain dire, despite global efforts to address the issue, with an increased rate detected in low- and middle-income countries, such as many African countries.

According to the WHO (2022), the rate of suicide in Africa is 11 per 100,000 compared to the world average of 9/100,000. As Ndosi (2006) notes, in Africa a suicidal act entails wishing to kill, wishing to be killed and/or wishing to die. African men are specifically vulnerable, with 18 cases of suicide per 100 000, which is high compared to the global average of 12.2 in males (Oyetunji et al., 2021). This aligns with the findings of the International Association for Suicide Prevention (2025), which notes that the majority of suicides took place in low- and middle-income countries (LMICs), which are mostly in Africa. The mortality rates as a result of suicide on the African continent in 2021 were as follows: in southern Sub-Saharan Africa, 16 out of 100,000, and in central Sub-Saharan Africa, 14 out of 100,000 (Suicide Collaborators, 2025). The average age of the people who committed suicide gradually became higher. In males, the average age at suicide death was 43.0 years in 1990 and 47.0 years in 2021; in the case of females, it was 41.9 years in 1990 and 46.9 years in 2021 (Suicide Collaborators, 2025). Furthermore, the African region had the highest prevalence of male suicides (18.4 per 100,000), as opposed to the estimated 5.2 per 100,000 among females (WHO, 2022; International Association for Suicide Prevention, 2025). It is also necessary to mention that the African suicide rate was the highest in the world in 2019; the estimated rate was 11.2 per 100,000 people, in comparison with the global average of 9.0 per 100,000 people (WHO, 2021b).

The highest suicide rate in Sub-Saharan Africa was in Lesotho at 72.4 suicides per 100,000 people between 2000 and 2019, followed by Swaziland (29.4), South Africa (23.5) – where South African men are four times more likely to die by suicide than women (Ahluwalia, 2025) – Botswana (16.1), Zimbabwe (14.1) and Kenya (6.1) (Mwangi & Armbruster, 2023). The WHO (2021d) indicates that 87.5 people per 100,000 of the population commit suicide in Lesotho, ten times the global average of 9/100,000 in 2024. Suicide is among the leading causes of death among young people (ages 15-29) in South Africa, and men account for around 80% of suicides in South Africa. While these statistics are startling, they are likely to be underestimates, and the reality may present a more sombre scenario because of many factors, such as internalisation of cultural norms and suicide taboos in many indigenous African cultures that lead to underreporting of suicide deaths. In terms of methods, hanging and pesticide poisoning are the most frequently used in Africa (Mars et al., 2014). However, males outnumber females in violent methods of self-destruction (Ndosi, 2006). Culturally, African men are expected to display a stiffer resolve in difficult life situations. They show greater intent in their suicidal acts, which typically involve hanging, slashing or stabbing and gunshots, whereas females predominantly opt for poisoning.

The literature shows that in Africa, suicide cases are most common among male youths and stem from social factors that are experienced as overwhelming (Jegede et al., 2024; Ndosi, 2006). This is exacerbated by pervasive poverty, which exerts pressure on males who culturally need to express strong masculinity and are socialised to be breadwinners despite harsh economic hardships

(Ezeugwu & Ojedokun, 2020). Suicidal ideation is also linked to underlying psychiatric disorders and lack of dependable social support, which leads to loneliness (Mokhwelepa & Sumbane, 2025). Men with disabilities in Nigeria often also cite financial hardship, family pressures and lack of accessible healthcare as reasons for suicidal planning and behaviours (Ibrahim, 2025), whereas a study conducted in eThekwini municipality, KwaZulu-Natal, South Africa found that male participants who struggle with experiences of persistent poverty and who experience violence often experience suicide ideation and resort to committing suicide (Mkhwanazi et al., 2025). Mars et al. (2014) highlight that in Africa the risk factors are similar for suicide and suicide attempts, and include interpersonal difficulties, mental and physical health problems, socioeconomic problems, and drug and alcohol use/abuse. The literature shows that in Lesotho, mostly male youths commit suicide in response to situations such as rape, unemployment, loss due to the death of people they value, and abuse of drugs and alcohol (Raphoka, 2024). However, the quality of suicide data is poor in Africa and, in the worst circumstances, unavailable (Mars et al., 2014). Therefore, available statistics are likely to underestimate the true magnitude and drivers of the problem, as religious and cultural sanctions may lead to suicide being under-reported, misclassified, left unexplained or deliberately concealed (Mars et al., 2014). Additionally, the situation in Africa is made direr as a result of poor public health provision and promotion. For example, in 2020, Africa spent less than $1 per capita on mental health, while European countries spent $46.49. Moreover, Africa averages 1.4 mental health workers per 100,000 people compared to the global average of 9/100,000 (Nicholas et al., 2022). This situation is aggravated by critical shortages of psychiatrists and community outpatient facilities. This means that few Africans can access the necessary treatment. For example, in Tanzania, the country has 1.31 mental health workers per 100,000 people, including 38 psychiatrists, 495 mental health nurses, 17 psychologists and 29 social workers for its 65.5 million population. Neighbouring Uganda faces a similar situation, with 2.57 mental health workers per 100,000 people, including just 42 psychiatrists. Kenya fares slightly better with 15.32 mental health workers per 100,000, including 115 psychiatrists and 6,493 psychologists (Oyetunji et al., 2021).

Several initiatives have been launched in the African context to address suicide. These include regional networks and coalitions such as the Africa Suicide Prevention Association (ASPA), which incorporates over 1,000 members and 80 organisations from around 39 countries, and the African Project Against Suicide (APAS) in the South African context. This raises awareness and provides support services and training. There is also the African Centre for Suicide Prevention and Research (ACSPR), which reciprocally seeks to address the hidden burden of suicide through research, the establishment of prevention strategies and awareness-raising (IASP, 2025; Kaggwa et al., 2022). The Friendship Bench Initiative has also been addressing mental health issues, including suicidal ideation, and operates from Zimbabwe and other African countries such as Tanzania, providing mental health community-based support and training of workers to provide cognitive behavioural therapy. Kenya has also developed its National Suicide Prevention Strategy (2021–2026),

emphasising youth participation, access to care, community engagement and multisectoral collaboration to address suicide.

In the Zimbabwean context, the suicide mortality rate (per 100,000 population) was reported at 17.34 in 2021 (World Bank Group, 2026). In 2020, suicide deaths in Zimbabwe reached 2,069 or 1.91% of total deaths, placing the country at the 34th highest suicide rate worldwide and 5th in Africa (World Life Expectancy, 2020). In 2018, Zimbabwe's suicide rate was 16.11 per 100,000, a 6.55% increase from 2017. This further declined by 1.68% to 15.84 in 2019 (Macrotrends, 2026). This further declined by 2.08% to 15.51 in 2020 and later rose to 17.24 in 2021 (Macrotrends, 2026). It is worth noting that in 2021, the male suicide rate (23.57) was more than double that of women's rate of 11.71. Between 2015 and 2019, the Zimbabwe Republic Police reported 2,058 male and 505 female suicides (Ibrahim, 2025). The increase in young adult male suicide behaviour has been linked to the strength of traditional masculine ideologies. However, White and Hungwe (2024) have found that disintegrated family and romantic relationships, economic frustrations, loneliness, academic failure, drug abuse, pressure to conform and stigma resulting from not conforming are important causes of male youth suicides in Zimbabwe. Mhlanga and Chidarikire (2025) have established that there is a growing trend of high rates of student suicides in Zimbabwe. This is compounded by the volatile socio-economic and political climate, which presents challenging dynamics that are catastrophic for young adult male university students as they struggle to conform to the masculine ideologies and gender norms (Mhlanga & Chidarikire, 2025). This is complicated by poor mental health provisions, poor male health-seeking behaviours, youth poverty and a collapsed health system (Biri, 2024). The literature shows that in the Zimbabwean context, suicide rates are higher among youths who use drugs and abuse alcohol (ActionAid, 2023; Gwarisa, 2023; Saruchera & Chidarikire, 2025). Apart from that, suicidal ideation also seems to intensify when male youths continue to feel they are not 'man enough' as they feel their behaviour becomes increasingly incongruent with the perceived ideal masculine and gender norms.

However, these authors do not interrogate further the male dimension in the context of masculine ideologies and the spiritual aspects of mental health. Hence, there is a dearth of scholarship on male youths' suicide cases in urban environments of Zimbabwe from an Afrocentric human factor perspective. This research gap justifies the consideration of Bindura town as the research site for the generation of new knowledge and to establish the nuances of the suicide cases among male youths. The study acknowledges research by the World Bank Group (2026) and the World Life Expectancy (2020), which shows the high mortality rate because of suicide in Zimbabwe to be at 17.34%, the 5th highest rate in Africa, but this does not adequately address the gendered data sets; hence, this study focuses on male youths in the context of a volatile socio-economic urban environment. Mhlanga and Chidarikire (2025) do not fully elucidate the rural-urban variations in suicide; this study therefore attempts to fill the gap as well as build on prior research to produce a more nuanced body of knowledge. The research further attempts to fill another gap by positioning social work in practices that address suicide from a human factor perspective, which can be best attuned to explain aspects of suicide from a cultural and spiritual perspective. The study therefore

adds to the body of knowledge on the drivers of suicide among male youths and proffers possible evidence-based social work interventions.

THEORETICAL PERSPECTIVES ON SUICIDE

Yöyen and Keleş (2024) point out that several theories account for the phenomenon of suicide, including biological, psychodynamic, cognitive-behavioural and developmental systemic approaches. Biological explanations mainly imply that suicidal acts occur as a result of a combination of predispositions that have a biological basis (Mann, 2003). The biological point of view considers suicide to be linked to the impaired functioning of the brain's noradrenergic system (Arango et al., 1993; De Luca et al., 2005; Mann, 2003). The psychodynamic viewpoint regards suicidal behaviour as an outcome of such inner processes as unconscious drives, the individual being overwhelmed by emotions, and the need to escape from intense psychological pain, which are all inner workings of the mind (Menninger, 2007). Cognitive-behavioural theories posit causal roles for hopelessness, the suicidal cognitive mode, autobiographical memory deficits and perceptions of entrapment, and emotional dysregulation. Developmental/systems theories indicate that causal factors stem from disturbed social forces (Durkheim, 1966; Jones, 1987) as well as family systems. Whilst each of these theories helps to explain the suicide landscape, our understanding, after reflecting on these mainstream theories, is that suicide ought to be looked at within a contemporary context, taking into account the local knowledge systems and worldview of the people, since environments are fluid and changeable. As such, we argue that the best theory to explain suicide cases in Bindura town is the human factor perspective, which views the act of suicide through the lenses of collectivism, spirituality, cultural sensitivity and positive self-evaluations (Wang et al., 2013). Tied to this notion is the role of the classic Africanist expression of 'A person is a person through other persons' and 'I am because we are' that is central to what has come to be known as the *ubuntu* philosophy. It considers suicide as a deep disruption of the sacred communal order and a total rejection and violation of the sanctity of life and the interconnectedness of human existence.

The human factor theory was propounded on the basis of works of Kwame Ajibolosoo. He coined the term to address the pervasive failure of growth or development projects in the political, economic and social institutions in the African context. Its central proposition is that the lack of the necessary personal integrity, positive attitudes and moral principles constitutes a human factor deficiency and is the main reason for destructive behaviour (Adjibolosoo, 2004). The human factor theory accounts for the recurrent failure of traditional development models. It posits that such failures stem largely from the neglect of the human element – that is, the people operating these systems often lack essential qualities such as honesty, dedication, and responsibility. Addressing this human factor deficiency is therefore critical to ensuring success. When applying the human factor perspective to suicide, we argue that suicidal behaviour among male youths arises when there is a breakdown in the very qualities that sustain human functioning – namely values, purpose, dignity and social belonging. This breakdown, which we refer to as *human factor decay*,

diminishes an individual's resilience and sense of meaning, ultimately increasing vulnerability to suicide. All such decay is an outcome of cultural, spiritual and institutional breakdown (Ikome, 2003; Mararike, 1998). Under normal circumstances, the norms, values and ideals of society hold society together and guide human and individual behaviour, which is rooted in the principles of *ubuntu*. Human capabilities for the management of problems reside within the community; thus, individual, group and community development begins and ends with the people, implying that the quality of the personalities and the characters of members matter. It follows that human beings need to develop competencies, nurture talent and cultivate spiritual capital, moral capital, aesthetic capital and the necessary skills for them to function effectively. However, when an individual fails to live up to the challenges and fails to utilise the community-based problem-solving capabilities, he or she slides into what Adjibolosoo (2004) calls severe human factor decay, in which suicide becomes part of the negative behaviours. Therefore, the human factor perspective is best attuned to explain the behaviour of male youths in the Bindura urban environment who eventually take their own lives.

RESEARCH QUESTIONS

1. What is causing male youth suicides in Bindura Urban?
2. How can social work intervene to address suicide among male youths?

METHODS AND MATERIALS

Research approach and paradigm

Guided by a constructivist paradigm, the study utilised a qualitative research approach through a descriptive phenomenological design. The research paradigm, approach and design focused on exploring and understanding the meaning that the research participants themselves gave to the issue of suicide among male youths in Bindura (Creswell & Creswell, 2018). The researchers used bracketing to eliminate and set aside their own biases, assumptions and preconceptions about suicide, to ensure that participants' own meanings and interpretations take precedence (Creswell & Creswell, 2018; Holloway & Galvin, 2016). The deployment of a descriptive phenomenological strategy of inquiry augmented a shift of the study's focus from measuring suicide as an objective phenomenon towards understanding the essence of male youths' lived experiences of it. This gave research participants room to wholly articulate their experiences, feelings, and attitudes towards suicide in their own terms. This methodology also shaped researchers' commitment to treating research participants' subjective accounts as trustworthy and legitimate basis critical for understanding the suicide phenomenon. Consequently, this augmented researcher's focus on identifying rich, descriptive themes that reveal the essence of participants' experiences across individuals.

Research team and reflexivity

The research was undertaken by two social scientists: a registered social worker and a sociologist with experience in social services and social protection in both government and non-governmental

settings. The researchers' Christian background, whose values are opposed to the act of suicide, is explicitly declared. Moreover, despite a limited practical background in dealing with suicide-related behaviour, the experience they gained during fieldwork shaped their appreciation of suicide-related realities and sustained their professional approach. The researchers were affiliated with two different universities in the study area, Bindura town, and they capitalised on the social worker's exposure as a volunteer to dealing with families that had experienced suicide cases. To avoid a conflict of interest, it was the sociologist who interviewed the participants from families who were already familiar to the social worker.

Study setting

This research was conducted in the Bindura Urban Area, located about 90 km north-east of Harare, the capital city of Zimbabwe, and is the capital town of Mashonaland Central Province, where most of the population is between the ages of 19 and 35 (Zimbabwe Statistics Agency [Zimstat], 2022). Conversations with key informants showed that the community was served by one drug and substance use referral centre in Chipadze Suburb. This centre was established by the government against the backdrop of an increase and surge in the number of youths who use drugs and other substances such as crystal meth, popularly known locally as *mutoriro.* According to Zimstat (2022), Bindura Urban has a total population of 51,394, with 24,615 males and 26,779 females. Bindura town's lifeline is dependent on mining, both formal and informal, which explains the influx of artisanal miners and risk behaviours. The town is served by two universities, which explains the high number of young people. The youth category therefore included artisanal miners, informal traders, university students and other unemployed people. Our field engagements showed that unemployed youths and those in informal activities usually resort to excessive drinking and smoking marijuana, and we noted that this was linked to mental health issues and suicide cases. Other economic activities include farming underpinned by the favourable ecological conditions that support the growing of crops such as maize, tobacco and legumes. Most of the youths are not formally employed, and those not in farming and mining engage in informal trading in the town's central business district and high-density suburbs of Chipadze and Chiwaridzo. Mostly male youths usually resort to driving informal transport operations (*mushikashika*) to earn a living. The setting was chosen for this study because it has been witnessing an increase in suicide cases over the past 5 years, even though this has not been explicitly documented. Also, Bindura houses and serves people from urban and surrounding rural communities as the capital town of Mashonaland Central, which records the highest number of suicides, according to the latest National Peace and Reconciliation Commission (NPRC) report, with 35 cases reported in 2021 and 53 in 2022 (Buwerimwe, 2023). The researchers assumed that accounts from the participants in the capital town would shed light on ways to offer interventions for the entire province. Proximity was also a factor, with the researchers working at universities in the study area. The researchers believed that phenomenological inquiries require closer personal engagement with participants to devote attention to detail; since the topic is also sensitive, the researchers wanted to choose the local community to augment rapport building and explore in greater depth without rushing matters. This

approach, the researchers believed, could offer a more robust and credible account of the facts related to the phenomenon of increasing suicides.

Target population

Male youths between the ages of 17 and 35 years who attempted suicide, parents/guardians, relatives, witnesses of suicide cases and close friends of those who committed or attempted suicide were targeted for this study. The researchers focused on male youths (17-35 years) because, in the context of Mashonaland Central where the study was undertaken, the NPRC indicated that they are part of the most affected groups in terms of committing and attempting suicide (Buwerimwe, 2023; Dzinesa, 2022). Additionally, the researchers believed that choosing this age group would provide experience-based information to capture the real gist of the problem from those who experienced it. This choice was also justified by the need for targeted prevention strategies based on age-specific risk factors, behaviours and help-seeking patterns. Parents/guardians, relatives, witnesses of suicide cases and close friends of those who committed or attempted suicide were also targeted because they could give an account of what transpired based on their closeness to the victims (Pitman et al., 2017; Sanford et al., 2023). Furthermore, these parties' involvement was justified because there was a need to understand familial, environmental or genetic factors associated with suicidal behaviours for the development of effective intervention strategies. Moreover, these groups also provided crucial information about the family environment, which can be a significant risk or protective factor. This also enhanced comprehension of family dynamics and communication patterns, and how these aspects would have contributed to the suicidal crisis. The researchers also believed that involving the family and close acquaintances would augment or inform an understanding of how to better involve the family in treatment plans and interventions, and strengthen the support for individuals at risk. It also helped the researchers to assess the impact of suicide and associated bereavement, as well as to ascertain ways to proffer support.

In addition to the above, the researchers targeted social workers from the Department of Social Development (DSD), professionals providing suicide-related services, i.e. Zimbabwe Republic Police (ZRP), Bindura Provincial Hospital, non-governmental organisations, and the local Council of Churches personnel. These were considered key informants based on their knowledge of suicide-related events and their particular roles in prevention, intervention and support. In this case, the DSD is strongly involved in policy and welfare, the ZRP in crisis response, the Hospital for clinical care, NGOs for specialised support and community outreach, and the churches are approached for spiritual and community resilience building, as well as fostering a comprehensive and multisectoral approach to deal with suicide. Therefore, their involvement is premised on their roles and knowledge in the Zimbabwean context.

Sampling strategies

The researchers adopted several sampling techniques to select participants from the above targeted population. The researchers knew that suicide is a sensitive and emotional topic, and sometimes concealed in some households, as well as being viewed as taboo in Mashonaland Central. Therefore, they initially used volunteer sampling. Strydom (2021) argues that this sampling technique is used when participants are readily available and volunteer to participate in the study. It is also used when participants are known to one another, and often also known to the researcher, and can easily persuade others to participate (Strydom, 2021). One of the researchers, the social worker, was aware of and familiar with two affected families (lost one youth each in 2023). He managed to reach out to the family members who voluntarily consented to participate in the study. In these families, the researchers managed to interview two male parents of the deceased. The researchers then adopted snowball sampling and were referred to another four families that had experienced suicide cases, securing an additional five parents/guardians.

Using the same snowball sampling technique, the researchers managed to reach out to seven relatives, seven friends of the deceased and four witnesses of suicide cases based on referrals from the families that lost their loved ones through suicide. Snowballing was ideal because it allowed access to hard-to-reach affected populations or families, as the issue under study is sensitive and kept hidden because of certain cultural taboos and beliefs.

Additionally, the researchers, using availability sampling, managed to reach out to five youths who had attempted suicide. Availability sampling was ideal because these five youths were readily available and receiving clinical support from a local organisation supporting affected families. In terms of inclusion and exclusion criteria, the researchers included parents or guardians who lost their sons while residing in Bindura. The deceased was a resident of the Bindura community. Moreover, interviewed relatives and close acquaintances were considered in the study only after confirmation that they were really related to the families of the deceased.

Of the above 30 participants, 18 were male, and 12 were female. Except for the first two male parents and three friends of the deceased, whose interviews lasted for an average of 35 minutes, all other participants managed to fully share their experiences regarding the tragic losses for more than an hour. The first male interviewed did not manage to give an exhaustive account of what transpired, but referred the researchers to their relatives. The researchers respected their rights. Some friends were overwhelmed in some instances, and the researchers would stop and later continue depending on their desire to speak about their experiences and loss. The researchers were not worried about data saturation initially because of the phenomenological nature of the study. The critical issue in phenomenological studies is to ascertain the real, in-depth essence of the experiences, not a large number of cases. However, guided by the principle of data saturation as espoused by Saunders et al. (2018), the researchers found that the above-mentioned number of participants proved to be adequate for the research purposes.

Researchers then purposively selected four social workers – three from the DSD, one from a local organisation – and three representatives, i.e. one from each relevant institution (the Council of Churches, Bindura Hospital and the police). Of these seven key informants, three were male, and four were female. All these representatives had an average of 7 years of working experience in Bindura and were well informed about suicide cases. These numbers were based on availability, and researchers believed that they sufficed for the purposes of a phenomenological study, which is more concerned with depth of information rather than high numbers. All professionals were considered for the study only if they had worked with suicide-affected families or individuals, or handled a suicide case in Bindura. They were expected to have lived in Bindura for at least two years.

Data collection methods and tools

The researchers collected narrative data from all participants using in-depth, semi-structured interviews (Rubin & Babbie, 2017). The researchers adopted this data-collection technique because it enabled them to build rapport with the participants and key informants (Rubin & Babbie, 2017). Additionally, their non-directive manner augmented the capturing of participants' rich, subjective and lived experiences from their own perspective without interjection or imposition of the researchers' perspectives.

The interviews were guided by semi-structured in-depth interview guides that had probing questions related to the two main study questions. The interviews' semi-structured nature allowed for flexibility and adaptability, opening the possibility for further probing where necessary to elicit more detailed views and responses (Creswell & Creswell, 2018). All interviews were recorded using Android voice recording software for later transcription.

Data processing and analysis

Data analysis started concurrently with the commencement of fieldwork. Themes were identified as the research progressed; hence, the detailed responses were subject to thematic analysis in line with the descriptive phenomenology as described by Sundler et al. (2019). The audio recordings were transcribed during the period of field visits, when the recordings in Shona (the local language) were translated into English. The process started with verbatim transcriptions into English, which were then sorted into sub-themes and eventually into broader themes. The process then followed Broome's (2011) guide to the five steps for phenomenological analysis:

(1) Bracketing or assuming the phenomenological attitude;

(2) Reading all the written accounts of the participants' responses to make sense of the data;

(3) Delineating meaning units;

(4) Transforming the meaning units (themes) into statements of lived-meanings; and

(5) Synthesising a general structure of experiences based on the constituents of each experience.

The researchers constructed descriptive themes by first individually formulating different meaning units, which were then merged, ensuring that the narratives attached to each thematic heading captured the 'lived experiences' of participants and remained descriptive in nature.

We made our assumptions and orientations clear, and used a deductive approach, which directed us toward a classic semantic coding technique as we focused on participants' submissions in line with their experiences. In accordance with the phenomenological approach, we were also guided by analysis of more latent meanings as we attempted to understand some of the assumptions and meanings behind the findings (Broome, 2011).

Techniques to enhance the trustworthiness of the study

The researchers followed well-established qualitative methodological approaches to augment the study's credibility. The researchers triangulated data sources to interpret the experiences associated with suicidal behaviour. Interviewing those who attempted suicide themselves, as well as the parents and close acquaintances of the deceased and those who attempted suicide, enhanced the credibility and dependability of the data, as confirmed by those who experienced the crisis. This also enhanced the confirmability of the data, as several parties gave an account of a particular case. The data analysis was done by both researchers, and all the themes were also agreed upon by both. After the collection and analysis of data, the locally-based social worker managed to contact the representatives from all families to share with them what the study had established. This member checking exercise confirmed the data, and some clarified in more detail what they meant by their accounts. Member checking was ideal for the study because phenomenological studies value experiences based on the individuals who experienced the issue directly. Additionally, all the procedures which were followed in the study were made clear.

Ethical issues

To prevent the relapse of participants into grief or from being overwhelmed, one of the researchers, a qualified and registered social worker, helped with on-the-spot counselling for cases of bereavement. This was done for some participants who were willing to give an account of their issues, but were overwhelmed by the emotions of bereavement. The researchers provided support and would stop the interview until the participant felt ready to continue with the conversation. In some cases, some participants withdrew even before explaining in more detail, and we respected their right to do so and explicitly gave them the freedom to withdraw voluntarily. The research team also referred some participants to a local organisation providing counselling and continued support for families affected by suicide.

This issue of voluntary participation was also clarified when we sought informed consent from the participants. Every aspect and dimension of the research which was deemed necessary was explained. The study upheld the principle of confidentiality, as only the researchers had passwords to encrypted folders with information, and no names were attached to the data sets to protect anonymity. We prioritised protecting the identities and experiences of participants, particularly

given the sensitive nature of the subject. A non-judgmental attitude, acceptance, empathy and good communication skills also helped the researchers during the interviews and enabled participants to share their stories openly and genuinely. We obtained ethics approval from Bindura University of Science Education, Department of Social Work. We adhered to several ethical considerations, including informed consent, debriefing, privacy, confidentiality and anonymity, as emphasised in the Helsinki Declaration of 1968 (Carlson et al., 2004).

RESULTS

The findings of this study are presented under two headings, as guided by the research questions: causes of male youth suicides and social work interventions to address suicide among male youths. Themes are then presented under these two headings.

Causes of male youth suicide

From participants' responses, the study established fractured and failed love relationships, socio-economic demands and evil spirits. These factors are presented, interpreted and discussed below.

Failed romantic relationships

The study indicates that the breakdown of romantic relationships contributes significantly to suicidal behaviour among male youths. One of the participants said:

> *Couples are adulterous and no longer sensitive to each other's feelings. My nephew failed to accept his wife's messy behaviour, having sex with another man, imagine. It was difficult for him to forgive and live with such a disgrace; knowing that his wife was sleeping around with another man was difficult for him to accept. He wrote it in the suicide note.* (Participant 13, relative of the deceased).

This response was confirmed by Participant 15:

> *If your wife is 'having an intimate affair' with another man, it is interpreted by society as a failure of the husband to satisfy his wife by society. It reduces the dignity of a man. My brother caught his wife red-handed, with pants down and killed himself.*

Participant 16 said:

> *His wife retaliated when she caught my nephew* [deceased husband] *having 'intimacy with another woman', sexual intercourse with a certain lady, and she started having a sexual affair with X* [pseudonym]. *My nephew was ashamed and guilty, considering that the whole community was informed about his adulterous incident, and worse, he was a respected person. He stated on that paper* [suicide note] *you saw."*

Participant 19, a friend of the deceased, said:

> *He was told by his wife that the children were not his after more than 25 years. When his son wanted to marry, the wife was boastful and insisted that she could secure better sex from other men whenever she liked it. The wife became irritable and verbally abusive. It was degrading, and after all the sacrifices, he could cry. He attempted to hang himself until he sneaked* [away] *and drank tobacco herbicides.*

Key informant 5 said:

> *It's about failed marriages and infidelity on both men and women. Marriage is no longer significant to many, unlike long ago when women used to be victims, but now they are striking back too when they find out that their husbands are being adulterous, yet men are failing to accept it. That's why they try to kill their promiscuous wives and lovers, and when they fail to do so, they kill themselves. They fear being judged as weak.*

The above sentiments pointed to a perceived erosion of moral principles within relationships, what one described as a "human factor deficiency" – now weaponised and used as a tool to inflict pain on partners, as evidenced by retaliatory tendencies among couples. This can also be reflective of the death or breakdown of the traditional family institution or marriage, which has been historically understood as the haven of consolation and rebuilding broken relationships. Loss of life under such circumstances also indicates the disappearance of indigenous marital dispute-resolution mechanisms. Retaliation and weaponisation of immoral behaviour, and consequently the decision to commit suicide, mirror poor moral judgment. Instead of seeking resolution, couples resort to actions that destroy their dignity. This finding also reflects interpersonal breakdown, limited emotional agency and self-worth crises. In the African context, young men acquire their identity validation and recognition in establishing stable romantic relations, but when such relations collapse, the consequence is emotional distress, which can overwhelm coping mechanisms, showing weakened human emotional resilience and problem-solving capacity. Suicide, therefore, can be a product of rejection or of a guilty conscience.

Socio-economic challenges

The study participants indicated that men are under pressure as a result of the current socio-economic decline. Participant 15, a relative of the deceased, said:

> *Given the levels of poverty, as women, we know that the father is the head and provider for the family. My brother was depressed and stressed after retrenchment in May 2023, and he started struggling to support the family. We tried to support him, but he continued to blame himself and decided to take his life.*

One of the participants also said:

> *The situation was worsened when the deceased started having in-house issues with his wife, who started disrespecting him when he was retrenched. She started discussing her husband with her friends that he was failing to pay rentals and school fees. So, it was tough for him, and I knew it would happen; he also once told me.* (Participant 20, friend of the deceased)

A relative of the deceased said:

> *The economy is not friendly for male youths. They are supposed to assume responsibilities to cater to their families, yet there is no employment. It's tough for them to be labelled lazy by their parents or society and remain in the same household. In the end, they choose death.* (Participant 15)

One of the participants said:

> *He failed to pay back the money he borrowed from a small financial firm. We heard that he borrowed from his neighbours trying to pay for his daughter's tuition, who is at the university, and he was failing to pay it back. So, he decided to kill himself by drinking poison.* (Participant 21, friend of the deceased)

Another participant said:

> *He borrowed chimbadzo* [an informal loan] *to pay for his son's health bill and several kids' fees and used his house as collateral, later on, he failed to pay back and he then hanged himself the very day when debt collectors were supposed to confiscate the house, so he told his wife that he would like to 'leave' so that the house could not be taken. She didn't know that by leaving, he meant suicide.* (Participant 27, witness).

The significance of the above sentiments and responses was confirmed by professionals who stated that:

> *Men are socialised to be the providers, and when they fail to fulfil this role due to economic hardships, they often blame themselves. Self-blame can spiral into a deep sense of worthlessness, especially when one's spouse expresses disappointment or frustration. They then engage in risky market transactions, which they escape through suicide.* (Key Informant 7, police officer).

Key informant 2, a social worker, said they adopt a broad perspective and indicated that:

> *The economy is tough for men who have roles and responsibilities, they face immense pressure from their families to meet developmental milestones, such as securing a job and when they fail, they feel they have no place in society, leading to a sense of irrelevance; parents are becoming insensitive for their children, whom they continuously take care of;*

> *they sometimes demand more from these jobless young adults who end up committing suicide.*

The above sentiments not only mirror material deficiencies, but threats to human dignity, masculinity and responsibility. African communities expect young men to fulfil a fatherly or provider role. Failure to meet these economic demands leads youths to experience moral distress and is perceived as personal failure. This erodes confidence among male youths in their ability to act meaningfully, leading them to make poor judgment calls. Suicide, therefore, reflects a form of human agency under conditions of a protracted socio-economic downturn. Male youths resorting to informal and illegal dealings as substitutes for formal and gainful employment reflects the failure of policy and institutional frameworks, which should be providing an enabling environment for the youths to participate gainfully in the economy. Additionally, parental pressure is also reflective of the insensitivity of African parents and the deep-rooted belief in intergenerational reciprocity, which ignores the realities affecting male youths who fail to live up to certain developmental milestones through no fault of their own.

Evil spirits

The study found that some suicide cases are believed to be manifestations of, and driven by, evil spirits. Participants had the following to say:

> *If we trace history in our family, he is not the first one to have committed suicide; my brother in the extended family also killed himself last year. We consulted the spirit mediums and realised that it's a spirit within the family that needs cleansing. It's not about his dispute with his wife; we have our family issues, and she* [wife of the deceased] *is not the troublemaker.* (Participant 17, relative of the deceased)

A parent of one of the youths who committed suicide said:

> *From my Christian perspective, it is satanic spirits that bring misfortunes such as suicides; you're a Christian; the thief comes only to steal, kill, and destroy. God gave us life. From the inquiries we did as a nuclear family, a death-causing ritual was performed by the extended family members to raise self-harming spirits, so that I may be affronted* [sic] *because he (the late) was now supporting me after securing a job. He was now having a good life, but he suddenly started drinking alcohol, and now he's no more. His life was stolen by an evil spirit from his family* [crying]. (Participant 9, parent of the deceased).

Another participant had this to say:

> *Spirituality is critical when we talk about suicide. We have the good and the dark worlds; evil spirits do exist, and they cause these misfortunes. In one of the suicide cases, the relatives said it was a family issue related to witchcraft and that they were in the process of holding a cleansing ceremony to do away with the evil spirit and the responsible people behind that spirit*

> *in their family, so yeah, let's not forget the spiritual explanation of suicide.* (Key informant 5, pastor)

Key informant 6, a church pastor, confirmed the above:

> *African traditional religion is associated with rituals and witchcraft that raise evil spirits, driving people to commit suicide. Disputes, poverty and drug use can be identified, but don't overlook Satan's work and be blinded to explain suicide entirely based on these objectively identified causes. Evil spirits can manifest in those acts of infidelity and drug use, among other causes of suicide, and deceive us into ascribing self-harm to other visible causes; Satan steals and destroys.*

Key informant 7, the police officer, concurred with the pastors and said,

> *I started having a spiritual perspective; witchcraft exists, and bad spirits take advantage of people's situations. He* [the deceased] *isn't the only one; the family members confirmed that it's a trend in their family, in every generation, two or three people die through self-harm, and witchcraft exists.*

The above verbatim comments are reflective of attempted rational explanations of suicide within the African context and the complexity of human life and death/dying. The belief that some male youths commit suicide because of spiritual forces shows how belief systems influence people's sense of everyday suffering and assign responsibility for misfortune. Furthermore, when youths attribute distress to external and supernatural forces, they perceive themselves as powerless, thereby weakening their agency and power for self-intervention. This externalisation of power or control reinforces feelings of resignation and can limit personal help-seeking behaviour, increasing vulnerability to suicidal behaviour.

Social work interventions

Information from participants suggested spirituality-based community education and sensitisation as a social work intervention to address suicide among male youths.

Spirituality-based community education and sensitisation

The study participants acknowledged that there is a need to educate society about suicide. Some of the participants had the following to say:

> *We need community education about suicide. Usually, we think that killing oneself is a way out of poverty and social challenges, but no, we are not aware that there is more to that; we have eternal life that is awaiting us. We need to be awakened and change our attitudes towards self-harm as a community.* (Participant 4, who attempted to kill himself)

> *The community is also unaware of potential causes; they can take things for granted while somebody is communicating something. They should be conscientized about the signs of*

> *suicidal ideation and how to prevent it. Spiritual education on suicide is key.* (Participant 11, guardian of the person who attempted suicide).

Key informant 5, a church pastor, said:

> *Social workers should educate people on the burden of suicide, especially on those left behind. However, acknowledging evil spirits is critical. Let's sensitise the community on the significance of cleansing, prayer and traditional rituals enshrined in our customs.*

Key informant 2, a social worker, confirmed the above:

> *Let's teach everyone, not only those with suicidal thoughts but the entire community, and let's educate even at the community level. The family's spiritual background is critical, yet the communities are now ignoring that; they should be educated about it, among other issues surrounding suicide. The spiritual custodians are strategically positioned to deal with such issues and must be sensitised to support society; as you can see, spiritual social work is key here.*

Possible social work solutions to suicide among male youths are premised on the need for promoting the restoration of human agency, meaning-making and moral reasoning amongst male youths. Integrating spirituality into community social work education acknowledges culturally relevant and embedded explanatory systems. This strengthens human capacity by reframing suicide as a preventable social and personal problem rather than being an inevitable spiritual affliction. This also enhances individual and collective capacity for effective and reflective emotional regulation and decision-making.

DISCUSSION

Marital disputes and failed romantic relationships dominated the causal factors leading to suicide among male youths. The research participants described marital disputes and the breakdown of romantic relationships as significant life experiences associated with suicidal distress among male youths. These experiences were perceived to contribute to conflicts within households, relationship breakdown, and feelings of social and emotional disconnection. The human factor theory underscores that a human being needs to develop moral capital for him or her to function properly (Jones, 1987), but this is the opposite of what happens in the Bindura community, where moral decay in the form of adultery among couples leads to divorce and suicide amongst male youths. In Bindura, infidelity leads to emotional dysregulation for both victims and perpetrators of extra-dyadic behaviours, and emotional manifestations of infidelity-based trauma include feelings of extreme anger, betrayal, insecurity, rage, shame, guilt, jealousy and sadness, and these are linked to suicide (Charny & Parnass, 1995; Fisher et al., 2008). We noted that some of these relationships become problematic because of the feeling of betrayal. Among male youths, the widespread sense of betrayal was associated with their greater financial and material investment in trying to demonstrate romantic love to their partners. Subsequently, when such investments are betrayed,

men often experience a deep loss of life's meaning and purpose. We argue that young people lack experience and knowledge of how to manage relationships; hence, the dead-end mentality of suicide as a release. From a human factor perspective, the traditional perception of masculinity that discourages emotional expression amongst males leads to severe human factor decay in which men find it difficult to seek emotional support (Kirtley & O'Connor, 2012). This view is supported by Oliffe et al. (2020), who state that young males may then withdraw from social connections and eventually indulge in substance abuse that in turn exacerbates suicidal thoughts. The involvement of the wife in an extramarital relationship is seen as indicating a 'weakness' in the masculine identity and is a clear reflection of the absence of trust and commitment in relationships. Marital betrayal can generate profound pain and dejection, creating a context in which suicidal thoughts may emerge (Khan et al., 2023). These experiences are compounded by masculine norms that emphasise self-reliance and emotional stoicism, potentially limiting men's willingness to express distress or seek support and thereby intensifying feelings of isolation and despair (Kirtley & O'Connor, 2012).

The study found that societal pressures on men to fulfil provider roles lead to feelings of hopelessness and inadequacy when they fail. Bindura's male youths who fail to meet these expectations experience a profound sense of worthlessness. The human factor theory postulates that these societal expectations directly and negatively impact on decision-making processes and mental health (Kirtley & O'Connor, 2012). Kirtley and O'Connor (2012) further indicates that masculine norms can lead to a normalisation of suicide as a response to perceived failure, reinforcing the notion that men must maintain a façade of control and ultimate strength (Fincham et al., 2011). This societal pressure can create a cycle where men feel trapped by their roles, leading to increased suicide risk. We established that some male youths in Bindura view themselves as inferior when they fail to cope with the reality of socio-economic hardships, while others of their age are excelling. Furthermore, some youths who attempt suicide or die by it have a history of experiencing economic hardships as a result of factors associated with polygamous marriages and relationships tainted by infidelity (Khan et al., 2023). Economic hardships and compounding factors push youths into costly dealings that they fail to cope with and consequently kill themselves.

The human factor perspective significantly provides a useful lens for understanding how social and economic pressures may shape men's experiences of suicidal distress. Financial strain, for instance, can generate feelings of despair and diminished self-worth, while economic instability may intensify psychological distress (Bennett et al., 2023). These pressures may be particularly significant for African men who are socially and culturally positioned as providers and heads of their households, making financial difficulties a potential source of considerable personal and relational strain. Within this perspective, suicidal distress can therefore be understood in relation to the interaction between individual experiences and the social expectations within which men navigate their lives.

Spirituality also emerged as a significant factor linked to suicide among male youths in Bindura urban. Participants frequently attributed suicide and its drivers to Satanic forces/evil spirits, drawing on biblical imagery such as the thief who "comes only to steal and kill and destroy" (English Standard Version Bible, 2001, John 10:10). This spiritual framing is largely reinforced by local burial practices, where those who commit suicide are often buried separately and excluded from Christian funeral rites. Such practices mirror a broader societal and cultural taboo surrounding suicide in many traditional African societies, where death by suicide is considered one of the strongest prohibitions (Ndosi, 2006). Participants explicitly linked specific causes of suicide – including infidelity, marital conflicts and poverty – to evil spirits and witchcraft, indicating that spiritual beliefs shape how suicide is understood and interpreted within the community. This is consistent with the human factor perspective, which emphasises the significance of cultural context in shaping individual responses to mental health issues and experiences (Candela, 2019). Reyes-Foster (2013) documents the interplay between mental health and cultural beliefs, noting that some cultures view suicide through a spiritual lens, whereby demonic influences are considered significant in cases of suicide. However, Biri (2024) cautions that the spiritualisation and demonisation of suicide may overshadow other complex and multiple factors that contribute to suicidal behaviour, a point worth acknowledging.

Our study found spirituality-informed community education and sensitisation could be possible social work-related interventions. These findings echo the sentiments of numerous other researchers (Maple et al., 2017; Munetsi et al., 2018; Nugent et al., 2019). Social workers and other responsible authorities should embark on awareness-raising campaigns concerning suicide warning signs, promoting mental health, drawing attention to the dangers of drugs and substance abuse, and the need for overall wellness. They emphasised the inclusion of spirituality in sensitising communities, with youths being at the centre of these initiatives. Strategies to prevent suicide need to adopt approaches that focus on community-based and clinical interventions (Ndosi, 2006). Gborie (2025), in line with the Africa Youth Charter and Agenda 2063, recognises the critical role of young people in addressing mental health challenges on the continent. The issue of spirituality is linked to the adoption of indigenous knowledge systems (IKS), which is premised on recognising indigenous customs and socio-cultural and supernatural factors. This is also a relevant approach towards indigenising social work practice in Africa (Masoga & Shokane, 2019). The human factor theory is in line with this by emphasising the consideration of the beliefs and values of the community in addressing suicide (Isaac et al., 2003). This perspective emphasises the crucial role of human capabilities, values and cultural context in driving development (Chivaura & Mararike, 1998). The study's emphasis on community-based interventions that incorporate people's spiritual practices, such as cleansing ceremonies and rituals, can effectively address mental health issues, including those leading to suicide, an element of human factor decay (Chivaura & Mararike, 1998; Mason, 2023). This highlights the necessity for culturally sensitive approaches in suicide prevention efforts.

CHALLENGES AND LIMITATIONS

Suicide is a sensitive issue which is associated with investigations by and involvement of law enforcement agencies. In this case, we tried and failed several times to get police clearance to interview the officers who handled suicide cases, because we felt it was necessary to tap into the views of the criminal investigators and law enforcers. Instead, the study resorted to informal conversations after obtaining informed consent. The study borrowed the concept of 'informal conversations' from Chikoko et al. (2019, 2020) to cover sensitive issues such as sexual debut and drug and substance abuse. Tied to the above limitation was the lack of trust amongst research participants. The Bindura urban community is replete with illicit activities ranging from drug peddling, artisanal mining, street corner vending and trade, which attract the attention of law enforcement. This meant that the research participants assumed that we were an undercover law enforcement agency masquerading as researchers; however, after proving beyond doubt that we were researchers affiliated with local research institutions, we were able to build rapport and trust.

IMPLICATIONS FOR SOCIAL WORK EDUCATION, PRACTICE AND RESEARCH

The study findings have critical implications for social work education, practice and research. Firstly, the study identified the prominence of the breakdown of a romantic relationship, which shows the need for male-specific, stigmatisation-free and safe spaces that encourage their emotional expression, relationship education and counselling. Social workers can support these male youths by institutionalising enhanced conflict resolution, emotional regulation and proper help-seeking behaviour to address problematic issues of masculinity.

Economic demands show the significance of integrated socio-economic help and support as part of suicide prevention as well as post-prevention strategies. This allows social work practitioners to link male youths to sustainable employment services, social protection options and livelihood programmes while concurrently addressing their sense of lost dignity and moral distress linked to poor economic growth. Consistent with the human factor theory, these interventions should address material hardships and restore confidence in male youths for better adaptive lifelong choices.

Societal attribution of suicide to the dark or evil world underscores the inevitability of spiritual social work or spiritually sensitive social work practice. Instead of side-lining spiritual explanations, social work practitioners should, therefore, engage clients constructively to appreciate their societal belief systems and engage with traditional leaders, families and faith-based actors to challenge deeply entrenched fatalistic interpretations of distress.

Academically, the study reveals the need for curriculum strengthening on culturally grounded social work practice, human agency and spirituality. Conceptual tools for enhanced moral reasoning should be central in social work training programmes and also capture belief systems and proper decision-making in the context of situations where there are spiritual explanations of human distress. Additionally, the study has revealed empirical gaps in the literature on male

suicide in small peri-urban or urban African communities. This future research can build on the above findings to analyse the evolution of human (specifically young male) agency in the context of protracted socio-economic and relational pressure. Furthermore, spirituality-based and informed community interventions for suicide prevention offer a valuable area for future research.

CONCLUSION

The research article explores the fundamental issues and dimensions of suicide amongst male youths in the Zimbabwean urban environment. The study starts by giving an introductory background to the study through a detailed literature review, which reveals that suicide is a global health problem. The literature brings to the foreground the age, gender, sex, ethnicity and geographical locations of these cases of suicide. Ultimately, the discussion provides a Zimbabwean picture of suicide and reveals a research gap regarding male youths who, because of certain expectations of traditional masculinity, are affected by these behavioural cultural norms. The study offers a theoretical reflection on the human factor approach, which provides discursive guidelines. Being part of the Afrocentric theoretical framing, the human factor perspective brings the cultural and spiritual dimensions of suicide and mental health to the fore and shows that societal expectations of young males, the socio-cultural environment and the spiritual aspects of life can take a toll on their mental health. The study argues that suicide amongst male youths is a product of a complex combination of social, psychological, spiritual and socio-economic demands which require the re-equipping of social workers so that their approach to dealing with suicide and mental health is in sync with the cultural-spiritual aspects of life in a specific environment. This calls not only for re-orienting social workers, but also fortifying the social work curriculum with community and spiritually sensitive education and training that is holistic and context-specific for social work practice.

AUTHOR BIOGRAPHIES

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