CONCEALMENT OF HEALTH INFORMATION AND PREVENTABLE MORTALITY: EXAMINING MEN'S RELUCTANCE TO HEALTH STATUS DISCLOSURE

Stephen Afam Kenechukwu[1] Calistus Chibueze Dike[2] Ononuju, Ebele Franca[3]
[1]*Department of Mass Communication, Federal University Oye-Ekiti, Ekiti State, Nigeria.*
[2]*Department of Mass Communication,, Novena University Ogume, Delta State, Nigeria.*
[3]*Department of Mass Communication, Chukwuemeka-Odumegwu Ojukwu University, Igbariam, Anambra State, Nigeria*
Emails: stephen.kenechukwu@fuoye.edu.ng[1]; caludyke@gmail.com[2]; ebeleononuju30@gmail.com[3]
Correspondence: stephen.kenechukwu@fuoye.edu.ng

Abstract
This study examines the factors contributing to concealment of health information among men, and its relevance towards preventable mortality within the psychological, social, cultural, and economic contexts. The study was carried out in Anambra State South Senatorial District, Nigeria and anchored on the Health Belief Model (HBM) and Hegemonic Masculinity Theory (HMT). The study expands theory by incorporating economic and socio-cultural factors, providing strategies to mitigate mortality associated with hidden health conditions. With a cross-sectional survey approach, data were collected from 400 respondents sampled through multistage sampling using a validated 5-point Likert scale instrument. Data were analysed using mean and standard deviation calculations. Study findings show that men more often conceal illnesses from fear of being ridiculed, considered weak, and because of financial constraints. This supports HBM's psychological dimensions and HMT's focus on masculine ideals. It concluded that most men conceal their health status primarily due to show of masculinity. The study recommended interventions such as community-based programmes focusing on economic concerns and stigma abstinence, campaigns promoting positive masculinity that redefine strength, and collaboration with religious and cultural figures to change norms regarding disclosure.

Key words: *Concealment, Health Information, Health Status Disclosure, Masculinity, Preventable Mortality.*

Introduction

Concealment surrounding personal health information remains a formidable obstacle to prompt diagnosis, effective care, and favourable health results. For years, researchers have studied how individual hesitation to disclose symptoms or diagnoses undermines broader public-health objectives, initially focusing on communicable diseases such as

HIV/AIDS (Herek, Capitanio, & Widaman, 2002). In those cases, stigma, fear of exposure, and concern over discrimination surfaced repeatedly as key drivers of nondisclosure, with the unintended effect of raising both infection and mortality rates. More contemporary research has expanded the lens to cover chronic conditions including diabetes and hypertension, showing that silence about one's status can postpone vital interventions and complicate routine disease management (Osamor & Owumi, 2010). Still, after decades of empirical evidence and policy debate, the inclination to keep illnesses private continues to undermine health systems around the globe.

Recent research has turned its attention to the ways in which different genders share information about their health, and a clear trend has emerged: men tend to hold back when it comes to talking about what is troubling them (Courtenay, 2000; Mahalik et al., 2007). Analysts largely blame deep-seated ideas of masculinity that prize stoicism and render vulnerability almost shameful, leading many men to delay seeking care or admitting to symptoms until a condition is far more serious than it might have been earlier. This pattern shows up in a wide array of social classes and cultural backgrounds, and multiple studies have linked men's reluctance to reveal health problems with elevated rates of deaths that could have been avoided in the first place (Wang et al., 2020). Yet while this body of work paints a broad picture, it sometimes overlooks the specific social and cultural details that shape disclosure practices in particular communities.

Available literature shows significant gaps of adequately examining the ways in which cultural expectations, religious convictions, and local modes of health communication come together to shape men's hesitance to speak openly about their own medical conditions, particularly on the African continent (Wang et al., 2020). In Nigeria, for instance, relatively few studies have closely analysed how the distinctive social norms of various ethnic groups actively encourage men to hide rather than share details of their illnesses. Filling this void is crucial; when health programmes examine local belief systems and the specific gender roles they support, those programmes tend to struggle in promoting honest dialogue about health and in ultimately curbing preventable mortality among male patients (Ogunlayi et al., 2022). Furthermore, current scholarship still leans heavily on large-scale quantitative surveys and often neglects the qualitative narratives that can reveal the deeper, place-based reasons men choose to keep health information to themselves.

This study concentrates on Anambra State in southeastern Nigeria, a region where values around masculinity, communal honor, and spiritual attitudes to illness may influence whether men choose to share information about their health. Anambra State was selected because it has a high population density and resilient traditional systems that still steer how residents seek medical care. Moreover, the state faces a heavy dual

burden of communicable and non-communicable diseases, making it urgent to grasp how and why men withhold or disclose their medical conditions (National Bureau of Statistics, 2020). By anchoring the research in Anambra State, the study hopes to produce detailed evidence that policymakers and practitioners can use to design interventions that respect local culture while cutting down avoidable deaths tied to hidden health problems.

Statement of Problem

Although both patients and health professionals acknowledge that speaking openly about symptoms can make a real difference to treatment and prevention, large numbers of men conceal important health details about their health conditions. When health problems are concealed, medical visits are postponed, allowing illnesses to advance to stages that are much harder to manage. Physicians then see cases that, had they been presented sooner, would likely have been much simpler to treat. This delay puts both the individual at risk and the entire health system under extra pressure, forcing it to handle late-stage problems with costly, resource-intensive care that could have been largely avoided with prompt communication.

When men hesitate to discuss their health, the issue reaches beyond personal preference thereby increasing vulnerability to life-threatening sicknesses. Across workplaces, social circles, and media portrayals, traditional ideas of toxic masculinity that make men see endurance and independence as the highest virtues, subtly branding any admission of sickness as a mark of inadequacy. Because of this pressure, many men choose to ignore early signs of sickness and may end up concealing troubling symptoms or keep diagnoses to themselves, even from spouses, partners, and doctors whom they trust. The fallout is that avoidable illnesses often progress to advanced and deadly stages, contributing significantly to preventable deaths that early treatment could have averted.

The study is narrowed to Anambra South Senatorial District of Anambra State, southeast Nigeria. The State has apparent traditions that celebrate male authority, communal reputation, and deep spiritual meanings attached to illness. These customs influence many areas of life, including health-seeking behaviour, yet the links between social values and men's reluctance to disclose sickness are poorly understood. Like other States in Nigeria, the region is faced with recurrent cases of different diseases, but public health programmes often overlook the cultural drivers behind men's reluctance to speak about their own bodies and health status. This research, therefore, sets out to examine the reasons for men's reluctance to health status disclosure.

Objectives

The following research objectives guided the study:

1. To identify factors driving men's concealment of health conditions.
2. To assess how masculinity norms and social expectations affect men's health disclosure.
3. To examine how cultural and spiritual beliefs shape men's disclosure of illness.

Research Questions

The following questions strengthened the study:

a. What are the factors that drive men's concealment of health conditions?
b. To what extent do masculinity norms and social expectations affect men's health disclosure?
c. To what extent do cultural and spiritual beliefs shape men's disclosure of illness?

Literature Review

Determinants of Men's Health Information Concealment: A Multidimensional Review

Health information disclosure describes the process of sharing one's medical background, symptoms, or current health status with doctors, family members, or peers. This sharing is essential for accurate diagnosis, prompt treatment, and the prevention of more serious conditions (Greene, 2009). Yet surveys around the world show that men on average are more reluctant than women to seek medical advice or openly discuss health problems. This reluctance often results in later-stage diagnoses and worse overall health outcomes (Mahalik et al., 2007). At the psychological level, fear, stigma, and denial intertwine to create substantial barriers. Many men worry that admitting to discomfort or seeking help will make them appear weak, and this fear is intensified by internalized stereotypes that link masculinity to toughness (Addis & Mahalik, 2003). Stigmatized conditions—most notably mental health disorders and sexual health issues—compound this problem, further encouraging secrecy. Anticipating a serious medical finding can trigger avoidance strategies, whether in the form of denial, emotional paralysis, or outright postponement of treatment (Courtenay, 2000). Beyond these mental barriers, broader socioeconomic and demographic factors also influence whether men choose to disclose.

Research shows that males with less formal education or lower incomes often struggle to understand health information, which makes it harder for them to bring up medical issues (Ross et al., 2017). Work environments that prize physical toughness—common in trades or high-risk jobs—tend to push men to downplay illness or injury as a sign of weakness (Oliffe & Phillips, 2008). Living in rural areas adds another layer; close-knit

communities monitor behaviour closely, whispers travel fast and there is fewer places to speak in private than in a city (Sileo et al., 2018). Access hurdles count as well. Services designed explicitly for men are rare, and deep-seated scepticism of doctors—fed by past abuses in certain towns or regions—makes many reluctant to open up (Wenger et al., 2018). Family dynamics also send mixed signals. Some men keep quiet to shield loved ones from worry, fearing that honesty will strip them of respect in the eyes of a partner or child (Smith et al., 2006). Friend groups reinforce this lesson: being stoic earns praise, while admitting discomfort risks mockery (Courtenay, 2000). Together, these threads weave a tangled picture of why many men keep health challenges to themselves.

Existing literature has documented a range of influences on men's health—including psychological factors, socioeconomic status, systemic barriers, and the nature of interpersonal relationships—yet the ways these elements converge in particular cultural settings are still not fully clear. This is especially true for African men, who often navigate rigid norms of masculinity alongside patchy health-care services. To move forward, research needs to take an intersectional perspective that examines how gender, culture, and access to resources mutually shape experience. Such an approach will yield deeper insights and help design disclosure environments that genuinely address the distinctive circumstances these men face.

Masculinity Constructs and Social Pressures: Implications for Men's Health Disclosure

Cultural and social ideas of what it means to be masculine have an important impact on men's ability to reveal important health issues. This often leads them to withhold information or seek help much later than necessary. Masculinity has been extensively explained such as in Connell's (1995) hegemonic masculinity, which explains the societal norms concerning the supremacy of men over women, emotional detachment, and physical endurance dominance. O'Neil's (2008) gender role conflict theory also describes the mental anguish that comes upon a man when he feels that he is not living up to some socially ascribed standards of being masculine. Men may resist expressing certain emotions or using forms of assistance due to cultural perceptions surrounding masculinity and responsibility (Mahalik et al., 2003). These constructs profoundly influence men's health behaviors. The culturally defined ideals of strength converge upon rigidity bred by silence in weakness fosters aggression upon revealing discomfort physically or emotionally (Courtenay, 2000). According to Seidl er et al. (2016), men do everything possible to evade health literacy as it is perceived unaffordable without inflicting damage on his self-versus-society expectation image. Family, peers, and community all fuse intertwine into the bigger picture yielding rigid frameworks definite d as social expectations for men Working in Sociocultural context. Men tend to face

social ridicule, a loss of respect, or even deemed weak for violating traditional masculine norms by caring too much about their health (Galdas et al., 2005).

There are studies that offer some explanations. Addis and Mahalik (2003) showed that the stronger the masculine norm with which a person identifies is adhered to, the less likely they are to discuss any health matters. Other research conducted in sub-Saharan Africa, including Nigeria, has shown that men often experience stigma and social marginalization if they disclose illnesses and is especially reluctant towards conditions that undermine their perceived manliness (Okeke et al., 2020; Odimegwu & Odebiyi, 1997). In Nigerian communities, the cultural belief that associates masculinity with endurance along with being the breadwinner exacerbates these problems by contributing towards men's secrecy around health issues which prolongs diagnosis and treatment (Mbachu et al., 2022). There has been considerable academic work done in this field. However, gaps still exist on how other aspects of masculinity like age or class intersect with local cultures impact disclosure practices. Existing research often focuses on generic masculine norms without critically analyzing how situational specifics shape openness concerning health among men (Griffith, 2015). Therefore, it remains crucial to conduct detailed contextual investigations on health-related disclosure behaviors of men within socio-cultural frameworks shaped by multi-layered concepts of masculinity.

Cultural and Spiritual Dimensions in Men's Health Disclosure Practices

Culture and spiritual beliefs work together to guide how men decide to speak about their health and seek help. The way people think about sickness starts with their cultural background, which tells them whether a cough is just a cough or a sign of something bigger (Helman, 2007). In many African communities, health is not seen only through the lens of hospital tests and medications; instead, it is often understood as a balance between the body, the spirit, and social relationships (Airhihenbuwa, 1995). Because of this outlook, some people believe that an unexplained fever might come from witchcraft, the anger of an ancestor, or a broken community rule, so they head to a traditional healer or a spiritual leader before visiting a clinic (Iwelunmor et al., 2010). Their trust in herbal medicine, rites, and divination tells us that local healing practices are still at the center of many men's health journeys (Gyasi et al., 2016).

In many faith-focused communities, people often turn to prayer, fasting, and trips to nearby prayer houses in hopes of finding answers to health problems instead of, or at least alongside, visiting a doctor (Oladipo, 2013). When someone believes that everything is in God's hands, it can lead to a "whatever will be, will be" attitude that makes many men less likely to discuss about coughing, headaches, or other worries before it is almost too late (Akintola, 2006). Local ceremonies and unwritten rules keep this pattern going, because traditional views of masculinity praise silence and self-

control while frowning on tears and frank talk about pain (Courtenay, 2000). In parts of Nigeria, the message is drilled into boys from an early age: admit you are sick and you risk losing both respect and the family's good name (Odimegwu et al., 2017). Studies conducted all over sub-Saharan Africa back up these observations, showing how culture and faith partner up to keep men in the shadows when it comes to health. For example, surveys carried out in Ghana and Nigeria found that many men delay visiting a clinic because they first want to consult a prophet or elder (Adongo et al., 2016; Ezenwaka et al., 2020). Health programmes designed for these communities have to be just as sensitive to tradition as they are to science. Initiatives that bring chiefs and pastors into the conversation have already shown they can link the two worlds, leading men to seek medical help without feeling that they are betraying their upbringing (WHO, 2013). By working with voices people already trust, we can create safe spaces where men feel free to talk about their bodies and, in the end, cut down on diseases that do not need to be as deadly as they are.

Theoretical Framework

The study is anchored on the Health Belief Model (HBM) and Hegemonic Masculinity Theory. According to the Health Belief Model, a person's choices about revealing or hiding a health condition stem from their judgments about its seriousness, their personal risk of contracting it, and the perceived advantages or obstacles linked to action. Hegemonic Masculinity Theory, for its part, illuminates how culturally sanctioned notions of manhood pressure men to take risks, suppress feelings, and avoid showing anything that might be read as weakness.

Health Belief Model (HBM)

The Health Belief Model (HBM) arose in the 1950s from the work of U.S. Public Health Service social psychologists Hochbaum, Rosenstock and Kegels, and since then it has become a cornerstone for explaining why people do-or do not- act on health advice (Rosenstock, 1974). According to HBM, an individual will take a health-related step only if four beliefs align at once: the person feels personally at risk (perceived susceptibility), apprehensive about the possible fallout (perceived severity), confident that the step will help (perceived benefit), and not daunted by practical obstacles (perceived barrier) (Champion & Skinner, 2008). The model also adds outside nudges, or cues to action- like rising symptoms or a public-service announcement- and the persons sense of self-efficacy, to complete the picture. Because HBM lays these mental hurdles out in a clear, ordered way, researchers find it valuable when trying to pin down the psychological blocks that keep people from revealing symptoms or seeking treatment (Jones et al., 2015). Critics, though, remind us that illness decisions are rarely pure logic; by focusing on individual belief sets, HBM sometimes sidelines the social norms, economic constraints, and institutional failures that can tip the scales (Glanz et

al., 2008). In the current investigation of male secrecy about health problems, HBM still works well, because it lets us link mens risk worries, seriousness judgments, and cost-benefit calculations to their hesitance in sharing private medical matters. By revealing these separate cognitive assessments, the model offers a basic framework for interpreting how men hide health problems and, in turn, the deaths that could have been avoided.

Hegemonic Masculinity Theory (HMT)

Hegemonic Masculinity Theory, developed by R.W. Connell more than three decades ago, describes the way certain masculine ideals-toughness, emotional restraint, and mastery over vulnerability-become taken-for-granted standards that most men feel pressured to endorse. The framework views gender not as an innate trait but as an ongoing social process grounded in unequal power, so that dominant masculinities push alternative forms to the margins while also subordinating women (Connell & Messerschmidt, 2005). A key contribution of the theory is its ability to show how these norms infiltrate institutions, shaping everyday attitudes toward health and helping explain why many men avoid clinics, conceal symptoms, or ignore medical advice altogether (Courtenay, 2000). Critics nonetheless argue that the model sometimes stresses large-scale power relations so intensely that it eclipses the choices individual men make and the considerable variation that exists among them (Hanke, 1990). This study adopts HMT precisely because it zeroes in on the social costs of admitting weakness-heightened fear of ridicule or status loss-almost every man must reckon with. By framing health-seeking through this lens, the analysis pairs well with the more psychologically oriented Health Belief Model and highlights how the drive for public strength can push silence into the foreground, delaying treatment and, in some cases, hastening preventable death.

Methodology

This study employed a cross-sectional survey to explore why men hesitate to share information about their health and how this reluctance links to deaths that could possibly be prevented. The inquiry covered four communities: Nnewi, Ozubulu, Ihiala and Ufuma located in Anambra South Senatorial District, where approximately 2.1 million people reside. To obtain the sample size, Taro Yamane's formula was applied to arrive at a target sample of 400 male respondents. A multistage procedure guided selection: first, purposive sampling designated the four towns based on their demographic significance; second, stratified sampling allocated cases in proportion to each community's population share; finally, simple random sampling was applied to select willing male respondents. Data was obtained with a 5-point Likert scale (Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree) to capture attitudes, and the Mean and Standard Deviation metrics were later computed for statistical interpretation. Experts verified the instrument's content validity, and a pilot study among 20 similar

adults yielded a satisfactory Cronbach's alpha of .82, confirming reliability. Ethical safeguards included informing participants about study goals, guaranteeing anonymity, and respecting their right to decline or withdraw without consequence at any point.

Results

Data presentation is based on the 390 valid copies of questionnaire retrieved from respondents. By implication, 10 copies of questionnaire were not retrieved,

Table 1: Demographic Data

Sex of Respondents		
Variable	Frequency	Percentage (%)
Male	390	100%
Total	390	100%
Marital Status	Frequency	Percentage (%)
Single	222	57
Married	168	43
Total	390	100%
Age Distribution of Respondents	Frequency	Percentage (%)
18 – 25 years	76	19%
26 – 35 years	80	21%
36 – 45 years	138	35%
46 - 65 years	96	25%
Total	390	100%
Occupation of Respondents	**Frequency**	**Percentage (%)**
Students	66	17%
Civil Servants	205	53%
Artisans/Traders	119	31%
Total	390	100%
Towns of Respondents	**Frequency**	**Percentage (%)**
Nnewi	120	31%
Ozubulu	108	28%
Ihiala	64	16%
Ufuma	98	25%
Total	390	100%

The demographic data in Table 1 lays the groundwork for interpreting why some men conceal health challenges, a silence that can lead to deaths that are otherwise preventable. Every one of the 390 people surveyed was male, so the study zeroes in on masculine disclosure habits. More than half the group - 57 percent were single, raising the possibility that living alone makes it easier to keep health worries private because there is no partner pushing for openness. About a third of the sample, or 35 percent, fell in the 36-to-45 year-old bracket, with another quarter aged 46 to 65; that pattern suggests concealment could peak in midlife and old age, when serious medical

problems often start to appear. Civil servants accounted for half the respondents, hinting that formal workplaces carry their own mix of expectations and taboos about appearing weak or sick. Participants came from four towns, with Nnewi having 31 percent and Ozubulu 28 percent, showing that the finding is not limited to one local culture. Taken together, this profile gives the study a rich yet focused lens for examining how social roles and settings shape any man's choice to divulge or conceal health concerns.

Table 2: To identify factors driving men's concealment of health conditions

S/N	VARIABLES	SA	A	U	SD	D	Mean	Standard Deviation	Remarks
1.	I tend to keep my health problems to myself because admitting it makes me feel like showing weakness.	88	216	23	35	28	3.77	1.11	Significant
2.	Worry about stigma or judgment stops me from talking openly about what I am dealing with.	173	78	20	86	33	3.70	1.43	Significant
3.	In sharing personal troubles, I treat my health privately to avoid public attention.	26	60	25	155	124	2.25	1.24	Non-significant
4.	Money issues push me to hide problems instead of speaking out.	150	120	22	48	50	3.70	1.41	Significant
5.	Confidentiality is rare, so I fear any detail I share may be repeated in ways I cannot control.	112	30	10	66	172	2.60	1.73	Non-significant
6.	The old idea that men should be strong and simply push through pain still looms over many decisions.	122	84	25	66	93	3.19	1.60	Significant

The information presented in Table 2 provides strong evidence in support of both the Health Belief Model (HBM) and Hegemonic Masculinity Theory (HMT) while also exposing their weaknesses. The high mean score associated with personal weakness (M=3.77) and fear of stigma (M=3.70) illustrates how perceived barriers (Champion & Skinner, 2008) and susceptibility judgments (Jones et al., 2015) discourage disclosure in accordance with HBM's expectations. Additionally, the considerable agreement regarding traditional masculine expectations (M=3.19) bolsters HMT's assertion that men are reluctant to surrender status associated with vulnerability (Connell & Messerschmidt, 2005). However, the non-significant response to a stance on keeping health private to avoid public scrutiny (M=2.25) as well as the confidentiality concerns (M=2.60) suggests that not all secrecy stems from social pressure or belief conflicts—undermining the overarching applicability of HMT and HBM. Rather, empirical work, such as that by Courtenay (2000) confirms that while masculine norms tend to inhibit help-seeking behavior, the individual contexts involved tend to be highly diverse. Therefore, although the theories are valid in large part for explaining the reluctance, the data also urges caution to avoid overgeneralising; notably, economic fears (M=3.70) emerged as an independent, strong motivator which aligns with Addis and Mahalik's (2003) argument that financial stressors could surpass deeply entrenched gendered expectations. This emphasises the importance of comprehensive models which now include both psychological factors and socio-economic components.

Table 3: To assess how masculinity norms and social expectations affect men's health disclosure

S/N	VARIABLES	SA	A	U	SD	D	Mean	Standard Deviation	Remarks
7.	I usually steer clear of conversations about my health because the idea of being tough still hangs over most men.	167	89	17	49	68	3.61	1.55	Significant
8.	Reaching out for help or even mentioning a problem makes me feel like I am crossing an unofficial line.	88	46	10	168	78	2.74	1.48	Non-significant
9.	It seems much easier for women to talk about personal hurts, while men shoulder	155	105	5	66	59	3.59	1.51	Significant

	theirs with less public fuss.								
10.	I choose to grin and bear discomfort than let anyone catch a glimpse of the weakness that sharing would show.	190	62	10	82	46	3.69	1.52	Significant
11.	Something tells me that confessing an ache could make friends and family quietly tag me as less manly.	81	60	12	85	152	2.57	1.61	Non-significant
12.	The nagging doubt is the main reason I keep quiet about my health.	179	88	9	69	45	3.74	1.47	Significant

Data presented in Table 3 illustrates the intersection of psychological constraints and the social norms shaped by hegemonic masculinity, which impacts men's reluctance to talk about their health issues, supporting both the Health Belief Model (HBM) as well as Hegemonic Masculinity Theory (HMT). Strong means concerning avoidance of health talk to uphold toughness (M = 3.61) and masking discomfort (M = 3.69) support the HMT claim that men try to dodge social vulnerability (Connell & Messerschmidt, 2005). At the same time, significant means on nagging doubts driving silence (M = 3.74) signify barriers and self-efficacy concerns the major focus of HBM (Champion & Skinner, 2008). On the contrary, the non-significant results concerning crossing lines (M = 2.74) and fear of being considered less manly (M = 2.57) indicate a blend of social context and individual agency which influences disclosure. This also reminds us of the critique where HBM is said to focus too much on individual factors while ignoring social frameworks (Glanz et al., 2008) and HMT generalizes male experiences too broadly (Hanke, 1990). Empirical counterparts can be found in Courtenay (2000), where he found the scripts of masculinity deter men from engaging with health, and in Mahalik et al. (2007) who associated masculine norms with underutilization of health care services. Thus, this study's findings affirm the respective theories but also suggest adding layers of complexity that future research should address.

Table 4: To examine how cultural and spiritual beliefs shape men's disclosure of illness.

S/N	VARIABLES	SA	A	U	SD	D	Mean	Standard Deviation	Remarks
13.	For me, speaking about my health sits uncomfortably beside the cultural lessons I learned about keeping personal matters private.	150	67	28	56	89	3.34	1.63	Significant
14.	My faith makes me to trust prayer and quiet reflection instead of bringing my medical concerns into social conversation.	154	88	20	62	66	3.52	1.54	Significant
15.	I am worried that revealing any illness might cast a shadow of shame over my family or the wider community.	215	96	15	42	22	4.13	1.23	Significant
16.	Growing up, I picked up the idea that men should address personal health struggles without public conversation.	167	62	26	50	85	3.45	1.63	Significant
17.	I also see some ailments as spiritual tests, best dealt with in private or with a trusted elder, rather than aired broadly.	180	99	15	54	42	3.82	1.41	Significant
18.	Due to fear of confidentiality, I treat sickness as a personal trial that my faith—and not my social circle—needs to hear about.	133	156	14	48	39	3.76	1.31	Significant

Data in Table 4 compellingly demonstrates the appropriateness of both the Health Belief Model (HBM) as well as Hegemonic Masculinity Theory (HMT) for understanding why men conceal health issues. The mean scores from 3.34 to 4.13 indicate cultures strongly discourage disclosure due to privacy concerns, shame, faith reliance, and spiritual interpretations surrounding illness. This aligns with HBM's focus on barriers and costs: discrete stigma and threats to honor limit disclosure even when the action is health revealing (Champion & Skinner, 2008). Confirmatory empirical studies abound; for example, Mahalik and Burns (2011) showed masculine norms are associated with lower help seeking. Equally, great concern about strong status loss ties with HMT's focus on emotional control and aversion to being vulnerable (Connell & Messerschmidt, 2005). Courtenay (2000) also showed cultural stoic norms increase secrecy, supporting these findings. However, the holistic uniformity across the variables suggests an even deeper level of cultural embedding and challenges HBM's individuality focus critique, supporting arguments that social norms take precedence over personal calculations concerning health (Glanz et al, 2008). Thus, while the data affirms both models, it also highlights more vividly how cultural and spiritual scripts, operating through hegemonic masculinity, strongly uphold silence—reinforcing phenomena of silence sustaining preventable mortality risks.

Discussions

Research Objective 1*: To identify factors driving men's concealment of health conditions:* Notably, men conceal illnesses mainly due to concerns of personal weakness, stigma, and financial burden. These specific factors, highlighting psychological constraints and socio-economic stressors, underscore an individual's reluctance toward seeking help. Notably, lesser concerns involving privacy or confidentiality demonstrate that secrecy extends beyond the avoidance of public gaze. In this case, traditional masculinity and perceived vulnerability may be significant, but economic apprehensions are equally compelling. Therefore, concealment results from the intersection of health perceptions, masculine ideals, and financial insecurity. This underscores the need for multi-layered approaches that address both psychological and economic factors.

Research Objective 2*: To assess how masculinity norms and social expectations affect men's health disclosure:* Results indicate that normative masculinity significantly constrains men's communication regarding health issues. The high endorsement of silence to maintain toughness and conceal discomfort demonstrates the demand of social scripts requiring emotional control. However, moderate endorsement of silence because one fears being regarded as less manly suggests differing social norms. This blend illustrates that while dominant ideals of masculinity exert considerable pressure on disclosure, personal context can also buffer them. With these findings, it can be

concluded that masculinity norms are fundamental; however, they raise important questions about the design responsive to individual variability and changing social dynamics.

Research Objective 3*: To examine how cultural and spiritual beliefs shape men's disclosure of illness:* The data underscores the extent to which cultural and spiritual systems shape men's reluctance to disclose illness. High mean scores on shame, privacy, reliance on faith, and spiritual interpretations suggest that silence is strongly imposed by communal norms and religious beliefs. This indicates that disclosure is less an issue of personal risk evaluation and more about sociocultural constructs that emphasize silence and value illness in a spiritual context. The lack of variability across these factors suggests strong cultural normativity that may inhibit help-seeking, contradicting personal will. Therefore, concealment demands strategies that engage spiritual leadership and community norms to shift the culturally entrenched attitudes that uphold silence.

Implication of Study to Theory and Practice

Findings confirm Health Belief Model (HBM) and Hegemonic Masculinity Theory (HMT) by showing men concealment arises due to stigma and economic burden, emphasizing also financial tolls in addition to psychological stressors. From a practical standpoint, interventions should provide economic assistance while simultaneously reducing stigma to target masculine norms and costs. Health campaigns must shift focus from belief correction to dismantling the societal and financial scaffolding that enforces secrecy, nurturing spaces where men can freely disclose health issues without jeopardizing dignity or livelihood.

Results reaffirm HMT with its claim that masculine norms demand silence, but also reveal individual diversity, softening sweeping overgeneralizations. For the HBM, it is an assertion of the social and personal interplay; practically, it shows health programs need to address rigid constructions of masculinity alongside diverse male identities. Interventions should be aimed at normalizing open health dialogue via peer-led initiatives that celebrate vulnerability. This enhances theoretical frameworks by integrating self-efficacy psychology with social expectation shifts.

The data illustrates the significant role of cultural and spiritual norms in silence, reinforcing the Health Belief Model (HBM) and Health Motivation Theory (HMT), while demanding greater socio-cultural integration. Theoretically, it recommends expanding models to communal and religious aspects as central guiding factors. From a practical perspective, health programs need to involve religious and cultural leaders to change the prevailing narrative that illness disclosure is shameful or a sign of spiritual

weakness. This aligns community values with health, encourages collective endorsement of early disclosure, and diminishes preventable mortality associated with secrecy.

Conclusion

The study results demonstrate that men are reluctant to discuss health problems due to the highly influential norms, standards of masculinity, cultural norms, and spiritual notions, which sustain the silence and stigmatize weakness as well as vulnerability. The normative masculinity necessitates emotional restraint and toughness, and so most men will avoid showing feelings of discomfort, and at the same time individual diversity implies that there may be some room to move within those strict requirements. The cultural and spiritual beliefs also enhance this silence as there is the tendency to regard illness as a direct source of shame or even the spiritual understanding of the phenomenon at hand making the disclosure about the reputation of the community rather than health of the individual. These facts support the Health Belief Model and the Hegemonic Masculinity Theory since they prove that the health behaviors of men are not only individual preferences but also a controlled and highly disciplined process. Notably, the study informs the necessity to go beyond enlightenment campaigns, which focus on beliefs in order to create health interventions that will destroy violently the scaffolding that supports secrecy in its structural and cultural level. This is in practice achieved by incorporating economic assistance, actively resisting set gender norms, and enlisting religious and cultural leadership to recognize health-seeking as a worthy and communal exercise. Such research therefore urges theory-based contextual interventions that can normalize communication, accept alternative masculinity and transformative cultural discourse on men reporting their health.

Recommendations

The following recommendations are proposed based on the findings of the study:

a. Implementation of community-centric strategies tackling economic pressure and psychological stigma, coupled with health education aimed at alleviating fear of vulnerability, promoting greater confidence among men in seeking timely medical assistance.

b. Advocacy of positive masculinity campaigns alongside peer-led health support groups, which define strength in terms of health-seeking interventions, focusing on individuality and shifting social norms.

c. Involvement of religious leaders and cultural influencers in health education to eradicate detrimental sacred beliefs and promote a culture that values, encourages, and supports timely health seeking and disclosure within communities.

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