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Stakeholder perspectives on suicidal behavior and suicide prevention opportunities in rural Uganda: A qualitative study

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Abstract

Worldwide, suicide remains a major public health challenge, with a disproportionate burden in low- and middle-income countries. Despite growing evidence on suicidal behavior in Uganda, little is known about how community stakeholders perceive its burden, drivers and opportunities for prevention in rural settings. We aimed to explore stakeholders' perspectives on suicidal behavior, its perceived drivers and opportunities for suicide prevention in Ntungamo District, southwestern Uganda. We conducted a qualitative study involving 19 face-to-face in-depth interviews and three focus group discussions with purposively selected stakeholders. Interviews were audio-recorded, transcribed verbatim and analyzed using rapid qualitative thematic analysis. Three themes emerged: (1) suicidal behavior was perceived as an increasingly visible community and public health concern; (2) participants identified interacting drivers of suicidal behavior, including access to lethal means, socioeconomic adversity, demographic vulnerabilities, and harmful alcohol and substance use; (3) participants identified community-informed opportunities for suicide prevention and to promote awareness, reduce stigma and encourage early help-seeking. Stakeholders perceived suicidal behavior as a significant community concern driven by interacting social, economic, demographic and environmental influences. Community-informed suicide prevention strategies that strengthen existing community structures and trusted local actors could inform policy and practice in Uganda and similar rural settings across sub-Saharan Africa.

Impact statement

Suicidal behavior is an important and increasingly recognized public health concern in rural Uganda, yet locally relevant approaches to prevention remain limited. This study brings together perspectives from health-system and community stakeholders, including people with lived experience, to identify factors perceived to contribute to suicidal behavior and opportunities for prevention in Ntungamo District. The findings highlight that suicidal behavior is understood within a combination of social, economic, interpersonal, behavioral and environmental circumstances. Participants also identified opportunities to build suicide prevention around existing community structures, including local leaders, religious institutions, community meetings, families and agro-input shop vendors. These findings suggest that suicide prevention in rural settings may benefit from approaches that complement formal health services with trusted community structures and locally accessible referral pathways. The study also highlights the need for caution when translating these stakeholder-informed ideas into interventions. Community gatekeeping, particularly around pesticide access, would require appropriate training, confidentiality safeguards, clearly defined roles and links to health services. More broadly, the findings provide locally grounded priorities that can inform the development and future evaluation of community-based suicide prevention strategies in rural Uganda.

Introduction

Globally, suicide remains a major public health challenge accounting for more than 700,000 deaths annually and ranking among the leading causes of mortality among young people (World Health Organization, 2014, 2021b). Although suicide occurs across all regions of the world, more

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than three-quarters of suicide deaths occur in low-and middle-income countries (LMICs), where limited access to mental health services and adverse social determinants of health increase vulnerability (World Health Organization, 2021b). In Africa, suicide has emerged as an increasingly important yet underrecognized public health concern, shaped by a complex interplay of social, economic, psychological and environmental influences (World Health Organization, 2014; Aboagye et al., 2022; Kirkbride and Paul, 2022; Van Der Walt et al., 2026). Despite growing recognition that suicide is preventable, many African countries continue to face substantial challenges in developing and implementing effective suicide prevention strategies because of inadequate surveillance systems, limited mental health resources, and persistent stigma surrounding suicidal behavior (Khan, 2005; Lubaale, 2018; Quarshie et al. 2026). Uganda reflects many of these regional challenges, with suicidal behavior reported across diverse population groups. Previous studies have documented suicidal ideation, suicide attempts, and suicide deaths among adolescents, refugees, people living with HIV, and other vulnerable populations (Rukundo et al., 2016; Bukuluki et al., 2021; Kaggwa et al., 2022b; Ainamani et al., 2025). Moreover, these studies suggest that suicidal behavior is shaped by multiple interacting social, economic and psychological influences, including poverty, unemployment, financial hardship, family conflict, exposure to violence, harmful alcohol and substance use, and untreated mental disorders (Canetto and Sakinofsky, 1998; Mars et al., 2014; Miranda-Mendizabal et al., 2019). However, accurately estimating the burden of suicide remains difficult because suicidal behavior has historically been underreported owing to stigma, fear of discrimination and legal restrictions that discourage disclosure and reporting (Lubaale, 2018). Consequently, the true burden of suicidal behavior in many Ugandan communities is likely to be substantially higher than official estimates indicated. Recognizing that suicide prevention extends beyond the health sector, the World Health Organization advocates for comprehensive, multisectoral approaches that engage communities alongside health, education, law enforcement, religious institutions and local government (World Health Organization, 2018). In this context, community stakeholders are often the first to identify individuals experiencing psychological distress, respond to suicidal crises, facilitate access to care and provide ongoing social support, particularly in rural African settings where specialist mental health services remain scarce (Wakida et al., 2026). Although quantitative studies have advanced understanding of the epidemiology and correlates of suicidal behavior in Uganda (Rukundo et al., 2016; Bukuluki et al., 2021; Kaggwa et al., 2022b; Ainamani et al., 2025), little is known about how community and health system stakeholders understand suicidal behavior, its perceived drivers and opportunities for prevention. Yet, these perspectives shape community responses, influence help-seeking behaviors and inform the design and acceptability of suicide prevention interventions. To address this gap, we conducted a qualitative study among district health managers, community leaders, law enforcement officers, religious leaders, representatives of non-governmental organizations and individuals with lived experience in Ntungamo District, southwestern Uganda. Specifically, we aimed to explore stakeholder perspectives on suicidal behavior, perceived drivers of suicidal behavior and locally relevant opportunities for suicide prevention in Ntungamo District, Uganda and similar rural settings across sub-Saharan Africa.

Methods

Study design

We conducted a qualitative cross-sectional study in August 2024 in Ntungamo District, southwestern Uganda, to explore stakeholders' perspectives on suicidal behavior, its perceived contributing factors and opportunities for suicide prevention in Ntungamo District, southwestern Uganda. A qualitative approach was considered appropriate because it enabled an in-depth exploration of participants' experiences, perceptions and interpretations of suicidal behavior within their community and health system context. Data were collected through face-to-face in-depth interviews (IDIs) and focus group discussions (FGDs).

Study setting

The study was conducted in Ntungamo District, located in the Ankole subregion of southwestern Uganda. The district borders the Republic of Tanzania to the south and Rwanda to the southwest and covers an area of approximately 2,158 km^2. According to the 2024 Uganda National Population and Housing Census, the district has an estimated population of 553,197, of whom approximately 52% are female. The majority of the population (85.8%) resides in rural areas where subsistence crop farming and livestock keeping constitute the principal sources of livelihood (Uganda Bureau of Statistics, 2024). The district was purposively selected because it represents a predominantly rural agricultural setting where access to agricultural pesticides as a commonly reported means of suicide in LMICs is widespread (Pagnani et al., 2021). Previous evidence from western Uganda has also identified Ntungamo as having a relatively high burden of documented suicide attempts compared with neighboring districts (Kaggwa et al., 2022b). In addition, recurring reports of suicide cases within the district have highlighted suicide as an important public health concern. These contextual characteristics made Ntungamo an appropriate setting for exploring stakeholder perspectives on suicidal behavior and identifying opportunities for community-based suicide prevention.

Research team

Data were collected by a multidisciplinary team comprising psychiatrists, clinical psychologists and trained qualitative researchers with prior experience conducting mental health research in Uganda. Before data collection, the research team underwent refresher training on qualitative interviewing techniques, ethical conduct, participant safety and management of emotional distress during suicide-related interviews.

Study participants and recruitment

Participants were recruited using purposive sampling to ensure inclusion of individuals with professional responsibilities or lived experience relevant to suicide prevention. Eligible participants included members of the District Health Management Team, health subdistrict leadership, local government officials, representatives of nongovernmental organizations, law enforcement officers, education officials, religious leaders, community leaders and individuals with lived experience of suicidal behavior. Participants were identified through consultation with district authorities and community networks based on their roles, experience and potential contribution to understanding suicide prevention within the district.

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The purpose of sampling across these stakeholder groups was to obtain a range of perspectives relevant to suicide prevention rather than to achieve proportional representation of the different stakeholder categories. All participants provided written informed consent before enrolment. Recruitment continued until thematic saturation was achieved, defined as the point at which subsequent interviews generated no substantially new concepts or themes.

Ethical clearance

Ethical approval was obtained from the Mbarara University of Science and Technology Research Ethics Committee (MUST-2024-1,493), and the study was registered with the Uganda National Council for Science and Technology (HS4371ES). Administrative permission was obtained from the District Health Officer before commencement of data collection. All participants provided written informed consent after receiving detailed information about the study objectives, procedures, potential risks and their right to withdraw at any time without consequences. Interviews were conducted in private settings to protect confidentiality and encourage open discussion. Given the sensitive nature of suicide-related discussions, a psychological support and referral protocol was developed before data collection. Participants who experienced emotional distress during or after participation were offered immediate support by clinicians on the research team and referred to appropriate mental health services where necessary.

Data collection

In-depth interviews

Prior to the interviews, participants completed a brief sociodemographic questionnaire. Data were collected using a semi-structured interview guide (Supplementary File 1) designed to explore participants' perceptions of the burden of suicidal behavior, its perceived drivers and opportunities for community-based suicide prevention. The guide comprised open-ended questions with flexible probes that enabled participants to elaborate on their experiences and perspectives. Face-to-face interviews were conducted in English in private locations to ensure confidentiality and minimize interruptions. With participants' consent, interviews were audio-recorded and supplemented with field notes documenting contextual observations and emerging reflections. Interviews lasted approximately 45–60 min. Participants received reimbursement of UGX 50,000 (approximately USD 13) to compensate for transport costs and time spent participating, in accordance with national ethical guidelines.

Focus group discussions

To complement the IDIs and explore shared community perspectives, we conducted three FGDs using a semi-structured discussion guide (Supplementary File 2). Each FGD comprised six to eight purposively selected participants drawn from community leaders, district officials and representatives of sectors involved in community health and social services. Discussions were facilitated by an experienced qualitative researcher and supported by a trained note-taker. All FGDs were conducted in English in private venues, lasted approximately 60–90 min and were audio-recorded with participants' consent. Field notes were recorded throughout the discussions to capture nonverbal interactions, group dynamics and contextual information that complemented the audio recordings.

Data management and analysis

Data preparation

All IDIs and FGDs were audio-recorded, transcribed verbatim using NVivo Transcription software and reviewed against the original audio recordings for accuracy. Field notes and structured post-interview summaries were integrated with the interview transcripts to provide contextual information and support data familiarization (Vindrola-Padros and Johnson, 2020). Three members of the research team independently reviewed the transcripts and accompanying field notes before analysis.

Data analysis

Data were analyzed using a rapid qualitative thematic analysis approach, which facilitates systematic data reduction and timely interpretation while preserving the depth and richness of qualitative findings (Palinkas et al., 2015).This approach was considered appropriate because the findings were intended to inform ongoing district-level suicide prevention planning and implementation (Ash et al., 2008; Nevedal et al., 2021).

The use of rapid qualitative analysis enabled the research team to systematically synthesize participants' perspectives while generating timely findings relevant to district-level suicide prevention planning.

Data analysis followed an iterative process. Initial codes were developed deductively from the interview and FGD guides and informed by existing implementation research frameworks (Rousseau et al., 2019). Additional codes were generated inductively from participants' narratives to capture emerging concepts and perspectives that were not anticipated during study design. Two researchers independently coded the transcripts, and coding discrepancies were discussed and resolved through consensus during regular research team meetings. A codebook containing code definitions and exemplar quotations was developed and iteratively refined throughout the analytical process. Related codes were subsequently grouped into categories and synthesized into overarching themes that reflected shared and divergent stakeholder perspectives on suicidal behavior. These procedures were used to maintain analytical consistency and transparency within the rapid analytical approach.

The same analytical framework was applied to both the IDI and FGD data to facilitate triangulation across data sources. The coding process considered both individual and group accounts, allowing similarities and differences in stakeholder perspectives to be examined across the two data sources. Data collection and analysis occurred concurrently, allowing emerging findings to inform subsequent interviews and FGDs. Recruitment ceased when thematic saturation was achieved, defined as the point at which additional interviews and discussions generated no substantially new themes or concepts.

Trustworthiness

The trustworthiness of the findings was enhanced through several strategies. Credibility was strengthened through methodological triangulation by combining IDIs and FGDs, independent coding by two researchers and regular consensus meetings to resolve coding discrepancies. Dependability was supported through the use of semi-structured interview guides, a systematically developed and iteratively refined codebook and a transparent analytical process. Confirmability was enhanced through reflexive discussions among the research team, maintenance of field notes and the use of verbatim participant quotations to ensure that the findings were

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grounded in the data. Transferability was facilitated by providing a detailed description of the study setting, participant characteristics and research procedures, enabling readers to determine the applicability of the findings to similar settings.

Patient and public involvement

Patients and members of the public were not involved in the design, conduct, analysis or dissemination planning of this study. Individuals with lived experience, as participants. All participants were clinically stable at the time of the interviews, and no referrals were required during data collection.

Results

A total of 19 purposively selected stakeholders participated in the IDIs, representing diverse sectors involved in suicide prevention, including the District Health Management Team, local government, law enforcement, education, religious institutions, nongovernmental organizations, community leadership and individuals with lived experience of suicidal behavior. Participants ranged in age from 28 to 55 years, and professional experience ranged from 2 to 30 years. To complement the individual interviews, three FGDs involving stakeholders from community and district-level settings were conducted to explore shared perspectives and enhance data triangulation. Participant characteristics are presented in Table 1.

Table 1. Demographic characteristics of the participants (N = 19)

Characteristic	*n* (%) or Range
Gender	
Male	11 (57.9)
Female	8 (42.1)
Age (years)	28–55
Residence	
Rural	8 (42.1)
Semi-urban	5 (26.3)
Urban	6 (31.6)
Education level	
Primary	2 (10.5)
High school	3 (15.8)
Tertiary	14 (73.7)
Stakeholder category	
District health management team	9 (47.4)
NGO representative	1 (5.3)
Law enforcement	1 (5.3)
Education official	1 (5.3)
Religious leader	1 (5.3)
Farmers representative	1 (5.3)
Village leader	1 (5.3)
Individuals with lived experience	4 (21.1)
Years of service and experience (range)	2–30

Note: NGO, nongovernmental organization.

Table 2. Thematic framework illustrating stakeholders' perspectives on suicidal behavior

Theme	Subtheme	Categories
1. Suicidal behavior as an emerging community and public health concern	Community encounters with suicidal behavior	Witnessing suicide death Learning about suicide attempts
	Lived experiences of suicidal behavior	Personal experiences of suicidal ideation or attempts Survivor experience
2. Interacting drivers of suicidal behavior	Access to lethal means of suicide	Pesticides and ropes and other materials used for hanging
	Demographic vulnerability	Young age Male gender
	Social economic adversity	Debt burden Unemployment Poverty and financial hardship
	Family conflict and interpersonal relationships	Domestic violence; Family conflict; Relationship breakdown
	Alcohol and substance use	Harmful alcohol and substance use
3. Community-informed opportunities for suicide prevention	Community gatekeeping for means restriction	Agro-input shop vendors; Local Council leaders; Family involvement before pesticide sales
	Leveraging existing community platforms	Churches; Mosques; Burial ceremonies; Community meetings; Suicide awareness; Stigma reduction; Early help-seeking

An overview of the themes and subthemes identified in the analysis

Analysis of the IDI and FGD data generated three overarching themes and related subthemes describing stakeholders' perspectives on suicidal behavior (Table 2). These included (1) the perceived burden of suicidal behavior within the community, (2) perceived interacting drivers of suicidal behavior and (3) community-informed opportunities for suicide prevention.

Theme 1: Suicidal behavior as an emerging community and public health concern

Community encounters with suicidal behavior

Participants consistently described suicidal behavior as a significant and frequently encountered community concern. Across both IDIs and FGDs, participants reported encountering suicide deaths, suicide attempts and individuals experiencing suicidal crises through their professional responsibilities, community leadership roles and personal experiences. These narratives suggested that suicidal behavior was perceived not as an isolated occurrence but as a recurring public health concern affecting individuals, families and communities throughout the district. Several participants described direct exposure to suicide deaths, either through personal loss or their professional responsibilities within the community. For some, these experiences had profound emotional consequences and highlighted the devastating impact of suicide on surviving family

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members. One participant with lived experience of suicide through the loss of a family member reflected on the emotional consequences of the event:

> It was devastating for me and my family to watch the lifeless body of my husband who took his life about 10 years ago. (IDI participant, lived experience)

Similarly, participants occupying leadership positions described regularly receiving reports of suicide cases within their communities, reinforcing the perception that suicidal behavior was a persistent and visible problem. One District Health Management Team member explained:

> Due to my position, I get to hear of many cases… the recent one was a friend who hanged herself at home. (IDI participant, District, Health management team member)

Community leaders participating in the FGDs also described frequent encounters with suicide attempts, emphasizing their role in identifying individuals at risk and intervening before suicide occurred. One community leader recalled:

> We rescued a young man who had bought rat poison and said goodbye to his siblings. We talked to him, and he is now okay. (FGD participant, community leader)

Lived experiences of suicidal behavior

Individuals with lived experience provided personal accounts of suicidal thoughts and attempts, illustrating both the emotional distress associated with suicidality and the importance of timely interpersonal support. Their narratives demonstrated that supportive interactions from family members, friends and community members could interrupt suicidal crises and foster hope during periods of intense psychological distress. One participant reflected on how mutual support during a suicidal crisis contributed to survival:

> Although I was contemplating killing myself, I found myself encouraging someone else not to commit suicide. We are both still alive today. (IDI participant, lived with lived experience)

Taken together, the accounts from participants with lived experience, community leaders and district stakeholders demonstrated that suicidal behavior was widely encountered across personal, professional and community settings. These experiences reinforced stakeholders' perception that suicidal behavior constitutes an important and emerging public health concern in Ntungamo District.

Theme 2: Interacting social, economic, demographic and environmental drivers of suicidal behavior

Participants consistently described suicidal behavior as arising from the interaction of multiple social, economic, demographic and environmental influences rather than from a single precipitating factor. Across both IDIs and FGDs, participants emphasized that suicidal behavior often resulted from the cumulative effects of financial hardship, family conflict, harmful alcohol and substance use, demographic vulnerability and easy access to lethal means. These factors were perceived to reinforce one another, increasing individuals' vulnerability during periods of psychological distress.

Access to lethal means

Participants consistently identified easy access to lethal means as an important driver of suicidal behavior. Agricultural pesticides were widely available because of the district's predominantly agrarian economy, while ropes, belts, bedsheets and other household materials used for hanging were readily accessible in most homes. Participants perceived that the widespread availability of these means increased the likelihood that individuals experiencing acute psychological distress could act on suicidal thoughts. One team member highlighted the ease with which highly lethal pesticides could be obtained:

> Pesticides are easily accessible… even rat poison costs less than a half dollar. (IDI participant, District Health Management member)

Similarly, participants in the FGDs emphasized that many of the commonly used methods required no special preparation because they involved ordinary household items. One participant explained:

> These means are available… ropes and bedsheets are things we live with every day. (FGD participant)

Collectively, these narratives highlighted how environmental availability of lethal means was perceived to facilitate suicidal behavior within the community.

Demographic vulnerability

Participants consistently perceived suicidal behavior to be more common among men and younger people. These demographic groups were viewed as particularly vulnerable because of prevailing gender norms, socioeconomic pressures and limited help-seeking behaviors. Participants described how societal expectations placed considerable responsibility on men to provide for their families, while simultaneously discouraging emotional expression and help-seeking during periods of distress. Young people were also perceived to be especially vulnerable because they often faced relationship difficulties, unemployment and uncertainty about their future. One participant highlighted how masculine social norms were perceived to discourage help-seeking among men:

> Men decide to commit suicide without communicating to anyone… we need counsellors specifically for men. (FGD participant)

Similarly, another participant reflected on the vulnerability of young people:

> Most people who commit suicide are youths… they act out of disappointment. (IDI participant)

Taken together, these accounts suggested that participants perceived the heightened vulnerability of men and young people as arising not simply from age or gender, but from the social expectations, responsibilities and life circumstances associated with these groups.

Socioeconomic adversity

Stakeholders consistently described debt and financial hardship as major contributors to suicidal behavior. Persistent financial obligations, particularly when individuals were unable to repay loans or meet basic household needs, were perceived to generate prolonged psychological distress, shame and hopelessness. *One participant reflected on how mounting debt could become overwhelming when individuals perceived no realistic means of repaying their financial obligations*:

> People borrow money from savings groups and banks. When they fail to repay and creditors begin demanding payment, some become overwhelmed and end their lives. (IDI participant)

Similarly, participants across the FGDs including police officers, community leaders, district officials and religious leaders described

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repeatedly encountering suicide cases preceded by severe socioeconomic hardship. One participant explained:

> When basic needs cannot be met, some people lose hope and think of ending their life. (FGD participant)

Taken together, these accounts suggested that prolonged socioeconomic adversity was perceived to erode hope and increase vulnerability to suicidal behavior.

Family conflict and interpersonal difficulties

Stakeholders consistently described family conflict and strained interpersonal relationships as important drivers of suicidal behavior. Across stakeholder groups, participants explained that many suicide cases they encountered were preceded by unresolved marital disagreements, domestic violence, relationship breakdown, family disputes and social isolation. Drawing on their experiences of responding to suicide cases and interacting with affected families, participants perceived that persistent interpersonal conflict often left individuals feeling emotionally overwhelmed, unsupported and without viable solutions to their problems.

One participant described family conflict as a common precursor to suicidal behavior:

> Most cases come from domestic violence and family misunderstandings. (IDI participant)

Several participants (FGDs) recounted described how financial pressures within families could escalate into conflict and, in some instances, contribute to suicide attempts. One participant recounted:

> We have had cases where men attempt suicide and, when asked what happened, they say they were carrying the burden of paying school fees alone. When they suggested selling family land to raise money, their wives and children opposed them and even beat them. (FGD participant)

Taken together, these accounts suggested that family conflict was often intertwined with broader socioeconomic pressures, particularly financial hardship and gendered family responsibilities, thereby increasing vulnerability to suicidal behavior.

Alcohol and substance use

Stakeholders consistently perceived alcohol and substance use as important contributors to suicidal behavior because they impaired judgment, reduced inhibitions and increased impulsive behavior during periods of emotional distress. Across both IDIs and FGDs, participants explained that alcohol and substance use often preceded suicide attempts and deaths, particularly among individuals already experiencing financial hardship, family conflict or other psychosocial challenges. Rather than being viewed as isolated drivers, alcohol and substance use were perceived to exacerbate existing vulnerabilities and increase the likelihood of acting on suicidal thoughts. One participant described how alcohol impaired judgment during periods of emotional distress

> When people take alcohol, they lose control and may act on suicidal thoughts. (IDI participant)

Similarly, participants in the FGDs emphasized that alcohol and other psychoactive substances could trigger impulsive suicidal behavior. One participant explained:

> Alcohol and drugs trigger the mind… someone can easily attempt suicide when intoxicated. (FGD participant)

This account reflects stakeholders' perceptions that intoxication diminished individuals' ability to cope with emotional distress and increased the likelihood of impulsive suicidal acts. Collectively participants perceived suicidal behavior as arising from the interaction of multiple social, economic, demographic, interpersonal, behavioral and environmental influences rather than from a single precipitating circumstance. Their accounts consistently highlighted how financial adversity, family conflict, demographic vulnerability, harmful alcohol and substance use and easy access to lethal means interacted to increase vulnerability to suicidal behavior.

Theme 3: Community-generated opportunities for suicide prevention

While participants described suicidal behavior as an important community concern driven by multiple interacting factors, they also identified practical and culturally appropriate opportunities for strengthening suicide prevention. Across both IDIs and FGDs, participants emphasized building on existing community structures rather than relying solely on formal mental health services. Two community-informed opportunities emerged consistently: engaging agro-input shop vendors as community gatekeepers and utilizing trusted community platforms to promote suicide awareness, reduce stigma and encourage early help-seeking.

Engaging pesticide vendors as community gatekeepers

Participants recognized that agro-input shop vendors are often the last point of contact before pesticides are purchased and suggested that they could play an important role in suicide prevention. They proposed training vendors to recognize individuals who may be experiencing psychological distress and, where appropriate and ethically acceptable, facilitate supportive engagement through trusted family members or Local Council leaders before completing pesticide sales. One participant explained:

> In our villages, we can work with pesticide shop owners. If someone comes looking disturbed or wants to buy poison under suspicious circumstances, the shopkeeper can first call a family member or inform the Local Council leader before selling it. That simple action may save a life. (IDI participant)

Participants emphasized that such an approach would require appropriate training, community sensitization and ethical safeguards to ensure that individuals are treated respectfully while reducing immediate access to highly lethal means.

Utilizing existing community platforms for suicide prevention

Participants in the FGDs also emphasized strengthening suicide prevention through existing community institutions and gatherings. Churches, mosques, community meetings and burial ceremonies were identified as trusted platforms for raising awareness about suicide, reducing stigma, promoting help-seeking and encouraging collective responsibility for supporting individuals experiencing psychological distress. One participant remarked:

> Churches, mosques, and even burial ceremonies bring people together. These are opportunities where leaders can openly talk about suicide, encourage people to seek help, and remind families that no one should suffer alone. (FGD participant)

Generally, participants proposed that suicide prevention should extend beyond formal mental health services by strengthening existing community structures and empowering trusted community members to identify, support and refer individuals experiencing psychological distress. These community-generated recommendations emphasized locally feasible and culturally acceptable approaches to suicide prevention within rural communities.

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Discussion

This study explored stakeholder perspectives on suicidal behavior in southwestern Uganda. Participants consistently portrayed suicidal behavior as an increasingly visible community and public health concern. Rather than attributing suicidal behavior to isolated events, they described it as emerging from the interaction of socioeconomic adversity, family and interpersonal conflict, harmful alcohol and substance use, demographic vulnerabilities, and access to lethal means.

Beyond identifying these interacting drivers, participants also proposed practical, culturally grounded opportunities for suicide prevention that build on existing community structures and social networks. Collectively, these findings highlight the complex and interconnected nature of suicidal behavior while demonstrating the potential of community-informed approaches to strengthen suicide prevention in rural settings.

The widespread perception that suicidal behavior has become a prominent community concern is supported by evidence from a review of primary healthcare records in southwestern Uganda, which reported that Ntungamo District had the highest incidence of nonfatal suicide attempts among the four districts studied (72.31 per 100,000 population) (Kaggwa et al., 2022b).

The convergence between stakeholders' accounts and routinely collected health service data strengthens confidence that suicidal behavior represents an important public health challenge in this setting rather than an isolated or sporadic phenomenon.

Participants' accounts were also consistent with repeated local media reports describing suicide deaths in Ntungamo District, including multiple highly publicized incidents involving teachers, police officers and other community members (Richard, 2022; Perez, 2022). Although media reports cannot be used to estimate the burden of suicide, they provide contextual evidence that suicidal behavior has become sufficiently visible to attract sustained public attention. Our findings may also highlight the importance of strengthening suicide surveillance systems in Uganda. For example, improved surveillance may facilitate more accurate identification, reporting and monitoring of suicide and suicidal behavior, particularly in settings where criminalization, stigma and underreporting may obscure the true burden (Lubaale, 2018). Taken together, evidence from stakeholder narratives, routine health facility data and media reports suggests that suicidal behavior is an important and increasingly recognized public health concern in Ntungamo District.

Importantly stakeholders perceived several interacting factors to influence suicidal behavior in Ntungamo District, including access to lethal means (particularly ropes and pesticides), male gender, young age, socioeconomic adversity (including debt burden and family conflict) and harmful alcohol and substance use. Participants' perceptions that hanging and pesticide poisoning were the most common methods of suicide are consistent with previous studies demonstrating that the availability of lethal means strongly influences the methods used in suicidal behavior (Runeson et al., 2010; Tsirigotis et al., 2011) and highlights that the availability of means significantly influences the methods employed. However, our findings differ from studies carried out in urban or high-income countries where firearms are more available or with those that identify jumping from heights as standard methods (Kaplan and Geling, 1998; Moore and Robertson, 1999; Molina and DiMaio, 2008; Reisch et al., 2008; Tsirigotis et al., 2011), thus confirming the idea that the means of suicide are often dependent on what is readily available. Collectively, together, these findings reinforce the importance of context-specific means restriction strategies that consider the local availability of lethal methods as a key component of suicide prevention in rural communities.

Our finding that stakeholders perceived suicidal behavior to be more common among men than women is consistent with previous studies reporting higher suicide mortality among men across diverse settings (Bachmann, 2018; Galvez-Sánchez et al. 2025; Lubas-Grzyb et al., 2026; Van Der Walt et al., 2026). This perception may partly reflect prevailing gender norms that position men as primary economic providers, potentially exposing them to greater financial pressures while simultaneously discouraging help-seeking during periods of psychological distress (Thompson et al., 2016; Lubas-Grzyb et al., 2026). Similar perception was also reflected in local media reports from Ntungamo District, which documented several recent suicide deaths involving men (Richard, 2022; Perez, 2022). In addition, previous research suggests that men are more likely than women to use highly lethal methods, such as hanging, which may contribute to higher suicide mortality among men (Moore and Robertson, 1999; Tsirigotis et al., 2011). Taken together, these findings highlight the importance of gender-responsive suicide prevention strategies that address socioeconomic pressures and barriers to help-seeking among men.

In line with participants' accounts, stakeholders perceived suicidal behavior to be more common among young people than older adults. This perception is supported by Ugandan evidence documenting a substantial burden of suicide among young adults, including evidence from Kampala showing that the peak age of suicide was 20–39 years (Kinyanda et al., 2011) and studies documenting suicidal behaviors among university students in Uganda(Kaggwa et al., 2022a). Previous research suggests that this increased vulnerability may be driven by interpersonal difficulties, financial strain, unemployment and limited access to basic necessities (Culbreth et al., 2018; Rukundo et al., 2020). Consistent with these observations, participants in our study associated suicidal behavior among young people with relationship problems, unemployment and an inability to meet basic needs (Kirkbride and Paul, 2022). These findings underscore the need for youth-focused suicide prevention strategies that strengthen psychosocial support, improve economic opportunities and promote early identification of young people experiencing psychological distress. However, this finding should be interpreted as a stakeholder perception rather than evidence that suicidal behavior is objectively more common among younger people than older adults in the study setting, as this qualitative study was not designed to estimate or compare age-specific rates of suicidal behavior.

Notably, socioeconomic adversity, particularly debt burden and family conflict, emerged as important perceived drivers of suicidal behavior. Participants described how persistent financial hardship, inability to meet basic household needs and escalating family conflicts often contributed to feelings of hopelessness and increased vulnerability to suicidal behavior. These observations are consistent with previous studies reporting higher suicide rates among individuals experiencing financial hardship and low income (Näher et al., 2020). Similarly, studies from Sweden have shown that individuals experiencing over-indebtedness are at substantially greater risk of suicide attempts and suicide than those without significant debt (Rojas, 2022; Levinsson et al., 2023).

Our findings also align with evidence from Uganda, where financial difficulties, unemployment and family breakdown have been identified as important contributors to psychological distress and suicidality among adolescents living in urban poor communities (Bukuluki et al., 2021). In general, this evidence underscores the

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need for suicide prevention strategies that address not only mental health needs but also the socioeconomic conditions, financial insecurity and family stressors that contribute to psychological distress and hopelessness.

Alcohol and substance use also emerged as important perceived drivers of suicidal behavior. Participants described alcohol and other psychoactive substances as contributing to impaired judgment, reduced inhibitions and impulsive behavior, particularly among individuals already experiencing financial hardship, family conflict and other psychosocial stressors. These observations are consistent with previous studies demonstrating strong associations between alcohol and substance use and suicidal behavior (Ikealumba and Couper, 2006; Nyundo et al., 2020). The finding that substance use poses suicide risks is also consistent with previous studies that have found correlations between alcohol/substance use and suicidal behavior (Pompili et al., 2010; Rizk et al., 2021). Previous research further suggests that some adolescents use alcohol and illicit substances as maladaptive coping mechanisms during periods of psychological distress (Nyundo et al., 2020). These findings suggest that suicide prevention efforts should integrate mental health and substance use services while simultaneously addressing the broader social and economic adversities that increase vulnerability to suicidal behavior (Hawton and Van Heeringen, 2009). An important contribution of this study was the identification of practical, community-informed opportunities for suicide prevention. Participants emphasized that suicide prevention should build on existing community structures and trusted social networks rather than relying solely on formal mental health services (World Health Organization, 2018, 2021b; Wakida et al., 2026).

One particularly innovative recommendation was engaging agro-input shop vendors and Local Council leaders as community gatekeepers to help identify individuals who may be at risk of self-harm before pesticides are purchased. This recommendation aligns with the WHO LIVE LIFE framework, which identifies restricting access to highly hazardous pesticides as one of the most effective population-level strategies for suicide prevention (World Health Organization, 2021a). It is also consistent with emerging evidence from South Asia and elsewhere demonstrating that training pesticide vendors to recognize and respond to individuals at risk of self-poisoning is both feasible and potentially effective in reducing suicide deaths (Weerasinghe et al., 2022; Zhou and Mohamed, 2025). However, involving agro-input shop vendors and Local Council leaders also raises ethical and practical concerns, including privacy, confidentiality, stigma and potential profiling of customers. Any such approach would require clearly defined roles, appropriate training, confidentiality safeguards and established referral pathways to health and psychosocial services.

We recommend future studies should evaluate whether training agro-input shop vendors and Local Council leaders as community gatekeepers is a feasible, acceptable and effective strategy for reducing pesticide-related suicidal behavior in rural communities.

Participants also highlighted churches, mosques, burial ceremonies and other community gatherings as trusted platforms for raising awareness, reducing stigma and encouraging early help-seeking. In many rural African settings, these institutions play a central role in community life and often serve as the first point of contact for individuals experiencing psychological influences (Koenig, 2009; Wakida et al., 2026). Building on these existing structures is consistent with growing recognition that effective suicide prevention requires active community engagement and multisectoral collaboration rather than relying exclusively on specialist mental health services (World Health Organization, 2018, 2021a). Future studies should evaluate the feasibility and effectiveness of integrating suicide awareness and prevention messages into faith-based institutions and other community platforms.

The legal context should also be considered when developing community-based suicide prevention interventions in Uganda. Criminalization of attempted suicide may have implications for disclosure, help-seeking and engagement with community and health services, particularly where individuals fear stigma or punitive consequences. This is relevant to the proposed gatekeeper approach because community-based identification should prioritize supportive engagement, confidentiality, appropriate referral and access to care rather than punitive responses. Gatekeepers should not be expected to make clinical or legal determinations regarding suicidal behavior. Any future intervention involving community actors would therefore require clearly defined roles, appropriate training, confidentiality safeguards and established referral pathways linking community-based identification with health services.

Overall, this study demonstrates that stakeholders perceived suicidal behavior as an important community concern arising from the interaction of multiple social, economic, demographic and environmental influences rather than from a single precipitating factor. Participants consistently described how financial hardship, family conflict, harmful alcohol and substance use, demographic vulnerability and access to lethal means reinforced one another, progressively increasing vulnerability to suicidal behavior. Beyond identifying these interacting drivers, participants also proposed practical, community-informed opportunities for suicide prevention, including engaging community gatekeepers and leveraging existing community structures to promote awareness, reduce stigma and facilitate early identification and support for individuals at risk.

Limitations

Our study has some limitations that should be considered when interpreting the findings. First, the qualitative design was exploratory and does not allow for causal inference or estimation of the prevalence of suicidal behavior. The findings therefore provide in-depth stakeholder-informed insights rather than population-level estimates. Second, the use of purposive sampling may have introduced selection bias, as participants were selected based on their roles, experiences and relevance to suicide prevention. Although this approach enabled the inclusion of diverse stakeholder perspectives, some stakeholder categories were represented by small numbers, and the sample was weighted toward health-system and community leadership perspectives. Only four participants had lived experience of suicidal behavior. The findings should therefore be interpreted as stakeholder-informed perspectives rather than representative accounts of the broader community or individual stakeholder groups. Third, the sensitive nature of suicidal behavior may have influenced participants' responses through recall and social desirability biases, and some participants may have been reluctant to disclose personal experiences or express views they considered socially or professionally sensitive. Interviews and FGDs were conducted with the support of translators where necessary, and some nuances in complex or culturally sensitive accounts may have been influenced or lost during translation. Despite these limitations, the study provides stakeholder-informed insights into perceived drivers of suicidal behavior and potential opportunities for suicide prevention in a rural Ugandan setting.

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Conclusion

Stakeholders perceived suicidal behavior as a significant community concern driven by interacting social, economic, demographic and environmental influences. They also identified practical, community-informed opportunities for suicide prevention that build on existing local structures and social networks. Harnessing these community assets alongside strengthened mental health services may enhance the effectiveness, acceptability and sustainability of suicide prevention efforts in Uganda and similar rural settings across sub-Saharan Africa.

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Competing interests. The authors declare that they have no competing interests.

Data availability statement. The datasets used and analyzed during the current study will be available from the author on request.

Ethics and approvals. Ethical clearance was obtained from The Mbarara University of Science and Technology Research Ethics Committee (MUST-2024-1,493). The study was further registered with the Uganda National Council for Science and Technology (HS4371ES). We further acquired administrative clearance from the District Health Officer (DHO) who oversees health activities within the district. We collected the participants' oral and written informed consent to ensure comprehension and full awareness of the content. Interviews were conducted in private settings to ensure confidentiality. Although participants were clinically stable at the time of the interviews, a referral protocol was in place. Participants who experienced distress during or after participation were offered psychological support by clinicians on the research team and referred to appropriate health facilities where necessary.

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