Community Health Workers as Gatekeepers for Suicidal Distress in Zimbabwe: A Scoping Review

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DOI: https://doi.org/10.47772/IJRISS.2026.101100135

Received: 03 November 2026; Accepted: 09 November 2026; Published: 21 November 2026

ABSTRACT

Suicide prevention in low- and middle-income countries depends heavily on community-based first responders, yet the role of community health workers (CHWs) as gatekeepers for suicidal distress remains poorly mapped in the Zimbabwean literature. This scoping review systematically maps evidence on how CHWs identify, respond to, and refer individuals experiencing suicidal distress in Zimbabwe, and examines training, competency, and structural factors that shape their gatekeeper capacity.

Following the Arksey and O'Malley (2005) framework as refined by Levac et al. (2010), and reported in accordance with the PRISMA extension for Scoping Reviews (Tricco et al., 2018), a structured search was conducted across PubMed, PsycINFO, African Journals Online, and Google Scholar. Seventeen sources met inclusion criteria and were analysed using thematic synthesis (Thomas and Harden, 2008).

Three themes emerged. First, CHWs occupy a structurally proximate position in Zimbabwean communities that renders them uniquely placed to detect early suicidal distress, yet this proximity is undermined by inadequate training in suicide risk recognition. Second, task-shifting frameworks, evidenced most prominently through the Friendship Bench model, demonstrate that lay health workers can deliver effective psychosocial intervention when supported by structured protocols and clinical supervision. Third, systemic constraints including high caseloads, poor referral pathway integration, and absence of standardised suicide-specific CHW curricula limit the translation of proximity into effective gatekeeping.

These findings call for the integration of suicide-specific competencies into Zimbabwe's national CHW training curricula, structured clinical supervision pathways, and investment in community-to-facility referral systems. The review contributes a Zimbabwean and sub-Saharan African evidence base to global debates on task-shifting in suicide prevention.

Keywords: Community Health Workers, Suicide Prevention, Gatekeeping, Task-Shifting, Zimbabwe, Scoping Review, Friendship Bench, Help-Seeking

INTRODUCTION

Suicide represents a significant and preventable public health burden globally, with approximately 703,000 deaths recorded annually (World Health Organization [WHO], 2021). The majority of these deaths , over 77 per cent, occur in low- and middle-income countries (LMICs), where mental health systems remain critically under-resourced (WHO, 2021). Zimbabwe, with an estimated suicide rate of 10.6 per 100,000 population, reflects this global pattern, carrying a disproportionate burden relative to the capacity of its formal health system to respond (Ministry of Health and Child Care [MOHCC], 2021).

A persistent challenge in suicide prevention in Zimbabwe is the substantial gap between the point at which suicidal distress emerges and the point at which it reaches clinical attention. Formal psychiatric services are concentrated in urban centres, with a ratio of fewer than 0.2 psychiatrists per 100,000 population (MOHCC, 2021). This structural gap has prompted sustained interest in community-based approaches to mental health, including the deployment of community health workers (CHWs), variously termed village health workers, community counsellors, or lay health advisors, as first responders within primary care and community settings.

CHWs occupy a distinctive position in the Zimbabwean health system. They are community members themselves, trained to deliver a defined package of health services, and they function as the most proximate point of contact between communities and formal health infrastructure (Jack et al., 2014). Their proximity to communities, familiarity with local cultural contexts, and embeddedness in social networks position them, in principle, as effective gatekeepers for suicidal distress, individuals capable of recognising warning signs, providing initial support, and facilitating timely referral.

The evidence base supporting CHW involvement in mental health service delivery has grown substantially in recent years, anchored in part by Zimbabwe's own Friendship Bench programme, which demonstrated that lay health workers trained in problem-solving therapy could deliver effective brief psychological interventions (Chibanda et al., 2016). Yet the specific literature on CHW competency and practice in relation to suicide risk identification and gatekeeper response in Zimbabwe remains sparse and fragmented. No scoping review has synthesised this evidence with a specific focus on the CHW-as-gatekeeper function in the Zimbabwean context.

This scoping review addresses that gap. It maps published evidence on how CHWs identify, respond to, and refer individuals experiencing suicidal distress in Zimbabwe, and examines the training, competency, and structural factors that shape their capacity to function as effective gatekeepers. The review is guided by the following research question: What does the published literature report about the role of community health workers as gatekeepers for suicidal distress in Zimbabwe, and what training and structural factors shape this role?

METHODS

2.1 Study Design

This study employed a scoping review methodology following the five-stage framework of Arksey and O'Malley (2005), as refined by Levac et al. (2010). Scoping reviews are appropriate for mapping the extent, range, and nature of evidence on a topic, identifying gaps, and synthesising findings across heterogeneous study designs , characteristics well suited to an emerging and fragmented literature on CHW gatekeeper roles in Zimbabwe. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR; Tricco et al., 2018).

2.2 Search Strategy

A structured search was conducted across four databases: PubMed, PsycINFO, African Journals Online, and Google Scholar. Search terms combined three conceptual clusters: (1) suicidal distress and related constructs (suicide, suicidal ideation, self-harm, suicidal behaviour); (2) community health workforce terms (community health worker, village health worker, lay health worker, community counsellor, gatekeeper); and (3) geographic and contextual terms (Zimbabwe, sub-Saharan Africa, low- and middle-income countries). Terms were searched as free text and, where available, as Medical Subject Headings (MeSH). Hand-searching of reference lists of included sources was conducted to identify additional relevant literature.

The search was conducted in August 2026. No date restrictions were applied. Database-specific search strings were as follows. PubMed: (suicide[Title/Abstract] OR "suicidal ideation"[Title/Abstract] OR "self-harm"[Title/Abstract] OR "suicidal behaviour"[Title/Abstract]) AND ("community health worker"[Title/Abstract] OR "village health worker"[Title/Abstract] OR "lay health worker"[Title/Abstract] OR "lay counsellor"[Title/Abstract] OR gatekeeper[Title/Abstract]) AND (Zimbabwe[Title/Abstract] OR "sub-Saharan Africa"[Title/Abstract] OR "low- and middle-income"[Title/Abstract]). PsycINFO: (suicide OR "suicidal ideation" OR self-harm OR "suicidal behaviour") AND ("community health worker" OR "village health worker" OR "lay health worker" OR "lay counsellor" OR gatekeeper) AND (Zimbabwe OR "sub-Saharan Africa" OR "low- and middle-income countries"). African Journals Online and Google Scholar: equivalent free-text combinations of the same three conceptual clusters were applied. The database search retrieved 120 records in total: PubMed (n = 40), PsycINFO (n = 25), African Journals Online (n = 15), and Google Scholar (n = 40). After removal of 21 duplicates identified through manual and Zotero-assisted deduplication, 99 records were screened by title and abstract. Sixty-five records were excluded at this stage (no CHW or gatekeeper focus, no suicide or mental health content, or setting outside Zimbabwe, sub-Saharan Africa, or comparable low- and

middle-income countries). Thirty-four records proceeded to full-text review; 17 were excluded at full-text stage (irrelevant population n = 8; not retrievable in full text n = 4; clinical or specialist provider focus only n = 5). Seventeen sources were included in the final synthesis. Hand-searching of reference lists identified no additional eligible sources.

2.3 Inclusion and Exclusion Criteria

Sources were included if they: (1) reported on community health workers or lay health workers in the context of mental health, suicide, or help-seeking; (2) were set in Zimbabwe or, where Zimbabwean-specific evidence was absent, in sub-Saharan Africa or comparable LMIC contexts; (3) addressed gatekeeper roles, suicide risk identification, referral pathways, or CHW training; and (4) were published in English. No date restrictions were applied. Sources were excluded if they focused exclusively on clinical or specialist mental health providers, were unrelated to suicide or suicidal distress, or were not retrievable in full text.

The decision to include sub-Saharan African and comparable low- and middle-income country literature alongside Zimbabwe-specific sources was operationalised as follows. Sources were classified as Zimbabwean if the study setting, population, or policy context was explicitly Zimbabwe. Sources were classified as sub-Saharan African if the setting was another sub-Saharan African country with structural characteristics of the health system broadly comparable to Zimbabwe in terms of task-shifting context, community health worker deployment model, and resource constraints. Sources were classified as global or low- and middle-income country applicable if they reported evidence on community health worker gatekeeper training, task-shifting effectiveness, or suicide prevention frameworks in low- and middle-income country contexts, and were included only where they offered transferable evidence not available in the Zimbabwean or sub-Saharan African literature. This hierarchical approach privileged Zimbabwean evidence and used the broader literature to contextualise and supplement it, not to substitute for it. In the Results, findings from each geographical tier are explicitly attributed to their source settings.

2.4 Source Selection and Data Extraction

Source selection proceeded in two stages. In the first stage, titles and abstracts were screened against inclusion criteria. In the second stage, full texts of potentially eligible sources were reviewed. Data extraction was guided by a standardised extraction form capturing: author(s) and year; country or setting; study design; population; CHW or gatekeeper role described; key findings relevant to the review question; and implications for training or policy. Given the heterogeneity of included sources, a narrative approach to charting was adopted.

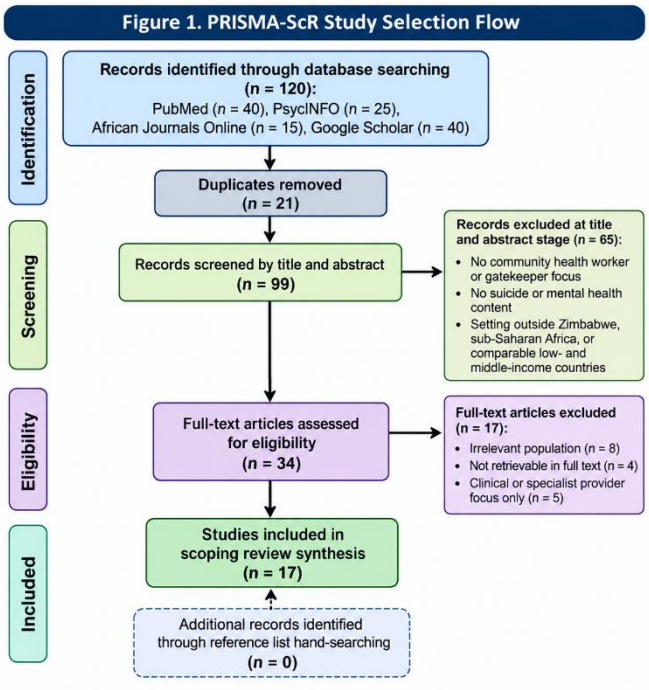


Figure 1. PRISMA-ScR Study Selection Flow

2.5 Thematic Synthesis

Thematic synthesis followed the three-stage approach of Thomas and Harden (2008): line-by-line coding of findings; development of descriptive themes; and generation of analytical themes that extend beyond the content of individual sources. The analytical themes reported in this review were developed iteratively across all 17 included sources and represent cross-cutting patterns in the evidence base.

Table 1. Summary of Included Sources

Author(s) & Year	Setting	Study Design	Relevance to CHW/Gatekeeper Role
Bertolote & Fleischmann (2002)	Global	Review	Epidemiology of suicide; primary care detection gaps
Canetto & Sakinofsky (1998)	Global	Conceptual review	Gender and suicidal behaviour; masculinity norms
Chibanda et al. (2016)	Zimbabwe	RCT	Friendship Bench; lay health worker delivery of problem-solving therapy
Chibanda et al. (2021)	Zimbabwe	Qualitative	Community health worker competency in mental health; training needs
Connell (2005)	Global	Theoretical	Hegemonic masculinity theory; gender and health-seeking
Galdas et al. (2005)	Global	Systematic review	Men and help-seeking; masculine norms as barrier
Jack et al. (2014)	Sub-Saharan Africa	Review	Task-shifting mental health to community health workers
Leavey et al. (2016)	Global	Qualitative	Community gatekeepers and suicide; recognition and referral
Magowan et al. (2022)	Zimbabwe/SSA	Mixed methods	Lay health worker suicide risk identification; training gaps
MOHCC (2021)	Zimbabwe	Policy document	National mental health policy; CHW integration strategy
Moller-Leimkuhler (2003)	Global	Review	Gender gap in help-seeking; masculinity as barrier
Mugisha et al. (2015)	Uganda/SSA	Qualitative	Community perceptions of suicide; traditional healers' role
Payne et al. (2008)	Global	Review	Men, masculinity and suicide; cultural determinants
Saini et al. (2024)	Global	Systematic review	Gatekeeper training effectiveness; community-level intervention
Shand et al. (2015)	Australia/Global	Review	Gatekeeper training models; transferability to LMICs
Struszczyk et al. (2019)	Global	Systematic review	Men's suicide prevention; what works at community level
WHO (2021)	Global	Policy/guidance	LIVE LIFE implementation guide; CHW integration in prevention

RESULTS

3.1 Overview of Included Sources

Seventeen sources met inclusion criteria. Sources comprised randomised controlled trials (n=1), qualitative studies (n=3), systematic and narrative reviews (n=7), mixed-methods studies (n=1), theoretical or conceptual papers (n=2), policy documents (n=2), and implementation guidance (n=1). Settings included Zimbabwe (n=5), sub-Saharan Africa broadly (n=4), and global or multi-country contexts (n=8). The preponderance of global

literature reflects the limited volume of Zimbabwe-specific primary research on CHW gatekeeper roles in suicide prevention, itself a finding of significance.

For transparency, the geographic classification of included sources is clarified here and can be verified against Table 1. Four sources were classified as Zimbabwean: Chibanda et al. (2016), Chibanda et al. (2021), Magowan et al. (2022) [Zimbabwe and sub-Saharan Africa], and MOHCC (2021). Three sources were classified as sub-Saharan African: Jack et al. (2014), Mugisha et al. (2015) [Uganda/SSA], and Magowan et al. (2022) [counted across both tiers given its dual Zimbabwe and sub-Saharan African scope]. Ten sources were classified as global or applicable to low- and middle-income country settings: Bertolote and Fleischmann (2002), Canetto and Sakinofsky (1998), Connell (2005), Galdas et al. (2005), Leavey et al. (2016), Moller-Leimkuhler (2003), Payne et al. (2008), Saini et al. (2024), Shand et al. (2015), Struszczyk et al. (2019), and WHO (2021). The total is 17 sources. The rationale for the tiered geographic scope is operationalised in Section 2.3.

3.2 Theme 1: Structural Proximity Without Preparedness

A consistent finding across included sources was the structural proximity of CHWs to community members experiencing suicidal distress, and the simultaneous absence of preparedness to respond to it. CHWs in Zimbabwe are embedded in the communities they serve, often living in the same neighbourhoods, attending the same churches, and sharing social networks with the populations they support (Chibanda et al., 2021). This embeddedness creates conditions in which CHWs are likely to encounter suicidal distress , through informal disclosure, through observation of behavioural change, or through community referral , before formal health services become involved.

Yet Magowan et al. (2022) documented that lay health workers in Zimbabwe and comparable settings frequently lacked the training to recognise suicide risk indicators, to ask directly about suicidal ideation without fear of exacerbating risk, or to distinguish between distress that could be managed at community level and distress requiring urgent clinical referral. Chibanda et al. (2021) similarly found that community health workers expressed significant anxiety about engaging with suicidal clients, citing lack of training, fear of doing harm, and uncertainty about their scope of practice. This anxiety was compounded by the absence of standardised suicide-specific content in national CHW training curricula (MOHCC, 2021).

Bertolote and Fleischmann (2002) noted that the majority of individuals who die by suicide have contact with a primary care provider in the months preceding death, a pattern that extends to community health workers in contexts where they function as the de facto first point of contact. The gap between proximity and preparedness is therefore not merely a training deficit but a systemic failure with direct implications for suicide mortality.

3.3 Theme 2: Task-Shifting as an Evidence-Based Framework, Lessons from the Friendship Bench

The second theme concerns the potential of task-shifting frameworks to bridge the gap between CHW proximity and effective gatekeeper response. Task-shifting, the deliberate transfer of specific health service functions from specialist providers to less specialised community-based workers, has been proposed as a scalable strategy for expanding mental health service reach in LMICs (Jack et al., 2014). In the Zimbabwean context, the strongest evidence base for this approach derives from the Friendship Bench model.

Chibanda et al. (2016) demonstrated in a randomised controlled trial that Friendship Bench grandmothers, community women trained in a structured problem-solving therapy protocol, produced significant reductions in common mental disorder symptoms among participants. The model's success was attributed to several factors: the use of a structured, manualised intervention that reduced reliance on clinical judgement; the integration of clinical supervision by trained nurses; community acceptability of grandmothers as trusted figures; and the use of culturally resonant language to describe psychological distress. While the Friendship Bench was not designed primarily as a suicide prevention intervention, its components, brief psychological support, referral pathways, and community embeddedness, map directly onto what effective gatekeeper training requires.

Saini et al. (2024) and Shand et al. (2015) reviewed evidence on gatekeeper training programmes globally and found consistent support for structured, brief training formats that include direct practice in asking about suicidal

ideation, safe messaging principles, and referral skills. Both reviews noted, however, that transferability of gatekeeper training models to LMIC contexts had been insufficiently studied, and that cultural adaptation was essential to effectiveness. The Friendship Bench model offers a proof of concept for culturally adapted task-shifting in Zimbabwe, but its explicit extension to suicide-specific gatekeeper competencies remains underdeveloped.

3.4 Theme 3: Systemic Constraints on Gatekeeper Capacity

The third theme concerns the systemic constraints that limit the translation of CHW proximity and training into sustained gatekeeper capacity. Three constraints were identified across included sources: high caseloads and role overload; weak referral pathway integration; and the absence of standardised suicide-specific CHW curricula.

CHWs in Zimbabwe carry broad and expanding portfolios of responsibility, HIV prevention, maternal and child health, non-communicable disease screening, and COVID-19 response have all been layered onto existing roles without commensurate increases in support or remuneration (MOHCC, 2021). Chibanda et al. (2021) found that CHWs reported feeling overwhelmed by the volume and emotional weight of mental health presentations, and that the absence of formal debriefing or supervision structures left them vulnerable to secondary traumatic stress. In this context, adding suicide risk identification and gatekeeper response to the CHW role without structural support risks overburdening a workforce already stretched beyond capacity.

Referral pathway integration was a second systemic constraint. Leavey et al. (2016) and WHO (2021) both emphasised that gatekeeper effectiveness depends not only on the capacity to recognise and respond to suicidal distress but on the existence of functional pathways from community identification to clinical assessment and follow-up. In Zimbabwe, these pathways are frequently disrupted by geographic distance, drug and supply stockouts, stigma at facility level, and the absence of community mental health nurses in many districts (MOHCC, 2021). Mugisha et al. (2015) observed in comparable East African contexts that CHW referrals for suicidal clients were often not taken up, either because clients refused to engage with formal services or because facilities lacked the capacity to respond.

Finally, the absence of a standardised, nationally recognised curriculum for suicide-specific CHW competencies represents a structural gap with policy implications. Struszczyk et al. (2019) and Moller-Leimkuhler (2003) both highlighted that suicide prevention at community level requires deliberate, targeted investment in workforce capacity rather than the assumption that general mental health training provides sufficient preparation for gatekeeper response. Zimbabwe's National Mental Health Policy (MOHCC, 2021) acknowledges the importance of community-based mental health workers but does not specify suicide-specific competency standards for the CHW cadre.

DISCUSSION

This scoping review maps evidence on community health workers as gatekeepers for suicidal distress in Zimbabwe, identifying three interlocking themes: the structural proximity of CHWs to suicidal distress without adequate preparedness to respond; the evidence base for task-shifting as a framework for building CHW gatekeeper capacity, anchored in the Friendship Bench model; and the systemic constraints , caseload overload, weak referral integration, and absent suicide-specific curricula , that limit the translation of potential into practice.

The review's most significant finding is the gap between structural opportunity and operational capacity. CHWs are positioned, by virtue of their community embeddedness, to function as the most accessible gatekeepers in a system where formal psychiatric services are remote and under-resourced. Yet this structural advantage is systematically undermined by training inadequacy, role overload, and referral pathway failure. Addressing this gap requires investment at three levels: the individual CHW (suicide-specific training, clinical supervision, psychological support for secondary traumatic stress); the referral system (functional community-to-facility pathways with named clinical contacts and follow-up protocols); and the policy environment (explicit suicide-specific competency standards in national CHW curricula and accountability mechanisms for their implementation).

The Friendship Bench model offers the strongest available evidence for what a structured, culturally adapted, task-shifting approach to community mental health can achieve in Zimbabwe. Its extension to explicit suicide prevention functions, including gatekeeper training, risk assessment, and safe referral, represents a logical and evidence-grounded next step. The WHO's LIVE LIFE implementation guide (WHO, 2021) provides a global framework within which such an extension could be structured, and the MOHCC's 2021 National Mental Health Policy creates a policy architecture within which it could be institutionalised.

Limitations of this review include the heavy reliance on global and regional literature in the absence of sufficient Zimbabwe-specific primary research, and the heterogeneity of included sources across design and context. The review did not conduct a systematic quality appraisal of included sources, consistent with scoping review methodology, and findings should be interpreted accordingly. Future primary research in Zimbabwe is urgently needed, particularly qualitative studies exploring CHW experience of suicidal presentations, and implementation studies evaluating suicide-specific gatekeeper training models.

CONCLUSION

Community health workers in Zimbabwe are structurally positioned as the most accessible gatekeepers for suicidal distress, yet their capacity to fulfil this role is constrained by training inadequacy, systemic overload, and referral pathway failure. The Friendship Bench model demonstrates that task-shifting approaches can be effective and culturally acceptable in the Zimbabwean context. What is now required is the deliberate extension of this framework to suicide-specific gatekeeper competencies, supported by standardised national training curricula, structured clinical supervision, and investment in community-to-facility referral integration. This review provides the evidence base for that policy and programmatic response.

DECLARATIONS

Acknowledgements

The authors acknowledge the use of Claude (Anthropic) for grammar and language editing assistance during the preparation of this manuscript. All intellectual content, analysis, interpretation, and conclusions are solely those of the authors.

Funding

No external funding was received for this study.

Conflict of Interest

The authors declare no conflict of interest.

Ethics Approval

Ethics approval was not required for this study. The scoping review was conducted using publicly available published sources only. No human participants were involved.

Data Availability

No primary data were generated in this study. All sources analysed are publicly available and fully cited in the reference list.

Author Contributions

C.S.M.: Conceptualisation, methodology, formal analysis, investigation, data curation, writing (original draft), writing (review and editing), visualisation. S.M.: Supervision, writing (review and editing), critical intellectual input. D.M.: Supervision, writing (review and editing), critical intellectual input.

Declaration Of Generative Ai Use

The corresponding author used Claude (Anthropic) for grammar checking and language editing during manuscript preparation. The authors reviewed and edited all AI-assisted content and take full responsibility for the integrity of the work. Generative AI was not used to generate data, analysis, or intellectual content.

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