

Exploring Targeted Interventions for Men Battling Suicidality in the United Republic of Tanzania

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Abstract

Suicide was reported to be the third leading cause of death among 15 - 29-year-old individuals, in 2021 by the World Health Organisation (WHO). It is a public health crisis affecting Tanzania too. Latest reports show that men die by suicide at a higher ratio than women in Tanzania. Financial problems, relationship and family problems being the top risk factors leading men to suicidality. This is argued to stem from longstanding societal views and cultural expectations, affecting them from childhood to adulthood. This qualitative research was conducted in Tanzania, collecting data from mental health care providers with the experience of treating men battling suicidality. A total of six participants were recruited through two Tanzanian non-government organisations and interviewed in person. The interviews aimed to explore the strengths in current interventions and recommendations for potential areas of improvement. Recommendations from mental health care providers in this research included increase in education and awareness, increase in facilities and centres, more government involvement, developing initiatives targeting men and decriminalisation of suicide attempt. Implementation of targeted interventions will require multidisciplinary action. A collaboration across institutions, the government, local initiatives and non-government organisations. Battling suicidality is a collective measure. Limitations identified in this research can be viewed as opportunities. Tanzania is in a unique position to develop suicide prevention measures that will be contextually, culturally and economically appropriate.

Keywords

Male Suicide, Suicidality, Tanzania, Mental Health

1. Introduction and Literature Review

This chapter introduces the topic of suicide and suicidality, and why this is an essential topic in the United Republic of Tanzania. Alongside is a short historical background of psychology in Tanzania for contextual purposes. Furthermore, there is a literature review that introduces theories and critically evaluates previous research. The United Republic of Tanzania will henceforth be referred to as Tanzania.

1.1. Suicide in Tanzania

“Suicide is the act of taking one’s own life” (Shneidman, 1989 as cited in [Kazdin, 2000](#)). Suicide is a highly sensitive topic that can be difficult to talk about. It was reported to be the third leading cause of death among 15 - 29-year-old individuals, in 2021, globally ([WHO, 2025](#)). Stigma, shame and limited resources are among the greatest barriers in suicide prevention measures ([Unicef, 2021](#); [Lyela et al., 2024](#); [Alemu et al., 2023](#)). Conducted research in the quest of understanding suicide has focused on several approaches including sociocultural, psychiatric, psychological, prevention/intervention/postvention and more ([Kazdin, 2000](#)).

Suicide among men in Tanzania have been reported to represent a higher suicide rate than women ([Edward et al., 2023](#)). This illustrates the vast gender disparity, increasing the need for targeted interventions supporting men battling suicidality.

1.2. Psychology History of Sub-Saharan Africa

Tanzania received its independence from British colonial power in 1961. It was previously called Tanganyika, before the merging of Tanganyika and Zanzibar that took place in 1964 (see [Figure 1](#)). From October 1964, the name United Republic of Tanzania was formed ([Mwakyembe et al., 2022](#); [VPO, 2025](#); [Chiteji & Mascarenhas, 2025](#)).

British colonialism left some marks, including the introduction of Euro-American educational system. The first psychology department, recorded in Sub-Saharan history, was established in Nigeria in 1964. In Ghana, this took place in 1967. The first recorded experimental psychology laboratory was established in Zambia in the year 1965. Tanzania had its first department of psychology, educational psychology, opening in 1990. This was twenty years after its neighbouring country, Kenya, whom had their first departments of psychology opened in 1970 ([Kazdin, 2000](#)).

To be a qualified psychologist in most Sub-Saharan countries, you need a bachelor’s and master’s degree combined. In Tanzania, a bachelor’s degree qualifies you to practice as a counsellor. It qualifies to teach in universities, conduct research, practice in the field and other related responsibilities ([Kazdin, 2000](#)). Educational psychology being the area University of Dar es Salaam ([UDSM, 2025](#)) offered for several years, led to most graduates working as teachers or administrators. Today, there are several institutions offering either a degree or specialisation

within psychology. University of Dar es Salaam (UDSM, 2025) offers BA in Psychology, University of Dodoma offers Bachelor of Education in Psychology, other institutions offer postgraduate degrees, diploma, certifications and more (UDOM, 2025; Health, 2022; OUT, 2023; MUHAS, 2024).



Ramani ikionesha eneo la Jamhuri ya Muungano wa Tanzania mwaka 1964

Figure 1. Map of United Republic of Tanzania in 1964. *Translated image description:* Map showing the area of United Republic of Tanzania in 1964. Picture source: (Mwakyembe et al., 2022: p. 45).

This historical background shows Tanzania as an emerging nation in respect to psychology. While there are recorded implementations and steps being taken, there are yet gaps to close. This paper will avoid comparing Tanzania to other nations due to the indifference in history, culture and economic status among other factors.

1.3. Mental Health in Tanzania

The mental health sector in Tanzania faces limitations due to scarce resources, challenged infrastructure and accessibility. Most mental health care institutions, facilities and specialists are found in the most populated areas such as Dodoma, Dar es Salaam, Mwanza and other urban areas (MHS, 2025). However, despite these challenges, civilians are rising as mental health advocates forming local initiatives, projects and non-government organisations to raise awareness and serve communities. Both professional mental health care providers and non-professionals are taking initiative. They are creating easily accessed safe spaces to provide support, reduce stigma and increase general knowledge about mental health.

Initiatives such as Mental Health Africa by Glory Livingstone, Tunasikiliza Platform by Ester Lwekiza, Tanzania Children and Youth Foundation, Mental Health Tanzania and others. These national NGOs and local initiatives are bridging the gap and creating access that government institutions may not have the capacity to.

Tanzania is one of the countries in Sub-Saharan Africa to yet develop a National Suicide Prevention Strategy. The World Health Organisation (WHO, n.d.) advocates for national suicide prevention strategies as tools to help coordinate and monitor joint efforts across the nation. Political measures, community measures and educational measures to mention a few. National strategies are to include critical elements in line with their local context (WHO, n.d.). While a national suicide prevention strategy for Tanzania is yet to be developed, there are apparent interventions made by communities, individuals and local organisations. These measures are recognised as bottom-up measures (WHO, 2018). These include all the local initiatives and national NGOs that exist to promote mental health and prevent suicide. Additionally, Tanzania is currently preparing for their national five-year strategic plan in respect to mental health and psychosocial support services (TAPA, 2024).

As of today, there are nationwide events and initiatives advancing the mental health sector in Tanzania. Firstly, Tanzania Mental Health Summit. This is a platform promoting collaboration, advocacy and action (MHS, 2025). They form partnerships with various stakeholders to increase awareness, create innovative strategies and create impactful solutions. Their mission is to ensure accessible mental health care access for all Tanzanians (MHS, 2025). Secondly, Tanzania Health Summit. They are holding their 12th summit October 2025 (THS, 2025). It is an annual gathering aiming to address existing challenges and recognise opportunities in advancing the universal health coverage of Tanzania (THS, 2025). In working to bridge existing gaps through technological innovation and AI advancement, this can also benefit the mental health care infrastructure.

Whether these bottom-up measures are perfectly aligned with the community engagement toolkit provided by WHO Geneva, is yet to be determined (WHO, 2018). Neither is it the main concern for this study. Furthermore, for the purposes of this study, it is more relevant to recognise the local community measures, rather than measuring its perfect alignments. The bottom-up activities of Tanzanian NGOs and local initiatives illustrate the active work in promoting mental health and battling suicidality in Tanzania, within given capacities.

1.4. Literature Review

Measures are being taken on a global scale to prevent suicide and battle suicidality. Organisations are educating, creating forums, influencing policies and raising awareness among other things (WHO, n.d.; IASP, 2022; Befrienders, 2025). However, hundreds of thousands of people are still dying by suicide annually (WHO, n.d.). This public health concern does not exclude Tanzania. This research seeks

to explore targeted interventions for suicidality among men in Tanzania, from the perspectives of mental health care providers. Research and literature focusing on targeted interventions for men battling suicidality in Tanzania is yet to be published. This literature review will therefore include relevant literature from both an African and global context.

1.4.1. Defining Suicidality

Suicidology, the study of suicide, has introduced different definitions of suicidality. Different definitions allow for flexibility to utilise the definition that best supports the context of the study. Understanding suicidology according to context helps develop contextually appropriate interventions (Jidong et al., 2024; Knippler et al., 2024). Individuals with lived experiences support this observation through the variety of their own experiences with suicidality (Farai, 2023; Vanessa, 2024; Hilda, 2023). This study will utilise the definition provided by the American Psychological Association.

Suicidality is defined as suicide risk, often indicated by suicidal ideation, especially when there is evidence of a suicidal plan. This term includes suicidal thoughts, plans, attempts and self-harm (APA, 2018; Anderson University, 2025, Suicidality). Suicidal ideation or thoughts is when an individual thinks about suicide or plans a suicide (Cleveland Clinic, 2024). Suicidal attempt is when an individual intentionally harm themselves trying to end their life but survives. It is recommended to neither label it as failure nor success (APA, 2023). Self-harm is when an individual injures themselves, with no intention of dying. Research suggests self-harm to be a method of suicide prevention (Curtis, 2017; Curtis, 2024), but other research claim it to develop suicidal self-injury leading to death (Hjelmeland, 2022; p. 57).

Edwin Schneidman, known as the father of contemporary suicidology, suggested that suicide or suicidality can be studied from different standpoints (Chavez-Hernandez & Leenaars, 2010). Literature, philosophy, theology, demographics, sociocultural, psychologically, psychiatric and more (Shneidman, 1996 as cited in Hjelmeland, 2022). His main point of view was psychologically. He argued that the best way to truly understand suicide or suicidality is through individuals that have experienced suicidality and are suicide survivors (Shneidman, 1996 as cited in Hjelmeland, 2022). His work included formalising suicide prevention centres, training mental health professionals and reflecting on how individuals can support those battling suicidality (Chavez-Hernandez & Leenaars, 2010). Therefore, his recommendation of qualitative or explorative research methods being the way to truly understand suicidality, is based on years of experience and research. His recommendation supports the argument of increasing more qualitative studies within suicidality research (Hjelmeland, 2022; Chavez-Hernandez & Leenaars, 2010; Knettel et al., 2024).

Suicidality can affect anyone regardless of racial background, health status, social status, education level or other factors. Unfortunately, historically most psychological research has been done by and with western, educated, industrialised,

rich and democratic (WEIRD) nations (Henrich et al., 2010; Muthukrishna et al., 2020). This has led to the understudying and exclusion of the African population, specifically Tanzanian. Given how psychology research often aims to educate and discover further recommendations, it is crucial to include understudied populations. Limited research by and of African populations suggest a further need for contextually appropriate interventions (Jidong, et al., 2024).

Suicidality can develop due to combined factors ranging from an individual level, relationship level, community level, societal or cultural level (CDC, 2022). Mental disorders or distress, financial problems, grief, loss of a loved one to suicide, stigma and shame associated with having suicidal thoughts are some of many factors. All these factors mentioned, among others, can be categorised as risk factors. However, the presence of these factors is not equivalent to the presence of suicidality (CDC, 2022: p. 14). Risk factors may overlap in cases of suicidal thoughts, suicidal attempt and death by suicide (Franklin et al., 2017 as cited in Hjelmeland, 2022).

1.4.2. Risk Factors of Suicidality

Risk factors of suicidality often increase levels of suicidal ideation, behaviour and attempts (CDC, 2022). Among many different risk factors, there are some selected ones this study will highlight.

History of suicide is a bigger factor than previously assumed. This includes suicide attempt and the loss of a family member or loved one to suicide. Research suggests that a big percentage of individuals who attempt suicide for the first time, and receive medical help, are likely to attempt again within one year (Bostwick et al., 2016). Suicide attempt is argued to be a lethal risk to a second suicide attempt or completed suicide. (Bostwick et al. 2016; Kim et al., 2020). Losing a loved one to suicide has shown to increase risk of suicide. The bereaved become at risk of developing mental health challenges and suicidality (Hilda, 2023; NIPH, 2024). Social stigma and shame add to the pain, increased isolation, hopelessness and loneliness (Hilda, 2023). In addition to this, studies have found bereaved men to seek mental health support the least, placing them at a higher risk to suicidality (NIPH, 2024).

Life crisis is a risk factor that can often be undocumented. Most research is conducted through the health care system; findings oftentimes include mental health challenges linked to suicidality. However, sudden life crisis has proved to be a risk factor in suicide and suicidality (Nyhus et al., 2025; CDC, 2022). Life crisis such as divorce or break up, sudden death of a loved one, financial problems and debts, legal problems, relationship problems, abuse and more (CDC, 2024; Ndosi, Mbonde & Lyamuya, 2004).

Thirdly, is criminalisation of suicide attempt. Some countries, including Tanzania, still punish suicide attempt if brought to the court (Jidong et al., 2024). Criminalisation of suicide attempt creates barriers in seeking professional help as it creates fear among individuals who need help. This amplifies social stigma for both the individual in need and their families or loved ones (Hilda, 2023). Fur-

thermore, leading to people suffering in silence, lack of accurate suicidality data, which further leads to insufficient strategies to provide the services needed (WHO, 2023; Onger, et al., 2023).

Last, but not least are chronic illness and depression. Depression is among the leading risk factors of suicide and linked to most suicidality and suicide cases (Ndosi et al., 2004; Knettel et al., 2024; Farai, 2023). Other mental health challenges include post-traumatic stress disorder (PTSD) and substance use disorder among others (Center). Some chronic illnesses can cause immense physical and emotional pain leading to hopelessness and feelings of entrapment as the “Cry of Pain” model suggests (Rasmussen et al., 2010). Other illnesses, such as HIV, adds to shame and stigma that increases risks of suicidality (Knippler et al., 2024).

The presence of one or more of these risk factors does not equate to the presence of suicidality in someone (CDC, 2022). However, identifying risk factors informs what measures can be considered and taken on different levels. Community level, medical level, educational level and legislation level. Furthermore, identifying risk factors associated with Tanzanian men is needed in exploring targeted interventions for men battling suicidality. A community’s suggestions, combined with professional and evidence-based suggestions, can produce more culturally appropriate interventions.

1.4.3. Suicidality Research in Tanzania

Research conducted in the African continent in relation to suicidality has made some repeated observations. Limited infrastructure, limited resources, stigma, and gap in contextual research output among other things. Total mental health research output in 2021 was 3.49% (WHO, 2022). Among the recorded 3.49% is also the suicidality research output, in which its specific data was not disclosed. However limited the research output is, there are some studies conducted with findings that further supports the need for further exploration of contextually appropriate interventions (Jidong et al., 2024; Knettel et al., 2023; Knettel et al., 2024; Onger, et al., 2023).

Suicidality can affect anyone regardless of background, health status or career. However, there are certain groups of people that are at a higher risk compared to the general population excluded from that category. Among groups experiencing high risk of suicidality in Tanzania, is people living with HIV (PLWH). Research by Knippler et al. (2024) suggests them to be seven times more likely to attempt suicide compared to the general Tanzanian population. Additionally, twice more likely to die by suicide. This is in significant alignment with the approximate frequency suggested by Tsai et al. (2022). A systemic review of 43 international papers, that suggested risk of suicidality among PLWH to be three times more than the general population (Tsai et al., 2022). Suicide being the second cause of death among PLWH in Taiwan region, also demonstrate the high risk among PLWH (Tsai et al., 2022). Some of the factors contributing to high risk in this group are internalised shame, gap in knowledge, stereotyping, stigma related to both HIV and suicidality, financial stress, family challenges, relational challenges and more

(Knippler et al., 2024). These factors may lead to isolation, which might develop depression or other mental health conditions contributing to suicidality (Ongeri et al., 2023).

Within this group, one crucial element was gender disparity. Mental health care professionals observed more women seeking and receiving mental health care than men (Knippler et al., 2024). This observation is supported by another research done in a different part of the world, Norway (Dietrichson, 2022). Norwegian suicidality researcher Kim Stene-Larsen argued that women tend to be more open and vulnerable with their trusted circles, than men. Which he suggested can lead to detecting suicidal ideation earlier and seeking help earlier (Dietrichson, 2022). This aligns with what the health care professionals of Northern Tanzania observed, how women tend to be more open than men, making men more prone to suicide (Knippler et al., 2024). Kim Stene-Larsen's years of research of men battling suicidality or dying by suicide, has revealed that men find it more difficult to share their problems. They have an idea of what a man is supposed to be. Being a provider, a protector and looking after his family and loved ones. Asking for help might disrupt this ideal role he is supposed to be capable of (Dietrichson, 2022). This is also the case in the Tanzanian context, where both women and men are raised to think of men as the financial providers, protectors who should not complain about anything, not cry, and that showing emotions equates to weakness (Knippler et al., 2024; Semeni, 2025).

This ideal manhood described by this researcher is further addressed through men who lived through suicidality and shared their stories with the world. A Norwegian journalist who battled suicidality while living in the United Kingdom with his family, found it difficult to seek professional help (Jostein, 2021). Other men shared how challenging they found it to seek help, despite battling suicidality (Egil, 2023; David, 2023). This is unfortunately the case for many men in Tanzania as well. Social and cultural expectations of men in Tanzania is leading some of them to suicidality (Semeni, 2025). This will be further explored through data collection.

Among these men are also adolescents experiencing high risk of suicidality. Studies show suicidality among adolescents in Tanzania being influenced by different factors (Shirima et al., 2023; Nyundo et al., 2023). Financial difficulties, poor relationship with parents and substance use among other factors. Unfortunately, the limited mental health infrastructure leaves them vulnerable, leading them to explore unhealthy coping mechanisms (Shirima et al., 2023; Tsai et al., 2022).

A cross-sectional study conducted in the region of Kilimanjaro in Tanzania found stigma and shame to be among limiting factors of help-seeking behaviour in fear of being judged by the community (Alemu et al., 2023; Shirima et al., 2023).

Both Shirima et al. (2023) and Knippler et al. (2024) were conducted in the Northern Region of Tanzania, Kilimanjaro, but found insight that relate to other parts of Tanzania. Such as stigma and shame, unhealthy coping mechanisms and

limited mental health services to provide support. To further build on these studies, it would be a recommendation to expand geographically and demographically. Expanding the study can increase the richness of the data (Ahmed, 2025) and provide further insight.

1.4.4. Men Battling Suicidality in Tanzania

Collected data illustrates how men have a higher completed suicide rate than women (Rasmussen, 2013; Knippler et al., 2024). Although suicidal ideation, thoughts and attempts can be of approximately equal quantity between both genders, the gender disparity shifts as it reaches completed suicides. This is reflected across different countries and cultures (see Daniel, et al., 2018; Egil, 2023; Jostein, 2021; Muthukrishna et al., 2020; Rasmussen, 2013). This is the case for suicide cases found in Tanzania too.

The gender disparity in suicide cases found in Tanzania is big. These cases include respected leaders, fathers, husbands, brothers, uncles, sons. However different the suicide methods were, the results were death by suicide.

Limited research output and lack of access to Tanzanian suicidality data, calls for research to be done. Developing and implementing targeted interventions requires knowledge and understanding. One of the recommended ways is through explorative research, as Shneidman argued (Shneidman, 1996 as cited in Hjelmeland, 2022). Individuals with lived experience can provide insight to inform researchers and mental health care providers (Rasmussen, 2013; Chavez-Hernandez & Leenaars, 2010). Mental health care providers can provide insight to both educate and equip the public, governments and policy makers. This research aims to explore interventions that will support men battling suicidality in Tanzania, in the collective measures of suicide prevention.

Although Tanzanian research output is limited in this topic, other research support similar challenges men are facing. Such as Rasmussen (2013) qualitative research, which revealed how young men often face challenges in the transition from adolescence to adulthood. How both the societal and internalised expectations can cause unbearable pressure, finding it difficult to live up to the “ideal man” standards. One of the key findings of this study was the inability to appropriately regulate emotions, often shame and anger, related to personal defeats of not meeting the societal expectations (Rasmussen, 2013). Durkheim’s sociological suicide theory supports this finding, as his theory was focused on how social integration and disintegration can lead to suicidality and completed suicide (Hjelmeland, 2022: p. 130). The young men studied in Rasmussen (2013) did not have any history of mental illnesses, nor financial difficulties or other known risk factors. This supports the knowledge of how suicidality can occur in the absence of mental illness, nor can it always be detected externally. This does not equate to there not being any risk factors involved, but rather the need for deeper insight (Knippler et al., 2024; Jostein, 2021).

What existing studies and shared lived experiences have suggested is the urgent need to accommodate men battling suicidality in ways that will be appropriate to

them.

1.4.5. Interventions

Evidence-based interventions utilised in cases of suicidality and suicide prevention are known to vary depending on context. Interventions in this study will focus on therapy interventions and approaches, public awareness and education, and legislative interventions.

Firstly, psychosocial treatments, such as cognitive behavioural therapy, hereby referred to as CBT (Brodsky et al., 2018). CBT is often utilised due to its focus on the cognitive functions in accepting reality and learning to face challenges in healthier ways (Brodsky et al., 2018). In addition to this, there is safety plan intervention (SPI), aiming to secure an individual battling suicidality and provide the tools they need. This is a plan created between a mental health care provider and receiver to identify warning signs, various coping skills, places and people that can serve as distraction, establishing private emergency contacts, professional contacts for help, and steps to take for safety measures (Brodsky et al., 2018). This intervention is not only for clinical care facilities, but also non-clinical (Nyhus et al., 2025).

Secondly, increasing public awareness and education (Jidong et al., 2024; Chavez-Hernandez & Leenaars, 2010). Shneidman emphasised on the importance of education as one of the pillars of interventions. Jidong et al. (2024) supports this recommendation by arguing how increased knowledge will encourage more conversations and might help foster early help-seeking behaviour. This is what national NGOs, mental health advocates and local initiatives in Tanzania are currently doing. Organising campaigns, workshops, visiting schools and providing corporate trainings (MHT, 2025; Ndoto Njema Foundation, 2025; Mauki, 2025; Kohrt et al., 2015). Education and awareness can help increase knowledge, reduce stigma and enlighten people. Education and awareness can challenge current societal views, cultural expectations and family relations. Education can also enhance the knowledge of mental health care providers in providing care and support in their respective fields. This applies to mental health advocates as well, who serve an important role in the mental health sector of Tanzania.

Education also applies to mental health care providers, advocates, community leaders, religious leaders and other key stakeholders, to increase skills and readiness (Shneidman, 1996 as cited in Hjelmeland, 2022). A study conducted in Liberia; West Africa found significant results in mental health training provided to law enforcement in Liberia. Knowledge among the officers increased from 64% to 82%. Although the aim was to introduce collaboration between mental health providers and law enforcement (Kohrt et al., 2015), it can inspire other forms of collaborations and multidisciplinary actions. Such as collaboration between mental health care facilities and the governments or policy makers.

This leads to the third aspect, legislative interventions targeting decriminalisation of suicidal attempt. Criminalisation being among risk factors in suicidality among men in Tanzania, makes this an appropriate intervention to evaluate.

Criminalisation often creates fear that leads to further shame, isolation and prevention from seeking help (Jidong et al., 2024).

Cultural perception of mental health and suicidality is important to factor in discussing interventions (Knippler et al., 2024; Jidong et al., 2024). Some cultural perceptions are doing more harm than good. Such as how implementation of suicide prevention clinics might seem shameful, as stated by the mental health care providers in Northern Tanzania (Knippler et al., 2024). Some religious beliefs also contribute to continued gap in knowledge and reduced help-seeking behaviour. Internalised stigma is a repeating factor across several African nations, as indicated by Alemu et al., (2023). The stressor being lack of awareness, making individuals fail to understand what is going on with them. Implementing interventions that will be culturally and contextually appropriate can be demanding, but research and lack thereof, demonstrates the need for it.

Interventions in many African countries is scarce (Knettel et al., 2023), leaving individuals in need of professional help vulnerable to further mental illnesses and suicidality. Limited financial resources, limited infrastructure, limited number of mental health care professionals per capita are some of the major factors affecting service provision in Tanzania (Ministry of Health Community Development, Gender, Elders, 2021; MHS, 2025). Therefore, assessing and implementing targeted interventions for the Tanzanian context is crucial in the battle of suicidality among men in Tanzania.

Interventions that provide positive results among male service receivers, need to continue and be scaled up. As of today, Tanzania has two national mental health hospitals, Tanzania Mental Health Institute and Lutindi hospital (TMHI, n.d.; ELCT Health, 2025). There are also other hospitals and clinics providing mental health care. NGOs and these medical facilities are creating impact through clinical treatment, psychosocial services, mental health support, raising awareness and educating communities. However, there are still gaps to be filled as revealed by Knettel et al. (2023), but these gaps create room for opportunities and innovative solutions to further battle suicidality among men in Tanzania.

1.4.6. The Impact of a Mental Health Care Provider

A mental health care provider is someone who can assess and diagnose mental health conditions presented, provide treatment or referral, and a few can prescribe medications (Medicine, 2022). The difference is found in the level of education, certification, licence and training. Mental health care providers play a key role in the lives of mental health care receivers. From clinical treatments, counselling or simply guidance in life. They play an important role in the receiver's wellbeing and life quality. In addition to professional mental health providers, there are several mental health advocates. In Tanzania, mental health advocates work actively to raise awareness, educate communities, and be the bridge between individuals needing support and mental health care professionals. It is a vital part of the Tanzanian mental health infrastructure, as bottom-up measures.

In Tanzania, you officially need a master's degree in psychology to start work-

ing as a mental health care provider (Kazdin, 2000). However, the scarcity of mental health care providers opens doors for bachelor's degree holders to offer counselling services and provide mental health support. One of the reasons to low output of educated providers is suggested to be stigma and negative reactions from family and friends. Unfortunately, this affects some people to not pursue a career in psychology (Knippler et al., 2024). Second factor is monetary ambitions. Some believe that there is not enough money to make in the mental health sector, therefore choosing other career avenues (Knippler et al., 2024).

The impact a mental health care provider has, can save a life. This was the case for the many individuals who shared their life experiences in respect to suicidality (THA). One key commonality was the care and support they received and how much that helped them gain hope (Egil, 2023; Jostein, 2021; David, 2023).

The mental wellbeing of mental health providers is also a factor to consider. Although it is not the focus of this study, it is crucial to mention the increase of burnout among healthcare providers globally, including the East African region (Mfuru et al., 2024; Ochola, 2020; Muteshi et al., 2024; Munyi & Mabonga, 2024). Among these healthcare providers, are mental health care providers of Tanzania. In exploring targeted interventions, this is important to consider. Their mental wellbeing has a direct effect on their service provision and effectiveness (Munyi & Mabonga, 2024).

Although this research explores interventions through the experiences of mental health care providers, it serves as an essential step to 1) contribute to the suicidality research output of Tanzania, 2) highlight which interventions to amplify, 3) provide insight and encourage change, and 4) pave the way for further research.

Most of the existing psychological research has not included Tanzania, it has been by and with Western, educated, industrialised, rich and democratic (WEIRD) nations (Henrich et al., 2010; Muthukrishna et al., 2020). This has led to the understudying and exclusion of the African population, including Tanzanian men. Psychology research often aims to educate and discover improved recommendations, hence the reason to conduct this research (Jidong et al., 2024). Suicidality research targeting interventions for men in Tanzania has not yet been found in any publications or journals. This research aims to fill the gap of knowledge and insight. These findings can benefit facilities, organisations, mental health care providers other local initiatives and policy makers.

Research questions:

- 1) What are the strengths and limitations found in current interventions for men battling suicidality in Tanzania?
- 2) How do mental health care providers contribute to proposing and implementing appropriate interventions?

2. Methodology & Method

This chapter discusses the methodology and method utilised. How and where data was obtained, the design, materials, procedures and the reason for conducting qualitative research. Acknowledgement of ethical considerations are included

with a brief conclusion.

Ethics statement

This research was approved by the Research Ethics Committee of Arden University. Further local approval was provided by the chosen gatekeepers, two Tanzanian non-government organisations. All risk assessments and safety measures were evaluated and approved. No participant experienced physical nor mental harm. All participants who volunteered were informed of their rights to withdraw and signed a consent form.

2.1. Why Qualitative Research Method

Quantitative suicidality research aims to measure the severeness of suicidality using scientifically approved measurement scales. One of these scales is the Suicide Intent Scale (SIS) developed by Beck Schuyler and Herman in 1974. It was designed to measure suicide intent on individuals who had already attempted suicide one time or more before (Mieczkowski et al., 1993). Their results suggested there to be more than one component of intent behind suicide (Mieczkowski et al., 1993). As thorough as these measurement scales were, they did not capture the individual's experience. The history of the individual, their challenges, their triggers, their thought process, questions and overall reflection. This is where qualitative research fills that gap by allowing for a deeper understanding.

A qualitative research method allows for a deeper insight into human behaviour and experience (Willig, 2019). Understanding their experiences, hearing their thoughts, learning about their own perspectives and overall deeper insight. Furthermore, both suicidology researchers and gap in literature encourages there to be more qualitative studies conducted in suicidality (see Hjelmeland, 2022; Darío & González, 2000; Jidong et al., 2024; Onger et al., 2023). Hence, the choice of utilising qualitative research method for this study. It allows for the study to be of benefit to other colleagues in the mental health sector, institutions and other local initiatives. It also serves to contribute to the collective measure of targeted interventions towards battling suicidality among men in Tanzania. This can consequently inform more appropriate ways of supporting them and potentially inspire for further research and implementations in the Tanzanian mental health infrastructure.

The epistemological position of the researcher in this study was interpretivism (Herber et al., 2025). This philosophical approach proved more fitting for this study given the aim of exploring and understanding, which also supports the choice of method (Research Bridge Consulting, 2026). Understanding the researcher's approach strengthens the replicability of this study.

2.2. Thematic Analysis

Thematic Analysis (TA) is argued to be a flexible and beneficial research tool within qualitative research, hence why it was chosen. However, the flexibility requires the researcher to have clarity of the research question(s) and the philosoph-

ical position of the research (Clarke & Braun, 2017). By identifying, analysing and reporting patterns within collected data, this approach strengthens the replicability of the research for future researchers. This research was conducted following the instructions of thematic analysis approach. 1) Get familiar with the data, 2) coding, 3) categorised coding and theme search, 4) review potential emerging themes, 5) name the themes, and 6) create the report (Braun & Clarke, 2006).

This study benefited using TA, using in vivo coding, because the deeper exploration provided rich data, which provided a good foundation for inductive coding. One critic of TA to address is the length it takes to analyse the data, adding to the timeline of the researcher (Fergus, 2019).

2.3. Participants and Recruitment

A total of six participants were recruited through two Tanzanian non-governmental organisations who approved this research. Three females and three males, providing both the male and female perspective. Age, educational background and place of work was collected as those details played a role for this study. All participants had to be over the age of 18, their educational background informed their level of expertise in the field, and place of work needed to be Dar es Salaam as that is where the research was conducted. The number of participants (6) provided enough data for this study, both challenging and supporting existing theories and literature. Qualitative research, utilising TA, is recommended to recruit approximately twelve participants to provide more context and richness to the data (Ahmed, 2025). However, limited time allocation and resources only allowed for six candidates. Future research could factor in more time and resources to interview at least twelve participants and include different geographical locations.

All participants were Tanzanian residents working in the mental health sector, with experience of supporting men battling suicidality. The selection of participants included mental health care providers of different roles, expertise and level of exposure, to gather a broader perspective, wide range of experiences and professional recommendations. Male participants consisted of two psychologists and one mental health trainer. Female participants consisted of one counselling psychologist and two mental health advocates. All participants had experience supporting men battling suicidality either through clinical care, counselling or community support.

Exclusion criteria were age limit of 18 years of age, lack of experience supporting men battling suicidality and being a non-Tanzanian resident. Tanzanian residency was an important criterion for the purpose of cultural perception and understanding (Jidong et al., 2024). All interviews were conducted in person, in Dar Es Salaam, Tanzania. The plan was to interview participants working in Dodoma for more data, but time and resources did not allow. All interviews were conducted in a private setting ensuring confidentiality and safety. Given the location of the research, all participants were informed of freely speaking English or Kiswahili. Parts spoken in Kiswahili were translated using an approved translation platform,

([Translate, 2025](#)), after being transcribed.

2.4. Procedure

Upon approval by the Arden University Research Ethical Committee, recruitment of participants began through the approved gatekeepers. Volunteers received a short brief of the research for context before agreeing or not. Upon agreement, participants were provided the Participant Information Sheet. They were informed about the purpose, risks and benefits of participating, their right to withdraw, how the collected data would be utilised and the possibility to read the findings upon submission of the dissertation. Consent form was signed before interviews began.

Length of the interviews varied, shortest lasted approximately 17 minutes and longest lasted approximately one hour. All interviews were audio recorded with Zoom audio, utilising the transcript function. Upon completion the transcripts were edited where needed, and portions spoken in Kiswahili were translated to English. Translation verified by [Translate.com \(Translate, 2025\)](#) as approved by the Ethical Committee. Participants received a randomly generated code ([Stat Trek, 2025](#)), and Participation Debrief Form upon completed interviews. All interviews consisted of only the researcher and individual participant, following semi-structured interview questions to allow for exploration. Questions pertaining to their unique experiences, current utilised interventions and future recommendations were asked to probe emerging themes.

This paper is exploring targeted interventions, based on the gap found in literature and previous research. Exploring contextually appropriate interventions, while adhering to the Tanzanian culture, beliefs, norms and way of life is the aim (see [Ongeri et al., 2023](#); [Jidong et al., 2024](#); [Darío & González, 2000](#)).

Each participant was provided the opportunity to share any additional reflection or comment or ask any questions at the end of each interview. They were thanked for their time and participation. All participants showed great interest in the research and requested to read the paper upon completion and submission.

2.5. Research Integrity

All ethical guidelines and protocol were followed to ensure integrity of the research. Authorised tools used in this study was the auto transcription on Zoom and a translation platform. Every instruction and correction were followed up to delivery time.

2.6. Data Management & Analysis

All interviews were recorded utilising Zoom audio, and its auto transcribe feature. All data was stored in a password protected and secured storage provided by Arden University. No data was stored on computer storage or other devices. Parts of interview sessions that were spoken in Kiswahili were translated to English by [Translate.com \(Translate, 2025\)](#). Researcher is a native Kiswahili speaker and could verify the translation. All raw data files collected were anonymised. Each

participant was provided a randomly generated code assigned to their interview (Stat Trek, 2025) to use in case of withdrawal within two weeks after the interview. All recordings were deleted after transcription was completed as instructed.

Collected data was handled and processed according to the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. Consent forms and data were kept separate. The anonymised data was used in this research and may be used in future reports, conference presentations and academic papers. Data will be destroyed by researcher after three years in compliance with Data Security Policy of Arden University.

Data collected was processed through inductive coding for thematic analysis, ensuring transparency and replicability. The coded data was analysed and themed, backed by direct quotes from participants. The methodology of qualitative coding of choice was in vivo coding to ensure the accuracy of the data collected, in combination with process coding and values coding (Jansen & Rautenbach, 2024). Full data analysis is available upon request.

2.7. Ethical Considerations

The research was conducted following ethical principles. This included a detailed risk assessment evaluating any potential risk towards researcher, participants and gatekeepers. Ethical challenge that occurred was the explanation of all the documents to some of the participants, as some did not understand why. This is partially due to the nature of Tanzanian culture being more relaxed and not too fixated on every single detail. However, upon explanation of ethical processes the ones in question understand. For further clarification, all documents were read and signed as per protocol.

2.8. Reflective Statement

Researcher conducted all the interviews in person, in the city of Dar es Salaam as initially planned. Out of six participants, no one withdrew. Strengths to consider for this study included the familiarity the researcher has with Tanzania, given it being their place of birth. The researcher speaks the national language, Kiswahili, understands the culture, the people, the customs and the awareness of the general social attitude towards mental health. Researcher upheld privacy regulations and ethical regulations as instructed. While simultaneously creating a safe space for the participants to speak freely and openly. The interview guide was followed to some degree, but researcher also used the answers from participants to explore further in certain topics such as government policies, cultural aspects, therapy structure and more. This provided more context to the question of how-to better target men who battle suicidality, as the unprepared contributions provided further understanding.

Some limitations to address included the language limitations researcher faced with some professional terms in Kiswahili, but English did not provide any challenges. Other observed limitations included time. Conducting explorative re-

search of this magnitude and this significance requires time. Delayed approval processes led to delayed interview scheduling, which delayed further processed of the study. However, this did not prevent the researcher from submitting the paper in the expected time of July 2025.

Throughout this research the researcher gained more knowledge pertaining to the topic area of suicidality, mental health infrastructure of Tanzania and research methods. Firstly, this topic. Although previous research and literature provided knowledge and information, interviewing mental health care providers of Tanzania provided more insight. The therapy procedures and expectations of service receivers, how the psychology education system is and qualification system. This research also taught he the researcher how significant of a role mental health advocates play in the mental health infrastructure of Tanzania.

During the interviews, the researcher observed their passion for creating impact and changing lives. Their dedication to spreading awareness, educating communities and creating innovative suggestions in helping men battling suicidality.

Researcher also observed how every participant interviewed mentioned God in their journeys and had their own personal faith. This reflects on the general society of Tanzania and plays a huge factor in them understanding service receivers who come to seek help. Many of them have found ways to integrate faith and theory to best communicate with individuals who seek their help and support.

Some key elements researcher struggled with was procrastination and constraint of time due to administrative challenges in the beginning. Constraint of time also affected the communication flow with assigned supervisor, not giving him enough time to supervise.

However, the researcher gracefully completed the journey in due time. The paper might not have become as “perfect” as desired, but it served its purpose in presenting the study to its fullness.

Researcher will gladly share the completed research paper to participants and gatekeepers who made this study possible to conduct. A summary will also be shared with interesting parties.

3. Results Analysis

This chapter represents the results of the conducted analysis. The process of coding and the themes that emerged. These are made available for visibility and replicability. However, important to note that replicability of this study might develop different themes depending on research questions, aims and theoretical framework of the researcher (Doctor, 2025).

3.1. Coding and Themes

Inductive coding was utilised due to the topic being under researched requiring explorative approach, in comparison to deductive coding which can limit the level of exploration by focusing on predetermined set of codes (Jansen & Rautenbach, 2024).

Hybrid approach is another option, but not optimal for this research. Qualitative coding of choice was in vivo coding to ensure the accuracy of the data collected, combined with process coding and values coding (Jansen & Rautenbach, 2024).

Analysis process followed the instructions of TA approach. 1) Familiarisation with the data, 2) initial coding, 3) categorised coding and theme development, 4) reviewing potential emerging themes, 5) name the themes, and 6) create the report (Braun & Clarke, 2006).

A total of seven themes emerged from conducted the analysis. However, due to the word count limitation and richness of data, a reduced sample is included (see Figure 2).

3.2. Instruments

Analysis was conducted using a laptop. Initial coding derived from the interviews that had been recorded, transcribed and translated to English. The platforms used were Microsoft word, using the comment function to detect statements of interest during initial coding. Upon completion, all the highlighted statements were added into an Excel sheet for further coding. The same Excel sheet document had three sheets (pages), one for “initial coding”, second for “categorising + patterns” and third for “emerging themes”.

PDF versions of the second and third page can be shared upon request.

3.3. Limitations

As with most research, this research has both strengths and limitations. This section will highlight some of the limitations of this study.

Firstly, the number of participants recruited for this study. All six participants met the necessary requirements and provided great insight. However, a higher amount of 12 participants and above would have been more aligned with the TA recommendations (Ahmed, 2025). Although this limitation presented itself, the six participants provided in-depth and rich enough data to answer the research questions. Increasing the number of participants and geographical locations could have increased richness of data and potentially added more themes.

Another limitation to this research was time and restricted resources. A submission deadline increases the speed of process which may result in certain details being less prioritised.

A third limitation worth mentioning is the choice of using thematic analysis. Its flexibility is criticised to create challenges in replicability of the study due to the individual aims of the researcher. However, it is not scientifically wrong given the nature of explorative design, is to explore based on the set research questions and literature framework. Another aspect of TA to address is the length it takes to analyse the data, adding to the timeline of the researcher which is already short given submission deadline (Fergus, 2019).

4. Discussion and Conclusion

4.1. Introduction

This chapter presents the emerging themes found through analysis. A total of seven themes emerged during the analysis of this data, but only five themes are presented due to limited space. The themes presented will be: “commitment and passion”, “working interventions and approaches”, “bottom-up & top-down measures”, “social and cultural stigma”, “education and awareness”. This discussion revisits previous literature and highlights limitations. The end of this chapter concludes the findings and provides recommendations for future research.

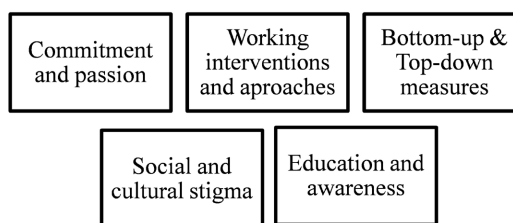


Figure 2. The five selected emerging themes from analysis.

4.2. Themes

4.2.1. Commitment and Passion

First emerging theme was commitment and passion; the commitment and passion mental health care providers share in serving their clients and communities (**Figure 2**). All six participants, in their own respective roles, shared a passion for mental health work and suicide prevention. This passion resulted from lived experiences and witnessing others around them struggling with their mental health.

“I really like psychology, and I saw the need of more psychologists, for example in organisations such as these, aside from really enjoying what I gain in salary and whatnot, accommodation and other benefits, I rejoice knowing I have helped someone heal, and the appreciation I receive. What motivated me to choose psychology was my background, my life experiences, things I encountered but also things I observed. I know the street life, I know how the average person’s life is, so I understand.” (Participant nr 4 - Psychologist)

They all had their personal journeys with mental health challenges and saw the need to be part of the change. Despite the negative reactions from family and friends, and the societal assumption of it not bringing monetary value. As participant 5 said:

“It needs a lot of passion, a lot of readiness from you personally, to be like I’m helping people, I’m doing this for society, not for me. Even if I’m not paid, it’s okay, but I feel good when someone heals, when someone goes back to his senses, when someone receives the ability to overcome their challenges without me present” (Participant 5 - counselling psychologist).

The mental health infrastructure of Tanzania is still under construction, as previously mentioned (MHS, 2025; Ministry of Health Community Development,

Gender, Elders, 2021). This makes every mental health care provider critical to the service and support for each man battling suicidality. The scarcity of mental health care providers increases the responsibility on the existing ones, hence needing them to be committed and passionate about their work. The data collected echoed their commitment and passion, making this the first strength found in the current interventions. Committed and passionate mental health care providers who are not serving the society for money, but for a healthier communities and healthier men.

Their experiences support previous literature arguing the reason for low output of mental health care providers in Tanzania (Knippler et al., 2024). One of them being the social stigma associated with mental health in general, and suicidality.

“I received a very big negative reaction” (Participant 3 - Counselling psychologist)

However, they still chose to become psychologists, mental health advocates, and counsellors to serve their communities.

Their commitment and passion are reflected through their presence both in person and online, encouraging men to seek help from them.

“I personally receive mostly men, more men than women, who seek help, they open up to me....I think I am approachable, and I talk to everyone.”

(Participant 6 - mental health advocate)

“In my sessions I think 70% of those I meet are men yeah and at least now they start to open up” (Participant 5 - counselling psychologist)

“For example, this guy that reached out through Twitter, he was not completely direct, but after speaking to him and levelling with him as a fellow young adult, that we can help each other and speaking up is not a sign of weakness, that's when he finally opened up. The other guy who called me at 2 am, he was someone I noticed change in behaviour prior to the call...I used to check in and ask, ‘how are you?’ and he kept saying he was okay. I kept following up until that night that he opened up.” (Participant 6 - mental health advocate)

Participant 5 and 6 also added to the importance of patience when supporting men battling suicidality. It might take them weeks or months to share what is really going on. They observed that it took time to build the trust, and to get to the core of their issues.

Issues that came up were usually relationship issues, financial problems or family problems.

All this reverts to their commitment and passion to serve and provide best possible care to those who seek help.

4.2.2. Working Interventions and Approaches

Second theme that emerged was working interventions and approaches. This theme emerged from the pattern discovered across the different interviews. The practicing psychologist and counselling psychologists all mentioned cognitive behavioural therapy (CBT) as the most efficient therapy intervention.

“Intervention that I usually use is cognitive behavioural therapy, and that is the,

I think is a universal, helping someone to accept the reality, and to be able to help them handle the challenges they go through every day. To also have the ability to accept what comes his way, understand his emotions, but also think in a manner that is rational and positive.”

(Participant 5 - counselling psychologist)

They also mention using other therapy interventions and combining other therapeutic approaches to best help a man battling suicidality. Such as emotional behavioural therapy (EBT) or gestalt therapy. Furthermore, participant 3 explained the need to be skilled and adaptable in using different approaches, referring to cultural values and expectations from service receivers.

“In my work I usually integrate approaches. In our culture you cannot only use CBT alone, or one approach alone. It is necessary to have multiple approaches to integrate to help a person. So that is how we do it here.” (Participant 3 - counselling psychologist)

“I use the client-centred approach, carefully listening to them” (Participant 4 - Psychologist).

Both participant 3 and 4 shared in detail some of their experiences using these approaches in helping men battling suicidality. However, they both highlighted something interesting relating to ability to be flexible and adaptable enough to meet the client’s need. They both described it as being “client-centred” or “personal-centred”, all meaning they put the man who seeks their help in the centre of their attention.

This is how Participant 4 explained his approach:

“...was doubting if someone at my level and brand uhm and status could be able to help someone who wants to kill himself? What I did, I think, was that I didn’t apply all those all those uhm psychology ways theories of psychology. I switched and had to become his friend, uhm I applied professionalism, but not much because I saw it would make it difficult, or my language could be too difficult for him to comprehend. So, I tried to speak using an easy language, I remained very calm, and I was trying to engage with him like when we leave each other I would check-in to see how far he has come, reassuring him to reach out if he runs into any problem, meeting with him frequently.” (Participant 4 - Psychologist)

4.2.3. Social and Cultural Stigma

Another theme was social and cultural stigma: the upbringing of a boy child, the social and cultural expectations of a man, neglect of seeking help and wrong beliefs. There is a certain way a Tanzanian man is expected to behave, speak and handle responsibilities which is developing suicidality among some of these men. Some even dying by suicide. This stigma is integrated in the way women have been taught to view men, and how men have been taught to measure themselves. As providers, as strong, no room for any weakness and must withstand whatever happens without complaining.

“there is a way a boy child is being raised and is not right...a male child is not supposed to cry. Not only in homes, but in schools, they are not supposed to be

vulnerable, even in churches...let's try to correct the upbringing" - (Participant 6 - mental health advocate)

Participant 4 added a valuable input:

"...because this man is being made from family level. Eeeh there shouldn't be an upbringing that raises a man that will later end his life, meaning that this education, in my opinion, should be taught to both sides. A woman who sees men, as man, failing should know that is part of life, not look at me as if I am weak, I am not right, that will bring me further down and I won't have confidence. If I fail to have confidence, I will feel shame and won't have freedom. I will now start wondering what to do to avoid all of that, and that thought trail can lead to suicidal ideation." (Participant 4 - Psychologist)

This cultural attitude of shaming a man for falling short financially or losing track of his career or failing in business is a crucial point. Adding more negative talk, when the man is most likely already feeling like a failure, will most likely cause increased risk of suicidality. The shame and judgment are what also limit many men from seeking help.

"another big challenge is that they don't seek service. A man might be struggling and still not seek help" (Participant 4 - Psychologist)

4.2.4. Education and Awareness

The fourth theme that emerged was education and awareness; educating men of all ages, educating parents and leaders of communities, create engaging learning platforms for men, use technology and media as educational channels and train mental health advocates to increase knowledge.

Among the several repetitive patterns in data was this. Increasing education will raise awareness, it will teach young boys and men how to withstand challenges in life and prevent suicide. It will also challenge the existing narrative of men from upbringing and on community level. All participants raised this to be one of the first steps to take in battling suicidality among Tanzanian men.

"I was going through a lot at that time, and people can't believe that I also can go through challenges. So I learned that there is a way society can look at you as someone who can't experience challenges, so I think we need to start at lower levels. People need to understand that anyone can face mental health challenges. After knowing that, the next step is knowing who to go to when mental health challenges occur. We need to start with education from lower levels of communities." (Participant 6 - mental health advocate)

Participant 6 further added *"I think education, many people are still not educated...They are adults and wise, but they need to be educated to remove stigma"*.

Educating parents and community leaders will benefit the young men and boy child during upbringing:

"Because you see even the issue of suicidality, it happens to mostly young men who still have parents, most of them. Was it not possible for this person to talk their parent?" (Participant 1 - mental health support)

“Another source that will be a better place to start is family. The education should involve those topics of suicidality, what it is to experience it and after experiencing it. It should be constantly trending, that men also go through one, two, three, just as women have had their many campaigns empowering them.” (Participant 4 - Psychologist)

4.2.5. Bottom-Up & Top-Down Measures

Fifth emerged theme to be presented in this paper is bottom-up and top-down measures. This refers to the collective measures a country takes in handling an issue, in this case suicidality among men in Tanzania. Literature review mentioned some of the measures Tanzania has taken in respect to bottom-up measures but also gaps existing in top-down measures. NGOs educating and reaching out to communities, local initiatives raising awareness and certain steps the government can take.

“We normally do different activities to raise awareness about mental health...we give the opportunity for the participants to express their feelings, to be free...we normally do community outreach programs to help people, but not only community outreach, but sometimes people they face us individually for the advice.”

(Participant 2 - Mental Health Trainer)

“We have focused on educating the younger generation because we believe that this people, when they are aware, it will be easy to spread the knowledge to other people. We have tried our best to do these campaigns in schools” (Participant 1 - Mental Health Support)

“We are open, we are free to talk to them, we are ready to help them without judging them” (Participant 2 - Mental Health Trainer)

“We as men also need our own campaigns of empowerment. To know that we as men also can reach a point and fail, that we as men have tears, have emotions, there are times we can cry.” (Participant 4 - Psychologist)

All these different statements from these different participants illustrates the vast bottom-up measures being done from community levels and upwards. However, to take bigger steps in battling suicidality there are certain top-down measures needed. Meaning the government needs to get involved. Some of the measures the government can take is funding. Dedicating a bigger budget to the mental health sector, as the current one does not sustain all that needs to be done (Ministry of Health Community Development, Gender, Elders, 2021).

One step in motion is having mental health services included in the national health insurance plan, which is beneficial for those with national health insurance.

“But a few days ago, they were speaking about...a question was asked in the parliament whether mental health services can be included in the NHF card which means someone with NHF can benefit from psychotherapy services, excluding psychiatry, medication, they can start benefitting with services of psychotherapy. ...it's big step because from that they also include that psychologists can pro-

vide those services...so every step has its own point and it's a big step that they have made now." (Participant 3 - Counselling Psychologist)

"in Tanzania issues of mental health issues like what I've told you before...but the government trying to level-based because you can see even I think last week, they have included this issue of mental health in health insurance."

(Participant 2 - Mental Health Trainer)

However, it still leaves out the population with no insurance and unstable income who cannot afford mental health services. The government is needed to get involved. The mental health care providers raised some important suggestions to be considered:

Decriminalisation:

"if I am going to be judged/prosecuted, how can I openly say that I have suicidal thoughts?" (Participant 3 - counselling psychologist)

"And also they need to revise the law and look at it from another perspective. A law stating that if a person attempts suicide has broken the law meanwhile in the health perspective, from the expertise of psychologists, this person is believed to be struggling. But legally, even if though the person is struggling, he is punished. So imagine passing through this challenge, and you are punished again because you need to commit suicide, I'm not sure if it is right. It is not right. So, we find a way to solve this problem."

(Participant 2 - Mental Health Trainer)

Need more local and accessible centres and facilities:

"...there is also a challenge of where to send someone. You see someone going through certain challenges causing anxiety or depression, he might go to one of our big hospitals today and will be placed together with others such as drug abusers. Someone there might be using drugs, and all that, having psychosis problems, and the other person having completely different challenges but will be placed same place as those others."

So, we need them established so people can get help. Others might rush to those centres if they know of their existence. There are those who are wondering where they can go when they need help." (Participant 4 - Psychologist)

4.3. Discussion and Conclusion

Tanzania has taken many steps in the mental health sector, but there are still gaps to be filled and opportunities to be taken. Both literature, research and data collected reflects the need for targeted interventions to support men battling suicidality. The purpose of this research was to answer these two research questions:

- Strengths and limitations found in current interventions for men battling suicidality in Tanzania
- How mental health care providers contribute to proposing and implementing appropriate interventions

There were a few strengths found in current interventions. Firstly, existing therapeutic approaches and service approaches. Men battling suicidality have shown

to respond positively to cognitive behavioural therapy (CBT), emotional behavioural therapy (EBT) and a combination of different approaches. The counselling psychologists that were interviewed shared how important it is to know CBT and how to combine different approaches. Their experience has taught them that when approached by men battling suicidality, it is already very severe. Being able to help them requires a combination of professional skills, knowledge and interpersonal skills.

While existing approaches are a strength, an interesting factor was revealed that challenges the argument of men not seeking help. Previous literature suggests that men are less likely to seek help and hence more prone to suicide (see [Alemu et al., 2023](#); [Daniel et al., 2018](#); [Knippler et al., 2024](#)). However, what these mental health care providers experienced was that they needed patience, consistency and someone with whom they feel safe. The men who sought out to them did seek help. This finding informs mental health care providers, institutions and facilities that there are men who do seek help. It opens an opportunity to learn and implement strategies that will allow men to receive the support and care they need, learning from places that succeeded in this. This includes private practices, local initiatives and digital spaces ([Nyhus et al., 2025](#); [Egil, 2023](#); [Jostein, 2021](#)). This finding calls for a re-evaluation of current facilities and practices, to develop approaches that are more contextually and culturally appropriate for Tanzanian men.

Secondly, the commitment and passion demonstrated by the mental health care providers. Data collected revealed the level of dedication needed to service individuals and communities in need of mental health support or treatment. All the participants who took part in this study had experienced some form of negative response to studying psychology or becoming a mental health provider. Although this is presented as a strength, it also represents a gap. The total number of mental health care providers recorded by WHO was 760 in 2020 ([WHO, 2022](#)), with a population of 58 million recorded in 2020. This gap in providers lead them to working overtime in meeting the needs of the service receivers, which can contribute to placing their own wellbeing at risk. The increased burnout among healthcare workers is a testament to this ([Muteshi et al., 2024](#); [Ochola, 2020](#); [Mfuru et al., 2024](#)). Mental health care providers interviewed in this study reported the exhaustion that sometimes comes with the responsibility of supporting a man battling suicidality. Some of them reported to answering the phone at all hours of the day, going the extra mile to provide emotional support beyond the allocated sessions. All of which reflects to their commitment and dedication but also increases the risk of burnout.

An increase of mental health care providers can be one of the actionable steps to reduce the workload of existing providers, while increasing mental health services. While social stigma is argued to be among the factors slowing down the increase of qualified providers, there are other factors to consider. One of them being education. As of today, a few educational institutions have been implementing either degrees or psychology courses ([UDOM, 2025](#); [MUHAS, 2024](#); [UDSM,](#)

2025). This progress contributes to the output of qualified providers who can provide overall mental health care but also support men battling suicidality. It should not end here. A further education in suicidality and suicide prevention is needed. This is needed to bridge the gap in the limited services available for men battling suicidality (Knettel et al., 2024; Knippler et al., 2024).

Thirdly, the bottom-up measures as recognised by WHO (WHO, 2018). Mental health advocates, national NGOs and other local initiatives are bridging the gap of limited access to care and awareness. By their commitment to educate communities, raise awareness using various media sources and organising forums, they are contributing to preventative measures of suicide and other mental illnesses. However, bottom-up measures are not enough to prevent suicide and battle suicidality. Top-down measures are needed.

The involvement of the government and big institutions is crucial to the collective measures in Tanzania. One of the first measures to consider is increasing the budget of the mental health sector, as the current one is not sustainable (Ministry of Health Community Development, Gender, Elders, 2021). As of today, most mental health care facilities are in the most urban areas such as Dar es Salaam, Dodoma, Arusha and others (MHS, 2025). Increased funding can combat the existing limitation of scarce facilities and centres, scarce providers and overall services. In addition to the direct care, funding could potentially combat the low psychology research output (WHO, Country Profile: Tanzania, 2022). Low psychology research output can be linked to low levels of evidence-based interventions in Tanzania. Studies and psychology research provide data aiming to educate and discover appropriate recommendations (Jidong et al., 2024). Tanzania and USA are two different countries economically, politically, culturally, geographically and demographically. Implementing recommendations and interventions based on their psychology research output does not provide the best outcome for Tanzanians. Literature keeps repeating the importance of developing evidence-based interventions that are culturally, contextually and economically appropriate to the respective area or country (Jidong et al., 2024; Knippler et al., 2024). During my literature search, there were scarce suicidality research and literature I could find conducted in Tanzania. The few studies found are the ones cited in this paper.

Another measure to be considered is the development of a national suicide plan as recommended by the WHO (WHO). This can contribute to the collective measure of suicide prevention across the country. However, it can be challenging to develop a national plan while suicide attempt is still criminalised, leading us to the next limitation.

Among the limitations found that needs to be addressed is criminalisation of suicide attempt in Tanzania. Criminalisation of suicidal attempt contribute to creating barriers in seeking professional help as it creates fear among individuals who need help. This amplifies social stigma for both the individual in need and their families or loved ones (Hilda, 2023). Furthermore, leading to people suffering in silence, lack of accurate suicidality data, which further leads to insufficient strate-

gies to provide the services needed (WHO, 2023; Onger et al., 2023). WHO is working to encourage and support countries in decriminalisation of suicide attempt (WHO launches new resources on prevention and decriminalization of suicide, 2023). These resources are targeting countries still legally punishing individuals caught attempting suicide. As one of the participants in this research argued, an individual caught attempting suicide needs help and not punishment.

As criminalisation is a legislative matter, this is among the top-down measures in which the government are in position to intervene. Decriminalisation of suicide attempt can help reduce fear, shame and social stigma. It can encourage more men to seek the help they need without the fear of legal repercussions.

Other limitations include social and cultural stigma, and the gap found in education and awareness of mental health, specifically suicidality. Education and awareness can target educational institutions, healthcare professionals, community leaders, caretakers, workplaces and other areas of primary contact.

5. Conclusion

Although Tanzania entered the field of psychology later than other Sub-Saharan countries, it has shown great progress politically, socially and academically. The government has an allocated budget for the mental health sector, psychosocial services are now being included in the national insurance health plan, academic institutions have implemented psychology degrees and courses. NGOs, other organisations and local initiatives are providing mental health services, educating communities and raising awareness. There are government funded institutions and other private facilities providing services, both physically and through digital platforms.

The gaps found and discussed in this research present opportunities. Opportunities for all stakeholders to play a part in suicide prevention measures. The current male suicide rate in Tanzania calls for action to be taken. Mental health care providers listed a few recommendations which can be translated to targeted interventions. These recommendations include more government involvement, increased facilities and centres, increased education and awareness, initiatives targeting men and decriminalisation of suicide attempt.

Mental health care providers and advocates play a crucial role in battling suicidality among men in Tanzania. They are on the ground, interacting with them daily. Their insight informs what is needed, and their commitment is saving lives. What they need is support and resources to execute the recommendations they have voiced during this study.

Implementation of targeted intervention will require multidisciplinary action. A collaboration across institutions, the government, local initiatives and non-government organisations. Battling suicidality is a collective measure. Tanzania is yet to develop a national suicide prevention plan, or other national suicide prevention measures. This places Tanzania in a unique position to develop and implement measures that will be contextually, culturally and economically appropriate.

Due to limited time and resources, this research collected data from Dar es Salaam only. Future research could expand to other cities and include remote areas. This will increase richness of data, providing more insight that will inform appropriate targeted interventions for those specific geographical locations. Additionally, future research should interview more than six participants, increasing it to twelve will be satisfactory to the recommendation (Ahmed, 2025).

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Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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