IJPH | SSPH+ SWISS SCHOOL OF PUBLIC HEALTH

TYPE Original Article
PUBLISHED 25 November 2026
DOI 10.3389/ijph.2026.1609578

Check for updates

OPEN ACCESS

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University of Pavol Jozef Šafárik Kosice, Slovakia

REVIEWED BY
Two reviewers who chose to remain anonymous

*CORRESPONDENCE
Irene Falgas-Bague,
irene.falgasbague@swisstph.ch

†These authors share first authorship

RECEIVED 21 January 2026
REVISED 28 September 2026
ACCEPTED 04 November 2026
PUBLISHED 25 November 2026

CITATION
Fernandez-Rodriguez A, Muleya C, Taguma R, Useche A, Villa S, Duque-Guerra A, Ali I, Huber CG, Paul R, Fink G and Falgas-Bague I (2026) Managing suicide care in a low-resource urban context: stakeholder perspectives on system barriers and opportunities for improvement in Lusaka, Zambia. *Int. J. Public Health* 71:1609578. doi: 10.3389/ijph.2026.1609578

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Managing suicide care in a low-resource urban context: stakeholder perspectives on system barriers and opportunities for improvement in Lusaka, Zambia

Andrea Fernandez-Rodriguez[1,2†], Chimuka Muleya[3,4,5†], Rumbidzai Taguma[3], Andrea Useche[4,5], Sarai Villa[6], Alejandra Duque-Guerra[6], Iman Ali[7], Christian G. Huber[5,8], Ravi Paul[3], Günther Fink[4,9] and Irene Falgas-Bague[3,4,5*]

[1]Child and Adolescent Health, Institute of Social and Preventive Medicine, University of Bern, Bern, Switzerland, [2]Graduate School for Health Sciences, University of Bern, Bern, Switzerland, [3]Department of Psychiatry, University of Zambia, Lusaka, Zambia, [4]Department of Research, Swiss Tropical and Public Health Institute, Allschwil, Switzerland, [5]University of Basel, Basel, Switzerland, [6]Department of Psychiatry, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain, [7]Johns Hopkins School of Medicine, Baltimore, MD, United States, [8]University Psychiatric Clinics (UPK) Basel, University of Basel, Basel, Switzerland, [9]Department of Economics, University of Basel, Basel, Switzerland

Objectives: Suicide is a leading public health issue, and particularly a serious threat in low- and middle-income countries including Zambia. This study mapped the public healthcare system for suicide management in the 6 main hospitals in Lusaka and explored stakeholder perspectives on barriers and opportunities for improvement.

Methods: We conducted 32 semi-structured interviews with key informants. Data was analysed using a framework informed directed qualitative content analysis, supplemented by healthcare process mapping to identify system functions, barriers, and potential strategies for improvement.

Results: Stakeholders described a system centred on emergency departments and hospital-based care, often deprioritizing mental health once physical stability is achieved. Key challenges include insufficient staffing, lack of standardised discharge and referral protocols, and inadequate infrastructure for suicide care. Three areas for improvement emerged: training non-specialists, strengthening infrastructure, and standardised clinical pathways.

Conclusion: Addressing structural and workforce gaps in suicide and mental healthcare pathways is critical. These findings provide practical guidance for improving suicide care management to policymakers and health planners in Zambia and similar settings.

KEYWORDS
barriers to care, low and middle income countries (LMICs), service improvement, suicide, systems analysis

Introduction

Suicide is a major global health problem. As the fourth-leading cause of death among individuals aged 15–29, it is particularly concerning in low- and middle-income countries, which bear the majority of these preventable losses [1]. About 88% of adolescent suicides occur in these countries, and, despite the underrepresentation in global data [2, 3], the African continent records the highest global suicide rate [4]. A recent survey across 13 African countries reported the highest regional prevalence of suicidal ideation (20.4%) and suicide planning (23.7%) [5].

Zambia reflects this global trend. It reported a suicide mortality rate of 7.3 per 100,000 people in 2019 [6]. During the COVID-19 pandemic, health facilities saw a surge of suicide attempts, particularly among young males [7]. However, the lack of systematic reporting and surveillance obscures a comprehensive picture of suicide within the country [8], and a recent meta-analysis on suicide attempts in Africa highlights the absence of high-quality studies from Zambia [9].

Despite rising political and social concern, Zambia's mental health workforce primarily addresses severe mental health conditions such as schizophrenia and has yet to implement systems for detecting and treating suicidal behaviour [10, 11]. The Mental Health Act No.6 of 2019 replaced the Mental Disorders Act of 1949 and established a rights-based framework for people with mental disorders and created the National Mental Health Council [12]. The Ministry of Health's 2022 Treatment Guidelines for Mental Disorders, provide context-adapted clinical guidance across levels of care [13]. Authorities have also issued press notes to raise awareness and launched support services, including call centres for services like support call centres [14]. Decentralization efforts following the Mental Health Act of 2019 established mental health units in most first-level facilities and provincial hospitals, staffed by clinical officers and mental health nurses, but have since struggled to achieve their objectives [12, 15]. Currently, these facilities manage most suicide attempts and suicide ideation crises, but lack systematic approaches to quantify frequency, severity, and sociodemographic characteristics that could inform public policy [16].

Addressing Zambia's suicide research and care gaps requires a multifaceted approach. Several international guidelines on managing people at risk of suicide are available [17–20]. Interventions have been integrated into a range of community and medical settings [21]. Accessibility and barriers, which determine who can use these services, have received less attention [22].

International studies illustrate recurrent weaknesses across the care continuum [23–25]. Research specific to Zambia is limited. A recent study in Chipata District revealed spikes in suicidal ideation and suicidal behaviour during and after harvest seasons, linked to domestic conflict and financial strain [26]. Another study highlighted the role of abuse history and overall child health in youth suicide [27]. Available data are neither coordinated nor routinely shared with public health authorities, and the incidence and presentation of suicidal ideation and suicidal behavior in healthcare facilities remain unknown. No studies have yet described how public health facilities manage individuals at risk, the accessibility of support services, or barriers to care. In the absence of systematic reporting, frontline healthcare workers can provide critical insights into structural and systemic barriers, informing culturally appropriate, resource-sensitive strategies.

We used Levesque's patient-centred access framework, which views access as an interaction between service characteristics: approachability, acceptability, availability and accommodation, affordability, and appropriateness [22]. As well as people's corresponding abilities to perceive, seek, reach, pay for, and engage with care. This perspective is especially relevant after a suicide attempt, when recognition of need, emergency treatment, referral, affordability, stigma and sustained engagement may each determine whether care is obtained and continued.

This study aims to understand the existing system for suicide care management in Lusaka's public health sector and explore key stakeholders' perspectives in describing and addressing barriers to providing and accessing effective suicide care.

Methods

Study design

This qualitative study is part of a larger project generating evidence on suicidal behaviour and suicidal ideation in Lusaka to inform surveillance, policy and intervention planning. Ethical approval was obtained from the Ethikkommission Nordwest- und Zentralschweiz (AOJ2023-00011), the University of Zambia Humanities and Social Sciences Research Ethics Committee (HSSREC-2024-JAN-026) and Zambia's national Health Research Authority (NHRA-2126/10/04/2025). To assess the suicide care system, its barriers and opportunities for improvement, we conducted 32 semi-structured interviews with key informants, including health workers, hospital police officers, and hospital registry staff.

Participants and recruitment

The study team recruited thirty-two participants directly involved in managing suicide attempts in six healthcare facilities in Lusaka. The sample comprised medical doctors (from different departments involved in suicide care), nurses (from emergency and mental health units), clinical officers, and community stakeholders (a youth counsellor and a police officer). Detailed demographic characteristics are presented in Table 1. Key personnel from the mental health and emergency departments, including senior nurses, were included due to their central role in managing patients with suicidal behaviour. Recruitment was via email, WhatsApp, and phone. Participants were purposefully selected for their direct engagement in suicide crisis care and record management.

Procedure

Guided by Andersen's behavioural model of healthcare use and Levesque's patient-centred access framework [22, 28], informed by preliminary findings in suicide attempts surveillance, and our research team's clinical and local expertise, a semi-structured interview guide was developed. Then, it was iteratively refined to incorporate emerging themes. Open-ended questions explored participants' experiences, challenges, perceptions of current and

TABLE 1 Demographic characteristics of the interviewed stakeholders (Lusaka, Zambia, 2024).

Socio-demographic characteristic	Category	Department	N (%)
Gender	Male		18 (56.25)
	Female		14 (43.75)
Age (Years, range)	20–30		4 (12.5)
	30–40		20 (62.5)
	40–50		6 (18.75)
	50–60		2 (6.25)
Medical facility	University teaching hospital[a]		13 (40.63)
	Chainama hills hospital[b]		5 (15.63)
	Chilenje level one hospital[c]		4 (12.5)
	Matero level one hospital[c]		4 (12.5)
	Kanyama level one hospital[c]		3 (9.38)
	Levy mwanawasa university teaching hospital[d]		3 (9.38)
Occupation	Medical doctors (departments) N = 17 (53.13%)	Emergency room	10 (31.25)
		Mental health	3 (9.38)
		Anatomical pathology	2 (6.25)
		Internal medicine	1 (3.13)
		Gastroenterology	1 (3.13)
	Nurses (departments) N = 9 (28.13%)	Emergency room	7 (21.88)
		Mental health	2 (6.25)
	Clinical officers		4 (12.5)
	Youth counselor		1 (3.13)
	Police officer (health department)		1 (3.13)
Total participants			32 (100)

[a]University Teaching Hospital is Zambia's principal national tertiary referral hospital.
[b]Chainama Hills Hospital is the national psychiatric referral hospital.
[c]Chilenje, Matero, and Kanyama are first-level general hospitals.
[d]Levy Mwanawasa University Teaching Hospital is a tertiary teaching and referral hospital serving Lusaka Province.

optimal care, and suggestions for improvement. The study aimed to: 1) understand and map the current care trajectory for patients presenting with suicidal ideation or suicidal behaviour, and 2) identify barriers to accessing care. The semi-structured interviews were conducted between February and April 2024 in English, Nyanja, Pemba, or Tonga, according to participant preference. Interviews were held in person or via Zoom. All participants provided verbal and written informed consent. The final interview is available in the Supplementary material.

The interviewers were trained to maintain objectivity and minimize bias. Two selected participants cancelled because of scheduling conflicts. Each interview was conducted privately, with only the participant and researcher present, in a designated room at the facility. No repeated interviews were undertaken. Field notes were recorded immediately following each session. Data saturation was reached after 32 interviews, with no new themes emerging. Transcripts were not returned to participants for verification or correction.

Analysis

Audio-recorded interviews were manually de-identified and transcribed using an automated program (Otter AI). Transcripts were reviewed by interviewers for accuracy and conceptual consistency. Interviews conducted in Nyanja, Bemba or Tonga (n = 3) were manually transcribed and translated by research team members. We used a framework-informed directed qualitative content analysis [29]. A codebook was developed *a priori* based on the interview guide and study objectives, Andersen's model, and Levesque and colleagues' access dimensions; it was then inductively refined during data collection and coding. Two trained researchers independently coded the same transcripts and reconciled discrepancies through discussion and consultation with a senior researcher until inter-coder agreement exceeded 75%. Coders then coded independently, periodically reviewing differences with the team. The final codebook comprised themes, codes and subcodes (i.e., Theme: *Usual care*

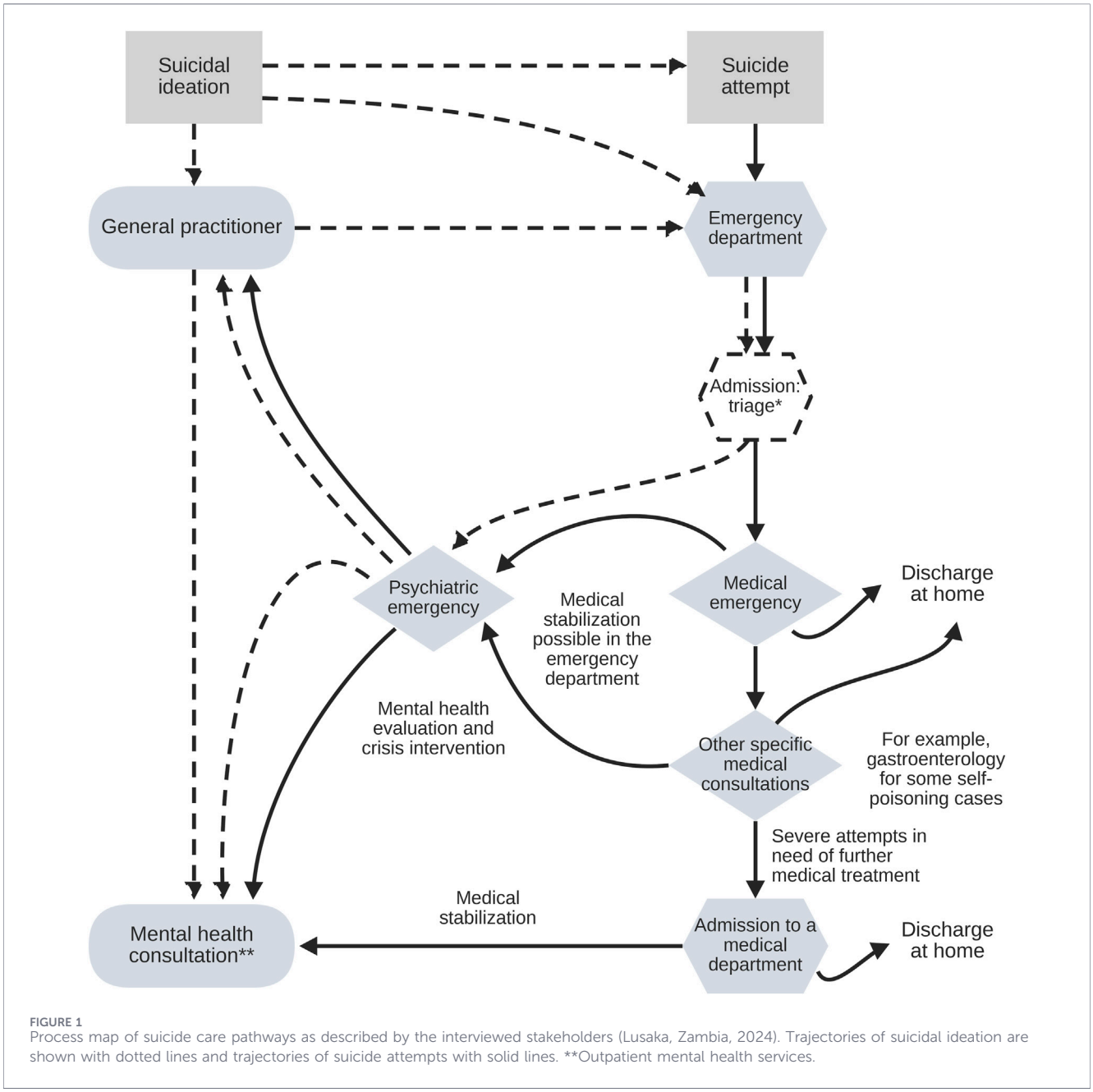

FIGURE 1
Process map of suicide care pathways as described by the interviewed stakeholders (Lusaka, Zambia, 2024). Trajectories of suicidal ideation are shown with dotted lines and trajectories of suicide attempts with solid lines. **Outpatient mental health services.

for suicide events Code: *Medical Care* Subcode: *Mental Health Usual Care*). Themes were derived from patterns across stakeholder groups and refined collaboratively.

To protect participant confidentiality, quotations are identified by participant number only and professional backgrounds are therefore reported only in aggregate.

For process mapping, we applied the healthcare process mapping framework to identify common workflows and clinical pathways [18]. This involved five steps [1]: *preparation and process identification* – engaging service providers and users, and training participants [2]; *data collection* through observations, interviews, patient reports, and document review conducted by our clinical researchers [3]; *map development* by integrating perspectives from different roles [4]; *analysis and validation* of the map to identify system gaps and improvement opportunities through later presentation of the map to participating providers and stakeholders; and [5] *implementation*, using the validated map to inform policymakers and improvement initiatives. The final map (Figure 1) was created using the online free version of Lucidchart (www.lucidchart.com) with care settings and decision points as nodes linked by arrows showing the patient trajectories reported by participants. No automated process-mining or pathway-generation software was used.

Results

Additional illustrative quotations for each theme and subtheme are provided in the Supplementary Material. Analysis generated

three overarching themes. Theme 1 describes the *current system of care*, including care trajectories and triage for individuals presenting with suicidal ideation or suicidal behaviour. Theme 2 covers systemic, structural, and attitudinal barriers to optimal care. Theme 3 explores *needed improvements* to strengthen suicide prevention and care within hospital settings.

Theme 1: current system of care

Participants described the usual care trajectory for individuals presenting with suicidal ideation or suicidal behaviour, outlining key elements of triage and treatment. Most reported that hospital cases in Lusaka involve high-lethality suicide attempts, while a few patients present with SI or non-lethal self-harm.

Treatment pathway and triage

The reported treatment pathway for individuals after suicide attempt largely depends on the severity of their condition. Upon arrival at the emergency department, patients undergo triage to assess the urgency: "red" (critical, immediate intervention), "yellow" (moderate, requires monitoring), "green" (stable), and "black" (deceased). Triage prioritizes care by presenting symptoms, while disposition (discharge, admission, or referral) depends on subsequent emergency department evaluation. However, referrals to outpatient mental health clinics for non-life-threatening cases are inconsistent due to time and resource constraints.

Following stabilization in the emergency department or intensive care unit ("red" or "yellow' cases), participants reported that patients requiring further care are admitted to relevant inpatient wards. The emergency department collaborates with specialty units, (e.g., gastroenterology for caustic ingestions), which oversee treatment and discharge planning and are responsible for contacting mental health services. One participant noted that decentralization efforts have made this coordination possible in several hospitals.

> "Right now, the options are there, especially here in Lusaka, because there is decentralization of health services. The Ministry has revamped mental health services in those level-one hospitals in Lusaka district, so it's an issue of making the services available as close to the people as possible" (Participant 26).

> "Usually, when we have such patients, on our plans, we write for psychiatric review, for psychotherapy" (Participant 8).

Despite this framework, the limited availability of mental health professionals often means patients are discharged with verbal instructions to attend the mental health unit on their own, without a specific time frame.

Figure 1 presents a schematic representation of the treatment trajectory as described by participants, reflecting their understanding rather than verified institutional procedures. Overall, participants emphasized that care remains primarily medical, with mental health pathways often unimplemented even after severe suicide attempts.

Theme 2: barriers to care for individuals with suicidal behaviour

Participants described significant barriers to managing patients with suicidal behaviour in Lusaka's six main hospitals.

Gaps in discharge, referral, and follow-up

Although some participants acknowledged the effectiveness of existing procedures, most identified a lack of systematic referrals and standardized discharge criteria as major challenges for individuals with suicidal behaviour or suicidal ideation. While physical stability and reduced self-harm risk guide discharge decisions, practical constraints like bed shortages often result in premature discharge before addressing mental health needs.

Inpatient mental health services varied across facilities; most care was outpatient. Reliance on follow-up appointments, combined with limited mental health professionals and the absence referral system, led to significant care gaps. As one participant noted:

> "In many cases, you will see that they would have a 10 to 15-minute chat with a mental health clinical officer (. . .). And that would be it. There will be very few that (. . .) would come back for further sessions or would come back for more help with medication, etc. So, the situation is very deplorable" (Participant 19).

Emergency physicians reported that while referrals to mental health clinics may be made, patients rarely attend due to financial constraints, distance, or stigma.

> "We always recommend psychiatric evaluation. I can't say for sure how often is done once they go". (Participant 9)

> "Discharge is just a formality. . . there are no follow-up sessions that the client or parents would agree to." (Participant 19)

Overburdened emergency departments

Some professionals noted how managing suicidal behaviour is often deprioritized in emergency departments due to high patient volumes and competing medical priorities. Life-threatening physical conditions take precedence over suicidal ideation, resulting in delays or inadequate attention to mental health needs.

> "People are helped by all the doctors that have interest, okay, those that have time, and here, it gets busy. You have somebody gasping there with a medical condition, and then this person comes with attempted suicide, they will look at them as people who are not thinking properly" (Participant 15).

However, some participants observed a gradual shift in perspective towards recognizing mental health cases as equally important:

> "So we tend to look at the one with a medical emergency as more important than someone who visited with a mental health issue. Yeah, they are. They are just as important, and I am realizing this." (Participant 8)

Insufficient mental health professionals

Participants consistently emphasized the limited availability of psychiatrists and psychologists, which places a significant burden on clinical officers and emergency physicians. Ideally, mental health professionals would collaborate with emergency teams to lead the management of patients with suicide attempt. However, given limited on-site staff, emergency physicians often assume the responsibilities–prescribing medication or providing brief counselling, despite lacking specific training.

At Level 1 hospitals, emergency physicians reported a lack of trust in clinical officers and limited service hours (mostly mornings only). In tertiary hospitals, where mental health specialists are available, participants still noted limited engagement:

> "I've never seen anyone from the psychiatric department, even when we have patients who present with acute psychosis, (. . .) we call the psychiatrist on call, they don't come" (Participant 8)

Where available, specialists face overwhelming workloads.

> "Because I'll be very frank with you, [. . .] Hospital has only got two psychologists. So the psychologists are quite overwhelmed. . . . (. . .) there are, say 400 patients at a time, I don't think two psychologists will be able to thoroughly give psychotherapy to all 400 patients" (Participant 24)

This shortage and excessive workload directly affect continuity and timeliness of care for patients with suicidal behaviour:

> "Yes, and you know, if something happens today, this is an acute incident and it has to be followed up in the shortest possible time, but if the clinic in the next week is already full, then it becomes difficult for that patient to be followed up in the next seven days. So, it comes down to this being resource-constrained". (Participant 10)

Health professionals lack specific training in suicide care management

The shortage of mental health professionals often leaves untrained general health workers responsible for managing patients with suicidal behavior. Participants emphasized the need for multidisciplinary teams including trained mental health staff:

> "But if we could have professions . . . like psychologists or psychiatrists who could be part of the management team, I think that will help a great deal(. . .) that we'll have because they are trained in that way. They can talk to people who can counsel people in different ways that we cannot do in the emergency department. Because we're not trained in that field" (Participant 8).

> "So as a facility or a hospital would require to have people who are ready to listen to those people, understand them, and know the reason why they want to commit suicide. And if possible, counsel them to find solutions and link them to the services or facilities where they are supposed to be helped. Unfortunately, it's not like that" (Participant 15).

Due to the limited availability of psychologists and psychiatrists, other healthcare workers frequently provide psychological support despite lacking specific expertise:

> *"But then, because of their unavailability, we do what we can."* (Participant 24)

While specialized mental health professionals expressed confidence in their ability to assess and treat suicide cases, most stakeholders reported frequent misdiagnoses or missed diagnoses.

> "*For a trained professional like us, it is impossible to miss a suicide diagnosis*" (Participant 17).

> "The only thing that comes close to that is a missed diagnosis. (. . .) the patient exhibited signs of having been exposed to an organophosphate. [. . .] But we noticed that there was something else that was lingering, that we could not identify" (Participant 10).

Accurate assessment and treatment often depend on information from relatives or caregivers, particularly when patients are unwilling or unable to communicate. Participants noted that gathering this information is time-consuming and lacks standardized protocols.

Stigma among providers and families was also reported to discourage seeking or sharing this information. Stakeholders stressed the need for provider training and awareness to improve diagnostic accuracy, particularly in cases where symptoms overlap with other conditions.

> *"Well, the most difficult thing, honestly, is most patients don't want to open up to what they have done. They won't tell you immediately what poison they took. Whereas if they're unconscious, but those who are able to talk usually are quite depressed, and they don't want to engage."* (Participant 18).

Theme 3: areas for improvement in suicide care

Participants suggested practical measures to improve routine care, closely linked to the barriers they identified.

Infrastructure improvements

Stakeholders across hospitals emphasized physical and operational infrastructure improvements. Many highlighted integrating mental health into the broader health system through further decentralization to improve community-level access.

> *"I would heavily encourage the integration of primary healthcare, I mean, into primary healthcare, mental healthcare as* well" (Participant 27).

Many participants called for designated wards or rooms, especially for youth, for patients with suicidal ideation or suicidal behaviour stressing the impact on patient safety.

> "Coming up with a ward whereby you have such patients. . .you will be assured that they won't take away their lives". (Participant 17)

> "It would be ideal if they are just admitted in a designated ward specifically for suicide" (Participant 22).

Stakeholders also emphasized privacy in counseling, as a lack of appropriate spaces could deter patients from sharing sensitive information.

> "And then the counseling. . . Confidential, not so much, because the neighbor will be able to hear some of the things that you're discussing. (. . .)So if it were possible, I don't know, the room can be created for such cases, in future if it's possible, to have a room or just a corner. (. . .) It's a very big challenge" (Participant 15)

Training health professionals in suicide care management

Stakeholders almost unanimously highlighted the need for additional training in psychological first aid and suicide management. Across roles, including those with prior mental health training, stakeholders felt better training could improve care for patients with suicidal behaviour and partially address workforce shortages.

> "*And I think that every health worker, regardless of their cadre, whether you're a nurse or a doctor or a clinical officer, needs to be trained on how to assess somebody who's at risk of committing suicide, or deliberate self-harm instead of leaving it to the mental health Hospital." (Participant 24)*

Participants also suggested training in standardized screening tools and structured suicide risk assessment to improve diagnostic accuracy and treatment.

> "Maybe also a questionnaire, especially since most of us have never really been trained in suicide attempt victims." (Participant 36).

Discussion

Key stakeholders described critical gaps in the care pathway for individuals with suicidal behavior in Lusaka, Zambia, including the absence of standardized discharge and referral pathways, gaps in mental health infrastructure, insufficient staffing, and inadequate training in psychological first aid.

From the stakeholders' perspective, Zambia's mental health system remains heavily centralized. Despite efforts to decentralize care by establishing mental health units in all first-level facilities tangible progress has been limited [11, 12, 15]. Regional examples from South Africa and Kenya, which have community-based mental health models, illustrate both progress and persistent gaps. In South Africa, integrating mental health into primary care has expanded community services and reduced reliance on long-stay institutional care [30]. Kenya has advanced deinstitutionalization and greater policy recognition of mental health as a public priority [31]. In both, gains remain fragile without continuous evaluation, adequate funding, and sustained community support [30, 31].

Our process map and analysis illustrate how emergency departments remain the first point of care for most patients with suicidal behavior and suicidal ideation. Triage prioritizes life-threatening physical conditions often leaving mental health needs inadequately addressed. Emergency departments, originally designed for physical trauma, increasingly serve as entry points for mental health crises [32]. Yet these services are frequently overcrowded and under-resourced, likely exacerbated by COVID-19 [33]. Deprioritizing physically stable suicidal patients reflects a global challenge for resource-constrained emergency departments [34]. The lack of private counseling spaces further undermines care, discouraging disclosure and help-seeking and reinforcing stigma. In Kenya, inpatient mental healthcare often delivered in general wards compromised privacy and reinforced stigma [33].

Continuity of care is another critical gap: discharge decisions were often based on physical stability, with little consideration of psychological needs. Without standardized discharge criteria, referral pathways, or arranged follow-up, many patients fall through the cracks, leading to higher risk of relapse or further attempts [35, 36]. Similar patterns are documented globally: in Bengaluru, India, only about 25% of individuals followed up with mental health services after a suicide attempt, particularly when no psychiatric diagnosis was documented [23]. In the United States of America, studies show that emergency departments that implement routine safety planning reduce readmissions and inpatient admissions, and that earlier outpatient follow-up care (within 7 days) is associated with significantly lower suicide risk compared to delayed or absent follow-up [24]. In Pakistan, emergency staff surveys reveal that patients with suicidal behavior are often considered less serious than those with physical conditions, and formal institutional policies or pathways for follow-up are lacking [25].

Limited mental health professionals, absent standardized suicide assessment guidelines and minimal provider training severely restrict care in Zambia. With few psychiatrists and psychologists available, frontline emergency workers often provide mental healthcare without adequate preparation, leading to delays in treatment and premature discharges. Government efforts to expand the workforce by staffing mental health units with clinical officers are undermined by hierarchical tensions with physicians. Strengthening multidisciplinary teams and training non-specialist providers, such as nurses and clinical officers, could help bridge this gap. The World Health Organisation's Mental Health Gap Action Programme (mhGAP), offers a promising model of structured training for non-specialist health workers in low- and middle-income countries. A review of mhGAP implementations across diverse settings shows consistent improvements in provider knowledge, attitudes, and quality of care [37]. In Nepal, a district mental health plan incorporating mhGAP for suicidality in patients with depression and alcohol use led to greater reductions in suicidal ideation [38]. In Malawi, mhGAP training in primary care significantly improved health workers' confidence and detection of severe disorders, including depression, suggesting potential for earlier recognition of suicide risk [39]. If full mhGAP implementation exceeds current capacity, training in context-adapted safety planning tools could still build confidence,

improve care, and help reduce re-attempt risk. Systematic risk assessment is also critical: the WHO's mhGAP Intervention Guide recommends routine use of standardized screening tools in non-specialist settings [37]. Evidence from neighbouring countries highlights their feasibility [40, 41]. Context-specific training and validated suicide management tools could substantially strengthen care pathways, discharge planning, and outcomes for individuals with suicide behaviour.

Strengths of this study include perspectives from 32 stakeholders across six major public hospitals and multiple professional roles, attainment of informational sufficiency during concurrent analysis, and integration of directed qualitative content analysis with healthcare process mapping. However, all participants come from Lusaka, an urban setting, limiting the generalizability of findings to rural areas, other provinces, and private services. Patient and family perspectives, which could have broadened understanding of barriers, were not included. Finally, the process map reflects stakeholders' reported understanding of usual care rather than direct observation or audit of institutional practice.

Conclusion and implications for policy and practice

The absence of standardized discharge and referral protocols, limited infrastructure, and shortage and inadequate training for frontline providers remain critical challenges for suicidal behaviour management in Zambia. Despite efforts toward decentralization, mental health services remain hospital-centred, with emergency departments serving as default entry points that often deprioritize mental health needs once patients are stable. These structural weaknesses contribute to discontinuity of care and increase the risk of relapses and reattempts.

For policy and practice, the findings highlight several priorities. First, standardized discharge criteria, referral pathways, and systematic follow-up mechanisms should be developed to strengthen continuity of care. Second, training non-specialist providers, drawing on the WHO mhGAP and context-adapted suicide risk assessment tools, can expand workforce capacity and improve early identification of risk. Third, private spaces for assessment and counselling would improve quality of care and help reduce stigma. Finally, community engagement and evaluation of decentralized models are essential to promote sustainable, accessible, and patient-centred mental health services.

Data availability statement

The interview transcripts analysed for this article are not openly available because they come from a small number of health professionals who could be identifiable from their role and workplace. All transcripts have been de-identified, and details of professions represented by only a few participants have been withheld to protect participant anonymity. De-identified data supporting the conclusions of this article are available from the corresponding author upon reasonable request. The study materials used, including the interview guides, participant information sheets, and informed consent forms, are provided as Supplementary Material submitted with this manuscript.

Ethics statement

The studies involving humans were approved by Ethikkommission Nordwest- und Zentralschweiz (AOJ2023-00011), the University of Zambia Humanities and Social Sciences Research Ethics Committee (HSSREC-2024-JAN-026) and Zambia's national Health Research Authority (NHRA-2126/10/04/2025). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

CM, GF, RP, and IF-B conceptualized the study, acquired funding, supervised study development and wrote the manuscript outline. AF-R and CM drafted and revised the manuscript. CM and RT conducted interviews, transcription, coding and analysis. AU, SV, AD-G, and IA contributed to process mapping, coding and analysis. CH contributed to data analysis and interpretation and critical manuscript revision. All authors revised and approved the final manuscript; CH also agreed to accountability for all aspects of the work.

Funding

The author(s) declared that financial support was received for this work and/or its publication. The Flourishing Minds Fund funded this study. The funder had no role in the study design; collection, analysis, or interpretation of data; preparation of the manuscript; or decision to submit the manuscript for publication.

Acknowledgments

We would like to thank Dr. Francisca Bwalya (National Mental Health Coordinator, Zambia Ministry of Health) for providing valuable insights into the study findings. We also thank all stakeholders involved in this study for their engagement and support, as well as for their daily commitment to patient care. During the revision of this manuscript, the authors used Claude Opus 5.5 (model ID: claude-opus-5-5), made by Anthropic, to assist with formatting, reference DOI checks, and language editing to reduce word count. The authors reviewed and edited all content and take full responsibility for the content of the publication.

Conflict of interest

The authors declare that they do not have any conflicts of interest.

Generative AI statement

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Supplementary material

The Supplementary Material for this article can be found online at: https://www.ssph-journal.org/articles/10.3389/ijph.2026.1609578/full#supplementary-material

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