


BMJ Open Sociocultural perspectives on suicidal behaviour at the Coast Region of Kenya: an exploratory qualitative study

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ABSTRACT

Objectives To explore perceived sociocultural factors that may influence suicidality from key informants residing in coastal Kenya.

Design We used an exploratory qualitative study design.

Setting Mombasa and Kilifi Counties of Coastal Kenya.

Participants 25 key informants including community leaders, professionals and community members directly and indirectly affected by suicidality.

Methods We conducted in-depth interviews with purposively selected key informants to collect data on sociocultural perspectives of suicide. Thematic analysis was used to identify key themes using both inductive and deductive processes.

Results Four key themes were identified from the inductive content analysis of 25 in-depth interviews as being important for understanding cultural perspectives related to suicidality: (1) the stigma of suicidal behaviour, with suicidal victims perceived as weak or crazy, and suicidal act as evil and illegal; (2) the attribution of supernatural causality to suicide, for example, due to sorcery or inherited curses; (3) the convoluted pathway to care, specifically, delayed access to biomedical care and preference for informal healers; and (4) gender and age differences influencing suicide motivation, method of suicide and care seeking behaviour for suicidality.

Conclusions This study provides an in depth understanding of cultural factors attributed to suicide in this rural community that may engender stigma, discrimination and poor access to mental healthcare in this community. We recommend multipronged and multilevel suicide prevention interventions targeted at changing stigmatising attitudes, beliefs and behaviours, and improving access to mental healthcare in the community.

INTRODUCTION

Suicide is a devastating and serious public health challenge. Globally, it affects over 800 000 individuals annually, most of whom (79%) come from low-income and middle-income countries (LMICs).¹ Suicide prevention is a priority and recognised as a target for the United Nations Sustainable Development Goals in an integrated effort to meet urgent global environmental, economic and political challenges.²⁻³ Some elements of suicidality are similar between LMICs and

Strengths and limitations of this study

- To our knowledge, this is the first published study to qualitatively explore sociocultural perspectives of suicide in Kenya.
- We present findings from a diverse and extensive pool of key informants.
- Saturation was reached in most layers of the various stakeholder groups.
- Our study findings may not be generalisable across different study participants, and prejudices by the participants about suicide may be present.
- Due to the COVID-19 restriction, we focused on in-depth individual interviews rather than include focus group discussions that may have provided consensus on perspectives shared.

high-income countries (HICs), for example, the strong association with comorbid mental health disorders. However, variations in underlying risk factors, preferred methods and legal considerations have especially been highlighted between the two settings.⁴ For instance, in Europe, substance use is strongly associated with suicidal behaviour,⁵ whereas in sub-Saharan Africa, poor socioeconomic status is identified as a crucial factor.⁶ In addition, while firearms are a common method of suicide in the USA,⁷ in Africa, it is poisoning by agricultural pesticides and hanging.⁸ These data are based on quantitative methodology that may inherently fail to provide deeper insights on knowledge, beliefs, custom and practices related to suicidality, necessitating qualitative approaches to contextualise suicide especially in Africa, a region with a rich, distinct and diverse culture and religion.⁹

Culture is a dynamic collection of customs, traditions and values to which a community or society ascribes,¹⁰ which may strongly influence an individual's perception of suicide.¹¹ Specifically, cultural values and societal structures impact on how a person perceives

circumstances as risk and protective factors. For example, religiosity has in some studies been shown to be a protective factor for suicidality, through increased social integrations and hope created by religious beliefs, especially in areas with high religious homogeneity.¹² Some cultures completely censure suicide and view it as an abominable act¹³; others may have some level of permissiveness,¹⁴ while others may view it as an honourable act.^{15 16} Moreover, the meaning and consequence of a suicidal act is heavily influenced by cultural norms of a society. Suicide in parts of Eastern and Southern Africa was traditionally attributed to spirits and supernatural forces. The fear of its consequences often led to ritualistic cleansing ceremonies following a suicide death,¹⁷ whereas in some communities suicide among certain groups of people (eg, the elderly) was acceptable and was in fact considered heroic (eg, among the Kalenjin of western Kenya).¹⁸ Recent media reports in Kenya have highlighted a disturbing increase in suicide rates especially among men.¹⁹ Masculinity issues have largely been considered to be a factor contributing to this high burden.²⁰ Culturally informed qualitative data not only allow for a deeper understanding of social and cultural factors influencing suicidal behaviour, but can also facilitate better understanding of the appropriate levels of care needed and identification of best persons to provide the care²¹ and inform the development or adaptation of impactful culturally appropriate suicide prevention strategies.

Suicidal attempt is currently illegal in Kenya and is punishable by a jail term sentence of up to 2 years.²² The criminalisation of suicide is likely to impact Kenyans' perspectives and attitudes on suicide. However, to our knowledge no study has thus far explored what impact this legalistic element has on the sociocultural perspectives of suicide at the Coast of Kenya. The Coast Region of Kenya is a culturally unique and diverse setting stemming from the amalgamation of various ethnicities as well as diversity in religious beliefs. A population survey conducted in the Coast Region found the suicide annual incidence rate of 4.61 per 100 000 population.⁶ Suicide was three times higher in men, and hanging was the most common method of suicide. A qualitative and cultural understanding of suicide in this community will help in understanding previous quantitative findings and in informing preventative strategies.

This study aimed at understanding sociocultural perspectives of suicide in the Coast Region of Kenya. Specifically, we sought to understand the following research questions: (1) what are the sociocultural perspectives of suicide in the Coast Region of Kenya? (2) do these sociocultural perspectives differ across various participants and mental health stakeholders? Are there age and sex differences in sociocultural perspectives of suicide in the Coast Region of Kenya?

METHODS

Study population and study design

Study area

This study was conducted in Kilifi and Mombasa Counties located along the Kenyan coast of the Indian Ocean. Kilifi

County has a population of approximately 1.4 million residents. The Kilifi County population comprises predominantly the Mijikenda ethnic group, a Bantu group of nine tribes with Giriama (45%), Chonyi (33%) and Kauma (11%) subgroups dominating. The population is regarded as of low socioeconomic status and of low literacy.²³

Mombasa is Kenya's oldest and second-largest city and in 2019 had an estimated population of about 1.2 million people. The main ethnic communities found in Mombasa County are the Mijikenda, Swahili and Kenyan Arabs, with Mijikenda being the largest community.²³

Sampling and participant selection strategy

In this study, we included adults residing in Mombasa or Kilifi Counties of Kenya that were willing to provide informed consent to participate in the study.

Key informants purposively sampled to participate included healthcare workers with experience of managing cases of suicidal behaviour, traditional health practitioners, persons known to have attempted suicide, local administrative leaders and the judiciary (police officer, chief and magistrate), clergy leaders and bereaved family members of persons who had died of suicide. We chose these stakeholder groups to provide a wider range of insight based on their first-hand knowledge and understanding being either a person with lived experience or a care and service provider for suicidal victims. Identification of study participants was through collaboration and guidance from the local community leaders such as the area chief and from healthcare workers in hospitals in Kilifi and Mombasa Counties. Some study participants, for example, traditional health practitioners and the clergy were identified through an existing research database, whereby they had indicated their willingness to be contacted for future studies. We approached potential participants in person and provided an overview of what the study was about and invited them to go through the informed consent process to obtain a more detailed understanding of the study goal and activities. Patient participants and bereaved family members were linked through their healthcare providers and interviews were conducted within the health facilities. Healthcare workers, local administrative leaders, traditional health practitioners and the clergy leaders were approached at their workplace and interviews conducted in a private space at the same venue. Only the study participant and researchers were present during the interviews. The study information including participant information and audio recordings was kept confidential and accessible only to study staff.

Study design

We employed an exploratory qualitative study design using in depth interviews to gather perspectives and experiences of key informant stakeholders residing at the Coast Region of Kenya. Data collection was undertaken by LO, a research psychiatrist, and MW, a research nurse

with a bachelor of science; both were female scientists with experience and training in qualitative research. LO has conducted previous studies in the subject of suicidality.^{24 25} The interviews were carried out in English or Kiswahili, the official languages of Kenya spoken by majority of Kenyans. Out of the 25 interviews conducted, 13 were in the Kiswahili and 2 had a mix of both English and Kiswahili. The interviews were audio recorded, translated and transcribed prior to analysis. The interviewers and the transcribers are fluent in both English and Kiswahili. The average duration of the interviews was approximately 30 min. The shortest interview lasted 16 min (ages 20–30, bereaved family member), while the longest interview lasted 1 hour, 27 min (ages 50–60 social worker and bereaved family member). No repeat interviews were undertaken. In addition to audio recording, following the interview, we documented striking observations using field notes. These field notes were used to better inform interpretation of transcribed data during coding and in the writing of the discussion.

The interview guide (online supplemental file 1) was developed based on the study's research question of trying to understand the perception of suicide in this community and local explanations for suicidality. We outlined broad areas of knowledge relevant to responding to our research question, seeking to explore clinical and sociocultural perceptions related to suicidal behaviour at the Kenyan Coast. This process was guided by both literature review and clinical experience. We developed the open-ended questions with probes and shaped them to fit respondents to allow us to gain insights on respondents' behaviour or experience, their opinions or beliefs, their feelings and knowledge of suicidality in that community. The interview guide was then piloted on a healthcare worker and social worker, and a few changes to the flow and structure were done for better comprehension and to contextualise the questions to various key informant groups.

Analysis

Qualitative analysis was conducted using both inductive and deductive theme identification. First, we familiarised ourselves with the transcribed data and then developed a coding schema that was informed by the key research questions. This coding schema was iteratively revised by adding new codes that reflected additional themes and topics that were generated from the data. The codes were then systematically applied across all the transcripts, and memos were used to elaborate on the codes and their application. Two coders (LO and MW) independently coded the data to allow for inter-rater reliability. The overall percentage agreement was 98.4%, while the kappa coefficient was 0.77, which represented substantial agreement.

Thematic content analysis was facilitated by immersion in the data, which was done through multiple readings of the transcripts and memo writing to highlight emergent themes and insights. LO, MN and SMK independently

Table 1 Sociodemographic characteristics of the study participants

Characteristics	Total (n=25)
Sex (male)	16
Age (years), median (range)	37 (20–61)
Level of education	
No formal education	1
Primary level	6
Secondary level	3
Tertiary level	15
County of residence	
Kilifi	19
Mombasa	6
Religion	
Christian	20
Muslim	5
Marital status	
Single	8
Married	13
Separated/divorced	4
Participant occupation/composition	
Healthcare provider (doctors, nurses, clinical officers, counsellors and social worker)	9
Religious leaders	3
Traditional healers	2
Local administration officers (chief, police or magistrate)	3
Persons with suicide attempt history	4
Bereaved family members by suicide	8
Prior experience with mental health services	
Provider of service	12
User of service	7
No direct experience	6

reviewed the themes, during which they closely examined the dataset and compared themes against each other to come up with the final list of defined themes. NVivo V.12 software was used to manage data analysis.

Patient and public involvement

Various stakeholders contributed in defining the research question and in the study design. Specifically, we engaged healthcare providers at various health facilities in the Coast Region to gain an understanding of the common care pathway in the region for persons with suicidal behaviour. This informed our decision to explore cultural perspectives from the various key informants. By engaging community liaison officers in the area, we were able to develop effective recruitment strategies for potential study participants. Aside from the publication, we plan to disseminate these findings to the community

**Table 2** Stereotypes of suicidal persons and the suicidal act

Suicidal victim	Suicidal act
Weak	Taboo
Cowardly	A curse
Cursed	Bad omen
Burdensome	Evil
Bewitched	Demonic
A black sheep/outcast	Illegal
Crazy	A criminal offence
Mentally unstable	Like having committed murder
Odd	Shameful

and health policy makers at the Coast Region of Kenya through various media platforms.

RESULTS

A total of 44 potential study participants were approached and requested to participate in the study. Out of these, 19 refused to participate. Reasons for refusal varied, with the majority (n=13) citing time constraints. Of the 25 participants interviewed, majority were male (68%), nearly half of whom were married (48%), and 60% had postsecondary level of education. The median age for the study participants was 37 years (range 22–60 years). The category of participants with the highest representation was healthcare workers (n=9), while the lowest representation was for traditional health practitioners (n=2). **Table 1** shows the demographics and categorisation of the participants.

We identified four key themes that influence suicidal behaviour from a sociocultural perspective. These included (1) the stigma of suicidal behaviour, (2) the attribution of supernatural causality to suicide, (3) the convoluted pathway to care, and (4) gender and age differences related to suicide.

Stigma of suicidal behaviour

Stigma as portrayed in stereotypical perceptions, prejudice, and discrimination of victims of suicide and suicidal attempt was repeatedly brought out in the interviews.

Negative perceptions of victims of suicide

The most common reported perceptions or descriptions of a suicide victim or person attempting suicide were being weak, crazy and sinful. The suicidal act was perceived as being evil and illegal, among others. **Table 2** shows stereotypical descriptors of suicidal victims and the suicidal act itself that were brought up by participants.

A local administrative chief from one of the counties highlights how suicide is portrayed as weakness and a way of escaping from one's responsibilities. This was the the most common stereotype used to describe a suicide victim:

don't know how to express it, but they are viewed as mentally weak because they have failed to take responsibilities. When such issues come, you are not supposed to carry them personally and if something is stressing you, you are supposed to share with others. (Chief, age 30–40)

A healthcare provider similarly reported on this negative perception related to the mental state of the suicidal victim:

For suicide attempters, the community perceives them as crazy in some way, or as if they have some illness or as if they are tired of living and can't be helped. They tend to stigmatize and segregate them completely, like telling children not to go near them as they will teach them bad habits. In some places you will hear them saying; "don't go near that man, he tried to commit suicide. (Psychologist, age 20–30).

Prejudice against suicidal persons

Prejudicial perceptions and beliefs that persons with suicidal behaviour were criminals who deserve some kind of punishment were noted. Nearly all interviewed study participants were aware that suicide was illegal in Kenya, and many would quote this as a reason for the negative attitude towards suicidal persons. Some viewed the existence of the law as a protective factor for suicide. Others emphasised the unacceptable stance towards suicidality based on both Christianity and Islamic fundamental religious beliefs. A chief and a healthcare provider offered the legal perspective, while a pastor observed the religious stance.

In my opinion if we can have a law that when we find in your family there is someone who has committed suicide ... we punish the whole family by arresting them and keeping them in police custody for some time. Through this, people will fear to commit suicide because if one person commits suicide but all of you are arrested and spend like five years in jail, everyone will fear to commit that act. (Chief, age 30–40 years old)

...That's okay because that person who attempted suicide will attempt it again if left free. It is better they be kept in police custody for them to know that the country and the world needs them (Clinical officer, age 20–30 years old)

Well, I don't know about other religions but in Christianity, if you take your life, its equivalent to having committed murder. You have killed. The bible says thou shall not kill, so anybody that commit suicide, in the Christian circle, he is perceived to have bought a ticket to hell... Just as murder is not welcome (Pastor, age 40–50 years old)

Discriminatory practices related to suicidality

Persons found attempting suicide were reportedly harassed and abused by members of the public. Also,

endorsed commonly is the atypical funeral and burial rites for suicide victims. The suicide victim in this case was viewed to be an outcast. Others mentioned burying suicide victims at night and would refrain asking a religious leader to officiate a ceremony due to the 'sinful nature of the act'. To avoid this level of discrimination, families felt compelled not to disclose the real cause of death.

They segregate them instead of embracing them at the very least... They tend to bash them or criticize them. You find that most nonfatal suicide attempters are beaten up, like they undergo mob justice for instance in town.... (psychologist, ages 20–30 years old)

If you have committed suicide, according to customs, like for the Giriama ... the day they are brought home, they are kept outside the compound. The grave is dug outside the compound and all ceremonies and burial will happen outside the compound because such a victim is considered to be a person of violence because they did not die naturally, but took their own lives (Traditional healer, age 60–70 years old)

Suicide is like a curse in the community, even you cannot be buried together with the others. Like among the Mijikenda's, they normally bury at their homestead compounds. But a person who commits suicide is buried outside the home compound. It's a bad omen so if he is buried among the rest, he might bring a bad spirit. (Pastor, age 40–50 years old)

...There are instances when the church will not bury people who have committed suicide... (Priest, age 40–50 years old)

Attribution to supernatural causes of suicide

Even with the mention of existing immediate stressors such as financial strain, infidelity, chronic physical and mental illnesses, many still highlighted that the overarching push for one to consider ending their lives was supernatural in nature. This attribution centred around sorcery, evil/satanic spirit possession or inherited curses.

Sorcery

A common belief in the community was that an individual who attempts suicide or dies by suicide is likely to have been bewitched. This belief was especially upheld if the suicide victim was young or successful. Often elderly persons in the community were suspected to be the sorcerers and behind such suicides.

They will always associate it with witchcraft, they will say spirits (majini) were thrown to him or her, Shulamoyo, they call it. Shula is like turning your heart back, it's like upside down so that you don't consider yourself worth, you feel you are worthless, you are hopeless, there is no reason for you to live so that you hang yourself and die. (Clinical officer, age 30–40 years old)

Spiritual possession

Others described suicidal intent as a powerful and impulsive spiritual force that overwhelms the individual, an evil or satanic spirit possession. Religious leaders are thus often sought for prayers to address these forces if an individual reports suicidal intent.

it's like a spirit that gets in them. Like for me there is a time the spirit got into me because I was laid off at work. But those who found me attempting to commit suicide rebuked me and prayed for me and the suicidal thoughts went away. (Patient who attempted suicide, age 30–40 years old).

it is Satan and once he gets in him, he must complete the act... That thing because it is brought by Satan, it is usually very fast... (Bereaved family member, age 40–50 years old)

Inherited curses

Yet another supernatural attribution was that suicidality arose from inherited/generational curses whereby a deceased family member may have snubbed a cultural or traditional taboo or flouted a norm. This belief was especially cemented by the nature of suicidal behaviour in some cases running in families. Often, traditional health practitioners are consequently consulted to perform rituals that remove these curses.

they can just pinpoint about that family and say that it's... a cursed family that is why it's happening or it's recurring in that community... (Psychiatric nurse, age 30–40 years old)

The father to this young man now who wanted to commit suicide. So, remember what I told you about customs. This one stayed for more than thirty years but still came to haunt them. I called another brother of mine and told him to come because of what was happening. When he came and we told him the story he said when his father was killed, they said they buy a red goat to cleanse the home but some people opposed. So you see now it has come again to haunt them again. (Traditional healer, age 60–70 years old)

Convoluting pathway to care

Delay in allocation of treatment

Participants interviewed reported that suicidal individuals seldom sought mental healthcare. Some reasons stipulated included a lack of awareness that the condition could be managed medically, lack of access to care, fear of legal repercussion and fear of stigma related to one being suicidal or of being labelled as a person with mental illness. Interaction with the healthcare system was often at the point of suicidal attempt when the individual needed emergency care.

... I know of a cousin of mine who feels he needs help but now he doesn't know how he will do it, ...should his parents have consent first before he goes. And if he is going to seek help where does he go to? He can't

go to Kilifi ... he says “when I go there I go sit there with people who are insane” ... the unit is thought to be for the serious mentally ill people. (Patient who attempted suicide, age 20–30 years old)

I think it's due to lack of awareness they will always come when they have attempted or they are in the wards...so you are called in the ward and when you ask them, this person has been having the ideas for almost ... six months but they have been sharing with others and they are told to go for prayers or to persevere. (Clinical officer, age 30–40 years old)

...when any person attempts suicide sometimes they are held because they know when they are taken there it can be a case... sometimes they are told to just go to a private facility so that they can get help and things will be over because they know when they go to a public one then it can be a criminal... (Clinical officer, age 30–40 years old)

Care seeking from an informal provider

Disclosure of suicidal ideation and intent when it happens would more commonly commence at the family level; family members would then link the individual to a religious leader for counselling and prayers.

Like me I got help when my mother saw me trying to hang myself, she said its better they take me to church so that I be prayed for. So, she took me to the church I was prayed for and that feeling ended. (Victim of suicide attempt, age 30–40 years old)

In other instances, the individual with suicidal thoughts and behaviour would be linked to a traditional healer to allow for rituals and traditional medicine.

Yes, and in our place, we usually consult the witchdoctors, but me I refused to go to them because I am a Christian... When you go to church you are told that if you fast and pray God will help you out of all your troubles. (Victim of suicide attempt, age 20–30 years old)

Occasionally, these informal providers would then link the individual to the formal healthcare system when their methods fail and if they felt the individual would benefit from this care.

Generally, as a priest in the parish there is an area I can do and where I cannot do I have to refer, that is why I had to refer this person to a specialist who has done training in the area of counseling particularly in that area of suicide. (Priest, age 40–50 years old)

Gender and age differences related to suicide

Gender differences

Gender in this community was reported to influence suicide motivation, method of suicide as well as care-seeking behaviour. Specifically, due to the cultural strongly held gender role, men were considered as the primary providers of the home. Perceived failure in this

role secondary to unemployment and financial strain was mentioned as a key motivator of suicide in men.

Yah, like even the gender role where people think the guy should provide for the family, so you find that even when your wife is working, some people actually commit suicide because they think the society is expecting them to still provide when they cannot. (Magistrate, age 40–50 years old)

In contrast, it was reported that women's risk of suicidality was more likely to be triggered by stressors like intimate partner violence and relationship discord.

Fatal suicidal behaviour was, in addition, seemingly higher among men compared with women, and this was attributed to the lethal methods of suicide employed by men such as hanging and jumping from heights as opposed to women who often attempted using poisoning or overdose of medication. In general, care seeking was also higher in women compared with men.

Most women use poison... So, you see poison once someone is rushed to the hospital, they are given some antidotes and the whole thing is taken from the system... but for the rope once it suffocates somebody dies. So, most men actually will use the rope. (Social worker and bereaved family member, age 50–60 years old).

...But for the male people they keep it to themselves their problems and normally most men even complete the suicide because they can use even lethal ways of doing it. But for the ladies you find they can speak about it before they do it and they can even use something like which is not lethal... (Nurse, age 30–40 years old)

Age differences

The age of an individual was repeatedly mentioned as a risk factor for suicide. Suicide risk was perceived to be higher among adolescents and young adults compared with older persons. The reason given for this difference in risk was that older persons had developed better coping skills and hence were more capable of persevering in comparison to younger persons. However, others emphasised that the elderly in the community tended to experience a greater sense of loneliness, abandonment and hopelessness, a precipitant for suicidality in this age group.

Here in casualty, most people who attempt suicide are teenage especially from Pwani University. (Doctor, age 30–40 years old)

For old age, it's when they get to the stagnation phase... So, getting to a stage where they are stagnant, not progressing and are segregated... Therefore, loneliness and feeling unappreciated or perceiving as if they are not appreciated since their families are not around contributes to suicide in old age. (Psychologist, age 20–30 years old).

Suicide in an older person was viewed as more permissive compared with a younger person. That the older person had lived their lives and had then resigned to end it was viewed as more rational than a younger person who still had more to give to the world. This was especially affirmed if the older individual was battling a chronic illness or disability. In some cultures, the death of a younger person by suicide would be attributed to witchcraft stemming from jealousy on the successes of that person. In such instances, elderly persons living in the community would be blamed or suspected to be behind this bewitching.

So, when a young person of 20 years commits suicide, it is easy for people to say his/her star was shining but because of witchcraft, they have committed suicide. But the older person, the perspective will be different. (Clinical officer, age 40–50 years old)

But for the old one, they will feel that this person has done his part even if he goes, maybe he has reached a point whereby he had found that he had accomplished what he wanted in life and therefore we are happy that he has gone. They have no problem with him. (Social worker and bereaved family member, age 50–60 years old)

DISCUSSION

Our study found two broad and distinct patterns of themes. The culture-specific nature of the first two themes on stigma and attribution of suicidality to supernatural forces was as striking in this setting as it was found to be present in other communities in LMICs, while the last two themes on a convoluted care pathway and gender and age differences are similar to what has been reported globally. Suicide is highly stigmatised in this rural community, where the commonly endorsed belief was that supernatural agents contributed to causation of suicide. This, in turn, influenced care-seeking behaviour, with the majority interacting with informal providers before presenting to healthcare facilities. Further, the age and gender of the suicidal individual was viewed to influence the risk, method of suicide, care-seeking behaviour, as well as the community's attitude towards the suicide victim.

The WHO recognises stigma and taboo as a challenge and obstacle to suicide prevention efforts.²⁶ Stigma is often fuelled by a lack of awareness of suicide as a health problem as well as existing taboos discouraging disclosure of suicidality. Our study found that stigma was directed towards the suicidal individual and, in cases of fatal suicidal behaviour, towards the bereaved family members. Similar to reports in the literature,²⁷ we found that stigma impedes access to care when the persons experiencing suicidal ideation refrain from disclosing their thoughts or plans out of fear of discrimination. Suicide and stigma have a reciprocal relationship, with stigma increasing the risk of suicide and vice versa.²⁸ Stigmatising attitudes and practices towards the bereaved survivors and the suicidal

individual further increase stress in these individuals but also impede access to care consequently increasing suicide risk in these vulnerable individuals.

Stigmatising attitudes and behaviour can also be attributed to existing laws, especially in countries where suicidal attempts are retained as criminal offences.²⁹ Though most countries globally have decriminalised suicide,²⁹ attempted suicide remains illegal in Kenya, punishable by up to a 2-year jail term sentence.²² It is unclear to what extent this law is enforced among those implicated in suicide. Structural stigma emanating from policies and cultural norms in this community was emphasised more compared with self-stigma. Consequently, bereaved families would often misreport the cause of death to avoid judgement and blame, as well as to spare discriminatory practices towards the body of the deceased and the family. An exploratory study by Ohayi³⁰ similarly found that bereaved suicide survivors would often deny and misreport suicide as cause of death because of fear of stigma. This misreporting contributes to underestimation of suicide statistics, especially those highlighted in LMICs.³¹

Attribution of death to supernatural agents has been documented in various cultures^{13 32} and can be ascribed to the violent nature of suicide as a cause of mortality and by the complexity in its prediction and prevention.³³ Similarly, in this study, both fatal and non-fatal suicidal behaviours were attributed to supernatural agents as an explanation even in the presence of a prevailing immediate stressor (such as depression or socioeconomic distress). Importantly though, respondents did acknowledge feelings of low mood and hopelessness are linked to suicidal ideation. Understanding this cultural perspective is important in understanding the impact of the care pathway suicidal persons follow. Our study, for example, found a delay in accessing healthcare as suicidal individuals would first seek help from religious leaders and traditional health practitioners, with others believing that prayers or traditional rituals would solely avert suicidal behaviour. Other studies conducted in LMICs have found a similar tortuous pathway to care,³⁴ perhaps emphasising the need for raising awareness about mental health and suicide, training of gatekeepers, specifically traditional health practitioners and religious leaders, and the collaboration of healthcare workers with these community gatekeepers as recommended by the WHO.²⁹

Our qualitative findings were in congruence with many studies that report higher suicide in men compared with women.⁴ Houle and colleagues concluded in their study that traditional male gender role expectation of power and control increased the risk of suicide in men.³⁵ In that study, two key mediating factors contributing to this male predisposition were poor help-seeking behaviour and low perceived social support compared with women, findings that are convergent with our reports. Additionally, the lethality of means has been shown to differ by gender, with men likely to use more lethal methods, for example, hanging, thereby increasing their risk of

completed suicide.³⁶ Similarly, participants in this study described men were more likely to attempt suicide by hanging contrary to women who commonly attempted with poisoning. An explanation for this provided in our interviews was gender difference in intentionality; that is, men in general have a stronger intention to die of suicide compared with women, a phenomenon supported by Mergl *et al.*³⁷ These differences further underscore the importance of targeted gender-based interventions such as reframing help seeking as masculine for men³⁸ and socioeconomic empowerment initiatives.³⁹

Suicide motivation and permissiveness differed by age group, with the older age group likely to report loneliness, abandonment and existing chronic illnesses as precipitants of suicide, while the younger age group was reported to be triggered by interpersonal problems and financial strain as potential stressors contributing to suicidality. Winterrowd *et al.*⁴⁰ similarly reported suicide was admissible among older persons. Chronic illness and disability were a common trigger of suicidality; however, loneliness and feelings of abandonment were not highlighted in their study. A striking finding was that the elderly in the community were falsely blamed for witchcraft in suicide cases. Witchcraft allegations targeting the elderly is a common problem on the Kenyan coast, and many elderly people are attacked by mob justice. In response to this, there are already ongoing awareness campaigns in the area dubbed ‘uzee si uchawi’, translated as being elderly does not equate sorcery.⁴¹ Awareness messaging for suicide prevention targeting the community can similarly focus on this vulnerable group of persons.

Study strengths and limitation

To our knowledge, first, this is the first published study to qualitatively explore sociocultural perspectives of suicide in Kenya. Second, we present findings from a diverse and extensive pool of key informants. Lastly, saturation was reached in most layers of the various stakeholder groups. For limitations, we recognise that qualitative research highlights perspectives and cannot be generalised to a broader population. Prejudices by the participants about suicide may be present. For example, healthcare workers may have a different perspective than traditional health practitioners. Due to COVID-19 restrictions, we focused on in-depth individual interviews rather than additional focus group discussions (FGDs) as had been earlier planned. FGDs are useful in gaining consensus on matters discussed. However, with suicide being a highly sensitive, criminalised and stigmatised subject in this region, in-depth interviews do provide a safer and private environment for data collection, hence allowing more open conversations. Also, due to COVID-19 restrictions, we did not return transcripts to participants for comments and corrections. Lastly, patient public involvement primarily focused on healthcare providers to inform the study design phase. This may have inadvertently limited the content of the interview guide.

CONCLUSION

Culture, specifically traditional norms, religion and criminalisation of suicidal behaviour, appears to impact on how this community conceptualises suicidality and may partially explain the discrimination and negative attitude towards persons needing specialised care related to suicidality. These stigmatising attitudes, in turn, are seen to contribute to delayed care-seeking behaviour. Interventions that focus on stigma reduction and improved access to care for persons with suicidality and other mental health disorders such as suicide decriminalisation, community-based suicide literacy, educational campaigns and strengthening of mental health systems are needed in Kenya. We propose that future research should focus on testing multipronged and multileveled interventions that are targeted towards suicide stigma reduction. We recommend a coordinated approach at the national, county and community levels to effectively address stigma and increase access to care for suicidal victims.

Contributors LO, SK, JT, BP and CRJCN conceptualised and designed the study. MN, LO and CT conducted the interviews. MN and CT translated and transcribed the data. LO and MN coded the data. LO, SK and JT and MN thematically analysed the data and wrote the first draft of the manuscript. All authors contributed to the interpretation and subsequent edits of the manuscript. LO is the guarantor for the study.

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