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Rethinking suicide prevention: insights from the global south for a new global agenda

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Despite decades of scientific advances, suicide remains a global public health challenge shaped by deep social, economic and cultural inequalities. Although substantial resources have been allocated to prevention efforts, these strategies have overwhelmingly been designed, tested and implemented based on evidence generated in high-income countries. As a result, the models and interventions commonly adopted worldwide often fail to adequately capture the diverse realities of the global south. Here we argue that the global south offers critical insights for rethinking suicide prevention, illustrating how socioeconomic factors, cultural practices and community connection and resilience shape mental health outcomes and suicide risk. Rather than relying exclusively on individual-centered, clinical approaches, a broader and more context-sensitive framework is necessary, one that integrates structural determinants, promotes social justice and values epistemological diversity. Through an analysis of epidemiological trends, mental health constructs, cultural practices, theoretical frameworks and public policy interventions, this Perspective proposes a reconceptualization of suicide-prevention strategies that move beyond traditional paradigms.

When examining suicide in the global north versus the global south, it is crucial to acknowledge that we are not addressing a uniform phenomenon. Suicide rates, patterns and underlying determinants vary substantially between these regions. Although overall suicide rates in many global south countries are lower than those observed in high-income nations, 70% of suicides occur in low- and middle-income countries (LMICs)[1].

Rethinking suicide prevention—why context matters in a global agenda

Between 2000 and 2019, the global age-standardized suicide rate declined by 36%. Notably, the Region of the Americas was the only area to experience an increase in age-standardized suicide rates during this period, rising by 17% (ref. 1) and 56% in number of deaths from suicide[2]. The average suicide rate is 9.0 per 100,000 individuals, with marked gender differences: 14.2 among men and 4.1 among women[3]. Nonetheless, substantial variation exists across countries, with rates ranging from as low as 0.3 per 100,000 in Barbados to as high as 40.8 in Guyana[3]. Of all 26 countries that exhibit a suicide mortality increase worldwide, eight are geographically part of Latin America or the Caribbean (Paraguay, Brazil, Uruguay, Guyana, Mexico, Dominican Republic, Jamaica and Bahamas)[4]. In 2019, within the American region and all subregions, suicide mortality rates were the highest among those 85 years of age and older (20.1 per 100,000), followed by individuals 80–84 years of age (16.6 per 100,000) and those between 75 and 79 years of age (14.9 per 100,000)[3]. As the highest suicide rates are consistently observed among older adults, and with rising life expectancy, increasing social isolation and a worsening of socioeconomic vulnerabilities, a continuous acceleration in suicide rates among this demographic can be anticipated.

The drivers of suicide in the global south are linked to broader structural inequalities[5–7]. Although suicide research and prevention efforts in the global north have traditionally emphasized psychiatric diagnoses and individual-level risk factors (aside from means restrictions)[8–11], emerging patterns in the global south show the importance of socioeconomic deprivation, racial and ethnic disparities,

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political instability, historical trauma and limited access to mental healthcare[7,12–17]. Addressing suicide in these contexts requires a comprehensive approach that accounts for both personal vulnerabilities and systemic forms of injustice, including those shaped by political and economic structures such as austerity policies and social spending cuts[15,18,19].

The epidemiology of suicide in the global south calls for more granular data collection and analyses. Without accurate data, targeted interventions remain out of reach. Investments in public health surveillance and culturally appropriate suicide research are needed to identify region-specific patterns. Without robust surveillance systems and culturally informed research, the development of effective, targeted interventions remains elusive, as well as the theories on which they are based. Investing in public health infrastructure, strengthening data quality, and promoting community-engaged research are critical steps toward a more comprehensive understanding of suicide and, ultimately, toward more effective prevention strategies tailored to the diverse realities of the global south.

Challenging universal guidelines toward context-sensitive prevention frameworks

Evidence production and epistemic inequity—a call for epistemological decolonization in suicide prevention

When designing suicide-prevention strategies, there is often a tendency to immediately turn to systematic reviews and international guidelines. However, it is important to recognize that although these guidelines and systematic reviews are based on scientific evidence, the majority of the underlying research has been produced in high-income countries (HICs) with the financial and infrastructural capacity to support large-scale studies[9,20–22].

As a result, relying uncritically or exclusively on these documents may fail to produce the intended outcomes when applied in settings with distinct social, economic and cultural conditions. Many LMICs still lack a national suicide-prevention plan, and suicide rates continue to rise in some of them, so the effectiveness of interventions may be compromised if they are not developed with local contexts and needs in mind. Merely adapting evidence-based interventions created in HICs may not be sufficient to address the complexities present in LMICs.

The epistemic imbalance not only affects the design of interventions, but can also marginalize the voices of locals[23,24], lived experience[25], researchers, practitioners and communities in the global south that face several barriers, including a language barrier. Funding flows, authorship in high-impact journals and standard-setting bodies continue to be concentrated in the north. As a result, prevention strategies often reflect assumptions and contexts that are foreign to the populations they are intended to serve[20,24].

It is crucial to broaden the scope of research efforts, diversify the production of scientific knowledge, and ensure greater inclusion of evidence generated in LMICs[20]. This also means reclaiming knowledge already produced in the global south, and accessing and integrating existing research produced in diverse contexts.

How to expand the global evidence of suicide

Expanding the global evidence base requires investing in south–south research collaborations, promoting inclusive research methodologies and valuing localized knowledge[26], such as the Suicide Prevention and Implementation Research Initiative in Bangladesh and India and the EMERALD program in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda[27]. Only through this broader and more inclusive scientific effort can suicide-prevention strategies become truly effective across different global settings.

Relying uncritically on global guidelines developed in contexts with vastly different social, economic and health infrastructures risks reproducing ineffective interventions. The asymmetric knowledge between north and south needs to be addressed. The global south is not exclusively a site for implementation, but could be a valuable source of innovation and theoretical advancement. To confront suicide effectively, we must move beyond importing solutions and start exporting insights. Embracing epistemological pluralism and decolonizing prevention strategies may hold the key to a more equitable and effective global response.

A shift toward epistemological decolonization entails questioning the universality of mental health constructs and embracing knowledge derived from different sociocultural paradigms. It also requires rethinking the training of mental health professionals, integrating community wisdom and empowering local actors to co-design interventions. By re-centering the lived experiences and explanatory models of diverse populations, suicide prevention can become more responsive, ethical and sustainable. This involves a philosophical and methodological commitment to social justice, recognizing that there is no single, universal way of understanding suffering, healing or community[12,17,28].

Mental health constructs and the limits of clinical paradigms

Regional differences in patterns of mental illness and suicide-prevention strategies have been observed, and these distinctions merit careful attention. In the global north, suicide is often associated with diagnosable mental disorders, a relationship that has been extensively documented in the literature[29,30]. This relationship is reflected in public health policies, which frequently prioritize the expansion of access to mental health services, the prescription of psychotropic medications, and the provision of psychotherapeutic interventions[30,31].

In other regions, particularly in the global south, a growing body of research highlights the importance of structural, social and economic factors in shaping suicide risk[7,24–26,28,29,32–37]. Although such factors are also relevant in northern contexts, they tend to manifest with greater intensity or in distinct forms in many countries across the south. Social, educational and economic inequality, poverty, discrimination, urban violence, homicide, crises and limited access to economic resources are critical determinants that increase vulnerability to suicidal behavior[7,32–37]. In some HICs, individual psychopathology and genetic reductionism are often considered the primary driver of suicide[29,30,38–43]. However, psychopathology and genetics are only part of the picture, and broader social determinants are indispensable to understanding patterns of risk.

Cultural differences and disparities in access to mental health services further compound these challenges. In some South American countries, for example, mental suffering remains highly stigmatized, often perceived as a moral weakness rather than a legitimate health condition[44,45]. This pervasive stigma can delay or even prevent help-seeking behavior, leading individuals to suffer in silence[44,45]. Moreover, specialized mental health services are unevenly distributed across the region, with severe shortages in rural and underserved areas. For example, rural regions in Brazil, Peru and Bolivia face a substantial lack of trained mental health professionals, resulting in large gaps in prevention and early intervention efforts[44,46].

Cultural practices and informal networks of care—lessons beyond the clinic

However, although access to mental healthcare is not a reality for millions of individuals in the global south, informal networks rooted in cultural and communal practices play a central role in providing emotional and social support. Community events, cultural gatherings, mutual aid initiatives and traditional healing practices offer contextually grounded responses to suffering and social fragmentation. These informal spaces often reach individuals normally excluded from formal health systems, functioning as vital arenas for expressions of mental distress, but also for meaning making, belonging and collective resilience[21,47,48].

Practices such as family gatherings, neighborhood meetings, story telling circles, community sports, local festivals and intergenerational activities can foster emotional expression, social cohesion and a sense

of shared purpose. Many of these practices might also carry symbolic dimensions that help support the processing of grief, the reinforcement of interpersonal bonds, and the reaffirmation of individuals' roles within their communities[49–51]. Regardless of religious faith, what these practices truly promote is the opportunity for connection and interaction, which serve as important protective mechanisms against social isolation.

This social dimension is echoed in population-level findings. A study conducted in the United States found that, after adjusting for sociodemographic covariates, Black and Hispanic older adults were less likely to experience severe social isolation than their white counterparts[52]. This difference may be linked to the preservation of cultural traditions in which community and collective support remains more central.

Moving forward, suicide-prevention frameworks could greatly benefit from the insights offered by culturally embedded practices. As loneliness—one of the strongest risk factors for suicide—continues to rise globally, understanding how communities organically cultivate connection and mutual care becomes increasingly critical. Social isolation represents a modifiable risk that impacts a substantial portion of the adult population. A study in Bogotá (Colombia), Buenos Aires (Argentina) and Lima (Peru) found that personal and social support systems, as well as artistic activities and sports, were among the most frequently recognized resources that help adolescents and young adults cope with mental health challenges[47].

Although existing research highlights the risk of suicide contagion under specific circumstances, such as exposure to a suicide case or behavior through media reports, personal contact or social media[53,54], this does not preclude the importance of fostering social connectedness. Collective support strategies, when thoughtfully designed and contextually adapted, may help mitigate these risks while addressing the broader harms associated with social isolation. Therefore, according to the World Health Organization[48], greater collaboration with 'informal healthcare providers', such as families, religious leaders, faith and traditional healers, schoolteachers, police officers and local nongovernmental organizations, is also essential. In this regard, South America, with its strong collective identity and cultural emphasis on connection and belonging, offers valuable insights for advancing suicide-prevention strategies by shifting the focus from individual screening to a wider approach centered on mental health promotion.

From individual pathology to collective suffering—reframing suicide risk

Most prevention strategies remain heavily centered on the individual at risk, with limited attention given to the broader social and contextual factors that shape vulnerability. The predominant biomedical model that frames suicide as a consequence of an individual psychopathology has shaped not only public perception but also research and policy, resulting in interventions exclusively focused on psychiatric diagnosis and pharmacological treatment, especially in the high-income context[28].

In contrast, studies in the global south have shown that structural drivers of distress—poverty, violence, systemic racism, gender inequality and displacement—play a disproportionately larger role in shaping mental suffering and suicidal behavior[7,32–37]. Therefore, psychiatric language alone often fails to capture the complex and collective nature of distress experienced in these settings. Evidence from community-level research highlights that mental suffering in South America, for example, often manifests through culturally specific expressions—such as *nervios* or *tristeza profunda*—which do not always align neatly with the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnostic criteria. This emphasizes the importance of understanding culture-bound syndromes within the specific cultural frameworks in which they arise, rather than interpreting them solely through Western psychiatric models that may overlook their distinct features and social meanings[55,56]. Such findings underscore the need for culturally attuned approaches to ensure more accurate and effective care for individuals from diverse backgrounds.

In terms of suicide, not all cases are attributable to psychiatric disorders[28]. In HICs, it is estimated that 80–90% of suicides are associated with a psychiatric diagnosis[29,57], whereas in LMICs, only 58% of individuals who die by suicide meet criteria for a diagnosable mental disorder[58].

Beyond economic vulnerabilities, other social issues significantly affect populations in the global south, including high rates of violence in certain regions, which impact not only direct victims, but also entire communities exposed to chronic levels of fear and distress[59–61]. Additional factors, such as gender-based violence, structural gender oppression and persistent economic precarity, further compound this burden. These conditions contribute substantially to psychological distress, suggesting that symptoms often emerge as understandable responses to ongoing adversity rather than as manifestations of isolated clinical disorders. This reality underscores the need for integrated mental health models that address both individual vulnerabilities and collective suffering.

Additionally, broader societal transformations in recent decades have added layers of complexity to mental health and suicide prevention. One notable shift has been the rising prevalence of individuals living alone, particularly in urban centers, coupled with a paradoxical development: although digital technologies have expanded online connectivity, they may have also contributed to increased emotional problems[62] and social isolation. This might happen because the widespread use of social media platforms has been associated with emotional problems, which can result from social comparisons and constant exposure to unattainable standards of success, beauty and happiness, fostering feelings of inadequacy and loneliness[62–64]—particularly among younger populations. This phenomenon is also on the rise in the global south.

Standards from the global north have never been so present and accessible in the global south. A key side effect of this global cultural diffusion is the implicit framing of northern societal values as superior, which may erode pride in local identities and disrupt cultural belonging. One striking example is the alarming rise in suicide rates among the young indigenous populations in Brazil[13,14]. In a world in which ancestral traditions are devalued or rendered invisible, the construction of self-esteem and the ability to authentically inhabit one's cultural identity become profoundly challenging.

Another contributing factor is the accelerated pace of modern life[65], which may have become a globalized norm. This shift, characterized by the relentless pursuit of productivity, economic competition and reduced time for family and leisure, has contributed to a widespread erosion of social bonds and essential collective support structures[49]. Individuals are increasingly embedded in a 'culture of speed', in which the pressure to achieve, perform and consume leaves little space for rest, reflection or meaningful interpersonal connection—factors that are essential for maintaining mental health and psychological wellbeing. These dynamics can intensify experiences of alienation, loneliness and existential distress, thereby compounding suicide risk in the global south and other parts of the world.

These transformations point to a critical insight—social suffering is frequently individualized and medicalized when, in many cases, it may be more accurately understood, and more effectively addressed, through collective and structural interventions[12,17,28]. A comprehensive public health approach to suicide prevention must recognize the profound interdependence between individual psychological distress and broader societal conditions. Failing to do so risks reinforcing a narrow biomedical narrative that obscures the root causes of suffering and limits the scope of effective prevention.

Therefore, reframing suicide not merely as an issue of individual pathology but as a symptom of collective suffering, deeply embedded within structural inequalities, cultural shifts and social fragmentation, is an urgent task for global mental health, especially in the global south.

Social protection and surveillance—evidence from the global south

Integrated strategies for suicide surveillance, prevention and mental health promotion

Countries in the global south have advanced mental health promotion by adopting community-based approaches that not only improve suicide surveillance but also strengthen local care capacities and social cohesion. In rural India, integrating data from health services, police reports and community informants, including village leaders and health workers, has contributed to a more accurate detection of suicides and attempts, while simultaneously fostering intersectoral collaboration and community engagement[66]. Similar strategies in parts of Africa involve lay health workers and traditional or religious leaders, who often provide culturally meaningful forms of support, despite their lack of formal integration into national health systems. These initiatives point to the value of connecting biomedical care with traditional and faith-based systems, not only to improve early identification and referral for individuals at risk, but also to expand culturally grounded networks of support[67,68]. In Latin America, culturally responsive frameworks, such as the Engaged Community Action for Preventing Suicide in Peru, have demonstrated the feasibility of training both professionals and community members to recognize and address distress, enhancing mental health literacy and fostering local ownership of care processes[69]. In parallel, digital tools, such as electronic decision support systems piloted in Peru[70] and India[71], have empowered community health workers to respond earlier and more effectively, reinforcing their role as trusted care providers within their communities. In Zimbabwe, the 'Friendship Bench' mobilizes community-trained lay health workers, often referred to as 'grandmothers', to provide empathic care in culturally familiar settings, such as benches outside primary care clinics, improving mental health outcomes through relational and accessible support[72]. In Sri Lanka, the national ban on two highly lethal pesticides, a structural measure aimed at reducing suicide means, also contributed to safer living environments and was estimated to have saved 93,000 lives by 2017 (ref. 73).

These experiences reflect a broader shift toward community-driven, culturally relevant and system-strengthening approaches that not only prevent suicide but also actively promote mental health—particularly in settings in which formal mental health services remain scarce. They move beyond crisis response by cultivating protective social environments and reinforcing the structural and relational foundations of mental health. Collectively, they demonstrate the feasibility and value of integrated, multilevel strategies for promoting mental wellbeing in low-resource contexts.

Prevention beyond the clinic—examples from South America

When considering the role of context in the global south, including South America, it is important to highlight the socioeconomic aspects. Findings from a systematic review of LMICs reported that ~62% of studies identified an association between suicide and general measures of poverty[35]. Therefore, although clinical interventions such as psychotherapy and pharmacological treatment are widely promoted in global suicide-prevention guidelines, these approaches alone may not be sufficient in South America. In addition to clinical care, the region has benefited from community-based, intersectoral initiatives that address the structural and social roots of distress. Community mental health initiatives in South America have also drawn from collective traditions and local knowledge systems. For example, in the Andean regions of Peru and Bolivia, mental health practitioners work alongside traditional healers, fostering collaborations to provide culturally resonant forms of care[21,74–76].

Another example is in Brazil, where a national psychosocial care network has been established, integrating mental health clinics and community-based services across its territory to promote more inclusive and context-sensitive mental healthcare[77]. The Brazilian Psychosocial Care Centers (CAPS) embody a decentralized approach that integrates mental health services into community life[78–81]. These initiatives not only expand access to care but also challenge the dominance of psychiatric institutions and clinical gatekeeping. Crucially, they embody a philosophy of mental health rooted in community, dignity and autonomy, in which care is not limited to treatment but extends to social support, political engagement and cultural affirmation.

Programs that strengthen social networks, provide psychosocial support in schools, and extend care to indigenous and remote communities have also shown promising results[77,82,83]. Another striking example is the cash transfer program *Bolsa Família* in Brazil. Between 2004 and 2015, this initiative reduced suicide risk by 56% among beneficiaries compared to non-beneficiaries[84]. Despite not being designed as a mental health intervention, *Bolsa Família* had an unprecedented preventive impact on suicide rates among beneficiaries[84], and has also been associated with reduced substance-use disorder hospitalizations[85] and decreased mortality among people hospitalized with psychiatric disorders[86]. This suggests that structural policies may be more effective than clinical interventions alone, especially in contexts of high inequality and socioeconomic deprivation.

As technological advancements accelerate labor automation, displacing large segments of the workforce and contributing to rising unemployment, the global demand for robust social protection systems is expected to increase substantially. Additionally, overlapping crises, such as armed conflicts, climate-related disasters and global disease outbreaks, further underscore the urgency and relevance of expanding these interventions. Although the implementation of cash transfer programs presents challenges, including feasibility, sustainable financing and effective scale-up, often shaped by political decisions and fiscal priorities[15,87], they remain promising strategies for suicide prevention and the promotion of social resilience. In Brazil, such a program has been successfully institutionalized as a national policy (Table 1).

Table 1 | Challenges to implement cash transfers as policy measures and potential recommendations

Component	Common challenge[a]	Example: Brazilian case
Feasibility	Ensuring sustainable funding	Institutionalized as a national policy, with stable federal funding ensured by law (Law No. 14.601/2023)[99]
Implementation	Defining target population, benefit amounts, coverage and conditionality	Benefit structure includes[b]: R$142 per family member R$150 for children 0–6 years of age R$50 for pregnant or lactating women or for each child/youth 7–17 years of age
Access	Reaching vulnerable populations, including in remote areas	Over 90% of national coverage is achieved through active search strategies and integration with the *Cadastro Único* (Unified Registry)
Scaling up	Expanding coverage in large, diverse populations	Program scaled through digital administrative systems and centralized registries
Conditionalities	Ensuring behavioral requirements to promote long-term outcomes	Conditionalities include regular school attendance and health check-ups, including nutritional monitoring for children 0–6 years of age, with the aim of improving access to education and healthcare among beneficiary families

[a]The challenges listed are common to the implementation of cash transfer programs in various global contexts. The Brazilian case is presented as an illustrative example, based on national policy developments and administrative data systems. Solutions may differ according to local political, economic and institutional conditions. [b]These values correspond to ~10–15% of the monthly minimum wage in Brazil (R$1,412 in 2024).

Why intervening at the base matters

This may be because interventions such as *Bolsa Família* operate at the base of multiple public health and mental health frameworks. As illustrated by Maslow's hierarchy of needs[88], addressing fundamental needs such as food, shelter and safety is essential for individuals to achieve higher-order psychological or self-fulfillment goals. Although more recent theories/studies suggest that individuals experience all needs simultaneously in a more multidimensional framework of human needs[87,89,90], this framework helps us to understand that social protection policies that reduce extreme poverty, hunger and insecurity contribute directly to the fulfillment of basic needs, laying the foundation for improved mental health and wellbeing.

This logic is reinforced by Frieden's health impact pyramid[91], which demonstrates that the greatest population-level impact results from interventions that address socioeconomic factors—those located at the base of the pyramid. In contrast, interventions that require more individual effort and are located at the top, such as counseling, have more limited population reach.

Similarly, the WHO's optimal mix of services pyramid[92] for mental health highlights that self-care and informal community care—services that require fewer resources and infrastructure—should form the foundation of mental health systems, with more intensive psychiatric and inpatient care positioned at the top. Strengthening the base of the pyramid can reduce the likelihood that problems escalate to a severity that requires specialized care. Investing mainly in clinical or hospital-based interventions, while neglecting the base of the pyramid, leads to limited population coverage and unsustainable system costs.

However, in a world in which most mental health services are overwhelmed, and the majority of individuals with mental disorders or at risk of suicide lack access to care (for example, treatment coverage for depression ranges from 23% in HICs to just 3% in LMICs)[93], and in which the number of people experiencing hunger has been rising since 2015, with a sharp acceleration in 2020 due to the pandemic and armed conflicts[94], no other intervention has demonstrated such a strong effect on suicide prevention as cash transfers[84], and we should aim for an even broader and more ambitious approach.

By investing in structural interventions and social protection measures, countries could potentially simultaneously reduce suicide rates, strengthen community resilience and alleviate pressure on overstretched mental health services. In this sense, suicide prevention should be viewed not only as a matter of individual clinical treatment but also as a question of public policy, economic redistribution and community strengthening. The integration of these models (Fig. 1) highlights the need for a paradigm shift—one that prioritizes the reduction of structural suffering and the strengthening of collective wellbeing before expecting individual behavioral change.

This demonstrates that structural policies tend to have the greatest population-level impact and reinforces the importance of community-based care. This perspective aligns closely with the strategies already implemented across the global south, where collective interventions and intersectoral approaches have proven particularly effective[67–71,85,95].

The inclusion of cash transfers in this framework (Fig. 2) illustrates the multiple levels at which income transfer programs can influence suicide prevention. At the individual and family level (center), cash transfers directly affect living conditions, food security, mental health and overall wellbeing. At the community level, these programs can enhance access to essential services, promote social integration and expand opportunities, thereby functioning as structural protective factors against suicide risk.

Why social protection programs are more crucial than ever

Socioeconomic crises further amplify structural vulnerabilities in the global south. Acute economic shocks, such as those triggered by austerity policies, debt or crises, have immediate and lasting effects on suicide risk, particularly affecting men, middle-aged individuals and black/brown populations[15,18,19,96]. Suicide-prevention strategies must therefore include macroeconomic planning that centers human wellbeing, and health impact assessments should become standard practice in the design of economic policies. Recognizing austerity as a public health threat opens new avenues for interdisciplinary advocacy and collaboration.

Additionally, with the rapid advancement of technology leading to the automation of many jobs, we can anticipate an even more pressing demand for such programs in the near future. Factors such as conflicts (for example, war in Ukraine, Palestine and so on), disasters resulting

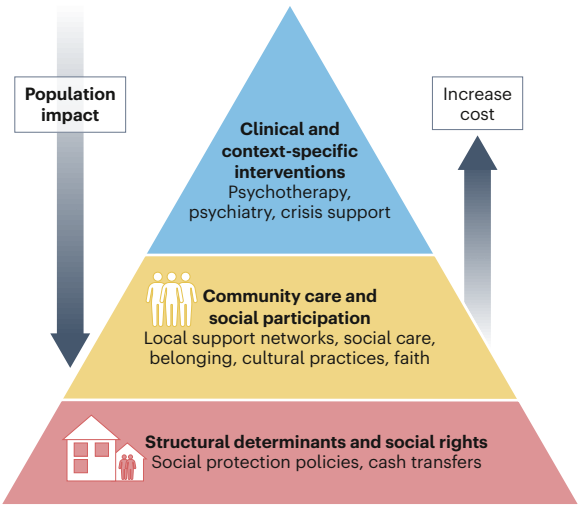

Fig. 1 | Integrated pyramid model for suicide prevention in the global south. A multilevel framework centered on structural determinants, community participation and personalized care. Figure created by adapting Maslow's hierarchy of needs [88], Frieden's health impact pyramid [91] and the WHO's optimal mix of services pyramid [92].

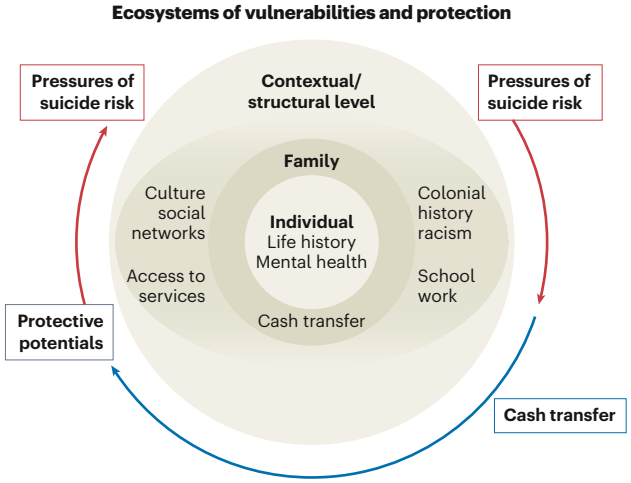

Fig. 2 | Multilevel framework of vulnerabilities and protection: the role of cash transfers in suicide prevention. This model illustrates how individual, familial and contextual/structural factors interact to shape both vulnerabilities and protective potentials related to suicide risk. Pressures such as social isolation, colonial history, poverty and limited access to services can increase suicide risk, while protective mechanisms, including social networks and school/work engagement, can mitigate it. Cash transfers are positioned as interventions that may reduce vulnerabilities and enhance protection across multiple levels by alleviating structural pressures and improving access to essential resources.

from climate change, and disease outbreaks further underscore the importance of these programs.

Therefore, evidence from the global south offers critical insights that could inform and reshape global suicide-prevention strategies. Rather than focusing exclusively on clinical interventions, there is an urgent need to broaden the scope of prevention to include social protection policies, equity promotion and community engagement. It may be time to reevaluate how the world approaches the complex challenge of suicide prevention, learning from the experiences and innovations emerging from the global south.

Beyond prediction—advancing suicide prevention through social promotion

Achieving this will require a fundamental shift in how we approach suicide prevention. Historically, much of the literature, rooted in psychological theories, has prioritized the prediction of suicidal behavior as a central prevention strategy. Over the past decades, scientists, practitioners and policymakers have increasingly focused on a persistent effort to answer the question 'How can suicidal behavior be predicted?', often at the expense of broader efforts to promote mental health.

Moving forward—prevention versus promotion

However, when prediction, screening and early identification are not sufficient and rates continue to rise, it may be time to broaden the debate by placing greater emphasis on social and structural determinants.

Income transfer programs, such as Brazil's *Bolsa Família*, were not originally designed with suicide prevention as a primary objective. Nevertheless, by targeting structural determinants—such as poverty, food insecurity and social exclusion—these programs have effectively reduced cumulative exposures to risk. As a result, they have contributed to the development of healthier, more resilient communities with lower vulnerability to suicide[84] and mental health problems[85,97].

The substantial impact observed from cash transfer programs such as *Bolsa Família*[84,97] suggests that effective suicide prevention strategies can—and should—extend beyond traditional clinical interventions, incorporating broader efforts to promote social wellbeing and reduce structural inequalities. However, although prediction tools and risk assessments remain central to research and prevention efforts[98], the promotion of mental health through structural and community-based/developed interventions remains underexplored and underfunded.

Experiences from the global south illustrate that a broader approach—one that explicitly includes the promotion of social equity and the reduction of systemic vulnerabilities—may be essential for reshaping the global agenda on suicide prevention. Moving beyond a narrow focus on clinical risk prediction toward the creation of supportive social environments could be a transformative step in addressing the complex, multifaceted nature of suicide worldwide.

Conclusions

As the world continues to grapple with rising mental health challenges and increasing suicide rates in parts of the global south, suicide-prevention efforts must evolve. It is imperative to reframe suicide not merely as a manifestation of individual pathology, but as a symptom of collective suffering, deeply rooted in structural inequalities, cultural transformations and social fragmentation. In this context, cash transfer programs can help reorient suicide-prevention strategies, as they not only address basic needs and mitigate structural disparities but also foster healthier, more resilient societies. Thus, they should be prioritized within global health agendas.

Ultimately, suicide prevention must move beyond the narrow objective of identifying individuals at risk and toward the broader goal of creating societies in which life is more livable. This requires reimagining public health from the ground up—investing in policies that reduce inequality, such as cash transfers, nurturing spaces of community and belonging, and ensuring that care is accessible, evidence based and culturally meaningful. Building a truly global suicide-prevention agenda demands decentering dominant narratives, embracing epistemological pluralism, and recognizing that advancing social justice and equity is as vital to saving lives as any clinical intervention.

References

1. World Health Organization. *Suicide in the World: Global Health Estimates* (World Health Organization, 2019); https://apps.who.int/iris/handle/10665/326948
2. Pan American Health Organization. *The Burden of Suicide in the Region of the Americas* (Pan American Health Organization, 2021); https://www.paho.org/en/enlace/burden-suicide
3. Pan American Health Organization. *Suicide Mortality in the Americas—Regional Report 2015–2019* (Pan American Health Organization, 2021).
4. Ilic, M. & Ilic, I. Worldwide suicide mortality trends (2000–2019): a joinpoint regression analysis. *World J. Psychiatry* **12**, 1044–1060 (2022).
5. Orellana, J. D. Y. & de Souza, M. L. P. Excess suicides in Brazil: inequalities according to age groups and regions during the COVID-19 pandemic. *Int. J. Soc. Psychiatry* **68**, 997–1009 (2022).
6. Hong, J., Knapp, M. & McGuire, A. Income-related inequalities in the prevalence of depression and suicidal behaviour: a 10-year trend following economic crisis. *World Psychiatry* **10**, 40–44 (2011).
7. Machado, D. B., Rasella, D. & Dos Santos, D. N. Impact of income inequality and other social determinants on suicide rate in Brazil. *PLoS ONE* **10**, e0124934 (2015).
8. Mann, J. J., Michel, C. A. & Auerbach, R. P. Improving suicide prevention through evidence-based strategies: a systematic review. *Am. J. Psychiatry* **178**, 611–624 (2021).
9. Ishimo, M. C. et al. Universal interventions for suicide prevention in high-income Organisation for Economic Co-operation and Development (OECD) member countries: a systematic review. *Inj. Prev.* **27**, 184–193 (2021).
10. LeFevre, M. L. & US Preventive Services Task Force. Screening for suicide risk in adolescents, adults and older adults in primary care: US Preventive Services Task Force recommendation statement. *Ann. Intern. Med.* **160**, 719–726 (2014).
11. Stanley, B. & Mann, J. J. The need for innovation in health care systems to improve suicide prevention. *JAMA Psychiatry* **77**, 96–98 (2020).
12. White, J. & Morris, J. Re-thinking ethics and politics in suicide prevention: bringing narrative ideas into dialogue with critical suicide studies. *Int. J. Environ. Res. Public Health.* **16**, 3236 (2019).
13. de Araujo, J. A. P. et al. Suicide among Indigenous peoples in Brazil from 2000 to 2020: a descriptive study. *Lancet Reg. Health Am.* **26**, 100591 (2003).
14. Alves, F. J. O. et al. The rising trends of self-harm in Brazil: an ecological analysis of notifications, hospitalisations, and mortality between 2011 and 2022. *Lancet Reg. Health Am.* **31**, 100691 (2024).
15. Machado, D. B., Pescarini, J. M., de Araújo, L. F. S. C. & Barreto, M. L. Austerity policies in Brazil may affect violence related outcomes. *Ciênc Saúde Coletiva* **24**, 4385–4394 (2019).
16. Herrera, A., Dahlblom, K., Dahlgren, L. & Kullgren, G. Pathways to suicidal behaviour among adolescent girls in Nicaragua. *Soc. Sci. Med.* **62**, 805–814 (2006).
17. Alvarez, K., Polanco-Roman, L., Samuel Breslow, A. & Molock, S. Structural racism and suicide prevention for ethnoracially minoritized youth: a conceptual framework and illustration across systems. *Am. J. Psychiatry* **179**, 422–433 (2022).

18. Chang, S. S., Stuckler, D., Yip, P. & Gunnell, D. Impact of 2008 global economic crisis on suicide: time trend study in 54 countries. *BMJ* **347**, f5239 (2013).
19. Guimarães, R. M. et al. The effect of economic crisis and austerity measures on deaths of despair in Brazil: an interrupted time series analysis. *PLoS ONE* **19**, e0314294 (2024).
20. Itua, I. et al. Are we using the right evidence to inform suicide prevention in low- and middle-income countries? An umbrella review. *Arch. Suicide Res.* **29**, 290–308 (2025).
21. Pham, T. V., Koirala, R., Wainberg, M. L. & Kohrt, B. A. Reassessing the mental health treatment gap: what happens if we include the impact of traditional healing on mental illness? *Community Ment. Health J.* **57**, 777–791 (2021).
22. Na, P. J. et al. Social determinants of health and suicide-related outcomes: a review of meta-analyses. *JAMA Psychiatry* **82**, 337–346 (2025).
23. Sjoblom, E. et al. Centering Indigenous knowledge in suicide prevention: a critical scoping review. *BMC Public Health* **22**, 2377 (2022).
24. Richardson, M. & Waters, S. F. Indigenous voices against suicide: a meta-synthesis advancing prevention strategies. *Int. J. Environ. Res. Public Health* **20**, 7064 (2023).
25. Bergen, C. et al. Implying implausibility and undermining versus accepting peoples' experiences of suicidal ideation and self-harm in Emergency Department psychosocial assessments. *Front. Psychiatry* **14**, 1197512 (2023).
26. Boshoff, N. South-South research collaboration of countries in the Southern African Development Community (SADC). *Scientometrics* **84**, 481–503 (2010).
27. *Emerging Mental Health Systems in Low- and Middle-Income Countries*. FP7. CORDIS https://cordis.europa.eu/project/id/305968/reporting (European Commission, accessed 20 July 2025).
28. Hjelmeland, H. & Knizek, B. L. Suicide and mental disorders: a discourse of politics, power and vested interests. *Death Stud.* **41**, 481–492 (2017).
29. Arsenault-Lapierre, G., Kim, C. & Turecki, G. Psychiatric diagnoses in 3,275 suicides: a meta-analysis. *BMC Psychiatry* **4**, 37 (2004).
30. World Health Organization. *Preventing Suicide: A Global Imperative* (World Health Organization, 2014); https://www.who.int/publications/i/item/9789241564779
31. World Health Organization. *MhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*: *Mental Health Gap Action Programme* (*MhGAP*) (World Health Organization, 2016).
32. Sánchez-Barriga, J. J. Mortality trends from suicide by state and socioeconomic region. Mexico, 2000-2020. *Papeles de Población* **28**, 71–95 (2022).
33. Buendía, J. A., Restrepo Chavarriaga, G. J. & Zuluaga, A. F. Social and economic variables related with Paraquat self-poisoning: an ecological study. *BMC Public Health* **20**, 404 (2020).
34. Machado, D. B. et al. Association between homicide rates and suicide rates: a countrywide longitudinal analysis of 5,507 Brazilian municipalities. *BMJ Open* **10**, e040069 (2020).
35. Iemmi, V. et al. Suicide and poverty in low-income and middle-income countries: a systematic review. *Lancet Psychiatry* **3**, 774–783 (2016).
36. Lange, S., Cayetano, C., Jiang, H., Tausch, A. & Souza, R. O. E. Contextual factors associated with country-level suicide mortality in the Americas, 2000–2019: a cross-sectional ecological study. *Lancet Reg. Health Am.* **20**, 100450 (2023).
37. Sánchez-Castro, J. C. et al. Mental health among adolescents exposed to social inequality in Latin America and the Caribbean: a scoping review. *Front. Public Health* **12**, 1342361 (2024).
38. Favril, L., Yu, R., Geddes, J. R. & Fazel, S. Individual-level risk factors for suicide mortality in the general population: an umbrella review. *Lancet Public Health* **8**, e868–e877 (2023).
39. Liu, B. P. et al. Associating factors of suicide and repetition following self-harm: a systematic review and meta-analysis of longitudinal studies. *eClinicalMedicine* **49**, 101461 (2022).
40. Edwards, A. C. et al. On the genetic and environmental relationship between suicide attempt and death by suicide. *Am. J. Psychiatry* **178**, 1060–1069 (2021).
41. Docherty, A. R. et al. GWAS meta-analysis of suicide attempt: identification of 12 genome-wide significant loci and implication of genetic risks for specific health factors. *Am. J. Psychiatry* **180**, 723–738 (2023).
42. Li, Q. S. et al. Genome-wide association study meta-analysis of suicide death and suicidal behavior. *Mol. Psychiatry* **28**, 891–900 (2023).
43. Mullins, N. et al. Dissecting the shared genetic architecture of suicide attempt, psychiatric disorders and known risk factors. *Biol. Psychiatry* **91**, 313–327 (2022).
44. Orozco, R. et al. Barriers to treatment for mental disorders in six countries of the Americas: a regional report from the World Mental Health Surveys. *J. Affect. Disord.* **303**, 273–285 (2022).
45. Vistorte, A. O. R. et al. Clinical decisions and stigmatizing attitudes towards mental health problems in primary care physicians from Latin American countries. *PLoS ONE* **13**, e0206440 (2018).
46. Kakuma, R. et al. Human resources for mental health care: current situation and strategies for action. *Lancet* **378**, 1654–1663 (2011).
47. Toyama, M. et al. Identifying resources used by young people to overcome mental distress in three Latin American cities: a qualitative study. *BMJ Open* **12**, e060340 (2022).
48. World Health Organization. *Comprehensive Mental Health Action Plan 2003–2020* (World Health Organization, 2013); https://www.who.int/publications/i/item/9789240031029
49. Liu, X. The role of cultural activities in enhancing social support and neighborhood cohesion among the elderly. *J. Res. Soc. Sci. Humanities* **4**, 46–55 (2025).
50. Jinna, M. A. J. Religious rituals and their impact on Indian family cohesion: a sociological analysis. *Xpertno Int. J. Interdiscipl. Res.* **2**, 1–18 (2024).
51. Springate, I., Atkinson, M. & Martin, K. *Intergenerational Practice: a Review of the Literature* https://files.eric.ed.gov/fulltext/ED502358.pdf (National Foundation for Educational Research, 2008).
52. Cudjoe, T. K. et al. The epidemiology of social isolation: national health and aging trends study. *J. Gerontol. B* **75**, 107–113 (2020).
53. Cheng, Q., Li, H., Silenzio, V. & Caine, E. D. Suicide contagion: a systematic review of definitions and research utility. *PLoS ONE* **9**, e108724 (2014).
54. Pirkis, J. et al. Public health measures related to the transmissibility of suicide. *Lancet Public Health* **9**, e807–e815 (2024).
55. Durà-Vilà, G. & Hodes, M. Cross-cultural study of idioms of distress among Spanish nationals and Hispanic American migrants: susto, nervios and ataque de nervios. *Soc. Psychiatry Psychiatr. Epidemiol.* **47**, 1627–1637 (2012).
56. Guarnaccia, P. J. & Rogler, L. H. Research on culture-bound syndromes: new directions. *Am. J. Psychiatry* **156**, 1322–1327 (1999).
57. Cavanagh, J. T., Carson, A. J., Sharpe, M. & Lawrie, S. M. Psychological autopsy studies of suicide: a systematic review. *Psychol. Med.* **33**, 395–405 (2003).
58. Knipe, D. et al. Psychiatric morbidity and suicidal behaviour in low-and middle-income countries: a systematic review and meta-analysis. *PLoS Med.* **16**, e1002905 (2019).

59. Axinn, W. G. et al. Findings from the World Mental Health Surveys of Civil Violence Exposure and its association with subsequent onset and persistence of mental disorders. *JAMA Netw. Open* **6**, e2318919 (2023).
60. Cuartas, J. & Leventhal, T. Exposure to community violence and children's mental health: a quasi-experimental examination. *Soc. Sci. Med.* **246**, 112740 (2020).
61. Benjet C et al. Associations between neighborhood-level violence and individual mental disorders: results from the World Mental Health surveys in five Latin American cities. *Psychiatry Res.* **282**, 112607 (2019).
62. Huang, C. Time spent on social network sites and psychological well-being: a meta-analysis. *Cyberpsychol. Behav. Soc. Netw.* **20**, 346–354 (2017).
63. Nesi, J. & Prinstein, M. J. Using social media for social comparison and feedback-seeking: gender and popularity moderate associations with depressive symptoms. *J. Abnormal Child Psychol.* **43**, 1427–1438 (2015).
64. Samra, A., Warburton, W. A. & Collins, A. M. Social comparisons: a potential mechanism linking problematic social media use with depression. *J. Behav. Addictions* **11**, 607–614 (2022).
65. Zherebin, V. M., Vershinskaia, O. N. & Makhrova, O. N. The modern perception of time and acceleration of the pace of life. *Soc. Res.* **54**, 189–202 (2015).
66. Vijayakumar, L. et al. Implementation of a comprehensive surveillance system for recording suicides and attempted suicides in rural India. *BMJ Open* **10**, e038636 (2020).
67. Williams, S. A. et al. Pathways to mental health services across local health systems in sub-Saharan Africa: findings from a systematic review. *PLoS ONE* **20**, e0324064 (2025).
68. Knettel, B. A. et al. A scoping review of counseling interventions for suicide prevention in Africa: few studies address this life-saving aspect of mental health treatment. *J. Affect. Disord.* **328**, 183–190 (2023).
69. Alonzo, D. The Engaged Community Action for Preventing Suicide (ECAPS) model in Latin America: development of the ¡PEDIR! program. *Soc. Psychiatry Psychiatr. Epidemiol.* **58**, 861–870 (2023).
70. Diez-Canseco, F. et al. Integration of a technology-based mental health screening program into routine practices of primary health care services in Peru (The Allillanchu Project): development and implementation. *J. Med. Internet Res.* **20**, e100 (2018).
71. Maulik, P. K. et al. Mental health care support in rural India: a cluster randomized clinical trial. *JAMA Psychiatry* **81**, 1061–1070 (2024).
72. Dambi, J. et al. Evaluation of the Friendship Bench' Circle Kubatana Tose (CKT): an add-on support group intervention - a mixed-methods pilot interventional cohort study protocol. *BMJ Open* **14**, e079842 (2024).
73. Knipe, D. W., Gunnell, D. & Eddleston, M. Preventing deaths from pesticide self-poisoning—learning from Sri Lanka's success. *Lancet Glob. Health* **5**, e651–e652 (2017).
74. Bussalleu, A. et al. Kaniuwatewara (when we get sick): understanding health-seeking behaviours among the Shawi of the Peruvian Amazon. *BMC Public Health* **21**, 1552 (2021).
75. Mathez-Stiefel, S. L., Vandebroek, I. & Rist, S. Can Andean medicine coexist with biomedical healthcare? A comparison of two rural communities in Peru and Bolivia. *J. Ethnobiol. Ethnomed.* **8**, 26 (2012).
76. Gureje, O. et al. The role of global traditional and complementary systems of medicine in the treatment of mental health disorders. *Lancet Psychiatry* **2**, 168–177 (2015).
77. Mota, N. B. et al. A Brazilian bottom-up strategy to address mental health in a diverse population over a large territorial area—an inspiration for the use of digital mental health. *Psychiatry Res.* **311**, 114477 (2022).
78. Sampaio, M. L. & Bispo Júnior, J. P. Towards comprehensive mental health care: experiences and challenges of psychosocial care in Brazil. *BMC Public Health* **21**, 1352 (2021).
79. Paiva do Carmo Mercedes, B., da Silva, E. N., Carregaro, R. L. & Miasso, A. I. Profile of individuals served and presumed coverage of Psychosocial Care Centers (CAPS) in Brazil: a study of the period 2013–2019. *PLoS ONE* **19**, e0308274 (2024).
80. Araújo et al. Use of routine health records to study mental health care of Brazilian children. *J. Brasileiro Psiquiatria.* **71**, 204–209 (2022).
81. Castro-de-Araujo, L. F., Machado, D. B. & Barreto, M. L. Care-seeking as a proxy indicator of the mental health of elderly Brazilians. *Braz. J. Psychiatry* **42**, 591–598 (2020).
82. Guzmán, J. et al. Evidence for the effectiveness of a national school-based mental health program in Chile. *J. Am. Acad. Child Adolesc. Psychiatry* **54**, 799–807. e1 (2015).
83. Harker Roa, A., Córdoba Flechas, N., Moya, A. & Pineros-Leano, M. Implementing psychosocial support models in contexts of extreme adversity: lessons from a process evaluation in Colombia. *Front. Psychol.* **14**, 1134094 (2023).
84. Machado, D. B. et al. Relationship between the Bolsa Família national cash transfer programme and suicide incidence in Brazil: a quasi-experimental study. *PLoS Med.* **19**, e1004000 (2022).
85. Toledo, L. et al. Associations between the Bolsa Familia conditional cash transfer programme and substance use disorder hospitalisations: a quasi-experimental study of the 100 Million Brazilian Cohort. *Lancet Glob. Health* **13**, e508–e516 (2025).
86. Bonfim, C. et al. Conditional cash transfers and mortality in people hospitalised with psychiatric disorders: a cohort study of the Brazilian Bolsa Família Programme. *PLoS Med.* **21**, e1004486 (2024).
87. Marmot, M. Social justice, epidemiology and health inequalities. *Eur. J. Epidemiol.* **32**, 537–546 (2017).
88. Maslow, A. H. A theory of human motivation. *Psychol. Rev.* **50**, 370–396 (1943).
89. Krieger, N. A glossary for social epidemiology. *J. Epidemiol. Community Health* **55**, 693–700 (2001).
90. Kreuter, M. W., Thompson, T., McQueen, A. & Garg, R. Addressing social needs in health care settings: evidence, challenges and opportunities for public health. *Annu. Rev. Public Health* **42**, 329–344 (2021).
91. Frieden, T. R. A framework for public health action: the health impact pyramid. *Am. J. Public Health* **100**, 590–595 (2010).
92. World Health Organization & World Organization of Family Doctors. *Integrating Mental Health into Primary Care: a Global Perspective* (World Health Organization and World Organization of Family Doctors, 2008); https://iris.who.int/bitstream/handle/10665/43935/9789241563680_eng.pdf
93. World Health Organization. *World Mental Health Report: Transforming Mental Health for All* (World Health Organization, 2022); https://www.who.int/publications/i/item/9789240049338
94. World Bank. *Global Hunger: Responding to the Present Crisis with the Future in Mind* (World Bank, 2023); https://www.worldbank.org/en/news/feature/2023/04/19/global-hunger-responding-to-the-present-crisis-with-the-future-in-mind
95. Machado, D. B., Rodrigues, L. C., Rasella, D., Lima Barreto, M. & Araya, R. Conditional cash transfer programme: impact on homicide rates and hospitalisations from violence in Brazil. *PLoS ONE* **13**, e0208925 (2018).
96. Organisation for Economic Co-operation and Development. *COVID-19 in Latin America and the Caribbean: Regional Socio-economic Implications and Policy Priorities* (Organisation for Economic Co-operation and Development, accessed 6 August 2022); https://www.oecd.org/content/dam/oecd/en/publications/reports/2020/04/covid-19-in-latin-america-and-the-caribbean-regional-socio-economic-implications-and-policy-priorities_fff0c611/93a64fde-en.pdf

97. Wollburg, C., Steinert, J. I., Reeves, A. & Nye, E. Do cash transfers alleviate common mental disorders in low-and middle-income countries? A systematic review and meta-analysis. *PLoS ONE* **18**, e0281283 (2023).
98. World Health Organization. *LIVE LIFE: an Implementation Guide for Suicide Prevention in Countries* (World Health Organization, accessed 12 May 2025); https://www.who.int/publications/i/item/9789240026629
99. Presidência da República, Casa Civil, Secretaria Especial para Assuntos Jurídicos. LEI Nº 14.601, DE 19 DE JUNHO DE 2023 (accessed 12 May 2025); https://www.planalto.gov.br/ccivil_03/_ato2023-2026/2023/lei/l14601.htm

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