VIEWPOINT

Rebalancing Global Suicide Prevention

Rakhi Dandona, PhD; Rajesh Sagar, MD

Suicide is among the leading causes of mortality globally, accounting for more than 700 000 deaths each year.[1] Suicide prevention presents an unusual paradox in global health. Nearly three-quarters of suicides occur in low- and middle-income countries (LMICs), yet much of the evidence, theory, and policy discourse architecture guiding prevention has been developed in high-income countries (HICs).[2] As a result, prevailing frameworks may overemphasize pathways and interventions characteristic of settings where the minority of suicides occur as it may not fully capture the social, health system, and demographic realities of settings where most suicides occur.[2]

India provides a particularly important lens through which to examine this imbalance. Accounting for more than 1 in 5 suicide deaths globally,[1] India is central to understanding the global burden of suicide. Although no single country can represent the diversity of LMICs, India's experience highlights several areas in which evidence from LMICs can challenge prevailing assumptions and reshape global thinking about suicide prevention. Three lessons are especially important as follows: (1) the importance of social and structural determinants alongside mental health conditions, (2) the gendered context of suicide, and (3) the central but underexamined role of police and justice systems in suicide surveillance and prevention.

Lesson 1—LMICs and the Importance of Social and Structural Determinants

One of the central assumptions of modern suicide prevention is that suicide is primarily a problem for mental health services to address. Much of the evidence base underpinning suicide prevention has emerged from HICs where specialist mental health services are comparatively accessible and where suicide research has historically been closely linked to psychiatry.[2] The experience of India suggests that many pathways to suicide originate outside the health sector. National suicide data consistently identify family problems, financial difficulties, unemployment, alcohol use, chronic illness, and social pressures among the factors associated with suicide deaths.[3] Although these categories do not establish causation, they suggest that many pathways to suicide originate outside the health sector. Although the specific social drivers of suicide vary across LMICs, evidence from multiple regions suggests that structural determinants often play a greater role where health systems have fewer resources and specialist mental health services remain inaccessible.[4] The particular balance of these factors differs across countries, but their prominence reinforces the need for prevention strategies that extend beyond the health sector.[5] Perhaps, the strongest challenge to conventional thinking comes from the intervention evidence itself. The largest reductions in suicide observed globally have often resulted from regulatory and social policies—restrictions on highly hazardous pesticides and social protection programs—by modifying the environments in which suicide risk emerges rather than expansion of specialist psychiatric care.[6,7] The success of these policies suggests that suicide prevention should be understood not only as a clinical endeavor, but also as a social, economic, and regulatory one.

Lesson 2—LMICs and Male-Centered Narratives of Suicide

Global suicide prevention discourse has been shaped by a striking epidemiological pattern; in most HICs, men die by suicide at substantially higher rates than women.[1] This pattern has influenced research priorities, public messaging, and prevention strategies, leading to an understandable focus on male suicide as a major public health concern. Yet it does not fully reflect the experiences of many LMICs.

Although men account for the majority of suicide deaths in India, women experience a disproportionately high burden of suicide mortality and account for a substantial share of female suicide deaths globally.[1] Their suicide death rate is approximately twice the global average for women. More broadly, suicide has overtaken maternal disorders as a leading cause of death among young women globally, yet it remains comparatively neglected within global health discussions.[8] The contrast is striking; although maternal mortality has rightly attracted sustained attention, investment, and advocacy, far less attention has been directed toward understanding why so many young women die by suicide. Studies from LMIC settings have highlighted elevated suicide risks among women exposed to gender-based violence, economic dependence, social exclusion, and restricted autonomy. Viewed through this lens, high rates of suicide among women are not simply a mental health problem; they are also manifestations of broader systems of gender inequality.

Lesson 3—LMICs and Understanding of Who Records and Prevents Suicide

Suicide surveillance is often viewed as a technical process of classifying and counting deaths. Yet the institutions responsible for producing suicide data vary considerably across countries, and these differences shape not only what is counted but also how suicide is understood and prevented.[9] Much of the global evidence base has emerged from settings where coroners, medical examiners, and health agencies play central roles in determining causes of death. Consequently, suicide is frequently conceptualized as a health-sector problem recorded through health-sector institutions.

In India, however, police are the primary gatekeepers of suicide data. Through the National Crime Records Bureau, information collected by police stations forms the basis of the country's most widely used suicide statistics. Although concerns about underreporting and data quality are well recognized, police-generated data often provide the most comprehensive information on suicide mor-

© 2026 American Medical Association. All rights reserved, including those for text and data mining, AI training, and similar technologies.

Downloaded from jamanetwork.com by Massachusetts Hospital, Sara DiBari on 09/09/2026

tality available. Many LMICs continue to face challenges related to incomplete vital registration, underreporting, and fragmented governance.[9,10] These institutional differences underscore the need to consider how surveillance systems themselves shape the evidence available for prevention.

This institutional reality has implications beyond surveillance. The organizations responsible for recording suicide influence which populations and risk factors become visible within public discourse and policy. In India, for example, categories such as farmer and student suicides have attracted considerable public attention and stimulated research and policy responses. At the same time, other forms of vulnerability may receive less recognition. Questions about who records suicide and how deaths are classified are, therefore, not merely technical; they influence which prevention priorities receive attention.

The lesson from India is not that police should replace health services in suicide prevention. Rather, it is that a field shaped largely by health-sector perspectives may underestimate the role of other institutions in determining how suicide is recorded, understood, and addressed. Effective suicide prevention in many LMICs will require stronger collaboration between health, justice, social protection, and community systems, alongside continued investments in surveillance infrastructure and data quality. More fundamentally, it requires recognizing that the institutions responsible for producing suicide data also help shape the solutions societies pursue.

Rebalancing Global Suicide Prevention

Although India does not represent all LMICs, whose epidemiology, social contexts, and health systems are highly heterogeneous, India's experience illustrates broader lessons that arise across many LMICs. The specific manifestations of these lessons differ across countries, but the underlying principle—that global suicide prevention should increasingly be informed by evidence from settings where most suicides occur—is widely applicable. The social and structural determinants of suicide, the gendered realities of vulnerability, and the governance arrangements through which suicide is recorded and addressed all demand broader attention. None of these observations diminish the central importance of mental disorders as risk factors for suicide. Rather, they suggest that a predominantly psychiatric framing alone is insufficient to explain or prevent suicide in many LMIC settings. Countries where the burden is greatest should not simply be recipients of knowledge. If most suicides occur in LMICs, then the future of suicide prevention should increasingly be shaped by evidence generated within them. Rebalancing whose evidence counts is not simply a question of equity—it is essential for building a science that reflects the epidemiology of suicide itself.

ARTICLE INFORMATION

Author Affiliations: PHFI Injury Prevention Research Centre, Public Health Foundation of India, New Delhi, India (Dandona); Institute for Health Metrics and Evaluation, University of Washington, Seattle (Dandona); All India Institute of Medical Sciences, New Delhi, India (Sagar).

Corresponding Author: Rakhi Dandona, PhD, PHFI Injury Prevention Research Centre, Public Health Foundation of India, 4th Floor, House No. 60, Property No Khasra No 293-295, Saidulajab Extn, South Delhi, New Delhi 110030, India (rakhi.dandona@phfi.org).

Published Online: September 9, 2026. doi:10.1001/jamapsychiatry.2026.2709

Conflict of Interest Disclosures: Dr Dandona reported receiving grants from National Institute for Health and Care Research, UK, during the conduct of the study. No other disclosures were reported.

REFERENCES

1. Institute for Health Metrics and Evaluation. Login page. Accessed March 15, 2026. https://collab2021.healthdata.org/gbd-compare/

2. Patel V, Saxena S, Lund C, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018;392(10157):1553-1598. doi:10.1016/S0140-6736(18)31612-X

3. National Crimes Record Bureau. Accidental deaths & suicides in India. Accessed June 3, 2026. https://www.ncrb.gov.in/accidental-deaths-suicides-in-india-year-wise.html?year=2024&keyword=

4. Pirkis J, Bantjes J, Dandona R, et al. Addressing key risk factors for suicide at a societal level. *Lancet Public Health*. 2024;9(10):e816-e824. doi:10.1016/S2468-2667(24)00158-0

5. Pirkis J, Dandona R, Silverman M, Khan M, Hawton K. Preventing suicide: a public health approach to a global problem. *Lancet Public Health*. 2024;9(10):e787-e795. doi:10.1016/S2468-2667(24)00149-X

6. Alves FJO, Machado DB, Barreto ML. Effect of the Brazilian cash transfer program on suicide rates: a longitudinal analysis of the Brazilian municipalities. *Soc Psychiatry Psychiatr Epidemiol*. 2019;54(5):599-606. doi:10.1007/s00127-018-1627-6

7. Gunnell D, Knipe D, Chang SS, et al. Prevention of suicide with regulations aimed at restricting access to highly hazardous pesticides: a systematic review of the international evidence. *Lancet Glob Health*. 2017;5(10):e1026-e1037. doi:10.1016/S2214-109X(17)30299-1

8. Dandona R, Mannan S, Mukerjee M, Sridhar P. Maternal health and beyond: Lost opportunities in suicide prevention for women. *Lancet Obstet Gynaecol Womens Health*. 2026;2(3):e175. doi:10.1016/s3050-5038(25)00181-5

9. Dandona R, Khan M. Engagement with death registration and cause-of-death reporting to strengthen suicide statistics. *Crisis*. 2024;45(4):249-253. doi:10.1027/0227-5910/a000962

10. Mikkelsen L, Hooper J, Adair T, Badr A, Lopez AD. Comparative performance of national civil registration and vital statistics systems: a global assessment. *Bull World Health Organ*. 2023;101(12):758-767. doi:10.2471/BLT.22.289033

© 2026 American Medical Association. All rights reserved, including those for text and data mining, AI training, and similar technologies.

Downloaded from jamanetwork.com by Massachusetts Hospital, Sara DiBari on 09/09/2026