Research priorities for suicide prevention in Southeast Asia

Sandersan Onie,[a,b,c,*,n] Vikas Menon,[d,n] Rakhi Dandona,[e,f,g] Prakarn Thomyangkoon,[h] Anish V. Cherian,[i] Lakshmi Vijayakumar,[j,k,l] and Soumitra Pathare[m]

[a]Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA
[b]Black Dog Institute, UNSW Sydney, Australia
[c]Wellspring Center Indonesia, Jakarta, Indonesia
[d]Department of Psychiatry, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Puducherry, 605006, India
[e]PHFI Injury Prevention Centre, Public Health Foundation of India, New Delhi, India
[f]Institute for Health Metrics and Evaluation, University of Washington, Seattle, USA
[g]Centre for Mental Health and Community Wellbeing, Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Australia
[h]College of Medicine, Rangsit University, Bangkok, 10400, Thailand
[i]Department of Psychiatric Social Work, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, 560029, India
[j]SNEHA, Chennai, India
[k]Department of Psychiatry, Voluntary Health Services, Chennai, India
[l]University of Melbourne, Melbourne, Australia
[m]Centre of Mental Health, Law and Policy, Indian Law Society (ILS), Pune, 411004, India

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Summary

Suicide remains a leading cause of preventable mortality in Southeast Asia (SEA), a region that bears a disproportionate share of the global suicide burden yet remains underrepresented in research, funding, and policy attention. In this article, we articulate ten priority research areas for suicide prevention across SEA, informed by surveys, workshops, and roundtable discussions convened around a regional forum, to guide key stakeholders including shaping funding calls, journal editorial focus, and interagency action. These priorities include strengthening suicide surveillance and data integration; embedding social determinants such as poverty, debt, gender inequity, and interpersonal violence into prevention frameworks; advancing family- and community-based approaches; integrating cultural, spiritual, and historical contexts; addressing alcohol and substance use; responding to youth suicide and online environments; addressing mental health needs; strengthening implementation science to adapt and evaluate interventions with fidelity; and improving translation of evidence into policy. Advancing this coordinated priority research agenda is essential to progress toward regional global reduction targets, by ensuring the research and funding ecosystem focuses the unique context of the SEA region.

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Southeast Asia (SEA), a diverse region that houses approximately 23% of the world's population in 10 World Health Organization (WHO) member countries,[1] has among the highest number of suicide deaths according to the latest WHO global health estimates (GHE).[2] This highlights the urgent need for targeted research and action to achieve the 2030 Mental Health Action Plan goal of reducing the suicide death rate by one-third.[3] Despite this, the region is underrepresented in global suicide literature, funding for suicide prevention research is still sparse, leading to critical regional pillars of suicide prevention being overlooked and the overreliance on studies from certain countries outside of SEA countries for practice and policy.

This viewpoint outlines research gaps and priorities for and suicide prevention in SEA, identified using a three-step approach. Under the auspices of the 11th IASP Asia Pacific Conference held in Bangkok, Thailand. First, we sent out an online survey several weeks prior to the conference to regional networks and participants who had registered for the Partnerships for Life pre-conference workshop. The survey asked the participants to identify up to five key research gaps and provide insights into cultural and contextual factors relevant to suicide-related research in the region. Two independent investigators (SO and VM) extracted and ranked the data based on the frequency of responses.

Next, we incorporated relevant information from the discussions and feedback gathered during the pre-

*Corresponding author. Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA.
E-mail address: sandersan_onie@hms.harvard.edu (S. Onie).
[n]Joint first authors.

conference workshop and early career researcher workshop, which ran simultaneously on the first day of the conference. Two independent notetakers consolidated their notes into a comprehensive summary of key comments and insights shared during the workshop.

Finally, feedback from the two working lunches held during the conference, attended by IASP regional coordinators and co-coordinators, and a panel discussion in the conference, further supplemented the previous steps. Apart from the surveys, information was collected by notetakers, who did not participate in the discussion, but listed key points and provided the reports to be analysed by the team. Given the large number of participants in the room, and the lack of infrastructure, we did not record the discussions. These discussions focused on identifying regional issues that could influence research priorities and formulating an action plan for region-specific commentary papers, aimed at guiding prospective researchers and funders in the region. While many of these points are mentioned previously in the literature, we present them as a key list of priorities that warrant immediate attention. Table 1 outlines the key areas and recommendations.

Evaluating interventions in a national suicide prevention strategy is almost impossible without accurate national suicide and attempt data. Seven out of ten or 70% of the SEA countries rank at the lowest level for data quality in the WHO GHE,[2] suggesting that suicide death data is either not routinely collected or its quality does not meet minimal GHE standards for inclusion. Many countries have multiple sources of data but lack the capacity to integrate the sources, and stigma that may lead to parties not willing to disclose a suicide.[4] While there are now some funding schemes targeted towards prevention efforts in low-to-middle income countries, specialized funding is urgently needed to strengthen data collection (e.g. by police, health systems, and death certificates), integrate sources, and address barriers such as stigma. For example, studies could compare different protocols and methods of inquiry to determine which uncovers the highest suicide count, assessing the impact of elements such as promised anonymity and semi-structured investigation guides. Some countries in SEA have begun strengthening their suicide surveillance system e.g. Thailand has established the 506 S self-harm and suicide surveillance system, leading to greater insights into national suicide epidemiology.[5] Once data is obtained, countries can then publish these data regularly to allow researchers and other stakeholders to identify and act on trends. For example, the National Crime Records Bureau in India publishes annual suicide data.[6]

Suicide prevention in SEA should focus more on social determinants, such as poverty, debt, interpersonal relationships, intimate partner violence, and academic stress. Poverty is a key social determinant, influencing suicide risk in several ways, including the stress from falling into poverty and debt leading to increased risk of suicide, and the lack of secure access to housing, food, and critically, physical and mental health services.[7] Eight out of ten countries in SEA exceed the world average poverty rate.[8] Current models of suicidal behaviour have an overreliance on individual vulnerabilities internal to suicidal behaviours, and do not sufficiently consider structural factors, as these models are developed in regions where basic human needs are typically met, which contrasts sharply with the situation in SEA[9,10]; for example, Mynamar is currently facing myriad human rights in the midst of a military coup.[11] Thus, approaches that focus only on improving the psychological state of vulnerable individuals, without addressing social determinants, may do little to reduce suicides at the aggregate level.[12] Research is needed to understand how these determinants interact to drive suicidal thoughts and behaviours, to develop a model of suicide prevention which more strongly considers social determinants, with the end goal of designing and evaluating effective interventions to address risk factors and bolster protective factors. For example, studies could assess the impact of integrating services that address common precipitating issues for availing crisis services, such as homelessness, drug and alcohol use, domestic abuse, or unemployment. Other potential areas of research include understanding the impact of a minimum wage, increased sustainable employment, and increased government commitment to social welfare programs. Beyond research, countries can address social determinants beyond mental health, such as strengthening social welfare systems to prevent suicide or embedding referral programs to existing social support programs in crisis services. For example, a nationwide cash transfer program in Indonesia—a country previously in the SEA region–reduced the suicide rate of the catchment region by 18% and buffered the effects of agricultural income shocks.[13]

In SEA, the female age-standardized suicide rate (8.3 per 100,000) is considerably higher than the global female average (5.6 per 100,000) with the region having the smallest male to female suicide rations globally.[2] The interplay of gender and risk factors may play a key role, with the protective effects of marriage being less robust in SEA.[14] Thus, studies could assess the impact of gender-tailored interventions on reducing risk factors in women. Gender tailored efforts in SEA are still sparse; however, efforts can target suicide means commonly used by women. For example, self-immolation—typically done by women–was reduced in Iran following a community based intervention.[15]

Family and community are important determinants of well-being in SEA society[16]; and cannot be ignored in any comprehensive approach to suicide prevention. However, family and community cohesion and

Priority area	Key issues	Recommendations	Stakeholder's role
Accurate suicide data	Poor data collection and quality in 7/10 SEA countries; lack of routine data collection; multiple sources	Develop national suicide surveillance systems; integrate suicide data collection into health systems; improve reporting and classification methods	Support capacity-building for national suicide registries and projects to strengthen suicide surveillance; inclusion of co-design and anthropological research to develop tools and protocols to increase disclosure of suicide; support open-access publication of suicide data studies to inform data-driven interventions
Social determinants of suicide	Social determinants such as high poverty, debt, IPV, academic stress not well integrated into suicide models	Research interactions between social stressors and suicide; develop intervention models that incorporate economic and social support	Support longitudinal studies and intervention studies on social studies on determinants and suicide, and intervention studies targeting social determinants
Female suicides	Socio-cultural factors may contribute to Southeast Asia's lowest male-female ratio, and the highest female suicide rate among regions.	Gender consideration in development and implementation of interventions – especially those targeting socio-cultural factors	Ensuring that gender is embedded in intervention research in Southeast Asia
Family as a societal pillar	Family cohesion is under-researched despite its key role in SEA societies	Investigate intergenerational family dynamics in suicide risk; develop and evaluate family-based interventions; integrate family into public health approaches to prevent suicide	Prioritize funding for family-based suicide prevention research; mandate consideration of family in adolescent intervention studies; encourage publications to include qualitative, culturally embedded studies
Cultural, spiritual, and historical influences	Cultural and religious views shape suicide perceptions and help-seeking	Conduct ethnological research on stigma and prevention; integrate cultural context into national strategies	Support anthropological and community-led research, including interventions which utilize culture
Alcohol use and suicide	Under-researched link despite high consumption rates in the region	Study alcohol's role in suicide across cultures; develop alcohol-focused suicide prevention interventions	Support research on alcohol policy and suicide risk
Youth and the internet	High social media use in SEA, mixed effects on mental health	Research into social media's role in suicide risk and prevention; explore digital tools for awareness and support	Support research on online interventions; promote studies on digital mental health strategies
Mental health services	Limited access to care, professional shortages, stigma barriers	Develop scalable, community-based mental health interventions; assess digital and low-cost solutions	Fund implementation research on accessible interventions; support publishing studies on low-resource settings
Evaluation & Implementation science	Limited evaluation of suicide prevention programs in SEA; implementation science lacking in SEA's unique context	Expand research on intervention effectiveness; integrate implementation science in suicide prevention programs to ensure implementation with fidelity	Provide funding for impact evaluation studies and process evaluation, and implementing national strategies
Policy engagement & Regional cooperation	Weak policy implementation; funding and capacity gaps	Assess current policies' impact; develop regional research collaborations and shared strategies	Fund policy impact assessments; support special journal issues on suicide prevention policy

Table 1: **Summary of priority area, key issue, recommendations and stakeholders' role.**

functioning are often neglected in funding schemes, published work, and suicide prevention as a whole. Research should explore how inter-generational family dynamics impact suicide risk, given their role as a possible risk or protective factor for suicide, and identify strategies to strengthen and leverage community and family support systems in the context of social change. For example, studies could develop and evaluate community and family-based interventions for suicide, including improving attachment patterns and meaningful relationships. Research may also seek to understand the intergenerational impact of suicide on a family's wellbeing, and how family differs from one context to another to further understand localized protective factors for suicide.

Cultural, spiritual, and historical factors significantly shape how suicide, and its prevention are approached in the region[17] but are often overlooked in funding and in prevention strategies. For example, while suicide is considered a mortal sin in predominantly Islamic countries,[18] suicide is not explicitly opposed in Hinduism and Buddhism.[19] Culture must be central to strategies, as SEA diversity strongly shapes help-seeking, perceptions of suicide, and willingness to act. In addition, SEA exhibits considerable diversity in how social determinants manifest, interact with local culture, and contribute to suicide, such as loneliness, unemployment, and trauma.[20] Research is needed to understand the impact of these factors on suicide, stigma, and help-seeking and to explore how these factors can be leveraged in prevention efforts. Practically integrating anthropological and epidemiological methods for suicide prevention is crucial to developing effective prevention strategies, and will best identify localized protective factors to bolster, and risk factors to address.

Alcohol and drug use is a significant but under-researched risk factor for suicide in SEA, despite being heavily consumed.[21] Whether as unhealthy coping mechanisms, catalysts for interpersonal conflict, or their link with other risk factors, research is needed to understand the relationship between substance use and suicide across different cultural contexts to inform targeted prevention strategies, including identifying emerging substances and their effects.

Youth suicide is another significant concern in the region. Closely tied to this is the use of social media and online platforms, with India and the Philippines among the top 10 global consumers of social media.[22] Evidence shows that online platforms affect wellbeing through mechanisms such as social comparison, doom scrolling, and by amplifying existing mental health states.[23] However, given the wide use of online platforms, research on how these can be harnessed for increased awareness, capacity building, and connection should also be conducted. Research should focus on understanding youth distress, self-harm and suicide, and how to minimize the harms of social media and online platforms while utilizing their benefits to contribute to prevent suicide.

Mental health conditions are risk factors for suicide, yet availability and access to appropriate care are limited.[24] Major barriers include too few professionals, poor training, stigma, and low mental health budget, with countries spending only an average of 1.1% of their health budget on mental health—the second lowest average country expenditure of any WHO region.[25] This has led to a significant treatment gap, especially for severe and chronic conditions. Untreated mental illness leads to prolonged suffering, which may contribute to suicide. Research is needed on scalable, low-cost interventions, including validated digital solutions and community-based approaches that necessarily simultaneously tackle the stigma associated with mental health. For example, task sharing in the form of training laypersons to conduct behavioral activation[26] may help reduce the burden of depression, which is associated with suicide. Laypersons have also been trained to deliver school programs which showed an overall reduction in suicides as part of a larger multicomponent intervention.[27] Special consideration must be given to severe mental illness (SMI), as those with SMI—such as schizophrenia or bipolar disorder—carry elevated risks.[28] Suicide among those with SMI shows less inter-sex difference than in the general population, raising questions as to whether this may contribute to higher female suicide rates observed in parts of SEA.[2] Moreover, comorbid alcohol and substance use disorders, which affect around half of individuals with bipolar disorder,[29] further compound risk and may be more pronounced in low-resource settings with limited treatment coverage and entrenched stigma. Research to strengthening service provision for these populations, while at the same time addressing stigma, is therefore essential.

While some interventions have been implemented well (for example, pesticide regulation[30]), a critical challenge in SEA is implementing evidence-based interventions in diverse contexts with fidelity. This is partly due to the lack of evaluation and documentation of existing efforts, creating gaps in implementation knowledge. Research in implementation science is needed to adapt and scale interventions with appropriate outcomes and indicators for sustainability. This includes evaluating suicide prevention strategies using outcomes and process indicators to ensure they achieve their intended impact and are sustainable over time. For example, the Plan-Do-Study–Act cycle has been used to optimize and scale up health interventions,[31] ensuring that learnings are implemented with each cycle to ensure ongoing sustainability and effectiveness.

Effective suicide prevention requires the translation of research into policy, then to action and finally to impact. Furthermore, structural barriers include overpolicing and lack of ethical oversight of research, and there may be political sensitives of supporting such a taboo topic. Efforts should examine the impact of current policies, how to best craft impactful policies, and how to best engage policymakers. Additionally, exploring regional cooperation and shared resources can promote learning, encourage mentorship, and enhance suicide prevention efforts. Structural barriers to research and implementation, such as the lack of funding and insufficient capacity building, need to be addressed, including through mechanisms such as establishing dedicated budget lines for suicide prevention, integrating activities into broader health and development financing streams, and leveraging international donor and philanthropic support. Furthermore, promoting cost-effectiveness analyses to build the case for sustained investment may be necessary to compel policymakers to implement evidence-based interventions, as economic impact can be a major factor in policymaker decision making.

This approach had several limitations. Despite extensive efforts to capture diverse perspectives, representation from some countries in the region was limited, with no representatives from Myanmar. Responses were self-reported and may have been influenced by participants' individual experiences and priorities. Nevertheless, we drew on a wide regional network of researchers, policymakers, and practitioners, and combined multiple data sources—including surveys, workshops, and panel discussions—to ensure a broad and contextually grounded set of priorities. This triangulation strengthens the validity of these findings and provides a foundation for future research and action. Taken together, these findings offer a clear starting point for building a regional research agenda that is responsive to context, inclusive of diverse voices, and capable of driving meaningful change in suicide prevention.

Declaration of interests

SO was supported by the Lynch Family Foundation Research Fellowship for Global Health Equity, to the Department of Global Health and Social Medicine, Harvard Medical School; receives consulting fees from WHO HQ, as part of the NCD & Mental Health team; and is currently the Vice President of the International Association for Suicide Prevention, and the President of the Indonesian Association for Suicide

Prevention. VM Dr Menon reports receipt of honoraria for delivering lectures and conducting workshops, at the invitation of psychiatric and medical institutions or societies. In all such instances, the honoraria were received directly from the event organizers. VM reports travelling to deliver guest lectures and conduct workshops at the invitation of psychiatric and medical institutions or societies in various parts of India. On most of these occasions, his travel, stay, and academic expenses are supported by the organizers, themselves, or by pharmaceutical companies at the behest of the organizers. SP obtained consulting fees from the Pan American Health Organization to develop mental health legislation for Caribbean countries. RD obtained a grant from the Mariwala Health Initiative. All other authors declare no conflict of interest.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lansea.2026.100718.

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