WHOSE NARRATIVE COUNTS? SUICIDE PREVENTION AND THE GEOGRAPHY OF WHAT WE KNOW

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There is a scene that plays out somewhere in the International Red Cross and Red Crescent (RCRC) Movement almost every day. A volunteer at a branch helpline takes a call from someone who expresses - in a subtle and perhaps gradually more explicit way - that they do not want to be alive. The volunteer listens, does not judge, stays on the line, calls a supervisor, works through a safety plan. It is sensitive, qualified, and maybe too often unacknowledged work, and it is exactly what the RCRC MHPSS Hub — then the IFRC Reference Centre for Psychosocial Support (PS Centre) — set out in its 2021 guidance on suicide prevention for National Societies (1).

Here is what usually does not happen next. That call does not become data. It does not enter a surveillance system, a peer-reviewed paper, or a systematic review. It does not shape the next global guideline. The conversation happened. It mattered deeply to an individual. But it was never accounted for in a way that allowed it to make a broader and more lasting difference.

This is the third and final year of the World Suicide Prevention Day (WSPD) triennial theme, *Changing the Narrative on Suicide*, with its call to action, Start the Conversation (2). It is a relevant theme, and it has generated change. However, as the triennium closes, I want to explore whether it might have been interpretated too narrowly. The understanding of "narrative" has perhaps been limited in scope. Indeed, it plays out in multiple arenas - anything from public discourse and social media debates to family conversations and school programmes. However, it has not in my opinion involved a systematic analysis of what the global evidence base tells us about where suicide happens, why, and what to do about it. Accordingly, we have not collectively acknowledged the asymmetry of the narrative we have tried to change – it is defined in the areas of the world that are least exposed to suicides.

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A DAY SHAPED BY A PRESUMPTION

WSPD was launched in Stockholm on 10 September 2003, an initiative of the International Association for Suicide Prevention (IASP) with the World Health Organization (WHO), which became a co-sponsor from 2004 (3). While the launch was and is of vital importance in putting suicide prevention on the formal agenda the hope for change was anchored in a perhaps deceptively simple causality chain: suicide is a public health problem, it belongs on government agendas, organizations and mobilized public can make this happen and ultimately it will lead to prevention.

Twenty-three years on, the numbers are still sobering. WHO's most recent estimates put deaths by suicide at 727,000 in 2021, with suicide the third leading cause of death among people aged 15–29 (4,5). The global age-standardised rate has fallen since 2000, but not fast enough to meet the Sustainable Development Goal target of a one-third reduction by 2030 (5).

The themes have shifted over time — *Creating Hope Through Action* between 2021 and 2023, and now *Changing the Narrative on Suicide*. IASP is explicit that the current theme is not merely about tone. Changing the narrative, it argues, requires systemic change: legislation, access to care, investment in research, and a shift from silence and stigma to openness and support (2). The theme was chosen because stigma is not a soft obstacle. It stops people reaching out, and it stops systems from measuring, funding and responding — WHO makes precisely this point about under-reporting and misclassification of suicide deaths (5).

So, the most recent theme already contains the ambition of broadening the scope. It just has not been pressed sufficiently or effectively enough.

THE UNCOMFORTABLE ARITHMETIC

Roughly three in every four deaths by suicide occur in low- and middle-income countries (5). Roughly the opposite is true of the research.

An analysis of three decades of suicide publications found that about 85% of papers came from high-income countries, and about 78% from just two regions — Europe and the Americas (6). A systematic mapping of poverty and suicide research in low- and middle-income countries found that most of the available evidence came from upper-middle-income settings, with only 6% of studies originating in low-income countries (7).

An umbrella review published in 2024 examined 147 systematic reviews on suicide and found that more than 80% failed to accurately represent the geographical relevance of the studies they contained. The abstracts and conclusions generalised to a global population; the underlying studies did not, with fewer than 10% drawn from low- and middle-income settings (8).

This means the documents that practitioners, ministries and humanitarian organisations reach for when they reach for "the evidence" are, in a substantial majority of cases, telling a story about high-income settings but ends up being understood as a story about the world.

And the consequences are not abstract but very concrete. The presumption — that 80–90% of people who die by suicide have a diagnosable psychiatric disorder — is itself derived largely from high-income country research. A systematic review and meta-analysis of studies from low- and middle-income countries produced a pooled estimate of 58% for suicide deaths, with wide heterogeneity and few high-quality studies (9). If the proportion is materially different, then so is the case for where scarce resources should go: a mental health service-led model may be the right emphasis in one context and a poor fit in another. We have been universalising the answer to a question we have not asked the most exposed areas of the world.

This is of course not simply a question of GDP. Socio-economic disadvantage carries a modest relative risk of suicide but an enormous population prevalence, which is why deprivation, unemployment and insecure and/ or seasonal work account for a substantial share of deaths by suicide even in wealthy countries with well-resourced psychiatric services (10). Inequality does not switch on below an income threshold; it runs through every country in the analysis, and it makes suicide, in significant part, a consequence of the material conditions in which people live.

GEOGRAPHY IS NOT THE ONLY AXIS

Asking which countries produce the evidence is necessary but not sufficient. Within any country, including the wealthy ones that dominate the literature, some populations are far more visible to research and to data systems than others.

WHO's own fact sheet is direct about who carries elevated risk: refugees and migrants, Indigenous peoples, LGBTI people and prisoners — groups defined, in that listing, by the discrimination they face (5). Persons with disabilities and young people belong there too. They are rarely the populations from which a national sample is drawn, and the barriers that raise their risk are usually the same barriers that keep them out of the denominator. Evidence from a high-income setting can therefore be narrow twice over: it describes a wealthy country, and within it, the people who were already easiest to count.

The instruments carry the same inheritance. Definitions, diagnostic categories and risk assessment tools were developed in a handful of settings, and they encode assumptions about what distress is, how it is expressed, and what asking for help looks like (11). Where those assumptions do not hold, the tool does not return a different answer. It returns a smaller number.

Gender is a very concrete illustration of this mechanism. Men die by suicide at roughly twice the rate of women globally, but that ratio is not a constant: it exceeds three to one in high-income countries, while the highest female rates are found in lower-middle-income countries (12). What is reported as a general fact about suicide and gender is, to a considerable degree, a fact about the settings that produce most of the research.

WHY THE GAP EXISTS AND WHAT WE ARE MISSING

It is tempting to explain all this as the result of a lack of capacity: fewer researchers, thinner institutions, less funding. That is part of it, but it is not the whole explanation. Pretending it is, comes with the risk of deflecting responsibility from key-actors.

There are at least four factors that must be recognized:

First, deaths are not counted. Only around 80 WHO Member States out of 194 have vital registration data of sufficient quality to estimate suicide rates directly (5). Elsewhere, national figures are modelled. You cannot build a prevention strategy[1] , or evaluate one, on a denominator that does not exist.

Second, the law suppresses the data. Suicide and suicide attempts remain criminalised in at least 23 countries by WHO's count (13), with civil society organisations placing the figure slightly higher (14). Criminalisation deters help-seeking, entrenches stigma, and — crucially for this argument — corrupts the record, since deaths and attempts are systematically misclassified where they carry legal consequences for the person or their family (5,13). The effect runs deeper than under-reporting. Where disclosure carries legal risk, the person does not say it, the family does not report it and the clinician does not write it down; the law does not merely shrink the count, it decides what is permitted to become visible as suicide at all. The Movement's own suicide prevention guidance recognises this challenge operationally, encouraging National Societies to identify alternatives to contacting the police in contexts where attempting suicide is illegal (1). This is a striking and illustrative precaution to include in a technical manual.

Third, the money never arrives. Mental health has historically received around 1.6% of government health budgets in low- and middle-income countries and roughly 0.4% of development assistance for health. Across health conditions, mental disorders attract the lowest share of philanthropic development assistance (15). Research funding is a fraction of a fraction.

Lastly, the credit is unevenly distributed. Systematic mapping of the poverty–suicide literature was confined to material published in English (7). Where research does happen in low-resource settings, the question of who frames it, who analyses it, who authors it remain ambiguous.

These factors of inequality constitute not only a barrier to the discourse. It is a barrier to counting, to funding, and to knowing.

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1 The most reliable current figure comes from WHO's Mental Health Atlas 2024, published in September 2025: nearly half of 138 responding countries (47%) reported having a distinct or integrated national suicide prevention strategy, policy or plan and a suicide prevention programme. That works out to roughly 65 countries. Only 144 of WHO's 194 Member States responded to the 2024 Atlas survey — a participation rate of 74%, down from 171 responses in 2020 — and the suicide-strategy question drew 138 of those. So 47% describes self-selecting respondents, not global coverage. Non-responders skew toward exactly the low-income and fragile settings, which makes the true global share lower. More details at https://iris.who.int/server/api/core/bitstreams/5897b3c7-2848-47a7-ba22-0a7902342a81/content

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THE STORY WE ALREADY HAVE, AND RARELY TELL

We are not short of evidence that suicide prevention works in low- and middle-income settings. We are lacking an interest in it.

Sri Lanka's sequential regulation of highly hazardous pesticides is credited for one of the largest falls in suicide mortality ever documented. Following the 2008–2011 restrictions, overall suicide mortality fell by 21% between 2011 and 2015, with pesticide-related deaths falling by half (16). Cumulatively, researchers estimate that around 93,000 lives were saved between 1995 and 2015, largely through regulation — achieved without first resolving the underlying psychosocial and economic drivers, and without measurable loss of agricultural output (17).

That is a magnificent public health story. It is a story with a "Global South" setting, a regulatory rather than clinical mechanism, and a significant effect. Pesticide regulation stands out as a high-impact public health victory with an enormous effect size, though its core lesson is often misunderstood. While organizations like the WHO have promoted pesticide bans in South Asia for decades, the broader strategic principle extends far beyond agriculture. The critical insight to harvest is context-specific means restriction: governments must identify the leading methods of self-harm within their own borders - from firearms and toxic substances to unsafe online environments—and target their regulatory power directly where the local risk is highest.

WHO's Mental Health Atlas 2024 found that 68% of responding countries had suicide prevention training for non-specialised health workers, 50% for gatekeepers such as teachers and first responders, and 49% for media professionals — but just 18% for pesticide registrars and regulators (18). The intervention with the strongest evidence and the largest potential yield in agricultural, low-resource settings is the one least likely to be resourced. That is a narrative failure with a body count.

WHO's LIVE LIFE guidance already names limiting access to means of suicide as the first of its four interventions, alongside responsible media engagement, socio-emotional life skills for young people, and early identification and follow-up (19). The framework is not the problem. Our collective imagination about which of its components counts as "real" suicide prevention needs to be broadened.

WHAT THE MOVEMENT CAN DO

The International Red Cross and Red Crescent Movement is not a research institution, but it holds a position few if any research institutions can occupy: 191 National Societies, present in nearly every country and working through community-based volunteers who are members of the communities they serve (20). We are already present in the rural, agricultural, under-registered, under-published locations where most deaths by suicide occur. The question is whether we treat that presence as a service delivery asset only, or also as an epistemic one.

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If the second, then six actions follow.

First, treat practice as a source of evidence. The MHPSS Hub's guidance already asks National Societies to compile national statistics where available, identify locally relevant risk profiles, and build suicide prevention data into monitoring and evaluation (1). Doing this consistently, safely and ethically — with strict attention to confidentiality and to do-no-harm — would over time generate exactly the kind of contextual evidence the global literature lacks. The standing commitment sits in the Movement MHPSS Policy, whose sixth policy statement asks components to contribute, where possible, to data collection, research and innovation in accordance with ethical guidelines (21).

Second, partner as co-investigators. The Movement already has a successful working model in the RCRC MHPSS Hub's collaboration with the Danish Red Cross and the University of Copenhagen. By deliberately extending this approach—ensuring National Societies in low- and middle-income countries hold the research questions, analysis, and authorship regarding local suicide risks—we can address academic inequities and build stronger, community-led suicide prevention strategies.

Third, National Societies must use their auxiliary role and humanitarian diplomacy. The Movement MHPSS Policy clearly mandates advocacy with states and key actors to meet mental health and psychosocial needs - a commitment formally reaffirmed in Resolution 2 of the 33rd International Conference and Resolution 5 of the 2019 Council of Delegates (21,22). National Societies, have unique and privileged access to national authorities as per their official auxiliary role, this places them at a competitive advantage to most advocacy organisations. Advocating for a strengthening of civil registration and suicide surveillance and supporting decriminalisation would, as also pointed out by WHO, improve access to help and data quality and align with RCRC Fundamental Principles.

Fourth, take means safety seriously where the burden actually sits. Creating safe environments and providing psychoeducation at community-level aimed at restricting access to means e.g. pesticides, guns, unsafe online spaces as well as engaging with agricultural and regulatory actors in alignment with LIVE LIFE (19) and with existing RCRC MHPSS Hub safety planning guidance (1) can be ensured through branch-level programming.

Fifth, change our own internal narrative. The 2019 Movement mapping found only 21 National Societies implementing suicide and self-harm prevention programmes, with lack of trained staff and cultural taboos among the reported barriers (1). The 2023 Movement MHPSS survey found that 42% of respondents reported limited or insufficient technical expertise (23), and the MHPSS Hub's 2025 Global Survey found that only 24% of the 118 responding National Societies implement suicide prevention and self-harm activities. The capability exists in the network; it is unevenly distributed, and that distribution is itself a variation of the problem described above.

We cannot ask the world to talk about suicide prevention while our own network lacks the training and protocols needed to hold those conversations safely. Volunteers, coming directly from the communities they

serve, are equally shaped by local cultural norms and stigma; many fear that acting as a "helper" without proper training might actually make a situation worse. Safe engagement requires addressing these fears directly through skill-building, clear guidance, and compassionate language—such as adopting "died by suicide" over "committed suicide" to reduce criminalization and stigma (1,24).

Sixth, widen what we count as suicide prevention. The narrative this article questions is also ours. Within the Movement, suicide prevention has been located almost entirely under MHPSS: training, helplines, safe conversations, referral. However, if the largest documented decrease in suicide mortality have been generated from regulation and restricting access to means rather than from services, then an approach that begins and ends with MHPSS capacity is incomplete by design.

THE LAST YEAR OF THE THEME

We have one last year under the theme of *Changing the Narrative on Suicide* and it is time to broaden our scope.

Starting the conversation cannot end by asking a neighbour how they are. It must expand to questioning why a systematic review that draws 90% of its studies from wealthy countries are defined as "global" (8) or universally applicable. It has to mean asking why the single most effective suicide prevention measure available to agricultural economies is the one least likely to be funded (18). It has to mean asking why a volunteer's careful, compassionate and competent work at a branch helpline in a rural district is a service but not a finding, a source of evidence.

There are two avenues of action to respond. One is aimed at high-income institutions — funders, journals, global agencies, and international organisations headquartered in Western capitals — advocating for revisiting the ownership of narrative they occupy by default rather than by right. The other is aimed at the countries and National Societies carrying most of the burden, because a narrative is not simply handed over, it is taken through agency — deciding which questions are worth asking, collecting the data, holding the authorship, and treating what happens in a rural district as evidence rather than local colour.

Silence about suicide costs lives. But the core problem in global mental health today is not silence — it is a crowded, noisy arena dominated by WEIRD[2] nations (25) and global institutions that too often transform their own local realities into universal truths. By imposing an external narrative on lower- and middle-income countries, we obscure the realities of the populations most affected. True progress requires two shifts: high-income institutions must recognize the limits of their own perspective and step back, while lower- and middle-income nations must seize the authority to ask their own questions, collect their own data, and reclaim their own stories.

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2 An abbreviated term used to refer to "western, educated, industrialized, rich, and democratic" countries. For further reading see Heinrich et al. 2010.

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