Commentary

Integrating Social and Cultural Research into the LIVE LIFE Framework for Implementation and Localisation of a National Strategy

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Abstract

Suicide prevention strategies traditionally focus on quantitative data-driven approaches, often overlooking the critical role of cultural contexts. While the World Health Organization's LIVE LIFE framework offers a robust structure for the development of a national strategy, explicit integration of social, cultural, and ethnographic factors could further strengthen the implementation and localization of national policies. This paper argues that national suicide prevention strategies would benefit from the inclusion of culturally-focused qualitative and anthropological approaches and provides a framework for qualitative inquiry using the LIVE LIFE framework as a foundation. By incorporating social and cultural analyses and understanding the diverse ways communities perceive and respond to suicide, these national and local suicide prevention strategies can be more effective and inclusive. Drawing on anthropological and ethnographic approaches, the paper presents key questions concerning local social and cultural contexts for each LIVE LIFE component, as well as how the answers may guide the implementation and localisation of a culturally informed strategy.

Keywords: suicide prevention, national strategy, anthropology, culture, ethnography

Introduction

Suicide is a public health crisis, claiming over 700,000 lives each year worldwide, with 73% of these deaths occurring in low- to middle-income countries (World Health Organization [WHO], 2024). Despite numerous prevention initiatives, suicide continues to be a leading cause of death, particularly among young people aged 15–29 (WHO, 2024). The ramifications of suicide extend far beyond the immediate loss, deeply affecting families, communities, and entire societies by fostering psychological distress, social isolation, and incurring significant economic burdens (WHO, 2021).

WHO LIVE LIFE Suicide Prevention

In response, the World Health Organization introduced the LIVE LIFE framework, detailed in *LIVE LIFE: An Implementation Guide for Suicide Prevention in Countries* (WHO, 2021). This comprehensive framework aims to reduce suicide mortality through four primary interventions and six foundational pillars. The interventions are designed to address both immediate risk factors

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and promote long-term protective measures. First, limiting access to means of suicide involves restricting the availability of commonly used means such as lethal substances, a strategy proven to significantly decrease suicide rates (Yip et al., 2012). Second, responsible media-reporting seeks to minimize imitation effects by guiding news outlets to avoid detailed descriptions of suicide methods and locations (Niederkrotenthaler & Sonneck, 2007). Third, fostering socio-emotional life skills in adolescents equips young individuals with resilience, stress management, and relational skills to better handle future challenges (Barry et al., 2013). Finally, early identification, assessment, management, and follow-up focuses on community-level support, training in suicide risk detection, and providing ongoing care for those at risk (Mann et al., 2005).

To implement these interventions effectively, the LIVE LIFE framework outlines six cross-cutting pillars: situation analysis, multisectoral collaboration, awareness-raising and advocacy, capacity-building, financing, and surveillance, monitoring, and evaluation. Situation analysis entails a comprehensive examination of suicide patterns, risk factors, and existing resources to identify action priorities. Multisectoral collaboration brings together various government agencies, community leaders, and service providers to ensure that policies and interventions address the multifaceted nature of suicide. Awareness-raising and advocacy aim to destigmatize mental health issues, while capacity-building focuses on enhancing the skills of professionals and community members involved in prevention efforts. Financing ensures the sustainability of these initiatives, and surveillance, monitoring, and evaluation suggest that outcomes should be tracked and strategies continually evaluated and refined for improvement (WHO, 2021).

The need for culturally sensitive qualitative and anthropological approaches

National suicide prevention strategy frameworks can be strengthened by considering local cultural contexts. In addition to considering each country's context, each national strategy should undergo a process of local adaptation and implementation. Anthropological research can provide a deep understanding of the local culturally and socially shaped experience, shedding light on the experiences of individuals in distress and suicidal crises, as well as the structural barriers individuals and families encounter when seeking help (Chandler & Lalonde, 2008). Such studies demonstrate that local social and cultural frameworks are pivotal in determining the effectiveness and sustainability of suicide prevention efforts. Cultural understandings and societal structures—families, schools, health care facilities—significantly influence how members of communities perceive mental health, communicate distress, and seek assistance (Kirmayer, 2012). While there has been substantial anthropological work on suicide (Colucci & Lester, 2013), it can be further integrated into existing national strategy frameworks.

Integrating anthropological and qualitative methods into suicide prevention strategies can provide a comprehensive and nuanced understanding of the cultural, social, and systemic factors that influence their success. These methods include interviews, focus group discussions and ethnographic observations, focused on identifying salient social and cultural subgroups in a community, investigating particular distinctive characteristics relevant to understandings of suicide, and exploring individual cases of suicide attempts within these groups. While suicide is often framed primarily as a mental health issue, it is deeply rooted in cultural norms and societal structures that shape individuals' perceptions and responses. For example, in communities guided by the First Nations Social Emotional Wellbeing (SEWB) Framework, suicide is perceived as a consequence of deteriorating relationships,

highlighting the importance of restoring familial and community connections to prevent suicidal behaviour (Gee et al., 2014). In contrast, in predominantly religious societies like Indonesia, suicide is often viewed as a sin, which significantly impacts how individuals and communities address and respond to suicidal ideation and behaviour (Onie et al., 2023a; 2023b). These differing cultural perspectives underscore the necessity for suicide prevention interventions to be tailored to align with local values and behaviours.

Qualitative research allows for an in-depth exploration of these cultural contexts, uncovering the lived realities and identifying structural barriers that may impede the effectiveness of prevention efforts. For instance, Tumilowicz et al. (2016) outlined the effectiveness of ethnographic methods in nutrition interventions by thoroughly understanding community practices and barriers. For example, one case study noted how nutritionist's recommendations directly conflicted with local beliefs among pregnant women in Puerto Rico in 1971 and how harmonising beliefs led to mutual understanding and greater uptake of evidence-based practices. This example illustrates how ethnographic insights can enhance the design and implementation of public health initiatives, ensuring they are culturally relevant and more likely to succeed.

By understanding how cultural norms, stigma, and traditional practices influence help-seeking behaviours and the acceptance of interventions, policymakers and practitioners can design strategies that are not only effective but also culturally respectful and relevant. This culturally informed approach ensures that suicide prevention initiatives can be more inclusive, sustainable, and capable of addressing the unique needs of diverse populations, ultimately leading to more meaningful and lasting outcomes in reducing suicide rates. Understanding the human experience behind the statistics is indispensable in this context as cultural backgrounds profoundly influence how suicide is perceived and how individuals seek support (Colucci & Lester, 2013). By integrating anthropological insights into the pillars and interventions of the LIVE LIFE framework, policymakers and practitioners can design and implement strategies that resonate with local communities. Such integration can lead to greater acceptance, sustainability, and effectiveness in suicide prevention efforts.

Article aims

In this article, we present key areas of inquiry for stakeholders—including policymakers, mental health professionals, community leaders, and researchers—to consider when a) developing a national suicide prevention strategy, and b) implementing the national strategy framework on a local level. This framework aims to ensure that interventions are culturally sensitive and contextually appropriate given the diversities that exist within a country. By addressing these critical questions, stakeholders can tailor their approaches to align with the unique social and cultural dynamics of their communities, thereby enhancing the overall impact and sustainability of suicide prevention initiatives.

Cultural Framework for LIVE LIFE

Here, we outline specific ways that ethnographic and culturally focused qualitative research can be integrated into national, regional, and local suicide prevention methods that can be embedded in a situation analysis, or conducted as the project is ongoing. Questions are provided, first focusing on general questions for the situation analysis which apply to a wide range of LIVE LIFE pillars and are central to the localisation of a national strategy, followed by additional questions specific to each relevant cross-cutting pillar or intervention. Recognizing that ethnological investigations may not be as relevant to certain sections of LIVE LIFE (e.g., the cross-cutting pillar of financing), we will emphasise sections relevant to culture and context.

1. Situation Analysis

Local social and cultural considerations are crucial in the initial situation analysis phase. This requires data on what social and cultural categories of individuals are at highest risk for suicide and how similar or different these groups are – beyond looking at the suicide rates of subgroups, as underreporting is common among marginalised groups. Age groups ('youth culture,' elders), gender, religious subgroups in a society, rural versus urban, and social categories such as caste, class, and status groups may have distinctive perspectives and require a deeper understanding of who is at risk. Understanding distinctive characteristics of local cultural and social settings can provide insights into how mental health and suicide are perceived, what most commonly leads to suicidal ideation and attempts, whom individuals who experience suicidal thoughts can confide in, and what factors influence their willingness to seek help and the types of interventions that will be accepted. These may vary by specific groups at high risk (students, rural and urban poor, educated urban workers). Traditional healing practices and support systems, including schools, religious groups, and social networks can be identified and potentially integrated into the formal health system to create a more holistic and culturally resonant approach. The situation analysis identifies key factors pertaining to suicide; here, the experience and perception of individuals and communities are emphasised.

Ignoring cultural context can lead to interventions that are ineffective or even harmful (Tumilowicz et al., 2016). For instance, in some cultures, mental health issues are stigmatized, and individuals may be more likely to seek help from traditional healers, religious specialists, or school teachers or counselors than mental health professionals. Conversely, destigmatisation efforts may not be effective in a community that does not stigmatize professional help-seeking but is hampered by the costs. By understanding these cultural nuances, interventions can be tailored to be more acceptable and effective.

Key questions:

1.0. What are the most important subgroups or subcultures within a society, which are at most risk for suicide, and in what ways do they differ?

1.1. How do individuals within these groups perceive suicide, suicide prevention, and help-seeking within the prevailing culture of their community?

1.1.1. What cultural and religious understandings and practices shape how individuals in the community view mental health and suicide?

1.1.2. What frameworks or concepts are commonly used by the population to talk about well-being, mental health, and suicide?

1.1.2.1. Where do these frameworks or concepts come from?

1.1.2.2. How do these vary in forms of expression – e.g. on social media, in religious preaching, in popular literature and news reports?

1.1.3. What words or phrases do people in the community use when discussing well-being in relation to suicide, and how are they related to help-seeking or, conversely, non-help-seeking?

1.1.4. How do people experiencing suicidal thoughts or who have attempted suicide feel they are perceived and treated by the community?

1.1.5. How are families or loved ones of individuals who have died by suicide viewed and treated within the community?

1.2. How do social, cultural, historical, and economic factors shape individuals' views on suicide, suicide prevention, and seeking help?

1.3. Where do people go and whom do they feel they can turn to when they are experiencing suicidal thoughts?

1.3.1. How do individuals feel they are received by those they approach for help?

1.3.2. What training and support do those providing help have, and how does this affect individuals' experiences?

1.3.3. What are some structural barriers to obtaining and providing help?

1.3.4. Are there recognized sources of support—such as particular individuals, organizations, or institutions—that people avoid approaching when experiencing suicidal thoughts, even though these sources are known to provide help? If so, what factors might explain why individuals avoid them?

How to use this information to implement or localize a national strategy:

The answers to these questions posed in the situation analysis provide a roadmap for developing culturally relevant and effective interventions. For instance, identifying key subgroups or subcultures who are at most risk of suicide provides a starting point for LIVE LIFE's universal interventions. Furthermore, if certain communities predominantly seek help from religious specialists or some categories of local healers, general physicians, or school counsellors rather than mental health specialists (as seen in Question 1.3), focusing capacity building on these individuals and integrating them into a network of care could improve early identification and referrals and help implement LIVE LIFE intervention 4. Conversely, a common source of support in one context may not be considered a source of support in another (as seen in Question 1.3.4). By understanding these challenges, a localized national strategy may seek to rectify modifiable risk factors or focus on alternative sources of support in implementing LIVE LIFE intervention 4.

Communities are often centralized around key organizations that shape their perception of suicide. Engaging these organizations is critical for the LIVE LIFE pillars of Awareness Raising, Capacity Building, and Multisectoral Collaboration, especially when these organizations are linked to government agencies.

Data on structural factors (Question 1.3.3) enable local and national authorities to consider policy changes, resource reallocation, or infrastructural improvements to enhance service access. Whether through subsidized transportation to mental health facilities, telehealth services in remote areas, or financial incentives for clinics to expand culturally appropriate care, policymakers can build systems that respond directly to the community's identified needs. For example, a lack of professional help-seeking may be due to stigma, a low number of professionals, cost, or a combination of these factors—each requiring different solutions.

The language and terminologies revealed through questions on how communities talk about suicide (Questions 1.1 and 1.1.1) can be integrated into all forms of public messaging. For example, awareness campaigns and educational materials can adopt the community's existing words and expressions for distress to resonate more deeply with local values. This approach can reduce stigma and prevent unintended alienation from imposing unfamiliar terminology or evoking unwanted emotions. Additionally, these linguistic insights can form the basis of competency training for healthcare providers and volunteers, enabling them to recognize and respect the community's "idioms of distress." Conversely, campaigns disregarding cultural nuances risk alienating their audience, reinforcing stigma, or being dismissed as irrelevant or invasive (Kral, 2019).

Insights into how families and individuals who have experienced suicide are treated (Questions 1.1.4 and 1.1.5) can guide the development of support systems that are sensitive to cultural stigma. This fosters a more inclusive and supportive environment, increasing the likelihood of disclosure of suicidal thoughts and behaviours and facilitating LIVE LIFE intervention 4. These questions can also inform

destigmatization programs and case registration practices, enhancing the likelihood of suicide disclosure and improving the monitoring, surveillance, and evaluation pillar of LIVE LIFE.

Finally, understanding how communities perceive and support those bereaved by suicide (Questions 1.1.4 and 1.1.5) is key to developing sensitive postvention strategies, aligning with LIVE LIFE intervention 4. Approaches can range from community-led bereavement groups to supportive dialogue sessions that help reduce isolation and shame. Embedding these strategies within broader monitoring and evaluation frameworks ensures that interventions remain responsive to community feedback and evolving cultural contexts.

2. Awareness-Raising and Advocacy

Culturally sensitive awareness-raising and advocacy efforts are central to reducing stigma and promoting help-seeking. Tailoring messages, delivery methods, and spokespersons to reflect local languages, symbols, and storytelling traditions can increase both acceptance and reach. As previously mentioned, campaigns that do not consider culture risk evoking unwanted emotions and having adverse effects on desired behaviour (Kral, 2019).

Additional questions:

2.0. Who are the community's leaders or influencers who shape the perception of suicide and help-seeking?

2.1. What communication formats (e.g., local radio, community theatre, social media) are most likely to be both culturally acceptable and accessible by people across the lifespan?

How to use this information to implement or localize a national strategy:

The questions in this domain lay the groundwork for constructing messages that resonate with local linguistic and cultural expressions. For instance, when certain communities are found to place great trust in religious leaders or local elders (as indicated by Question 2.1), national strategies can integrate these figures into awareness campaigns to enhance credibility and reach. In many cases, it may become apparent that community members rely more on radio broadcasts, street theatre, or social media (Question 2.2) than on other channels for their information. By tailoring campaigns to these preferred communication methods, messaging can extend to broader segments of the population and elicit more meaningful engagement. Furthermore, incorporating the everyday language communities use to talk about distress or help-seeking (Question 1.1.3) can reduce stigma and avoid the pitfalls of employing terminology that might be perceived as foreign or inappropriate.

3. Surveillance, Monitoring, and Evaluation

Surveillance, monitoring, and evaluation systems must consider local cultural contexts to promote accurate reporting and reduce stigma. Families, individuals, and professionals (such as the teachers, police, coroners, and healthcare staff) may be reluctant to disclose suicide-related information when social repercussions or cultural sanctions are perceived to be severe (Colucci & Lester, 2013; Onie et al., 2023a). Ethnographic insights can reveal the local factors that shape disclosure and reporting practices, helping policymakers and practitioners design effective data collection tools and protocols.

Additional questions:

3.0. How does a person in the process of case registration for suicide feel when having to report a suicide, and how does the community perceive them?

3.1. What is likely to encourage an individual to disclose or record a suicide?

3.2. What are some structural barriers or factors relating to the accurate reporting of suicide?

How to use this information to implement or localize a national strategy:

Effective surveillance systems depend on building trust with communities that may be hesitant to report suicide-related information, as revealed by Questions 3.0, 3.1 and 3.2. In some settings, families or individuals registering a suicide case may feel shame, fear legal repercussions, or worry about cultural sanctions, which leads to underreporting. Drawing on these insights, local and national authorities can design reporting protocols that mitigate such fears, for example, by offering anonymity or ensuring that data collection processes are culturally sensitive. These measures may not only create a safer atmosphere for disclosure but may also supply more accurate data for the monitoring, surveillance, and evaluation pillar of LIVE LIFE.

4. Limiting Access to Means of Suicide

Restricting access to lethal means is a core strategy in suicide prevention. However, the sociocultural significance of certain methods—such as pesticides in agricultural communities or firearms in rural areas—varies greatly. Ethnographic research can elucidate these local meanings and practical uses, helping policymakers design more acceptable, context-specific regulations (Kral, 2019).

Additional questions:

4.0. Which methods of suicide are most prevalent in different social and cultural subgroups within a society, and what sociocultural factors shape their usage?

4.0.1. Given that means are often selected based on familiarity, how does the group engage with the method in daily life?

4.1. How do local perceptions or practices influence acceptance of limiting access to lethal means (e.g., perceptions of firearms as a constitutional right, or lethal pesticides as essential for farming)?

4.1.1. Are there established non-suicidal uses for these means, and how might alternative solutions be introduced to maintain livelihoods?

How to use this information to implement or localize a national strategy:

Questions 4.1 and 4.2 illuminate the significance of lethal means in specific cultural and economic contexts. For example, pesticides may be integral to a farming community's livelihood, or firearms may hold historical or constitutional importance in rural regions. Recognizing these factors prompts policymakers to balance regulation with respect for local needs. In communities dependent on particular pesticides, requiring diluted or substitute agricultural chemicals or buy-back initiatives could diminish suicide risk without threatening farmers' economic stability.

5. Interacting with the Media for Responsible Reporting

Media coverage has a demonstrable impact on suicide-related behaviours and attitudes. Culturally tailored guidelines for reporting can prevent sensationalism, reduce imitative behaviours, and limit stigmatizing language (Kirmayer, 2012; WHO, 2021). However, norms about discussing death or mental distress vary widely, and anthropological research can illuminate cultural practices that influence the way media outlets portray suicide.

Additional questions:

5.0. From where are particular subcommunities likely to receive news about a suicide?

5.1. How do people in the community and particular subgroups feel after hearing about a suicide?

5.2. How can the media be leveraged to reduce stigma and encourage help-seeking behaviours in culturally resonant ways?

How to use this information to implement or localize a national strategy:

The questions in this section underscore the role of mass media and community-specific channels in shaping attitudes and behaviours related to

suicide. If a region relies predominantly on community radio or local newspapers for news about suicides (Question 5.1), tailored guidelines for responsible reporting can be disseminated to those specific outlets. If youth receive most information from social media, how can such media be guided? Equally important is identifying and training the media personalities and influencers who can effectively champion help-seeking messages (Question 5.3).

6. Fostering Socio-Emotional Life Skills in Adolescents

Developing socio-emotional competencies in adolescents is a key protective measure against suicidal behavior. Yet the ways in which adolescents learn and express these skills are shaped by cultural norms around family, education, and community life. Integrating ethnographic insights into program design ensures that socio-emotional learning (SEL) initiatives resonate with local contexts.

Additional questions:

6.0. In which community settings (e.g., schools, youth clubs, religious institutions) do adolescents naturally gather, and how can socio-emotional skills be taught in those spaces?

6.1. What cultural practices already promote emotional well-being among adolescents?

6.2. How do cultural norms around parenting, extended family, and educational roles shape adolescent development and mental health?

6.2.1. Who plays key roles in guiding adolescents' emotional and social development?

How to use this information to implement or localize a national strategy:

While LIVE LIFE focuses primarily on schools (WHO, 2021), adolescents may congregate in other settings in which SEL can be fostered (Question 6.1) – such as religious communities and arts community centres, which may have greater coverage or be better equipped than the education system (Onie et al., 2023a). Furthermore, answers to these questions will shape the design and delivery of SEL interventions in ways that respect local cultural traditions (Question 6.2). For example, in some cultures, grandparents or hired caretakers may have a larger role in a child's social development than parents, and thus must be considered in efforts. By recognizing the informal networks and influential figures that support adolescent well-being in local communities (Question 6.2.1), policymakers can enlist these community actors in program implementation, improving acceptance and efficacy.

7. Early Identification, Assessment, Management, and Follow-Up

Early identification, assessment, management, and follow-up are cornerstones of comprehensive suicide prevention. Cultural factors, however, may determine how individuals articulate distress, seek care, and adhere to follow-up recommendations (Colucci & Lester, 2013). Incorporating anthropological perspectives helps practitioners and programme designers recognize culturally specific manifestations of distress—such as physical complaints in contexts where emotional language is less common—and adapt interventions accordingly.

Additional questions:

7.0. How do various cultural groups express emotional distress or suicidal ideation, and what local idioms of distress might healthcare providers need to recognize?

7.1. To whom are troubled individuals from particular groups most likely to disclose suicidal thoughts and behaviours?

7.1.1 How can such persons be taught to respond most effectively?

7.2. How can forms of culturally grounded follow-up care—such as community-based support circles or spiritual practices—be integrated into formal suicide prevention protocols?

How to use this information to implement or localize a national strategy:

By identifying local idioms of distress (Question 7.1), professionals can refine screening tools and training programs to detect suicide risk more accurately. Addressing cultural barriers to care (Question 1.3.3) informs the creation of supportive systems that normalize help-seeking, for instance, by linking traditional healers with medical clinics or sponsoring community-led peer support groups. Finally, embedding culturally acceptable follow-up procedures (Question 7.2)—such as making space for spiritual or communal rituals—may enhance treatment adherence and reduce the recurrence of suicidal behaviour through provision of follow up support.

Conclusion

Integrating cultural competency into the WHO LIVE LIFE framework may be key for the successful implementation and localization of national suicide prevention strategies. This approach ensures that interventions are not only evidence-based but also resonate deeply with the unique cultural, social, and economic contexts of diverse communities – allowing a national framework to be translated into local action. By leveraging anthropological, qualitative, and ethnographic insights, policymakers and practitioners can design and execute programs that honour local traditions, address specific stigmas, and utilize trusted community leaders and communication channels. Such tailored strategies enhance the effectiveness and acceptance of suicide prevention efforts, fostering an environment where individuals feel understood, supported, and empowered to seek help. Moreover, culturally informed surveillance and follow-up mechanisms may improve the accuracy of suicide data, enabling more precise monitoring and evaluation of prevention initiatives. As suicide remains a complex and multifaceted public health issue, embracing cultural diversity within prevention frameworks stands as a critical step toward achieving meaningful and lasting outcomes.

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