Letter to Editor

When Infrastructure is Absent, Education Steps in: Limits of School-Based Suicide Prevention in Low- and Middle-income Countries

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Received: 22 February 2026 **Revised:** 30 March 2026 **Accepted:** 4 April 2026
Online Published: 13 May 2026

Dear Editor

In many low- and middle-income countries (LMICs), suicide prevention unfolds in a context marked by fragile health systems, limited mental health infrastructure, and deep social stigma surrounding psychological distress. Faced with the absence or inaccessibility of specialized services, schools are increasingly positioned as front-line sites for suicide prevention. Educational settings offer sustained access to young people, relative institutional stability, and existing human resources, making them an attractive platform for intervention. However, while school-based suicide prevention initiatives can play a critical role, their expanding use also reveals significant structural, ethical, and practical limits. This article critically examines the promise and constraints of relying on education systems to compensate for infrastructural gaps in suicide prevention across LMICs.[1]

Schools occupy a unique position within LMIC contexts. They often represent one of the few formal institutions that consistently engage children and adolescents over long periods. In settings where primary health care is overstretched and mental health specialists are scarce, educators are seen as accessible and trusted adults capable of identifying at-risk students. Moreover, international organizations and donors frequently favor school-based programs because they are comparatively cost-effective, scalable, and measurable. Common interventions include life skills education, social-emotional learning curricula, peer support programs, and teacher training in recognizing warning signs of suicidal behavior. Evidence suggests that such programs can improve mental health literacy, reduce stigma, and enhance help-seeking intentions. In contexts of infrastructural absence, schools thus appear to "step in" not only as educational spaces but as surrogate mental health systems.[2]

Despite their appeal, schools in LMICs are often ill-equipped to shoulder this expanded responsibility. Teachers are rarely trained as mental health professionals, yet they are increasingly expected to identify, manage, and sometimes even counsel students experiencing severe psychological distress. This role expansion risks overburdening educators already facing large class sizes, limited resources, and high occupational stress. Furthermore, the effectiveness of school-based suicide prevention is fundamentally constrained by the absence of referral pathways. Identifying a student at risk has limited value if there are no accessible clinical services for

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follow-up care. In many LMICs, mental health services are concentrated in urban centers, financially inaccessible, or culturally misaligned with local understandings of distress. As a result, schools may become sites of detection without the capacity for sustained intervention, raising concerns about ethical responsibility and potential harm.[3]

Another critical limitation lies in the cultural framing of suicide and mental health. Many school-based programs are adapted from high-income country models that emphasize individual cognition, emotional regulation, and self-disclosure. In collectivist or highly stigmatized contexts, these assumptions may not align with local norms. Discussions of suicide may be taboo, perceived as morally transgressive, or feared as socially contagious. Schools themselves are not culturally neutral spaces. They often reproduce dominant social hierarchies related to gender, ethnicity, and socioeconomic status. Students who are most vulnerable to suicide risk such as those experiencing poverty, displacement, or discrimination may also be those least likely to feel safe disclosing distress within school environments. Without careful cultural adaptation, school-based interventions risk being superficial, exclusionary, or even counterproductive.[4]

Positioning schools as primary suicide prevention sites also raises ethical concerns. When teachers are tasked with identifying suicide risks without adequate training or support, misclassification becomes a real danger. False positives may lead to stigma or disciplinary action, while false negatives may create a false sense of security. Additionally, asking students to disclose distress in environments lacking confidentiality safeguards can expose them to social or familial repercussions. There is also a broader systemic risk: over-reliance on schools may inadvertently legitimize the continued neglect of mental health infrastructure. When education systems are framed as sufficient substitutes for health services, governments and donors may deprioritize long-term investment in community-based and clinical care, reinforcing the very infrastructural gaps that necessitated school-based interventions in the first place.[5]

School-based suicide prevention in LMICs should be understood as a necessary but insufficient response to infrastructural absence. Schools can play a valuable role in early awareness, stigma reduction, and basic psychosocial support. However, their effectiveness depends on integration within a broader, multi-sectoral system that includes health services, social protection, families, and communities. Policy approaches should therefore focus on building referral networks, investing in teacher support and supervision, and ensuring cultural relevance through local participation. Crucially, school-based programs must be framed as interim or complementary strategies rather than permanent replacements for mental health infrastructure.[6]

When infrastructure is absent, education does step but it cannot stand alone. School-based suicide prevention in LMICs reflects both pragmatic innovation and systemic failure. Recognizing its limits is essential to avoiding ethical pitfalls and ensuring that responsibility for suicide prevention does not rest disproportionately on institutions never designed to bear it. Sustainable progress requires moving beyond substitution toward the gradual construction of accessible, culturally grounded mental health systems in which schools are partners, not proxies.

Acknowledgement

We appreciate and thank all the authors whose articles we have used in writing the text.

Authors' Contribution

R.A. developed conceptualization, performed document search, wrote the drafted of the manuscript, revised it, and approved the final version for publication.

Funding Source

There is no financial support for this article.

Conflict of Interest

None declared.

Declaration on the use of AI

The author of this manuscript declares that in the writing process of this work, neither artificial intelligence (AI) nor AI-assisted technologies were used.

Please cite this article as: Abdollahi R. When Infrastructure is Absent, Education Steps in: Limits of School-Based Suicide Prevention in Low- and Middle-income Countries. IJCBNM. 2026;14(4):359-361. doi: 10.30476/ijcbnm.2026.110537.3019.

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