



Suicídio entre povos indígenas brasileiros: um estudo de revisão sistemática

Suicide among Brazilian indigenous peoples: a systematic review study

Suicidio entre los pueblos indígenas brasileños: un estudio de revisión sistemática

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RESUMO

Introdução: O suicídio é um problema de saúde pública no Brasil, com taxas particularmente elevadas entre os povos indígenas, refletindo desigualdades sociais, culturais e territoriais. **Objetivo:** Descrever a incidência de suicídio entre povos indígenas brasileiros e caracterizar os casos por fatores sociodemográficos, distribuição geográfica e métodos utilizados. **Método:** Foi realizada uma revisão sistemática em oito bases de dados em outubro de 2024, incluindo estudos que apresentassem dados de incidência. A seleção e extração foram realizadas por dois revisores independentes, e a qualidade metodológica foi avaliada utilizando a ferramenta do Instituto Joanna Briggs. **Resultados:** Vinte e quatro estudos publicados entre 1991 e 2024 foram incluídos, com taxas variando de 0,1 a 111,7 por 100.000 habitantes. Observou-se uma tendência de aumento, com concentração no Norte e Centro-Oeste, especialmente no Amazonas e Mato Grosso do Sul. As taxas foram mais elevadas entre homens e jovens de 10 a 29 anos. O enforcamento predominou, ocorrendo comumente em casa e associado ao consumo de álcool. **Conclusão:** As elevadas taxas de suicídio entre os povos indígenas no Brasil revelam vulnerabilidades marcantes e reforçam a necessidade de políticas interculturais que abordem os determinantes sociais e culturais desse fenômeno.

ABSTRACT

Introduction: Suicide is a public health problem in Brazil, with particularly high rates among indigenous peoples, reflecting social, cultural, and territorial inequalities. **Objective:** To describe suicide incidence among Brazilian indigenous peoples and characterize cases by sociodemographic factors, geographic distribution, and methods used. **Method:** A systematic review was conducted in eight databases in October 2024, including studies presenting incidence data. Selection and extraction were performed by two independent reviewers, and methodological quality was assessed using the Joanna Briggs Institute tool. **Results:** Twentyfour studies published between 1991 and 2024 were included, with rates ranging from 0.1 to 111.7 per 100,000 inhabitants. An upward

Palavras-Chave

Suicídio.

População indígena.

Revisão sistemática.

Keywords

Suicide.

Indigenous population.

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trend was observed, with concentration in the North and Midwest, especially Amazonas and Mato Grosso do Sul. Rates were higher among men and youths aged 10–29 years. Hanging predominated, commonly occurring at home and associated with alcohol use. **Conclusion:** Elevated suicide rates among indigenous peoples in Brazil reveal marked vulnerabilities and reinforce the need for intercultural policies that address the social and cultural determinants of this phenomenon.

RESUMEN

Introducción: El suicidio es un problema de salud pública en Brasil, con tasas particularmente elevadas entre los pueblos indígenas, lo que refleja desigualdades sociales, culturales y territoriales. **Objetivo:** Describir la incidencia del suicidio entre los pueblos indígenas brasileños y caracterizar los casos según factores sociodemográficos, distribución geográfica y métodos utilizados. **Método:** Se realizó una revisión sistemática en ocho bases de datos en octubre de 2024, incluyendo estudios que presentaban datos de incidencia. La selección y extracción de datos fueron realizadas por dos revisores independientes, y la calidad metodológica se evaluó mediante la herramienta del Instituto Joanna Briggs. **Resultados:** Se incluyeron veinticuatro estudios publicados entre 1991 y 2024, con tasas que oscilaron entre 0,1 y 111,7 por 100.000 habitantes. Se observó una tendencia al alza, con mayor concentración en el Norte y el Centro-Oeste, especialmente en Amazonas y Mato Grosso do Sul. Las tasas fueron más elevadas entre hombres y jóvenes de 10 a 29 años. Predominó el ahorcamiento, que comúnmente ocurrió en el hogar y se asoció con el consumo de alcohol. **Conclusión:** Las elevadas tasas de suicidio entre los pueblos indígenas de Brasil revelan marcadas vulnerabilidades y refuerzan la necesidad de políticas interculturales que aborden los determinantes sociales y culturales de este fenómeno.

Palabras Clave

Suicidio.

Población indígena.

Revisión sistemática.

INTRODUCTION

Suicide is a global public health challenge of considerable magnitude. Each year, approximately 800,000 people die by suicide worldwide, with 80% of these deaths occurring in low- and middle-income countries ⁽¹⁾. Of particular concern is the trend observed in the Americas, which stands as the only region in the world where suicide mortality increased between 2000 and 2019, with a 17% rise in the number of deaths during this period ⁽¹⁾. In Brazil, suicide mortality rates have risen progressively, and suicide currently ranks as the second leading cause of death among adolescents aged 15 to 19 and the fourth among young people aged 20 to 29 ⁽²⁾.

Within this context, indigenous populations emerge as a particularly vulnerable group. Evidence consistently indicates that indigenous communities experience higher suicide rates than the general population, although the specific contextual and structural risk factors underlying this disparity remain insufficiently explored ⁽³⁾. A systematic review published in 2017 examining suicide among indigenous peoples in Latin America found that the suicide rate among indigenous peoples exceeded those of the general population across all regions studied, reaching 96.3 suicides per 100,000 indigenous people in the state of Amazonas ⁽⁴⁾. From 2010 to 2018, the highest risk of suicide deaths among indigenous peoples was among adolescents and young adults aged 15 to 19 and 20 to 29, with mortality rates of 41.1 deaths per 100,000 inhabitants ⁽⁵⁾.

These alarming figures must be understood within a broader historical and structural context. Indigenous peoples in Brazil have endured centuries of colonization, land dispossession, forced assimilation, and systematic marginalization. These historical processes have produced cumulative disadvantages that are now reflected in persistent health inequalities, including some of the worst health indicators recorded in the country ⁽⁶⁾ .

A critical challenge in addressing these inequalities is epidemiological invisibility - the scarcity of reliable health and socioeconomic data disaggregated by ethnicity, which severely limits the capacity to develop effective and culturally appropriate public policies⁽⁷⁾ . Furthermore, existing health services frequently fail to recognize the cultural, linguistic, and sociopolitical dimensions of indigenous health, undermining the provision of comprehensive care aligned with the principles of Brazil's Unified Health System⁽⁸⁾.

Despite legal and institutional frameworks aimed at guaranteeing indigenous health rights, public policies have systematically failed to bridge gaps in specialized care. Fragmented and emergency-based service delivery persists, accompanied by high discontinuity of care, administrative barriers, inequalities in access, and weaknesses in social oversight mechanisms⁽⁶⁾.

The high proportion of deaths attributed to ill-defined causes further exposes the fragility of health information systems and constrains the understanding of mortality determinants among indigenous populations, reflecting not only the precariousness of available care, but also the profoundly unequal living conditions to which these peoples are subjected⁽⁹⁾. Against this backdrop of intersecting vulnerabilities (biological, psychological, social, economic, political, anthropological, and cultural) suicide emerges as a multifactorial and collective phenomenon that demands systematic epidemiological investigation. Understanding its magnitude, distribution, and specific characteristics among indigenous peoples is essential for developing effective and equity-oriented intervention strategies⁽¹⁰⁾.

This systematic review aims to address a key gap in the literature: despite growing recognition of the disproportionate burden of suicide among Brazilian indigenous peoples, no comprehensive synthesis has quantified its incidence, temporal trends, geographic distribution, and sociodemographic profile across diverse indigenous groups and regions⁽¹¹⁾. Filling this gap is essential for informing culturally sensitive public health responses.

The objective of this study is to describe the incidence of suicide among indigenous peoples in Brazil and characterize the cases according to sociodemographic characteristics, geographic distribution, and methods used.

MATERIALS AND METHODS

This is a systematic review study was conducted following a pre-registered protocol available on the Open Science Framework (OSF) platform (osf.io/8w5ps)⁽¹²⁾ and adhered to recommendations of the Statement for Reporting Systematic Reviews And Meta-Analyses of Studies (PRISMA)⁽¹³⁾.

The research question was formulated by the CoCoPop mnemonic, recommended for prevalence and incidence reviews (Table 1).

Table 1 - Mnemonic used for prevalence/incidence reviews.

Mnemonic	Representation	Word
Co	Condition	Incidence of suicide
Co	Context	Brazil
Pop	Population	Indigenous

Source: Prepared by the authors, 2025.

The guiding research question was: What is the incidence of suicide among indigenous peoples in Brazil?

Searches were conducted in October 2024 across the following electronic databases: Latin American and Caribbean Health Sciences Literature (LILACS), SciVerse Scopus (SCOPUS), Institute for Scientific Information (WEB OF SCIENCE), Scientific Electronic Library Online (SCIELO), PsycINFO, Cochrane Library, CINAHL, and EMBASE, as well as the PubMed search engine of the US National Library of Medicine. Gray literature databases — including MedNar, WorldWideScience.org, and OpenGrey - were also consulted, and a manual search of reference lists from included studies was performed.

The search strategies were developed based on controlled vocabularies from DECS (Health Sciences Descriptors) and MeSH, as well as free terms, synonyms, and keywords. The strategy was validated by a librarian and by the *Peer Review of Electronic Search Strategies* (PRESS) checklist. The search strategy used the terms: Suicide AND Incidence OR Proportion OR Mortality AND Brazil AND Indigenous people OR Indigenous Population OR First Nation People OR Tribes OR Native People. Strategies were adapted to the

controlled vocabularies and filters of each database, with specific filters applied for prevalence and incidence study designs.

Eligibility criteria were defined a priori. Primary studies, governmental and non-governmental institutional reports, national health system databases, and reviews were eligible for inclusion if they presented absolute data or the incidence of suicide in indigenous populations. No restrictions were applied regarding sex/gender, age, place of residence, or prior health status. No restrictions were imposed on publication year or language. Case reports/series, editorials, qualitative studies lacking numerical data on suicide occurrence at the community level, and studies evaluating health programs were excluded.

Study selection was performed independently by two reviewers, following a two-stage process. Initial screening was conducted to identify and remove duplicate records using the Systematic Review Accelerator software (<https://sr-accelerator.com/#/>). The Rayyan platform (Qatar Computing Research Institute) was used to operationalize the screening of titles and abstracts, followed by full-text assessment. Reference lists of included studies were also examined for additional eligible sources.

Data extraction was performed independently by two reviewers using standardized spreadsheets in Google Docs. Extracted variables included: title, first author, year of publication, study design, geographic scope, study population, number of deaths, crude and age-standardized incidence rates (overall and stratified by sex, age group, and ethnicity, where available), and relevant contextual observations. Discrepancies were resolved through discussion with a third reviewer until consensus was reached.

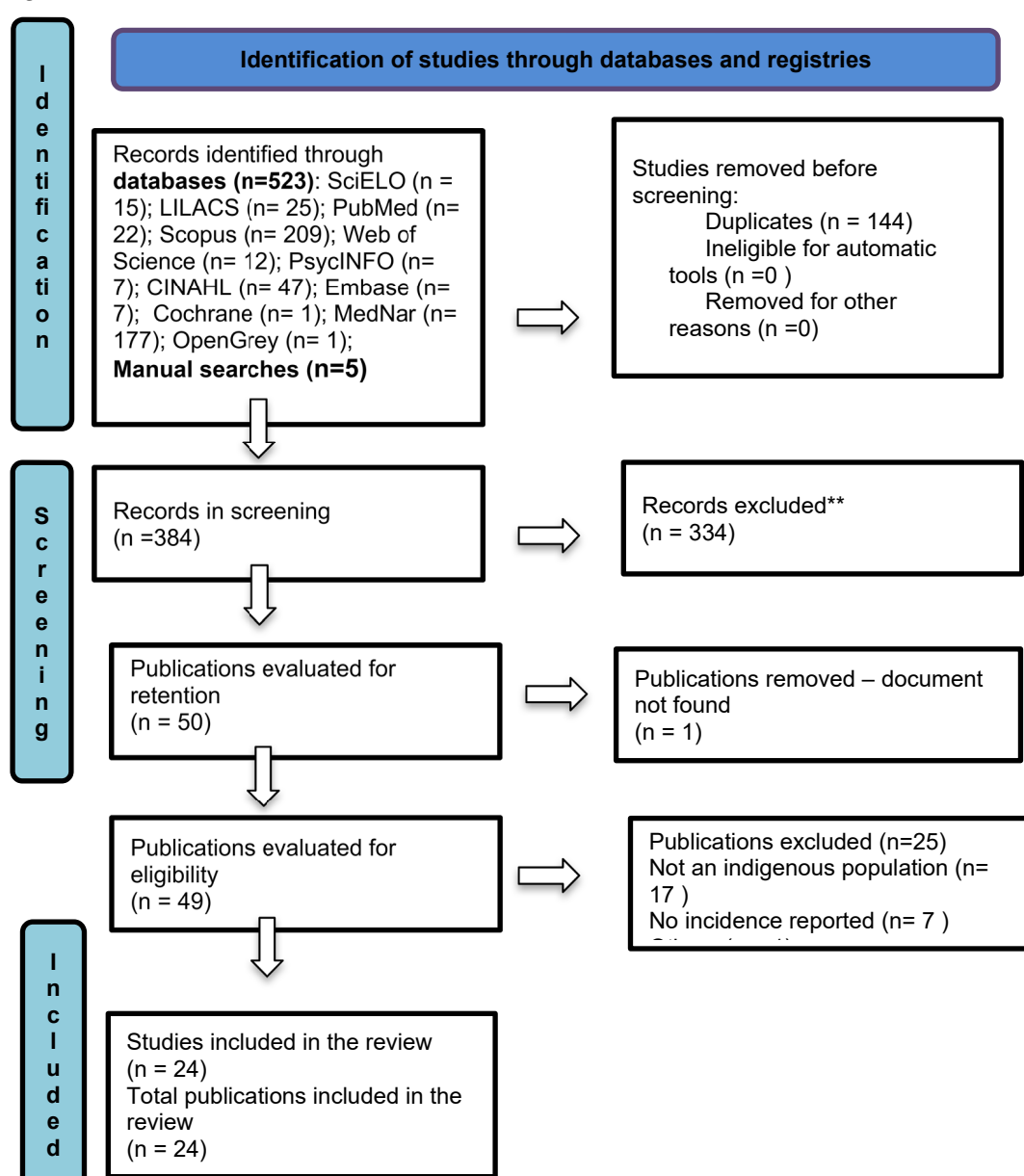
Methodological quality of included studies was assessed using the Joanna Briggs Institute (JBI) critical appraisal checklist for studies reporting prevalence and incidence data. Each study was independently appraised by two reviewers; disagreements were resolved by consensus. Results of the quality assessment are presented in Supplementary Material 2. Studies were not excluded based on methodological quality alone; rather, quality scores were considered in the interpretation of findings. A narrative synthesis approach was adopted due to the substantial heterogeneity among included studies. Key sources of heterogeneity included: (a) divergent operational criteria for calculating incidence - some studies presented crude rates per 100,000 inhabitants, while others provided age-standardized rates or absolute counts without corresponding population denominators; (b) considerable variation in geographic scope, ranging from single municipalities to national coverage; and (c) a wide range of incidence estimates (0.1 to >100 deaths per 100,000 inhabitants), reflecting both true epidemiological variation and

methodological differences. Given these considerations, meta-analysis was deemed inappropriate, and findings are presented descriptively.

RESULTS

A total of 528 studies were identified across all sources, and 144 were excluded due to duplication (Figure 1). During the screening of titles and abstracts, 334 records were excluded for not meeting eligibility criteria. After full-text assessment, 24 studies were included in this systematic review.

Figure 1 – Flowchart of the studies evaluated



Source: Research data. Prepared by the authors (2025).

The 24 included studies span publications from 1991 to 2024. The years 2024 and 2019 had the highest number of included publications (four articles each), followed by 2020, 2017, and 2012 (two articles each), suggesting a more recent growth in scientific output on this topic (Table 2).

Table 2 – Characterization of the included studies

First author, year of publication	Location and period of collection	Type of study	Population	Deaths	Incidence rate per 100,000 inhabitants	Male Incidence rate per 100,000 inhabitants	Female Incidence rate per 100,000 inhabitants	Observations
Alves, 2024 ⁽⁹⁾	Brazil, 2011 to 2022	Ecological	Not cited	Not cited	2011: 11.59; 2012: 10.54; 2013: 17.12; 2014: 17.70; 2015: 19.77; 2016: 17.93 2018: 19.93; 2019: 19.61; 2020: 17.71; 2021: 20.46; 2022: 16.58	Not cited	Not cited	Annual percentage increase of approximately 4.78% over the period.
Palma, 2024 ⁽¹⁴⁾	Brazil, 2010 to 2019	Ecological	Not mentioned	98	19.5	33.7	5.2	Included ages 14 to 65
Amazonas State Health Department,	Amazonas, 2023	Epidemiological Bulletin ^Ω	168,680	72	14.7	Not cited	Not cited	The Alto Solimões Regional Health Authority accounts for most of the suicide cases (59.5%), followed by the

2024 ⁽¹⁵⁾								municipality of São Gabriel da Cachoeira (n=17), Tabatinga (n=16), and São Gabriel da Cachoeira.
Secretariat of Health Surveillance and Environment, Ministry of Health, 2024 ⁽¹⁶⁾	Brazil, 2021	Exploratory ecological analysis ^Ω	Not cited	161	Not cited	Not cited	Not cited	Indigenous people had rates of self-harm by hanging and firearm use that were 5.0 and 5.7 times higher than those observed in non-indigenous people, respectively.
Araujo, 2023 ⁽¹⁷⁾	Brazil, 2001 to 2017	Ecological	North: 343,836 Northeast: 232,739 Southeast: 99,137 South: 78,773 Midwest: 143,432	2021	2001: 8.53 2017: 22.04	Not cited	Not cited	The two states with the highest suicide rates were Amazonas and Mato Grosso do Sul. The main method of suicide for both sexes was hanging, strangulation, or asphyxiation (88.3% for men and 90.1% for women).
Braga, 2020 ⁽¹⁸⁾	Pará, 2010 to 2015	Epidemiological and descriptive	Not cited	14	0.1 (95% CI 0.3;1.6) standardized:	Not cited	Not cited	2010 to 2012, highest frequency in the municipalities of Alenquer, Itaituba, Cametá, and Tucumã 0.1/100,000

					17.9			inhabitants to 4.9/100,000 inhabitants; and for 2013 to 2015, the municipalities with the highest suicide rates were Altamira, Jacareacanga, and Portel.
Macedo, 2020 ⁽¹⁹⁾	Roraima, 2014-2017	Descriptive	Not cited	45	Not cited	Not cited	Not cited	There is no additional information.
Orellana, 2019 ⁽²⁰⁾	Tabatinga - Amazonas, 2007 to 2011	Description ^β	15,159	64	Standardized : 111.7 (95% CI, 84.6-148.6).	Standardized : 174.6	Standardized: 42.9	Over 9 years old. Most deaths occurred by hanging and at home, 17.2% of records were associated with alcohol consumption prior to the suicidal act, and 17.2% of suicide victims had some level of kinship.
Indigenous Health Secretariat, Brazilian Ministry of Health, 2019 ⁽⁵⁾	Brazil, 2010 to 2017	Descriptive ^β	Not cited	725	12.23	Not cited	Not cited	Men die by suicide twice as often as women. Hanging was the method used in 81.6% of deaths, self-poisoning (9.2%), and firearm discharge (4.4%).
Souza, 2019 ⁽²¹⁾	Brazil, 2010 to 2014	Description	94,826	55	11 (95% CI: 8.4;14.3)	9.1 (95% CI: 6.1; 13.7)	12.9 (95% CI: 9.1; 18.2)	Hanging was the most frequent method and occurred at home; 49.1% occurred in the North, 45.5% in the Midwest, 3.6% in the Northeast, and 1.8% in the Southeast. By state, 41.8% occurred in Amazonas, 43.6% in Mato Grosso do Sul, and 14.5%

								in other states.
Victal, 2019 ⁽²²⁾	Brazil, 2005 to 2014	Cross-sectional	Not cited	935	10.5	Not cited	Not cited	The mortality rate among indigenous people was about twice the national average. The highest number of deaths occurred in Mato Grosso do Sul (42.2%), followed by Amazonas (35%). Among indigenous youth aged 15 to 19, the rate was 8.7 times higher than in the Brazilian population.
Lazzarini, 2018 ⁽²³⁾	Dourados - Mato Grosso, 2003 to 2013	Retrospective cohort	14,666 in 2015	119	73.4	107.5	41.7	The highest suicide rates were observed in villages with the highest proportion of Guarani-Kaiowá (88.1% Guarani-Kaiowá, Terena, and Guarani) and 29.3% Jaguaripu. 23.1% of suicide victims had the same residential address. Most cases (93%) were reported as hanging.
Secretariat of Health Surveillance and Environment, Ministry of Health, 2017 ⁽²⁾	Brazil, 2011 to 2016	Descriptive [□]	Not cited	Not cited	15.2	23.1	7.7	Twice the risk when compared to the white population. 44.8% of suicides occurred among adolescents (10 to 19 years old), eight times higher than that observed among whites and blacks.

Souza, 2017 ⁽²⁴⁾	Roraima, 2009 to 2013	Descriptive	50,453,648 in 2010	29	15	20.3	9.3	Most by hanging (90%) and at home (72.4%). The median age was 24 years, with the maximum age being 41 years.
Orellana, 2015 ⁽²⁵⁾	Mato Grosso do Sul, 2009 to 2011	Ecological	73,471 in 2010	118	65.2 (95% CI: 53.2; 79.5)	Not cited	Not cited	Risk of suicide among indigenous people compared to the non-indigenous population (RR 8.1; 95% CI 7.2-9.0). Risk among men RR 2.4 (95% CI 2.1-2.8). Higher incidence in Dourados, Amambai, and Coronel Sapucaia, inhabited mainly by Guarani-Kaiowá and Guarani-Ñandeva. About 96.6% were by hanging, and 90.4% of cases occurred at home.
Machado, 2015 ⁽²⁶⁾	Brazil, 2000 to 2012	Descriptive	Not cited	Not cited	2000: 8.6 2012: 14.4	Not cited	Not cited	The proportion of deaths among indigenous people was 132% higher than in the general population.
Souza, 2013 ⁽²⁷⁾	Amazonas, 2006 to 2010	Retrospective cohort	184,764	131	18.4	28.2	8.6	The main cause of suicide was hanging (88.5%).
Marín-León L, 2012 ⁽²⁸⁾	Brazil, 2004 to 2010	Ecological descriptive	Not cited	588	São Gabriel da Cachoeira: 32.0 Tabatinga: 24.8	Not cited	Not mentioned	Mostly in the North region, Amazonas (São Gabriel da Cachoeira and Tabatinga) and Roraima, and in the Midwest, Mato Grosso do Sul (Dourados).

Souza, 2012 ⁽²⁹⁾	São Gabriel da Cachoeira, Amazonas, 2000 to 2007	Retrospective and descriptive	76% of 29,947 inhabitants	44	16.8	26.6	6.3	Most deaths occurred by hanging (97.7%).
Ferreira, 2011 ⁽³⁰⁾	Mato Grosso do Sul, 2001 to 2007	Ecological	68,526	127	65.9	92.9	38.6	The two largest contingents were found in the base centers of Amambai (with five indigenous lands) and Dourados (with six indigenous lands) and accounted for 35% of the indigenous population studied.
Santos, 2010 ⁽³¹⁾	Mato Grosso do Sul, 1998 to 2008	Sectional	68,860	408	59.3	Not cited	Not cited	There is no additional information.
Coloma, 2006 ⁽³²⁾	Mato Grosso do Sul, 2000-2005	Action research, longitudinal ^Ω	Per year 2000: 47,414 2001: 49,466 2002: 51,497 2003: 53,325	Total 194 Per year 2000: 45 2001: 41 2002:	86.3	2000: 121.5 2005: 113.2	2000: 63.7 2005: 59.1	In the Guarani population during 2000-2005, it was approximately six times the proportion in Mato Grosso do Sul and 12 times the overall proportion in Brazil in 2004. Causes: 97.4% by hanging, 2.13% by poisoning, and 0.47% by firearm. People under 30 years of age represented 70% of the Guarani population and 85% of suicides. Among people aged 20-29 in 2005, the suicide rate was 159.9 per

				55 2003: 54				100,000 population; among people aged <20, suicide accounted for 28.0% of deaths, and the suicide rate was 90.3 per 100,000 inhabitants.
Erthal, 2001 ⁽³³⁾	Amazonas, 1990 to 1997	Not cited	1993 to 1996: 21,792	55	Not cited	Not cited	Not cited	Tikuna people – Tabatinga.
Morgado, 1991 ⁽³⁴⁾	Location not specified, 1987 to 1991	Not cited	Approximate ly 7,500 indigenous people	52	Not cited	Not cited	Not cited	Guaraní-Kaiwá people

Regarding geographic coverage, 10 studies presented national-level data, 10 presented state-level data, three presented municipal-level data, and one study did not specify a geographic delimitation. Approximately 54.2% of the included studies covered the North and Central-West regions of Brazil.

With respect to study design, descriptive studies were most frequent (n=8), followed by ecological studies (n=6), retrospective cohort studies (n=3), and cross-sectional or sectional studies (n=2). The remaining studies included longitudinal action-research designs, documentary analyses, and epidemiological bulletins produced by health departments or the Ministry of Health.

Study populations ranged from 14,666 to 1,694,836 indigenous individuals, reflecting the diversity of geographic scopes covered. Incidence rates varied markedly, from 0.1 to 111.7 deaths per 100,000 inhabitants. Studies examining temporal trends consistently documented an upward trajectory: the national rate rose from 8.6 per 100,000 in 2000 to 14.4 per 100,000 in 2012, and from 8.53 per 100,000 in 2001 to 22.04 per 100,000 in 2017⁽¹⁷⁾.

Suicide cases were geographically concentrated in the North and Central-West regions, with Mato Grosso do Sul and Amazonas consistently identified as the states with the highest rates. At the municipal level, the highest rates were recorded in Dourados, Amambai, Coronel Sapucaia, Tabatinga, São Gabriel da Cachoeira, Altamira, Jacareacanga, and Portel. In 2023, the Alto Solimões Regional Health Authority alone accounted for 59.5% of all suicide cases registered in the state of Amazonas⁽¹⁸⁾.

Regional temporal trends revealed divergent patterns. In the Central-West, rates declined from 58.8 per 100,000 in 2008 to 29.55 per 100,000 in 2013⁽¹⁷⁾. In Mato Grosso do Sul specifically, rates fluctuated markedly: from 0.99 per 100,000 in 2000, rates surged to 105.03 in 2005, subsequently declining to 47.7 in 2013 and 44.94 in 2014. In contrast, the North region exhibited a progressive increase, rising from 2.77 per 100,000 in 2000 to 35.99 per 100,000 in 2017. A single data point for Roraima (2017) recorded a rate of 44.47 per 100,000 inhabitants (See Supplementary Material 3)⁽¹⁷⁾.

Regarding sex, incidence rates among males ranged from 9.1 to 121.5 per 100,000 inhabitants, while female rates ranged from 5.2 to 63.7 per 100,000 (Table 2 and Supplementary Material 3)⁽¹⁹⁻²¹⁾. It should be noted that approximately 14 of the 24

included studies did not report sex-disaggregated rates, limiting the scope of gender-based comparisons. Among studies that did provide such data, a consistent pattern emerged: indigenous men died by suicide at rates approximately two to three times higher than women. For instance, one study reported male and female coefficients of 92.9 and 38.6 per 100,000, respectively⁽²²⁾. With respect to age distribution, studies consistently identified young people aged 10 to 29 years as the most affected group across both sexes^(19;16;1;22;23;25).

Hanging was the overwhelmingly predominant suicide method across all included studies, with proportions reported as follows: 97.7%⁽²⁹⁾, 96.6%⁽²⁵⁾, 93.0%⁽²³⁾, 90.0%⁽²⁴⁾, 88.5%⁽²⁷⁾, 88.3%⁽¹⁷⁾ and 81.6%⁽⁵⁾. Other methods included self-poisoning (9.2%), firearms (4.4%), and intoxication (2.13%)⁽³²⁾. Most deaths occurred at home, with domestic settings accounting for 90.4%⁽²⁵⁾, 88.5%⁽²⁷⁾ and 72.4%⁽²⁴⁾ of cases in the studies that reported this variable. One study reported that 17.2% of cases were associated with alcohol consumption prior to the suicidal act, and that 17.2% of victims shared a kinship relationship⁽²⁰⁾.

Regarding methodological quality, the majority of included studies were appraised as having high methodological quality. Three studies were classified as moderate quality^(32;33;34). The main limitations identified in these studies included insufficient description of sampling methods, lack of population denominators, and absence of stratified data. Quality assessments did not result in the exclusion of any study, but these limitations were considered in the interpretation of findings (Supplementary Material 2).

DISCUSSION

The findings of this systematic review document a persistent and widening disparity in suicide rates between indigenous peoples and the general Brazilian population. While national suicide rates fluctuated modestly between 5.3 and 5.7 per 100,000 inhabitants from 2011 to 2015, rates among indigenous peoples showed a consistent upward trend, rising from approximately 9.3 deaths per 100,000 in 2000 to 17.6 per 100,000 in 2020. This pattern reflects not merely an epidemiological difference, but a structural condition rooted in historical injustice, territorial dispossession, and the

ongoing failure of public policies to address the specific needs of indigenous communities^(9;17;18; 26).

The multifactorial and complex nature of suicide among indigenous peoples in the Brazilian Amazon has been widely recognized in the literature. Psychological dimensions, such as family conflicts and difficulties in intimate relationships, intersect with social factors, including the introduction of elements of urban consumer culture into villages, geographic isolation, and restricted access to goods and services. Cosmological and spiritual dimensions also play a significant role: beliefs regarding malevolent spiritual forces, which according to indigenous interpretive frameworks may induce self-destructive behavior, are reported in several communities. These dimensions cannot be reduced to biomedical or psychiatric categories; they must be understood within their own cultural logics⁽³⁵⁾.

Understanding this disparity requires going beyond epidemiological description. Suicide among indigenous peoples must be situated within the framework of the social determinants of health and the historical and political conditions that shape the health-disease process in these populations. The rising rates reflect the cumulative effects of epidemiological invisibility, insufficient and culturally inappropriate public policies, and the structural racism embedded in Brazilian state institutions and society⁽⁶⁾. In this sense, self-inflicted death among indigenous peoples should be understood as a collective expression of accumulated vulnerabilities, not as a merely individual, psychological, or biological event, as has been argued by scholars working at the intersection of public health, anthropology, and indigenous studies⁽³⁶⁾.

Comparative evidence from other national contexts corroborates and deepens these findings. A global systematic review examining suicide rates among indigenous peoples across 30 countries and territories found consistently elevated rates compared to non-indigenous populations, with particularly marked disparities documented in Canada, Australia, the United States, and New Zealand - contexts in which colonialism, forced assimilation policies, and land dispossession have been systematically identified as structural determinants of mental health crises among indigenous communities⁽³⁷⁾. The concept of "historical trauma", defined as the cumulative emotional and psychological wounding across generations resulting from massive group trauma, has

been applied across these contexts and offers a productive analytical framework for understanding suicide among Brazilian indigenous peoples as well⁽³⁸⁾.

The temporal variations identified in this review, including upward trends in the North region and fluctuating rates in Mato Grosso do Sul, reflect the influence of historically and territorially specific processes on suicide risk. These findings underscore the inadequacy of homogeneous national-level approaches and point to the need for region- and community-specific surveillance and intervention strategies that account for sociocultural, historical, and territorial determinants⁽¹⁸⁾.

With respect to sex differences, this review confirms a higher incidence of suicide among indigenous men, with male rates exceeding female rates by approximately two- to threefold. This pattern is consistent with findings from international literature on suicide and gender. However, explanations centered solely on behavioral traits associated with masculinity, such as impulsivity or competitiveness, risk oversimplifying a phenomenon that is deeply shaped by structural conditions⁽¹⁸⁾. The progressive disruption of traditional male roles and social functions within indigenous communities, driven by land loss, forced sedentarization, and the erosion of cultural practices, generates profound psychosocial distress that must be recognized as a structural, not merely behavioral, determinant. The increasingly early and harmful use of alcohol among indigenous men has been documented as both a risk factor for suicide and a marker of cultural and social disruption, linked to the erosion of traditional community life and the structural vulnerability produced by territorial dispossession^{(20;}

35; 39-41)

The disproportionately high rates among young people aged 15 to 29, a pattern documented across multiple studies in this review, contrast sharply with the general Brazilian population, where the highest suicide rates are observed among individuals aged 60 years and over⁽¹⁷⁾. This inversion reflects the unique vulnerabilities faced by indigenous youth, who occupy a particularly precarious position at the intersection of multiple adverse forces: territorial dispossession, the dismantling of traditional social structures, limited access to education and the labor market, cultural discontinuity, and the absence of future prospects⁽⁴²⁾. In many Amerindian cosmologies, "living well" is fundamentally tied to territorial belonging and community cohesion⁽⁴¹⁾. When these

foundations are eroded, through land invasions, forced displacements, urban migration, and inadequate infrastructure, young people experience profound psychosocial suffering rooted not in individual pathology but in collective loss⁽⁴³⁾.

The significant variation in suicide rates across ethnic groups, including Panambizinho, Panmbi, Bororo, Sucos, and Ojaguarpi, deserves particular attention⁽²³⁾. This variation should not be interpreted as reflecting inherent cultural differences, but rather as an indicator of differential exposure to structural risk factors: varying degrees of land insecurity, geographic isolation, access to health services, and the intensity of intercultural contact. The epidemiological invisibility of many of these groups, compounded by underreporting and geographic barriers, results in an underestimation of true rates and further hinders the development of tailored public health responses. Food insecurity, structural racism, the lack of intercultural attention in health services, high staff turnover, unstable funding, and deficient epidemiological surveillance systems all function as mutually reinforcing factors that amplify the vulnerability of these communities⁽⁴³⁻⁴⁷⁾.

The near-universal predominance of hanging as the method of suicide across all included studies - reported in proportions ranging from 81.6% to 97.7%. From a public health standpoint, the consistent use of a single highly lethal method with low rescue potential underscores the severity of suicidal intent and the limited effectiveness of means-restriction strategies as applied to this population⁽⁴⁸⁻⁴⁹⁾. From an anthropological perspective, for example, among Guaraní-Kaiowá peoples, hanging (*jejuvy*) is not merely a pragmatic choice but a culturally meaningful act. A form of response to territorial dispossession, interpersonal violence, and the absence of sacred lands (*tekoha*), situating the act within a cosmological framework of resistance and rupture⁽³⁸⁾. Any public health approach that ignores this symbolic dimension risks reproducing the epistemic violence that has historically characterized indigenous health policy in Brazil⁽⁵⁰⁾.

This review has limitations that must be acknowledged. The marked heterogeneity of included studies, in terms of geographic scope, population definition, study design, time periods, and methods for incidence estimation, precluded the conduct of a meta-analysis and limited the direct comparability of findings. The

divergence in incidence calculation methods across studies, combined with the absence of standardized population denominators in several cases, may produce non-comparable estimates. The quality of primary studies, while generally rated as high, revealed important gaps in reporting, particularly regarding sex and age disaggregated data and the specification of denominators used for rate calculation. Critically, the pervasive underreporting of indigenous deaths in Brazilian vital statistics systems, a well-documented phenomenon, means that incidence rates presented in this and other studies likely represent significant underestimates of the true burden of suicide. This underreporting is particularly severe in remote and isolated communities, precisely those that may be most affected. These limitations compromise both the internal and external validity of the synthesized estimates and should be central considerations for future research and surveillance efforts.

Notwithstanding these limitations, this review presents important methodological strengths. The use of a pre-registered protocol, adherence to PRISMA 2020 guidelines, a comprehensive multi-database search strategy encompassing both peer-reviewed and gray literature, independent dual-reviewer selection and extraction processes, and formal JBI quality appraisal all contribute to the rigor, transparency, and reproducibility of the findings. The breadth of the search reduces the risk of publication bias. Epidemiologically, the study provides the most comprehensive available synthesis of suicide incidence among Brazilian indigenous peoples, identifying temporal trajectories, geographic concentrations, and demographic risk profiles that are foundational for planning more equitable and culturally responsive public health strategies.

CONCLUSION

This systematic review confirms that suicide rates among indigenous peoples in Brazil are substantially higher than the national average, disproportionately affecting young men residing in the North and Central-West regions. The evidence synthesized here reveals a consistent pattern of concentration of deaths at home, frequent use of hanging as the predominant method, and documented associations with alcohol

consumption and family clustering — all of which point to a persistent and deeply rooted condition of structural vulnerability.

These findings carry direct implications for public policy and health practice. Surveillance systems must be strengthened with ethnic-specific data collection and reporting protocols to reduce the current levels of underreporting and epidemiological invisibility. Mental health funding must be stabilized and directed toward intercultural, territorialized, and community-based strategies that recognize and respect indigenous knowledge systems and ways of life. These approaches must be co-constructed with indigenous communities themselves, rather than designed and imposed from above. For health professionals working in indigenous territories, continuous training in cultural competencies, long-term community presence, and sustained relationships of trust are essential prerequisites for effective care.

Beyond the health sector, recognizing indigenous suicide as an expression of structural inequality demands broader societal engagement: support for land demarcation processes, active opposition to institutional racism, and unequivocal defense of indigenous rights must be understood as public health imperatives, not merely political demands.

Significant knowledge gaps remain. Many regions and ethnic groups remain absent from surveillance databases, and the existing literature provides insufficient coverage of the social, historical, and symbolic determinants of suicide among specific indigenous peoples. The scarcity of data disaggregated by age, sex, and ethnicity continues to impede in-depth analysis of risk and protective factors. Future research should prioritize qualitative and mixed-methods designs capable of integrating the voices, knowledge, and perspectives of indigenous communities themselves - centering indigenous epistemologies not as objects of study, but as essential sources of understanding for the development of contextually valid and ethically grounded interventions.

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