Suicide prevention: the urgent need in developing countries

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Data on suicide is not available for roughly half the countries (53%) of the world and one third (27%) of the population. Seventy-three percent of suicides in the world occur in developing countries, though data is unavailable for 73% of countries. More than half the suicides (54%) in the world

occur in China and India. Considering that under-reporting of suicide is a major issue in developing countries, the enormity of the problem and the urgent need for suicide prevention is evident.

There are marked differences in suicidal behaviour between developed and developing countries. In developed countries suicide rate is high in the age group of 15 to 24 years and highest in the elderly; the male/female ratio is wider at 3:1 and the divorced/widowed/separated have a higher risk of suicide. In developing countries the highest rate is found in the young (below 30 years), the male/female ratio is narrower (India 1.4:1, China 1:1.3) and the married women are at a higher risk. The methods used in developed countries are firearms, car exhaust and poisoning, whereas in developing countries they are pesticide poisoning, hanging, and self-immolation. Research in developed countries reveals that above 90% of people who die by suicide have mental disorders, while it is only 60–90% in developing countries. Studies from developed countries reveal that over 70% of those who died by suicide had a diagnosable depressive disorder, whereas it was only 35–40% in China and India (1, 2). The crucial and causal role of depression in suicide has limited validity in Asia. Only 7–10% of those who committed suicide had ever seen a mental health professional.

The social stressors associated with suicide are loneliness, rejection, and marital conflicts in developed countries, whereas inter-generational conflicts, love failure, and exam failure are found in developing countries. A highly significant relationship between domestic violence and suicidal ideation in women has been found in many developing nations in population-based studies (3). In Brazil (48%), Egypt (61%), India (64%), Philippines (28%), Indonesia (11%) and Thailand (41%), women who had experienced physical violence by an intimate partner had significant suicidal ideation. Suicide pacts and family suicides are frequent in India, China and Sri Lanka. Women outnumber men in pacts, which are often for social and economic reasons and as a protest against societal norms and expectations. Religious beliefs discourage suicidal behaviour. A study in India found that religiosity was a protective factor, and lack of belief a risk factor for suicide (odds ratio, OR 6.83; confidence interval, CI 2.88–19.69) (4).

José Bertolote emphasizes the need to integrate public health and clinical actions to prevent suicide. This is a necessity in developing countries. South East Asia and Africa, which account for 89% of the world population, have only 0.44 and 0.34 mental health professionals per 100,000 population (5).

The different risk and protective factors and the scarcity of human and economic resources necessitates the development of integrated suicide prevention strategies in developing countries, which function at the individual, family, community and societal level. Specially designed programmes for the women and the young, who are the most vulnerable populations, need to be initiated. Forming alliances with non-governmental organizations, native/faith healers and practitioners of alternate medicine would be necessary. More importantly, suicide prevention programmes need to be locally relevant, culturally appropriate and cost effective.

Suicide prevention in developing countries is more a social and public health objective than a traditional exercise in the mental health sector.

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