

Suicide research and prevention in developing countries in Asia and the Pacific

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Low-income countries in Asia and the Pacific have the highest burden of suicide in the world. These countries are among the poorest globally, and face many social and political challenges.

Suicide trends in these countries differ from those recorded in Europe and North America. For example, compared to high-income countries where suicide among males is predominant, China, India and Pacific island countries report a proportionately higher number of female suicides. There are also noticeable differences in the age distribution of suicide, with young people at greater risk in India and the Pacific islands and elderly people of growing concern in Asia. As in high-income countries, hanging is among the most common suicide methods; however, a large number of suicide deaths throughout Asia and the Pacific also occur through ingestion of toxic substances, such as agricultural pesticides, and inhalation of burning charcoal fumes. These distinctions between risk groups and suicide methods not only indicate the urgent need for suicide research and intervention, but also raise the question of whether the strategies designed for populations in high-income countries are appropriate for developing countries and culturally diverse settings.

Many low-income countries in this part of the world face challenges such as poverty, poor education, rapid industrialization and limited health services. These countries have a high burden of deaths due to both infectious and noncommunicable diseases. As a consequence, there is very limited availability of resources or professionals needed for suicide research and prevention (e.g. doctors, nurses and mental health specialists). Fragmented data on suicide mean that it is often difficult to have a clear understanding of the size of the problem and to identify specific groups "at risk".

Aside from these practical barriers, reporting of suicidal behaviours may be affected by the complex and often

conflicting cultural attitudes towards suicide. Suicide is openly condemned in Muslim countries of the region, a fact related to its explicit prohibition in the *Koran*.¹ Many Asian cultures hold contradictory attitudes towards suicidal behaviour, where it may be condemned in some circumstances and accepted in others.² Women, in particular, are affected by these ambiguous cultural attitudes. Arranged marriages, dowry vindications and unequal rights are some of the most common themes involved in suicidal behaviours of women in India and Muslim countries.^{3,4} Family conflict and powerlessness, combined with the easy availability of pesticides, are at the basis of the particularly high rates of suicide in rural Chinese women,⁵ and constitute a serious public health concern. The fact that suicide is still considered a criminal offence in several countries (e.g. Tonga) may further impact on the willingness of people to seek treatment for suicide, or to report suicide cases to hospitals or the police. Suicide prevention initiatives need to be specifically developed for each area or country and should consider both contextual limitations (e.g. limited funding and human capital, negative cultural attitudes) and strengths (e.g. motivation to reduce suicide, effective community engagement and support).

In establishing a suicide prevention agenda, researchers and health professionals need to draw attention to the issue at the highest governmental level (e.g. ministry of health). It is also crucial to obtain support (both financial and in human resources) from major stakeholders such as government officials and policymakers, coroners, health professionals, community organizations and police departments.

Suicide mortality data is reported regularly to WHO by only India, Sri Lanka and Thailand (WHO South-East Asia Region) and only Australia, China, Hong Kong Special Administrative Region of China, Japan, New Zealand,

the Philippines, the Republic of Korea and Singapore (WHO Western Pacific Region). Information from other (non-reporting) countries and areas is often difficult to obtain and usually must be drawn from a variety of sources. Considering that suicide is more often under-reported than other causes of death due to stigma, cultural issues and legal prohibitions, insufficiencies in official data recording systems pose a serious challenge to the development of targeted suicide prevention activities. However, monitoring systems might not be particularly difficult to establish, and can begin within a specific sample area by recording basic demographic information about suicide attempts and deaths. Initiating a system to capture this information can be facilitated by resources such as the WHO-based partnership, Health Metrics Network.

In 2008, WHO launched the "mental health Gap Action Programme" to address the shortage of mental health professionals by broadening the skills of motivated general health workers under the supervision of experts. This allows suicide prevention interventions to be conducted by people without a psychiatric background, in areas with only basic resources. Interventions for suicide should also integrate existing support networks in the family or community.

The application of research or clinical materials that were designed for high-income countries to lower-income countries in the Pacific region are yet to be evaluated, and may in fact be culturally or socially inappropriate. As an example, the validity of diagnostic criteria such as the International Classification of Disease is questionable in "non-western" contexts, particularly when mental illness takes the form of somatic rather than psychological complaints.⁶ Sensitivity to these differences is necessary to understand suicidal behaviour in diverse social and cultural environments.

Increasing awareness of suicide at the government level as well as public

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education campaigns may help to address stigma, to obtain support for suicide prevention activities and to work towards decriminalizing the behaviour. This clearly requires a long-term approach, involving frequent consultation with local researchers and stakeholders.

Perhaps the best approach to stimulating a suicide prevention agenda in Asia and the Pacific is to concurrently

encourage basic research (e.g. collection of mortality and morbidity data from controlled areas; identification of main risk-factors from consecutive samples of attempters; qualitative studying of suicide victims) and intervention practices (e.g. treatment for “at risk” populations; establishing a national suicide prevention agenda). However, reflecting the diverse range of cultural, social and economic

backgrounds in the area, these strategies need to be innovative, low-cost and sensitive to local traditions and values. Researchers also need to allow appropriate time for piloting and evaluating these initiatives, so as to create an empirically reviewed basis from which to establish suicide prevention strategies. ■

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Corrigendum

In volume 88, Number 9, September 2010, p. 709, the affiliation for Edward J O'Rourke should have read:

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