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COMMENTARY

The Trends of Suicidality Over the Past 10 Years (1999–2022) in the Ethiopian General Population and the Way Forward in Tackling It

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Abstract: Suicide is defined as a death caused by willful acts of taking one's own life. It might be a way for people to get away from suffering or anguish. Globally, an estimated a million people individuals lose their life due to suicide annually. Before the age of 50 years old more than half (58%) of all suicide deaths occur. This commentary aims to highlight the Ethiopian context, feasible preventive measures, and the way forward in tackling suicidal behavior. Worldwide in adolescent age groups between the ages of 15 and 29, suicide is the fourth leading cause of death. Even though suicide occurs everywhere in the world, according to data in 2019, 77% of all suicides that occurred in the world reside in developing countries. Due to the numerous psychosocial pressures present in Ethiopia, one in four citizens suffers from a mental disorder. According to Ethiopian national data figures, suicide ideation affects 9%, 5–16% of people, whereas suicidal attempt affects 4%, 1–8%. Even though, there is a variation of prevalence over the years based on the variation in design, settings, and sample size. There is an increment in the prevalence's suicidal ideation and attempts in the past 10 years. The country's Ministry of Health needs to act to address and prevent this urgent public health situation. The prevention of suicide should be a top concern, and working with numerous stakeholders is an efficient and practical approach.

Keywords: suicide, Ethiopia, prevention, public health emergency

Introduction

Suicide is described as a death brought by self-inflicted harm and is intended to bring about one's own death. Suicidal ideation is when someone considers, mulls over, or plans to taking their own life.[1] Suicide attempt is a potentially harmful, self-directed behavior that is done to end one's life. Every year, around a million people lose their life because of suicide out of these 86% of those deaths occur in developing countries.[2] Suicide is higher in the young age below 25 and it is the top three causes of death in these age groups. Women in 1-year post-delivery time suicide accounts for 10–20% of deaths.[3] Other factors COVID-19 pandemic showed a rapid increment in suicidal behaviors. A study done on suicidal ideation and suicidal thinking in the era of COVID-19 among university students showed the pooled average prevalence of suicidal ideation and thoughts was 17.8%. The review illustrated an increment in suicidal behaviors during the COVID-19 pandemic.[4]

Suicide occurs when the psychache is unbearable to the individual. The occurrence of suicide can be influenced by individual thresholds for enduring psychological pain.[5] Psychache and physical pain tolerance have been identified as risk factors for suicide.[5] Individuals with repeated exposure to psychological pain or fear-inducing and physically painful life events will develop fearlessness and pain insensitivity referred to as acquired capability to enhance lethal and nonlethal suicidal behaviors.[6] Previous evidence suggests the risk of suicide become high psychache becomes unbearable, tolerance decline.[7]

According to the world health organization's mental health gap action program (MH-GAP), suicide is one the important health-related issue that fosters urgent action. The guideline recommends strategies for data recording, early

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screening of mental illness and giving emphasis to special populations (children, elderly, and women), and limiting access to suicide methods.[8] It is a significant public health issue that can have a long-lasting impact on families, and communities. Most persons who suffer from mental illness do not take their own lives. Yet, more than 90% of people who took their own life have battled a mental illness in the past.[9] Suicidal behavior does not necessarily result from mental disease alone. Suicidal thoughts and actions may arise from the distress brought on by a mental condition combined with extreme living circumstances. This commentary aims to highlight the Ethiopian context, feasible preventive measures, and a way forward in tackling suicidal behavior.

Ethiopian Context on Trends of Suicidal Behavior

In Ethiopia, the prevalence of common mental disorders is 7.93%, while the percentage of years spent with a mental illness-related disability is 10.99%.[10] Mental diseases are not regarded as life-threatening conditions in low-income countries like Ethiopia. In Ethiopia, despite several contradictory different studies on the total lifetime suicidal thoughts (1% to 55%), attempted suicide (0.6% to 14%), and suicide as a cause of death (7.2 to 8.4 per 100,000). Limited attention is given to suicide when compared to other nationwide causes of death like highly contagious mortalities.[11] Furthermore, the lack of readily available healthcare facilities, a skilled workforce, and guilt, transgressive, and social criticism of those who engage in suicidal behavior can delay mental health care. The Ethiopian's pathway to mental health care is late and most use traditional methods to treat mental illness.[12] In addition to this, there were 150 psychiatrists in the country serving about 115 million.[13] There is still a lot of need to be done by policymakers and treatment providers to improve these limitations. An epidemiological study of suicidal behavior is necessary to create culturally specific suicide therapies. According to national data figures, suicide ideation affects 9%, 5–16% of people, whereas suicidal attempt affects 4%, 1%-8%.[14] Even though, there is a variation of prevalence over the years based on the variation in design, settings, and sample size. There is an increment in the prevalence's suicidal behaviors in the past 10 years, as shown in Figure 1 and Table 1. To support efforts to promote the population's mental health and fulfill the needs of Ethiopians with mental, neurological, substance use (MNS), and psychosocial disorders, the Ministry of Health (MoH) has developed the National Mental Health Plan 2020–2025, its second strategic plan.[15] For every 100 million Ethiopians, there were 150 trained psychiatrists, 2461 psychiatric nurses, 274 psychologists, and three social workers, according to a 2019–2022 research by the National Mental Health Plan (of Ethiopia).[13]

It's a positive idea that suicide can be prevented. Every level of society needs to have strategies in place to prevent suicide.[25] This covers protection and proactive measures for people, families, and communities. By being aware of the

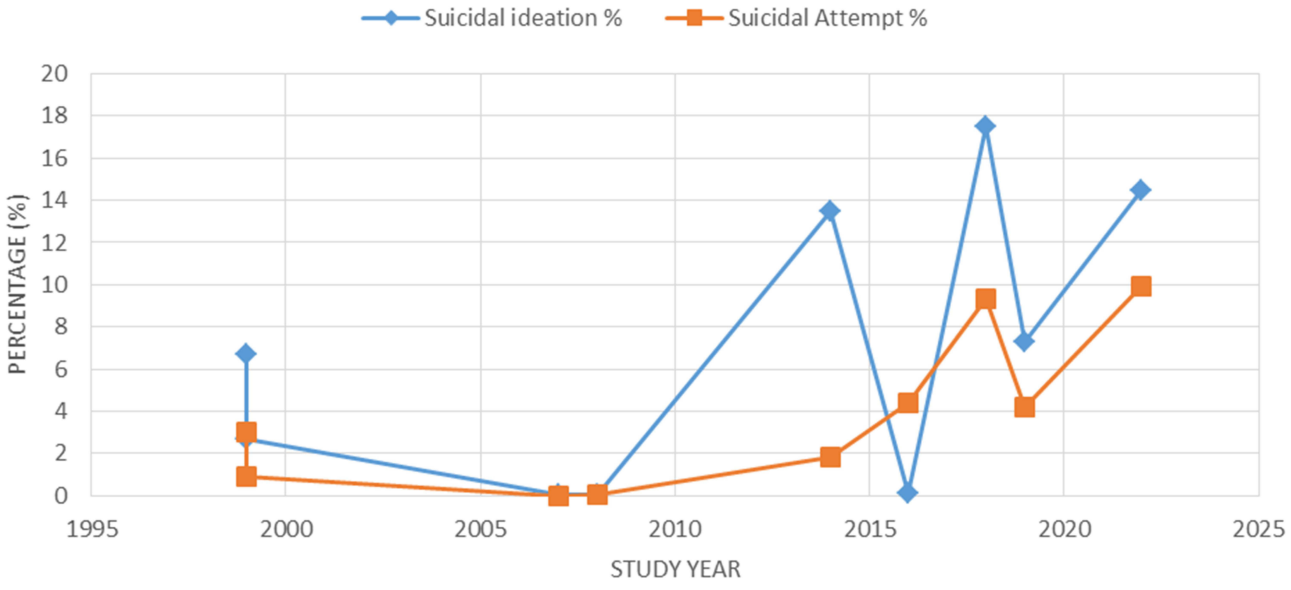

Figure 1 A 10-year trend (1999–2022) of suicidal behavior in Ethiopia.

Table 1 Summary of Studies Illustrating 10 Year Trends (1999–2022) of Suicidal Behavior in Ethiopia

Authors	Year of Publication	Sample	Male	Female	Mean Age (SD) in Years	Suicidal Ideation %	Suicidal Attempt %
Alem A, et al[16]	1999	10,468	(42%)4396.5	58%(6071.4)	28.9(7.8)	6.7	3
Kebede D, et al[17]	1999	10,203	(45.1%)4601.5	54.9%(5601.4)	22.7(6.8)	2.7	0.9
Fekadu A, et al[18]	2007	68,378	42.5%(29,050)	57.5%(39,317)	27.7(9.1)	0.003	0.01
Fekadu A, et al[19]	2008	1714	54.6%(913)	(45.4%)936	33.6(6.1)	0.06	0.02
Fekadu A, et al[20]	2014	1497	49.6% (743)	50.4%(754.4)	37.7(13.5)	13.5	1.8
Fekadu A, et al[21]	2016	2499	45.7%(1142)	54.3%(1356)	39.7(12.4)	7.9	4.4
Jordans M, et al[22]	2018	2503	49.4%(1236)	50.6%(1267)	37.45 (15.4)	17.5	9.3
Nyundo A, et al[23]	2019	2010	51.2%(1029)	48.8% (980.8)	13.7 (2.65)	7.3	4.2
Melkam M, et al[24]	2022	372	73.7% (274)	25.8%(96)	20.5±2.6	14.5	9.9

warning signs, encouraging prevention and resilience, and being committed to societal change, everyone may help prevent suicide. Three levels of interventions are suggested in the general suicide prevention action plan: universal suicide prevention strategies, intended to reach every member of the population; selected suicide prevention strategies, which focus on vulnerable members of the population; and indicated suicide prevention strategies, which are intended to help people who have engaged in non-fatal suicidal behavior or who are left behind.[26] The following universal strategies are employed: encouraging ethical media coverage of suicide; religious and cultural practices; school-based parenting education and awareness programs, guidance counselors, etc.; mental health services provided through training of the health workforce, the infrastructure of hospitals and psychiatric wards, etc.; and pesticide means restriction.[27] Selective techniques include programs for disadvantaged women and children, drop-in centers, outreach centers, rehabilitation services, community resilience, and support initiatives, and counseling services like those provided by peer, health, and social counselors. The respective strategies are recommended: access to care and services for people who are more likely to taking their own life, such as crisis hotlines, health information services, etc.; survivor rehabilitation services, which include lowering the risk of further suicidal behavior and preventing suicide contagion by identifying other family members who are at high risk.[28] Health professionals need to perform a comprehensive assessment of suicide risk and involve the family in the therapeutic process. In compressive suicide risk assessment using formal risk assessment instruments. Suicide prevention is one of the cost-efficient interventions. Early detailed evaluation of potentially suicidal patients by a physician should be acquainted with the assessment of ten major risk factors (sex, age, depression, previous attempt, ethanol abuse, rational thinking loss. And Social supports lacking) as described in SAD PERSONS scale. This scale has a positive influence on performance in evaluating suicidal patients and early prevention.[5] SAD PERSONS scale is scored from 10; scores of 3–4 should be closely monitored, scores of 5 and 6 hospitalizations should be strongly considered and patients with scores of 7–10 should be hospitalized for further assessment.[6] In addition, involving multidisciplinary teams in mental health care can be beneficial.[29]

The Way Forward in Tackling Suicidal Behavior

Although suicide has a complex nature, it is unrealistic to expect doctors alone to prevent suicide. But doctors can perform a critical role in preventing suicide or reducing the impact of suicide on families. Multi-faceted approaches to address all the potential risk factors are required.[30] Policy interventions, such as controlling the means of suicide and other risk factors, should be top of the list of any preventive approach. Every clinician must be aware of assessing suicide risk. It is important to understand that deliberately seeking to harm oneself is not healthy behavior, even though it is normal for doctors to feel upset by patients who appear to be wasting their time away from "real" responsibilities.[31] Any expression of hopelessness or

suicide thoughts should be taken seriously, and intervention should be planned. These could be family members, priests, or traditional healers in Ethiopia and other impoverished nations. The person who is expressing hopelessness may be convinced that they are deserving of respect as people and that life is worthwhile if they are given a compassionate approach, good rapport, and attentive listening.[32] Most patients are relieved when their loved ones learn of their suicidal thoughts. Approximately 90% of people who take their own life have a co-morbid mental illness. All medical professionals should be capable of treating a suicidal attempt victim in an emergency.[33] When a loved one commits suicide, the survivors experience a range of emotions, including sadness, remorse, humiliation, anger, perplexity, and terror. They might start a torturous quest for a purpose. The grieving process could be difficult. It's critical to comprehend these feelings, to be kind, and to offer assistance.[34] All medical practitioners should pay close attention to trends that go beyond information at the individual level and carefully observe, note, and gather data on them. All physicians are clinical scientists with the potential to have a big impact on the policy if they take their duties as practitioners of applied research seriously.[35] There is limited data available about suicide in Ethiopia, including typical causes, accessibility to resources, options for therapy, regions with a greater mortality rate, and the work that has to be carried out on a nationwide scale.[36] "Creating hope through action" is set to be World Suicide Prevention Day's three-year focus from 2021 to 2023. By encouraging that there are plenty of solutions to suicide, this concept aims to foster hope and optimism in every one of us.[37] This can be shown via our acts of kindness that there is hope for individuals that are considering suicide as well as that we care about them and desire to be the source of assistance to them. It also suggests that our efforts, no matter how large or small, might provide individuals who have difficulty with hope.[38] Last, but not least, it highlights how important it is for governments to make prevention of suicide an immediate concern for the health of the public, particularly in circumstances where access to mental health services and access to scientifically proven solutions has become inadequate.[39] By developing the subject and spreading the message throughout a three-year period, it is feasible to envision a world where suicides are less likely. We can all aid those who are in a suicidal crisis or who have lost a loved one to suicide as members of society, whether we be children, parents, friends, employees, or someone with lived experience.[40]

Conclusion

Suicide is a global health concern that can be prevented. A key role in the preventative process can be played by healthcare professionals. Every clinician should be capable of performing basic skills in assessing suicide risk, managing suicide attempts, and providing support for policy contributions. In doing so, healthcare professionals should understand self-compassion and self-care. We can all raise awareness of the issue, provide assistance to those in need, and share our personal stories. There is a need for all to share hope and light with our deeds.

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Author Contributions

All authors made a significant contribution to the work reported. Both authors were involved in the conception, study design, execution, acquisition of data, analysis, and interpretation, took part in drafting, and critically reviewing the article; gave final approval of the version to be published, have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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