SITUATION REPORT ON SUICIDE IN NIGERIA

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ABSTRACT

The World Health Organization (WHO) constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In time past, much attention was placed on physical well-being at the detriment of other components of health especially mental health. However, evidence of the association between mental illness and chronic medical conditions, as well as the impact mental health has on public health is leading to changes. The prevalence and increasing incidences of non-communicable diseases in low-and- middle income countries such as Nigeria, confers a state of double disease burden with existing prevalent infectious diseases. In Africa, Nigeria has the 13th highest suicide mortality rate of 9.5 per 100,000 above the Regional (African) average of 7.4. The paucity of structured, state-specific, region-specific and national-specific data are areas that clearly need to be improved upon. It is however clear that the rise in suicide rate in Nigeria from 6.5 per 100,000 people in 2012 to 9.9 in 2015 makes it a serious public health concern of national imperative

1. INTRODUCTION

The World Health Organization (WHO) constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". By implication, mental health transcends the absence of mental disorders or disabilities (World Health Organization, 2018a). Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community. It is related to the promotion of overall health, the prevention of disease, and the treatment and rehabilitation of people negatively affected by illness (World Health Organization, 2017a).

In time past, much attention was placed on physical well-being at the detriment of other components of health especially mental health, however evidence of the association between mental illness and chronic medical conditions, as well as the impact mental health has on public health is leading to changes. Mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease and diabetes (World Health Organization, 2018b). . Today, the prevention of suicide and other mental health related issues have become a global imperative owing to the increase in rates of suicide, depression and other mental health disorders, which constitute non-

communicable diseases (NCDs). Indeed, NCDs, including mental health conditions are responsible for 71% of deaths worldwide, with the poorer people being disproportionately affected (World Health Organization n.d). Mental and neurological disorders (MNDs) – including depression, anxiety disorders, bipolar disorder, schizophrenia and dementia can be a precursor to or a consequence of NCDs. They share many of the same determinants and consequences, and frequently occur in the same person. Both MNDs and NCDs are risk factors for suicide (World Health Organization n.d).

Around 20% of the world's children and adolescents have mental disorders or problems (World Health Organization, 2018b). Over 800, 000 people die due to suicide every year, with suicide known to be the second leading cause of death in 15-29 years old. There are indications that for each adult who died of suicide, there may have been more than 20 others attempting suicide. These statistics notwithstanding, suicide is preventable. Mental disorders and harmful use of alcohol contribute to many suicides around the world (World Health Organization, 2018b). Notable mental conditions include depression, developmental disorders, dementia, behavioural disorders, drug use disorders, psychosis, epilepsy/seizures and bi-polar disorders (World Health Organization, 2010).

2. Suicide in Nigeria

Nigeria is the most populous country in Africa with numerous cultural, economic and social diversities, and their attendant challenges. With a population of about 190 million people, the increasing health care demands and weak health systems, along with inadequacies in social determinants of health, are some of the challenges faced by the population. The prevalence and increasing incidences of non-communicable diseases in low-and- middle income countries such as Nigeria, confers a state of double disease burden with existing prevalent infectious diseases.

Suicide has been defined in various ways. It is the act of deliberately killing oneself (World Health Organization, n.d) or a fatal self-injurious act with some evidence of intent to die (Bilsen¸ 2018). It could also be defined as intentional self-inflicted death (Masango et al., 2008). The scourge of suicide has assumed grave dimensions globally and nationally, where 75% of suicides occur in low-and-middle income countries, such as Nigeria where resources and services are often scarce and limited for early identification, treatment and support of people in need World Health Organization, 2014).

2.1 Suicide Rates

In Africa, Nigeria has the 13th highest suicide mortality rate of 9.5 per 100,000 above the Regional (African) average of 7.4 (World Health Organization, 2018c).. Males have a higher suicide rate of 9.9 per 100,000 population while females have a rate of 9.2 per 100,000 population. As at 2012, there were 7,238 reported suicides in the country – 5,653 males and 1,584 females – with the likelihood that the figures are under-reported (World Health Organization, 2019a). Figure 1 below shows the suicide mortality rates from 2000 to 2016. Suicide rates have fluctuated between 10.2 per 100,000 population in the year 2000 and 9.5 per 100,000 population in 2016.

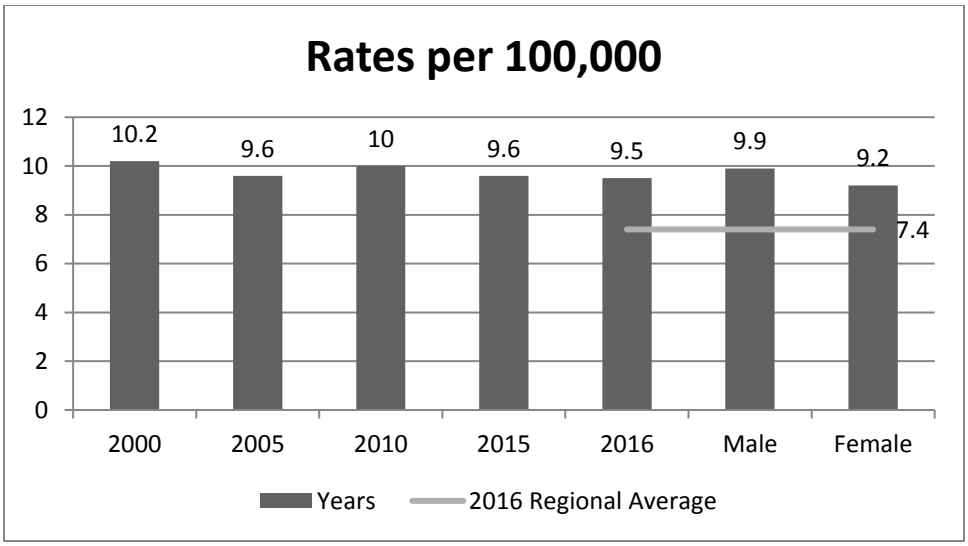

Figure 1: Suicide Mortality Rates
Source: World Health Organization Data (Global Health Observatory Data)

2.2 Risk Factors

Despite being recognized by the World Health Organization as a significant social and health concern, information on suicidal behaviours in Nigeria is limited. Some identified risk factors for suicide include depression, job or financial loss, hopelessness, harmful use of alcohol and other substances, chronic pain and illness, family history of suicide and genetic/biological factors[8] (World Health Organization, 2014). In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behaviour. By far, the strongest risk factor for suicide is a previous suicide attempt (World Health Organization, 2019a; Blasco-Fontecilla et al; 2019).

2.2.1 Depression

Depression, as defined by the WHO, is a common mental disorder, characterized by persistent sadness and a loss of interest in activities that are normally enjoyed, accompanied by an inability to carry out daily activities, for at least two weeks (World Health Organization, 2019a). It is a common mental disorder that affects more than 300 million people globally and can lead to suicide at its worst (World Health Organization, 2019a). Depression is the leading cause of illness and disability worldwide, affecting more women than men (World Health Organization, 2019a; World Health Organization, 2019b). Energy loss, appetite change, sleep deprivation/hypersomnia, anxiety, reduced concentration, indecisiveness, restlessness, feelings of worthlessness, guilt, hopelessness and thoughts of self-harm or suicide are characteristic of people with depression (World Health Organization, 2019a). On average, 22% of Nigerians - 74% who are household heads, 27% who are female - have depressive symptoms (The Mind, Behaviour, and Development Unit, 2018).

Depression in the Young

Worldwide, it is estimated that 10%-20% of adolescents experience mental health conditions, yet these remain underdiagnosed and undertreated (World Health Organization, 2019, October 23c). A study on depression among students of Ahmadu Bello University (ABU), Zaria revealed that 58.2% suffered from depression, with 37.0%, 15.7%, 3.9%, and 1.6%

showing mild, moderate, moderately severe, and severe depression respectively (Abdulrazaq & Dabana, 2018). In another study conducted among adolescents attending secondary schools in Enugu and Ebonyi states in South East Nigeria, adolescents exhibited different levels of depression with a female preponderance where prevalence of moderate depression was highest at the age of 13 while prevalence of severe depression was highest at the age of 12. A study identified factors associated with depressive symptoms in 13-18 years old attending senior secondary schools as parental depressive symptoms, adolescents' perception of family functioning as poor, adolescents' problems with peers, adolescents' low self-esteem, adolescents' drinking, female gender, and large family size (Adewuya & Ologun, 2006).

Depression in the Old

Achievements in healthcare have contributed to changes in national demographic structures, with a positive impact on population aging. Older persons are those considered 60 years or older (United Nations¸ 2013). About 15% of adults aged 60 and above suffer from mental disorders and global population of older persons is projected to increase from 12% in 2015 to 22% in 2050 (World Health Organization, 2017b).

Nigeria's older population was estimated at 9,622,056 (2016) (National Bureau of Statistics, Nigeria, 2017). accounting for about 5% of the total population. A cross sectional survey of older adults conducted in Uyo revealed that 45.5% of the adults had depression (Akosile, C.O et al., 2018). Depression is underdiagnosed in primary care settings and symptoms are often overlooked and untreated among older adults (World Health Organization, 2017b), sometimes related to difficulties in carrying out normal ever day function[6] (World Health Organization, 2010)

Partum and post-partum depression

Studies have shown the existence of depression during and after pregnancy (World Health Organization, 2017b; Aminu et al., 2016; Aina et al., 2015 & Bzeala-Adikaibe et al., 2012). Up to 1 in 5 women who give birth experience post-partum depression. A significant proportion of new mothers have postnatal depression which may negatively affect their parenting skills and have adverse effects on them and their children (Aminu et al., 2016)

2.2.2 Other co-existing health conditions

Existing health conditions such as epilepsy, asthma and HIV/AIDS have been found to increase the risk for suicidal ideation and depression. A study showed that there was a modest frequency of suicidal ideation among patients with asthma. Persons with suicidal ideation were more symptomatic for depression and most had poor asthma control, highlighting the need for increased recognition and treatment of co-morbid psychiatric illness among asthma patients (Aina et al., 2015). Another study highlighted the need to regularly assess for and manage epilepsy-related depression in this population (Bzeala-Adikaibe et al., 2012).

2.2.3 Conflict and terrorism

The psychological consequences of Boko Haram-affected children in Nigeria are largely unknown. It is recognized that children who are exposed to ongoing violence in Nigeria may suffer severe cognitive dysfunction, depression, panic disorder, generalized anxiety disorder, and psychiatric illnesses (Djalovsk et al., 2016) Studies have shown that an estimated 3.7 million children exposed to Boko Haram insurgency had mental health needs that are unmet (Hawke, 2015) The failure to update the Mental Health Act to cater

to the mental health need of children exposed to terrorism is a gap that continues to put Nigerian children into high risk of permanent psychological health illnesses (Adepelumi¸ 2018). The bill was not passed even after its introduction to the National Assembly in 2003 and re-introduction in 2013.

2.3 Methods of Suicide

It is estimated that around 20% of global suicides are due to pesticide self-poisoning. (World Health Organization, 2019a). Indeed, in the last 2 – 3 years, the use of a pesticide called Sniper has been one of the most common methods of suicide in Nigeria. Other common methods of suicide are hanging and drowning. A study revealed that the choice of how to die often depends on the most available and most convenient means at hand. Women chose less violent means of suicide such as drowning or poisoning, while males often chose violent methods such as hanging or firearm (Offiah & Obiorah, 2014).

The paucity of structured, state-specific, region-specific and national-specific data are areas that clearly need to be improved upon. It is however clear that the rise in suicide rate in Nigeria from 6.5 per 100,000 people in 2012 to 9.9 in 2015 makes it a serious public health concern of national imperative.

Emerging Issues

The emerging issues (World Health Organization, 2017c) that may impact the rates of suicide in Nigeria, directly or indirectly, are described below.

Mental Health System Governance

Suicide is currently treated as a criminal offense within the Nigerian law. Attempting suicide is a criminal offense in Nigeria under Section 327 of the Criminal Code Act, and it carries a penalty of up to one year in prison (Constitution of Nigeria, 2019). Lagos State has amended its laws to review the punishment for attempted suicide from imprisonment to hospitalization stating that, “Any person who attempts to kill himself is guilty of a simple offense and the court shall make a hospitalization order," reads Section 235 of the Criminal Law of Lagos”.

There is a stand-alone policy for mental health (National Policy for Mental Health Services Delivery, 2013). It however does not contain specified indicators or targets against which its implementation can be monitored.

- No designated desk for mental health within the department of public health in the national and state ministries of health.
- There is no plan or strategy for child and/or adolescent mental health.
- There is no dedicated authority or independent body to assess compliance of mental health legislation with international human rights.

There is no known ongoing collaboration in the area of mental health with service users and family or caregiver advocacy groups.

Access to Mental Health Services

- The care and treatment of persons with major mental disorders is not included in the national health insurance schemes (NHIS) secondary and tertiary care levels, and at primary care level only states, “Psychosomatic illnesses, Insomnia, Other illnesses may be listed from time to time by NHIS”- NHIS Operational guidelines, Primary care level, Section 1.1.3.1.
- Persons with mental disorders pay mostly or entirely out of pocket for services and medicines.

- The human resources for health is in crisis situation due to the shortage of skilled manpower; regular attrition due to brain drain; and distribution and skill mix in the healthcare work force. As such, there is also a paucity of human resources for mental health.

Mental Health Service Availability

- There are few community-based/non-hospital mental health outpatient facilities, operated by NGOs.
- There are few outpatient facilities specifically for children and adolescents, and these exist within large teaching hospital environment.
- Available interventions are mostly clinical with little done to intervene in mental health conditions from a public health standpoint.

Mental Health Promotion and Prevention

- There are presently no specific programmes being implemented for mental health as a national priority.
- Absence of a suicide prevention strategy (i.e., as a standalone document or as an integrated element of the national policy/plan adopted by government).

Gaps in Data and Research

- Absence of national specific data on suicide and depression based on scientific research.
- There is paucity of intervention-based research from the public health angle; most researches are clinical-based or descriptive.

Inadequate Funding

- There is inadequate funding for mental health services, research and community–based intervention

Lack of up-to-date Mental Health Legislation

- There is a lack of a mental health law applicable to modern times, that will protect the mentally ill and their professional caregivers and decriminalize suicide among other things, even though professional associations have made presentations for a bill to the recent past legislative chambers. In the current National Assembly, some progress has been made and a bill has passed second hearing at present.

4.0 Recommendations

Mental Health System Governance

- Expedite passage of the mental health bill into las in order to provide mental health legislation that meets international standards.
- Establishment of self-help groups and support will help in providing supportive, enabling legal and human rights focus environment for mental health, specifically suicide.

Resources for Mental Health

- Advocacies for inclusion of mental health services in health insurance schemes, implementation of task-sharing policies and training of health workers in the assessment and management of mental health will help in building capacities to provide mental health services at all levels.

Mental Health Service Availability and Uptake

- The addition of mental health services as part of Basic Heath Care Provision Fund (BHCPF) should be advocated for and Community Health Workers should be trained to provide mental health services.
- The use of digital platforms such as suicide prevention apps should be leverage upon to promote mental health awareness and management.

Mental Health Promotion and Prevention

- Simple screening of general and high-risk population should be promoted at various points of care e.g. ANC, and outreach services. Deliberate awareness creation and exercises should be undertaken.

Gaps in Data and Research

- Existing surveillance systems should be strengthened and established where they are non-existent.
- For effective data management, facility and district level Monitoring and Evaluation officers should be trained on data management.

Inadequate Funding

- Advocacies to the government should be undertaken to include funds for mental health in the country's yearly budget.
- Building capacities of Civil Society Organizations, Community-based Organizations and local Non-governmental Organizations on grant proposal writing, grant seeking and fund raising would help in ensuring that more funds are available for implementation of mental health interventions.

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ABOUT SUICIDE RESEARCH AND PREVENTION INITIATIVE OF NIGERIA (SURPIN)

Profile

Suicide Research and Prevention Initiative of Nigeria (SURPIN) is an initiative originating from the Lagos University Teaching hospital, established for the purpose of:

- Suicide prevention through research
- Crisis intervention
- Health education
- Early treatment depression & drug abuse

Our vision is to be the reputable, reference central body coordinating and maintaining global, best practices in suicide research and prevention activities in Nigeria, ultimately to reduce the rate of suicide.

Our mission is to reduce the risk of suicide arising from mental health and chronic general medical conditions, through ingenious community-based approaches, cost-effective crisis intervention, improved suicide record-keeping, and high-quality suicide-related research and education in Nigeria.

Our goals of SURPIN are to:

- Reduce risk in key high-risk groups
- Promote mental well-being in the wider population
- Reduce the availability and lethality of suicide methods
- Improve the reporting of suicidal behavior in the media
- Promote research on suicide and suicide prevention
- Improve monitoring of progress through campaigns

SURPIN has provided some mental health support to the population of Nigeria. From March 2017 to December l2019, a total of 215 phone calls were logged at SURPIN call centres. Out of 215 calls, the highest callers were from Lagos State (69.8%) followed by in FCT (2.8%) and Rivers State (2.8%) while there was only 1 (1.2%) call from outside Nigeria. Out of the 215 callers, 113 (52.6%) were crisis related, 37 (17.2%) called to verify authenticity of SURPIN's intervention, 36 (16.7%) called to seek enquiry about mental health service, 31(13.5%) called for other reasons including help for drug abuse while 3 (1.4%) of the callers were reported to decline further help.

Structure

SURPIN has presence in 28 states of the federation and in 43 centres/ institutions. In moving forward SURPIN plans to achieve its aims and objectives through its various components listed in Table 1 below:

Table 1: Theory of Change through SURPIN structure

S/N	SURPIN Components	Components of Theory of Change
1	Grant Seeking Committee	Inadequate Funding
2	Media Reporting Committee	Mental Health Promotion and Prevention
3	Primary Health Care (PHC) Involvement Committee	Mental Health Promotion and Prevention
4	Suicide Register Committee	Gaps in Data and Research
5	Research Committee	Gaps in Data and Research
6	Medico-religious Collaboration Committee	Mental Health System Governance Mental Health Promotion and Prevention
7	School Mental Health (Primary and Secondary Schools) Committee	Mental Health Promotion and Prevention
8	School Mental Health (Tertiary Institutions) Committee	Mental Health Promotion and Prevention
9	Publicity and Social Media Committee	Mental Health Promotion and Prevention
10	Government Relations, Partnerships and Advocacy Committee	Mental Health System Governance Resources for Mental Health Mental Health Service Availability and Uptake
11	Special Projects Committee	Mental Health Service Availability and Uptake
12	Monitoring and Evaluation Committee	Gaps in Data and Research