Meeting on Suicide Prevention in the Western Pacific Region

Manila, Philippines
15-19 August 2005

World Health Organization
Western Pacific Region
REPORT

MEETING ON SUICIDE PREVENTION
IN THE WESTERN PACIFIC REGION

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NOTE

The views expressed in this report are those of the participants in the Meeting on Suicide Prevention in the Western Pacific Region and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Meeting on Suicide Prevention in the Western Pacific Region, which was held in Manila, Philippines from 15 to 19 August 2005.
SUMMARY

The Meeting on Suicide Prevention in the Western Pacific Region was held from 15 to 19 August 2005 in Manila, Philippines. Participants from 22 countries and areas attended the meeting.

The objectives of the meeting were:

(1) to present updated suicide statistics and to discuss quality data management;

(2) to share knowledge and experiences in development, implementation, and evaluation of national suicide prevention strategies; and

(3) to identify priority actions required at country and regional levels in the WHO Western Pacific Region.

Mental health and suicide are major public health concerns in the Western Pacific Region. In 2002, approximately 331 000 people committed suicide in the Region, comprising 38% of the world suicides. Although the magnitude of the suicide problem in the Region is acknowledged, little is known about the specific situation in most of the low- and middle-income countries. The report from participants clearly demonstrated the diversity in the delivery of suicide prevention services in the Region. Some have well-developed suicide prevention programmes, while others struggle with the organization of their basic mental health programme.

With recognition of the broad differences in the characteristics and capabilities of various countries in the Region, the group made its recommendations to Member States and WHO Secretariat in the following areas:

(1) strengthening the morbidity and mortality data surveillance system for suicide;

(2) initiating and expanding suicide prevention activities; and

(3) developing mechanisms for Member States to cooperate and share technical expertise, human resources, and lessons from their experiences with suicide prevention.
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### Key words

- Suicide - prevention and control / Western Pacific
1. INTRODUCTION

In 2002, the estimated number of deaths due to self-inflicted injuries (873 000) exceeded the number of deaths by homicide (559 000) and war (172 000) combined.\footnote{World Health Report 2004: Changing History. Geneva, World Health Organization, 2004.} Of the total number of suicides, 331 000 (37.9\%) were in the Western Pacific Region. Based on WHO estimates, the crude suicide rate for the Region was 19.3 deaths per 100 000 persons, compared with a global estimate of 14.0 per 100 000.\footnote{Ibid.} Suicide is currently among the top 10 causes of death and is increasing in numbers and rates in some countries and areas of the Western Pacific Region.

Suicide contributes 1.4\% of the global burden of disease, and 2.5\% of the burden of disease in the Region. Moreover, there are estimated to be 10 to 20 times more suicide attempts than deaths, resulting in injury, hospitalization, and emotional and mental trauma, although no reliable data is available to better depict this figure.

Suicide is a tragic global public health problem with a number of underlying causes. These causes include: a lack of connectedness, loss of loved ones, breakdown in relationships, poverty, unemployment, and legal or work-related problems. A family history of suicide, as well as alcohol and drug abuse, childhood abuse, social isolation and some mental disorders including depression and schizophrenia, also play an important role in a large number of suicides. Physical illness and disabling pain can also increase suicide risk.

Protective factors include high self-esteem and social connectedness (especially with family and friends), being in a stable relationship, and religious or spiritual commitment. Early identification and appropriate treatment of mental disorders are important preventive strategies. Psychosocial interventions, suicide prevention centres and school-based prevention programmes are also promising strategies.

This meeting was proposed to address the high burden of suicide and suicidal behaviour in the Region and to bring about action.

1.1 Objectives

(1) To present updated suicide statistics and discuss quality data management.

(2) To share knowledge and experiences in development, implementation, and evaluation of national suicide prevention strategies.

(3) To identify priority actions required at country and regional levels in the WHO Western Pacific Region.

1.2 Opening remarks

Dr Shigeru Omi, Regional Director of the World Health Organization (WHO) in the Western Pacific Region, welcomed psychiatrists, public health officers,
programme managers, nurses, and counsellors from 22 countries and areas (see Annex 1). In his opening speech, Dr Omi highlighted the fact that suicide is a huge but highly preventable public health problem (see Annex 2). Dr Omi encouraged everyone to actively share their country’s suicide situation and discuss preventive strategies that can be undertaken in the Region. He also announced that WHO remains committed to supporting efforts that develop and promote suicide prevention and intervention programmes.

1.3 Appointment of Chairperson, Vice-Chairperson and Rapporteur

After the participants introduced themselves, the Regional Director proposed the following delegates as Chairperson, Vice-Chairperson and Rapporteur, respectively: Professor Helen Fung-Kum Chiu (Hong Kong [China]), Dr John Wren (New Zealand) and Dr Nurashikin bti. Ibrahim (Malaysia). The proposals were seconded with no objection from the participants.

Professor Chiu then presided over the meeting. Dr Wang Xiangdong, Regional Adviser in Mental Health and Control of Substance Abuse, presented the meeting’s key discussion points: (1) suicide is a major public health problem, (2) it is preventable, and (3) much is still left to be done. The proposed agenda was then adopted by the body (see Annex 3).

2. PROCEEDINGS

2.1 Overview of suicide and suicide prevention

Dr Manoel Bertolote opened the session with a global overview of suicide behaviours. Professor Ian Webster reviewed the major determinants of suicide, followed by Dr Michael Robert Phillips' presentation on the relationship between completed and attempted suicide. Dr Professor Xiao Shuiyuan concluded the session with a discussion on the public health approach in suicide prevention.

Over the past 50 years, suicide rates have notably increased, with the average age of those committing suicide becoming much younger. Suicide accounted for an estimated 815 000 deaths in 2000,\(^3\) climbing to 873 000 in 2002. Surprisingly, the number of suicides reported in the Region declined from 343 000 (42% of the global figure) in 2000,\(^4\) to 331 000 (37.9%) in 2002.\(^5\) This figure translates to 2.5% of the disability-adjusted life years (DALYs) in all ages and both sexes.

Many developed countries have witnessed remarkable declines among the young and elderly populations, which has puzzled the scientific community. On the other hand, China and India - which together explain nearly half of the total number of deaths due to suicide - have recently witnessed substantial stability in rates

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and absolute numbers. Still, data from other countries have shown increases in the number of suicides in specific populations. Guam, for example, reported an increase in suicides among 20-29 year olds from 2001 to 2004.

While data collection on completed suicides has been problematic, it has become more difficult with the non-reporting of suicidal attempts. It is estimated that the number of suicide attempts is 10 to 20 times the number of deaths from suicide. Trends are also affected by the methods becoming more lethal in certain populations, which may contribute to the displacement of figures from attempted to completed suicide.

The reasons for committing or attempting suicide are varied. In part, the causes are related to the culture, tradition, and socioeconomic environment of a given population. It is widely acknowledged that mental disorders also play a major role in suicidal behaviour. Among these disorders are affective disorders, alcohol and substance abuse, schizophrenic disorders, and personality disorders. Other co-morbid conditions also exert influence on the problem.

Prevention, while emphasizing the necessity of promoting mental health, is an absolute priority. WHO encourages the widest possible approach to suicide prevention given its many complexities, and in this light, substantially encourages a public health approach.

Some countries have carried out successful public health interventions, including: the control of firearms, the restriction of toxic substances (particularly pesticides and herbicides), the detoxification of domestic gas and car exhaust fumes, toning down of media reports on suicide, and early detection and treatment of mental disorders.

2.2 Current suicide situation and suicide prevention strategies in the Region

Representatives from 22 countries and areas gave an update of their suicide situations and shared experiences and lessons learnt in the development, implementation, and evaluation of national suicide prevention strategies (refer to Annex 4 for country report summaries).

2.2.1 Current situation of suicide in the Region

In recent years, countries and areas in the Western Pacific Region have shown varying suicide trends. In China, a slight decline has been observed. There are similar indications from Australia, New Zealand, and more of late, Hong Kong (China). Others like Guam, Japan, Micronesia, the Republic of Korea and Singapore have shown steady or increasing trends.

Patterns in specific populations are also different among countries. In China, for example, suicide rates are highest among rural women of reproductive age. In some Pacific countries, young females show higher suicide rates relative to males. In Japan, there appears to be an increasing trend among middle-aged men.

Indicators from other countries and areas in the Region are limited. Valid and reliable epidemiological data have not been collected because of the absence of a
mortality data collection system for suicide, or of morbidity and mortality data in general. Sources of data for estimates of suicide trends are likewise varied. Overall trends in the Region are strongly conditioned by the trends in China, which is the most significant contributor to suicide, although most countries report a perceived increase in suicide deaths even if not supported by reliable data.

Methods of suicide differ within the Region. Poisoning by pesticides is prevalent in China, Fiji, and Samoa. Overdosing with drugs has been reported in Cambodia and the Philippines, while jumping from high-rise apartments has been confirmed in Hong Kong (China), Japan and Singapore.

Despite the recognized lack of epidemiological evidence, there is a general consensus that suicide is a major health concern in the Region, with most countries, if not all, being interested in starting activities and initiatives in order to contain the problem.

2.2.2 Suicide prevention programmes

The increase in suicide rates in the developed countries in the 1990s, and the initiation of National Strategies for Suicide Prevention in Australia, Finland, New Zealand, Norway, and Sweden, have encouraged other countries to set up national plans for suicide prevention. Germany, the United Kingdom of Great Britain and Northern Ireland, the United States of America, Wales, and others have launched national plans in subsequent years. Presently, a number of countries including China, Estonia, Ireland, and Scotland are nearing the inauguration of their national campaigns. Many of the current and upcoming suicide prevention plans have been influenced by the United Nations’ Guidelines for the Formulation and Implementation of National Strategies for the Prevention of Suicide, drafted by an ad hoc committee in 1993 and published in 1996.

Based on the results of an ad hoc survey on suicide prevention plans, only three out of 14 countries participating in the meeting have a suicide prevention plan or prevention guidelines. However, activities aimed at developing a plan are underway in Guam, Mariana Islands, and Samoa. Almost all countries and areas surveyed expressed an interest in developing one.

In general, the integration of the National Suicide Prevention Strategies within mental health plans has been a frequent occurrence. On one hand, such strategies may be integrated with alcohol and drug abuse control programmes. The abuse of or acute intoxication with alcohol has been recognized as one of the many important contributory factors to suicidal behaviour worldwide.

The absence of a national suicide prevention programme does not mean that suicide prevention initiatives are absent. Among the initiatives reported by specific countries during the meeting are various forms of advocacy (radio and television talks, brochures, newsletters), restrictions of means of suicide (control of pesticides, some drugs and guns), easy access to help (crisis help lines, telephone counselling services), detoxification of domestic gas and of exhaust fumes through catalytic converters, limited access to suicide sites (fencing of bridges and other high places), and toning down of media reports. Some suicide prevention activities are integrated
in school-based programmes. Most of the prevention programmes, however, still need to be evaluated.

2.2.3 Suicide surveillance

Some Member States do not regularly record suicide-related data, making it difficult to observe regional trends. In order to support the formulation of a national plan for suicide prevention, it is crucial to start data collection in countries where it is not yet done, and periodically monitor and evaluate the quality of the data collected in countries where surveillance systems are in place. In some places, the establishment of morbidity and mortality registry have yet to be institutionalized.

Existing data collection methods on suicide and suicidal behaviours include police reports, hospital deaths, emergency room contacts, death certificates, and telephone help line records. In some countries and areas, like China and Guam, surveys have been conducted.

2.3 Priority actions required at country and regional levels in the Region

Summarized below are the results of group and plenary discussions on priority actions required at country and regional levels. Considering the diversity of the member countries represented in the meeting in terms of geography, demographic characteristics, culture, economic development, health infrastructure, manpower resources, and availability of mental health programmes in general and suicide prevention programmes in particular, the following areas were identified as priorities.

2.3.1 Mental health and suicide as national health concerns

(1) Limited resources

While some countries and areas in the Western Pacific Region have health systems in place, others are just starting to develop their health infrastructures, and have yet to establish mental health programmes. Some countries also have very poor human resources for mental health.

In countries and areas where human resources are available (for example, Guam and New Zealand), the challenges are to sustain the human resources and to prevent burnout.

(2) Poor prioritization of suicide and mental health by the government.

Mental health and suicide prevention are low priorities for governments of countries that face other pressing health issues like infectious diseases (for instance, Cambodia and the Lao People's Democratic Republic). Governments pay very little attention, not only in terms of budget, but also in terms of any support in general.

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2.3.2 Better understanding of the nature of suicide

Suicide is still poorly understood as a health issue. The media sometime depict negative images of the persons who commit suicide or their families. Reports are often found under the police columns of the newspapers (for example, in the Philippines). There are varying ways through which suicide is viewed - crime, sign of weakness, rational choice, symptom of an illness, or the result of spirit possession. The stigmatization of suicide and the fall-downs of it deeply affect families.

2.3.3 Development of suicide surveillance

Many countries do not have morbidity and mortality data. There is an obvious lack of epidemiological data on mental health problems and suicide. Currently, suicide data come from varying sources - anecdotal reports from the community, service providers (counsellors, telephone help lines), church, police reports, hospital deaths, emergency ward contacts, community surveys, and mortality data, if available.

2.3.4 Development of culturally sensitive suicide prevention programmes

(1) Lack of appropriate research and relevant service in the area

The delivery systems of suicide-related services vary from country to country. While some countries provide no suicide-related services, others have centres specifically focused on suicide. In the survey conducted for the meeting, suicide-related research has not substantially changed in many countries.

Globalization is bringing new types of social stressors. Rapid urbanization, changing family structures, economic crises and unemployment, and a variety of social situations considered as significant to depression and suicide are actually creating new high-risk groups.

(2) Lack of formal assessment of current interventions

Currently, no systematic evaluation is available for most prevention programmes. This makes it more difficult to secure funding for sustainable programmes. Countries are also reluctant to adopt models if an evaluation of them has not been convincingly performed. There is a need to strengthen the arguments for the implementation of suicide prevention programmes and their sustainability, which can only be addressed by obtaining evidence that interventions actually work.

2.3.5 Collaboration

While there is a general interest in suicide prevention, there is also a perceived lack of technical expertise in several specific areas, like research, surveillance,
data management, advocacy and prevention. There is a critical mass that could effectively work on suicide prevention, but this critical mass needs training and support.

2.3.6 Other areas of concern

(1) Perceived need to decriminalize suicide

In countries where suicide is considered a crime, the act might not be reported as such, thus increasing the underreporting of suicide and, of course, feeding the stigma attached to it, as well as the psychosocial consequences that the survivors are forced to suffer.

(2) Other legislation

Some countries have legislation in place to restrict access to drugs and other means for committing suicide. Others still need to push for specific legislation. For example, overdosing with drugs is a common method of attempting suicide; consequently, regulatory measures to prohibit the sale of these drugs may be particularly useful. Ingesting pesticides/herbicides is a frequent method of suicide in the Region. A double-locker system for containers of these substances (the two keys being possessed by two different persons) may prevent a huge number of deaths.

Legislation should not be focused exclusively on suicide prevention. Countries also need laws that ensure the availability of services for mental health needs.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

3.1.1 The management of mental health problems and suicide should be essential components of the national health agenda in all countries. Mental health and suicide are major public health concerns in the Western Pacific Region. In 2002, approximately 331,000 people committed suicide in the Region, comprising 38% of the world suicides. Suicides in the Region account respectively for 33% of all violent deaths among men and 57% of all violent deaths among women in the world. Self-inflicted injury, or suicide, is among the top five causes of injury deaths, accounting for more than road traffic accidents and falls combined in the Region. It accounts for 2.5% of the total burden of diseases. Mental disorders are one of the most relevant risk factors for suicide. From a global perspective, more than 95% of those who committed suicide had mental disorders. Studies from countries in the

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Western Pacific Region, however, have indicated a somewhat lower percentage, ranging from 63% to 83%.9

3.1.2 Although the magnitude of the suicide situation in the overall Region is acknowledged, little is known about the specific situation in most of the low- and middle-income member countries. Hence, utilizing and managing existing data, organizing new data sources for surveillance, and eventually establishing a mortality registry system, are essential in these countries. The implementation of a valid and reliable monitoring system is necessary to determine the relative importance of all health conditions, and thus, essential to health planning and a critical first step to the allocation of the usually limited resources available.

3.1.3 There is diversity in the delivery of suicide prevention services in the Region. Some have well-developed suicide prevention programmes, while others have less developed programmes. Australia, Japan and New Zealand for instance have their own National Suicide Prevention Strategy, while Cambodia is struggling with the organization of its basic mental health programme. Suicide prevention services are typically provided through mental health systems, but may also be provided in a variety of other systems, services and/or settings: general health services, school systems, military, nongovernmental organizations, professional associations, alcohol and drug abuse programmes, accident prevention initiatives, programmes on domestic violence, survivor groups, spiritual leaders, traditional healers, and others.

3.1.4 Finally, recognizing the broad differences in the characteristics and capabilities of the different countries in the Region, there is a need for member countries to cooperate and share technical expertise, human resources, and lessons from their experiences with suicide prevention.

3.2 Recommendations

The participants made the following recommendations:

3.2.1 Valid and reliable data are needed to support initiatives for suicide prevention programmes relevant to specific countries. Depending on the level of morbidity and mortality data collection systems available, it is recommended that the countries:

1. set up a morbidity and mortality data surveillance system for suicide;
2. develop human resources (for example, epidemiologists) needed to maintain a valid and reliable data collection system on morbidity and mortality including suicide;
3. set up periodic monitoring of the quality of the surveillance system; and
4. conduct research on the causes, risk and protective factors for suicide, in addition to the surveillance system.

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3.2.2 Suicide prevention initiatives vary across the Region, from countries with no suicide prevention programme, to others with comprehensive prevention programmes. In order to initiate and expand suicide prevention activities, WHO should:

(1) encourage countries to move towards the development and implementation of national strategies for effective management and prevention of suicidal behaviours;\(^{10}\) and

(2) provide support to operationalize the strategy, and promote its implementation and evaluation.

3.2.3 As there is a general agreement that mental health and suicide are of concern for every country, member countries should:

(1) integrate suicide prevention strategies, including bereavement support for those affected by suicide and suicide attempts, in their health policy and programmes;

(2) identify existing systems and programmes through which data on suicide behaviours can be initially generated (for example, hospital admissions, emergency room contacts, police reports);

(3) identify existing systems, programmes, projects or activities in which suicide prevention advocacy could be initially integrated (for example, general mental health promotion activities, school programmes, workplace safety, primary health care, drug and alcohol abuse programmes, help lines, and others);

(4) engage and create partnerships with media to promote suicide prevention efforts in order to improve the quality and appropriateness of the press reports;

(5) develop and enhance access to and quality of mental health services, for example, improving early detection and treatment of depression and other mental disorders; and

(6) develop and enhance access to and quality of other health services, for example, equipping emergency rooms with poison antidotes and improving treatment of persons with poisoning symptoms.

3.2.4 Acknowledging the differences in the capabilities of the various countries to carry out suicide prevention initiatives on their own, the following collaboration among member countries is highly recommended:

(1) Develop a formal network within the Region, and where appropriate, in subgroups of countries (for instance, the Pacific islands).

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\(^{10}\) The strategy may include the basic elements recommended by the 1996 United Nations guidelines (*Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategy*, New York, United Nations, 1996): government policy, supporting conceptual framework, general aims and goals, measurable objectives, identification of agencies/community organizations to implement the objectives, monitoring and evaluation.
The network should work to continuously disseminate information; promote research; exchange culture-specific understanding of suicides, as well as the different approaches to dealing with it; share human resource and technical expertise; and to actively support the implementation and evaluation of mental health and suicide prevention programmes through education and training (including familiarization with ICD-10 categories).

(2) Develop a common instrument for suicide surveillance that can be implemented in the Region, or subregions, in order to standardize suicide reporting and thus permit the observation of regional or subregional trends (including trends in attempted suicide and methods of self-injury).

(3) Develop a collaborative research proposal to share current knowledge, generate a better understanding of the suicide problem at country levels, foster advocacy, and establish and evaluate prevention programmes.

3.2.5 A follow-up meeting should be organized to sustain the initial efforts and to monitor the progress of suicide prevention and management initiatives in the Region. The follow-up meeting should also serve as a venue to discuss regional collaboration.
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OPENING SPEECH

BY

THE REGIONAL DIRECTOR

FOR THE WESTERN PACIFIC, WHO

AT THE MEETING ON SUICIDE PREVENTION IN THE WESTERN PACIFIC REGION

15-19 AUGUST 2005

MANILA, PHILIPPINES

Distinguished participants, colleagues, ladies and gentlemen,

Good morning to everyone and welcome to the WHO Regional Office for the Western Pacific. I am indeed grateful that you have come to attend this very important meeting.

Suicide, as we all know, is a serious public health problem. It affects men and women, the young and the old, people in developed countries and developing countries alike. Every 40 seconds, one person commits suicide somewhere in the world. In this Region alone, about 1000 lives are lost to suicide everyday. In addition, 10 000 to 20 000 people attempt suicide everyday.

It is these alarming numbers and the pain, suffering and the huge social and economic costs of suicide that have brought us together. Over the next five days, we are going to hear about suicide and suicide prevention in 20 countries and areas in our Region. We will have a variety of opportunities to share knowledge and experiences in the development, implementation and evaluation of national suicide prevention strategies. And by the end of the meeting, we should have clearer understanding of where we are and what practical and concrete actions should be taken at country and regional levels, to address the problem of suicide. I look forward to being informed of the progress of your work and your conclusions.

Suicide is a tragic global public health problem, yet it is largely preventable. We already have success stories in a number of countries and areas in the Region. Examples include the restriction of firearms in Australia, domestic gas detoxification in Japan
and the control of paraquat sales in Japan and Samoa. Restrictions on access to firearms have been associated with a decrease in their use for suicide in some countries.

High self-esteem and social connectedness are proven protective factors against suicide. Interventions based on the principle of connectedness and easy access to crisis help hotlines, as well as telephone check-up programmes on the elderly, have provided encouraging results.

Early identification and appropriate treatment of mental disorders is also an important preventive strategy. There is evidence that educating primary health care personnel in the identification and treatment of people with mood disorders may result in a reduction of suicides among those at risk. Psychosocial interventions, suicide prevention centres and school-based preventions are likewise promising strategies.

We have no reason for pessimism, but much remains to be done.

We must be well prepared for the difficulties and obstacles in our fight against suicide. One of the major obstacles standing in the way is the stigma associated with suicide and mental health. We all need to examine our beliefs, and insensitivities with regard to mental illness and suicide. We have to give serious thought to several questions: Why are some lives seen as worth saving and others are not? Are we doing enough for the people awaiting life-saving assistance?

Most of these people suffer silently. Most of them are struggling in the dark. We must send out a clear message to policy-makers, to professionals, to the public and even to ourselves: Suicidal people are not weak, they are not crazy. Suicide is not a scandal. Suicide is not a personal failure. It is a tragedy of the family, the community, and the society at large. It is a failure of the mental health service system in particular and the health care system in general. It is a call for harmonized social economic development and the development of human beings per se.
Because suicide is a major concern in the Region, as soon as I assumed the post of Regional Director six years ago, I asked a group of experts that included anthropologists, psychiatrists, sociologists and epidemiologists for their opinion. Of course, there were many factors and slightly different perceptions each expert mentioned to me. But there was one common denominator. They were unanimous in concluding that everything boils down to one thing – a lack of connectedness. And this lack of connectedness permeates modern life, impacting society at three distinct levels – the family, the community and the work place.

And in my view, if we really want to address the issue of ever-increasing mental health problems, such as suicide, I believe that we have to revitalize our communities so that the connectedness people once felt in their communities, work places and even families will be restored.

A huge amount of work is in front of us. By being here together, we are taking a very important step. WHO will stand shoulder-to-shoulder with all of you in your efforts to develop and promote suicide prevention and intervention programmes that work for the people who deserve understanding, care and love; who deserve support, treatment and life-saving assistance.

Let us all be part of the fight for life.

Thank you.
PROVISIONAL AGENDA

(1) Opening session

(2) Overview of suicide and suicide prevention

(3) Suicide and suicide prevention practices in countries and areas in the Western Pacific Region

(4) Country report summary: Common issues and outstanding practices

(5) Improving suicide surveillance

(6) How to improve suicide surveillance systems in countries and areas in the Western Pacific Region

(7) Development, implementation and evaluation of a national strategy for suicide prevention

(8) Panel discussion on issues of special interest:
   (a) Suicide and gender
   (b) Media, Internet and suicide

(9) Priority actions required at country and regional levels

(10) Closing session
### TENTATIVE TIMETABLE

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<th>Time</th>
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AUSTRALIA

Current suicide situation.

According to the Australian Bureau of Statistics (ABS), suicide rates in Australia are similar to what they were at the end of the last century. The age distribution of suicide rates has changed throughout this period, particularly in relation to the male suicide rate, as the rising suicide rates in young males has offset the declining suicide rates witnessed in older male age groups.

Latest available suicide data in 2003 show that there were 2,213 suicides registered in Australia representing an age-standardized death rate of 11.1 per 100,000. This is 6% lower than in 2002, when 2,320 deaths were recorded (11.8 per 100,000) and well below (24%) the figures of 1997 when there were 14.7 deaths per 100,000 and the highest recorded number of suicides with 2,720 suicide deaths registered. For the period 1993-2003, the overall male suicide rate was approximately 4 times higher than the overall female suicide rate.

The figures in relation to youth suicide remain encouraging. In 2003, there were 300 deaths in this age range, continuing the lower trends from the peak in 1997. Those aged 15 to 24 have been the target of suicide prevention efforts since the inception of the National Youth Suicide Prevention Strategy in 1995.

In 2003 the most common method of suicide was hanging, which was used in almost half (45%) of all suicides. The next most used methods were poisoning by “other” (including motor vehicle exhaust) methods, poisoning by drugs, and methods involving firearms. This distribution is consistent with the previous few years. Over the previous decade strong trends were apparent such as an increase in the use of hanging, and a decrease in methods using firearms.

Suicide Programs.


The Australian Government developed the National Youth Suicide Prevention Strategy (NYSPS) in 1995 to address the issues of suicide and suicidal behaviours, specifically in Australians aged 15-24 years. This Strategy was developed by the Government in partnership with the community, and in consultation with a broad range of stakeholders. The NYSPS was overseen by the National Advisory Council on Youth Suicide Prevention, which was comprised of experts in a range of fields including people with academic expertise, business leaders, community representatives, and suicide prevention project managers.

The National Suicide Prevention Strategy (1999- Present)

In 1999, the National Youth Suicide Prevention Strategy was replaced with the National Suicide Prevention Strategy (NSPS) as a means of addressing the issue of suicide prevention in a range of age and population groups identified as being at risk of suicide.
The Australian Government has committed around $10 million annually since 1999 under the NSPS for the development of national and community models of suicide prevention. Since then, the NSPS has made significant achievements in the establishment of viable structures and processes for developing and implementing suicide prevention policy and programs both nationally and at community levels.

The *Living is for Everyone: A Framework for the Prevention of Suicide and Self Harm in Australia (Life Framework)* was developed in 2000 to guide and inform the implementation of the NSPS. The Framework provides the evidence base and strategic direction for suicide prevention activity at the community level, as well as promote good practice and a consistent approach through complementary planning and joint projects between programs with related social justice, community development and health promotion goals. Currently, the *LIFE Framework* comprises three companion documents – Areas for Action, Learnings about Suicide, and Building Partnerships.

In order to oversee the NSPC, the Australian Government established the National Advisory Council on Suicide Prevention (NACSP) in October 2000. Furthermore, the NACSP provides strategic advice to government on suicide prevention. It is comprised of a Board, a Community and Expert Advisory Forum, and Suicide Prevention Committee based in each Australian State and Territory (8 in total). These structures include representatives from NSPS funded projects, researchers in the field of suicide prevention, community representatives, business leaders, and Indigenous representatives. Structuring the NSPS this way has ensured the views and needs of local communities across Australia are effectively addressed in NSPS planning and prioritization processes. This structure has contributed to the growing community awareness and ownership of issues relating to the prevention of suicide and self harm in Australia.

**Major barriers to the development/implementation of national suicide prevention plan.**

To date, the major barrier experienced in the continued development and implementation of the National Suicide Prevention Strategy is the need to establish a 'learning loop' or system to ensure that lessons learned from NSPS-funded projects are accessible and serve to inform good practice in suicide prevention activities. Such a mechanism would underpin decisions about NSPS priorities, provide suicide prevention 'models' for addressing areas of high need, and allow for critical assessment of the strength of evidence, both in terms of the need, and preferred solutions.

**Priority Areas for the Future**

During the National Advisory Council on Suicide Prevention (NACSP) Annual Suicide Prevention Planning Forum (August 2004), the following population groups and settings should be the focus of attention (until June 2006, the end of the current phase of the NSPS):

- Young people – the early years
- People bereaved by suicide
- People with a mental illness
- Men
- General practice and primary care settings
- Criminal justice/prison settings
- Workplace settings
- Responses to self harm and suicide
• Aboriginal and Torres Strait Islander peoples
• Accident and emergency departments
• Research and evaluation

Urbis Keys Young is currently undertaking a national evaluation of the NSPS, which is expected to be completed in December 2005. When completed, this evaluation will provide the evidence base for all future planning and prioritization processes.

CAMBODIA

Current suicide situation.

Suicide mortality and morbidity are collected from the Registry of Calmette Hospital Wards. Available data reports 10 deaths due to suicide in 2004 due to pesticide ingestion and overdose with other substances. A total of 256 suicide attempts were reported of which 76.56% were between ages 18-40 and 61.32% were females. The most common method was overdose (78.52%). Other methods include pesticide ingestion and drowning.

Suicide Programs.

There is currently no suicide program in Cambodia.

Major barriers to the development/implementation of national suicide prevention plan.

The following are considered barriers to the development/implementation of national suicide prevention plan:
• Lack of awareness that suicide is a public health problem that is preventable
• No suicide prevention programmes
• Lack of human resources, facilities, budget
• No research on suicide and suicide prevention
• No surveillance system.

Priority Areas for the Future

The following are considered mental health priority areas in the next three to five years:
• Development of a National Mental Health Policy/National Suicide Prevention Policy
• Development of a National Mental Health Strategic Plan/National Suicide Prevention
• Development of Guidelines for the Treatment of Mental Disorders and Suicide
• Development of a Mental Health Information System
• Integration of Mental Health Care to General Health Care
• Development of Consultation-Liaison Psychiatry Program in the General Hospital
• Improvement of knowledge on mental health among general practitioners
• Increase in the mental health literacy among the general population
CHINA, PEOPLE'S REPUBLIC OF

Current suicide situation.

Suicide is a major public health problem in China. In 1998, official country statistics reported 18.30 deaths per 100,000; urban rate was 6.83 deaths per 100,000 and rural rate was 23.31 deaths per 100,000. Although the death rate decreased at a slow but steady state to 14.55 deaths per 100,000 population in 2002, the suicide death rate in the urban areas increased to 12.76 deaths per 100,000, while the suicide death rates were down to 15.32 deaths per 100,000 in the rural areas.

An analysis of the suicide data in the recent years shows that two thirds to three fourths of suicidal people come from the were in rural areas; 63% of them suffer from mental disorder and 62% were sent to emergency institutions but failed to survive. Nearly half (47%) of the cases had relatives with suicide behaviours and 25% had no any education. In terms of suicide behaviour, 58% used pesticide and 27% had suicide attempt in the past. Unlike most countries worldwide, there are more females committing suicide in China. The proportion of suicide was highest among the young (20s) and lowest in the elderly over sixty years old.

A recent survey reported that many of those committing suicide exhibited impulsive suicidal behaviours after experiencing intensive interpersonal conflicts. About 70% of the completed and attempted suicide cases have never sought any help. It is estimated that 60% of completed suicide and 40% attempted suicide cases suffered from serious mental disorders. In general hospitals, there were 2 million attempted suicide patients in emergency departments, but less than 1% of them received psychiatric assessment and treatment.

In a report of 659 attempted suicide cases, 38% suffered from mental disorder. Impulsive suicidal behaviour was evident with 37% of them attempting suicide within five minutes and 60% within two hours. Regarding reasons of suicide, spouse conflict and financial difficulties were the most common identifiable stressors. One suicidal person would strongly influence five people around him/her.

Suicide Programs.

The Chinese government approved to set up suicide prevention centers in Nanjing (1991) and Beijing (2001). Meanwhile, mental health hotlines had been running in many cities, and the rescue services by community volunteers were developing. A pilot project to testify the efficacy of the suicide prevention program was ongoing under cooperation with IASP. The National Suicide Prevention Program will soon be launched on a nationwide basis in China.

Since 1995, under the leadership of Ministry of Health and cooperation with CDC and international organizations, there have been many researches on suicide in China.

Major barriers to the development and implementation of a national suicide prevention plan.
- Awareness of suicide prevention is not sufficient to develop prevention plan.
- Facilities and grants are not enough to implement a national suicide prevention plan.
• Few overseas rantankerous politicians attack the Chinese government by some incorrect figures of suicide.

Priority Areas for the Future

In the future years the priority areas for China are as follows:
• Advocating health promotion and enhancing social mobilization for suicide prevention;
• Seeking for further supports from various disciplines;
• Developing and implementing a national program on suicide prevention;
• Continuing the cooperation with international organization;
• Seeking further cooperation with professional facilities to unfold profound research and exploring the appropriate model of public education;
• Enhancing the communication with the media, the NGOs, and other organizations to improve their influence on the public; and
• Training professionals for suicide prevention and supporting the rescue services of community volunteers.

FIJI

Current suicide situation.

Suicide data in Fiji is available from the Fiji Police Crime Office. From 2000 to 2004, there were 949 reports of completed suicides and 1082 attempted suicides or 104.8 deaths (sex ratio = 1:0.8) and 113.8 attempts (sex ratio = 1:1.6) yearly. In 2003, completed suicide was highest among those above 50 years old, followed by the 25-29 and 15-19 age groups. Attempted suicide, however, was most common among those 20-24 years old. According to ethnicity, those committing suicide were predominantly Indians (87% to 90%).

Available data (2003) shows that hanging was the most common method of committing suicide among completed suicides, executed by 68% of the cases, followed by paraquat ingestion (17%), and burning (11%). Among those who attempted suicide, chemical ingestion was the most common method employed (57%), followed by tablet ingestion (12%), paraquat ingestion (12%), and hanging (9%). The most common precipitating event for both completed and attempted suicide is interpersonal conflict (70% and 88%)

Suicide Programs.

Currently, there is no national suicide control program, however, there is a National Committee On Prevention Of Suicide (NCOPS), a multisectoral management group on suicide prevention. Created in 2001, the NCOPS is chaired by Minister of Health and members of government ministries, non government agencies, civil societies, academic institutions, religious organizations, and others.

In March 2004, a National Consultation Forum On Prevention Of Suicide was held to raise awareness of NCOPS and the role it plays in suicide prevention and to use the information gathered in the workshop to strengthen goals and direction of NCOPS.
Annex 4

Major barriers to the development and implementation of a national suicide prevention plan.

Among the major barriers in the development and implementation of a national suicide prevention plan is the poor understanding of the nature of suicide. This poor understanding is reflected in the following myths:

- People who threaten or attempt suicide are just attention-seeking.
- If people really want to commit suicide nothing they read in read or see on TV will convince them otherwise.
- Most suicides occur without warning.
- All suicidal people are depressed.
- Asking or talking about suicide with a suicidal person increases the risk of suicide.
- Once a person is suicidal, he or she will be suicidal forever.

Priority Areas for the Future

Some priority areas are elaborated in the goals and objectives of the National Consultation Forum On Prevention Of Suicide:

- To lobby government to actively pursue the drafting and implementation of policy that may decrease suicides
- To identify areas of concern, challenges and problems faced by those involved in the prevention of suicide
- To identify strategies and plans of action to help meet these challenges
- To develop NCOPS to play a facilitating and coordinating function, building a resource base and a framework for community access
- Raise the awareness of NCOPS and the role it plays in suicide prevention

FRENCH POLYNESIA

Current suicide situation.

Suicide mortality in French Polynesia can be summarized as follows:

- Mortality by suicide:
  - 1994-98 : 11/100 000 (25 by year)
  - 1999 : 24
  - 2000 : 26
  - 2001 : 21
  - 2002 : 37
  - 2003 : 30
- Maximum between 25 and 44 years (12/an), 15 and 24 ans (10/an).
- 3.5 male for 1 female
- 2nd cause of mortality for 25-44 years after tumors and for 15-24 years after accidents.

The following information show suicide attempts recorded through hospitalization at the emergency department during 1989 and 1999:

- 86 SA/year/100 000  Female: 70% .
- average age: 29.
- Peak between 15 and 24 ans.
- Peak between September and November.
Annex 4

- Means used:
  - medication (57.7%),
  - violent (14.75%, phlebotomia 5 %, hanging 3%),
  - toxics (12.2 %, including pesticide gramoxone 1 %).

Suicide Programs.

French Polynesia has the following suicide prevention programmes:
- Specialized Care Unit (Unité d'Accueil et de Surveillance for Suicid attempters): 13 beds in the psychiatric hospital CHPF, hospitalization and follow up.
- Prevention unit in the public health department with direct interventions in islands and crisis phone line with Association SOS suicide (NGO).
- Epidemiological study on suicide: Image in Mental Health with transcultural and biological aspects.
- Program SUPRE from WHO

GUAM

Current suicide situation.

Based on the WHO Country Health Information Profiles, suicide ranks the fifth leading cause of mortality in 2002 (13.66/100,000 population) following diseases of the heart, malignant neoplasm, cerebrovascular disease, and all other accidents. The actual number of reported suicide cases in Guam has decreased from 30 in 1996 to 16 in 2004 (but already 14 from January to July of 2005). Cases are predominantly males and below 40 years of age. In 2003 the single age group that had the most number of suicide cases was 30 – 39 but in 2004, it was 20 – 29. According to ethnicity, suicides were more common among the Chamorro followed by the Chuukese and Filipinos.

Suicide Programs

The Department of Mental Health and Substance Abuse (DMHSA) serves as the single state agency for mental health and substance abuse prevention and treatment services for the U.S. Territory Government of Guam. It has a Prevention and Training Branch that has come up with a five-year strategic framework for action from 2005-2009. Suicide prevention activities are incorporated in its program of activities.

Currently, Guam is involved in developing a US National/Island Strategy through the Indigenous Suicide Prevention Research and Programs in Canada and the United States.

Major barriers to the development and implementation of a national suicide prevention plan

Among the barriers to the development and implementation of a national suicide prevention plan are the stigma that comes with mental illness and committing suicide and the lack of understanding of the nature of suicide. Many workers who are interested to deal with suicide are not adequately equipped at this point.
HONG KONG, CHINA

Current suicide situation.

Suicide ranks 7th of 10 leading causes of deaths in Hong Kong, and is increasing in the general population in the recent years. The standardized suicide death rate was 12.4/100,000 population in 1997 to 17.6 in 2003, with an average annual increase of 0.87/100,000 population. Sex ratio is 2:1 (2003). Suicide is highest among the elderly (65 years old and above) and lowest among the youth (5-24 years old), with standardized suicide death rates at 37.0/100,000 population and 5.7/100,000 population, respectively. Among those between 35 to 54 years old, the standardized suicide death rate is 19.7/100,000 population. Suicide methods include jumping from height, charcoal burning, and hanging.

In a study of 70 suicide cases and 100 control cases aged 60 and over, psychological autopsy revealed 87% of suicide cases had a mental disorder, in particular depressive illness, compared to 9% of controls. Suicidal intention was expressed before suicide in 60% of cases while 75% of them had consulted a doctor within 1 month of death compared with 39% of controls.

In a multigroup-controlled study of elderly suicide attempters, major depression was associated with 60-fold increased risk for attempted suicide. Past suicidal attempts, poor ADL, arthritis, low conscientiousness also increase the risk for suicide while co-residence with children decreases it.

Suicide Programs.

There is no national suicide prevention program in Hong Kong, however, suicide programs are run by the Social Welfare Department (SWD) and non-government organizations. Such programs include various hot-line services; Suicide Crisis Intervention Centre by Samaritan Befrienders Hong Kong; Family Crisis Support Centre; Life Education Centre to promote public education and positive life values, targeting youth and students; training on suicide prevention to frontline social workers provided by the SWD.

An Elderly Suicide Prevention Program (ESPP) is conducted territory wide in Hong Kong from October 2002 onwards. This program provides fast assessment and management/crisis intervention, access enhancement to mental health service from community gate-keeper, close monitoring of at risk cases in community by nurses, and education of the general medical practitioners in the management of depression and referral of suicidal cases to ESPP.

Major barriers to the development/implementation of national suicide prevention plan.

- Lack of research data
- Problem given little attention by the government
- Family doctor system not well developed
- Lack of training among frontline workers
- Sigma of mental illness; lack of knowledge, misconception
- Lack of funding
Priority Areas for the Future

- Commitment from government
- Comprehensive policy on suicide prevention
- Strategies and interventions may be different across the lifespan
- Emphasis on co-ordination of different sectors

JAPAN

Current suicide situation.

Available data from Japan's National Police Agency shows a dramatic increase of the suicide rate from 1998 to 2004. The suicide rate per 100,000 population is 25.3 in total. The rate is 37.4 in men and 13.8 in women. A notable increase in the suicide rate among middle-aged men was observed in the early and late 1990s.

According to the Ministry of Health, Labour and Welfare, health and financial problems appear to be the most common reasons for committing suicide based on suicide notes. Almost half (49%) of the reports were unemployed at the time of committing suicide. On a daily average, 64 men and 24 women Japanese commit suicide.

The leading method of suicide is hanging in both genders. Other methods include the use of gas, poisoning with agricultural chemicals, drowning, leaping to car or train, and jumping from height. Among men, use of gas is more frequent especially in young and middle-aged men. Among women, on the other hand, leaping to train or car is more frequent especially in young women.

Suicide Programs.

The increasing suicide led the Advisory Expert Panel on Suicide Prevention to propose a Call to Action to Prevent Suicide. As of July 19, 2005, the Committee of the House of Councilors passed a resolution on comprehensive measures for suicide prevention. A National Plan on Suicide Prevention will be launched within the year.

Under the Ministry of Health, Labour and Welfare, the Statistics and Information Department conducts periodic survey on suicide. The Mental Health and Welfare Division has developed a manual on depression for public officers of local governments. The Industrial Safety and Health Department developed a mental health guideline for workplace, a manual for suicide prevention programs, and a manual for rehabilitation programs to return to work. The Health and Welfare Bureau for the elderly developed a care manual for depression prevention.

In addition to these offices, the Japan Medical Association has also developed a Manual for Suicide Prevention for General Practitioners.

Major barriers to the development and implementation of a national suicide prevention plan.

In spite of serious efforts to address the problem of suicide in Japan, some challenges remain to be addressed:
First, effective approaches have not been widely spread yet. Second, successful approach for the target population, the middle-aged men, is still unknown. Recently, a new type of suicide is emerging. This is through the internet where the chatters die together.

**Priority Areas for the Future**

There are 3 short-term priority areas:
1. Initiation and conduct of the National Strategic Research for Suicide Prevention
2. Dissemination of suicide prevention programs, especially to urban areas
3. Establishment of a National Plan of Suicide Prevention through joint efforts of relevant Ministries

**LAO PEOPLE’S DEMOCRATIC REPUBLIC**

*Current suicide situation.*

Data on suicide comes from the Masohot Hospital, the biggest central and teaching hospital in Laos. The hospital’s mental health service has psychiatric beds and 16 staff. Attempted suicide is the second leading cause of hospitalization at the Emergency Unit of Masohot, following road accidents.

In 2004, there were 173 consults to the Emergency Room because of attempted suicide, 123 (71%) of were aged 15-24. Because of the sensitivity of the issue in Laos, it is difficult to get a reliable data on suicide. Available information is mostly from young people with relational problems (with parents, spouse, lover).

**Suicide Programmes.**

Currently, there is no suicide prevention program in Laos.

**Major barriers to the development/implementation of national suicide prevention plan.**

The major barrier to the development of a national suicide prevention plan ins the lack of an effective Mental Health System in place.

**MALAYSIA**

*Current suicide situation.*

There is a gross underreporting of data on suicide in Malaysia, hence, national data is considered inaccurate. The Ministry of Health in 1999 however reports suicide rate to be 6.3/100,000. In 2004, the suicide rate was estimated to be 10-12/100,000.

Available studies show Indian ethnic groups to have the highest suicide rates, followed by the Chinese and the Malays. An increase in the suicide rate among the Malays has been noted in recent years.
The most common method of committing suicide is poisoning (pesticides, agricultural biocides, other poisons including paracetamol). Other methods include hanging, jumping from heights, and carbon monoxide poisoning.

**Suicide Programs**

- Increasing public awareness and advocacy on suicidality and suicide prevention
- Development of IEC materials
- Mass media strategy (television and radio programs)
- Training
- Political will
- National suicide action plan
- Guideline for media reporting
- Multisectoral involvement
- National Suicide Registry

**Major barriers to the development/implementation of national suicide prevention plan**

- Under reporting of suicide – related to legal issues, religious prohibitions, poor certification.
- Resources constraint – human resource and materials
- Social stigma

**Priority Areas for the Future**

- Overcoming stigma – public health sector involvement rather than purely clinical psychiatry-driven; effective health education
- Overcoming sociocultural barriers
- Formation of a Task Force
- Formation of State Coordinators
- Training of health care providers, school counselors, and other relevant agencies.
- Establishing counseling and help-line services at primary health care and community level.
- Promote responsible media reporting
- Research on suicide behavior
- Improvement of data collection

**MARIANA ISLANDS, COMMONWEALTH OF THE NORTHERN**

**Current suicide situation**

Suicide is the fourth leading cause of death in the Marianas Islands, following cancer, stroke, and heart disease.

Much like elsewhere, females suicide attempt is much higher than males and completed suicide much higher for males than females. The most common method is by hanging. There is a "no handgun" laws in the CNMI.

**Suicide Programs**

Currently, there is no suicide prevention program in the Marianas Islands.
Major barriers to the development and implementation of a national suicide prevention plan.

Priority Areas for the Future

1. Suicide, especially among the youth, is a growing concern.
2. Need to look at the underlying causes so that Prevention Programs could be instituted.
3. Merge Suicide Prevention efforts with efforts to address Tobacco and Substance Abuse Prevention and other mental health issues.
4. Educate the community about the importance of Suicide Prevention Programs.
5. Work closely with the private and public school systems
6. Develop a reliable data collection method to record all deaths with ability to isolate and confirm suicide deaths.

MICRONESIA, FEDERATED STATES

Current suicide situation.

Suicide enormously increased in Micronesia since late 1960s, perhaps as a function of social change. The average 3-year suicide rate per 100,000 population (1997-1998) is 25.8 compared to 3.6 between 1961-1965. More than half (57%) are between 15-24 years old while 14% are between 25-29 years old. It is said that one of every 40 boys kills himself; one of every 10 boys attempts suicide; and one of every 2 or 3 considers suicide.

The most common method of committing suicide is by hanging in 90% of the cases. Other methods include gunshot, poisoning, and drowning. More than half are drunk at the time of death.

The main reasons for suicide are linked to a problem with blood family while in some cases, it is prompted by quarrel with wife or lover. Recently, there seems to be a creation of “culture of suicide”, as seen in songs, stories, etc.

Suicide Programs.

Currently, there is no National Suicide Prevention Program in Micronesia.

Major barriers to the development and implementation of a national suicide prevention plan.

Priority Areas for the Future

The following are the suggested Intervention and Prevention Strategies:

1. Parenting education for a new age
   - Emphasis on easier communication between parents and children
   - Developing stronger links between children and their extended family
   - New guidelines for parenting where these are needed.
2. De-romanticize suicide
   • Message that suicide is selfish and harms the community
   • Must be proclaimed in practice (eg, make funeral of victim less appealing)
   • Must be a total community effort, involving churches, government and other institutions

3. Provide social buffers for youth
   • Purpose: to cushion frustrations within family and lessen self-absorption
   • Peer support from youth organizations and other interests outside family
   • Activities could include: sports, singing, education, skills training

4. Keep good data on suicide

MONGOLIA

Current suicide situation.

According to the Centre for Poisoning, 17 suicides were recorded in Ulaanbaatar in 1990 and this number increased to 415 in 2001. A research on the medical and social issues of suicide in Mongolia reports that suicide cases were highest among those 15-24 years in 2002 (551/1765 or 31.22%), and among males (1428/1765 or 80.90%). The most common method was strangling oneself in 60% of the cases. Other methods include jumping from height, inflicting injuries to oneself using various methods, poisoning and drowning.

Suicide Programs.

There are no educational materials on prevention of suicide; National Program also not developed.

Major barriers to the development and implementation of a national suicide prevention plan.

• Inconsistent data from the police department and medical services.
• Data from countryside is not collected regularly.
• Psychological support services are not always available for everyone.
• There are no specialists on suicide such as psychologists and social worker.
• Awareness on mental health education is very poor.
• Some religious streams also influence increasing suicide attempts.
• There is no work collaboration and network on suicide prevention activities among government and non-government organizations.
• Refusal to report.

Priority Areas for the Future

• To organize “Stress Relief Centres” through mass media
• Set-up psychotherapy centers
• Set-up “Confidential Lines”
• To integrate Life Management Skill Education in the health education subject in secondary schools.
Annex 4

- Control the sale of psychotropic drugs and medicines from drugstores.
- Develop early detection of mental disorders and prevention.

NEW ZEALAND

Current suicide situation.

More people die by suicide in New Zealand now, than do in traffic crashes. Men complete suicide at rates significantly higher than women, however females attempt suicide at a significantly higher rate than men. The evidence currently available suggests that the difference between the sexes is due to the lethality of means used: men use more lethal methods than women. Men for example hang themselves or use guns, while women use poison.

Since 1998, New Zealand's suicide rates have declined by 25% and are now amongst the lowest recorded for over 20 years. Rates of suicide are now highest amongst men in the 25 to 44 year age group, previously were those under 25 years of age. Maori also have high rates of suicide disproportionate to their population.

Suicide Programmes

In 1998 a New Zealand Youth Suicide Prevention Strategy was launched under the leadership of the Public Health Directorate of the New Zealand Ministry of Health. Shortly thereafter, the administrative responsibility for the leadership and coordination of the implementation of the strategy was transferred to the Ministry of Youth Affairs, which had responsibility for strengthening the role of youth in New Zealand.

Recognizing that suicide is not just a youth issue, the Ministry of Health committed to develop a new all-age focused strategy in October 2003 under a new New Zealand Injury Prevention Strategy. Currently, a New Zealand Suicide Prevention Strategy is being drafted. One of the key aims of this is to promote a comprehensive approach to suicide prevention across the whole of government.

The Principles informing the proposed Strategy include the following:

1. Population and Strengths Based Public Health Response
2. Responsiveness To Māori
3. Valuing Our Diverse Communities, People and Cultures
4. Leadership and Collective Responsibility
5. Long Term Approach, Monitoring and Evaluation

Currently, there is a wider awareness amongst government agencies of the issue of suicide prevention compared to previous years. A core community based infrastructure for suicide prevention has been built. A significant amount of resources aimed at the medical professions and the community have also been developed. Other resources that have been developed include brochures in a range of Pacific Island languages which are freely available; a guide to individuals and family members on how to identify and respond to those at risk of suicide; and a brochure aimed at providing advice to communities on how to respond to suicides. The New Zealand Ministry of Health has commissioned over the last 4 years a significant number of research based papers on the causes and prevention of suicide,
analyses of a range of social and economic explanations for the trends in New Zealand's suicide rates to 1999, and a significant study of the Cost of Suicide to New Zealand society.

Major barriers to the development and implementation of a national suicide prevention plan.

Because of the complexity of the issues, and the existence of strong and divergent opinions about the causes and prevention of suicide, the major barrier from a policy perspective, is the desirability of finding a middle pathway through the competing perspectives. Finding such a path is important in order to retain the commitment of all those with an interest: community groups, researchers and medical practitioners. However, the pathway must also have some basis in the evidence if the strategy and action program is to have some credibility and to be effective.

Another issue is how to best encourage community groups to develop new and innovative suicide prevention activities, which are "safe", innovative and "appropriate". The issue is many community groups or well meaning individuals may undertake actions that are known to be highly risky, that is increase the risk of suicide. However, we don't want to discourage groups from undertaking "appropriate" activities that offer new ways of taking suicide prevention to communities that are not being reached by mainstream services and activities. For example, what is safe and appropriate suicide prevention for Maori people, people from the Pacific Islands, new Asian immigrants, and refugees? Many of these groups argue that the western medical model of suicide is inappropriate, and service delivery is not reaching them: things need to change if we are truly committed to reducing the toll of suicide on our people, communities and society.

Priority Areas for the Future

The following initiatives are underway:
- Development of a program aimed at assisting health providers to institute a process of systemic change to ensure that those admitted to hospital for a suicide attempt are followed up with appropriate postvention services.
- Development of new national depression initiative, which will aim to raise awareness about depression and how to get help.

PAPUA NEW GUINEA

Current suicide situation

Available data on suicide in the National Capital District and Central Province (1987) reports 44 total deaths due to suicide from 1986 to 1887 compared to 53 in 1961 to 1965. The peak age from committing suicide was 20-24 for both sexes.

Method of suicide include overdose with drugs and poisons, hanging, jumping from moving vehicles, shooting, cutting throat/wrist, poisoning with roots/herbs, burning self.
Suicide Programs

There is no specific suicide prevention program in place, however, Mental Health Promotion programs where suicide is incorporated have been undertaken.

Major barriers to the development/implementation of national suicide prevention plan

- Inadequate funding
- Human resource shortage
- Lack of culturally appropriate materials
- Inadequate equipment, materials, technical support

Priority Areas for the Future

- Improve reporting system for suicide and other mental health problems.
- Establishment of working committee to develop National Suicide Prevention Policy and National Suicide Prevention Program.
- Encourage research in suicide, establish priority areas and plan culturally appropriate interventions.

PHILIPPINES

Current suicide situation.

Current reliable data for a national suicide rate is not available. Data can be generated from emergency wards (for poisoning and other suicide attempts), National Bureau of Investigation and the Police Department since suicide reports are considered as medico-legal cases.

Methods of suicide according to a general hospital research (1984) include overdose (with isoniazid, paracetamol,, and other pesticides), shooting, jumping, an hanging.

Suicide Programs.

Currently, there is no suicide prevention program in Philippines.

Major barriers to the development/implementation of national suicide prevention plan.

- Lack of factual data to cite magnitude of the problem, hence, lack of evidence to support need and fund for program.
- Competing interests within the Health System where budget is limited.
- Strong Catholic faith which frowns upon suicide discouraging families from reporting.

Priority Areas for the Future

- Currently, the priority of the Department of Health is to establish a Mental Health and Substance Abuse Office.
- There appears to be no immediate plan for a specific suicide program
REPUBLIC OF KOREA

Current suicide situation

Suicide mortality rate in Korea ranks 4th among OECD nations following Hungary, Finland, and Japan. From 1983 to 2002, suicide mortality rate has increased by 6% annually. As of 2003, the suicide mortality rate is 22.8/100,000.

Suicide among males is 2.7 times higher relative to the females, constantly increasing as one gets older, peaking after the age of 80. According to place of residence, suicide rate is 1.2 times higher in small city/rural areas (22.5) compared to those from the metropolitan city (19.1). Methods-wise, hanging/strangulation is most common followed by pesticide ingestion, other intoxication, and falling.

Suicide Programs

There is currently no National Suicide Prevention Program in area, however, there are several initiatives. These initiatives focus on the early detection & treatment of high-risk group including education of counselors, teachers, police or social workers, provision of Telephone Hot Line counseling and referral to emergency team as well as internet consultation about suicide, and development of suicidal-risk screening tools.

Major barriers to the development and implementation of a national suicide prevention plan.

Priority Areas for the Future

SAMOA

Current suicide situation.

Suicide attempts and deaths have been increasing in Samoa since 2001 to 2004. Cases from 2003 to 2004 alone comprise 25% of the suicide deaths and attempts in Samoa from 2001 to 2004 (42 of 163 deaths and 20 of 76 attempts). Paraquat ingestion is the most common method employed, half of who eventually die. Males appear to commit suicide more than females from 20 years and above, while females commit suicide more often in the younger age group.

Suicide Programs.

There is currently no national suicide prevention program.

Major barriers to the development and implementation of a national suicide prevention plan.

The barriers at the Ministry of Health Level are:
- Lack of leadership skills among workers;
- Ignorant of workers about existing policies;
- Little or no participation of workers in policy development or policy consultation;
- Inexperiance of workers to budget preparations;
Annex 4

- Financing support;
- Lacks networking

Programs also lack periodic evaluations and constructive reviews:
- Incidents do not have patterns;
- Causal factors have high linkage with “generation gap” and traditional societal practice or culture;

Priority Areas for the Future

Key areas for action include the following:
- Ensuring appropriate financing of prioritized services
- Observing legislation and human rights
- Organizing Services
- Human Resources and Training
- Facilitating and providing support to affected families

Areas of focus for Promotion, Prevention, Treatment and Rehabilitation are:
- Suicide Prevention
- Drug and Alcohol Abuse
- Sexual Abuse: Child and Adolescent Abuse
- Early Recognition and Management of Mental Disorders
- Domestic Violence
- Dignity of the family

Other needs include:
- Ensuring essential drug procurement and laboratory support
- Building Capacity for Leadership and Advocacy
- Quality Improvement
- Improving Information Systems for more informed care
- Strengthening Research, Monitoring and Evaluation
- Strengthening Community and Inter-sectoral collaboration

SINGAPORE

Current suicide situation.

About 300 to 400 suicides are committed in Singapore every year, about one a day. Singapore rate of female suicides ranked 14th and male suicides 28th out of 50 countries ranked worldwide, behind Japan, Korea, Hong Kong and China. The rate at which Singapore’s female aged 15-24 are committing suicide is now among the highest in the world. In particular the Malay female suicide is rising. In the same age group, Singapore’s young suicidal males ranked 33rd position.

While females attempt suicide more often, males use more violent methods to end their lives and are more likely to die. The gender ratio of those who take their own lives is about 1.7 men to 1 woman. According to ethnic origin, Chinese and Indians are predominant.

Suicides in >45 years old has dropped over last 10 years; but younger victims aged 5-44 are now replacing that decrease. In 1998 the young accounted for 55% and the
old 45% of the suicides. This is in sharp contrast to the data in 1950 when studies showed that the old committed 60% of all suicides worldwide and the young 40%.

Seventy percent of reported suicide deaths are through jumping from high-rise buildings. The rest are through hanging, gas, burning or drowning. Although there is no seasonal association, a popular days of committing suicide is on the second day of Chinese New Year, New Year’s Day, Christmas, Labor Day and Deepavali. There are certain peaks of suicide that coincide with changes in the socio-economic and political climate, the most recent being the Asian economic crisis in 1999.

Financial problems (from debts, losses, gambling, unpaid credit card bills and loan shark pressures) accounted for about one-third of Singapore male suicides and 12% female suicides between 2000-2002.

In the recent a new high risk group, the foreign workers, is developing. This group includes domestic helpers, taxi drivers, army personnel, and gamblers.

**Suicide Programs.**

There is no National Suicide Prevention Program in Singapore, however, there are ongoing suicide prevention related programs in different levels.

Suicide prevention is integrated in some hospital services through psychiatrists in both private and government hospitals, and in community-based services and organizations like the National Council of Social Services (NCSS), Singapore Association for Mental Health (SAMH), Singapore Anglican Welfare Council (SAWC), Ministry of Community Development, Youth and Sports (MCYS), Family Service Centres (FSC), and various Helplines.

There is also a TTSH Suicide Management Program Suicide Management Workgroup composed of doctors, nurses, allied health workers, and patients. The Workgroup developed a training program on equipping different groups of staff with the knowledge and skills in recognizing, preventing and managing suicide risks and attempts.

*Major barriers to the development and implementation of a national suicide prevention plan.*

Priority Areas for the Future

**TONGA**

*Current suicide situation.*

Available data on suicide deaths report 32 deaths for the country of 500,000 population from 2000 to 2004. The cases are predominantly males (80%) and young adults between ages 16-32. The most common method is hanging (71%).

Data is gathered by the Referral Network of the LifelineTonga (LT) under the Free Wesleyan Church of Tonga. It maintains active links with the Ministry of Health, Police Department, and the other relevant organizations.
Annex 4

Suicide Programs.

There is no National Suicide Prevention Program in Tonga. However Lifeline Tonga responds to the rapidly growing concerns of cross cutting issues which include the using of destructive substances and behaviours that may cause suicide.

The Lifeline Tonga (LT) is a non-governmental and non-profitable organization under the responsibility of the Free Wesleyan Church of Tonga. The LT has a long history in the field of working and caring problem people, especially the community as a whole. In 2005 Lifeline Suicide Hotline was established and designated to be under the umbrella of a Board that the Free Wesleyan Church of Tonga, Ministry of Health, Police Department, and NGO are cooperating in monitoring its strategies and programs.

Major barriers to the development and implementation of a national suicide prevention plan.

Priority Areas for the Future

VANUATU

Current suicide situation.

It is estimated that about 7/1000 population could attempt suicides every year in Vanuatu, thus showing that Vanuatu has the highest rates suicide than the world’s rate. Unfortunately, recording of suicides at the national level is not always accurate due to lack of cooperation between the hospital, police, and family members.

Suicide Programs.

There is no Nations Suicide Prevention Program in Vanuatu.

Major barriers to the development and implementation of a national suicide prevention plan.

The mental health situation in Vanuatu is neglected by government. Vanuatu has a mental act that has been implemented but never replaced with new appropriate legislation.

Priority Areas for the Future

1. Training of doctors and nurses in primary mental health about the early detection of depressed patient and treatment.
2. Provision of access to communication lines (for example, tele-radio) to nurses so they could seek the assistance of a specialist in any difficulties they face.
3. The government to build a separate block apart from hospital, either in towns includes the six provinces where people could go and rehabilitated themselves eg: watching movies, weaving or doing something that makes them feels relieving from stressful situation.
4. Program that could be carried out by public health officer and other non-governmental organizations like counseling in order to educate the public.
VIET NAM

Current suicide situation.

Available statistics from the Vietnam Ministry of Health specifies the suicide rate to be 1.0 deaths/100,000 in 2000 and 1.2 deaths /100,000 in 2001. This figure does not include suicide cases by accidents, jumping from height, of hanging that were not brought to the hospitals.

Analysis of researches conducted in psychiatric hospital 1976-2004 shows that 45.4% - 53.3% of suicidal in-patients have attempted suicide in the past more than once. Hanging was the most common method used (65.3 %– 76.7%) followed by drowning (10.2%-17.3%); and use of sedatives (4.3%-6.7%). Co-morbid mental disorders were depression, schizophrenia, and adjustment disorders.

Suicide Programs.

There is no national suicide prevention program in Vietnam, however, there are ongoing activities resulting from the participation of the country in the WHO multi-site intervention study on suicide behaviour (SUPRE-MISS). Eighty eight suicide attempters enrolled in intensive care units in urban hospitals in Hanoi with a mean age of 25.1 ± 9 were followed-up interviewed at 1 week, 2 weeks, 4 weeks, 7 weeks, 4 months, 6 months, 12 months and 18 months. None reported feeling bad or not good on interview at 4 months.

Major barriers to the development and implementation of a national suicide prevention plan.

Some barriers identified are:

- Lack of research data
- Short of suicide prevention policy
- Family doctor system not well developed
- Stigma of mental illness, lack of knowledge
- Lack of funding

Priority Areas for the Future

The next steps currently considered are:

- Nationwide collecting data of suicidal behaviours (integrating this investigation into mental disorders survey)
- Having policy on suicide prevention
- Establishing the suicide prevention centers, crisis intervention center
- Tightly co-operating with other organizations on suicide prevention