Introduction

(adapted from: World Health Organization. Figures and facts about suicide. WHO, Geneva, 1999)

According to WHO estimates, in the year 2000, approximately one million people died from suicide, and 10 to 20 times more people attempted suicide worldwide. This represents one death every 40 seconds and one attempt every 3 seconds, on average.

This also indicates that more people are dying from suicide than in all of the several armed conflicts around the world and, in many places, about the same or more than those dying from traffic accidents. In all countries, suicide is now one of the three leading causes of death among people aged 15-34 years; until recently, suicide was predominating among the elderly, but now suicide predominates in younger people in both absolute and relative terms, in a third of all countries.

Some WHO Member States have been reporting on causes of death since WHO's inception. For several countries, information series are available from 1950 onwards, whereas other countries started sending this information later on. Although country data are available almost always on a yearly basis, an option was made to present the data on a five-year interval, because it was generally felt that this time interval provided a reasonable overall picture.

Whenever figures on suicide are presented or discussed, there is always someone to question their reliability, insisting that in many places - and due to several reasons - suicide is hidden and that the real figures must be much higher. This point is acknowledged, which only reinforces the gravity of what is presented here. Another question frequently raised refers to the comparability of data across countries. The information on which the graphs are based reflects the official figures made available to WHO by its Member States or by their national officers responsible for suicide prevention; in turn, these are based upon real death certificates signed by legally authorized personnel, usually doctors and to a lesser extent police officers. We prefer to believe that they have not as a rule, misrepresented the information and that the real dimension of eventual distortions introduced by misreporting remains to be demonstrated. It is our hope that these graphs will be a solid ground against which corrections and improvements will be brought about.

The most recent data refer to some years ago and a word about the time to process the information is appropriate. Mortality data (due to all cases, not just suicide) in a given year are collected and processed in subsequent years at a central level in each country. Once the data have been collected, there is an internal verification; should there be any inconsistency, these are returned to where they originated from for rectification. If a single province delays sending its data, the information on the whole country will be delayed. Also, when there is a judicial procedure to define the cause of death, this may represent a certain delay in the compilation of the country's whole mortality information. Only when

the country’s central level is satisfied with the data set, it is sent to WHO, where it is again re-examined for internal consistency. In the best of conditions this whole process usually takes 2-4 years. This explains why, the “most recent data” refer to a few years ago, but vary from country to country.

A word of caution is needed in relation to the interpretation of rates (per 100,000) in countries with small populations: a few more - or less - suicides can greatly modify the rates, thus giving a wrong impression of important increases or decreases, respectively.

The reduction of mortality and morbidity associated with suicidal behaviours is high in WHO’s agenda. Obtaining appropriate information is the first step in a public health strategy for the prevention of undesirable outcomes. Unfortunately, information about means employed for committing suicide - a fundamental information for suicide prevention programmes - is not available at the same level as the information presented here on the incidence of suicide. This is something to be rectified in the future.

Since monitoring mortality related to suicide and updating the pertinent information is an ongoing task of WHO, any additional information or comments are most welcome.