FEDERAL MINISTRY OF HEALTH
AND SOCIAL WELFARE

NATIONAL SUICIDE PREVENTION STRATEGIC FRAMEWORK

2023-2030

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FOREWORD

Suicide is a complex yet preventable public health problem resulting from the interaction of psychological, social, biological and environmental factors. It is among the leading causes of death among young people, and investment in its prevention has been relatively small.

The prevention of suicide is complex, though feasible, not an easy task. It requires a coordinated multi-sectoral and system-wide response of the health and social welfare, education, faith-based organisation, youth and sports, justice, finance and economic planning, and agriculture private sectors, among others, at all levels of the governance structure of the country.

Age 15- 29 are at high risk of suicide, which is the fourth leading cause of death within that age bracket. Nigeria is ranked 7th in Africa and 15th in the global suicide rates, with an estimated age-standardised suicide rate of 17.3 persons per 100,000 people.

Nigeria is among the countries that are committed to the WHO Comprehensive Mental Health Action Plan 2013-2020 at the 66th World Health Assembly in May 2013 to work towards the global target of reducing the rate of suicide to one-third by 2030.

The National Suicide Prevention Strategic Framework (NSPSF) (2023-2030) was developed by the Federal Ministry of Health and Social Welfare in response to the increasing suicide rate in the country and to ensure the attainment of the Sustainable Development Goal (SDG).

The purpose of this NSPSF is to establish a framework for reducing the rate of suicide by instituting cost-effective programmes, health and socio-economic interventions that change behaviour and lifestyle and address the population at large as well as vulnerable groups. It involves a whole series of activities, ranging from the environmental control of risk factors and means for suicide, to early identification and effective treatment of people with mental health conditions, establishment of suicide prevention helplines and integration of care at community and primary health level as well as responsible reporting of suicide by the media.

I, therefore, call upon all Nigerians, the public and private sector, civil society organisations, faith-based organisations, development partners and other stakeholders to support the implementation of this National Suicide Prevention Strategic Framework 2023- 2030 across all relevant sectors to achieve the set vision of a healthy nation where there is a reduction in the rate of death from suicide or suicidal behaviour.

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ACKNOWLEDGEMENT

In the background of the high rate of suicide in Nigeria, with one of the highest rates in the African sub-region, this National Suicide Prevention Strategic Framework (NSPSF) 2023-2030 is anchored on a greater determination to reduce the rate of suicide in Nigeria. This document aims to serve as a useful tool and guide for the national response to suicide and suicidal behaviour for the next seven years in Nigeria.

The Leadership role of the former Director of the Public Health Department, Dr. Alex M. Okoh, National Coordinator of the National Mental Health Programme; the coordination of the process by the hardworking staff of the Programme and the contribution of other officers from the Federal Ministry of Health and Social Welfare and other agencies is well commended.

The zero-draft was reviewed and re-reviewed by representatives of many key stakeholders, including those from other Ministries, Departments, Agencies (MDAs), parastatals of the Federal Ministry of Health, professional bodies (such as the Association of Psychiatrists in Nigeria, Nigerian Association of Clinical Psychologists, Nigerian Association of Social Workers, among others), development partners, Non-Government Organisations and Civil Society Organisations. The Nigerian Office of the World Health Organization (WHO), Wellbeing Foundation Africa and Jhpiego provided technical and financial support throughout the different stages of the development of this NSPSF document.

The actualisation of this NSPSF document would not have been possible without the commitment of all the officers of the National Mental Health Programme of the FMOH and the leadership of the Honourable Ministers of Health, initially in the person of Dr. Osagie Ehanire and later, Prof Muhammad Ali Pate, in making suicide prevention a top public health priority in Nigeria.

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EXECUTIVE SUMMARY

The National Suicide Prevention Strategic Framework (NSPSF) 2023-2030 is a guide for the national response to suicide and suicidal behaviour for the next seven years in Nigeria. The WHO Live Life, an implementation guide for suicide prevention in countries, guides the development of the NSPSF. The document aligns with the National Health Strategic Development Plan II (NHSDP II) and the Sustainable Development Goal, 2015-2030.

Suicide prevention is a public health priority. The NSPSF is designed to mitigate risk factors and enhance protective factors to improve resilience, which aims at reducing deaths by suicide and suicidal attempts within the context of the Nigerian health system and community in general.

This document intends to inform stakeholders on the strategic direction to be considered when developing programmes on the prevention of suicide and suicidal attempts in Nigeria. Development partners and other stakeholders will use this document to align their priorities and support the country in its effort to reduce the rate of suicide in Nigeria.

The development of this document was led and coordinated by the National Mental Health Programme of the FMOH in consultation with relevant stakeholders from Ministries, Departments and Agencies (MDAs), professional bodies, Non-Government Organisations/ Civil Society Organisations (NGOs/CSOs) who participated actively in the development.

The development of the NSPSF followed the Medical Research Council (MRC) framework for developing complex interventions. It was developed after theoretical conceptualisation as a first step, followed by expert review and stakeholder engagement before finalisation. The theoretical development and expert reviews were done by technical experts in the Federal Ministry of Health while field experts were drawn from academia and professional bodies to develop a zero-draft using relevant documents such as WHO Live Life Guide, WHO Preventing Suicide Community Engagement Toolkit and WHO Preventing Suicide a Global Imperative.

The goal of NSPSF is to attain a 15% reduction in suicide mortality by the year 2030. These strategic objectives will be pursued to achieve this goal will include the establishment of a suicide prevention governance structure, strengthening the policy and legal framework, resource mobilisation for improved access to quality and integrated, cost-effective and accessible mental health promotion and suicide prevention interventions at all levels of care, raising awareness, strengthening suicide surveillance and research, and addressing barriers to uptake of suicide prevention interventions in the country. The implementation framework and responsible organisation/agency for these strategic objectives are clearly outlined in the document.

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ABBREVIATIONS & ACRONYMS

BCI	Brief Contact Intervention
BHCPF	Basic Health Care Provision Fund
CSR	Corporate Social Responsibility
FMOH&SW	Federal Ministry of Health & Social Welfare
HAT	Helping Adolescents Thrive
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HRMH	Human Resource for Mental Health
IASP	International Association for Suicide Prevention
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
LMICs	Low- and Middle- Income Countries
MDA	Ministry, Department and Agency of Government
M&E	Monitoring and Evaluation
MH	Mental Health
MRC	Medical Research Council
MTEF	Mid-term Expenditure Framework
NAFDAC	National Agency for Food and Drug Administration Control
N/A	Not Available
NBC	National Broadcasting Commission
NCDs	Non- Communicable Diseases
NFVCB	National Film and Video Censor Board
NGOs	Non-Government Organisations
NHIMS	National Health Information Management System
NHSDP II	National Health Strategic Development Plan II

NMHP	National Mental Health Programme
NPF	Nigeria Police Force
NPHCDA	National Primary Health Care Development Agency
NSPSF	National Suicide Prevention Strategic Framework
PHC	Primary Health Care
SDG	Sustainable Development Goals
SOP	Standard Operating Procedures
SURPIN	Suicide Research and Prevention Initiative
SWOT	Strengths Weakness Opportunities and Threats
TWG	Technical Working Group
WHO	World Health Organisation
YAM	Youth Aware Mental-Health

CHAPTER 1:

1. INTRODUCTION

Suicidal behaviour includes a range of behaviours that occur along a continuum from ideation to intent, planning and attempting to end one's life.[1] All of these are precursors to suicide, which is an act of deliberately ending one's life. Suicide and suicidal behaviours are global phenomena of public health concern that affect people irrespective of their age, socioeconomic or any other status. They contribute significantly to the burden of mental health conditions, specifically, and non-communicable diseases (NCD) in general.[2]

The need for early identification and assessment of suicidal behaviours is crucial as it affords the window of opportunity to intervene because, once completed, suicide is irreversible and has numerous untoward effects on the family and friends of the victim. Furthermore, suicide is a complex phenomenon that can be an index of the state of a society.

Globally, more than 800,000 people take their own lives every year, and many more people attempt suicide.[3] Every suicide is a tragedy that affects families, communities, and society and has long-lasting effects on the people left behind. Suicide can occur at any point across the life span and was the 10th leading cause of death globally across all age groups and 4th leading cause of death among 15-29 years old globally in 2019.[4]

According to the Nigerian National Mental Health Survey conducted two decades ago in Nigeria, about 12% or one in every eight Nigerians have had or experienced some sort of mental health condition, with anxiety disorders being the most common.[5] The continued rising cases of suicide and other mental health conditions have become a problem of public health priority, and accelerated action is required to improve mental health service delivery in Nigeria.

Suicide is preventable, though the heterogeneity in causation presents challenges for suicide prevention. This can be addressed by adopting a multilevel and organised approach through comprehensive multi-sectoral, integrated, and synergistic suicide prevention strategies, with considerations of best practices and evidence-based interventions as well as the cultural and social context. Effective preventive strategies should mitigate risk factors and enhance protective factors to improve resilience.

Suicide prevention is a public health priority, and this Suicide Prevention Strategy aims at lessening suicide and suicidal behaviour by reducing factors that increase suicide risk and

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[1] Nock MK, Borges G, Bromet EJ, Cha CB, Kessler RC, Lee S. Suicide and suicidal behavior. Epidemiol Rev [Internet]. 2008 Nov [cited 2023 Mar 11];30(1):133–54. Available from: https://pubmed.ncbi.nlm.nih.gov/18653727/

[2] Nock MK, Hwang I, Sampson N, Kessler RC, Angermeyer M, Beautrais A, et al. Cross-National Analysis of the Associations among Mental Disorders and Suicidal Behavior: Findings from the WHO World Mental Health Surveys. PLOS Med [Internet]. 2009;6(8):e1000123. Available from: https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000123

[3] Roth GA, Abate D, Abate KH, Abay SM, Abbafati C, Abbasi N, et al. Global, regional, and national age-sex-specific mortality for 282 causes of death in 195 countries and territories, 1980-2017: a systematic analysis for the Global Burden of Disease Study 2017. Lancet (London, England) [Internet]. 2018 Nov 10 [cited 2023 Mar 11];392(10159):1736–88. Available from: https://pubmed.ncbi.nlm.nih.gov/30496103/; World Health Organization (WHO). Suicide worldwide in 2019: global health estimates. (WHO) WHO, editor. 2021 [cited 2021 Nov 13];Licence: CC BY-NC-SA 3.0 IGO. Available from: file:///C:/Users/Pessoal/Downloads/9789240026643-eng.pdf

[4] World Health Organisations. Suicide [Internet]. 2021 [cited 2021 Nov 20]. Available from: https://www.who.int/news-room/fact-sheets/detail/suicide

[5] Gureje, O., Lasebikan, V. O., Kola, L., & Makanjuola, V. A. (2006). Lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health and Well-Being. *The British journal of psychiatry: the journal of mental science*, *188*, 465–471. https://doi.org/10.1192/bjp.188.5.465

increasing factors that promote resilience. It highlights integrative strategies to help prevent suicide that encompass work at the individual, systems, and community levels based on the best available evidence.

1.2 Risk Factors for Suicidal Behaviours in Nigeria

Suicide is a product of complex interactions between biological, socio-economic and psychological factors. Research into risk factors of suicide is challenging, but psychological autopsies, which are strategies for understanding a person's mental state just before death by reconstructing his thoughts, feelings, and behaviour at the time of death, have been a useful resource. Another helpful resource for gaining insight into the risk factors for suicide is the review of media reports. Generally, WHO categorises suicide-related risk factors into five (5) broad categories, including factors related to the individual, their relationships, the community, society, and the health system (Table 1).

The link between psychiatric disorders and suicide is established. About 90% of persons who die from suicide globally experienced a mental health condition.[6] About 4% of persons who experience depression globally will take their own lives, with the majority having contacted mental health services.[7] Other mental disorders commonly associated with suicide are bipolar affective disorder, schizophrenia, and psychoactive substance misuse.[8] Poor physical health, including chronic diseases such as HIV/AIDS, cancers, and epilepsy, are also recognised as risk factors.[9]

Lack of strong social ties and unemployment, among others, are recognised social risk factors for suicide. Additionally, suicide has been linked to increased economic downturn and conflict.[10] Social media and techniques in media coverage are known factors associated with copycat suicides.[11] Among biological factors, a family history of suicide is reported to increase the risk of suicide two-fold.[12] According to several researches on suicide, the risk of suicide increases several folds after a serious attempt and is thought to be the most common risk factor for suicide.[13]

As previously noted, media reports may provide insight into the trends, patterns, and factors associated with suicidal behaviour in the Nigerian context and thus attempt to bridge the gap that currently exists concerning data on suicide. An analysis of 350 newspaper reports on

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[6] Arsenault-Lapierre G, Kim C, Turecki G. Psychiatric diagnoses in 3275 suicides: a meta-analysis. BMC Psychiatry [Internet]. 2004 Nov 4 [cited 2021 Nov 20];4. Available from: https://pubmed.ncbi.nlm.nih.gov/15527502/

[7] Fu, X. L., Qian, Y., Jin, X. H., Yu, H. R., Wu, H., Du, L., Chen, H. L., & Shi, Y. Q. (2023). Suicide rates among people with serious mental illness: a systematic review and meta-analysis. *Psychological medicine*, *53*(2), 351–361. https://doi.org/10.1017/S0033291721001549

[8] Ibid 7

[9] Abraham N, Buvanaswari P, Rathakrishnan R, Tran BX, Thu GV, Nguyen LH, et al. A Meta -Analysis of the Rates of Suicide Ideation, Attempts and Deaths in People with Epilepsy. Int J Environ Res Public Heal 2019, Vol 16, Page 1451; Zaorsky NG, Zhang Y, Tuanquin L, Bluethmann SM, Park HS, Chinchilli VM. Suicide among cancer patients. Nat Commun 2019 101 [Internet]. 2019 Jan 14 [cited 2021 Nov 21];10(1):1–7. Available from: https://www.nature.com/articles/s41467-018-08170-1

[10] Inoue K, Hashioka S, Kawano N. Risk of an Increase in Suicide Rates Associated With Economic Downturn due to COVID-19 Pandemic. Asia-Pacific J Public Heal [Internet]. 2020 Sep 1 [cited 2021 Nov 21];32(6–7):367.

[11] Copycat suicide, often called the Werther effect, is an imitative suicidal behaviour that occurs after exposure to another persons' suicide, often through the media; Luxton DD, June JD, Fairall JM. Social media and suicide: A public health perspective. Am J Public Health [Internet]. 2012 May 12 [cited 2021 Nov 21];102(SUPPL. 2). Available from: https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2011.300608

[12] Jang J, Park SY, Kim YY, Kim EJ, Lee G, Seo J, Na EJ, Park JY, Jeon HJ. Risks of suicide among family members of suicide vict ims: A nationwide sample of South Korea. Front Psychiatry. 2022 Oct 14;13:995834. doi: 10.3389/fpsyt.2022.995834.; Qin, P., Agerbo, E., & Mortensen, P. B. (2002). Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *Lancet (London, England)*, *360*(9340), 1126–1130.

[13] Bostwick, J. M., Pabbati, C., Geske, J. R., & McKean, A. J. (2016). Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew. *The American journal of psychiatry*, *173*(11), 1094–1100; Demesmaeker A, Chazard E, Hoang A, Vaiva G, Amad A. Suicide mortality after a nonfatal suicide attempt: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry*. 2022;56(6):603-616.

suicide in Nigeria identified the risk factors of suicide as being male, student, married, aged between 25 and 34 years, and living in a semi-urban area.

Financial constraints and marital conflict were identified as the most common triggers. Olibamoyo and colleagues at the University of Lagos, in a more recent review of research work conducted in Nigeria, suggested that age is an important correlate of suicidal behaviour, with the highest risk of suicidal ideation and attempts being among young adults aged 18 to 34 years.[14] They, however, reported that males were more likely to proceed from having suicidal ideation to making plans. In the work by Olibamoyo et al., as well as, Oyetunji et al., both public health researchers from Lagos State University and the University of Ibadan respectively, up to 75% of persons who had made suicidal attempts or completed suicide were males.[15]

Furthermore, in all studies conducted in Nigeria, among mental health disorders, mood disorders, especially depression were reported to be a strong risk factor for suicidal behaviour as it increases the risk of having suicidal attempts by up to 15 times.[16]

Other factors that have been reported to increase the risk of suicide among adolescents and adults in Nigeria include socio-economic difficulty, interpersonal conflict, physical or sexual abuse, dysfunctional family, including parental separation and a history of mental disorder in the mother.[17] In old age, the loss of a partner and rural dwelling are associated with increased risk of suicidal behaviour.[18]

Table 1 - Key Risk Factors for Suicide

Categories of risks	Risk factors
Individual/Personal	• Previous suicide attempt(s) • Mental health conditions (depression, bipolar, and psychotic disorders) • Harmful use of alcohol and other substances • Job or financial loss • Hopelessness • Chronic pain • Family history of suicide • Other genetic factors
Individual Relationships	• Sense of isolation and lack of social support • Relationship conflict, discord, or loss

[14] Olibamoyo O, Ola B, Coker O, Adewuya A, Onabola A. Trends and patterns of suicidal behaviour in Nigeria: Mixed-methods analysis of media reports from 2016 to 2019. S Afr J Psychiatr [Internet]. 2021 [cited 2023 Mar 7];27. Available from: /pmc/articles/PMC8008030/

[15] Oyetunji TP, Arafat SMY, Famori SO, A kinboyewa TB, Afolami M, Ajayi MF, et al. Suicide in Nigeria: observations from the content analysis of newspapers. Gen Psychiatry [Internet]. 2021 Jan 13 [cited 2021 Nov 20];34(1):100347; ibid 12

[16] Gureje O, Kola L, Uwakwe R, Udofia O, Wakil A, Afolabi E. The profile and risks of suicidal behaviours in the Nigerian Survey of Mental Health and Well-Being. Psychol Med [Internet]. 2007 Jun [cited 2023 Mar 11];37(6):821–30; Adewuya AO, Ola BA, Coker OA, Atilola O, Zachariah MP, Olugbile O, et al. Prevalence and associated factors for suicidal ideation in the Lagos State Mental Health Survey, Nigeria. BJPsych Open [Internet]. 2016 Nov [cited 2023 Mar 11];2(6):385. Available from: /pmc/articles/PMC5153566/

[17] Mapayi B, Oginni O, Osilaja R, Oyebode B, Ogunyemi M, Adewole O, et al. Gender differences in suicidal ideations and attempts among secondary school students in Ile-Ife, Nigeria. African J Gend Dev [Internet]. 2016 [cited 2023 Mar 11];3:48–64. Available from: https://www.researchgate.net/publication/309351111_Gender_differences_in_suicidal_ideations_and_attempts_among_sec ondary_school_students_in_Ile-Ife_Nigeria/citation/download; ibid 14

[18] Ojagbemi A, Oladeji B, Abiona T, Gureje O. Suicidal behaviour in old age - results from the Ibadan Study of Ageing. BMC Psychiatry [Internet]. 2013 Mar 13 [cited 2023 Mar 11];13. Available from: https://pubmed.ncbi.nlm.nih.gov/23497382/

Factors within the Community	• Disaster, war, and conflict • Stresses of acculturation and dislocation • Discrimination of any kind (racial, ethnic, gender, religious, sexual orientation, disability, etc.) • Criminalisation of Suicide and Suicide attempt • Trauma or abuse
Societal Factors	• Access to means (methods and tools) • Inappropriate media reporting • Stigmatisation of mental health issues
Health System	• Barriers to accessing mental health services

1.3 Protective factors

Protective factors guard people against the risks of suicide. It is important to have interventions geared towards strengthening factors that have been shown to increase resilience and connectedness. Some protective factors counter specific risk factors, while others protect individuals against several different suicide risk factors.

Table 2 below shows some protective factors:

Table 2 - Key protective factors for suicide

Categories	Protective factors
Individual/Personal	• Life skills and lifestyle • Self-esteem and self-worth • Effective coping and problem-solving skills • Strong sense of purpose in life
Individual Relationships	• Strong personal relationship and social connectedness • Reasons for living (for example, family, friends, pets, etc.) • Strong sense of cultural identity • Support from partners, friends, and family • Feeling connected to school, community, environment, and other social institutions
Factors within the community	Cultural, religious, or spiritual beliefs that discourage suicide Reduced access to lethal means of suicide among people at risk
Societal Factors	• Restricted access to means of suicide • Ethical media reporting • Tolerant attitude and empathetic disposition towards mental health issues
Health System	Availability of responsive and high quality physical and mental healthcare

1.4 Rationale for the Suicide Prevention Strategy

According to WHO, in 2019, about 3% of Nigerians had thoughts about ending their lives during their lifetime, while some who attempted to kill themselves must have told somebody who waved it aside. Additionally, the country has a suicide rate of 15 per 100,000 population, which is higher than that of Africa's which is 11 per 100,000 population as at 2019 .[19] Nigeria is located in the high suicide-rate belt of the world.

The Federal Ministry of Health, through the National Mental Health Programme, has the mandate to catalyse and co-ordinate all stakeholders' efforts aimed at addressing Mental Health, Neurological and Substance Abuse Disorders including suicide in the country, by developing and strengthening surveillance for both suicide and attempted suicide in Nigeria.

Suicidal behaviour places a heavy burden on the nation in terms of the emotional suffering that families and communities experience, as well as the economic costs associated with medical care and loss of productivity.

Nigeria is among the African countries committed to implementing the WHO Mental Health Action Plan 2013-2030. This plan is geared towards the reduction of mortality by suicide under the Sustainable Development Goal (SDG 3.4.2). The target is to reduce premature mortality from NCDs by one-third by 2030 through prevention and treatment and promoting mental health and well-being. In addition, the New National Mental Health Act (2021) supports the promotion of mental well-being and a place of safety for anyone experiencing mental health condition and suicidal ideation.

The Federal Ministry of Health, through this Suicide Prevention Strategy (2023), aims to address suicide and suicidal behaviour in Nigeria, through the following:

- ➔ Decriminalisation of attempted suicide in the criminal law of Nigeria
- ➔ Declaration of suicide as a National Public Health Priority
- ➔ Integration of mental health services into primary health care to identify suicidal behaviour at the community level and improve access to counselling and mental health care
- ➔ Establishment of suicide governance structure (suicide prevention steering committee and technical working group) at the national and state level
- ➔ Ensuring responsible reporting of suicide by the media
- ➔ Conducting surveillance and data collection of suicide and suicide attempts for monitoring and evaluation of suicide prevention interventions
- ➔ Restriction of access to means of suicide
- ➔ Collaboration with other stakeholders to strengthen social and emotional life skills in adolescents.
- ➔ Establishing 24-hour crisis hotlines at the national and sub-national levels for emergency and acute situations

The suicide prevention strategy will address the needs and existing gaps in providing multi-sectoral coordination in the reduction of suicide-related deaths as required by the Global Action Plan, National Mental Health Act, and the vision of the Federal Ministry of Health to promote the attainment of universal health coverage for mental health in the country.

1.5 Strategy Development Process

This strategy has been developed through a consultative process that involved the National Mental Health Programme of the Public Health Department of the Federal Ministry of Health; other relevant Ministries, Departments, and Agencies (MDAs); Academia; Professional Health Bodies; Media; Persons with Lived-experience; Non–Governmental Organisations (NGOs); Development Partners and other stakeholders.

The development of the strategy followed the Medical Research Council (MRC) framework for the development of complex interventions, that is, theoretical development as a first stage followed by expert review, stakeholder engagement, finalisation and validation. The theoretical development and expert review were done by technical experts in the Federal Ministry of Health while field experts drawn from academia and professional bodies developed a zero-draft using relevant documents such as: WHO Live Life Guide, WHO Preventing Suicide a Community Prevention Toolkit, WHO Preventing Suicide a Global Imperative, Kenyan Suicide Prevention Strategy 2021- 2026 and best practice examples from global literature review.[20]

A review of the zero draft was undertaken by stakeholders drawn from diverse fields and sectors, including local NGOs working in suicide research and prevention, development partners, mental health professionals, persons with lived experience, policymakers, and other relevant MDAs. All inputs from the stakeholder engagements were incorporated into the final draft.

CHAPTER 2

2.0 SITUATIONAL ANALYSIS

Nigeria is among the African countries committed to the WHO Mental Health Action Plan 2013-2030. Being an African country, Nigeria lies in the high-suicide-rate belt of the world.

2.1 Methods of Suicide in Nigeria

Several methods of suicide have been described, including the use of firearms, jumping from heights and in front of vehicles, drowning, hanging, poisoning, overdose, etc. The most common means reported in Nigeria were hanging and poisoning. *Olibamoyo* et al. using news media reports of suicide-related events, found that up to 41% of suicide-related deaths in Nigeria were by hanging, which was followed by poisoning which accounted for 34.2% of deaths.[21] Further, they noted that variations existed between gender and the reported methods of suicide. In women, poisoning (64.5%), hanging (18.4%) and jumping (6.6%) were the most common methods, whereas in men, it was hanging (47.7%), poisoning (25.4%) and jumping (12.7%).[22] See the figure below:

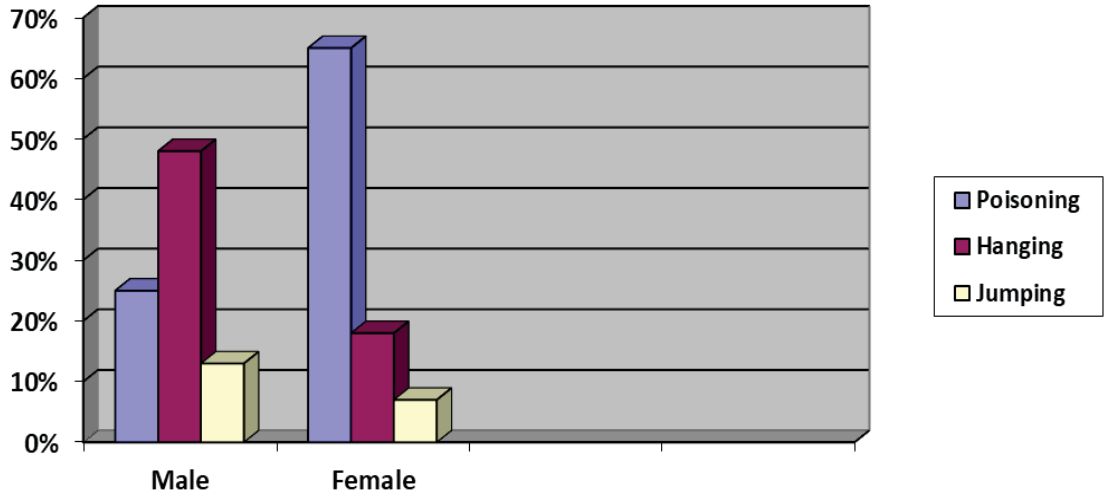


Figure **1: Methods of suicide in Nigeria**

In line with the above, *Oladeji* et al., at the WHO Collaboration Centre at the University of Ibadan, systematically reviewed 23 journal articles and reported similar findings, with the most common methods employed being hanging.[23] Literature highlights the availability of means as one of the determinants of the methods of suicide employed in different communities. For example, with regard to the use of poisons as a means to engage in suicidal acts, the use of organophosphate pesticides such as ***"sniper"*** or ***"otapiapia"*** which can easily be purchased from roadside vendors and supermarkets, is particularly common in Nigeria. Literature acknowledges an increase in the use of pesticides in low- and middle-income countries (LMICs), which has been attributed to the ease of access.

[21] Ibid 12
[22] Ibid 12
[23] Oladeji B., Ayinde O, Adesola A, Gureje O. The Epidemiology of Suicide and Suicidal Behaviour across the Lifespan in Nigeria: A Systematic Review of the Literature - PubMed. West Afr J Med [Internet]. 2021 [cited 2023 Mar 11];38(9):817–27. Available from: https://pubmed.ncbi.nlm.nih.gov/34672509/

2.2 Location of Suicide Attempts

With regards to the location of suicidal behaviours, the work by *Olibamoyo* et al., revealed that 77.5% of the suicide events took place at home, while other locations included workplace/educational institutions (7.9%) and notable public locations (3.9%) among others.[24]

2.3 Suicide Reports

Suicide is underreported in Nigeria due to stigma, cultural, legal and religious sentiments associated with it. People prefer to hide the mode of death, declaring suicide as accidental death. Lagos State has the highest number of suicide reports (which may be a result of its more advanced surveillance methods), with several reports of people jumping off bridges. The criminalisation of attempted suicide according to section 327 of the Nigeria Criminal Code Act and section 231 of the Penal Code has worsened help-seeking attempts by persons with suicidal ideation and, thus, under reporting of suicidal behaviours and suicide.[25]

2.4 SWOT Analysis

There has not been a situational analysis of suicide prevention in Nigeria. Therefore, there is no data-informed background to a nuanced suicide prevention framework in the country. However, this fact in itself is not a reason not to attempt the development of a prevention framework for suicide in Nigeria, but it must be addressed to handle prevailing challenges adequately. The table below shows the indicators of strengths, weaknesses, opportunities, and threats (SWOT) within the pathway to the development of a suicide prevention framework in Nigeria and the steps that need to be taken in the future to navigate potential pitfalls.

Table 3 shows the outcome of the SWOT analysis:

TABLE 3 SWOT ANALYSIS

Strengths	1. Abundance of potential collaborators in the development of suicide prevention framework (NGOs, Ministry of Youth and Sports, Ministry of Women Affairs, mental-health desk in State Ministries of Health, National Primary Health Care Development Agency (NPHCDA), Federal and State Neuropsychiatric hospitals with good national spread, Commission on Persons with Disabilities, Development Partners) 2. Other existing governance and coordination structures and resources within the Federal Ministry of Health that can be leveraged: ● National Mental Health Programme ● National Mental Health Policy ● National Mental Health Act 2021 ● Mental Health Gap Action Programme (mhGAP)

[24] Ibid 12
[25] Alabi O, Alabi A, Ayinde O, *et al*Suicide and suicidal behavior in Nigeria: a review. Psychiatry Journal 2014;**37**:1–6.

	3. Universal Health Coverage as a key national agenda
Weaknesses	• Criminalisation of attempted suicide and suicidal behaviours in the law • Weak mainstreaming of mental health into other health programmes and services • Inadequate budgetary allocation for mental health care and services • Lack of national surveillance and reporting system on suicide or attempted suicide • Poor integration of mental health care into primary healthcare service delivery. • Inadequate mental health care facilities • Shortage of mental health care professionals • Weak multi-sectoral collaboration with other sectors, for instance, Education, Youth and Sports, Judiciary, Humanitarian, Finance, Human Rights Commission, etc. • Lack of access to prevention interventions, treatment and aftercare services • Insufficient implementation of technical or existing measures of suicide prevention programmes • Discriminative health care budgetary provision by the Insurance Authority in the treatment of mental illness and suicidal behaviour • Non-incorporation of suicide prevention strategy into the National Mental Health Act • Limited funding to psychosocial mental health services with a preponderance going to biomedical interventions
Opportunities	• Approval of the National Council on Health for the creation of Mental Health Units across all the States and FCT • The Mental Health Act, which already imposes a responsibility on the State to commit to protecting the population's mental health and well-being • An appropriately led mental-health programme at the national level • An existing vibrant Civil Society Organisation pool working on suicide prevention and other relevant stakeholders for collaboration • Basic Healthcare Provision Fund (BHCPF)
Threats	• Sensationalised media reporting on suicide and suicidal behaviour

	• Stigma and taboo associated with suicidal behaviour • Lack of regulatory framework for control of the availability of poisonous substances, including pesticides and herbicides • Policy changes and lack of implementation as a result of no regulatory foundation and political will

CHAPTER 3

3.0 STRATEGIC DIRECTION

Vision

A Nigeria where the mental well-being of the citizens is prioritised, and individuals, organisations, and communities are empowered, leading to a significant reduction in deaths due to suicide.

Mission

To promote, coordinate, and support appropriate inter-sectoral action plans and programmes for preventing suicidal behaviours at the national, state, local government, community, and individual levels.

Goal

To achieve a 15% reduction in mortality due to suicide by 2030[26]

3.1. The guiding principles:

1. **Multi-sectoral approach**: Coordinated multi-sectoral approach involving a collaboration of public and private sectors such as NGOs/CSOs, faith-based organisations, traditional institutions, and development partners.
2. **Intervention to reduce means of suicide**: Intervention to reduce suicide as well as steps to address access to means of suicide
3. **Best available scientific evidence**: Interventions should be based on global best practices, based on scientifically sound and socially acceptable methods and technology, and universally appropriate to all age groups, taking into consideration the cultural context of the people.
4. **Universal Health Coverage approach**: All people, irrespective of age, race, gender, socio-economic/political, tribe, disability, or any other status, should have access to quality health services without experiencing financial hardship.
5. Prevention and protection of vulnerable groups in addition to treatment and rehabilitation of persons with suicidal behaviours.
6. **Human rights approach**: Health is a fundamental human right as enshrined in the constitution of Nigeria and international human rights laws.
7. **Inclusiveness and awareness**: The general population, especially vulnerable groups, persons affected by suicide and suicide survivors (e.g., bereaved families and friends), should be involved in advocacy, awareness creation, policy planning, and implementation.
8. **Equity principle**: People of all ages in the community, irrespective of their gender, race, religion, geographical location, disability, culture, tribe, socio-economic or any form of diversity, should have access and equal opportunities.

9. **Implementation framework:** This should be applicable at the federal, state, local government and community levels**.**
10. **Research and Innovation**: The framework shall involve innovations and research that will help to prevent suicide and emerging causes of suicide.
11. **Monitoring and evaluation:** Systematic, consistent, and regular review of this strategy to ensure it is tracked and utilised to achieve its stated objectives.

3.2 Key effective suicide prevention interventions

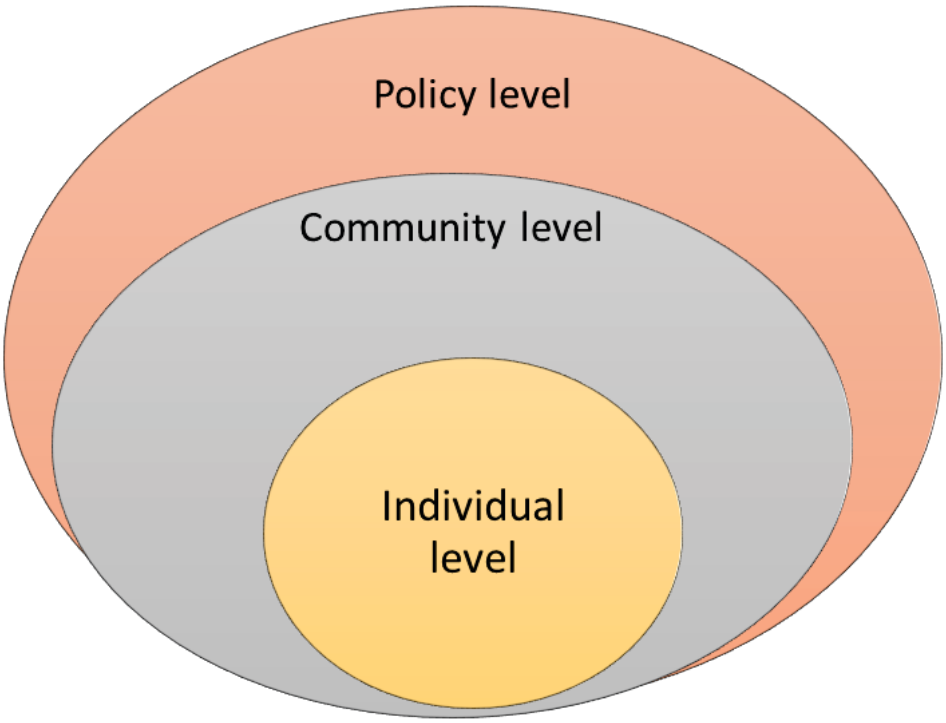


Figure 2

- Individual-level interventions
- Community-level interventions
- Policy and Governance level interventions

3.2.1 Individual-Level Interventions

Individual-level interventions: Involve different evidence-based practices, which include the following interventions: universal, targeted, indicated and crisis.

I. **Universal Interventions:** These are individual-level interventions intended to promote positive mental health and reduce the risk of suicidality among persons, especially adolescents. They are often in the form of psychosocial interventions such as instructions delivered in groups to people irrespective of their mental health status and aimed at promoting positive mental health, preventing mental health conditions and suicidality, and reducing risk-taking behaviours. It is usually delivered in groups and targeted at adolescents and youth. It is delivered in schools, youth camps and other

places where healthy youth aggregate in large numbers. The advantages of universally delivered interventions include less stigma and the opportunity to reach more youth. The core components of such training programmes include emotional regulation, problem-solving, interpersonal skills, mindfulness, assertiveness, stress management, safe use of social media, as well as, education on substance use and abuse. There are existing validated and effective programmes with already developed protocols and manuals for these kinds of training programmes from which a context-appropriate version can be drawn for Nigeria. Examples include the WHO's Helping Adolescents Thrive (HAT)[27] and the Youth Aware Mental Health (YAM). [28]

II. **Targeted Interventions:** Targeted interventions are delivered to persons who are known to be at increased risk of self-harm because of exposure to specific adversities (domestic and sexual violence, poverty, humanitarian emergency), chronic illness (HIV/AIDS) and/or life circumstances (adolescent pregnancy and/or parenthood, youth involved with the juvenile or criminal justice system, being a sexual or gender minority persons, internally displaced persons, persons with disability and other individuals receiving social-welfare services). These persons may be unable to access resources for universal mental health promotion in the communities and may benefit from tailored approaches and more intensive psychosocial interventions. The essential principle is to have a framework to address the identified known risk factors and challenging life circumstances. There are WHO guidelines for targeted interventions (e.g., WHO Guideline: Responding to intimate partner violence and sexual violence against women, The Adolescent Girls Empowerment Programme, Enhancing Resilience Amongst Students Experiencing Stress, WHO Early Adolescent Skills for Emotions, etc.) which has shown effectiveness in reducing mental health and suicidal risk in developing countries elsewhere and which is adaptable to the Nigerian context.

III. **Indicated Interventions:** Indicated psychosocial interventions are delivered to people who present with early signs or mild symptoms of mental health problems/suicidality. The aim is to avert the progression to worse forms of mental health conditions or the progression of suicide risk. Such interventions are often more tailored to individual needs. The interventions that have worked include-

(i) Early identification and effective management of early symptoms of emotional/behavioural disorders and (ii) management and follow-up of suicide attempters. There are existing intervention packages to reduce symptoms of emotional/behavioural disorders, which have shown effectiveness in other LMICs. The WHO Early Adolescent Skills for Emotions and Scalable Technology for Adolescents to Reduce Stress. In fact, a psychosocial intervention for adolescents with existing aggressive behaviours has been tested and found effective in reducing symptoms of conduct disorder in schools in Nigeria.[29] Regarding effective interventions for previous attempters, the Brief Contact Intervention (BCI) is a low-cost, non-intrusive brief intervention with persons who have attempted to end their

[27] WHO: Helping Adolescents Thrive Toolkit. https://www.who.int/publications/i/item/9789240025554;
[28] This is a universal, school-based mental health promotion and suicide primary prevention intervention for adolescents. YAM was designed to raise mental health awareness about common suicide risk and protective factors, such as depression, anxiety, and social support.

lives by suicide.[30] It may be augmented with additional therapies such as telephone contacts and text messages. BCI was associated with a lower risk of suicide after attempts in places where it has been implemented. For instance, in a model in Korea, trained case managers contact patients (usually via telephone but can be physical contact) within 24 hours of their presentation to the emergency department with a suicide attempt for two distinct purposes: (1) providing psychosocial support and (2) proactively ensuring the preservation of a benevolent, non-intrusive link with healthcare systems in case of renewed crisis.[31]

IV. **Crisis intervention for suicidal persons:** This involves providing a 24-hour crisis care telephone service where individuals at risk can reach out to and receive immediate psychosocial support, and linkage with available services can be done. Some NGOs including SURPIN and The Sunshine Series 112 helpline in Nigeria, already have a framework for this. These helpline services shall be replicated in all the public health institutions and at the National and State levels in Nigeria.

3.2.2 Community-level Interventions

The most popular and effective community-level intervention which has proven efficacy in LMICs include public awareness raising, limiting access to the means of suicide and interacting with the media for responsible reporting of suicide.

***Public-Awareness Raising*:** Awareness-raising is crucial for health problems such as suicide prevention, targeted at a public audience to increase knowledge and change attitudes.

***Limiting Access to the Means of Suicide*:** This is a universal evidence-based intervention for suicide prevention. Depending on the country, this may mean banning highly hazardous pesticides, restricting firearms, installing barriers at "jump sites," limiting access to ligature points (points that could be used to attach a cord or other material to hang or strangulate) or taking other measures to make it more difficult to access the means of suicide. Most people who engage in suicidal behaviour experience ambivalence about living or dying, and many suicides are a response to acute stressors. Making lethal means of suicide less readily available gives persons in distress time for acute crises to pass before taking fatal action.

Interacting with the media for responsible reporting of suicide: There is evidence that media reporting of suicide can lead to a rise in suicide due to imitation, particularly in cases of celebrity suicide and where suicide methods are described. There is also evidence that portrayals of suicide written following media guidelines have the potential to help prevent suicide. The media plays an important role in shaping public opinion and attitudes and is an important stakeholder in raising awareness and reducing the stigma of suicide. There is research evidence that shows that media reporting of suicide in Nigeria hardly follows the WHO guidelines for suicide reporting. Working with the media can include collaboration in developing local guidelines on suicide reporting and regulating responsible coverage of

[29] Abdulmalik J, Ani C, Ajuwon AJ, Omigbodun O. Effects of problem-solving interventions on aggressive behaviours among primary school pupils in Ibadan, Nigeria. Child Adolesc Psychiatry Ment Health. 2016 Sep 2;10(1):31. doi: 10.1186/s13034-016-0116-5.
[30] Milner, A., Spittal, M.J., Kapur, N. *et al.* Mechanisms of brief contact interventions in clinical populations: a systematic review. *BMC Psychiatry* 16, 194 (2016). https://doi.org/10.1186/s12888-016-0896-4
[31] Kim H, Park J, Kweon K, Ahn J. Short- and Long-term Effects of Case Management on Suicide Prevention among Individuals with Previous Suicide Attempts: a Survival Analysis. J Korean Med Sci. 2018 Aug;33(32):e203. https://doi.org/10.3346/jkms.2018.33.e203

suicide. There is a need to work with media regulatory agencies to pre empt and identify content that fails to meet reporting guidelines. Interactions will include building the capacity of media professionals to report responsibly.

3.2.3 Policy Level Interventions

These are the interventions that are done at the level of policymakers. The policymakers primary responsible for driving suicide prevention initiatives in Nigeria are the Federal and State Ministries of Health through their respective Mental Health Desks. The policy-level interventions that have worked elsewhere include advocacy, the building of multi-sectoral collaborations and the facilitation of capacity building.

3.3 Strategic Objectives

I. To establish a suicide prevention governance structure in Nigeria, which will include the following: National Suicide Prevention Steering Committee and National Suicide Prevention Technical Working Group at both national and state levels.

II. To establish and strengthen policy, legal framework as well as mobilise resources to operationalise the suicide prevention governance structure effectively.

III. To improve access to quality and integrated services for suicide interventions at all levels of care

IV. To increase awareness- raising activities and advocacy on suicide and suicide prevention

V. To strengthen research, surveillance, monitoring and evaluation of suicide.

3.3.1 OBJECTIVE ONE:

To establish a Suicide Prevention Governance Structure (Inter-sectoral Steering Committee and Suicide Prevention Technical Working Group) at national and state levels.

There is a need to establish a suicide prevention governance structure to mitigate the rate of suicide both at national and state levels. The governance structure shall include an Inter-sectoral Steering Committee, and Technical Working Group on suicide prevention at National, State and Local Government levels. The governance structure shall provide leadership in planning, coordination, implementation, supervision and resource mobilisation of the suicide prevention strategic framework.

Table 4: Strategic One

Implementation Domain	Sub-objectives	Key Activities
Governance structure	Establishment of an Inter sectoral Steering	• Development of Terms of Reference
	Committee that involves all relevant stakeholders on suicide prevention at all levels	• Identify members from key Ministries, Departments and Agencies, Professional bodies, Associations, Research Institutes, Academia, Civil Society Organisations, Non-Governmental Organisations, Bilateral/Multilateral Organisations, Faith and Traditional leaders, amongst others • Inauguration of the steering committee • Conduct bi-annual meeting
	Establishment of a Technical Working Group with clear terms of reference at the National and state levels	• Development of Terms of Reference • Identify members from key Ministries, Departments and Agencies, Professional bodies, Associations, Research Institutes, Academia, Civil Society Organisations, • Non-Governmental Organisations, Bilateral/Multilateral Organisations amongst others • Conduct quarterly meetings of the Technical Working Group • Establish sub-committees per thematic areas identified
Coordination	Establishment of Suicide prevention/mental health focal points in 36 states and the FCT	• Identify focal points • Capacity building of the state focal persons on suicide prevention and mental health

3.3.2 OBJECTIVE TWO:

To strengthen the policy, legal framework and resource mobilisation for effective operationalisation of the suicide prevention strategic framework in Nigeria.

The National Policy for Mental Health Services Delivery 2013 does not provide interventions for suicide. However, the National Mental Health Policy 2023-2028 has considered this gap.

Although Section 327 of the Nigeria Criminal Code and Section 231 of the Northern Nigeria Penal Code criminalise suicide in Nigeria, there is a need for a coordinated effort to ensure that people who attempt suicide get adequate treatment and care contrary to a one-year jail term currently prescribed by the criminal code. There is a need to review the criminal code act of the Federal Republic of Nigeria to align it with constitutional dispensation, the provisions of the National Mental Health Act and international laws such as the U.N. Convention on Rights of Persons with Disabilities (CRPD), and to address emerging issues.

The Mental Health Act 2021 aims to promote and protect the rights of persons with mental health conditions and persons with intellectual, psychosocial or cognitive disabilities and to provide for enhancement and regulation of mental health services in Nigeria.

Mental health care in Nigeria is grossly underfunded; the total government expenditure on mental health is 3.3 - 4% of the country's GDP with over 90% of the budget going to neuropsychiatric hospitals.[32] The underfunding of mental health has greatly affected the availability and accessibility of mental health services in Nigeria. Additionally, improved mental health financing is necessary to ensure successful and impactful suicide prevention interventions. There's a need to intensify resource mobilisation efforts to finance and strengthen the policy, legal framework and resource mobilisation for effective operationalisation of the suicide prevention strategic framework in Nigeria.

Table 5: Objective Two

Implementation Domain	Sub-Objectives	Key Activities
Policy	To strengthen the existing policies that limit access to means of use for suicide	• Conduct mapping of existing policies that regulate activities bearing on suicide and hazardous items used to commit suicide, such as firearms, pesticides, etc. • Develop a policy prescription based on mapping and review at sessions with relevant stakeholders.
	To develop a comprehensive package for the prevention of suicide, including life skill training and psychosocial support	• Collaborate with relevant stakeholders to decrease activities and use of means of suicide. • Connect at risk individuals, especially adolescents' and other vulnerable populations, to socio-economic opportunities in the public and private sectors.
Legal	To decriminalise suicide by repealing Section 327 of the Criminal Code Acts of Nigeria, Section 231 of the Northern Nigeria Penal Code, and similar laws at the sub-national levels	• Convene national stakeholder dialogue on decriminalising attempted suicide. • Develop draft legislation to repeal the criminalisation of attempted suicide. • Conduct advocacy visits to the National and State Assemblies as well as the Executive Arm to introduce and pass legislation repealing the criminalisation of attempted suicide. • Conduct mass awareness campaigns at all levels and to increase public will on decriminalising attempted suicide.

		• Communicate updated policy, law, and guidelines to first responders, police, and security agencies.
Financing	To include mental health in the Implementation of Basic Health Care Provision Fund	• Advocacy to the National Primary Healthcare Development Agency and National Health Insurance Authority to expand the coverage of mental health services to include other mental health conditions outside of depression screening. Also, scale-up coverage of psychotropic drugs, counselling, psychosocial services, etc. for coverage under the Basic Health Care Provision Fund (BHCPF) by the Federal Government. • Engage with the National Primary Healthcare Development Agency and National Health Insurance Authority for inclusion of mental health in implementing BHCPF through capacity building of primary healthcare workers on mental health.
	Mainstream suicide prevention and mental health support in national and state health insurance packages.	• Assess the scope of the basic minimum package of health services as contained in the National Health Insurance Act (NHIA) to see the extent of inclusion of suicide prevention and mental health services. • Review best practices and develop a minimum package for the inclusion of suicide prevention and mental health services. • Advocacy to the National

		Health Insurance Agency to adopt an updated minimum package. • Raise awareness to the general public on updated health insurance packages for mental health care
	Increase budgetary allocation	• Conduct mapping of the financial landscape for suicide prevention and mental health at the National and State levels. • Prepare an investment case for increased budgetary allocation. • Advocacy to Federal and State Ministries of Health's leadership to increase mental health budget, especially provision of psychosocial services. • Advocacy to National and State Assemblies to increase the budgetary allocation for mental health.

3.3.3 OBJECTIVE THREE:

To improve access to quality and integrated services for suicide interventions at all levels of care.

Improved access to and availability of evidence-based suicide prevention interventions and treatment services at all levels of care are necessary to mitigate the burden of suicide in Nigeria. Access to holistic and quality care is important for the promotion and enhancement of mental health and well-being. There has been an increase in suicidal behaviour in Nigeria due to socio-economic factors. However, most of the people who are affected lack access to adequate preventive, treatment and aftercare services. This specific objective aims to reduce the barriers to accessing services and ensure the availability of quality and evidence-based suicide prevention interventions at various levels of healthcare in a continuum of care that includes crisis intervention, treatment, and follow-up.

Table 6: Objective Three

Implementation Domain	Sub-objectives	Key Activities
Preventive Interventions	Establish a national suicide prevention helpline and referral pathway across all levels of healthcare	• Map current crisis and emergency hotlines in Nigeria and understand their operations • Assist in coordination and financing to support national coverage of crisis hotlines to ensure provider availability, especially in underserved areas • Identify institutions and facilities that can serve as referral pathways for crisis hotlines and establish connections • Mainstream the sharing of crisis hotline information in public announcements and awareness concerning emergencies and social crisis

Quality Treatment	Establish best practices document on effective mental health policies for organisations	• Research best practices for public and private sector organisational practices and policies on mental health • Develop standard operating procedure (SOP) policy documents. • Develop a clear, concise view of the need for mental health screening to help explain its need early in the implementation process.
	Integrate screening and assessment of suicide risk factors at all levels of healthcare	• Establish guidelines and protocols for domestic mental health screenings, which should include a review of medical history to understand substance abuse, trauma, or mental health conditions; directly asking about suicidal ideation as part of integrated history and physical examination; identify standardised screening tool or tools that will be utilised; screen for substance abuse; and develop action plan, referral pathway, decision rule or response policies. • Disseminate approved guidelines to health care facilities and providers. • Build response resources to screening results. • Conduct training on established guidelines for primary, secondary, and tertiary medical facilities

		and other institutions (e.g., at-risk populations, correction systems, etc.) • Research best practices for rehabilitation and aftercare. • Assess aftercare service providers that are being conducted through best practices, including outpatient and home visits, telephonic check ins, and social skills training. • Establish linkages, provide resources, and establish referral pathways for effective rehabilitation and aftercare service providers.

3.3.4 OBJECTIVE NUMBER FOUR

To increase awareness-raising activities and advocacy on suicide and suicide prevention

Improved awareness and advocacy are key actions that contribute to overall suicide prevention efforts by influencing decision-makers and public opinion, attitudes and behaviours. It reduces stigmatisation and discrimination of suicide among the general populace and increases the number of people seeking help. There has been an increase in the number of suicides in Nigeria, which may be attributed to a lack of awareness and advocacy on suicide issues. Awareness-raising and advocacy for suicide prevention can be conducted in communities (such as villages, schools or workplaces), and in the form of nationwide public communication campaigns. Additionally, integration of awareness-raising activities such as meeting with relevant stakeholders, dissemination of information on suicide prevention on radio, television, social media and print media as well as press briefing and billboards should be implemented.

Table 7: Objective Four

Implementation Domain	Sub-objective	Key Activities
Public Awareness and Advocacy Campaign	To strengthen effective mass media and advocacy campaigns to raise	• Develop Information, Education, and Communication (IEC) materials on suicide and suicide

	awareness on prevention and responses to suicide	prevention for target groups. • Develop modalities for stakeholder engagement advocacy and public sensitisation on suicide prevention. • Conduct annual nationwide sensitisation and awareness campaign on suicide prevention during the month of September. • Conduct targeted media campaigns on suicide and suicide prevention. • Convene community feedback meetings and mechanisms for input that are treated and reviewed at high political levels of the Federal Ministry of Health and relevant stakeholders.
Media Reporting	Implement de-sensationalisation of media reports of suicide and attempted suicide.	• Engage with the National Broadcasting Corporation and media organisations to raise professional standards billboard messages for responsible reporting as a suicide prevention strategy. • Capacity building of targeted groups (e.g., healthcare workers, media practitioners, law enforcement agencies, educational institutions, religious and traditional leaders, first responders, etc.) on suicide and suicide prevention.
Education and Training	Include psycho-education for depression and suicide prevention in the education curriculum	• Engage law enforcement and First Responders in innovative models of caregiving and community engagement in Suicide and Suicide Prevention. • Provide support to the survivors and victims of suicide attempts.

3.3.5 OBJECTIVE FIVE:

To strengthen research, surveillance, monitoring and evaluation of suicide interventions, including prevention and management.

Monitoring and evaluation is one of the strategic interventions required for surveillance and data for decision-making, policy formulation and financing. However, there is a need for country data collection to develop a full understanding of suicidal behaviour in the population. This strategic objective will ensure the availability of data on suicide in the National Health Information System.

Table 8: Objective Five

Implementation Domain	Sub-objective	Key Activities
Research	To strengthen research on mental health and suicide prevention.	• Conduct a study to identify commonly used means of suicide • Conduct a study to identify risk factors for suicide (behavioural, socio-economic, environmental, religious, cultural, etc.) • Conduct mapping of "hotspot" areas for suicide. • Conduct an assessment to identify available surveillance systems at the facility level. • Conduct an evaluation to determine baseline and annual data of suicide mortality rates.
Surveillance	Development of dat collation systems for timely decision-making on mental health and suicide prevention	• Liaise with the Federal Ministry of Health's Health Planning, Research, & Statistics Department (DHPRS) to include suicide indicators in the National Health Management Information System (NHMIS) and Integrated Disease Surveillance and Response (IDSR). • Collate data on suicide and suicide attempts from the Nigeria Police Force and other community structures (Ward Health Committee/Village Health Committee). • Establish a facility-level suicide registry and a national suicide

		repository at all levels. • Conduct regular National Surveys on mental health, including suicide behaviours, suicide attempts, suicide reports, risk factors, means of suicide, etc.
Monitoring and Evaluation	Ensure monitoring and evaluation of interventions	• Develop indicators for monitoring and evaluating suicide, suicide attempts and suicide prevention interventions. • Regularly monitor interventions to ensure they are on track and maintain fidelity. • Conduct evaluation of interventions to assess impact and to inform scale-up.

CHAPTER 4: IMPLEMENTATION FRAMEWORK

4.1. COORDINATION AND GOVERNANCE

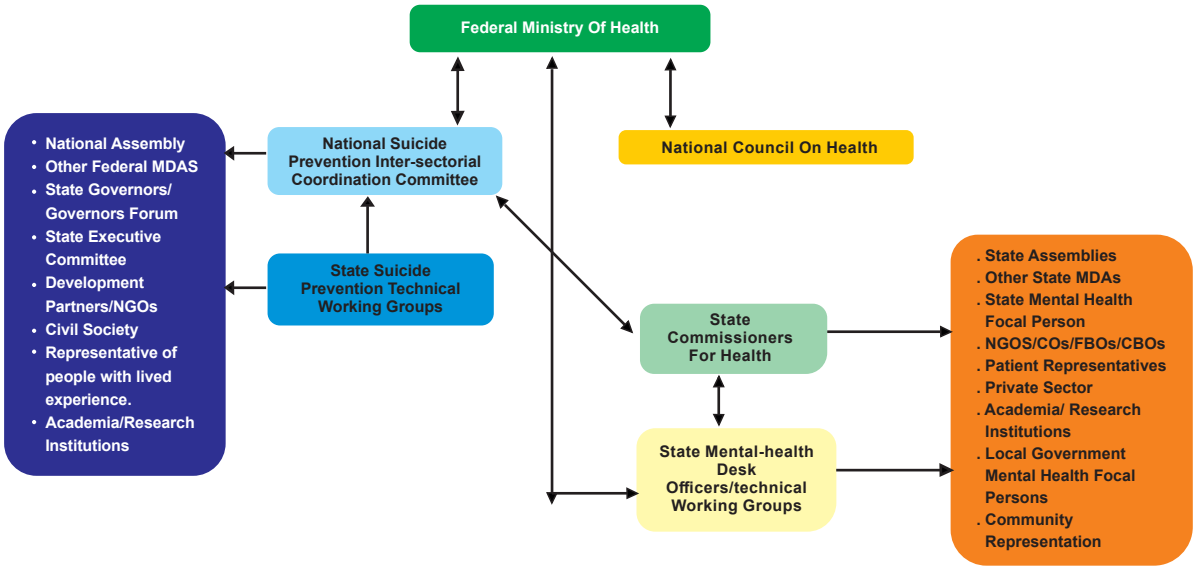
4.1.1. Overview

Leadership and governance will play a critical role in successfully implementing this Suicide Prevention Strategy by providing a framework for engagement with various institutions, the private sector, state governments and relevant ministries working in suicide programming within the country. This will be critical because of the devolution of health service delivery and the need for functional governance mechanisms at all levels. The Ministry of Health will lead the oversight and coordination through this Suicide Prevention Strategic Framework of the National Mental Health Programme.

The strategy will be implemented in accordance with existing relevant policies and legislative frameworks. The established National Programme will provide the necessary tools, guidelines, technical support, monitoring and evaluation. It will establish state mental health councils/committees/boards and mental health coordination units to cascade programme elements to the community level through Local Government Focal Persons. The financing of the suicide prevention programme annual work plan will be through the Midterm Expenditure Framework (MTEF). Other sources of financing will be through donations and funding from civil society organisations, philanthropists, the diplomatic community and Corporate Social Responsibility (CSR) of the private sector.

The strategy will be implemented in seven (7) years by monitoring specific targets and indicators using an evaluation tool. The multi-sectoral actors will be responsible for various activities and interventions upon which they will report to the national level. The roles and responsibilities of the various actors may be cross-cutting and may overlap. The baseline survey, annual review (operational work plan, processes, and targets), and mid-term and final evaluation will be conducted to inform the progress of interventions and strengthen systems.

Figure 3: To Establish Suicide Prevention Governance Structure



National Suicide Prevention Institutional and Accountability Framework

For the structures outlined in the figure above to function efficiently, this strategy was envisioned to strengthen collaboration, linkages and harmonisation of approaches between the various stakeholders. A clear understanding of the roles and responsibilities of each of the actors towards the realisation of the broad objectives of this strategy is vital.

4.1.2 Roles and Responsibilities

Table 9:

Stakeholder	Roles and Responsibilities
Federal Ministry of Health	• Provide overall leadership and stewardship in suicide management (e.g., prevention advocacy, social mobilisation, treatment, etc.) • Development and review of policies and guidelines for prevention of suicide • Prepare a framework for stakeholder engagement and revitalisation of multi-sectoral stakeholders' coordination mechanisms. • Strengthen international collaboration in support of national plans for the prevention and control of suicide • Provide technical oversight for activities aimed at suicide prevention in Nigeria • Mobilise and allocate resources for suicide prevention activities • Proffer sector frameworks to guide investments in suicide prevention • Maintain a resource mapping repository. • Coordinate suicide prevention data management and dissemination as well as research and technology platforms. • Develop Capacity for human resources for mental health (HRMH). • Support country efforts to prevent and control suicide. • Facilitate systematic and timely information exchange among stakeholders. • Strengthen advocacy to raise the priority accorded to the prevention of suicide.
Ministries, Departments, and Agencies (MDAs)	• Partner and collaborate in the implementation of suicide prevention strategies • Formulate and implement relevant policies on suicide prevention • Build capacity and strengthen systems aimed at addressing mental health determinants and suicide risk reduction

Stakeholder	Roles and Responsibilities
	• Implement workplace mental health and suicide prevention programmes • Institute school mental health program and socio-emotional skills training
State /Local Government	• Implement national policies and guidelines on suicide prevention at the state and local government levels. • Suicide prevention service provision at all levels. • Prioritising suicide prevention in the health financing policy and planning. • Provision of well-equipped health facilities. • Hiring, training, retention, and remuneration of human resources for health (HRH) in line with Nigeria's HRH strategy. • Advocacy and policy geared towards suicide management and prevention. • Ensuring availability of essential health products and technologies (HPTs). • Resource mobilisation, allocation and creating a conducive environment for implementing partners towards suicide prevention. • Streamlining referral services. • Establish multi-sectoral forums geared towards suicide management and prevention.
Private sector	• Provide financial support for Suicide prevention and control interventions. • Ensure manufacturing of quality, affordable, accessible healthcare goods and services (e.g. medicines, pharmaceutical products, and rehabilitation). • Undertake corporate social responsibility (CSR) activities targeting community awareness for Suicide prevention. • Insurance companies should develop medical cover packages that do not discriminate against the management of suicidal behaviour. • Conduct responsible advertising and follow suicide risk control laws and policies. • Support technology innovation and use in the health sector. • Support implementation of suicide prevention and control initiatives at their workplaces. • Comply with policies, strategies, and guidelines on suicide

Stakeholder	Roles and Responsibilities
	prevention. • Develop workplace policies that do not discriminate against people who have attempted suicide. • Participate in resource mobilisation. • Provide a healthy and friendly environment to support suicide prevention. • Create incentives for employers to reduce psychological and job-related stress, enhance stress management, and introduce easy-to-implement programmes to promote well-being in the workplace.
Private health facilities	• Offer quality and affordable healthcare for persons who have attempted suicide seeking care in private hospitals. • Undertake CSR activities targeting community awareness for Suicide prevention. • Comply with policies, strategies, and guidelines on Suicide prevention and control. • Build capacity for suicide prevention and control. • Participate in data sharing on suicide-related information.
Faith-based organisations	• Suicide care provision in line with the suicide prevention strategy. • Linkage to patients/people that have prior Suicide attempts. • Mobilise resources for suicide prevention activities. • Contribute consensus building and connect local communities with the health care system. • Provision of care and support to vulnerable groups. • Strengthen human resources for health. • Promote healthy lifestyles to address risk factors for suicide.
Development partners	• Provide technical support and capacity building. • Support resource mobilising and financing of suicide prevention interventions. • Participate in a multi-sectoral coordination mechanism.
Regulatory and professional bodies	• Review and development of curricula to incorporate suicide prevention strategies. • Implementation of the HRH for mental health, specifically addressing staffing gaps, task sharing, career progression and recognition.

Stakeholder	Roles and Responsibilities
	• Expanding the availability of specialists, guideline development and dissemination • Capacity building, research and conducting advocacy at both national and subnational levels.
Lawmakers (Federal and State))	• Pass bills for the prevention and control of Suicide • Lobby for increased allocation of resources for suicide prevention strategies. • Provide an oversight for suicide prevention implementation in the country. • Implement suicide prevention and management laws
Academic, research and health training institutions	• Support education and training on suicide prevention. • Review education curricula in consultation with regulatory bodies to respond to evidence-based suicide prevention interventions. • Carry out research that will inform policy and plans for suicide prevention
People with lived experience (survivors and their families)	• Participate in strategic planning and multi-sectoral implementation of suicide prevention strategy. • Participate actively in the promotion of mental health and evidence-based suicide prevention interventions. • Advocate for increased resources toward the implementation of suicide prevention programmes at community levels. • Provide peer support and care programmes. • Advocate for inclusive policies, access human rights-based community mental health services and decriminalisation of suicide attempts and suicide.
Individuals and communities	• Adopt appropriate mental well-being and healthcare-seeking behaviours. • Participate actively in health promotion and suicide prevention activities. • Increase demand by lobbying and seeking insurance policies for financial and social protection. • Participate in social mobilisation activities to raise awareness for suicide prevention and stigma reduction activities. • Participate in the budget-making process and implementation of policies and plans.

Stakeholder	Roles and Responsibilities
	• Adopt annual screening on mental well-being and suicide risks.

4.2. Monitoring and Evaluation Framework

The monitoring and evaluation framework identifies results expected in the course of implementation of the Suicide Prevention Strategy, together with indicators that will measure the progress of achievement of these results. These high-impact indicators, if achieved, will contribute significantly to the ultimate goal of reducing the suicide mortality rate in the country. Federal, state and local government health facilities and all other stakeholders will be expected to align with the reporting tools and processes in this strategy to ensure standardised data collection.

The Ministries of Health will maintain an implementation tracking plan. There will be an annual Suicide Prevention Strategy review meeting that will involve key stakeholders to discuss performance, implementation challenges and best practices and recommend any modifications needed to inform decisions on how to accelerate the achievement of set targets. Further, there will be a mid-term and end-term evaluation to complement the knowledge base of routine monitoring data to assess the utility, relevance and effectiveness of the strategy .

Strategic Objective 1: To establish suicide prevention governance structure (Steering Committee, and Suicide Prevention Technical Working Group) at national and state levels

Activity/Sub-Objective	Indicators for Measurement	Frequency of Measurement	Data Source	Responsible Person(s)	Baseline	Targets						
						2024	2025	2026	2027	2028	2029	2030
Establishment of Intersectoral Steering Committee	Terms of Reference developed	N/A	Records and documents	Program Coordinator,	N/A	N/A						
Establishment of Intersectoral Steering Committee	Terms of Reference developed	N/A	Records and documents	Program Coordinator,	N/A	N/A						
Coordination: Establishment of Mental Health Focal Points in all the state	Focal point Assigned	N/A	Focal point registry	Program Coordinator, SMOH	5.4%	50%	100%	100%	100%	100%	100%	100%

Strategic Objective 2: To strengthen the policy, legal framework and resource mobilization for effective operationalization of the suicide prevention strategic framework in Nigeria.

Activity/Sub-Objective	Indicators for Measurement	Frequency of Measurement	Data Source	Responsible Person(s)	Baseline	Targets						
						2024	2025	2026	2027	2028	2029	2030
Policy: Strengthening existing policies to limit access to means of suicide	Anti suicide policy reviewed	N/A	Updated policy document	Programme coordinator With support from partners	Existing	Improved						
Legal: Decriminalization of suicide through dialogue	National dialogue meeting conducted	Once	Dialogue reports	Programme coordinator with support from Partners and relevant stakeholders	N/A	Legislation Passed						
Financing: Inclusion of mental health in Basic Health Care Provision Fund	Percentage of Basic Health care provision fund allotted to Mental Health.	Ongoing	Advocacy reports	DFA, Programme coordinator. Budget and Planning	N/A	N/A						

Financing: Mainstream suicide prevention in national and state health insurance packages	Inclusion in insurance packages assessed	N/A	Assessment reports	NHIA Policy Analyst	10%	15%	30%	45%	60%	75%	90%	100%
Financing: Increase budgetary allocation for mental health	Budgetary allocation mapped	Once	Budget documents	Finance Officer, Budget Authorities	Current allocation	20%	40%	60%	80%	100%		

Strategic Objective 3: To improve access to comprehensive, integrated and quality service for suicide interventions at all levels of care.

Activity/Sub-Objective	Indicators for Measurement	Frequency of Measurement	Data Source	Responsible Person(s)	Baseline	Targets						
						2024	2025	2026	2027	2028	2029	2030
Preventive Interventions: Establishment of national suicide prevention helpline and referral pathway	Hotlines and referral pathways established	N/A	Helpline records, reports	Program Manager, Crisis Helpline Team	N/A	N/A						

Quality Treatment: Integration of screening and assessment of suicide risk factors at PHC level	Guidelines and training protocols developed. Percentage of health facilities offering suicide screening	N/A	Guideline documents	Mental Health Specialist, Healthcare Facilities	6%	30%	60%	90%	100%		
Quality Treatment: Research best practices for rehabilitation and aftercare	Best practices identified	Once	Research findings	Research Team, Aftercare Providers	N/A	Implemented best Practices					
Quality Treatment: Establish linkages and referral pathways for rehabilitation and aftercare	Referral pathways established	Ongoing	Referral records		N/A	Functional pathways					

Strategic Objective 4: To increase awareness-raising activities and advocacy on suicide and suicide prevention.

Activity/Sub-Objective	Indicators for Measurement	Frequency of Measurement	Data Source	Responsible Person(s)	Baseline	Targets						
						2024	2025	2026	2027	2028	2029	2030
Public Awareness and Advocacy: Strengthen mass media and advocacy campaigns	Awareness campaigns conducted. Number of IEC material on suicide prevention produced and disseminated Availability of Jingles on suicide prevention	Ongoing	Campaign reports	Communication Officer, Advocacy Team	N/A	10,000	20,000	30,000	40,000	50,000	60,000	70,000
Media Reporting: Implement de-sensationalisation of media reports	Number of radio station airing jingles on suicide prevention	Programme Report	Guideline documents	Media Regulatory Authorities, Communication Officer		4	8	12	16	20	24	28
Education and Training: Include psycho-		NA	Assessment reports	Education Officials, Programme managers	N/A	Curriculum Integration						

education in education curriculum	Curriculum integration assessed					
Education and Training: Engage law enforcement and First Responders	Law enforcement engage	NA	Engagement reports		N/A	

Strategic Objective 5: To strengthen research, surveillance, monitoring and evaluation of suicide interventions, including prevention and management

Activity/Sub-Objective	Indicators for Measurement	Frequency of Measurement	Data Source	Responsible Person(s)	Baseline	Targets						
						2024	2025	2026	2027	2028	2029	2030
Research: Strengthen research on mental health and suicide prevention	Research studies conducted	Ongoing	Research reports	Research Team	N/A	Improved research						
Surveillance: Development of data collation systems	Systems integrated into NHMIS and IDSR	Ongoing	Integration reports	Surveillance Specialist, DHPRS	N/A	N/A						
Surveillance: Collate data on suicide and	Data collection initiated	Routine	DHIS2	Data managers	N/A	N/A						

suicide attempts						
Monitoring and Evaluation: Develop indicators for monitoring and evaluation	Indicators defined	N/A	Data tools or treatment register	Data manager Program Coordinator	N/A	N/A
Monitoring and Evaluation: Regularly monitor and evaluate interventions	Monitoring and evaluation reports	Ongoing	Monitoring and evaluation reports	Data manager, Program Coordinator	N/A	N/A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