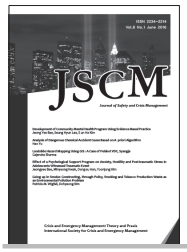

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Preventive Strategies for Suicide in Asian Countries: Focusing on China, Japan, Korea, Sri Lanka and Vietnam

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A B S T R A C T

Purpose: The aim of this review was to provide the preventive strategies for suicide in Asian countries with the understanding the current status of suicide in Asian countries such as China, Japan, Korea, Sri Lanka and Vietnam. **Methodology:** We searched a systematic review and online literature from journal articles and other documents about suicide. **Results:** Sri Lanka has one of the highest suicide rates in the world and Vietnam has the lowest estimated prevalence, followed by China, Korea and Japan have low to medium rates. Some suicide-preventive strategies are used in the Asian countries but they are not popular. There are many training programe about mental health problems for community. **Conclusion:** Suicide intervention programs in Asia are limited because they are depended the sociocultural situations and economic transitions in the region so we need to coordinate with national suicide prevention organization to prevent the most effectivily suicide.

Key words: suicide, suicide prevention, China, Japan, Korea, Sri Lanka, Vietnam

Background

Suicide is defined as “the death caused by self-directed injurious behavior with an intent to die as a result of the behavior” (CDC, 2017). Suicide is one of the most health problems in the world. According to the World Health Organization and The World Bank (2017), every year in the world there are more than 800,000 persons die because of a consequence of suicide. This means that the death of suicide equals with road traffic accidents in many countries. Suicide is a major health concern in many countries, especially developed and developing countries. Suicide does not just occur in high-income countries, but is a global phenomenon in all regions of the world. In fact, over 78% of global suicides occurred in low- and middle-income countries in 2015(World Health Organization, 2017).

Particularly in Asia where high suicide rates in a few countries with large populations account for a majority of the world’s suicides.

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According to WHO, Vietnam has the lowest estimated prevalence of 7,4 per 100,000, followed by China at 10 per 100,000. Korea and Japan have low to medium turn rates 14,8 per 100,000 and 17,2 per 100,000. And Sri Lanka has one of the highest suicide rates in the world, 34,6 per 100,000 (World Health Organization, 2017). Suicide is an extremely important public health problem. However, people have not show interest in suicide. Throughout the world, resources devoted to the prevention of suicide are only a tiny fraction of those devoted to the prevention of comparable problems.

China, Japan, Korea, Sri Lanka, Vietnam are the Asian countries where are experiencing different stages of economic and social development, with likely profound effects on people in social. Because the researchers come from Vietnam and Sri Lanka, they want to find the real situation and preventive strategies for suicide in their countries. Korea achieved economic transformation in a very short period of time. From being an agriculture country, Korea became one of the Asian tiger economies within decades. However social change in the country did not keep pace with economic change. This sudden transformation has massive social implications and the suicide rate also increased proportionately. For this reason Korea is infamous for being one of the countries with the highest suicide rates in the world. Besides that Japan is also develop country and has very high societal pressure and their methods of coping with this pressure differ from the West. Every Japanese is always filled with idea they must work hard, get into a good university, enter a good profession, contribute to family and society. On the other hand in Japanese culture, there is a long history of considering certain types of suicides honorable, especially during military service. Hence suicide the leading cause of death for the young people in social of Japan. Besides, China has the largest population in the world. Suicide in China has become a focus of study in recent years, partly because of increasingly available data and the astonishingly high rates of Chinese suicide publicized in previous reports. However study of suicide in China is complicated by political concerns which cause official statistics to vary (sometimes greatly) from the findings of independent studies. Generally speaking, China seems to have a lower suicide rate than neighboring Korea and Japan. So how does China prevent the suicide and have low suicide rate in the largest population country in the world, this is question researchers want to explore.

Despite this, suicide has received relatively less attention in Asia than it has in Europe and North America. Lack of resources and competing priorities in many Asian countries have contributed to this under-emphasis. Cultural influences, religious sanctions, stigmatization of the mentally ill, political imperatives, and socio-economic factors have also played a significant role(Vijayakumar L, 2005). Economic development has seen movement from rural villages to urban centers, and this has been associated with a heightened risk of suicide among those remaining in rural settings, perhaps because of economic hardship, lack of social support, isolation and access to lethal means like pesticides. Cultural factors also play a role in shaping the profile of suicides in participating countries. In many Asian settings suicide contravenes religious, cultural, or legal traditions(suicide is still criminalized in several countries) or is seen as a reflection of poor governance. Suicide represents a serious public health burden, however suicide attempts confer morbidity and economic burden on individuals, their families and friends, their workplaces, and on healthcare settings as well as the economic costs associated with medical care and lost productivity.

Although suicide in Asia is widely recognized as a compelling problem, obtaining accurate data about suicide in Asia has proved difficult. Some countries make no effort to collect data on the causes of death. In many Asian countries deaths occur without medical certification of the cause and may be reported by family members or other lay people who do not wish to acknowledge suicide for fear of stigma or shame. The present study presents an opportunity to explore the influence of social change on the rates of suicide in five counties of Asia: China, Japan, Korea, Sri Lanka and Vietnam. Despite increasing rates of suicide in Asian, there is a lack of suicide data among the countries, and little is known about the risk and protective factors for suicide. Therefore, the objectives of this study are as follows: (1) identify prevalence of suicide in Asian countries such as China, Japan, Korea, Sri Lanka and Vietnam, (2) develop the preventive strategies for suicide in Asian countries.

Research Methods

The review was based on the reporting items for systematic reviews. We conducted a systematic search from The US National Library of Medicine's PubMed electronic database, PsycInfo, ISI Web of Science and World Health Organization (WHO). All databases related to the terms and the article. It's included epidemiologic studies and prevention strategies of suicide from their start date until 2017.

We searched keywords to identify eligible studies. Keywords are related to suicide and has combination with each individual country in Asia (e.g., "suicide" and "Vietnam"). Then these were combined with keywords relating to suicide prevention or intervention. Keywords were adapted for the specific requirements

of each electronic database. No restrictions were placed on publication status or language, but if we were unable to obtain adequate details for data extraction these studies were later excluded.

The reference lists of articles identified by the search strategy were also searched for relevant articles. Reviews and book chapters were cited to provide opportunities for further reading. Despite a lot of countries in Asia, but we only select 5 countries because they are develop and developing countries and had shown either some unique features or some significant changes in the suicide patterns in many years.

Suicide status of Asian Countries and development of Preventive Strategies

China

In general, although prevalence of suicide in China has decreased over past decade, it has been a major public health challenge in China. Based on data from WHO, the prevalence of suicide was 10.0 per 100.000 people in 2015 (World Health Organization, 2017). The suicide rate among women was 11.5, which was higher than the rate of 8.7 among men. Suicide rates were higher in rural areas compared with urban areas (Liu, *et. al.*, 2015). Wang C.W. and Colleagues (2014) presented the time trend of suicide rate among people aged 15 or above in China over the period 2002-2011. The results found that 44% of all suicides occurred among those aged 65 or above and 79 % among rural residents. Among Chinese people, young adults in rural China aged 25 to 34 years had an increased risk of suicide (Zhao & Zhang, 2014). Cao, *et. al.* (2015) estimated the pooled prevalence of suicidal ideation and suicide attempts in China. The finding highlighted that the estimated lifetime prevalence figures of suicidal ideation and suicide attempts were 3.9% (95% Confidence interval [CI]: 2.5%– 6.0%) and 0.8% (95% CI: 0.7%–0.9%)

Demographic, psychological and social, psychiatric and other risk factors are related to increased suicide rate in China. Age, duration of formal education, marital status, job and suicidal ideation seem to have an impact on attitudes towards suicide among residents (Zou, *et. al.*, 2016). They also found that gender, ethnicity, religious belief, housing style and economic status might not influence residents' attitudes towards suicide. Zhao & Zhang (2014) showed that age-related factors such as education, marital status, whether having children, status in the family, physical health, and personal income all have varying degrees of impact on suicide risks for rural youth. Negative life events and high psychological stress were associated with increased risk for suicide (Zhang, *et. al.*, 2015; Tong, *et. al.*, 2015). Depressive symptoms have been associated with suicide (Phillips, *et. al.*, 2007). It is important to identify factors that influence attitudes towards suicide in order to guide suicide prevention policy in China.

Some interventions were offered to control suicide rate in China. China national mental health work plan was conducted with the purpose of effects and prevention of suicide The Chinese Association of Mental Health has offered counseling services over telephone hotlines in suicide prevention program. News media professionals were introduced in Hong Kong as working partners in suicide prevention (Cheng, *et. al.*, 2014). Zhang, *et. al.* (2002) offered four suggestions to prevent suicide such as more psychological counseling services; the Chinese government should do more; do more in education, and promote more suicide research in China.

Japan

In 2015, suicide rate was 15.4per 100,000 (World Health Organization, 2017).Historically, Japan has had a higher suicide rate than these countries. In 2011, the suicide rate per 100 000 people was 20.9 in Japan and 6.7–16.4 in the aforementioned Western countries (Miharu, *et. al.*, 2015). In Japan, the incidence of suicide rose dramatically, from 20,100 (17.2 per 100,000) to 30,600 (24.2 per 100,000) between 1995 and 2005 (Mutsuhiro, 2008). The number of suicides per year has increased in all age categories over the last 10 years, and the increase was particularly remarkable among those in their 40s to 60s (Mutsuhiro, 2008).

The Basic Act for Suicide Prevention was to clarify the responsibilities of all stakeholders, including local authorities, employees, and citizens, for preventing suicide in Japan in 2006 (Miharu, *et. al.*, 2015). The results of Miharu' s study in 2015, suggest that the national fund for suicide-prevention programs promotes in community systems for suicide prevention as well as the implementation of initiatives among local authorities.

In addition, systematic intervention for suicide prevention has been conducted in focusing the community-based health promotion and other prefectures in the Tohoku region. For example, a community-based intervention was conducted in Akita Prefecture between 2001 and 2004 (Makiko, 2009). The intervention program consisted of implementation of a resident-based survey on mental health, specialist training on suicide prevention for public health and welfare staff, residents' cooperation in performing basic resident surveys, planning independent meetings for mental health lectures, and raising awareness of theatrical performances, distribution of list of counseling centers for residents with worries or concerns, and establishment of a community network among senior citizens to eliminate the sense of psychological isolation by elderly people (Makiko, 2009).

The importance of community-based intervention for suicide prevention was identified in Japan, and now many prefectures have programmed their own public health approach for suicide prevention. The Committee has addressed one strategy for contemporary Japanese society that differs from the United Nations and WHO guidelines. It highlights that relationship between human beings, social supports, and social capital within communities are key factors to prevent suicide death (Makiko, 2009). Therefore, seven community-based intervention trials implemented for five years or more have been conducted between 1985 and 2005 in Japan and these suicide prevention programs included the development of social support networks in the community and/ or depression screening for residents with follow-up by physician solder (National Strategy for Suicide Prevention in Japan, 2003).

The tasks and measures of current society for suicide prevention are; promotion of research on suicide, promotion of mental health and social support, financial support for individuals by job training ,amendment of laws applying to temporary staffs, appropriate legal measures for the multiple debts, prompt removal of illegal and harmful information from websites, support of the Internet Hotline Center of the private sector, requests to local police departments to delete illegal appeals on the web, support the internet providers to change their contract stipulations on authorizing to delete illegal notes, education of school children to convince them that they are valuable persons, requests for cooperation with the emergency services of the fire and disaster managing agency to care the suicide attempters for a long-term follow-up (Makiko, *et. al.*, 2009).

Korea

The prevalence of suicide in South Korea is one of the highest in the world. The trend of suicide in South Korea has been increased from 14.8 per 100.000 people in 2000 to 28.3 per 100.000 people in 2015) (WHO, 2017). The suicide rates of males were higher than those of females. Chan, *et. al.* (2015) found that prevalence of suicide increased in all regions of South Korea from 1992 to 2012. Although suicide is the leading cause of death for people aged from 13-40 years (Korean Statistic Information Service, 2017), the suicide rate among elderly had rapidly increasing (Kim & Yoon, 2013). Futhermore, suicide trend in the rural areas was higher than that in the urban areas (Choi & Kim, 2015). In addition, Kim, *et. al.* (2015) reviewed the medical charts of subjects who had attempted suicide and subsequently visited the emergency rooms of 17 medical center in 2013. The results showed that drug poisoning, pesticide poisoning, gassing, cutting, and hanging were common suicide attempt methods.

The results of study suggest that to boost suicide prevention strategies it is necessary to define their targets. Further, suicide prevention interventions should be focus on gender, age, socio-economic status and psychiatric aspects (Ju, 2014). The provision of case-management services is an essential approach to reducing suicide mortality and continuous evaluation of mental status and encouragement of adherence to psychiatric treatment regimens are needed to prevent suicide attempt (Sung & Jin, 2013)

It is found that the individuals who have religion are less likely to have suicide intentions based on the previous studies (Choi, 2016). It was planned to build a foundation for youth suicide prevention in 2015~2016, to develop a suicide prevention program, to enhance the early diagnosis and treatment system, and to conduct a youth suicide prevention support system in 2017 (Kyung & Dong, 2015). The finding of suggests that alcohol consumption-related variables may be used as a risk stratification tool for a long-term suicide prevention programme. In addition, constructing a national network of suicide research, data surveillance, developing tools for suicide prevention including early detection and safety planning, and comprehensive insurance coverage are recommended (Sang & Jong, 2011).

Sri Lanka

World health organization stated that high suicidal rate in Sri Lanka and it was 34.6per 100,000 among both sex groups in 2015 (World Health Organization, 2017). Sri Lanka has one of the highest suicide rates in the world, 25 per 100,000 in 2005 (Saranga, *et. al.*, 2016).

With the introduction of HHPs in the 1960s, the suicide rate steadily rose to 24 per 100 000 in 1976, followed by a more dramatic rise after 1977 that coincided with Sri Lanka relaxing import trade restrictions (Knipe, 2017). Therefore, the restriction of highly hazardous pesticide (HHP) use in agriculture is an effective reduction method of suicide attempt in Asia and Sri Lanka as well (Knipe, 2017). Most of Sri Lanka's suicide prevention strategies have been focused on restricting access to lethal means, such as pesticides because it is the most common method of suicide in the country (Saranga, *et. al.*, 2016).

Members of the public such as public health inspectors, the large number of minimally trained health workers, and social workers can play an important role in preventing suicide in Sri Lanka. The experts in the field of mental health and suicide, developing suicide first aid guidelines for members of the public and training programs based on these, might engage to community capacity to prevent suicide. It is also necessary to enrich the awareness regarding suicide and to reduce the stigma associated with suicide and suicidal behaviors (Saranga, *et. al.*, 2016)

The Sumithrayo Rural Programme is conducted by Sumithroyo organization is one of the suicide prevention programme in Sri Lanka (Sri Lankan Rural Programme, 2017). Program was set up in May 1996 due to high rates of suicide in the rural areas. The Sumithrayo is experimenting with a three pronged effort to contain the problem of suicidal behavior in the villages; befriending, the offer of emotional support to the depressed and despairing; Awareness and education programmes in schools and village communities; provision of lockable secure storage boxes to farming families for safely storing pesticides and household poisons to prevent suicide and accidental poisoning (Sri Lankan Rural Programme, 2017).

Vietnam

In Vietnam, DoiMoi reform program in 1986 has been considered as the successful model in economic and social development, and in parallel, health challenges have also occurred rapidly such as increasing in drugs and alcohol use, psychosocial distresses, mental disorders, suicide ...(Harpham T & Tran T, 2006; Giang, *et. al.*, 2008; Vuong, *et. al.*, 2011; Phuong, *et. al.*, 2013). Suicide is one of the top ten leading cause of death and becomes public health problem in Vietnam. According to data from the WHO, the suicide rate in Vietnam has increased from 6.5 in 2005 to 7.4 in 2015. There was a different gender that the rate of men is 11.2 which was higher than women (3.7) in 2015 (World Health Organization, 2017). Besides, Tran, *et. al.* (2006) revealed that the ratio of suicidal thoughts, suicide plans and suicide attempts on a lifetime basis was 22.3:2.8:1. Among young people, the prevalence of suicidal behaviours ranged from 5.28% in the 2003−2004 survey and 12.21% in the 2009−2010 survey (Le, *et. al.*, 2012). Furthermore, Blum R, and Colleagues (2012) conducted a cross-sectional survey of 17,016 youth aged 15−24 years in rural and urban areas of Vietnam, China and Taiwan. The results involved that the rates of suicidal ideation were highest in Taiwan (17.0%), China (8.1%), and lowest in Vietnam (2.3%). In addition, Le, *et. al.* (2016) highlighted that prior year suicidal thoughts among adolescents were reported by 21.4% of the female respondents and 7.9% of the male respondents. Prior year suicidal plans were reported by 7.8 % of the girls and 4.0% of the boys. Therefore, the prevalence of suicide in Vietnam is lower than other Asian countries however, it tends to develop rapidly.

Some factors influence patterns of and responses to suicide were argued. Tran, *et. al.* (2006) showed that suicidal thoughts were associated with multiple characteristics including female gender, single/widowed/separated/divorced marital status, low income, lifestyle (use of alcohol, sedatives and pain relief medication). Poly-victimisation was associated with increased risks of suicidal ideas among Vietnamese adolescents (Le, *et. al.*, 2016). Blum, *et. al.* (2012) revealed that female gender, younger age, family structure, parental support, family history of suicide, migration status, and substance use were associated with suicidal ideation. This finding also showed that female gender, family history of suicide, parental support, and substance use associated with suicidal attempt. Personal conflicts and lack of support were found to be the main reason for suicide attempts (Nguyen, *et. al.*, 2010). Moreover, Blum, *et. al.* (2012) showed that having no religion and being a Buddhist appear to be protective factors for suicidal thought. Understanding in deep factors related to suicide is the best method to decrease rates and help to guide preventive efforts.

In Vietnam, no national program is conducted to prevent suicide. However, based on increasing rapidly the rate of suicide, some activities were implemented to prevent and decrease prevalent but it still limited such as counseling services with delivered via hotlines (and, in some cases, the Internet); having formal undergraduate and postgraduate training about mental health problems for medical students. Therefore, intervention and guideline consist of psychosocial intervention, increasing public awareness, improving treatment of depression and other disorders and so on should be offered in suicide preventative strategy to reduce the prevalence of suicide.

Conclusion and Suggestion

The rate of suicide and Suicide intervention programs in Asia reflect specific sociocultural situations and economic transitions in the region. However, research in Asia is still limited and unfrequent. If there is no research evidence and the suicide intervention program, it's very difficult to identify the target groups will still be missing, and cost-effective interventions will be impossible. Moreover, suicide is a complex and multifaceted problem that often involves several interdisciplinary efforts for prevention. As the rate of suicide is a limit relatively researched area in Asia, evidence on the effectiveness of prevention programs is limited. Nevertheless, in many Asian countries, both government and nongovernment organizations have been conducting different types of suicide prevention program. Even though many of these programs may lack adequate evidence about their effectiveness, they reflect culturally specific and locally applicable experiences.

General speaking, suicide prevention solutions in five countries are focused on counseling, public health care and specialist training on suicide prevention. For example, for suicide prevention in China,

the majority of authors agree that superstructural measures such as education, research, and counseling are important and in Japan, they also focused on the community-based health education and social support, in Korea they encoraged adherence to psychiatric treatment regimens. Besides that Sri Lanka has the suicide prevention programme in rural by making friends, emotional support to depressive person and educated in village communities. And in Vietnam there is no national program to prevent suicide, however some activities were implement such as training mental health or increasing public awareness about suicide knowledge and supporting counseling services.

Suicide is a serious problem but preventable public health problem because suicide can have lasting harmful effects on individuals, families, and communities. While its causes are complex, the goals of suicide prevention are simple reduce factors that increase risk and increase factors that promote resilience or coping. With a large population sizes and available resources, a public health program can be applied that emphasizes community-based intervention strategies is viable and practical. They focus on counseling services, education community program for student, and people who live in rural and urban areas. These programs are mainly applied by number of countries such as Korea, Japan and China where they are developed economic countries and more available resources to allow for interventions. Many developing countries in Asia such as Vietnam, Srilanka need to coordinate with national suicide prevention organization to prevent the most effectivily suicide.

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