Ministry of Health

Suicide Prevention Implementation Framework

January, 2023

Table of Contents

List of Acronyms and Abbreviations

HBP	Health Benefit Package
CCPF	Chipatala Cha Pa Foni
CHAM	Christian Health Association of Malawi
CSOs	Civil Society Organizations
DHSS	Director of Health and Social Services
FBOs	Faith-Based Organizations
HSSP	Health Sector Strategic Plan
LMICs	Low- and middle-income countries
MDAs	Ministries, Departments and Agencies
MH	Mental Health
MOH	Ministry of Health
MIP	Malawi 2063 first 10-year Implementation Plan
MHRC	Malawi Human Rights Commission
MoGCDSW	Ministry of Gender, Community Development and Social Welfare
NCDI	Non communicable diseases and injuries
NGOs	Non-Governmental Organizations
SDGs	Sustainable Development Goals
SWOT	Strengths Weaknesses Opportunities and Threats
UHP	Universal Health Package
UNICEF	United Nations Children Fund
WHO	World Health Organization
YONECO	Youth Net and Counselling

Foreword

Malawi, just like many other countries, is facing a rise in incidence of mental health problems, including suicide, resulting from the interaction of psychological, social, biological and environmental factors. Suicide is very complex and yet a preventable act. It is among the leading causes of death in Malawi yet investment in its prevention has been relatively small. The prevention of suicide is feasible but complex; it requires a coordinated multisectoral response of different ministries, departments and agencies (MDAs). It also needs the engagement of various partners such as the private sector, faith-based organizations (FBOs), civil society organisations (CSOs) and non-governmental organizations (NGOs). There is also a need for comprehensive action to prevent suicide at the population level as well as with vulnerable groups. This involves a series of activities, ranging from control of risk factors and means for suicide, to early identification and effective treatment of people with mental health disorders as well as responsible reporting of suicide by the media.

This framework aims to reduce suicide through relevant effective evidence-based suicide prevention activities. It also sets a framework for improving access to mental health services including integration of care at community and primary health level as well as education on suicide prevention and how to combat stigma.

The Ministry of Health is fully convinced that this framework provides excellent suicide prevention mechanisms and the Ministry is committed to the implementation of the strategy. I therefore trust that everyone will contribute to the successful implementation of this strategy on prevention of suicide in Malawi, and call upon all relevant stakeholders to support this process.

I am certain that this framework will inform the coordination necessary to guide successful implementation of suicide prevention activities in order to achieve the set vision of a nation where no life is lost to suicide, and people live with hope and resilience.

Finally, I would like to like to take this opportunity to call upon all the stakeholders and partners for continued collaboration, engagement and investment with the goal of implementing the framework.

Dr. Charles Mwansambo

Secretary for Health

Acknowledgements

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We are grateful to the Division of Non-Communicable Diseases and Mental Health for leading the process and we also appreciate the Department of Social Welfare in the Ministry of Gender, Community Development and Social Welfare for collaborating in the development process. Special thanks go to the Mental Health and Psychosocial Support Task Team for the guidance in the development of this first ever Suicide prevention implementation framework. We also appreciate various Ministries, Departments and Agencies, Non-Governmental Organizations, Civil Society Organizations, Faith based Organizations and all other persons whose effort, contributions and support made it possible to have the Suicide implementation framework.

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Chapter 1: Introduction

Suicide is a serious global public health problem that affects people across the lifespan, and is a leading cause of mortality especially among young people. Suicide has a devastating impact on families, friends and communities as every life lost represents someone's partner, child, parent, friend or colleague.

Suicide has multifaceted causes and is often a result of a convergence of genetic, bio-physiological, psychological, socioeconomic, cultural and other risk factors can be present at family, community, and societal levels. There is a well-established link between suicide/suicidal behavior and mental health though many suicide cases happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up, chronic pain and illness, use of drugs and alcohol. Certain groups are more vulnerable to suicidal behavior. Globally, 20% of suicide cases are through pesticide self-poisoning with the other most common methods being hanging and use of firearms [1]. In Malawi hanging and self-poisoning are the common methods[2].

Suicide is preventable. However, the complexity in causation presents challenges for suicide prevention. Adopting a multilevel and cohesive approach through comprehensive multisectoral, integrated and collaborative suicide prevention strategies will assist in addressing these challenges. Effective preventive strategies should mitigate risk factors and enhance protective factors to improve resilience with considerations of best practices and evidence-based interventions as well as the cultural and social context.

1.2. Risk factors for suicide

There are multiple contributing factors and causal pathways to suicide and understanding them is important to help devise a range of interventions for its prevention. These factors interact in a complex way to contribute to suicidal behaviors directly but can also contribute indirectly by influencing individual susceptibility to mental health conditions. The following are some of the risk factors[3]:

- Social and economic hardships such as unemployment, poor quality of harvests or poverty
- Loss of employment/source of earning a living, loss of property
- Relationship difficulties
- Physical health problems
- Problematic use of drugs and alcohol

[1] World Health Organization. "Suicide." Accessed 4th September, 2022. https://www.who.int/news-room/fact-sheets/detail/suicide.
[2] Annual prevalence of suicide in Malawi, by Charles Masulani Mwale & Chitsanzo Mafuta 2019 https://sjog.uk/pdf/Research/ Suicide-Prevalence-in-Malawi.pdf
[3] World Health Organization. (2014). Preventing suicide: a global imperative. World Health Organization. https://apps.who.int/iris/handle/10665/131056

- Personality traits that contribute to increased risk of depression Exposure to violence, including intimate partner violence
- Bullying and cyberbullying
- Previous experiences of self-harm

1.3. Protective factors

Protective factors guard people against suicide. It is important to have interventions geared towards strengthening factors that have been shown to increase resilience and connectedness and that protect against suicidal behaviour. Some protective factors counter specific risk factors while others protect individuals against a number of different suicide risk factors. The following are some of protective factors[4];

- Strong personal relationships and social connectedness (social support)
- Cultural, religious or spiritual beliefs that discourage suicide
- Life skills
- Lifestyle (Physical activity)
- Strong coping mechanisms
- Self-esteem, resilience and a sense of purpose in life
- Effective and accessible mental health care
- Economic and social support factors including access to education/vocational training and access to a livelihood
- Safe environments, including safe school environments

1.4. Suicide prevention interventions

Effective suicide prevention is comprehensive and requires a combination of efforts that work together to address different aspects of the problem, addressing vulnerabilities and leveraging on the protective factors. The evidence-based interventions strategies can be classified into three levels as follows[5][6];

Universal interventions: these are designed to reach whole populations, with the aim of reducing risk factors and enhancing protective factors across the entire population. Typically, such approaches include (but are not restricted to) reducing access to means of suicide, improving media reporting of suicide and providing community education on suicide prevention.

Selective interventions: these target vulnerable subgroups whose members are not yet manifesting suicidal behaviours but exhibit immediate or underlying risk factors that predispose

[4] World Health Organization. (2014). Preventing suicide: a global imperative. World Health Organization. https://apps.who.int/iris/handle/10665/131056

[5] World Health Organization. (2014). Preventing suicide: a global imperative. World Health Organization. https://apps.who.int/iris/handle/10665/131056

[6] Nordentoft M . Crucial elements in suicide prevention strategies. Prog Neuropsychopharmacol Biol Psychiatry 2011;35:848–53.doi:10.1016/j.pnpbp.2010.11.038 pmid:http://www.ncbi.nlm.nih.gov/pubmed/21130823

them to do so in the future. These may include gatekeeper training or programs that involve screening those thought to be at elevated risk.

Indicated interventions: these are designed for specific vulnerable people who are identified through screening programs or by clinical presentation as already beginning to exhibit suicidal thoughts or behaviours and may include psychological or pharmacological treatment of underlying mental disorders.

Key Effective Interventions for Suicide Prevention

The WHO Live Life guidance[7] describe the four key effective interventions for suicide prevention as follows;

- Limit access to means
- Interact with Media on responsible reporting
- Foster life skills of young people
- Early identification and support of those affected.

Limiting access to the means of suicide is a universal. This may mean banning highly hazardous pesticides, restricting firearms, installing barriers at "jump sites", limiting access to ligature points or taking other measures to make it more difficult to access the means of suicide. Restricting access to means of suicide requires multisectoral collaboration between all relevant stakeholders, including ministries of health, agriculture, transport, regulators and registrars, as well as community leaders. At the personal level, family members may be asked to remove the means of suicide (e.g. pesticides, firearms, knives, medication) from a household where a person is at risk of suicide.

Interacting with the media for responsible reporting of suicide is significant because media reporting of suicide can lead to a rise in suicide due to imitation – especially if the report is about a celebrity or describes the method of suicide. The aim is to work with national media (and social media) bodies and at local level to work with local media outlets such as local newspapers or radio stations. It also requires working with social media companies to increase their awareness and improve their protocols for identifying and removing harmful content.

Fostering socio-emotional life skills in adolescents is the focus of WHO's Helping adolescents thrive (HAT) guidelines. While adolescence (10–19 years of age) is a critical period for acquiring socio-emotional skills, it is also a period of risk for the onset of mental health conditions. Rather than focusing explicitly on suicide, the HAT guidelines recommend that programmes employ a positive mental health approach. Other recommendations include training for education staff, initiatives to ensure a safe school environment (such as anti-bullying programmes), links to

[7] https://www.who.int/publications/i/item/9789240026629

support services, clear policy and protocols for staff when suicide risk is identified, and increasing parental awareness of mental health and risk factors. Teachers or caregivers should be reminded that talking about suicide with young people will not increase suicide risk but will mean that young people may feel more able to approach them for support when needed. The well-being of staff should also be ensured.

Early identification, assess, manage and follow up anyone who is affected by suicidal behaviours. This advice is intended to ensure that people who are at risk of suicide, or who have attempted suicide, receive the support and care that they need. It applies to health workers and others, including family members, who are likely to come into contact with someone at risk. The advice also applies to health systems which need to incorporate suicide prevention as a core component in order to intervene early when people are found to be at risk of suicide. Additionally, support should be offered to people who have attempted suicide and those who have been bereaved by it.

1.5. Rationale for the Suicide prevention implementation framework

Suicide is a major public health issue and therefore renders suicide prevention is a public health priority as the number deaths by suicide as reported by the Malawi Police Services shows an increasing trend as follows: January to August 2019: 116; January to August 2020: 182; January to December 2021: 296; January to October 2022: 231. The aim of this Suicide prevention implementation framework is to reduce suicidal behaviors by reducing factors that increase suicide risk and increasing factors that promote resilience, consequently reducing deaths by suicide. The framework highlights integrative evidence-based approaches to help prevent suicide at individual, systems and community level.

Process of developing the Suicide implementation framework

The key stakeholders whose inputs contributed significantly in a variety of ways developed the Suicide prevention implementation framework. Ministry of Health, Ministry of Gender, Community Development and Social Welfare (MoGCDSW) and the Mental Health and Psychosocial Support (MHPSS) Taskforce Team participated in the development of the suicide prevention implementation framework. The development process included meetings with national level officers from different Ministries, Departments and Agencies (MDAs), District officers, officers from different Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), and from UNICEF Country office among others.

Linkages with existing instruments (policies & strategies) (national/international)

The implementation framework will operate in line with other existing legal instruments and strategies, policies and strategic frameworks both at national and global levels as indicated in the following sub-sections:

Linkages with overarching national documents

The Constitution

The implementation framework is aligned with the Constitution of the Republic of Malawi under Chapters III and IV section 13 which states that: *'The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving (the goal of:) (c) Health - To provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care'.*

Malawi Vision 2063

The Vision seeks to transform Malawi into a wealthy and self-reliant industrialized upper middle-income country by the year 2063. One of the enablers to achieve this goal is the human capital development, where health and nutrition are key components. The goal is to attain universal health coverage with quality, equitable and affordable health care for all Malawians. The implementation of this framework will, therefore, contribute to the achievement of Malawi Vision 2063 (MW2063) health goals.

Malawi 2063 First 10-year Implementation Plan (MIP-1)

The Malawi 2063 First 10-year Implementation Plan (MIP-1), as an overarching medium term development strategy, identifies Health and Nutrition as key components of the Human Capital enabler. The MIP-1 envisions a healthy population with improved life expectancy working towards socio-economic transformation of Malawi. The implementation of this framework will contribute to the achievement of health targets of the MIP-1.

Health Sector Strategic Plan III (2023-2030)

The Health Sector Strategic Plan III (HSSP III) 2023-2030 is the health sector's medium-term strategic plan which outlines objectives, strategies and activities of the health sector. The HSSP III operationalizes the National Health Strategy. HSSP III has identified and prioritised mental health as one of the intervention packages in the Health Benefit Package (HBP). This provides a clear linkage with the framework.

Linkages with relevant legislation

The framework will operate in a legal environment where other legislation touches on health issues and/or facilitates the delivery of healthcare services, as follows:

Public Health Act No. 12 of 1948, Reviewed and Amended 1975
The Public Health Act consolidates the law regarding the preservation of public health in Malawi. It addresses issues regarding infectious diseases and creates institutions for responding to emerging public health challenges. The framework will contribute towards the improvement of overall health in Malawi.

Local Government Act (1998)
The Local Government Act (1998) consolidates the law regarding local government. It provides for health service delivery to be decentralized to district and city councils and empowers communities to be responsible for their own health and healthcare services. It also mandates the Ministry of Health to be responsible for health-related policies, training and supervision. The Suicide implementation framework will ensure that mental health services are accessible at the local level.

Child Care, Protection and Justice (NO. 22 0F 2010)

The Act provides for the protection of children in Malawi. It consolidates the law relating to children by making provision for childcare and protection and for child justice; and for matters of social development of the child and for connected matter. The suicide prevention implementation framework will ensure the rights of children are adhered to followed to the latter.

Pharmacy and Medicines Regulation Authority Act (2019)
The Act provides for the establishment of the Pharmacy and Medicines Regulation Authority; the registration and disciplining of practice; the licensing of traders in medicines and poisons, and for the control and regulation of the profession of pharmacy in Malawi in general. The provisions of this Act also cover the regulation of health medicines and medical supplies.

Public Private Partnership Act (2011)
The Act provides for partnerships between the public and private sectors for the supply of infrastructure and delivery of services as a means of contributing towards sustainable economic growth, social development and infrastructure development. The implementation framework will provide a platform for channeling private sector support for implementation of it.

Linkages with other policies and strategies

Decentralization Strategy
The Decentralization Strategy seeks to create a democratic environment and the institutions for governance and development at the local level that facilitate grassroots participation in decision making. This will ensure that suicide prevention services are planned, managed and implemented at local level. Significant improvements in access to preventive and curative mental health care are essential to the success the of the framework. This will ensure that human resources are adequately recruited and equitably deployed to support suicide prevention activities

National Education Strategy
As regards to suicide implementation framework, the National Education Strategy advocates for the promotion of school health, water, sanitation and hygiene, HIV and AIDS prevention, gender, and for the management of health training institutions. The implementation framework will ensure that all children and adolescents are effectively targeted with various suicide prevention and management programmes in schools.

Malawi National Community Health Strategy (2017-2022)
The focus of this strategy includes integration of health services, community engagement, and sufficient and equitable distribution of well-trained community health workforce. The community health strategy provides a platform for the suicide prevention implementation framework for engagement with community members in addressing suicide through integration of the prevention activities.

National Social Welfare Policy (2018)

The policy seeks to promote access to social justice and improved wellbeing of the vulnerable and disadvantaged groups of people through an integrated, well-coordinated and regulated social welfare services delivery system. The national mental health policy will ensure that the vulnerable groups are effectively targeted with different mental health promotion programmes.

National Youth Policy (2013)

The National Youth Policy whose overall goal is to provide a framework that guides youth development and implementation of all youth programmes in the country. The policy addresses issues that impinge on the ability of adolescents and young people to contribute to national development. The National Mental Health Policy will ensure that the youth are effectively targeted with different mental health programmes.

Linkages with international instruments

Sustainable Development Goals
The Sustainable Development Goals (SDGs) Goal 3 is to "Ensure healthy lives and promote well-being for all at all ages", with the aim of achieving Universal Health Coverage (UHC), including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. On the same Target 3.4 is: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. Within Target 3.4, suicide rate is an indicator (3.4.2)[8]. By improving the delivery of the suicide prevention and management services, the framework will contribute towards achieving SDG 3.

[8] https://www.who.int/teams/mental-health-and-substance-use/data-research/suicide-in-the-sdgs

Comprehensive Mental Health Action Plan 2013-2030

The Plan seeks to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. WHO's Comprehensive Mental Health Action Plan 2013–2030 includes a target to reduce the global suicide mortality rate by one third by 2030. This provides a clear link with the implementation framework.

Chapter 2: Situation Analysis

2.1 Global suicide burden

Globally, suicide is a major health problem. Currently approximately 703,000 people are taking their own lives annually making suicide the 15th leading cause of death worldwide [9]. In 2019 over 77% deaths by suicide occurred in the low- and middle-income countries (LMICs) where there are huge gaps in the health systems and resource limitations in early identification, treatment and support of people in need. In recent years, because of the public health and socioeconomic impact of suicide, countries have mobilized resources for management and identification of suicide cases and suicide attempts.

Suicide is the fourth leading cause of death among 15–29-year-olds globally. In LMICs the male-to-female suicide ratio is 1.5: 1. The ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally, but many other methods are used with the choice of method often varying according to population group. Approximately 48 million people are impacted by suicide bereavement and around 135 people are directly exposed to suicide death annually [10].

The World Health Organization has continuously addressed suicide as a worldwide phenomenon. Suicide remains a sensitive issue and illegal in some countries as it often involves law enforcers. However, suicide is frequently misclassified and under- reported. it is believed that an individual who has attempted to commit suicide before has a higher risk of committing suicide again than individuals who have not. Identifying these high-risk individuals and providing them with follow-up care and support should be a key component of all comprehensive suicide prevention strategies[11].

2.2 Malawi situation analysis

There is dearth of data on suicide and self-harm in Malawi. The available data is variable and captured using fragmented reporting systems on suicide morbidity and mortality. Recent studies have reported different trends on suicide. Masulani-Mwale and Mafuta (2019)[12] reported a crude suicide prevalence rate of 9 per 100,000 cases sampled in 6 administrative districts of the country.

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[9] World Health Organization. “Suicide.” Accessed 4th September, 2022. https://www.who.int/news-room/fact-sheets/detail/suicide.

[10] Ross, V., Kõlves, K., & De Leo, D. (2021). Exploring the Support Needs of People Bereaved by Suicide: A Qualitative Study. OMEGA - Journal of Death and Dying, 82(4), 632–645. https://doi.org/10.1177/0030222819825775

[11] World Health Organization. “Suicide.” Accessed 4th September, 2022. https://www.who.int/news-room/fact-sheets/detail/suicide.

[12] Annual prevalence of suicide in Malawi, by Charles Masulani Mwale & Chitsanzo Mafuta 2019 https://sjog.uk/pdf/Research/ Suicide-Prevalence-in-Malawi.pdf

Malawi is registering an increase in suicide cases just like many other countries, as the country is facing a rise in incidence of mental health problems, due to different factors ranging from adverse life events, social-economic difficulties, substance use, chronic physical illness or pandemics like Covid-19. Consequently, the national STEPS survey which was conducted in Malawi indicated the likelihood of Malawi seeing an increase in this phenomenon. According to the STEPS survey report of 2017[13], 7% of the respondents had seriously considered suicide (suicide ideation) with women having a higher percentile as compared to men and affecting the quartile with lower household income. Furthermore 3.8% of the respondents made a plan over the past year of how they would attempt suicide, and 0.8% had a history of attempts and 5.4% had a family member who had attempted suicide, and 2.5% had a family member who died by suicide.

The situation is worsening with the rise in suicidal behaviors as a recent report from Malawi Police Services, shows that; from January 2019 to August, 2022; 802 people died by suicide[14]. According to the same report the associated factors include male gender, young age and substance use, especially alcohol. The factors that contributed to the suicide cases include, economic hardships (men failing to settle debts), extra marital affairs, poor social relationships, lack of family support and men's reluctance to report personal problems thus among adults while, abuse, academic failure among children and adolescents. Furthermore, according to the MPHSS Needs and Gaps Assessment Report 2021 by the Ministry of Gender, suicidal ideas and other self harm forms are common among Gender Based Violence (GBV) survivors.[15].

2.3 Challenges in addressing suicide in Malawi

Malawi faces challenges in the implementation of WHO LIVE LIFE pillars[16] and key intervention due to the following reasons:

- Some of the laws relating to care of persons with mental health problems are outdated including the Mental Treatment Act of 1948 and some of the clauses in other legislations negatively impact people with mental health challenges including criminalization of suicide attempts under section 229 of the Penal Code. Due to the criminalization of suicide, people are afraid to report cases of suicide attempts or seek help.
- Limited availability of mental health facilities which affects the accessibility of services for people living with mental health conditions and related suicide issues[17] . The other available services include medical stabilization for poisoning and injuries in all levels of care, limited psychosocial counseling for affected individuals and their families. In regard to accessibility and equity of services for all among Malawians, there are three mental

[13] WHO, STEPS survey Report, 2017; https://extranet.who.int/ncdsmicrodata/index.php/catalog/629
[14] Malawi Police Services Suicide Cases Report, 2022
[15] MPHSS Needs and Gaps Assessment Report, 2021
[16] https://www.who.int/publications/i/item/9789240026629
[17] Udedi M. Improving access to mental health services in Malawi. Ministry of Health Policy Brief. 2016;26:505–18.

health facilities which are found in the urban areas despite the majority of Malawians living in the rural areas [18].

- Lack of quality services in sectors including Labour, Education, Gender and Social Welfare continues to affect implementation of suicide prevention activities but also ability to conduct a clear situation analysis, and ongoing Surveillance, Monitoring, and Reporting.
- Malawi has limited medical forensic services which makes it difficult to even ascertain causes of death including suicide.
- There is limited and poor-quality data to give a clear picture of suicide cases in Malawi. However, efforts are being undertaken by various stakeholders to produce quality data for decision-making. Case registration of suicide cases and self-harm is quite fragmented with Police and Hospitals being the main sources of such data. However, the Nkhoma study of 2021 reported a lack of a standardized reporting system[19].
- *Fragmented multisectoral collaboration, has been a key challenge.* However, the rise of suicide cases has provided a platform for improvement as concerned stakeholders including politician and policymakers have been discussing collaborative efforts to address suicide issues.
- Suicide awareness and advocacy is relatively new as well as uncoordinated as such denying the public provides the opportunity of accessing evidence-based suicide prevention information
- Limited or no capacity at all to address suicide related issues by majority of relevant stakeholders. However, the numbers of mental health and psychosocial practitioners being trained in the country are increasing but underutilized.
- *Inadequate funding toward the health sector including mental health.* Mental health and suicide are now trending issues globally and are a public health concern requiring attention and financial support. There is a need to review and amend relevant laws to align them with the constitutional dispensation, the provisions of the Public Health Act and international laws such as the Convention on the Rights of Persons with Disabilities (CRPD) and to address emerging issues. Additionally, improved mental health financing is necessary to ensure a successful and impactful suicide prevention program.
- *Ineffective surveillance as well as monitoring and evaluation.* The country is experiencing a rise in cases of mental health conditions and suicide as such there is need to establish strategic surveillance to monitor and address these emerging issues.
- *The commonest methods of suicide are easily accessible. It* is difficult to limit access to ropes as hanging suicide method. Ropes can be made from many materials including mosquito nets and clothing materials. Pesticides are easily accessible on the local market.
- *Uncensored social media is still problematic.* The media sometimes carry risk by exposing people to sensational graphic content, including methods of harm. Access to such content can be distressing, and triggering and may act to encourage, maintain or exacerbate self-harm and suicidal behaviors.

[18] Udedi M. Improving access to mental health services in Malawi. Ministry of Health Policy Brief. 2016;26:505–18.
[19] Nkhoma Mission Hospital (2021), Phenomenology and Preventive Strategies of a socio-cultural Menace: Suicide in Nkhoma Mission Hospital catchment area, Malawi.

- Early identification, assessment, management and follow up of anyone who is affected by suicidal behaviours is still a challenge

2.4. Government Response to address the challenges

- The development of the national mental health policy to increase access to mental health care
- The country media houses are being engaged in order to be responsible with their reporting.
- The capacity of stakeholders including human resources and infrastructure is being enhanced including training of MHPSS providers in Psychological First Aid, Narrative Exposure Therapy and Interpersonal Group therapy
- Mental Health awareness is being promoted in the general population through print and electronic media
- Releasing a public service announcement on suicide prevention
- Collaboration among sectors on mental health and psychosocial support
- The establishment of the Multisectoral MHPSS Task Team
- The establishment of the Suicide Prevention Task Team
- The studies which have focused on understanding the issues of suicide and its prevention
- Round table discussion on suicide prevention

Chapter 3: SWOT Analysis and Experience of Care

This chapter summarises the knowledge on the recognition and treatment of suicide according to the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, demonstrating the Strengths, Weaknesses, Opportunities and Threats.

STRENGTHS	**OPPORTUNITIES**
• Availability of the Mental Treatment Act that mandates the provision of mental health services. • There is Chipatala Cha Pa Foni hotline which runs 24/7 and tackle issues of mental health, 54747 • There other hotlines run by government and its partners: Child helpline 116 and GBV helpline 5600 (toll free numbers), *646*2# (Toll free for Human Rights Information), 351 (Covid Urban Cash Initiative toll free line), 0993892234 (Ufulu Wanga Helpline for reporting general violence) • Multisectoral taskforce on mental health and psychosocial support at national level • National Mental Health Policy/strategy • Increasing awareness on mental health issues • Availability of a section on Mental Health in the Ministry of Health	• Availability of screening tools • Availability of health and social care services. • Availability of Psychological First Aid Trainer of Trainers and providers • Increased social awareness of suicide and the need to address mental health concerns underpinning increasing suicide rates Availability of media platforms to be utilized for effective communication • Government political will • Use of technological innovation to reach the wider population • Public Private Partnerships provides a platform for collaborative efforts on prevention activities • Availability of community and faith based CSOs.
WEAKNESS	**THREATS**
• Suicidal behaviours remain unpredictable. • Low availability of psychiatric care and psychotherapy • High rate of non-adherence to treatment • Low screening rate for depression and suicidal ideations among clients in all service areas • Service Gap • Inadequate awareness • Low rate of appropriate treatment among patients with suicidal ideations • Inadequate surveillance and reporting systems • Lack of comprehensive and country wide coordinated suicide prevention program • Weak mental healthcare systems at district level	• Stigma around mental health conditions and associated help-seeking. • Suicide incidences can impact not just closed loved ones but the whole community. • Mental Health conditions or suicide can affect anyone. • People have the access to means for suicide like chemicals including pesticides, prescription drugs and other lethal means of suicides. • Sensational media and internet reporting

• Poor access to prevention interventions, treatment and aftercare services. • Lack of mental health and psychosocial coordination taskforce at district level • Lack of integration of MH in other sectors • Weak Multisector collaboration and coordination of MH with other sectors • Inadequate financing towards MH system	• Increased access to suicide promoting materials on the internet/ digital space by children and youth • Cultural and religious beliefs which promotes stigma and also hinders help seeking • Social media associated such as cyberbullying • Poverty, unemployment and societal conflicts • Addictive use of technology e.g. gaming, gambling • Easy access and rising trends of alcohol and drug use. • Criminalization of the suicide and suicidal behaviours in the law. • Wellbeing of MHPSS staff working in the area of suicide

Chapter 4: Strategic Direction

The Suicide Prevention Implementation Framework is from 2023 to 2030

4.1 Vision

A nation where no life is lost to suicide, and people live with hope and resilience.

4.2 Mission

Promote reduction of suicidal behavior through comprehensive and intersectoral action plans and programs at national, district and community levels.

4.3 Goal

Reduce suicidal behaviors among the population.

4.4 Core values and Principles

4.4.1 Coordinated multi sectoral approach:

Harmonized coordination of intersectoral partnerships and collaboration of public and private sectors (such as health, education, social services, criminal justice system, agriculture, trade unions, NGOs, CSOs, Corporates)

4.4.2 Universal Health Coverage approach:

All people, regardless of race, sex, socioeconomic or any other status should access quality comprehensive health services without experiencing financial hardship.

4.4.3 Human rights approach:

Health is a human right as enshrined in the constitution of Malawi and international human rights instruments.

4.4.4 Evidence Based interventions;

Interventions should be based on scientific evidence and/or best practices, taking into consideration the cultural context.

4.4.5 Empowerment and inclusion:

Vulnerable populations, people with lived experience and bereaved families should be empowered and involved in advocacy, awareness creation, strategy planning and implementation.

4.4.6 Primary health care approaches;

Life course: Social accountability: People centered; and Participatory.

Provide interventions based on scientifically sound and socially acceptable methods and technology, universally accessible to all age cohorts, coordinated around people's needs, respects their preferences, with community participation and responsiveness.

4.4.7 Equity:

All individuals in a community irrespective of their sex, age, race, geographical location, culture, socioeconomic or any form of diversity should have equal opportunities. Focus should be on inclusiveness, non-discrimination, social accountability, and gender equality.

4.4.8 Innovation and Technology:

Application of innovative technology to increase efficiency and effectiveness of interventions for better outcomes.

4.5 Strategic Objectives

Key Strategic Objective

1. To establish and operationalize suicide prevention program at national and district level.
2. To strengthen supportive strategy (platform), legal and financing environment for effective implementation of suicide prevention program.
3. To improve access to comprehensive, integrated, and quality services for suicide interventions at all levels of care.
4. To increase awareness on suicide, suicide prevention, and reduce stigma and discrimination.
5. To strengthen systems for surveillance and research on suicide.

4.6 Strategic Intervention

To achieve the key objectives, multicomponent interventions will be implemented along several domains as below;

4.6.1 Objective 1: To establish and operationalize the suicide prevention program at national, district and community levels

This strategic objective will ensure implementation of coordination mechanisms for effective suicide prevention across the country in a multisectoral approach. This will amongst others entail:

i. Establishment of a coordinating unit for suicide prevention
ii. Appointment of focal person for coordination of suicide prevention program at all levels.
iii. Development of the national suicide prevention program
iv. Dissemination of the suicide implementation framework and program
v. Designate focal persons at MDAs for coordination and implementation of suicide prevention program.
vi. Integrate intersectoral committee on suicide prevention at national, district and community levels into existing structures
vii. Conduct mid-term review of the suicide prevention program

4.6.2 Objective 2: To strengthen supportive strategy, legal environment and financing for effective implementation of the suicide prevention program

The Malawi National Mental Health policy provides for a framework on interventions for securing mental health systems in Malawi. The Mental Treatment Act enacted in 1948 which consolidates the laws relating to the care of persons with mental disorders is now outdated. The aim of the implementation framework is to provide a supportive platform/environment to implement the suicide prevention program.

Key Implementation Domains	**Key Activities**
Legal	i. Advocate for decriminalization of suicide by Repealing Section 229 of the Penal Code. i. Advocate for the finalization and enactment of the Mental Health Bill
Strategy	Collaborate with relevant stakeholders towards regulation of all lethal means used in suicide incidents e.g. pesticides
Financing	i. Advocate for integration of mental health and suicide prevention in all MDAs and stakeholder's programs to leverage ii. Mobilize financing for suicide prevention at national, district, and community levels

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

Although suicidal behavior has continued to be highly prevalent in the Malawian population, many of those who are affected do not have adequate access to preventive, treatment and follow up services.

This objective aims at reducing the barriers to accessing services and ensuring provision of quality and evidence-based suicide interventions at various levels in a continuum of care that include crisis intervention, treatment, follow up and postvention.

Key Implementation Domains	**Key Activities**
Access to promote, preventive care, rehabilitative and aftercare services	Develop and disseminate multisectoral guidelines and protocols for comprehensive management of suicide
	Mainstream and integrate screening, assessment and treatment interventions for suicide risk factors at all levels of health care system. Integration into other relevant sectors via relevant gatekeepers (e.g. schools, workplaces, religious institutions, social protection services)
	Integrate and operationalize a national suicide implementation framework into existing helpline (s).
	Integrate mental health care and referral pathways for persons with suicidal behavior at community and all health care service levels including referral pathway linkages from other sectors as well.
	Increase capacity of mental health and psychosocial care providers through; - training of existing workers and recruitment - ongoing supportive supervision for providers -strong support for staff care and wellbeing
	Strengthen provision of psychological and suicide first aid at all levels of care including within the health care system, but also among other relevant gatekeepers (e.g. schools, workplaces, religious institutions, social protection services) who are often the first responders in crises

	Integrate mental health into existing community health activities to include suicide prevention during household visits and dialogue days with emphasis on building and strengthening resilience for persons at risk of suicide and their families.
	Embed risk assessment processes and provide mandatory risk assessment that focuses on suicide and self-injury to ensure there is early identification of those at high risk for appropriate intervention
	Conduct psycho-social assessments to have a more comprehensive picture that could be incorporated into care and personal safety management plans. - Strengthen referral services of those at increased risk of suicide by maintaining links with other local services and organisations - Provide clear pathways for referral services and post discharge - Conduct post discharge monitoring visits of clients/patients who accessed in patient care services and have been discharged. - Implement clear post discharge plans with details of the follow-up arrangement and relevant contact numbers as the highest risk of suicide occurs at points of transition from in-patient services to the community services - Include family and carers in risk assessments and care planning whenever possible - Conduct mapping of mental health delivery service points and service providers to facilitate timely referrals and quality service provision to those at risk of suicide - Provision of life skills for young people

4.6.4 Objective 4: To increase awareness on suicide, suicide prevention and stigma and discrimination.

Suicide issues have not been adequately addressed in Malawi due to under reporting of mental health cases by the general public. This is compounded by lack of awareness/ information on the available services especially by those at risk of suicide. Adequate information on suicide plays a significant role in preventing suicide and mitigating stigma against affected individuals, families and communities. This strategic objective aims to equip stakeholders with knowledge and skills on responsible case reporting and how to identify persons at risk of suicide, offer brief interventions and refer them for appropriate treatment.

Key Implementation Domains	**Key Activities**
a) Advocacy, public awareness and communication b) Media reporting c) Education and training	1. Develop a capacity building program on suicide prevention program to address some of the other causal factors, like GBV, lack of access to opportunity and the need for social support 2. Develop a communication and resource mobilization strategy to facilitate public awareness, communication and responsible reporting 3. Mobilize and engage key stakeholders at national, district and community levels on suicide prevention i. Conduct targeted training of relevant groups (HCWs, media practitioners, Police, teachers, clergy, administrative leaders and youth) on suicide prevention ii. Conduct an annual Countrywide awareness campaign on suicide prevention during the month of September as the Global awareness month on Suicide prevention iii. Conduct targeted media campaigns on suicide prevention

4.6.5 Objective 5: To strengthen systems for surveillance and research on suicide.

Timely, accurate and quality data on suicide and suicide prevention is critical for decision making and financing. The aim of this strategic objective is to increase availability of data on suicide and suicide prevention in the Malawi District Health Information Software (DHIS 2) or other appropriate registry for evidence-based programming.

Risks and safety of data collection

The design of surveillance systems will consider the utility and necessity of all data collected, as well as inherent risk to the entire affected community, in particular those who may experience adversity as a result of data collection (GBV survivors, older persons, children and youth). Additionally, the legal context of suicide in the country will be considered so that collected data are de-identified/ anonymized and not traceable, in order to prevent criminalization of survivors. Only data necessary for targeted public health interventions, as agreed upon by the affected community, will be gathered.

Key Implementation Domains	**Key Activities**
• Surveillance • Data management • Reporting • Research • Learning • Innovation	i. Establish a harmonized national suicide and suicide attempts as well as self harm surveillance, registry system and database ii. Integrate collection and reporting of disaggregated data (by age, sex, and method at a minimum) on suicide and suicide attempts by all health facilities through appropriate registry including documentation of actions taken / services provided iii. Generate regular reports with disaggregated data on suicide and suicide attempt iv. Develop and disseminate guidelines for data collection,

	and management on suicide and suicide prevention v. Establish and support research grant awards on suicide and suicide prevention vi. Collaborate with academia to integrate mental health and suicide research in their studies vii. Prioritize multi-faceted mental health, suicide and suicide prevention issues in the national research agenda viii. Integrate mental health, suicide and suicide prevention in education, training programs for social service providers and the national research agenda ix. Organize an annual symposium on suicide and suicide prevention x. Integrate technology in information dissemination, safety, and access to information and education. xi. Conduct routine data quality assessment all data sitting in the system xii. Develop the capacity of the mental health and social service providers at district and

	community level in data collection, collation, analysis, reporting and application of the tools’

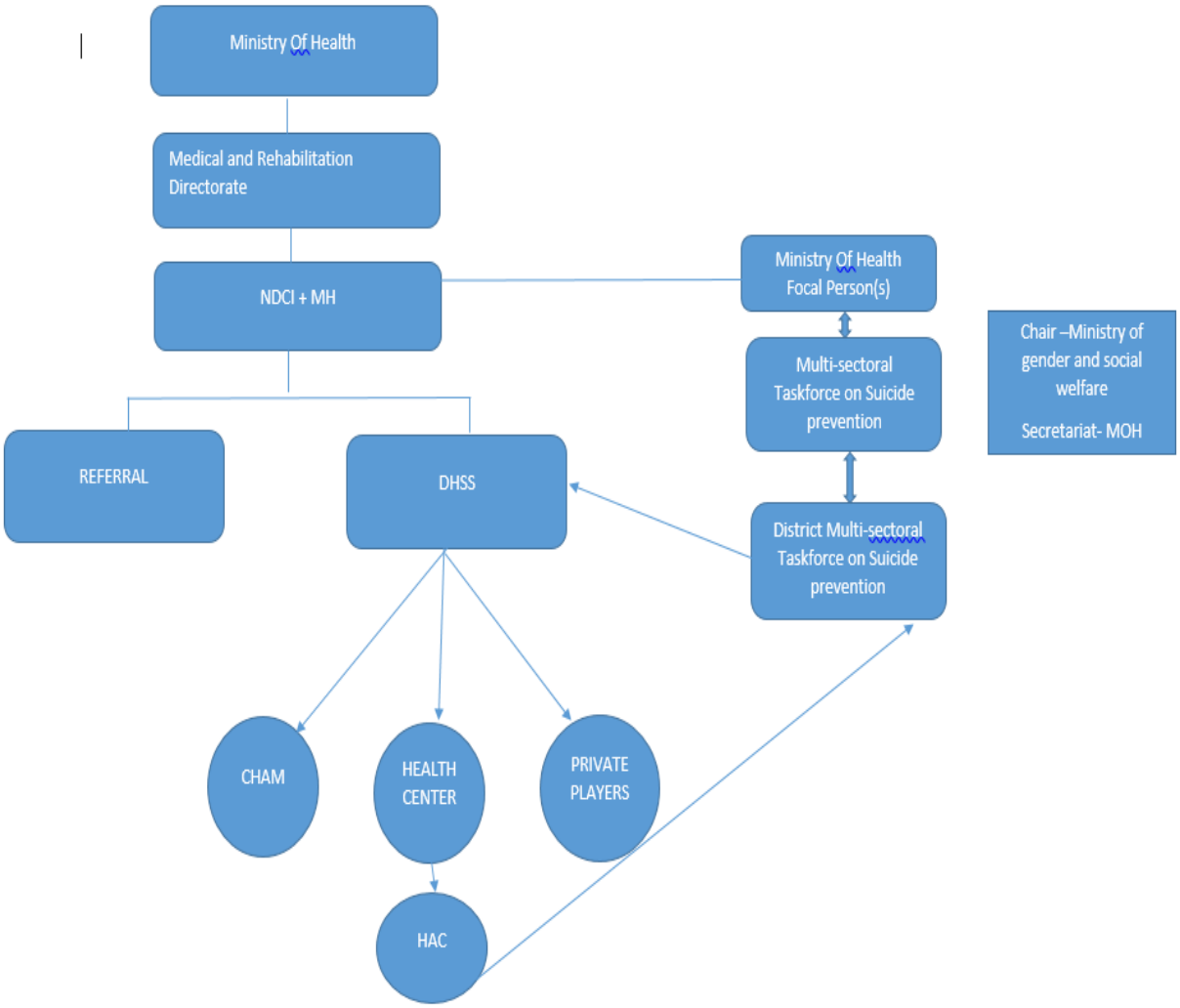
Chapter 5: Institutional Arrangements

This is to develop a strategic view of the human and institutional landscape, and the relationships between the different stakeholders and how they can work with a common goal in implementing the suicide implementation framework. It will require grouping them according to their levels of participation, interest, and influence in the framework.

<table>
<tr><th colspan="2">National Multi Stakeholder Taskforce on Suicide Prevention and Management</th></tr>
<tr><td>
Members of Parliament – Committee responsible for Social Services & Committee responsible for Health
Parliamentary committee responsible for health and social services
Ministry responsible for Education
Malawi Police Services
Ministry responsible for Agriculture
Malawi Human Rights Commission (MHRC)
Pharmacies, Medicines Regulatory Authority
Pesticides Control Board
Malawi Congress of Trade Unions (MCTU)
Malawi Chamber of Commerce and Industry
Public Affairs Committee (PAC)
Ministry responsible for Youth and Sports
Development Partners (UNICEF; UNFPA; UNDP; USAID, WHO, DFID)
St John of God Hospitaller Services
Malawi Traditional Healers Umbrella Organization (MTHUO)
</td><td>
National Planning Commission
Employers Consultative Association of Malawi
Civil Society Organization
Non-Governmental Organizations
Ministry responsible for Health
Ministry responsible for Finance
Training Institutions
Ministry responsible for children and Social Welfare
Ministry responsible for Youth
Ministry responsible for information
Ministry responsible for Labour
Ministry responsible for Homeland Security
National Association of Para-Medical Private Practitioners in Malawi
Christian Hospital Association of Malawi (CHAM)
Media
Nurses and Midwives Council
Medical Council of Malawi
National Inter Faith Committees
Health Education Services Unit
</td></tr>
<tr><th colspan="2">District Multi Stakeholder Taskforce on Suicide Prevention and Management</th></tr>
<tr><td>
District Inter Faith Association Committees
Malawi Police Service
District Commissioner
</td><td>
Civil Society Organizations
Non-Governmental Organizations
District Executive Committee
District Health and Environment Committee
</td></tr>
</table>

● Director of Health and Social Services ● Ministry responsible for Youth and Sports ● Ministry responsible for Education ● Ministry responsible for children, Gender and Social Welfare ● Ministry responsible for Agriculture	● Herbalist Association ● Hospital Advisory Committee ● Ministry responsible for Labour ● Survivors of suicide ● District information office

Proposed National Suicide Prevention Institutional Framework



5.1 Roles and responsibilities

A clear understanding of different stakeholders above needs to be understood by all actors for the objectives of the framework to be achieved

Stakeholder	Roles and responsibilities
Ministry of Health	• Coordinate capacity building for multi-sectoral stakeholders in suicide prevention and management • Development of standardized care in management of suicide survivors and their families • Provide overall leadership and stewardship in suicide management and prevention, advocacy and social mobilization. • Develop and review of documents and guidelines for suicide prevention and management. • Provide a platform for stakeholder engagement • Introduce and champion multisector stakeholder coordination mechanisms. • Engage and advocate for stakeholders support of national plans for the prevention and management of suicide. • Provide overall technical oversight for suicide prevention and management activities. • Resource mobilization and allocation of resources for suicide prevention and management activities. • Spearheading appropriate regional and local multi-sector partnerships. • Coordinate data management and dissemination of suicide prevention and management of activities. • Provide oversight on evidence based scientific research and technology relating to suicide prevention. • Adopt an intersectional approach, which recognizes that women and girls have specific needs in relation to suicide prevention, including but not limited to the reduction of their exposure to gender-based violence • Strengthen the surveillance system pertaining to suicide related information.
District Councils	• Support Data management systems on suicide prevention and management • Support district-based research and dissemination on suicide prevention and management. • Supportive supervision and mentorship on suicide prevention and management.

Stakeholder	Roles and responsibilities
	• Implement national policies and guidelines on suicide prevention at the district level. • Ensure availability of trained personnel for suicide prevention and management services. • Mobilize resources and allocate resources towards suicide prevention. • Streamlining referral services by developing referral and disseminating referral pathway. • Monitoring and evaluation • Strengthen the surveillance system pertaining to suicide related information.
MDAs	• Establish workplace mental health and suicide prevention programmes • Strengthen educational and institutional mental health programs • Strengthen educational & institutional social emotional skills training, including through schools • Streamline Pro-Youth Mental Health programs in existing youth friendly services. • Promote mental health programs in recreational facilities. • Adopt and implement relevant policies on suicide prevention • Enforce regulations of access and sale of hazardous poisonous products such as pesticides and other agro-related products • Engage in continued efforts to equip children and adolescents with necessary academic and vocational skills • Mobilize resources for the implementation of the suicide prevention programmes
Private Sector	• Provide financial support for Suicide prevention and management. • Ensure manufacturing of quality, affordable, accessible health care goods, and services (e.g. medicines, pharmaceutical products, and rehabilitation). • Undertake corporate social responsibility (CSR) activities targeting community awareness for Suicide prevention. • Adopt workplace well-being to reduce psychological and job-related stress. • Offer quality healthcare for persons who have attempted suicide seeking care in hospitals. • Comply with policies, strategies, and guidelines on Suicide prevention and management.
Private Health Facilities	• Offer quality health care services for persons who have attempted suicide and suicide ideation.

Stakeholder	Roles and responsibilities
	• Comply with policies, strategies and guidelines on suicide prevention and management. • Build capacity for suicide prevention and management among health care workers. • Strengthen the surveillance system pertaining to suicide related information.
Faith Based Organization	• Linkage to people/patients that have prior suicide attempts. • Mobilize resources for suicide prevention activities. • Contribute consensus building and connect local communities with the healthcare system. • Provide spiritual support to the vulnerable groups. • Strengthen human resource for health. • Promote healthy lifestyles to enhance resilience and address risk factors for suicide cases. • Strengthen the surveillance system pertaining to suicide related information.
Development Partners	• Provide technical support • Support resource mobilizing and financing of suicide prevention interventions. • Participate in multisectoral coordination meetings.
Regulatory and professional Bodies	• Review and develop curricula to incorporate suicide prevention strategies. • Implement the Human Resources for Health strategy focusing on mental health. • Support compliance to standard guidelines.
Law makers	• Review and enact the outdated Act for Mental health • Fast-track the repeal of the provisions of the Penal Code criminalizing suicide • Pass Bills for prevention and management of suicide. • Allocate resources for suicide implementation framework. • Provide a legal oversight for the suicide prevention in the country • Champion new laws pertaining to suicide prevention and management to communities.
Training Institutions	• Support education and training on suicide prevention. • Review education curricula in consultation with regulatory bodies to respond to the evidence-based suicide prevention and management.
Media	• Conduct advocacy and community mobilization in implementation of suicide framework. • Participate in development and dissemination of suicide prevention and management IEC materials

Stakeholder	Roles and responsibilities
	• Sensitize and mobilize their members for effective reporting on suicide issues. • Adherence to ethical principles in mass media as they pertain to the portrayal of suicide
Individuals and communities	• Adopt appropriate health seeking behaviours. • Participate actively in health promotion and suicide prevention activities. • Participate in social mobilization activities to raise awareness of suicide prevention • Adopt annual screening on mental health wellness and suicide risks. • Adopt positive healthy living styles • With improved life skills, apply those skills in interpersonal relationships such that risks such as interpersonal violence, bullying and cyberbullying are mitigated
Survivors of suicide.	• Participate actively in promotion of mental health and evidence-based suicide prevention interventions. • Participate in the development of plans and interventions • Advocate for increased resources toward implementation of suicide prevention activities at community level. • Provide peer support and care programs. • Advocate for inclusive policies, access human right based community mental health services and decriminalization of suicide attempt and suicide.
Children and youth	• Advocate for laws and policies on improving children and adolescents' safety and protection • Participate in the development of plans and interventions • Advocate for increased resources toward implementation of suicide prevention activities for in and out of school youths • Provide peer support and care programs. • Advocate for improving environments within schools, communities and online to promote and protect adolescent mental health • Provide advice on how best to engage their peers and to identify risk factors specific to their community. • Supporting carers; • Improving on their psychological skills

ANNEXES

Implementation plan

Strategy & Description	Activities
Objective 1 : **To establish and operationalize suicide prevention program at national, district and community levels**	
	• Establish a coordinating unit for suicide prevention • Appointment of focal person for coordination of suicide prevention program at all levels. • Development of the national suicide prevention program • Dissemination of the suicide implementation framework and program • Designate focal persons at MDAs for coordination and implementation of suicide prevention program
Objective 2: To strengthen supportive strategy, legal environment and financing for effective implementation of suicide prevention program	
Provide a supportive platform to implement suicide program	• Advocate for decriminalization of suicide by Repealing Section 229 of the Penal Code. • Advocate for the finalization and adoption of the Mental Treatment Act • Collaborate with relevant stakeholders towards regulation of all lethal means used in suicide incidents e.g. pesticides • Profiling mental health and suicide prevention in all MDAs and stakeholder's programs • Mobilize financing for suicide prevention at national, district, and community levels
3.7.3 **Objective 3:** To improve access to comprehensive, integrated, and quality services for suicide interventions at all levels of care.	

Access to promote, preventive care, rehabilitative and aftercare services	• Develop and disseminate multisectoral guidelines and protocols for comprehensive management of suicide • Mainstream and integrate screening, assessment and treatment interventions for suicide risk factors at all levels of health care system.
	• Integrate and operationalize a national suicide implementation framework into existing helpline (s). • Integrate mental health care and referral pathways for persons with suicidal behavior at community and all health care service levels • Increase capacity of mental health and psychosocial care providers • Strengthen provision of psychological and suicide first aid at all levels of care • Strengthen existing community health activities to include mental health and suicide prevention during household visits and dialogue days with emphasis on building and strengthening resilience. • Embed risk assessment processes and provide mandatory risk assessment that focuses on suicide and self-injury to ensure there is early identification of those at high risk for appropriate intervention
	Awareness-raising and development of key messages should engage key stakeholders (see section 1.1), build on results from the assessment/situational analysis (common misconceptions, available resources: see section 1.2) and can cover topics such as: • Suicide and its associated risk and protective factors • Warning signs and early identification of suicidal behaviours (including age and gender differences and population sub-groups) • Supporting at-risk groups • Common misconceptions

	• Positive ways to cope with psychological distress and suicidal thoughts • How to help and support people with suicidal thoughts or behaviours • Postvention support including tips on supporting bereaved families. **NB:** Ensure that messages are always kept positive and hopeful. It is critical that information is included on where and how to access help (information on available local MHPSS hotline numbers, MHPSS centres or local mental health services, and child protection helplines). Integrate awareness-raising and key messages with available services and supports that at-risk groups may be accessing, such as: • Health services • Community-led MHPSS activities • Group activities for the mental health and psychosocial well-being of children and adolescents • Formal and informal education and learning spaces • Protection services, including safe spaces for women and girls • Registration or verification points, distribution sites and service delivery points.
3.7.4 **Objective 4:** To increase awareness on suicide, suicide prevention and stigma and discrimination.	
Advocacy, public awareness, and communication	• Develop a capacity building program on suicide and suicide prevention program • Develop a communication guideline to facilitate public awareness, communication and responsible reporting • Mobilization and engagement of key stakeholders at national, district and community levels on suicide prevention • Train the targeted groups (HCWs, media practitioners, Police, teachers, clergy, administrative leaders) on suicide prevention

	• Conduct an annual Countrywide awareness campaign on suicide prevention during the month of September in line with the global community • Conduct targeted media campaigns on suicide prevention
3.7.5 **Objective 5:** To strengthen systems for surveillance and research on suicide.	
	• Establish a harmonized national suicide and suicide attempts surveillance, registry system and database • Integrate collection and reporting of desegregated data on suicide and suicide attempts by all health facilities through appropriate registry • Generate regular reports with desegregated data on suicide and suicide attempt • Provide guidelines for data collection, and management on suicide and suicide prevention • Establish and support research grant awards on suicide and suicide prevention • Collaborate with academia to integrate mental health and suicide research in their studies • Prioritize multi-faceted mental health, suicide and suicide prevention issues in the national research agenda • Integrate mental health, suicide and suicide prevention in education and training programs

	• Organize an annual symposium on suicide and suicide prevention • Integrate technology in information dissemination, safety, and access to information and education.

Monitoring and Evaluation Framework

Strategic Objective 1: To establish and operationalize suicide prevention program at national, district and community levels											
Key Activities	**Indicators**	**Source of Data**	**Periodicity**	**Target**							
				2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Establishing a coordinating unit for suicide prevention	Appointment of focal person for coordination of suicide prevention program at all levels	Appointment letter	Once	1							
	Development of the national suicide prevention program	Meeting minutes, report on development process		60%	100 %						
	Dissemination of the suicide implementation framework and program	Report on dissemination process				1	1	1	1	1	1
	Designate focal persons at MDAs for coordination and implementation of suicide prevention program	Appointment letter	1								
Integrate intersectoral	Suicide prevention committee established	Appointment letters, TORs,	1								

committee on suicide prevention at national, district and community levels into existing structures	at national level	Meeting minutes									
Conduct mid-term review of the suicide prevention program	Number of midterm reviews done	Technical report on the review					1				
Objective 2: To strengthen supportive strategy, legal environment and financing for effective implementation of suicide prevention program											
Key Activities	**Indicators**	**Source of Data**	**Periodicity**	**Target**							
				2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Advocate for decriminalization of suicide by Repealing Section 229 of the Penal Code	Relevant regulations and legislature address the decriminalization	Penal Code					1				
Advocate for the finalization and adoption of the Mental Treatment Act	Accented through required due process of Ministry of Justice	Parliament Records				1					
Collaborate with relevant stakeholders towards regulation of all lethal means used in suicide incidents e.g. pesticides	Pesticides control policy on Suicide means prevention	Pesticides control policy					1				
Profiling mental health and suicide prevention in all	Number of MDAs and stakeholder programs	MDA reports on suicide	annually	20%	50%	70%	90%	100 %	100 %	100 %	100 %

MDAs and stakeholder's programs	profiling suicide prevention										
Mobilize financing for suicide prevention at national, district, and community levels	Proportion of required resources allocated towards the suicide prevention	Finance allocation reports	annually	1	1	1	1	1	1	1	1
	Number of District Councils with dedicated mental health budget	Council report on Mental Health	annually	50%	70%	100 %	100 %	100 %	100 %	100 %	100 %
Objective 3: To improve access to comprehensive, integrated, and quality services for suicide interventions at all levels of care											
Key Activities	**Indicators**	**Source of Data**	**Periodicity**	**Target**							
				2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Access to promote, preventive care, rehabilitative and aftercare services	Developed and disseminated multisectoral guidelines and protocols for comprehensive management of suicide	MoH Guidelines	once		50%	100 %					
Mainstream and integrate screening, assessment and treatment interventions for suicide risk factors at all levels of health care system.	Number of Facilities mainstreaming and integrating screening, assessment and treatment interventions for suicide risk factors at all levels of health care system.	DHIS2	annually	0%	20%	30%	50%	70%	90%	100 %	100 %
	Proportion of facilities that are effectively	Report on number of assessment	annually	0%	20%	30%	50%	70%	90%	100 %	100 %

	utilizing screening and assessment tools	tools validated									
	Proportion of persons attending health facilities screened for suicide risk.	DHIS2	annually	0%	40%	70%	90%	100 %	100 %	100 %	100 %
	Proportion of persons at risk receiving interventions .	DHIS2	annually	0%	20%	30%	50%	70%	90%	100 %	100 %
Integrate and operationalize a national suicide implementation framework into existing helpline (s).	Operational suicide helpline in place	Implementation reports		Helpline active							
	Proportion of callers with suicide risk linked to care through the helpline.	Helpline reports	annually		1	1	1	1	1	1	1
Integrate mental health care and referral pathways for persons with suicidal behavior at community and all health care service levels	Proportion of community and health care services that have care and referral pathways activities.	DHIS2	annually	0%	20%	30%	50%	70%	90%	100 %	100 %
	Proportion of health facilities with access to a mental health service provider	Mapping Report	annually	0%	20%	30%	50%	70%	90%	100 %	100 %
Increase capacity of mental health and psychosocial care providers	Number of health workers trained in Mental Health	Training reports	annually	1	1	1	1	1	1	1	1
	Number of	DHIS2, Mental	annually	1	1	1	1	1	1	1	1

	facilities providing psychological and suicide first aid at all levels of care	Health Reports									
Objective 4: To increase awareness on suicide, suicide prevention and stigma and discrimination.											
Key Interventions	**Indicators**	**Source of Data**	**Periodicity**	**Target**							
				2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Develop a capacity building program on suicide and suicide prevention program	Capacity building modules/ training packages developed				100 %						
Conduct annual wide awareness campaigns for suicide prevention	Annual public awareness conducted	Campaign reports	annually		**1**	**1**	**1**	**1**	**1**	**1**	**1**
Conduct target Media campaigns	Media campaigns conducted	Media Reports			**1**		**1**		**1**		**1**
Objective 5: To strengthen systems for surveillance and research on suicide											
Key Interventions	**Indicators**	**Source of Data**	**Periodicity**	**Target**							
				2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Establish a harmonized national suicide and suicide attempts surveillance, registry system and database	Suicide surveillance system and registry established	Police, Mortuary, Hospital records						100 %			
Integrate collection and reporting of desegregated data on suicide and suicide attempts by all health facilities through	Proportion of health care facilities reporting on suicidal attempts and deaths	DHIS2	annually	0%	20%	30%	50%	70%	90%	100 %	100 %
	Number of reports	DHIS2							**1**	**1**	**1**

appropriate registry	generated annually.										