



## **Suicide Prevention Inequities in Colombia: A Call to Action**

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In Colombia (South América), suicide care is focused on prevent people to kill themselves. Prevention guidelines have been designed without a sensitive understanding of particular population needs and its social determinants, which can lead to the accentuation of social and health inequities, due to differential exposures to risk and protective factors and cumulative advantage/disadvantage throughout life. Therefore, preventive actions that seek to prevent damage and risk control, create a space for reflection on the task prevention, health promotion and quality of life.

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Suicide is a global phenomenon that occurs in all regions of the world, every year, about 700,000 people die from suicide [2]. The highest rate of these deaths is found in those between 15 and 29 years of age [2].

In Colombia, between January and May 2022, a total of 1,130 deaths by suicide have been reported [3].

Under this framework, suicide death prevention guidelines have been established at national and local levels. The national level, is deeply influenced by the World Health Organization strategies such as limiting access to means of suicide like pesticides, firearms and certain medications, reinforcing socio-emotional tools, identifying and assessing suicidal behaviors at an early stage, and providing early warning of suicide [2]. Colombia has a Clinical Practice Guide for the prevention, diagnosis and treatment of suicidal ideation and/or behavior (Adoption) where the Ministerio de Salud has made inroads in suicide prevention based on three fundamental aspects:



increase and control of the most frequent mechanisms of suicide such as firearms and pesticides; follow-up of people who have attempted suicide, as well as their families; and finally, guaranteeing access to health services for people with associated disorders such as depression, schizophrenia and bipolar disorder [4]. In addition, the Ten-Year Public Health Plan 2012-2021 established the goal of reducing the suicide rate to 4.7 per 100,000 inhabitants [5]. With these provisions, death by suicide has been monitored since 2016; since then, there has been a trend of a continuous increase in cases every year [6]. At this point, it is pertinent to ask the reasons why this goal has not been reached.

The answer can be related to suicide prevention strategies. These strategies, have focused on attending to attempts, limiting access to elements that can cause one's own death and reducing the number of people who die as a result of suicide. This perspective constitutes a system focused on disease care (suicide attempts or completed suicide) rather than on health (suicide prevention) [7].

Moreover, suicidal ideation, which, in the suicide spectrum, constitutes the element that opens the way to action, has not been widely observed or intervened. The proportion of people who experience suicidal ideation is even higher than those who commit suicide, these people suffer in silence because they are experiencing unpleasant ideas [8].



Currently, it is clear that suicide prevention strategies must be questioned in multicultural and unequal countries like Colombia, with rates of suicide rising while little has been done to address the emotional and social needs [10].

In summary, the reduction of deaths by suicide cannot be the goal to be achieved, since it leads to decontextualized actions, oriented to prevent damage, prevent risks, and do little or nothing for the quality of life. These strategies are oriented to implement standardized and homogeneous protocols that accentuate the inequities of those who have suicidal ideas or behaviors. This is a call to action, to move towards a comprehensive approach to the person who presents suicidal ideation from the dialectic and location of the individual, generating a broad vision composed of multiple dimensions that in turn cross the life course of the person.

In this line, recent research has reported that black males living up to twice the poverty line are more likely to have suicidal thoughts, young people with lower educational attainment and poor health are more likely to have suicidal thoughts than their peers, and young people with lower educational attainment and poor health are more likely to have suicidal thoughts than their peers [11]. This result, highlights the need to provide a comprehensive public health approach to suicide prevention that recognizes and addresses the various intrapersonal, community, occupational, environmental and social elements that contribute to suicide risk [12]



As a result, it is necessary to change understanding people and their lives as properties into more complex and dynamic comprehensions, so that it is possible to create interventions improving life quality conditions and preventing deaths by suicide.

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The authors declare that this publication has no conflict of interest.

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