

Lives within reach: Suicide prevention in the Eastern Mediterranean Region

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Every year, more than 720 000 people die by suicide globally—the vast majority in low- and middle-income countries (1). In the WHO Eastern Mediterranean Region (EMR), over 27 000 lives were lost to suicide in 2021 alone. Seventy-one percent were male and nearly half were under the age of 30 years (2). Suicide remains the third leading cause of death among adolescents aged 15–19 years, and while rates have declined over 2 decades, the region is not yet on track to meet the United Nations Sustainable Development Goal of one-third reduction by 2030 (1). Behind every figure is a family shattered, a community diminished. These deaths are not inevitable—they are preventable.

The regional age-standardised suicide rate of 4.0 per 100 000 population is below the global average of 8.9, but aggregate figures conceal striking disparities (1). Country rates range from 0.7 per 100 000 in Jordan to 15.3 in Somalia, and in Pakistan, Islamic Republic of Iran and Libya, young adults bear a disproportionate burden. A regional situation analysis commissioned in 2023 identified mental health conditions, family history of suicide, interpersonal conflict, and domestic violence as key risk factors, and migrant workers, refugees and sexual and gender minorities as populations at higher risk (4).

Hanging, pesticide poisoning and self-immolation are the leading methods identified across the region (4,5), with poisoning—by pesticide and medication—particularly well-documented in Pakistan over several decades (3,11). Hospital-based surveillance consistently shows that deliberate self-harm clusters among adolescents and young adults, mirroring global trends (3).

The true burden of suicide is almost certainly greater than available figures suggest, given the widespread stigma attached to mental health conditions. Stigma tends to delay help seeking, compounded by criminalisation of suicidal behaviour and poor quality of data, resulting in deaths by suicide going unrecorded (6).

A public health response takes shape

The launch of LIVE LIFE initiative by WHO in 2021 provided countries with a practical, evidence-based framework on means restriction, responsible media reporting, life-skills development for young people, and

strengthened mental health support, underpinned by multisectoral collaboration and robust surveillance (7).

Countries have responded with increasing resolve. Nine countries now have national suicide prevention strategies (9). Pakistan's 2022 decriminalisation of attempted suicide stands as a landmark—a fundamental shift from punishment to public health, removing barriers to care, reducing stigma, and laying the foundation for more accurate reporting (6). Pesticide bans have been established in 4 countries, with 6 training regulators, and life-saving potential of these interventions is well demonstrated in Bangladesh, China, Japan, Sri Lanka, and beyond (7,8).

Surveillance has advanced, with Pakistan strengthening self-harm monitoring and Islamic Republic of Iran developing a minimum data set to integrate suicidal behaviour data across systems (9,10). A media monitoring toolkit launched in 2023 helps governments to track adherence to WHO reporting guidelines, with training delivered in at least 7 countries (12). In schools, programmes such as Helping Adolescents Thrive and the Good Behaviour Game are building the socio-emotional skills that protect young people over a lifetime (13). At the community level, the WHO Mental Health Gap Action Programme (mhGAP) has been rolled out in at least 13 countries, equipping non-specialist health workers to assess and follow-up on people at risk. This is complemented by gatekeeper training in 7 countries and an online self-help module for those experiencing suicidal ideation or bereavement (9,13).

The road ahead

These gains are real—but they are fragile. The escalating conflict across the region threatens mental health infrastructure and compounds the very conditions—poverty, displacement and domestic violence—that drive suicidal behaviour. Sustaining the momentum requires clarity about what comes next.

Three priorities must guide our action. First, suicide data must improve. Without reliable surveillance, it is impossible to evaluate impact or respond to emerging trends; innovations underway in Pakistan and Islamic Republic of Iran offer models worth scaling-up across the region (9,10). Second, decriminalisation must remain a policy priority—legal frameworks that punish suicidal

behaviour obstruct care, reinforce stigma and undermine the data systems on which effective response depends (6). Third, suicide prevention must be recognised as a whole-of-government challenge. The determinants of suicidal behaviour—poverty, inequality, violence, social exclusion—extend far beyond the health sector and demand coordinated national strategies that bring

policy-level action and evidence-based interventions under coherent leadership (4).

The EMR has demonstrated that progress is achievable. The task now is to accelerate that progress—ensuring that no country faces this challenge alone, that hard-won gains are not eroded by conflict or complacency, and that the goal of preventing 1 in 3 suicide deaths by 2030 moves from aspiration to reality.

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