Suicide in Puducherry, India: A Public Health Burden

Sir,

The Union territory (UT) of Puducherry in South India has been consistently observed to have high suicide rates in India in the past decade according to the authentic statistics of the National Crime Records Bureau (NCRB), New Delhi, India. In 2010, the suicide rate in Puducherry was 45.5 per 1,00,000 population, which was four times that of the Indian national average suicide rate.
(11.4 per 100000 population) and two times that of suicide rate in Tamil Nadu (24.5 per 100000 population). From 2000 to 2010, Puducherry has ranked either first or second in its suicide rate in India. Youths (15-29 years) and lower middle-aged people (30-44 years) were the prime groups taking recourse to the path of suicides. Around 35.4% suicide victims were youths in the age group of 15-29 years and 33.3% were middle aged persons in the age group 30-44 years. Delhi reported the highest number of suicides (1,543) among Union Territories (UTs), followed by Puducherry (508). While all seven UTs together accounted for 1.8% of total suicides (1,34,599) in India, the thirty five mega cities on the contrary, accounted for 10.2% of the total suicides in the country. A critical analysis of these statistics yields useful insights into their significance from a public health perspective.

First, the psychological and social impact of suicide on the family and society is immeasurable in any society. On an average, single suicide intimately affects at least six other people. If a suicide occurs in a school or workplace it has an impact on hundreds of people. Globally, the burden of suicide can be estimated in terms of disability-adjusted life years (DALYs) and in year 1998, suicide was responsible for 1.8% of the total burden of disease worldwide, varying between 2.3% in high-income countries and 1.7% in low-income countries. Unfortunately, absolutely no data is available on the DALY’s due to suicide for either Puducherry or for India. As a consequence, suicide remains an ignored and neglected health problem in our society to date.

Second, it is intriguing to accept that the high suicide rate in Puducherry has robust internal and external validity. NCRB suicide statistics are obtained from police and hospital records only. Several researchers in India have examined suicide based on analyses of police data. These studies have revealed regional differences, with suicide rates, which vary from 8/100,000 to 95/100,000 population. The majority of studies are based on analyses of police or hospital records with the assumption that all suicides are reported to the police and misclassifications do not exist. A recent study from Bangalore observed that the incidence was 35/100,000 population for completed suicide and 250-300/100,000 for attempted suicide, with 60% of deaths occurring in the age group of 15-34 years. These studies clearly indicate that many cases of suicide may not be reported to the police. Sadly, no such research data are available from Puducherry. All these studies show that suicide statistics are an underestimate to what is reported, which provokes one to further overlook suicide as a health issue of concern.

From the above viewpoints, major conclusions need to be quickly ascertained. Although the above limitations have always prevented any initiatives from the Ministry of Health and Family welfare, Government of India, perspective can be drawn from the 2008 WHO theme for suicide prevention namely “Think Globally, Plan Nationally, Act Locally.” It is high time, the NCRB suicide estimates of Puducherry are taken as strong and sufficient evidence to make suicide a “public health burden” and initiate strategies towards its prevention.

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