MINISTÉRIO DA SAÚDE
Direção Nacional da Saúde

GOVERNO DE CABO VERDE
A TRABALHAR PARA TODOS.

Disease Prevention and Control Service

NATIONAL MENTAL HEALTH PROGRAM

NATIONAL SUICIDE PREVENTION STRATEGY

November, 2023

REPUBLIC OF CABO VERDE

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Datasheet

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PREFACE

At the heart of Cabo Verde's Ministry of Health, our mission is to promote comprehensive and sustainable health that embraces every citizen of the archipelago. Recognizing the intricate tapestry that makes up human well-being, it is with a deep and contemplative responsibility that we launch the National Strategic Plan for Suicide Prevention. This document is not just a milestone, but a beacon in our never-ending journey of dedication to the mental health of our community.

We are at a decisive moment, marked by the clear vision of the Cabo Verdean government, which, in line with global health and well-being guidelines, has proclaimed 2024 as the Year of Mental Health in Cabo Verde. This proclamation mirrors our unchanging commitment to nurturing a more enlightened, resilient society based on foundations of empathy and mutual understanding, echoing the motto "Mental Health, Priority for All".

In this plan, we propose a vision that transcends the conventional boundaries of health, embracing the inseparability between mind, body and spirit. Mental health is understood here not only as the absence of illness, but as a crucial element that is inseparable from full health, which allows for a life full of satisfaction and harmony in the personal, family and social dimensions.

Recognizing the complexity of our daily existence, this strategic plan underlines the importance of cultivating the intangible values that enrich our quality of life. Happiness, emotional well-being, solidarity and social cohesion emerge not only as goals, but as essential pillars for the sustainable development and wealth of our nation.

This document is, above all, an invitation to collective mobilization and deep introspection. We call on everyone, from health professionals to specialists from different sectors, under the banner of health in all policies, and the entire Cabo Verdean population, to join in this effort to build a culture of care, prevention and reciprocal support. It is a call for everyone to become a protagonist in valuing mental health, recognizing it as a fundamental human right and a foundation of our dignity and essence.

With the implementation of this strategic plan, we renew our vow to move towards a future where every Cabo Verdean has universal and equitable access to effective assistance, adequate tangible and intangible resources and the necessary understanding for a full and meaningful existence. United, we have the power to make this vision a tangible reality, ensuring that mental health is seen and treated with the same priority that is given to all health specialties and areas of sectoral action, as well as by the civic conscience of every citizen.

The Minister of Health,

Filomena Mendes Gonçalves

Minister of Health

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The National Suicide Prevention Strategy is the culmination of a long process, which involved the participation of several institutions and working groups, whose contribution made it possible to present this final product.

Our thanks go to all the people who, directly or indirectly, collaborated in all stages of the development of the National Suicide Prevention Strategy.

We would like to highlight the commitment and dedication of all sectors and institutions that made it possible to achieve this result.

For the preparation of this National Suicide Prevention Strategy and its publication, we relied upon the financial assistance of the World Health Organization (WHO), to which we take this opportunity to express our special thanks.

A word of appreciation to the technical monitoring team and the international consultancy for the excellent performance in the activities carried out which now allows us to make available this important guidance document with the main strategies for suicide prevention in Cabo Verde.

Our many thanks.

The National Director of Health

Dr. Angela Gomes

ACRONYMS AND ABBREVIATIONS

(in chronological order of use)

WHO	World Health Organization
UNICAMP	Universidade Estadual de Campinas (State University of Campinas)
PAHO	Pan American Health Organization
PENSM |2021-2025|	National Strategic Plan for Mental Health |2021-2025|
CRISES	*Center for Research on Social Innovations*
UQAM	Université du Québec à Montréal (University of Québec at Montreal)
GHE	*Global Health Estimates*
WHO	*World Health Organization*
COVID-19	*Coronavirus disease 2019*
HDI	Human Development Index
MS	Ministry of Health
LMICs	*Low and Low Middle-Income Countries*
FDI	Foreign Direct Investment
INE	National Institute of Statistics
GDP	Gross Domestic Product
GNI	*Gross National Income*
MpD	Movimento para a Democracia (Movement for Democracy)
PAICV	Partido Africano da Independência de Cabo Verde (African Party for the Independence of Cabo Verde)
FDI	Foreign Direct Investment
GEP	Global Economic Perspective
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
CCS-AIDS	Commission for the Coordination of the Fight against HIV/AIDS
CCAD	Commission for the Coordination of Alcohol and Other Drugs
MSSS	Ministry of Health and Social Security
SVIR	Integrated Surveillance Response Service

DNS	National Health Department
IDNT	National Survey on Risk Factors of Non-Communicable Diseases
CPLP	Community of Portuguese Speaking Countries
GOs	Government Organizations
NGOs	Non-Governmental Organizations
ST, MT and LT	Short-Term; Medium-Term and Long-Term
INSP	National Institute of Public Health
GTCIS	Office of Technology, Communication and Information in Health
ERIS	Independent Health Regulatory Authority
MAA	Ministry of Agriculture and Environment
INSA	National Institute of Health Dr. Ricardo Jorge
ARC	Regulatory Authority for Social Communication
AJOC	Cabo Verde Journalists Association

INTRODUCTION

Suicide is a complex and multidimensional phenomenon and, as such, must be understood from this perspective. It is also a public health problem, since its effects affect society as a whole. Therefore, public health concepts should be used to their full extent, so that it can be seen as a preventable event that requires the use of tools and knowledge in this field.

Identifying risk factors and protective factors is extremely important for developing evidence-based interventions. Reducing or reversing risk factors and promoting protective factors are effective strategies. The importance of a strategic approach to suicide prevention, supported by research with evidence-based interventions that focus on risk and protective factors, is recognized worldwide.

As a considerable number of suicide cases and attempts have a diagnosis of mental disorders, this should be situated in this field of intervention, but associated with other sectors. Considering that these disorders constitute risk factors, although they are not the only ones, and depend on protective factors, such as the availability of services that attend to these cases, the impact of risk factors is modified in the presence of significant protective factors.

Although the association between suicide and mental disorders (particularly depression and harmful use of alcohol) is well established, suicides can occur impulsively in times of crisis. Other risk factors include experience of loss, loneliness, discrimination, relationship breakdowns, financial problems, chronic illness, violence and abuse. However, the greatest risk of suicide is a previous attempt (Ministry of Brazil, UNICAMP & PAHO, 2006) [02] .

And as a health event that occurs in a social context, whether in the family, at school, at work or in a public place, it suffers the impacts of the social and cultural factors present in society. So, it is important to be aware of the social risk factors associated with suicide, as minimizing them can lead to mistakes.

Interventions focused on families and communities have a greater impact than those focused exclusively on individuals. Interventions should include standards that promote support and well-being in all contexts, including the family, work, school and the community.

Primary mental health care is a strong point of a strategy and must be robust and with actions focused on health promotion, prevention and early detection of diseases, and that care is provided to people in the communities where they are integrated (Ministry of Health of Portugal, 2013) [03] .

Law No. 37 on Mental Health of the Republic of Cabo Verde, of August 7, 2013 states: *"The provision of care by mental health services is carried out as a priority and whenever possible, as close to the community as possible, in order to avoid removing patients from their usual environment and facilitate their rehabilitation and social integration"* [04] .

The vast majority of strategies developed by countries, and at the moment the World Health Organization (WHO) identifies 38 **National Strategies** which are at different stages of implementation, works with this vision and these concepts. Narrow views on the issue of suicide prevention are a major risk when drawing up any strategy.

The National Strategic Plan for Mental Health |2021- 2025| of the Ministry of Health of Cabo Verde advises that "*accelerating the implementation of a suicide prevention strategy will come from sharing learnings between countries - regardless of the stage of implementation of national suicide prevention strategies* (PENSM, 2021:14) [05] and reaffirms that evaluation is essential to accelerate progress. This guideline is also shared by the CRISES Research Center of the Faculty of Psychology of the University of Quebec at Montreal (UQAM, *acronym in French*) in the comparative study of the implementation of suicide prevention strategies that it carries out between countries, in different stages [06].

According to the Global Health Estimates (*GHE*), which provide the most recent available data on death and disability globally, by region and country, and by age, sex and cause, data for Cabo Verde indicate a reduction in suicide rates since 2013 (WHO, 2020) [07].

Despite this national downward trend, it is important to note that this rate cannot be defined as an indicator of the impact of implementing the strategy without an explanatory model, in this case a mathematical model, which includes several social and economic variables, including those associated with the COVID-19 Pandemic, such as the level of employment, particularly among the young population.

Table 1-Age-Standardized Suicide Rate

Year	Both sexes	Men	Women
2019	15,23 [9,49–23,19]	27,4 [17,27–41,81]	5,06 [3,08–7,79]
2018	15,96 [10,02–23,99]	28,88 [18,31–43,48]	5,16 [3,2–7,88]
2017	16,16 [10,09–23,6]	27,83 [17,45–40,6]	5,31 [3,31–8,08]
2016	16,53 [10,41–23,96]	28,27 [17,84–40,92]	5,51 [3,48–8,33]
2015	16,73 [10,54–23,94]	28,66 [18,08–40,98]	5,6 [3,57–8,35]
2014	16,91 [10,69–24]	29,01 [18,37–41,14]	5,67 [3,64–8,4]
2013	17,46 [11,12–24,54]	30,02 [19,15–42,13]	5,83 [3,76–8,56]
2012	17,98 [11,47–25,17]	31,02 [19,81–43,32]	5,89 [3,8–8,6]
2011	18,21 [11,71–25,53]	31,59 [20,36–44,16]	5,79 [3,74–8,5]
2010	18,44 [11,79–25,99]	32,02 [20,5–45,04]	5,94 [3,83–8,69]

Source: WHO, 2020. (07)

An econometric regression model can be constructed by analyzing a time series that has as a dependent variable, for example, the suicide rate, and as independent or explanatory variables, for example, economic growth, the Human Development Index (HDI), educational and health indicators, with the aim of identifying which variables are most significant and explain the increase or reduction in the suicide rate.

An indicator for monitoring and evaluating the impact of implementing the strategy could be the reporting of suicide attempts. This indicator, in addition to directing the focus to identified vulnerable populations, enables due attention and surveillance to be given to cases that represent a well-identified population at risk. This would enable specific interventions aimed at this section of society.

However, this notification is not yet mandatory in Cabo Verde, although there are scattered records made by health professionals, but not grouped together in a centralized database. This is a challenge, but it can be overcome with some investment and political decision.

The authors of the Suicide Attempt Notification Form established in the city of Rio de Janeiro in 2001, granted public use of the Form, which may be adapted to the Cabo Verdean reality. One of the changes to be made concerns the exclusion of the race data. which does not apply in Cabo Verde, as it does in Brazil [08] (**ANNEX I)** .

It is important to highlight that changes in suicide rates should not be expected after implementing interventions in a period of less than five years, for example. Suicide rates and their records move with particularities in populations, which is why it is of great importance to select available and accessible evaluation indicators so that planned, monitored and evaluated interventions can be built.

A **National Suicide Prevention Strategy** it is an incentive to incorporate the theme into the State Political agenda. It should be emphasized that a well-designed **Strategy** , which considers all the variables and challenges involved, together with an efficient **Action Plan** developed afterwards, has the capacity to stimulate and promote the effective implementation of suicide prevention measures.

Cabo Verde is a country on the African continent, considered Lower Middle Income (LMICs *)* by the World Bank, and with a growth trend in different social and economic items. The country has shown interest in projects coordinated by multilateral agencies and bodies, as well as exchanges with other countries.

The interest of the Ministry of Health of Cabo Verde in implementing a Suicide Prevention Strategy is expressed in the **PENSM |2021-2025| (MS, 2021)** . This Plan was prepared by a diverse set of institutions linked to the Ministry of Health, other government and civil society institutions, and professionals from various sectors, and had the technical and financial support of WHO in Cabo Verde.

The proposal is based on the **LIVE LIFE Suicide Prevention Program (WHO, 2021)** [09] which has some effective intervention strategies, such as: **limit access to means of suicide; interact with the media to produce responsible reporting on suicide; stimulate socio-emotional life skills in adolescents and identify early, assess, care for and monitor those affected by suicidal behavior, especially those who have made attempts.**

This last strategy is fundamental to making progress with the integration/reporting of suicide attempts in the health information system, closer monitoring of surviving families and the strengthening of health services, ensuring scientifically valid healthcare interventions.

PART I

GEOGRAPHICAL, ECONOMIC, DEMOGRAPHIC AND SERVICE ASPECTS

Located 500 kilometers off the west coast of Africa, Cabo Verde is an archipelago made up of 10 islands, nine of which are inhabited. The country has an estimated population of 491,233 (National Statistics Institute, 2021)
[10]. Only 10% of its territory is classified as arable land and the country has limited mineral resources.

The Cabo Verdean economy is based on tourism - which accounts for 25% of the Gross Domestic Product (GDP) and drives around 40% of overall economic activity - with a temperate climate all year round, beautiful beaches, low risks of insecurity and proximity to the European continent.

Despite the challenges associated with a small island economy, Cabo Verde has seen remarkable economic progress since 1990, largely spearheaded by the rapid development of tourism, particularly all-inclusive resorts, in addition to considerable social developments resulting from the implementation of strong social policies over the years.

By 2019, Cabo Verde could be considered one of the examples among sub-Saharan African countries in terms of poverty reduction. Poverty projections based on its economic growth suggest that poverty rates, as measured by the poverty line of 5.5 dollars a day, fell by 6 percentage points between 2015 and 2019, from 41% to 35%, which corresponds to around 23,000 people being lifted out of poverty. In addition, between 2001 and 2015, inequality (as measured by the Gini Index) fell from 53 to
42. In 2016, the GNI*(Gross National Income*) index in dollars per person was 3.13 and in 2020, 3.33. About a dollar above Lower Middle Income Countries (World Bank, 2022) [11].

Cabo Verde has been highlighted as an example of democracy in Africa, largely thanks to its political stability. The electoral processes have taken place without conflict, being held regularly and considered free and legitimate, with a peaceful alternation of power between the two largest parties on the country's political scene, the Movement for Democracy (MpD) and the African Party for the Independence of Cabo Verde (PAICV).

Before the global economic crisis caused by COVID-19, Cabo Verde experienced robust economic growth, driven by a thriving tourism sector and strong structural reforms, but the crisis brought the economy to a standstill in 2020. Between 2016 and 2019, the average growth was 4.7% (3.2% in per capita terms). Sustained and robust economic growth led to a decline in poverty from 35% in 2015 to 28% in 2019.

The COVID-19 shock has had a negative impact, particularly on the tourism sector, which accounts for 25% of GDP and drives around 40% of all economic activity; and by reducing

Foreign Direct Investment (FDI), a critical source of external finance and a key engine of growth. As a result, the economy contracted by 14.8% in 2020.

Average life expectancy at birth has improved significantly, reaching 80.5 years for women and 73.0 years for men (INE, 2019).

On the demand side, economic growth measures led by private consumption and investment, supported by the gradual reopening of the economy, put in place by the government to support hard-hit companies and sectors, and the progressive resumption of FDI projects helped the recovery.

On the supply side, the trade and construction sectors drove economic growth. The overall fiscal deficit was 8.8% of GDP, and public debt increased to 155.3% of GDP in 2021, with the need to resort to additional external concessional loans to finance the public investment program and the issuance of Treasury bonds on the domestic market.

According to estimates from the Global Economic Prospects (*GEP*), published by the World Bank, the Cabo Verdean economy grew by 4.0% in 2021 and is expected to grow by 5.2% in 2022 (World Bank, 2023) [12].

Real GDP growth is projected at 4.0 % in 2022, but above potential (4.5 %) in 2023 and 2024, with real GDP per capita expected to return to the 2019 level in the latter year.

Cabo Verde's population growth (%) went from 1.19 in 2010 to 1.16 in 2020, while in the other Lower Middle Income Countries it went from 1.5 to 1.3.

Its population density expresses its size. In 2016 there were 131.8 people per square km and in 2020 there were 138.

Average life expectancy at birth has improved significantly, reaching 80.5 years for women and 73.0 years for men (INE, 2019).

The mortality rate in children under 5 years of age fell from 17.0 per thousand live births in 2016 to 13.0 in 2020 (Ministry of Health Report, 2020). Meanwhile, in Lower Middle Income Countries, the mortality rate varied from 51.2 per thousand live births in 2016 to 44.9 in 2020.

The measles immunization rate increased from 93% of the population up to 23 months old in 2016 to 95% in 2020, a trend of increasing vaccination coverage, a good indicator of the functioning of a program and services. According to the country's latest Vaccination Bulletin, more than 86% of the population has been vaccinated against COVID-19.

In 2021, 98% of people living with HIV had antiretroviral therapy coverage. This is important within the Cabo Verdean health system because it involves various processes, including logistics.

The provision of mental health care in Cabo Verde began from a hospital perspective, even though the political guidelines for this sector have already emphasized the advantages of primary care for mental health.

The national policy for mental health establishes primary health care as the basis of the system, being the gateway for patients and where the majority of care should be provided. Secondary or hospital care is intended for patients with acute conditions and is provided in general hospitals, with the aim of providing holistic health care and combating the stigma associated with mental illness. In turn, tertiary care or psychosocial rehabilitation must have a community base, focusing on the person and offered through Day Centers. These Day Centers should provide support and rehabilitation services for people with mental disorders, helping them to reintegrate into society and develop skills for independent living.

Therefore, the national mental health policy seeks to ensure a comprehensive, person-centered approach, with different

levels of care suited to each need.

The process of decentralizing mental health care from hospitals to primary care (health departments and health centers) is currently being implemented; the creation of conditions in regional hospitals for the hospitalization of acute cases; and the design of psychosocial rehabilitation projects, with the aim of psychosocial integration of people with chronic mental illness and intellectual disabilities.

The level of healthcare coverage and the resources available are crucial factors for decision-making at different levels. Sharing this information between managers, health professionals and other professionals is strategic in all public health policies.

Finally, the country has several services that provide mental health care: psychiatric wards in central and regional hospitals (Dr Agostinho Neto University Hospital, Dr Baptista de Sousa Hospital, João Morais Regional Hospital) for the hospitalization of people in acute mental crisis, an occupational therapy center in São Vicente (psychosocial rehabilitation day center) for patients with chronic psychosis and intellectual disabilities, and therapeutic communities in Praia and São Vicente, for the treatment of people with problems arising from the use of legal and illegal drugs.

PART II

ANALYSIS OF THE SITUATION

Suicide remains a serious problem in high-income countries. However, almost 80% of all suicides occur in low- and middle-income countries, which account for a large proportion of global suicides (WHO, 2021) [13].

The global rate of deaths by suicide has been declining since 2000, from nearly 800,000 to around 700,000 in 2019. The crude suicide rate fell by 29% during this period, from 13.0 deaths per 100,000 inhabitants to 9.2 deaths per 100,000.

> ***With the aim of identifying specific groups at risk of suicide, it is important that countries use rates disaggregated at least by sex, age and methods. Like this, essential information is provided to understand the scope of the problem so that interventions can be tailored to the needs of specific populations and trends" (WHO, 2021).***

The suicide rate among men was twice as high as the rate among women in 2019 (12.6 per 100,000 compared to 5.7 per 100,000, respectively). Suicide rates among men are generally higher in high-income countries (16.5 per 100,000), while among women the highest suicide rates are observed in Lower-Middle-Income Countries (WHO, 2022) [14]. For comparative purposes, however, the wide range of data diversity between all these countries must be taken into account.

The analysis of the situation was based on the following instruments: official documents from Cabo Verdean institutions; documents from multilateral institutions (WHO, World Bank); studies carried out; collection of records through active search in some health units; information collected from health professionals and others involved during technical visits in the field; information collected during the workshop held on 3 and 4 November 2022, in Praia (**ANNEX II)**.

National and local data collection and analysis to prepare a more reliable analysis is indicated. All information matters, as long as it is reliable. At this stage, it was important to identify institutional partners and community associations/groups to support the strategy and planning of the actions to be implemented.

The organization of health services in Cabo Verde is structured according to a specific hierarchy by levels: primary, secondary and tertiary care (organic structure of the Ministry of Health, 2021).

The structure of the health units is spread across all the islands. Two Central Hospitals (Santiago and São Vicente); 04 Regional Hospitals (Santiago Norte, Santo Antão, Sal and Fogo); 19 Health Departments (03 in Santo Antão, 01 in São Vicente, 02 in São Nicolau, 01 in Sal, 01 in Boa Vista, 01 in Maio, 07 in Santiago, 02 in Fogo and 01 in Brava); 34 Health Centers (15 in Santiago, 06 in São Vicente, 03 in Fogo, 02 in Sal, 02 in São Nicolau, 03 in Santo Antão, 01 in Boa Vista, 01 in Maio and 01 in Brava); 40 Health Posts and 98 Base Health Units.

Cabo Verde also has two special structures: the HIV/AIDS Combat Coordination Commission (CCS-SIDA) and the Alcohol and Other Drugs Coordination Commission (CCAD), the latter responsible for two residential units specializing in the treatment and social reintegration of people dependent on alcohol and other drugs, namely the Granja São Filipe Therapeutic Community, in Santiago, and the Ribeira de Vinha Therapeutic Community, in São Vicente.

In Cabo Verde, suicide is the leading cause of death from external causes. On average, there are eight cases of male suicide for every woman, according to national statistical data between 2015 and 2018 (MSSS, 2015-2018) [15].

According to the Mental Health Atlas 2020 (WHO), the age-standardized suicide mortality rate in Cabo Verde **dropped from 17.46 deaths/100,000 inhabitants in 2013 to 16.53 deaths/100,000 inhabitants in 2016 and to 15.23 deaths/100,000 inhabitants in 2019** .
This means that **between 2013 and 2016 there was a 5.3% reduction in the suicide rate and between 2016 and 2019 this reduction was 7.8%** Between 2010 and 2019, the suicide rate in Cabo Verde decreased by around 17.4%, for both the male and female populations.

According to data published by WHO, in 2021, **the age-adjusted suicide rate in 2019 in Cabo Verde was 15.23 per 100,000 inhabitants**

According to the 2020 Statistical Report, published in 2022 by the Ministry of Health of Cabo Verde, there were a total of 49 suicides, 45 in men and 4 in women [16]. It should be noted that this has been the national trend in terms of suicide records over the last 10 years (2011-2020), as can be seen in Table 2.

Table 2: Evolution of deaths and suicide mortality rate in Cabo Verde, between 2011 and 2020

Year	Male	%	Female	%	Total	Mortality rate*
2011	37	88.1	5	11.9	42	8.4
2012	36	81.8	8	18.2	44	8.8
2013	32	86.5	5	13.5	37	7.4
2014	42	85.7	7	14.3	49	9.8
2015	51	91.1	5	8.9	56	11.2
2016	47	79.7	12	20.3	59	11.8
2017	45	91.8	4	8.2	49	9.8
2018	48	88.9	6	11.1	54	10.8
2019	38	92.7	3	7.3	41	8.2
2020	45	91.8	4	8.2	49	9.8

**per 100,000 inhabitants*
Source: SVIR/DNS/MS

The Government of Cabo Verde, through the Ministry of Health and the National Institute of Statistics, and in partnership with the WHO, carried out in 2020 the second National Survey on Risk Factors for Non-Communicable Diseases (II IDNT) [17]. The study was carried out with a sample of 4,563 individuals aged between 18 and 69, of whom 2,726 were women, representing 59.7%, and 1,837 men, representing 40.3%. The overall response rate was 80.5%, 73.6% for men and 85.9% for women. The WHO *STEPS* methodology was used [18].

Suicide and suicide attempts are in a category called external causes, along with homicides and traffic accidents, and as a non-communicable event. And they are identified in surveys of chronic non-communicable diseases, mainly because of their relationship with mental disorders.

This mental health survey calculated the percentage of the population who in the last 12 months: (a) seriously considered attempting suicide, (b) planned to attempt suicide and (c) made a suicide attempt.

THE *STEPS* 1 and 2, which was the sample where questions about suicide were asked, responded differently in the age groups of 18-29 and over 60, between men and women. Young men answered around 68.5%, while women 83.9%, and men over 60 answered 37.1%, while women in this age group answered 62.7%.

There is a discrepancy in the responses between men and women, especially in the over-60 age group.

Among the results of interest, the following stand out: with regard to the **consumption of alcoholic beverages** in this population, it was observed that only 13.4% of men said they had never drunk, while this figure was

reported that they had not drunk in the last 12 months; 62.3% of men had consumed alcoholic beverages in the last 30 days and 28.6% reported that they had consumed more than 6 glasses of drinks in this period. Meanwhile, in the same period of the last 30 days, around 27% of women consumed alcoholic beverages, but the percentage of consumption above six glasses was 6.5% of the women in the study.

In the *STEP* 1 Mental Health/Suicide assessment, around 2.1% of men reported that they had seriously considered attempting suicide in the last 12 months, while the percentage for women was 4.5%. The percentage of men and women who had planned suicide in the last 12 months was 0.8% and 2.3% respectively. **According to the same survey, among those who have ever attempted suicide, 15.4% of men and 41.2% of women did so in the last 12 months, prior to the survey. We are therefore talking about information from the period 2019 to 2020.**

This publication highlights its usefulness in strengthening interventions and implementing policies that aim to promote not only healthy lifestyles, but also multi sectoral integration as a response from the health, education, culture, agriculture, industry, and environment sectors, among others. On the other hand, this information becomes an input for the different actors and academic institutions that wish to deepen the development of research for the prevention and control of non-communicable diseases, including the topic of suicide that is important in this strategy.

PART III

SUICIDE PREVENTION: STRATEGIES AND THEIR PILLARS

The importance of a strategic approach to suicide prevention is strongly based on research evidence of interventions that mitigate or counteract risk factors and increase protective factors for suicidal behavior (Platt & Benson, 2021) [19].

Measuring the success of a national strategy is not always easy, but there are ways to ensure that evaluations of national strategies can be as strong as possible. One of the most important aspects to consider is that, by their very design, national strategies have multiple components. Additionally, there are a variety of factors that influence a country's suicide rates, and these rates can fluctuate over time. These two factors make it difficult to detect changes in suicide rates that can be specifically attributed to a national strategy. The best evaluations are geared towards an approach that uses a "logical program" and uses multiple indicators of success (WHO, 2018) [20].

Reduction of Means

Among the primary means used for suicide and attempted suicide in Cabo Verde, hanging and the ingestion of psychoactive and cardiological medications were recorded.

The II IDNT study showed that 43.8% of men and 21.4% of women had attempted suicide by drug overdose. Another of the most used means was hanging, 35.6% of men and 39.3% of women.

Although prescribing medications is exclusively the responsibility of medical professionals in the country, they use their own strategies to avoid over-dispensing, especially when it comes to psychoactive medications, such as issuing monthly prescriptions. However, the lack of adequate control of these medications, as well as others, is universal. It is important to note that psychoactive drugs do not have special control prescriptions in Cabo Verde.

The lack of control over prescriptions for special medications is a risk for suicide attempts using this method.

A debate involving the Order of Doctors and the Order of Pharmacists would be necessary to establish special prescriptions. The control of psychoactive drugs not only serves to control the means used for suicide attempts, but also to control the quantity of drugs dispensed to the population and other studies.

Regarding hangings, there is no effective control method. However, one measure that is proving to be effective is monitoring individuals who have already made an attempt or show suicidal behavior.

The use of firearms and pesticides as a method of attempted suicide and suicide is not prevalent among suicide mortality data in Cabo Verde. In any case, control, including standardization and inspection of pesticides and other chemicals, must be put in place.

The diagnosis of suicide involves a multidisciplinary approach that goes beyond the forensic sphere. The involvement of mental health professionals, psychologists,

and psychiatrists, among other specialists, are necessary to ensure a complete understanding of the case.

The National Institute of Legal Medicine and Forensic Sciences, with its expertise, can play a crucial role in assisting in the diagnosis of suicide, ensuring a rigorous analysis of cases and contributing significantly to the prevention and adequate treatment of this serious problem.

Also according to data from the II IDNT, 36% of adults aged between 18 and 69 sought medical attention the last time they attempted suicide. Monitoring these cases is fundamental to the suicide prevention strategy.

In the sample observed, around 9% of the population had someone in the family who had already made at least one suicide attempt, which once again demonstrates, here with national evidence, that these people, together with their families, must be monitored and cared for by health services, using the available tools, such as telephone calls or care through telemedicine, established in several health units in Cabo Verde. In 2020, out of a total of 786 teleconsultations, only 9 were carried out in healthcare by psychiatrists. This model could be expanded to make the system more efficient.

Multisectoral and Intersectoral Action

The conceptual framework that suicide occurs in different sectors of society drives the need for a strategic approach involving multidisciplinary and intersectoral actions. This vision is fundamental for the effective implementation of Suicide Prevention Strategies.

The workshop and technical visits held in Cabo Verde, from October 27 to November 5, 2022, also met this pillar of the strategy in the organizational composition of the meetings.

Sensitivity and Promotion: Communication in Suicide Prevention

"*The media plays an essential role in society and in maintaining and promoting mental health, and is also an important universal prevention strategy (prevention for the whole of society) for any suicide prevention campaign* [21].

The issue of communication in cases of suicide, especially in written or virtual communication, is associated with the damage that can be caused by inappropriate news that can induce other people to "contaminate" themselves and run the risk of being led to suicide attempts or even suicide.

This concept, widely known and mentioned in various documents such as the WHO's LIVE LIFE program and the Portuguese Ministry of Health's Manual for Journalists, originates from the so-called ***Werther Effect***.

This effect is named after Wolfgang Goethe's book, *The Sorrows of Young Werther* , written in the form of letters that a young man sends to his best friend recounting the unfolding of an irrepressible passion, the end of which is death. This novel caused a wave of suicides in Europe when it was published in 1774.

And the impact of these suicides on society has led the media to be concerned about this reality, leading to the inclusion of a ban on addressing the subject of suicide in most editorials, especially in newspapers. This prohibition persists to this day, but the importance of the visibility of the subject of suicide and mental health has allowed this exclusive conception to be broken and the subject to be brought into the general communication as a protective factor in cases of suicide.

This transforms a risk factor into a far-reaching protective factor that is fundamental to any strategy.

Today we know that the phenomenon known as the Werther Effect can cause significant damage, especially in cases of suicides committed by famous people who are admired by certain population groups. In this sense, these groups need to identify with these "celebrities" in order to feel the desire to follow the same path. Certainly, in these groups, there are more fragile people who may be more affected and induced by this identification.

Typically, suicide cases are not reported in the media, but when they involve well-known people, such as artists, these occurrences become of public interest and attract the attention of the media. In addition, cases of homicide followed by suicide are also reported, especially attacks on schools, as well as feminicide or femicide.

However, when the media approach these sensitive subjects in the wrong way, describing details of the methods used, there is a risk of causing harm. In these cases, the media can contribute to inducing suicides or attempts, which reinforces the importance of following the manuals and protocols that guide the proper way to deal with this issue.

An extremely relevant topic today is how we should deal with the so-called Werther Effect in relation to virtual communication. Unlike printed communication, as was the case with Goethe's book, virtual communication is fast, has a wide reach and projects images which, due to all these characteristics, can have a detrimental impact on the treatment of this delicate subject.

Furthermore, the media can and should become a key partner in implementing suicide prevention strategies, through dialog with experts in suicidology and other professionals who have in-depth knowledge of the subject. By using the so-called Papageno Effect, it is possible to approach the topic in an educational and conscious way, aiming to disseminate correct and supportive information for those who are going through difficult times.

This effect refers to the character in Mozart's opera, *The Magic Flute*. In the opera, Papageno manages to overcome his initial suicidal thoughts with the help of others.

A conscious and responsible approach to the subject of suicide and the stigmas suffered by people with mental disorders not only does not constitute a risk factor, but also sheds light on a problem that affects society as a whole. Bringing up discussions about suicide and the prevention of suffering can be extremely beneficial for those who feel trapped in their anguish, showing them alternatives and possibilities.

As PENSM |2021-2025| describes: **“Reducing stigma is essential, including in structures and institutions. Otherwise, suicide will continue to be a silent public health crisis. We all need to know about the help available”**

Given these extremely relevant facts, it is indisputable that the media has become an indispensable part of any suicide prevention strategy, and it is even an initiative that should be applied from the outset of any strategy. In this way, journalists, communicators and digital influencers are called upon to participate as essential partners in this strategy drawn up by the Cabo Verde Ministry of Health with the support of the WHO.

The media are moving from the position of harming and inducing suicide, which would be a risk factor, to the position of partner in a strategy, because they can be active in various actions, becoming a protective factor for society.

Raising awareness about mental health and suicide faces a major challenge due to the stigma associated with these issues. However, the agents involved in the strategy can mobilize society and its institutions in different ways, for example by recognizing suicide as a public health problem that requires national intervention. Furthermore, it is essential to take into account the needs of the most vulnerable groups, as this step cannot be neglected.

Actions to raise awareness in society can generate a mobilization involving various bodies, such as institutions, researchers and national or local associations, advocating to make suicide prevention a State Policy. This mobilization must not just be one-off, but must be sustainable and

have continuity over time, so that the initial effects of raising awareness are not lost along the way and there is a real paradigm shift in relation to mental disorders and suicide.

Stigmas, myths and taboos related to mental disorders and suicide are obstacles to the effective implementation of prevention strategies. Therefore, raising awareness of these issues is a crucial element in any comprehensive suicide prevention strategy. These can become challenges in implementing the strategy. Only through enlightenment and education will it be possible to overcome such challenges and provide a more conducive environment for the prevention and promotion of mental health.

We must be cautious when developing educational materials for suicide prevention. These should be produced with a focus on the target populations and awareness of how they can affect these populations.

Currently, studies that show
o the impact, for example, of an intense campaign on
o suicide in the most vulnerable populations, are is important. Some people feel pressured about the intense impact of advertising on suicide and disorders, as some studies evaluating intense campaigns have shown.

The work around the stigma of mental disorders and suicide must be constant, not limited to a certain annual period. Society must be mobilized through actions that do no harm.

In raising awareness in society, through the various communities, it is important to bring in leaders with valid experiences who can support the implementation of the strategy.

Capacity Building

This work/training must be continuous throughout the implementation period of the VIVER A VIDA program. Therefore, identifying the needs in each period and in each location is essential to ensure progress in implementing the strategy. Strategies, in all their actions, are dependent on the development of the capabilities of available resources. Development must be sustainable and this depends on several elements.

Risk assessment training for health workers should be ongoing and planned in line with the implementation of the strategy in health service networks. And this definition of identification priorities must take into account the capacity to multiply training.

An important strategic action is the implementation of management and clinical supervision, which supports the organization of services according to the profile of the units, primary care or greater complexity, which can/should be done in person or via videoconferences.

Collaboration, including between countries, facilitates the sharing of knowledge, the exchange of methodologies and lessons learned. The Community of Portuguese Speaking Countries (CPLP), which has already been implementing suicide prevention strategies, such as Brazil and Portugal, could be useful in this sharing. These exchanges must always be adapted to local contexts, mobilizing local leaders, and based on evidence.

An example of collaboration between countries is the study “Conversation on National Suicide Prevention Strategies”, coordinated by the Research Center (CRISE) of the University of Quebec in Montreal (UQAM).

This project consists of a comparative study of different suicide prevention strategies in six countries. The six are at different stages in the development and implementation of their strategies. Four phases were constructed: Phase 1 awareness and mobilization (Mexico); Phase 2 initial national strategies (Bhutan and Brazil), Phase 3 revised strategies (Québec and Portugal) and Phase 4 evaluation and experience (New Zealand).

It is of particular interest for Portuguese-speaking countries to also follow Portugal's National Suicide Prevention Plan from 2013-2017, which is currently being renewed. A significant advantage is the ease of access to the documents and materials made available because of the common language.

Most national strategies contain planned and implemented activities, such as: close monitoring; reducing access to means of suicide; promoting good practices in the media; reducing stigma; increasing awareness of the problem; training of caregivers; intervention services and post-prevention activities.

Postvention is defined as any appropriate and helpful act that takes place after the suicide, with the aim of helping survivors to live longer, more productively and with less stress than they would without this help (Shneidmam, 1973) [21].

These are actions, activities, interventions, support and assistance for those impacted by a completed suicide, that is, the survivors. It is a tool recognized worldwide as an important component in caring for the mental health of these people.

Survivors are all the people affected by a suicide:

parents, children, siblings, relatives, friends, colleagues, etc. Additionally, people who have lost a significant other to suicide and those whose lives have been affected or changed by that death are also considered survivors.

The document **SUICIDE PREVENTION**, a manual aimed **at professionals in mental health teams**, published in 2006, through a project between the Brazilian Ministry of Health, the University of Campinas and the Pan American Health Organization, can support the qualification of health professionals in the Suicide Prevention Strategy, if it is updated and adapted to the Cabo Verdean reality [22].

Surveillance

Reporting suicide attempts is fundamental in suicide prevention strategies. They identify the most vulnerable cases and enable diagnosis and care actions.

Currently, there is no obligation to report cases of attempts and therefore no reporting tool. However, the notification system of the Ministry of Health of Cabo Verde for other diseases can/should be used in the implementation of a notification of suicide attempts, electing three or four sentinel health units, which should be identified by some profiles, such as: entry point for attempted cases, services on different islands and local support/sustainability in health.

A retrospective cross-sectional descriptive study, from January 2017 to September 2022, carried out in the Mental Health Service of the three municipalities of Santo Antão Island and registered in the statistics service of the Dr. João Morais, found the following data: fifteen cases of

attempts among men and thirty cases among women; 62.2% of the identified cases had already made previous attempts, 70% of the cases used pill ingestion [23].

In Santiago Norte, in the last three years, a psychiatrist at the Santa Rita Vieira Regional Hospital recorded 167 cases of attempts. All these cases are registered locally, but not within an information system, which prevents local, regional and national consolidation of cases.

Hence the importance of mandatory reporting within a computerized system.

Monitoring and Evaluation

Monitoring and evaluating the implementation of strategies, in all lines of action, depends initially on the definition of reliable and accessible indicators, which are fundamental conditions.

The number of indicators for evaluating each action must be very well constructed and restricted to relevant actions. Having too many indicators per action is counterproductive and reduces the reliability of the results. It is therefore recommended to identify a maximum of two indicators for each action. Furthermore, it is essential that this process is constantly monitored and periodically re-evaluated.

PART IV

LOGICAL MATRIX

The Matrix includes the basic pillars of the WHO's LIVE LIFE approach to implementing a National Suicide Prevention Strategy for Cabo Verde, namely: **situation analysis; multisectoral collaboration; awareness raising and promotion; capacity building; surveillance and monitoring and evaluation**

The Matrix also includes the main effective interventions to prevent suicide**: limiting or reducing access to means of suicide; interacting with the media so that they treat suicide in a responsible way and are partners in the Strategy; developing socio-emotional attitudes for young people, based on actions in the communities; and acting to identify, assess, care for and monitor anyone affected by suicidal behavior, particularly those who have already made a suicide attempt.**

In order to create a comprehensive model, the Matrix is made up of the following columns: **action; target population; goal; products/instruments; executor; partners; execution period; budget and financing** .

Thus, 9 (nine) strategic axes were designed where the planned actions are developed:

Axis 1 – Organizational leadership;

Axis 2 - Raising awareness and mobilizing society;

Axis 3 – Qualifying professionals: training; Axis 4 –

Supporting the organization of services;

Axis 5 – Restriction and reduction of the means

used; Axis 6 – Health surveillance;

Axis 7 – Promotion of studies on suicide prevention;

Axis 8 – Support for the organization of society based on community;

Axis 9 – Communication and suicide prevention

The axes are connected to each other and depend on each other. This, rather than limiting action, as some might think, makes it more powerful and expresses the complexity of the responses that must be given to this phenomenon as complex as suicide.

Below is the Matrix of the National Strategic Plan for Suicide Prevention in Cabo Verde.

Action Plans

The National Suicide Prevention Strategy will be materialized through Annual Action Plans, with the main objective of aggregating specific and concrete measures and activities that can be carried out at all levels (national, regional, local and institutional), being organized through integrated and intersectoral suicide prevention actions.

The National Action Plan for Suicide Prevention will be drawn up by the Intersectoral Technical Commission and will involve the participation of all parties involved in the implementation and facilitation of the strategy.

The overall budget is **$18,904,800.00 CVE,** equivalent to **180,000 USD** .

NATIONAL SUICIDE PREVENTION STRATEGY MATRIX

Overall Goal: Reduce Suicide and Attempt Rates, as well as Harm

AXIS 1 Organizational Leadership								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Establish an Intersectoral Technical Committee	National institutions	Commission established	Ministerial order	MS(Coordinator)	GOs and NGOs; WHO	Short Term	Does not apply	Does not apply
AXIS 2 Raising awareness and mobilizing society								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Creation of Suicide Prevention Week alongside Mental Health Week, September/October	Associations/NGOs Secondary schools / universities Health professionals (Universal prevention)	Resolution enacted	Week established	MS; National Assembly	Ministry of Education Health professional associations WHO	Short Term	Does not apply	Does not apply
Formation of survivor groups and networks	Survivors	% of groups formed	Groups formed	Local MS units (Health Departments); Community leaders	Family and friends Religious institutions	Medium Term	Does not apply	Does not apply

NATIONAL SUICIDE PREVENTION STRATEGY MATRIX

AXIS 2 Raising awareness and mobilizing society (cont)								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Holding lectures/health education/open talks on suicide in communities, secondary schools and universities	General population	10 events per year as a baseline	Events held	Health professionals from health structures Community leaders Digital influencers	INSP Community associations/ Municipal Councils/ Secondary schools / universities Digital influencers	Medium Term	288,000.00	MS World Bank WHO
AXIS 3. Qualification of professionals: training								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Offer an internationally validated suicide prevention and postvention course	80 Public health professionals and others	80 Trained professionals and with certificates	Online classes Recorded classes Support monitor Various materials	MS	WHO Professional associations in the area of health (doctors, pharmacists, nurses and psychologists)	Medium Term	3,000,000.00	MS World Bank WHO
Provide a document for teams to consult: Suicide Prevention: A Manual for Mental Health Professionals	Health team professionals	100 Manuals printed and available in the structures	100 Manuals printed and available in the structures	Updated and printed manual	WHO	Medium Term	1,097,350.00	MS WHO

NATIONAL SUICIDE PREVENTION STRATEGY MATRIX

AXIS 3 Qualification of professionals: training (cont.)								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Supervision and/or annual monitoring of trained professionals for better implementation of acquired knowledge	Health team professionals	Number of supervisions carried out (1 for each structure involved)	Reports	MS	WHO Order of Physicians and Psychologists	Medium Term	527,400.00	MS World Bank WHO
AXIS 4 Support the organization of health services								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Develop protocols/ flowcharts in internal service circuits (review procedures) and necessary referrals. (institute degrees of differentiation in care).	Health Professionals In general	2-3 Instruments	Protocols developed; Updated flowcharts;	MS Central and Regional Hospitals and Health Departments;	Order of Physicians University of Santiago	Medium Term	947,350.00	MS WHO
Expand teleconsultations to discuss cases and/or supervisions	Health professionals and priority populations.	Enlarge by 10-15%	Consultations held	MS National e-Health Telemedicine Service (SNT-eS)	Order of Physicians; Order of Psychologists;	Long Term	Does not apply	Does not apply

NATIONAL SUICIDE PREVENTION STRATEGY MATRIX

AXIS 5. Restriction and reduction of the means used								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Implement protocols for dispensing medication	General population (universal prevention); Health Professionals	Protocols developed	Protocols	MS ERIS	Order of Physicians and Pharmacists	Long Term	Does not apply	Does not apply
Support medication control psychiatric and other by supervisory bodies	General population	Legislation modified	Legislation	MS ERIS	Order of Physicians and Pharmacists	Long Term	3,000,000.00	MS WHO
Support the control of agrochemicals	General population	Legislation modified	Legislation	MS ERIS MAA	Professional bodies	Long Term	3000000	MS WHO

NATIONAL SUICIDE PREVENTION STRATEGY MATRIX

AXIS 6 Health surveillance (cont.)								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Implement a suicide and attempted suicide notification form in sentinel units	Cases of suicide attempts and survivor	4 Sentinel Units	Notification form prepared and implemented in the online system	MS/SVIR GTCIS INSP Hospitals	WHO	Medium Term	Does not apply	Does not apply
Create a database to record reports	Cases and survivors; Health services	System implemented	Notifications registered in the system	MS/SVIR GTCIS INSP Hospitals	WHO	Medium Term	Does not apply	Does not apply

NATIONAL SUICIDE PREVENTION STRATEGY MATRIX

AXIS 7 Promotion of studies on suicide prevention								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Conducting research on suicide at regional and national levels	General population	1 survey carried out/year	Published articles	INSP University of Cabo Verde University of Santiago Jean Piaget University	WHO	Medium and Long Term	2,000,000.00	MS WHO WAHO Universities
Support the inclusion of the PS Strategy of Cabo Verde in comparative studies	Universities	1 Study carried out every 3 years	Published articles	University of Cabo Verde University of Santiago Jean Piaget University INSP	INSA. Portugal Fio Cruz, Brasil CPLP INSPs Network	Medium and Long Term	2,000,000.00	MS WHO WAHO Universities

AXIS 8 Support for the organization of society based on community (cont.)								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Support groups and/or associations to create organizations in society involved in the Strategy	Community groups	2 groups and/or associations	Project supported	Associations NGOS Local health units	MS Associations/Community Groups Donor organizations Universities	Medium Term	1,000,000.00	MS, WHO, WAHO Municipal Councils Private Companies Religious Organizations Community Associations

NATIONAL SUICIDE PREVENTION STRATEGY MATRIX

AXIS 9 Communication and suicide prevention								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Introduce the debate on suicide with qualified health professionals in the media	The entire population Secondary schools / universities	1-2 debates/year	Debates/ Testimonies/ Calls	MS Journalists. Digital influencers	Secretariat of State for Social Communication ARC Journalists Association; Digital Influencers/Artists Ministry of Education; CCAD Secondary schools / universities Digital influencers	Short Term	Does not apply	Does not apply

AXIS 9 Communication and suicide prevention (cont.)								
Action	**Target population**	**Goal**	**Product/ Instrument**	**Executor**	**Partner**	**Term**	**Budget**	**Funding source**
Support the dissemination of suicide prevention material from other Portuguese-speaking countries	Health professionals, communication professionals, school teachers; public and private managers	Expand the material disseminated	Material disseminated	MS Universities	Brazilian Ministry of Health; Portuguese Ministry of Health; WHO; NGOs Universities of Cabo Verde.	Medium Term	1,097,350.00	MS WHO
Standards/guidelines regulating the way of reporting suicide cases in the media	Communication Professionals	Established standards	Standards	MS/DNS	State Secretary for Social Communication ARC, AJOC WHO	Medium Term	947,350.00	MS WHO

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ANNEXES

ANNEX 1 MODEL REPORT FORM MODEL

INSTITUTION LOGO

SUICIDE AND ATTEMPTS NOTIFICATION FORM

1. Health Unit _____ 2. Service/Outpatient Clinic: _____

IDENTIFICATION:

3. Name: _____

4. Age: _____ 5. Date of birth: __/__/__ 6. Sex: male ☐ female other

7.Rac MINISTÉRIO DA SAÚDE GOVERNO DE CABO VERDE A TRABALHAR PARA TODOS lack ☐ yellow ☐ indigenous ☐ other

8. Marital status: ☐ single ☐ married/stable union ☐ separated/divorced ☐ widow(er)

9. Current address: _____ ood _____ 11. City _____

Organização Mundial da Saúde Cabo Verde

12.Occupation: _____ _____ /_____

14. How long have you lived in the city? ct telephone number _____

HISTORY OF THE CURRENT EVENT:

16.Date of appeal: ✓ __/__ 17. Time: _____

18.Method: firearm hanging fire/smoke ☐ vehicle ☐ (engine/train) impact

☐ drowning ☐ obj. cutting: _____ ☐ precipitation from high place: _____

☐ pesticide medicine _____ ☐ (chumbinho, DDT, etc.): _____ ☐ gas bath/kitchen

☐ other method: Which one? _____ ☐ ignored

19. Nature, location and extent of the injury: ☐ burn fracture laceration Other: _____

20. When was the patient's last consultation/care with a healthcare professional (whatever the reason for the consultation), before this condition? _____ days/weeks/months ago ☐ Ign;

21.Nature of consultation (doctor/psychologist, etc.) _____ ☐ Ign; 22. Reason for consultation _____ ☐ Ign;

23. At the time of the incident, the patient was under the influence of:

1) alcohol: ☐ Yes ☐ No ☐ Ign.;

2) illicit drug: ☐ Yes: Which one? _____ ☐ No ☐ Ign.;

3) medicine: ☐ Yes: Which one? _____ ☐ No ☐ Ign. (up to 24h before the event);

24. Intentionality attributed by the patient: ☐ without suicidal intention suicidal intention ign.;

CIRCUMSTANCES AROUND THE CURRENT EVENT:

25. Complaint/problem(s) reported: _____

family, sexual conflict; work, school, financial problems; physical/sexual violence/abuse; illness; unemployment; romantic separation (marriage, dating); widowhood; change of residence; loneliness; other;

26. How long has it been? _____

RISK FACTORS:

27. 1) History of previous attempt: ☐ Yes ☐ No ☐Ign.;

2) History of suicide in the family: ☐ Yes ☐ No ☐Ign.;

3) Dependent on illicit drugs (SEE INSTRUCTION) Yes: Which one? _____ ☐ No ☐Ign.;

4) Regular use of psychoactive medication ☐ Yes: Which one? _____ ☐ No ☐Ign.;

5) Dependent on alcoholic beverages: ☐ Yes ☐ No ☐Ign.;

PATIENT DESTINATION:

28. Treated and released ☐ hospitalized ☐ removed: _____ debt

Guidance: _____

OBSERVATIONS:

29._____

Date of service: __/__/__ Completed by: _____

SUICIDE AND ATTEMPTS REPORTING FORM: INSTRUCTIONS FOR PREE Na- ilM E N T

When to fill out the form: in cases of self-inflicted injuries with the intention of suicide or, regardless of the intentionality declared by the patient, when the circumstances of the injury suggest an attempt at suicide or risky behavior: drug intoxication with the intention of analgesia , traffic accident involving a drunk driver, etc.

Who notified the health professional that attended to the case that meets the above definition whatever the nature or stage of the treatment: emergency, ICU physiotherapy, etc.

1. Record the name of the hospital, center or health post , etc.

2. Record the service responsible for filling out the form (emergency / orthopedics , etc.). 3 to 13 .

Record the identification information **of the** patient.

14 and 15 . State The length of time of living in the city. For those who resided outside the country and returned, consider the time since returning. Please provide your contact telephone number.

16 and 17 . Record the day and time of the injury; if it is not possible to specify, inform the period in which the injury occurred: , morning, afternoon, night, dawn , between 2pm and 8pm, etc.

18. Record the method or agent of the injury.

19. State the type, location and extent of the injury: Thorax burn in the 1st and 2nd degrees , etc.

20,21 and 22. State the *last time* that the patient consulted a health professional before an attempt of suicide - *whatever the nature or reason for the landing* -, the and *reason* for consultation (gynecologist, physiotherapist , etc. / headache drx, insomnia , *etc.):* scientific studies reveal before trying suicide, the victims seek assistance from health services for distinct reasons.

23. State if the patient was under the influence of alcohol, drug or medication **at the time of the attempt .** Consider the consumption of medicines up to 24 hours before the event.

24. Register, strictly, **the patient's response.** If not possible to obtain this information, select the option *ignored.* NOTE: In the event of a situation Suggestive of a suicide attempt (drug intoxication) with the intention of fighting insomnia, etc.), in which the patient does not recognize the suicidal intention , record these observations in field 28.

25 and 26. Record duration and problem (s) associated with the attempt at suicide.

27. Assess the existence of suicide risk factors listed selecting the option, ignore case, when it is not possible to obtain the information. Items 3 and 5: exclude the consumer or eventuality. Consider the possibility of dependency if there is mention of regular abusive consumption of drugs or drinking alcohol or, regardless of frequency and quantity, if there is a report of difficulty stopping or decreasing the usual pattern of consumption.

28. Record the referral given, stating the guidance offered to the patient.

29. Record observations that you judge relevant to better understand the case.

IMPORTANT OBSERVATION : To protect the sigil put it in a sealed envelope to:

1_ INSTITUTION
ADDRESS

Annex 2 List of participants of the workshops, 2, 3 and 4 November

Development of a NATIONAL SUICIDE PREVENTION STRATEGY

November 2022

Name of the Participants	Position/Institution
Ana Moniz	Coordinator of the Nursing Course/Uni-Piaget
Ana Paula Pina	HUAN, Trindade
Ângela Paiva Tavares	CS TC, Psychologist
Angela Tavares	CMP
António Vaz	HUAN Psychiatry Service
Aristides da Luz	Psychiatrist/DNS/HBS
Belmira Miranda	Psychologist/MS/DNS/PNSA
Carlos D'Oliveira	Consultant – WHO
Cecilia Semedo	Order of Pharmacists
Celestina de Barros Martins	OECV
Damilton Rodrigues	HUAN Psychiatry Service
Denise Almeida Lima	Psychologist - PF. Mental Health at DSSV
Denise O. Centeio	Installation Commission Order of Psychologists of Cabo Verde
Dirce Varela	NGO Platform

Name of the Participants	Position/Institution
Dircelena Melo	ME-DNE
Edith Pereira	Health Promotion, WHO Cabo Verde
Edemilson Fernandes	Institute of Sport and Youth
Edna Silva	Psychologist, PF. Health Hospital Reg. Santo Antão
Elisabete Évora	CS Tira Chapéu
Elisangela Barros	UNI-Piaget
Elisângela Mendes	DS Santa Catarina
Emilia Monteiro	DNS
Elizabeth da Veiga Moreira	HUAN, Enf BUA
Ercília de Carvalho	Psychologist, HRSN
Eurídice de Andrade	APIMUD NGO
Evandro Monteiro	Secretário de Estado/GMS
Francisca Freyre Monteiro	Professora, Uni-CV
Gilson Cabral	Nos Saúde (Our Health) Association
Hector Gutierrez Medina	Psychiatrist, DSS/HRRF
Indira Inocencio Silva	CS Achada Grande Trás
Jaclin Freire	MS/GMS Advisor
Jorge Barreto	National Director of Health/DNS
José Teixeira	INSP
Kassi Silva	HRSFA

Kátia Furtado	Cabo Verde Red Cross

Name of the Participants	Position/Institution
Lenisa Elisete Ramos	MS
Leonilde Borges de Almeida	UNI-Piaget
Letícia Tavares	CSCV
Lourenço Tavares	Health Department Praia
Madalena Monteiro	CS ASA
Margarida Cardoso	APONTE
Maria de Fátima Djassi	Cabo Verde Red Cross
Maria José Pereira	Child Health National Program Coordinator
Maria Natalina Silva	PNSI/DNS
Orlando Andrade	OMCV (Organization of Women of Cabo Verde)
Paula Casimiro	INSP
Paula Fortes	Social Worker/DGIS and AASCV
Paulo Jorge L. S. Tavares	PN / SES
Romine Oliveira	HBS
Rosana Carvalho	APIMUD
Sandra Dercy Fernandes	CS Fazenda
Suely Carvalho	NAT - Mental Health
Suely Sanches	APIMUD NGO
Ulardina Furtado	DSP, Medical Delegate of Health

Vanusa Pereira	CCAD
Zania Silva	CTGSF

MINISTÉRIO DA SAÚDE

Direção Nacional da Saúde

GOVERNO DE CABO VERDE

A TRABALHAR PARA TODOS.

Organização Mundial da Saúde

Cabo Verde