

Short Communication

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Abstract

Suicide among adults has been a neglected area of research. The objective of the study was to estimate the prevalence of suicidal ideation and determine its socio-demographic correlates among patients attending primary health care facilities in Lusaka, Zambia. A cross sectional study was conducted among primary health care attendees in Lusaka urban clinics. The Yates corrected Chi-squared and the Fishers exact tests were used where appropriate. The level of statistical significance was set at the 5%. A total of 71 patients participated in the survey. The suicidal ideation rate was estimated at 18.3%. Marital status was significantly associated with suicidal ideation with 26.1% of married and 4.3% of not married patients ($p=0.047$) reporting having recently had suicidal thought. The observed prevalence of suicidal ideation is worrisome and attendees in primary health care clinics should be screened for mental health.

Introduction

The World Health Organization estimates suicide rate for Zambia at 6.1 (8.8 among males and 3.5 among female) per 100000 population [1]. Despite this high rate, suicide among adults has been a neglected area of research. However, there has been increased interest in research in mental health among adolescents, especially suicidal ideation. In the suicide process, suicidal ideation may lead to suicide attempt that may in turn lead to suicide. Early treatment for persons with suicidal ideation may be prevented because of stigma. Persons with stigma are considered as weak, shameful, sinful and selfish [2]. Suicidal ideation is common among person reporting to primary health care facilities in low-and middle-income

countries. Jordans et al [3] reported that 10.3% of persons presenting at primary health care facilities in Ethiopia, Uganda, South Africa, India and Nepal reported suicidal ideation within a year prior to the survey. In another study [4] in California, 2.4% of adult primary care patients aged 18-70 years reported suicidal ideation during the past month. In Pennsylvania, 3.3% of outpatients attending the faculty general internal medicine practice reported having thoughts of killing themselves [5]. In yet another study, Linden et al (2003) reported a 9.7% suicidal ideation rate among patients from 15 international centres who admitted that they had or recently had suicidal ideation [6]. Socio-demographic factors associated with suicidal ideation among primary health care attendees include: young age [5-7], divorced [5], lower education status [3,6] and being female [3]. In Zambia, no studies have been documented on the magnitude and correlates for suicidal ideation among primary health care attendees despite a similar study having been conducted among school going adolescents [8]. The objective of the current study was to estimate the prevalence of suicidal ideation and determine its socio-demographic correlates among patients attending primary health care facilities in Lusaka, Zambia.

Methods

Study site and population: The study was conducted in three Lusaka urban clinics namely: Chawama, Mtendere and Mate-ro Reference Clinic. The participants were patients who came for consultation and were recruited as they waited to see the doctor.

Sample size and sampling: The sample size was estimated considering 5 to 10 respondents in each cell when analysing

the data using cross tabulation (WHO, 2003). No reliable information was available to be used in determining the sample size. A systematic random sample was used to select patients.

Data collection tool: A questionnaire was used to collect data. Suicidal ideation was determined by asking the following question: Have you recently found that the idea of taking your own life kept coming into your mind? The responses were Definitely not, I do not think so, The idea crossed my mind and Definitely the idea kept coming into my mind. Patients who responded that the idea of taking own life had crossed their mind and definitely had were classified as having had suicidal ideation.

The data collection instrument was translated into a local language, Chinyanja, from the original English version, a pilot study to pre-test this Chinyanja questionnaire was done on eight (8) patients at Chainama Teaching Clinic which was one of the urban clinics which was not involved in the study. The pre-testing exercise helped to assess the clarity of questions.

Data analysis: Data analysis was conducted using IBM SPSS version 20. Associations were established using the Yates corrected Chi-squared in 2 by 2 contingency tables when expected frequencies were more than 5. In the case of expected frequencies being less than 5, the Fishers exact test was used. The level of statistical significance was set at the 5%.

Ethical considerations: The research proposal was submitted to Mzuzu University for approval by the review board. After approval, permission was sought in Zambia from the District Health Management Team (Clinical Care Expert) to conduct the study in Lusaka Urban Clinics as they are under their jurisdiction. After arrival at the clinics, the permission issued at the

District Health Management Team was presented to the In-Charges of the Clinics who introduced the researcher to the clinicians and thereafter got access to the patients for interview. The confidentiality of the patient was respected and protected by maintaining anonymity in the information collected and informed consent was obtained from the study participants before commencement. The benefits of the study were explained to the patient before the consent and the possible risks in being involved in the study. Those with evidence of a common mental disorder were referred for possible intervention. After interviews in all the three clinics, about eight subjects needed psychotherapy with a psychologist or a counsellor and efforts were made to arrange this but high charges hindered the whole thing since there were no counsellors and psychologists in urban clinics and the high fees were quoted by private psychologist.

Results

A total of 71 patients participated in the survey of whom 47.8% were males, 27.5% were aged 25 years or younger, 66.7% were married, 42.3% were employed and 64.3% had attained secondary or tertiary level of education (Table 1).

The suicidal ideation rate was estimated at 18.3%. Socio-demographic factors associated with suicidal ideation are shown in Table 2. Only marital status was significantly associated with suicidal ideation. About a quarter (26.1%) of married patients had suicidal ideation compared to 4.3% not married patients ($p=0.047$).

Discussion

The study documents for the first time findings on the prevalence of suicidal ideation and its correlates among attendees in primary health care clinics. An estimate of suicidal ideation rate in the current study was 18.3% with a higher rate of 26.1% observed among married than 4.3% unmarried patients. The observed rate of recent suicidal ideation in the current study is higher than what Jordans et al [7] reported of 10.3% of persons presenting at primary health care facilities in Ethiopia, Uganda, South Africa, India and Nepal reported suicidal ideation within a year prior to the survey, 2.4% of adult primary care patients reported during the past month prior to the survey in South

Tables

Table 1: Sample description

Variable	n (%)
Gender	
Male	33 (47.8)
Female	36 (52.2)
Age (years)	
≤25	19 (27.5)
26+	50 (72.5)
Marital status	
Married	46 (66.7)
Not married	23 (33.3)
Occupation	
Unemployed	41 (57.7)
Employed	30 (42.3)
Education level	
Up to primary	25 (35.7)

Table 2: Factors associated with suicidal ideation in bivariate analyses

Factor	Suicidal ideation		p value
	Yes (%)	No (%)	
Age (years)			
≤25	2 (10.5)	17 (89.5)	0.491
26+	11 (22.0)	39 (78.0)	
Gender			
Male	5 (15.2)	28 (84.8)	0.658
Female	8 (22.2)	28 (77.8)	
Marital status			
Married	12 (26.1)	34 (73.8)	0.047
Not married	1 (4.3)	22 (95.7)	
Occupation			
Unemployed	9 (22.0)	32 (78.0)	0.537
Employed	4 (13.3)	26 (86.7)	
Education level			
None/primary	7 (28.0)	18 (72.0)	0.199
Secondary/tertiary	6 (13.3)	39 (86.7)	

Carolina [4], 3.3% of outpatients attending the faculty general internal medicine

practice in Pennsylvania reported having thoughts of killing themselves [5] and 9.7% suicidal ideation rate among patients from 15 international centres who admitted that they had or recently had suicidal ideation [6]. Differences in the reported rates may partly be due to differences in operational definitions for suicidal ideation over varying reference period (over a year, month and recently). There is need to standardize the operational definition for suicidal ideation in order to make meaningful comparisons.

Suicidal ideation was associated with be

ing married in the current study. Studies are needed to elucidate this association. Contrary, Zimmerman et al [5] reported that suicidal ideation was associated with being divorced. Differences in the directions of associations between marital status and suicidal ideation may partly be due to differences in cultural influence on marital relationship. Generally, persons in Zambia may stay in marriages despite being unhappy for fear of being labelled as the one who failed to keep the marriage. Conversely, healthy marital relationships may be protective against mental illness by partners offering support to spouses. Our study may not have been powered to establish associations of other socio-demographic factors with suicidal ideation.

In conclusion, the observed prevalence of suicidal ideation is worrisome and attendees in primary health care clinics should be screened for mental health. Upon establishing other correlates for suicidal ideation, interventions should then be designed to avert deaths due to suicide.

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