Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

A brief report on confronting Africa's suicide crisis

Faith Agumya
Africa Suicide Prevention Association
Elizabeth Ajalo
EDPA International Hospital
Enock Mukiibi
Ubora Foundation Africa
Jacqueline Muwanga
Uganda Parliamentary Forum on Mental Health
Mercy Gracy Omona
Uganda Parliamentary Forum on Mental Health
Melanie Nagumya
Africa Suicide Prevention Association
Bonita Gumoshabe
Africa Suicide Prevention Association
Yunusu Ssengooba
Uganda Parliamentary Forum on Mental Health
Nusula Nakato
Uganda Parliamentary Forum on Mental Health
Martha Kamini
Uganda Parliamentary Forum on Mental Health
Innocent Ayesiga
ayesiga49@gmail.com

Mbarara University of Science and Technology

Short Report

Keywords: suicide, prevention, advocacy, policy, decriminalisation, mental health

Posted Date: November 4th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11116017/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License

Additional Declarations: No competing interests reported.

Abstract

Africa loses hundreds of citizens to suicide annually. This burden is exacerbated by weak surveillance, chronic under-resourcing of mental health services, and a colonial-era law criminalising attempted suicide. This perspective situates Uganda's crisis within global and regional trends, examines legal, systemic, and social barriers to prevention, and argues for decriminalisation, increased financing, and multi-sectoral coordination as the foundation of an evidence-based national response.

Introduction

Suicide remains one of the most under-prioritised yet preventable causes of premature death worldwide. The World Health Organisation (WHO) estimates that approximately 727,000 people die by suicide each year, making it the second leading cause of death among 15- to 29-year-olds globally [1]. Close to three-quarters of these deaths occur in low- and middle-income countries [1]. Regionally, the African continent carries a disproportionate share of this burden. The WHO African Region recorded a suicide mortality rate of 11.5 per 100,000 population in 2021, higher than the global average of 8.9 and higher than the rates recorded in Europe and South-East Asia [1–3]. Uganda mirrors, and in places exceeds, these regional patterns. National estimates place Uganda's suicide rate as high as 19 per 100,000 population [4]. Uganda has also been ranked the 17th country globally for suicide as a cause of death, with the South-West and Northern sub-regions bearing the heaviest toll. More recent WHO-derived estimates place Uganda's age-standardised rate at approximately 11.6 per 100,000, which is above the global average [5]. Further evidence has demonstrated that men die 5 times more than women. In 2025, the Directorate of Criminal Investigations at the Uganda police force recorded approximately 267 suicide cases, with the highest being in West Nile [6].

The human and social cost of these figures extends far beyond mortality statistics. Every suicide resonates through families, schools, workplaces, and communities, and is compounded by an estimated twenty or more non-fatal attempts for every completed death [1]. In Uganda, this burden intersects with poverty, unemployment, substance abuse, gender-based violence, displacement, and occupational trauma, placing the greatest strain on populations that are least equipped to absorb it: adolescents, refugees, and uniformed security personnel [7, 8]. Despite this scale, suicide prevention in Uganda continues to suffer from three major pitfalls. The country lacks a comprehensive, standalone national suicide prevention strategy integrated into its broader mental health policy [4, 9]. Mental health services remain severely under-resourced, with only around one per cent of Uganda's annual health budget allocated to mental health, and the ratio of psychiatrists to the population stands at roughly 1:600,000, far below the internationally recommended benchmark of 1:30,000 [10]. Attempted suicide remains a criminal offence under Section 210 of Uganda's Penal Code Act [11]. This provision was inherited from colonial-era law and continues to push suicidal distress toward criminalisation rather than offer appropriate care. This brief review presents arguments concerning the need for urgent and coordinated action.

Arguments

A Preventable Crisis Hidden in Plain Sight

Suicide is preventable through timely, evidence-based, and often low-cost interventions [1, 12–14]. Yet in some countries, like Uganda, prevention has been undermined by the persistent framing of suicide as a private tragedy or moral failing rather than a public health priority. Parliamentarians at the engagement described suicide as increasingly visible in schools, communities, and workplaces. Within these spaces, suicide is driven by intersecting stressors such as environmental shocks, evictions, family breakdown, and unaddressed depression. Suicide is typically preceded by identifiable psychological and social drivers rather than occurring purely impulsively. This highlights the feasibility of early identification and intervention where health systems are adequately equipped to detect and respond to warning signs.

Criminalisation as a Barrier to Care

A recurring and forceful argument at the engagement concerned the continued criminalisation of attempted suicide under Section 210 of Uganda's Penal Code Act. The act classifies attempted suicide as a misdemeanour punishable by up to two years' imprisonment [11]. Parliamentarians noted the colonial origins of this provision and questioned its constitutional and legal footing in contemporary Uganda. Legal evidence has argued that the offence of attempted suicide lacks a coherent doctrinal foundation, since suicide itself is not proscribed under Ugandan law [15]. Survivors would be better served by psychiatric assessment and care rather than by prosecution. Criminalisation does not merely fail to deter suicidal behaviour. It actively discourages help-seeking, since individuals in crisis, and the families who might otherwise intervene, reasonably fear arrest and stigma rather than support [16–18]. Comparative evidence from jurisdictions that have decriminalised suicide, including several Commonwealth countries, indicates no corresponding rise in suicide rates following reform [19, 20]. Decriminalisation should therefore be understood not as a symbolic legal adjustment but as a substantive public health intervention that removes a structural barrier to care.

A Stretched Health System

Even where survivors and at-risk individuals are willing to seek help, Uganda's mental health system is not structured to receive them. The country's psychiatrist-to-population ratio remains very low, at approximately 1:600,000 [10]. Sadly, most are concentrated in Kampala's central business district,

leaving other regions deficient in this critical health workforce. This means that the vast majority of Ugandans in psychological distress may never, at any point in time, see a specialist. The District-level mental health services are similarly thin and rely on the expertise of clinical psychiatric officers. One challenge of this uneven distribution is the Ministry of Health's inadequate wage bill. Uganda's budget allocation is estimated at approximately 1% for mental health services. However, this does not differ significantly from other settings. Globally, government spending on mental health has stagnated at a median of 2% of health budgets since 2017, with low-income countries spending as little as 4 US cents per person compared with up to 65 US dollars in high-income countries [21, 22]. Participants at the engagement, including a financial advisor invited to speak on resource mobilisation, argued that mental health financing cannot remain an afterthought appended to broader health budgets, but must be treated as a distinct, protected line item tied explicitly to suicide prevention outcomes. Complementary calls to embed counsellors in secondary schools and integrate mental health screening into routine primary care reflect a broader consensus that prevention must be decentralised beyond Uganda's single psychiatric national referral hospital.

Populations at the Margins: Youth, Refugees, and Security Personnel

The engagement repeatedly returned to three populations whose vulnerability to suicide is structurally produced rather than incidental. Among youth, academic pressure, peer influence, unemployment, and increasing exposure to digital and social media pressures were identified as compounding risk factors. Evidence has demonstrated that 1 in 4 young Ugandans experiences a mental health challenge [23]. Among refugee and displaced populations, the disruption of family structures leaves children particularly exposed to silent suffering and untreated depression. Evidence demonstrates that 190 suicide attempts and 59 deaths were recorded among refugee settlements in 2024 alone [24]. Some of the triggers within this setting included family conflict, financial hardship, and domestic violence. Among security personnel, including police and military officers, occupational stress, combat exposure, colleague fatalities, indebtedness, and inadequate remuneration were identified as under-addressed contributors to suicide risk. These findings align with previous literature exploring suicidality among these population categories [25–27]. The discussions highlighted the absence of structured occupational mental health systems in Uganda's security sector. These three populations illustrated that suicide prevention strategies designed around a generic “public” fail to reach the specific structural conditions, displacement, institutional stress, and developmental pressure that place particular groups at an increased risk.

The Data Deficit: Building the Evidence Base

A further constraint raised at the engagement was the poor quality of suicide-related data. Stigma, criminalisation, and the misclassification of deaths mean that officially recorded suicide statistics in most low- and middle-income countries, Uganda included, likely understate the true burden [1, 28]. Speakers called specifically for a national suicide surveillance system capable of tracking attempts and deaths across health facilities. Without reliable, disaggregated surveillance data, neither Parliament nor the Ministry of Health can adequately target resources, evaluate interventions, or hold the system accountable for progress. This gap also weakens Uganda's capacity to contribute credible evidence to continental efforts

From Dialogue to Delivery: Coordination as the Missing Link

Finally, the engagement highlighted that no single sector, health, justice, security, education, or media, can address suicide alone. Effective prevention requires coordinated action across the Ministry of Health, the Judiciary, education stakeholders, security agencies, and civil society. Contributions from the Office of the Prime Minister emphasised the need for stronger inter-ministerial collaboration. Media and creative-arts representatives further argued for responsible reporting and culturally resonant messaging, including through music. They noted that these messages can meaningfully reduce stigma and shift public narratives around suicide and help-seeking. The upcoming Africa Suicide Prevention Summit in October 2026 offers a solid opportunity and platform to translate this cross-sectoral consensus into measurable commitments

Conclusion and Call to Action

Suicide in Uganda, as elsewhere, is a preventable public health challenge rather than an inevitable tragedy. The evidence assembled here and the deliberations of the Parliamentary Stakeholders' Breakfast Engagement from which it draws converge on a clear conclusion: Uganda's suicide burden persists not for lack of understanding but for lack of coordinated investment, legal reform, and system-level capacity. As the country prepares to engage with the Africa Suicide Prevention Summit, this perspective calls on the Parliament of Uganda, the Ministry of Health, and their partners to act on five fronts. Parliament should expedite the review and reform of Section 210 of the Penal Code Act to decriminalise attempted suicide, redirecting survivors from the criminal justice system into psychosocial and clinical care. Government should develop and adopt a standalone, adequately costed National Suicide Prevention Strategy nested within a strengthened Mental Health Policy, with a protected budget line rather than residual funding. The Ministry of Health, working with training institutions, should accelerate the recruitment of, and ensure the equitable geographic distribution of, psychiatrists, psychiatric clinical officers, and school- and community-based counsellors. Uganda should invest in a functional national suicide and self-harm surveillance system to guide evidence-based resource allocation and enable honest progress tracking. Government, security agencies, civil society, media, cultural leaders, and development partners must institutionalise multi-sectoral coordination mechanisms that outlast any single engagement or summit.

Declarations

Ethical Considerations

Not Applicable

Consent to Participate

Not applicable

Consent to Publish

Not applicable

Conflict of Interest

Non to declare

Clinical Trial number

Not applicable

Funding

No official grant funding was obtained for this perspective.

Author Contribution

FA, EA, and IA conceptualised the manuscript.EA, FA, JM, MGO, MN, YS, BG, MK, NN, and IA organised the breakfast meeting at the parliament.EA, FA, JM, MGO, and IA developed the initial manuscript.EM provided technical input in the manuscript.All authors reviewed and approved the final manuscript version for submission.

Acknowledgement

We thank the Parliament of Uganda for hosting this breakfast engagement. Appreciation is also expressed to every stakeholder who participated in this engagement.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

References

1. World Health Organization. Suicide worldwide in 2021: global health estimates. World Health Organization; 2025 May 22. https://books.google.co.ug/books?hl=en&lr=&id=nCZgEQAAQBAJ&oi=fnd&pg=PP6&dq=The+World+Health+Organisation+(WHO)+estimates+that+approximately+727,000+people+die+by+suicide+each+year,+making+it+the+third+leading+cause+of+death+among+15-+to+29-year-olds+&ots=Tq8ssD78xt&sig=BPNwp7N_8Ow1s9faUS7u7szr7Kw&redir_esc=y#v=onepage&q&f=false Accessed on 26 June 2026
2. Ghizlane C, Zougrar I, Benayad A, Abdelaal O, Bouaddi O, Elbadisy I, Bitanihirwe B, Boutayeb S, Belyamani L, Husky M, Khalis M. Prevalence of suicidal thoughts and behaviors among individuals with mental disorders in Africa: a systematic review and meta-analysis of the past 25 years. BMC psychiatry. 2026 Feb 12;26(1):158.
3. Meda N, Angelozzi L, Poletto M, Patane' A, Zammarrelli J, Slongo I, Sambataro F, De Leo D. How many people die by suicide each year? Not 727,000: a systematic review and meta-analysis of suicide underreporting across 71 countries over 122 years. Frontiers in psychiatry. 2025 Aug 12;16:1609580.

4. Ntono V, Kabwama S, Kadobera D, Lukwata H. Distribution of attempted suicide in Uganda, 2016-2017. Uganda National Institute of Public Health. 2021
5. WHO. Suicide in Africa, a neglected reality. Analytical Factsheet; World Health Organisation. 2022. https://files.aho.afro.who.int/afahobckpcontainer/production/files/iAHO_Suicide_Regional_Fact_sheet_August2022.pdf Accessed on 27 June 2026
6. Uganda Police Force. Annual Crime Report 2025. Criminal Investigations Directorate. 2026. https://upf.go.ug/wp-content/uploads/2026/04/2025-Official-Annual-Crime-Report-Web-Version.pdf Accessed on 27 June 2026
7. Akunzirwe R, Carter DJ, Hanna L, Zinke-Allmang A, Akim A, Datzberger S, Parkes J, Knight L, Atuhaire L, Nakuti J, Mirembe A. Associations between violence in childhood, depression and suicide attempts in adolescence: evidence from a cohort study in Luwero district, Uganda. BMC Public Health. 2024 Dec 18;24(1):3405.
8. Alol E, Favina A, Ashaba S, Rukundo GZ. Suicidality and associated factors among people living with mental illness attending an outpatient clinic at a tertiary hospital in Uganda. BMC psychiatry. 2026 Jan 9.
9. Parliament of Uganda. The Mental Health Act 2018. https://bills.parliament.ug/attachments/Mental%20Health%20Act%202018.pdf Accessed on 20 June 2026
10. Wakida EK, Obua C, Haberer JE, Bartels SJ. Enhancing the capacity of providers in mental health integration (ECaP-MHI) in rural Uganda: the adaptation process. Journal of multidisciplinary healthcare. 2023 Dec 31:387-96.
11. The Judiciary Uganda. Penal Code Act; 2024 Legislation. 2026. https://media.ulii.org/media/legislation/112333/source_file/967601432642ffb5/1950-12.pdf Accessed on 20 June 2026
12. Mann JJ, Michel CA, Auerbach RP. Improving suicide prevention through evidence-based strategies: a systematic review. American journal of psychiatry. 2021 Jul;178(7):611-24.
13. Fleischmann A, Arensman E, Berman A, Carli V, De Leo D, Hadlaczky G, Howlader S, Vijayakumar L, Wasserman D, Saxena S. Overview evidence on interventions for population suicide with an eye to identifying best-supported strategies for LMICs. Global Mental Health. 2016 Jan;3:e5.
14. Vaivada T, Lassi ZS, Irfan O, Salam RA, Das JK, Oh C, Carducci B, Jain RP, Als D, Sharma N, Keats EC. What can work and how? An overview of evidence-based interventions and delivery strategies to support health and human development from before conception to 20 years. The Lancet. 2022 May 7;399(10337):1810-29.
15. Uwaegbulem IL. An Appeal of the Legal Framework for the Prohibition of Attempted Suicide in Nigeria. African Journal of International and Comparative Law. 2024 May;32(2):217-34.
16. Lubaale EC. The crime of attempted suicide in Uganda: the need for reforms to the law. Journal of Law, Society and Development. 2017;4(1):19-pages.
17. Adinkrah M. Anti-suicide laws in nine African countries: Criminalization, prosecution and penalization. African Journal of Criminology and Justice Studies. 2016;9(1):17.
18. Nwaechefu H, Ajayi MA. Addressing the High Rate of Suicides Recorded in 2018 and 2019 in Nigeria Vis-A-Vis the Statutory Rights to Life of the Victims: A Socio-Legal Appraisal. African Journal Of Law And Human Rights. 2021 Aug 17;5(1).
19. Wang SS, Eapen V, Lin PI. The relationship between mental health reforms and general population suicide rates in Australia over the past three and a half decades: 1987–2021. Psychiatry research. 2024 May 1;335:115884.
20. Hiam L, Dorling D, McKee M. Changing suicide trends: A shift in regional disparities across the UK. Public Health. 2025 Jan 1;238:90-3.
21. WHO. Over a billion people living with mental health conditions – services require urgent scale-up. WHO. 2025. https://www.who.int/news/item/02-09-2025-over-a-billion-people-living-with-mental-health-conditions-services-require-urgent-scale-up Accessed on 28 June 2026
22. UN. 'Shift the narrative' on suicide to prevent loss of 720,000 lives annually. 2025. https://news.un.org/en/story/2025/09/1165817 Accessed on 28 June 2026
23. Mbithi G, Sarki A, Mabrouk A, Odhiambo R, Namuguzi M, Atukwatse J, Kabue M, Mulupi S, Abubakar A. Exploring adolescents' mental health in Kampala, Uganda in the context of COVID-19: a mixed methods study. Frontiers in Child and Adolescent Psychiatry. 2025 Feb 24;4:1419043.
24. Medical Teams International. Lives on the Line: Combating the Rising Suicide Rates in Uganda. 2026. https://www.medicalteams.org/blog/lives-on-the-line-combating-the-rising-suicide-rates-in-uganda/ Accessed on 28 June 2026
25. Sousa B, Azevedo V, Andrade R, Oliveira C, Gonçalves T, Correia-Santos P, Costa P, Maia Â. Suicide thoughts and behaviors among police officers: A systematic review with meta-analysis. Death Studies. 2025 Oct 16:1-8.
26. Talavera-Velasco B, Gutiérrez-Carvajal A, Martín-García J, Luceño-Moreno L. Suicidal ideation in police officers and associated risk factors: A systematic review. Policing: A Journal of Policy and Practice. 2024 Jan 1;18:paae057.
27. Krishnan N, Steene LM, Lewis M, Marshall D, Ireland JL. A systematic review of risk factors implicated in the suicide of police officers. Journal of police and criminal psychology. 2022 Dec;37(4):939-51.
28. Kabir R, Hasan MR, Arafat SY. Epidemiology of suicide and data quality in Bangladesh. InSuicide in Bangladesh: Epidemiology, risk factors, and prevention 2023 Mar 15 (pp. 1-15). Singapore: Springer Nature Singapore.