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COMPARATIVE ASPECT-VOLUME AND DYNAMICS OF SUICIDES IN A PART OF THE WORLD AND IN KOSOVO 2000-2019

Dr. VJOSA JONUZI-SHALA

Assistant Professor, Email: vjosa.shala@universitetiaab.com

Dr. VETON VULA

Assistant Professor, Email: veton.vula@universitetiaab.com

Abstract

Suicide (mors voluntaria) is violent and voluntary termination of one's life, undertaken by a mentally-healthy person, who in the condition of pathological affect experiences internal battle with suicidal motives. By committing the suicidal act, the individual achieves his or her primary goal: escaping from oneself. Alongside other phenomena, suicide is also a social pathology, widespread all over the world. There is no similar predisposition of increase or decrease of this phenomenon. Taking into consideration the data throughout the years and decades from different countries, this issue is very relative. In some countries there is a predisposition of decrease of suicide rate, in others there is an increase, and in some countries, it is difficult to determine it. This paper is based on historical, statistical, comparative methods and interviews. It addresses the volume and dynamics of suicides in Kosovo throughout several decades. In the comparative aspect, the paper addresses also the volume and dynamics of suicides in Albania and other countries of the world. Regarding quantitative analysis, the WHO and Eurostat data were used for other countries, whereas the data used for Kosovo are the official recently updated data of the KAS up to 2019. Scientific sources were used due to lack of official data for the past decades, whereas other sources were used for 2000 and 2001. In regard to Albania, scientific data were used presented in the conference proceedings, which referred to archival sources and INSTAT. The data in the paper were presented through tables and graphs.

Keywords: suicide, causes, volume**,** figures, rates, dynamics

Suicide as a violent and voluntary termination of one's life

Despite the claims "everyone knows what suicide is", there is no definition acknowledged worldwide about this phenomenon. However, as a reference point is recognised the definition of the National Institute of Mental Health for the Studies of Suicidal Prevention meeting in 1972-1973, which has been refined through subsequent research. This definition describes the terminology used about suicide and moments related to this phenomenon. According to this institution, suicide is a fatal self-inflicted destructive act with explicit or inferred intent to die, which includes method, location, intent and diagnoses. Suicide attempt is a non-fatal, self-inflicted destructive act with explicit or inferred intent to die, which includes the frequency and recency of attempt(s), and the person's perception of the likelihood of death from the method used. Suicidal ideation means thoughts of harming or killing oneself. Frequency, intensity, and duration of these thoughts are all posited as important to determining the severity of ideation. Suicidal communications are direct or indirect expressions of suicidal ideation, expressed verbally or through writing, artwork, or other means. High-risk groups are those that are known to have a higher than average suicide rate, and suicidality means all suicide-related behaviours

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and thoughts including completing or attempting suicide, suicidal ideation or communications.[1] Other definition derives from the WHO Regional Office for Europe in 1986, which states that "Suicide is an act with fatal outcome, which was deliberately initiated and performed by the deceased, in the knowledge or expectation of its fatal outcome, and through which the deceased aimed at realising changes he/she desired."[2]

Suicide is the act of taking one's own life consciously and voluntarily.[3] The term "suicide" derives from Latin sui - of oneself and occidere - to kill and it refers to active or passive auto-destructive act of taking one's life consciously and deliberately.[4] This means that the act of suicide includes only that action taken by a person who is mentally capable – a person with conscience and will. Brining oneself into a certain mental situation, thus into a situation caused by oneself, such as deliriums, acute phases of mental illness, alcoholism or psychotropic substances is considered an accident.

Suicide is consequence of a joint action of suicidal predisposition (lack of born or acquired instinct for restraint) and suicidal motive (problem that the person committing suicide deems to be a reason to take one's life because it is impossible to resolve it, which problem often remains unknown for the surroundings).[5] Synonyms for suicide are self-destruction, self-immolation, self-slaughter, self-termination.[6] Persons who commit suicide are those who do not want to continue living and who do not hope to survive this act.[7]

Motives of Suicide

There are many theories about motives of suicide. According to É. Durkheim[8], motives of self-destruction are several: altruistic suicide, which is result of sacrificing one's life for the wellbeing of others (it happens more often in Japanese culture), anomic suicide, which is result of loss or inability to find meaning of life, loneliness, isolation, lack of contact with societal norms and values, egoistic suicide, which is a result of a powerful experience of personal failure, which pushes the person to accuse oneself of believing that he/she will never be able to fulfil personal and societal expectations. In regards to methods, direct suicide is committed with an active action of the person, double suicide is usually committed by two people in relationship, mass suicide occurs when more people simultaneously kill themselves in the same location, complicated suicide means a person committing suicide following killing of someone, simulated suicide means a murder which is intended to look like suicide, and dissimulated suicide, where suicide is intended to look like murder. In general, suicide is committed in isolation, but for the cases when a person intends to attract public's attention through suicide because of, according to his/her beliefs, societal injustices. This is referred to as protesting (tendentious) suicide.

Causes of suicide differ depending on location, geography, cultural, ethnic, and economic context. Thus, suicidality is a multicausal behavioural phenomenon and may be examined through multiple aspects: biological, historical, epidemiological, cultural, sociological, psychological, legal, theological, economic, which has a spectre expanding from the suicidal ideation until its realisation.[9]

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Studies show that in the United States, [10] mental illnesses and alcoholism, personal loss, and increased age were associated with the greatest risk to commit suicide, whereas humiliation, shame, economic hardship, examination failure, and family disputes were the greatest risk factors for suicide in India. In general, in all the cases, factors affecting suicide are psychiatric – mental illnesses and disorders, such as: Mood Disorders among adults, Major Depressive Disorder, Chronic Depressive Disorder (Dysthmia), Bipolar Disorder, Anxiety Disorders, Panic Disorder, Post-Traumatic Stress Disorder, Schizophrenic Disorders, and Personality Disorders. Personality disorders are characterised with major mood disorders, impulsive behaviour and difficulty in establishing meaningful personal relationships (Borderline Personality Disorder), disorders caused by alcohol or substance use; psychological causes that include aspects of thought, judgment and behaviour, including impulsiveness, loss of relation with people, hopelessness, loss of control, the way how individuals manage stressful conditions and events, their emotional reaction, temperament and personality, and psychic pain. According to the same study, apart from these causes, suicide is also caused by biological factors, which deal with physiological system of stress and neurochemistry connected to the Serotonergic System, brain levels, Cerebrospinal fluid levels, the Noradrenergic System,, and other neuro-chemical factors, then the genetic factors – genetic predisposition to mental illnesses and impulsive aggressiveness (although these factors interact with social factors and family circumstances, but not in genetic context, because even in cases of suicidal behaviour in the family, this was not proved as genetics, but may serve as a model of behaviour of a family member by imitating it, and secondly, there may be other family factors that increase the risk of suicide, e.g. parental psycho-pathology, lack of support, disagreements, even abuse through frank abuse, family predisposition (risk of suicidal behaviour is four time higher if the first-degree relatives have died of suicide)[11] and childhood trauma, such as: lack of care, psychological abuse, physical and sexual abuse, and other trauma in the cases when the role of parents as physical and emotional supporters of children is compromised.[12] Social and cultural circumstances[13] were addressed in four aspects: individual (the individual is influenced by specific events or critical life circumstances, such as divorce, economic crises, political pressure), geographical (living in areas of limited social integration), societal (countries with different institutional arrangements significantly differ vis-à-vis suicide, especially Finland and Austria, with very high suicide rates, then the post-Soviet countries of the Eastern Europe, such as Hungary and Russia, Confucian societies, such as Japan and China,[14] which have a relatively high suicide rate compared to other Asian societies), and historical (all suicide rates are compared through time periods and relevant predispositions linked to the changes through time in rapport with the social and cultural indicators. Medical and psychotherapeutic interventions also cause suicide. The study shows that almost half of the individuals who complete suicide in the United States were diagnosed with a mental disorder and were under treatment by a mental health professional, although some of the medication used for treatment of this category of people may have an impact on the risk of suicide.[15] On the other hand, five to six percent of suicides in United States and Great Britain occurred during psychiatric hospitalisation, although individuals, who do not adhere to their treatment regimens, including medication and therapy, are at greater risk for suicide.[16]

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General Data on Suicide in the World

Some of the facts show that suicide is the act of purposely ending one's own life. More than 800,000 people worldwide commit suicide each year -- over 45,000 in the United States (2016).[17] In 2000, this number was about 35,000, while in 2001 approximately 650,000 people had attempted suicide.[18] According to WHO, worldwide one person dies by suicide every 40 second.[19] Suicide was the fourth leading cause of death among 15-29 year-olds globally in 2019. Further, another fact about suicide is that there is a much higher number of attempted suicides.[20] Also, according to WHO, in 2000, the number of people who committed suicide was 815,000 or 14.5 per 100,000 people.[21] Globally, 1.4% of deaths were from suicide in 2017, although in some countries over 5% of overall number of deaths was from suicide.[22]

In 2017, over 48,000 people died of suicide across EU countries. The highest number was among men over the age of 45 years-old, who represent over 3/4 of suicides in the EU countries, while in Lithuania, the suicide rate among men was more than five times higher than that for women.[23] According to Eurostat, in 2017, Lithuania registered the highest suicide rate among the EU countries with 26 deaths per 100,000 population, followed by Slovenia (20), Latvia (18), Estonia and Hungary (17).[24]

Table 1: Suicide rate in the world, 2000-2010 per 100,000 population (rate)[25]

Year	Global Level	Europe	America	Africa	South-East Asia	Eastern Mediterranean	Western Pacific
2000	13.0	21.9	7.5	9.2	13.6	6.3	13.8
2001	12.4	21.3	7.8	9.0	13.2	6.4	12.7
2002	12.2	21.1	7.9	8.8	12.8	6.3	12.2
2003	12.1	20.7	7.9	8.7	12.2	6.3	12.9
2004	12.1	20.2	7.9	8.6	12.1	6.2	13.3
2005	12.0	19.9	7.9	8.5	12.3	6.1	13.0
2006	11.6	18.6	7.9	8.4	12.3	6.1	12.3
2007	11.3	17.7	8.0	8.4	12.0	6.2	12
2008	11.2	17.6	8.2	8.5	11.8	6.1	11.7
2009	11.0	17.0	8.3	8.4	11.5	6.1	11.6
2010	10.8	16.7	8.4	8.2	11.6	6.1	11.2
2011	10.6	16.2	8.6	7.9	11.5	6.2	10.7
2012	10.3	16.0	8.6	7.8	11.2	6.2	10.0
2013	10.0	15.7	8.6	7.7	10.7	6.2	9.6
2014	9.7	15.6	8.8	7.5	10.1	6.1	9.3
2015	9.5	14.9	9.0	7.3	9.8	6.1	9.1
2016	9.3	14.3	9.2	7.2	9.6	6.1	8.9
2017	9.2	13.6	9.7	7.1	9.6	6	8.8
2018	9.3	13.4	9.6	7	10	5.9	8.9
2019	9.2	12.8	9.6	6.9	10.1	5.9	8.7

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Between the years 1980-1984, Western European countries reported the following suicide rate per 100,000 people: Finland 27, Italy 5, Austria and Denmark over 20.[26] In 1997, Italy reported an 8.2 rate, Norway 12.1, Sweden 14.2 (1996), Finland 23.8 (1998), UK and Northern Ireland 7.4 (1998), Poland 14.3 (1996), while the suicide rate in 1999 in Austria was 19.2, in Hungary 33.1 and in Lithuania 41.9.[27]

Estonian-Swedish Suicidology Institute in Tallinn provided detailed data on suicides in the former USSR. According to a 1993 report, the suicide rate in the former USSR was doubled in the period 1966-1984, with the 1984 rate as follows: Russian Federation 38, Belarus 29, Ukraine 27, North Caucasus in Dagestan 3, Caucasian Republics (Armenia 3, Azerbaijan 4, Georgia 5), Central Asia Republics (Tajikistan 6, Turkmenistan 8, Uzbekistan 8), Kyrgyzstan 15, Moldova 23, Kazakhstan 26, and Udmurtiya, a republic in central Russia 41.[28] In 1998, Russian Federation had a 35.5 rate,[29] the rate in 1993 and 1994 was 31, in Kuzbass Republic the rate was 55 and 62. The suicide rate in Ukraine in 1990 and 1994 was 20.6.[30] in 1999, the suicide rate was 29.1, with 34 in Belarus.[31]

The suicide rate in the Democratic Republic of Germany in 1970 was 19, whereas in 1989 it was 12, while in the Federal Republic of Germany the rate for the same years was 22, respectively 19.[32]

In Italy[33] during the period 1959-1988 there was a slight increase of suicide rate. The regions with the highest suicide rate are the northern ones (up to twice the national average), the age groups with the highest suicide risk are those over 74 years. The highest specific suicide rate was recorded among the divorced (32.4), while the level of education with the highest suicide rate is the secondary school (9). Suicide methods include hanging (30%), jumping (22.4%) and firearms (11.5%).

In Hungary, suicide statistics are recorded since 1887 and they differ depending on the region. By the end of 1980s, the rates were lower in the north-western region of Györ (26), and the highest were in the south-eastern region of Bács-Kiskunn (64.4). Bulgaria had a suicide rate of 9 (1970), respectively 11 (1989), while the suicide rate in the former Czechoslovakia during the same years was 23 and 16.[34]

In former Yugoslavia, [35] the rate in 1978 was 13, in 1989 was 14, and based on the data presented in 1986 in the first symposium on "Suicidal behaviour on the suicide rate in Vojvodina," the rate across the years increased from 20.5 (1960-1964) to 26.0 (1980-1984), whereas the average rate for the whole of former Yugoslavia was 13.8 per 100,000 people. However, studies show that suicide rate in Slovenia has always been and is much higher: from 1931-1959 the rate increased from 19.4 to 23.3, in 1976 the rate was over 30, in 1984 it was 35.8, and in 1989 it was 35.2.

Suicides in Kosovo and Albania

According to the scholar Sofokli Duka, "there were no suicide rites among Albanians, as there were in the world, apart from heroic suicides to avoid falling into the enemy's hands."[36] In fact, the most well-known mass suicide is the suicide by Souliot women in 1792 when they were

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assaulted by Ali Pasha.[37] However, there are no other suicides with such motives known or they belong to legends of the past.

Guillame Apollinaire (1880-1918), the French poet and intellectual, a good friend of Faik Konica, said, "Although handsome, noble and courageous, Albanians are inclined to suicide,"[38], although he does not refer exclusively to suicide rites, but to individual cases.

Official data for Kosovo indicate that during the period from 1969-1971 and 1988-1990, although the number of populations in Kosovo increased by 59%, the suicide rate decreased by 42%, whereas in the entire period between the years 1953-1990, the suicide rate in Vojvodina was two times higher than in Serbia, whereas the rate in Kosovo was five times lower than in Serbia.[39]

Table 2: People who died of suicide according to ethnicity[40]

Ethnicity	Number of suicides during the years			Suicide rates per 100,000 people		
	1970-1972	1980-1982	1990-1992	1970-1972	1980-1982	1990-1992
Total	**1111**	**1271**	**1465**	**15.48**	**15.28**	**18.78**
Serbs	762	906	1103	12.7	14.6	17.1
Albanians	**18**	**32**	**9**	**1.9**	**2.4**	**0.5**
Montenegrins	16	17	20	12.8	11.3	14.4
Croats	53	43	38	28.7	28.8	35.7
Yugoslavs	3	7	17	2.2	1.7	5.3
Hungarians	176	176	175	41.0	44.7	51.0
Muslims	8	10	10	5.2	4.6	4.1
Roma	3	9	10	6.7	7.8	7.1
Slovaks	20	12	21	26.5	16.4	31.4
Others and unknown	51	61	62	17.1	20.5	21.2

Table 3: Total number of populations in Serbia, Vojvodina and Kosovo vis-à-vis suicides[41]

Period	Total population	Serbia	Vojvodina	Kosovo	Total number of suicides	Serbia	Vojvodina	Kosovo
	Total population					Number of suicides		
1953-1990	8501391	5248168	1936694	**1316530**	41341	22358	17850	**1133**
1953-1955	7104478	4546355	1729134	**828989**	2322	1283	958	**81**
1969-1971	8387690	5219209	1947444	**1221037**	3352	1718	1538	**96**
1988-1990	9831974	5841079	2050901	**1939994**	4038	2364	1618	**56**
	Structure in percentage							
1953-1990	100.0	61.7	22.8	**15.5**	100.0	54.1	43.2	**2.7**
1953-1955	100.0	64.0	24.3	**11.7**	100.0	55.3	41.3	**3.5**
1969-1971	100.0	62.2	23.2	**14.6**	100.0	51.3	45.9	**2.9**
1988-1990	100.0	59.4	20.9	19.7	100.0	58.5	40.1	1.4

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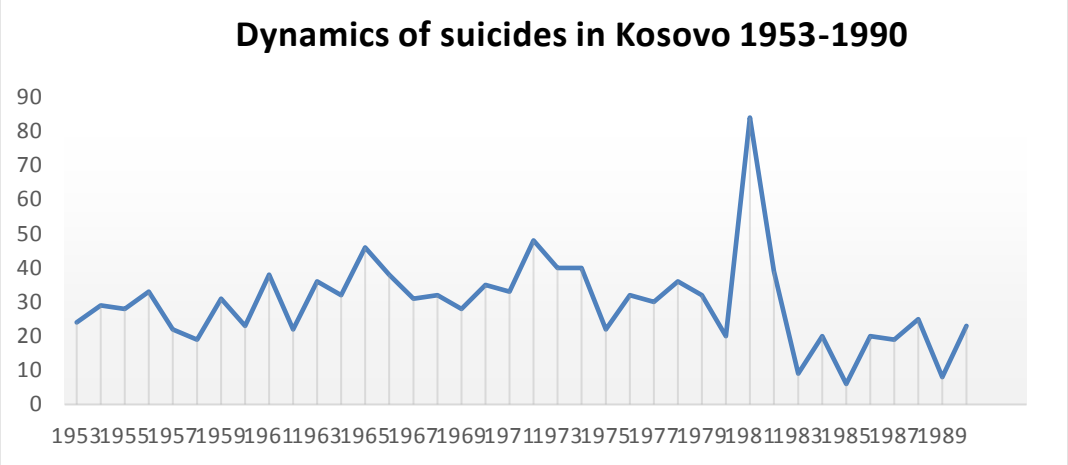
Table 4: Number of suicides in Kosovo from 1953 to 1990[42] and from 2000 to 2019[43]

Year	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965
Total suicides	24	29	28	33	22	19	31	23	38	22	36	32	46
Year	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978
Total suicides	38	31	32	28	35	33	48	40	40	22	32	30	36
Year	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	**2000**
Total suicides	32	20	84	39	9	20	6	20	19	25	8	23	**33**
Year	**2001**	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total suicides	**59**	14	19	18	28	27	33	23	25	48	29	34	40
Year	2014	2015	2016	2017	2018	2019							
Total suicides	44	36	43	32	27	39							

Note: Table 4 shows official statistics with the exception of years 2000 and 2001, which were not included in the KAS. Other sources were used as reference.[44]



Graph 1: Dynamics of suicides in Kosovo 1953-1990

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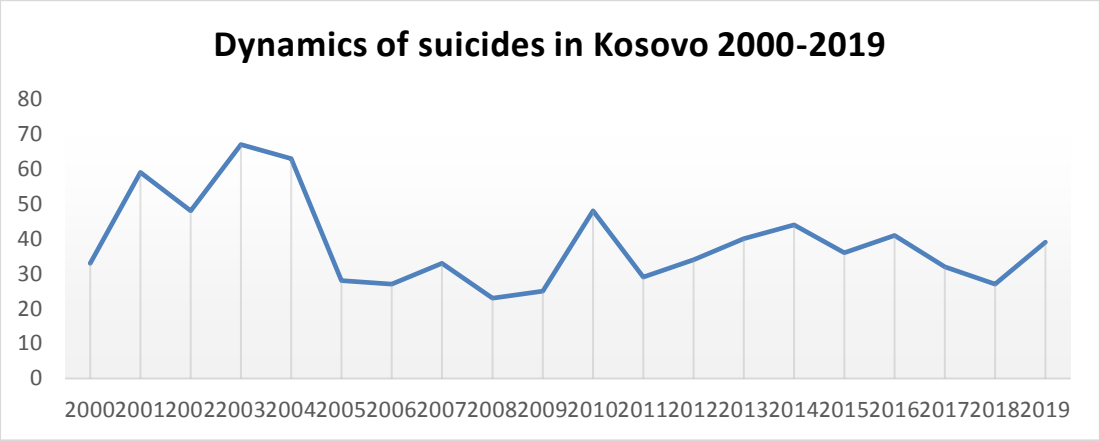

Graph 2: Dynamics of suicides in Kosovo 2000-2019

It should be noted that police or scientific data differ significantly compared to data presented and published by KAS. According to police data, the number of individuals who committed suicide in Kosovo is much higher. Even the sources referring to Kosovo Police data differ from each-other. Thus, according to some data, from January 2000 until June 2008, in Kosovo there were 460 deaths of suicide.[45]. However, according to a scientific study, there were 270 deaths of suicide in Kosovo during the period 2008-2012.[46]

According to Kosovo Police data, 975 people committed suicide between the years 2010-2017, with 3646 attempted suicides. The Police data present the situation annually, too.[47] According to this source, during a 17-year span, on average there were 57.3 suicides in Kosovo per year (more than one person every week), and on average 214-215 people attempted to commit suicide (over four people per week). Also, the same data reveal that in 2001 and 2002 the number of suicides was higher than the number of attempted suicides!

According to forensic pathologist, Arsim Gërxhaliu, the difference between the official and police data occurs because as soon as the police receive the information, it classifies the death as "suspicious death", but not necessarily a forensic examination is demanded for all deaths. Nevertheless, despite the difference between the police and official statistics on suicides, research papers use "only official data, in this case those provided by the Kosovo Agency of Statistics."[48]

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Table 5: Rapport of suicides and other violent deaths (accidents and homicide) 2002-2019 presented in figures and percentages compared to all other violent deaths.[49]

Year	Violent deaths	Accident		Suicide		Homicide	
2002	174	104	59.8%	14	8.0%	56	32.2%
2003	184	129	70.1%	19	10.3%	36	19.6%
2004	233	172	73.8%	18	7.7%	43	18.5%
2005	225	167	74.2%	28	12.4%	30	13.3%
2006	248	184	74.2%	27	10.9%	37	14.9%
2007	214	142	66.4%	33	15.4%	39	18.2%
2008	201	157	78.1%	23	11.4%	21	10.5%
2009	203	159	78.3%	25	12.3%	19	9.4%
2010	278	195	70.1%	48	17.3%	35	12.6%
2011	249	187	75.1%	29	11.6%	33	13.3%
2012	208	142	68.3%	34	16.3%	32	15.4%
2013	225	155	68.9%	40	17.8%	30	13.3%
2014	203	142	69.9%	44	21.7%	17	8.4%
2015	195	142	72.8%	36	18.5%	17	8.7%
2016	190	128	67.4%	43	22.6%	19	10.0%
2017	175	131	74.8%	32	18.3%	12	6.9%
2018	177	129	72.9%	27	15.2%	21	11.9%
2019	157	103	65.6%	39	24.8%	15	9.6%
2002-2019	**3739**	**2668**	**71.15% Average**	**559**	**15.14% Average**	**512**	**13.71% Average**

Data show that accidents during this period comprise between 59.8% to 78.3% (an average of 71.15) of violent deaths, whereas only in 2002-2007 and in 2011 there were more homicides than suicides.

Table 6: Suicide by gender, age, and ethnicity 2010-2019[50]

	Total	10-14	15-19	20-49	+ 50	Albanian	Serb	RAE	Turkish	Bosnian	Others	
M	41	3	2	22	14	**48**	**0**	**0**	**0**	**0**	**0**	**2010**
F	7	1	0	3	3							
M	20	0	3	12	5	**26**	**1**	**1**			**1**	**2011**
F	9	2	0	4	3							
M	30	0	0	17	13	**32**	**1**		**1**			**2012**
F	4	0	0	4	0							
M	30	0	1	13	16	**37**	**2**				**1**	**2013**
F	10	0	3	2	5							
M	35	0	4	21	10	**42**	**1**			**1**		**2014**
F	9	0	2	5	2							
M	22	0	1	10	11	**32**	**3**			**1**		**2015**
F	14	0	0	9	5							
M	27	0	1	19	7	**38**	**1**			**2**		**2016**
F	14	0	2	8	4							
M	24	0	1	14	9	**31**	**1**					**2017**
F	8	0	1	6	1							
M	19	0	1	9	9	**26**	**1**					**2018**
F	8	0	0	3	5							
M	38	0	0	21	17	**38**	**1**					**2019**
F	1	0	0	0	1							
Total	**370**	**6**	**22**	**202**	**140**	**350**	**12**	**1**	**1**	**4**	**2**	
M	**286**	**3**	**14**	**158**	**111**							
F	**84**	**3**	**8**	**44**	**29**							

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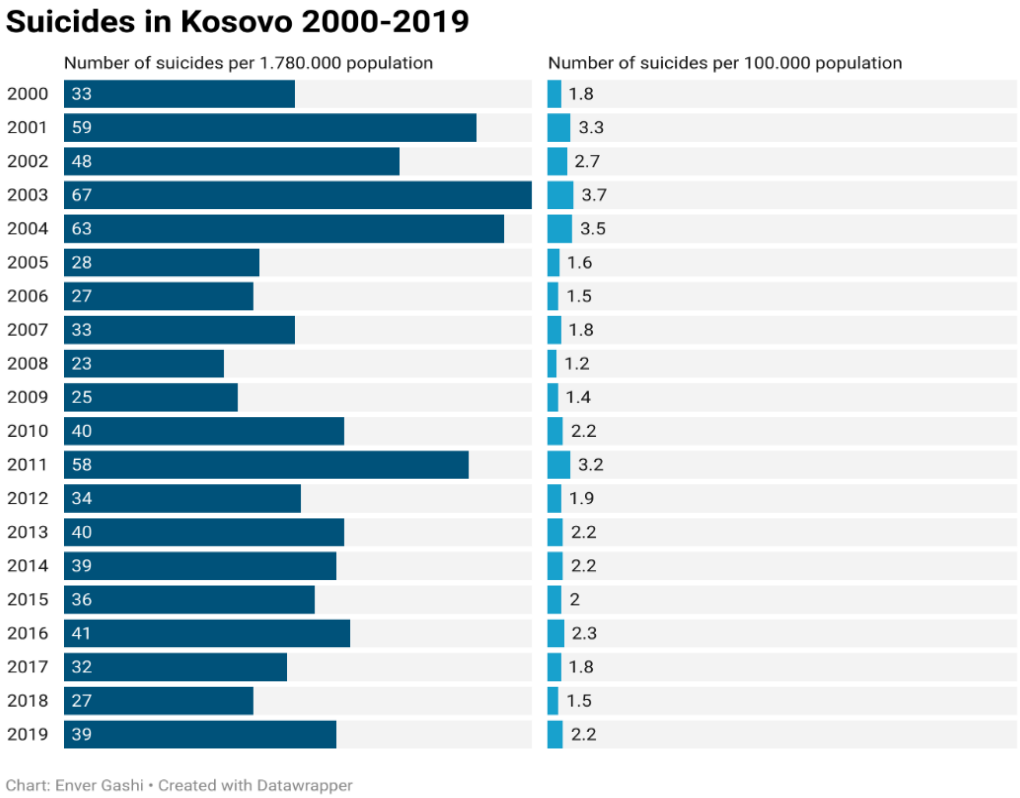
Data for 2010-2019 show that 94.6% were Albanians, about 3.3% Serbs, and 2.2% of other minorities, with 77.3% of suicides committed by men. Then, divided by age, the highest number of suicides is among 20-49 - 54.6%, followed by people over 50 years-old (37.8%). The rate among the people between 15-19 years-old is 6%, and among children between 10-14 years-old is 1.6%. The fact that the data of the Police and of KAS do not match is also shown in the reporting about ethnicity. According to the Regional Directorate of the Kosovo Police (Mitrovica North), in 2015-2020, in Mitrovica North, Zvecan, Leposavic and Zubin Potok there were 29 suicides registered.[51]

Further, throughout the period 1953-1990, the ratio of suicides between men and women in Kosovo was 745 to 388 or 65.8% to 34.2%. Yet, in 1955, 1959, 1960, 1973, and 1985, the number of suicides of women was higher compared to men (although a minor difference).[52] In regard to age, from 1953 until 1990, the highest number of suicides was committed by individuals between 20-49 years-old. In 1985, all the individuals who had committed suicide were of this age group.[53]



Graph. 3: Suicides in Kosovo 2000-2019 - Number of suicides per 1.780.000 population / Number of suicides per 100.000 population

In Albania, there were 5492 suicides between the years 1959-2015.[54] This proves that in the time frame of 56 years (672 months), in Albania approximately there were over 98 suicides (about 8.2 individuals per month) per year. The highest rate in 100,000 people between the

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years 2005-2015 was recorded in 2014 (about 11), in 2012 (over 9.6), in 2013 (about 9.5) and in 2015 (8.5). The lowest rate was recorded in 2010 (4.5).[55] According to Eurostat, in 2017, the suicide rate in Albania was 7.5, ranking it among the ten (10) countries with the lowest rate within the EU. The highest number of suicides was recorded in 2014, 262 individuals, while in 2019 the number was 216.[56] However, based on daily communication of the state police data, in Albania there were 1372 people who had committed suicide between the years 2000-2007.[57] According to these data, on average there were 171.5 suicides per year.

CONCLUSIONS

The following conclusions can be drawn from the object of study on suicides:

The act of taking one's own life consciously and voluntarily is, thus depriving oneself of own life, is called suicide. The causes of suicide are complicated, but generally may be internal (psychological) and external factors (social). These factors are always combined with each other, which mean that only one of these factors cannot be considered as a sole cause. The trend of suicides cannot be determined; there can be a continuous decrease during particular period of time, while in the next coming year there is an increase or vice versa.

This trend differs even among the countries that have same or very similar standards, socio-economic circumstances, geographical and climatic extent, historical and cultural past. The main source of statistical data on suicides worldwide is the WHO with regional offices on all continents. In addition to this source, another source for Europe is Eurostat. The volume of suicide is calculated by rate – the number of people per 100,000 population. According to WHO regional offices data throughout the world, the suicide trend from 2000 to 2019 marks a decrease globally (from 13 to 9.2 per 100,000 population). In fact, the rate decreases sharply in Europe over the years (from 21.9 to 12.8).

A downward trend exists in Africa, too (from 9.2 to 6.9) and in Southeast Asia (from 13.6 to 10.1), with negligible exceptions. On the other hand, there is an increase in America (from 7.5 to 9.6). In regard to European countries, in general the highest suicide rates are recorded in the former USSR, nowadays independent states, such as: Russian Federation, Lithuania, Estonia, Latvia, Belarus, Ukraine, Kazakhstan, Moldova, etc. Whereas, the countries with the highest suicide rate in the Western Europe are: the Nordic countries, Hungary, Slovenia, Serbia, Croatia, Austria, France, Czech Republic, Switzerland, Poland, Netherlands, etc.

The lowest suicide rates in Europe are recorded in Greece, Malta, Cyprus, Turkey, Italy, United Kingdom, Spain, etc. In terms of suicide rates, there are large differences within the specific countries' regions, too. In some regions of Russia, the rates were over 60 in the respective years; in the regions of Hungary, they were about 65, in the north of Italy, the rates were almost two times higher than in the south of the country; whereas in the former SFRY, the highest rates were marked in Vojvodina. We have the same situation in France, Spain and Greece, where in certain regions (2017), the suicide rate was 3.

In regard to the suicide rates of the former SFRY ethnicities, the highest rates and increasing trends from 1970 to 1992 was recorded among Hungarians, Slovaks and Croats, while the

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lowest rates and decreasing trends were recorded among Albanians, with the exception of the period 1980-1982. According to official statistics, although constantly increasing as a population, the number of suicides in Kosovo from 1953 to1990, has decreased. Data on suicides in Kosovo are numerous and diverse. While, on one hand, police data and media texts match, on the other hand, official statistics – KAS's data are almost by half lower in relation to sources above.

According to KAS, of all violent deaths in Kosovo, from 2002 to 2019, suicides rank second with 15.14%, followed by traffic accidents (71.15%), while homicides rank third (13.71%). Expressed in numbers, 2668 people lost their lives in traffic accidents, 559 committed suicides, while 512 people were killed. In terms of ethnicity, from 2010 to 2019 in Kosovo, about 95% were Albanians, over 77% were men and the age of the highest number of suicides was 20-49 years old (202), followed by the age of over 50 years old (140).

Between the years 2000 to 2019 in Kosovo, the lowest suicide rate was in 2008 with 1.2, while the highest was in 2004 with 3.5. From 2005 to 2019, 31 people were convicted in Kosovo for committing the criminal offense "Incitement and assistance in suicide". A very lenient punitive policy was applied, as evidenced by the type and extent of punishment of persons: with suspended sentence 11, with fine 10, court reprimand 3, with imprisonment of 2-6 months 4, with imprisonment of 6-12 months 2 and 1 person was sentenced to imprisonment of 1-2 years. Compared to Kosovo, over the decades almost two times higher suicide rates were recorded in Albania, although in relation to other countries in the world, Albania is considered to have a relatively low rate.

There is generally a slight increase since 1959. It is a fluctuating trend. According to periods, the suicide rate was as follows: in the 60s the rate 0.9, 1961-1965 it was 1.2, 1966-1970 it was 2.8, 1980-1990 rate was 2.5, 1991-2000 it was 3 and 2011-2012 the rate was 9.3. From 2005 to 2015, the lowest rate was in 2008 with 4.5, while the highest in 2014, when the rate was 11. Despite certain trends that are characterised by ups and downs and are fluctuating, Albania, compared to European countries, has a low rate, more precisely at the lower limit. Developed countries of Europe, especially the EU have taken measures, drafting long-term policies to prevent suicide; therefore, their trend over the years is decreasing.

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