

A review of the evidence: suicide among women in Nepal

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ACRONYMS

ANM	Auxiliary Nurse Midwife
APROSC	Agricultural Project Services
BVS	Burns Violence Survivors
CEDAW	Convention of the Elimination of All Forms of Discrimination Against Women
CRDS	Central Record and Drugs Section
CRS	Crime Record System
DoHS	Department of Health Services
EVAW	End Violence Against Women
FCHV	Female Community Health Volunteer
GBD	Global Burden of Disease
GBV	Gender Based Violence
GDP	Gross Domestic Product
GNP	Gross National Product
GoN	Government of Nepal
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
HIV/AIDS Syndrome	Human Immunodeficiency Virus/Acquired Immune Deficiency
HMIS	Health Management Information Section
ICD	International Classification of Diseases
ICIMOD	International Centre for Integrated Mountain Development
IDMC	International Displacement Monitoring Centre
IFAD	International Fund for Agricultural Development
KII	Key Informant Interview/Interviewee
MCHW	Maternal and Child Health Worker
MDGs	Millennium Development Goals
MIRA	Mother Infant Research Activities
MMM	Maternal Mortality and Morbidity
MMMS	Maternal Mortality and Morbidity Study
MWCSW	Ministry of Women, Children and Social Welfare
NDHS	Nepal Demographic and Health Survey
NGO	Non Government Organisation
NHSP-II	Nepal Health Sector Programme-II
SAARC	South Asian Association for Regional Cooperation
SAIPAL	South Asian Institute for Policy Analysis and Leadership
SEARO	South East Asia Regional Office
SLC	School Leaving Certificate
STI	Sexually Transmitted Infection
TB	Tuberculosis
TUTH	Tribhuvan University Teaching Hospital
TV	Television
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commission for Human Rights
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women

USD	United States Dollar
VAW	Violence Against Women
VDC	Village Development Committee
WHO	World Health Organization
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

In contrast to many health indicators, the rate of suicide globally is increasing. With a global suicide mortality rate of 16 per 100,000: nearly one million people commit suicide worldwide every year. In Nepal, suicide was the leading cause of death among women of reproductive age in the 1998 and 2008/09 Maternal Mortality and Morbidity (MMM) Studies, indicating that it is a major hidden public health problem in Nepal. Suicide poses a considerable obstacle for improving women's health and for the wider public health agenda, and funding may need to be redirected to reflect this pressing health concern.

The main objectives of this report are:

- *To review the available evidence on suicide in Nepal.*
- *To explore the burden of suicide among women in Nepal.*
- *To explore the means of suicide used by women in Nepal.*
- *To explore the characteristics of female suicide victims in Nepal.*
- *To explore the underlying reasons for suicidal tendencies among women in Nepal and explore the interaction between multiple factors.*

This includes a review of the international literature; interviews with key informants; analysis of secondary quantitative data (MMM study 1998, MMM study 2008/09, household survey, police data, and hospital records) and qualitative analysis of verbal autopsies of suicide cases (MMM study 2008/09) to get a better understanding of suicide, the prevalence and determining factors.

SCALE OF THE PROBLEM

Accurate statistics are essential to provide an effective suicide prevention programme. Nepal has a dearth of systematic, reliable and nationally representative data due to: poor quality registration systems; suicide cases being mis-categorised by hospitals; and under-reporting of suicide in police data - possibly intentionally due to suicide being stigmatised and illegal in Nepal. ***Mis- and under-reporting of suicides obscures the true urgency of the situation, and can lead to efforts being misdirected.***

Suicide was the leading individual cause of death for women of reproductive age in both the 1998 and 2008/09 MMM studies, with the percentage of deaths attributable to suicide increasing from 10% to 16%. The rates give an indication of the severity of the problem, at 22 per 100,000 in 1998 and 28 per 100,000 in 2008/09. The national rates computed from the police suggest significant under-reporting.

MEANS OF SUICIDE

Poisoning was the most common means of committing suicide among women of reproductive age in the 2008/09 MMM study mainly through ingestion of pesticides, which are readily available in most rural households in Nepal. ***Monitoring trends in methods is crucial for targeting prevention strategies,*** and accessibility and lethality of methods are often determining factors in the choice of means. Misconceptions about the lethality of methods may have undesired consequences: in-depth case studies showed some victims only intended to shock and were unaware their actions would be fatal. The inability of health facilities to treat poisoning cases and delays in reaching care were apparent.

PROFILE OF SUICIDE VICTIMS

Given data limitations it is difficult to compile a profile of suicide victims in Nepal. Findings are often inconsistent and should be interpreted with caution. Police data suggest that men have a slightly

higher risk of suicide than women overall, but risk varies by age. ***Suicide rates are higher for women at younger ages (10-24), and higher for men after 35,*** with the gap between the sexes increasing dramatically after the age of 50. The 2008/09 MMM study suggests that among women of reproductive age there may be an increased risk between 15-34, a reduced risk between 35-44, and an increased risk again after 45.

The 2008/09 MMM study indicated that ***suicide accounted for a far greater proportion of deaths among the unmarried*** than those married. This is supported by household survey data revealing that unmarried respondents were more likely to have contemplated or attempted suicide than married respondents. Dalits were more likely to report contemplating or attempting suicide than other ethnic groups.

UNDERLYING REASONS

Many underlying reasons lead to suicide. Without understanding why these underlying reasons increase suicide risk in a given context, suicide prevention efforts will only target factors on an *ad hoc* basis, rather than provide a comprehensive strategy to discourage suicide on a wider basis. ***Underlying conditions cultivate an environment that is either conducive to or protective against suicidal tendencies;*** both individual characteristics and the wider societal framework must be considered in an analysis of suicide risk.

AGE

Younger age groups (e.g. adolescents) are emerging as a high-risk group as their psychological coping mechanisms may be inadequate to manage when encountering life's major stressors for the first time. International literature shows the elderly to be at highest risk of suicide as vulnerability increases with age. The 2008/09 MMM study, reflected this with

high rates at either end of the age spectrum, while the police data showed little variation in rates by age.

MARITAL & PARENTAL STATUS

Married individuals and parents are frequently found to be at lower risk of suicide, possibly due to a protective or selection effect. ***However, protective effects are less evident in Nepal*** where women are expected to marry and bear children, often at a young age, with little say in their choice of partner and a large spousal age gap. International literature has shown depression is more prevalent among those having an arranged marriage and marrying at a younger age. In-depth case studies in Nepal revealed that intimate partner relationships were a common underlying factor behind suicides, and victims often had children. In some cases young children were present when the victim committed suicide.

EDUCATION, RELIGION & EMPLOYMENT

International studies show a ***heightened risk of suicide with unemployment.*** This may be limited to men, although, the ***general lack of economic opportunities for women may affect their mental health.*** Globally, research on the impact of education is inconclusive. Religion may have a beneficial effect when suicide is viewed negatively, but can increase suicidal tendencies in contexts where belief systems sanction it. Reflecting the international literature, the data analysed for this study remained inconclusive on these factors.

ETHNICITY / CASTE

A caste / ethnic hierarchy is entrenched in Nepal's laws, institutions, and culture; ***being from a lower caste / ethnic group represents a barrier to social inclusion, and hence may impact upon risk of suicide.*** Whilst moves have been made to reverse systemic prejudice and outlaw

caste / ethnic discrimination in national legislation it has not been entirely eradicated and inequity continues to operate in daily life.

CHRONIC ILLNESS

Chronic illness is associated with a lower quality of life, poorer physical health, increased risk of depression, and suicide; it was a common underlying problem highlighted in the in-depth case studies and the links with high cost of treatment, being a burden on their family and the affect on marriage prospects were apparent. The risk of suicide due to chronic illness (such as epilepsy) may be elevated in contexts such as Nepal, given the increased likelihood of experiencing a chronic illness, poorer access to healthcare and treatment, cost of healthcare, and the 'culture of silence' putting pressure on women to suppress negative emotions. Women avoid expressing suffering or seeking help, and reach a stage where they see suicide as their only option.

MENTAL ILLNESS

Mental illness places individuals at increased risk of suicide. The in-depth case studies revealed that whilst ***poor mental health can have a range of causes, it was often a consequence of social determinants.*** This illustrates the complexity of mental health in its social context, and how social norms, poverty and poor access to healthcare overlap with mental ill-health. Data from Nepal show a lower proportion of suicide cases linked to mental illness than in other studies, possibly linked to under-reporting due to lack of awareness and stigma. There has been a recent change in global attitudes towards mental health, and interventions have begun to encompass preventative as well as curative strategies. In Nepal, the burden of mental healthcare payments fall almost entirely on family members and mental health is often perceived to be related to evil spirits, hence many who

need medical attention go without or care is sought from traditional faith healers. Mental health is often stigmatised, and provider discrimination, social ostracism or abandonment by families is not uncommon.

MATERNAL MENTAL HEALTH

Globally maternal mental health is receiving increasing attention. It is estimated that ***up to one in three pregnant and postpartum women in developing countries suffer from mental health problems*** and poor maternal mental health has far-reaching adverse effects for both mother and child. However, in many countries, including Nepal, maternal health has largely neglected related mental health issues, e.g. maternal depression. Pregnant women have a relatively low rate of suicide, but those who develop mental conditions during the postpartum period may be at high risk, particularly during the first 18 months postpartum. Risk factors for postnatal depression in Nepal include partner violence, unsupportive husband or mother-in-law, son preference, husband's alcoholism, and multi-parity. Hence, suicidal tendencies resulting from gender-based risk factors may constitute an even greater burden among postpartum women.

PREVIOUS SUICIDE ATTEMPT & FAMILY HISTORY

Previous suicide attempts, whether personal or by a family member, increase the likelihood of future suicidal behaviour and family history of mental disorder may also be a significant factor. Case studies from the 2008/09 MMM Study referred to other suicides in the community, indicating suicide is not rare and possibly indicate an imitation effect. All suicide attempts should be taken seriously and not just dismissed as attention seeking behaviour.

POVERTY, SOCIAL EXCLUSION & INEQUALITY

The association between poverty and suicide is widely **reported as one of the main motivating factors of suicide**. Poverty may serve both as a conditioning and a precipitating factor and may have an indirect effect through poor mental and physical health, or a direct effect. Whilst suicide is more complicated than just economic loss, individuals who subscribe to karma and are poor may resort to suicide in the belief that they will never move up the economic ladder. Women may face additional financial pressure if their husband is deceased or has migrated in search of work. As well as economic aspects of poverty, underlying social determinants may increase suicide risk, including social discrimination, which may affect a person's ability to realise their right to equal social and economic opportunities. Nepal consistently performs poorly in the Asian inequality indices; huge disparities exist in privileges by sex, and caste / ethnicity.

GENDER & WOMEN'S STATUS

Gender is an independent and confounding factor of suicide, not only in terms of differentials in vulnerabilities (such as parental and marital status), but also in terms of disadvantages inherent in socially constructed notions of gender. Whilst gender equality has been on the international agenda for some time, it is not a priority for many developing countries in spite of governments' legal commitments. **Legally a number of discriminatory provisions are still in force, restricting women's access to and control over resources (Joshi & Kharel 2008)**. Women's activities include domestic chores and agricultural labour, but are rarely granted any economic value, leaving them economically dependent on husbands. Women are often considered men's property and systematically controlled, becoming trapped in a

perennial cycle of dependence, which may lead some to view suicide as their only option. However, Nepalese attitudes towards women and the beliefs and practices which maintain their low status, are slowly changing and significant efforts have been made to reduce the number of discriminatory laws.

GENDER BASED VIOLENCE (GBV)

GBV is both a cause and consequence of women's low status. It transcends purely physical abuse, encompassing sexual abuse; psychological abuse; neglect; deprivation of food, money or healthcare and is not solely perpetrated by husbands or relatives. Transcripts from the 2008/09 MMM study indicated that husbands are the main perpetrator and that psychological abuse is commonplace. **GBV is so commonplace that it is widely accepted**, with husbands openly reporting how they treated wives prior to them committing suicide. Underreporting is common due to the cultural silence surrounding women's suffering, fear of reprisals, stigmatisation, discrimination, and damaging the family reputation. Healthcare providers and public officials are often unsympathetic and ignorant of women's rights, while poor legal and social protection precludes faith in the justice system. These factors discourage help-seeking behaviour and provide a facilitating environment for GBV. GBV frequently occurs within the home, which is usually viewed as the private sphere, outside the realm of public intervention. Castes that accord women better status, such as Newars, generally experienced far lower rates of GBV at home (Paudel 2007). In spite of the modernist legal frameworks, cultural norms are more resistant to change. Given the lack of access to efficient social and legal protection in Nepal, sufferers of GBV may opt for informal coping mechanisms, such as confiding in friends and maternal family members, but many victims may see suicide as their only way out.

TRAFFICKING

Trafficked women are regularly exposed to sexual and physical violence, facing **increased risk of HIV, reproductive problems and likely to experience poor physical and mental health, and increased risk of suicide**. In Nepal, trafficking victims are often deceived with false promises of work or sold by parents or relatives. Even when victims are recovered and able to return home, they are often ostracised and receive limited support from the government. Recent legislative action to reduce the incidence of trafficking has been poorly implemented and endemic corruption means that officials often facilitate rather than prosecute trafficking and agencies recruiting Nepali nationals to work abroad are not monitored. Without a change in political will, legal protection is unlikely to reduce trafficking. Widespread stigma prevents support for victims of sexual abuse, and hence there is limited protection against suicidal behaviour.

MODERNISATION, URBANISATION & SOCIETAL CHANGE

Modernisation, urbanisation and societal change can bring benefits that reduce suicide risk, such as improved health and reduced poverty, **but can also increase vulnerability to suicide**. Modern lifestyles may challenge existing cultural structures, which in turn determine individuals' aspirations and conduct, and can have serious implications for individual wellbeing. They can increase exposure to: substance abuse; job competition; intergenerational and gender conflicts; nuclear households; migration; spousal separation; social exclusion and widen the gulf between the richest and poorest, resulting in serious implications for health and suicide risk. Equally, those residing in rural areas may experience: increased vocational insecurity; increased access to means (e.g. pesticides); poverty; limited access to health care; and reduced support

from individuals who have migrated. Furthermore, there may be a selection effect with healthier individuals (i.e. less likely to commit suicide) being more likely to migrate away from rural areas.

DISPLACEMENT: MIGRATION, CONFLICT AND REFUGEES

Displaced persons may feel socially excluded, which can precipitate in poor mental health and suicidal behaviour. Nepal's population is at risk of displacement due to natural disasters, civil unrest and economic migration. Displacement, forced or voluntary, has implications for personal wellbeing as individuals diverge from their customary environment, resources and coping mechanisms. The effects are varied and far-reaching, affecting mobile individuals, those left behind and those in the host community. **It is common for women in Nepal to be left behind while husbands migrate overseas for employment, which may have adverse consequences including a detrimental impact on relationships with spouses** for their physical and mental health, leaving them with increased propensity to depression, with implications for suicide risk. The transcripts suggest this is having a **detrimental impact on relationships with spouses**.

Forced displacement due to conflict has huge potential for violations of physical and mental wellbeing, and may increase suicidal tendencies. In 2010, up to 70,000 persons remain displaced from the People's War, often with no documentation, rendering them economically and socially vulnerable families were separated, and loss of land and resources compromised individuals' ability to maintain a livelihood. **Many aspects of conflict increase suicidal tendencies, often through psychological distress and post-traumatic stress disorder (even without direct exposure to violence)**, and conflict-induced displacement can have an independent

impact on mental and physical wellbeing. In this setting, more focused research is needed to understand the effect of conflict on suicide

Refugees suffer similar social and economic disadvantages as other displaced persons, but are seldom able to return to their place of origin. They often face widespread exclusion and xenophobia. Sustained exposure to these stressors places them at increased risk of physical and mental disorders and suicide. Exposure to torture in the past can also have a long-term impact on their mental health. Many Tibetan and Bhutanese refugees have sought refuge in Nepal and **suicide rates in the Bhutanese camps are more than four times higher than the surrounding areas.**

ALCOHOL AND SUBSTANCE ABUSE

The **link between suicidal tendencies and alcohol / substance abuse is well established globally.** The literature suggests that in developing countries it is often the impact of a husband's substance abuse that leads to an increased risk of suicide in female counterparts. This may be due in part to the increased risk of physical and sexual violence following their husband's consumption. However, in-depth transcripts from the 2008/09 MMM study suggest that in Nepal **alcoholism amongst women is equally a direct contributory factor in women's suicidal tendencies.**

ACCESS TO MEANS

Easy access to means of committing suicide can increase the likelihood of suicide, in particular, impulsive suicides. Restricting access to materials that are capable of causing death (such as pesticides) is an increasingly common suicide prevention strategy. **Pesticides are a common means of suicide in Nepal and as such, preventative initiatives should target access.**

ROLE OF THE MEDIA

The media have enormous power and responsibility in influencing attitudes and opinion towards suicide. However, they frequently misinform readers, focusing on immediate individual stressors rather than ingrained cultural and societal practices or mental illness. Hence public understanding is often deeply flawed, with the resultant danger that the real issues that policies need to address are overlooked. **Accurate reporting is essential to garner public support for suicide prevention strategies.** The portrayal of suicide by the media can influence copycat suicides and publishing exam results can precipitate suicide. In other countries the **introduction of media guidelines has increased the likelihood of suicide coverage including positive information about warning signs and treatment.**

NEPAL'S LEGAL SYSTEM

Suicide risk is often mediated by protective measures operating within legislation outlawing practices and products encouraging or facilitating suicide. Nepal is party to international conventions relating to the rights of women, and is taking steps towards GBV, sexual harassment and marital rape, but this is not always reflected in legislation based on principles set out in 1854 and is entrenched with many discriminations on the basis of religion, caste / ethnicity, and sex. However, **the existence of appropriate legislation alone does not guarantee that appropriate legal action is taken:** awareness of laws relating to women's rights remains low; traditions and customs are so rigid that women do not seek justice; and laws protecting women from GBV are rarely invoked as authorities often sympathise with the perpetrator. **Changes in awareness, attitudes, and behaviour must supplement legal advances if meaningful progress is to be made.**

Another essential legal domain for suicide prevention efforts is mental health legislation. Nepal formulated a National Mental Health Policy in 1997, outlawing the discrimination and maltreatment of individuals with mental disorders. It is one of the only four South Asian Association for Regional Cooperation (SAARC) countries with a national mental health policy / law, and ***whilst the mental healthcare budget remains low (only 1% of the entire health budget), the issue is at least receiving increasing attention.*** The effectiveness of such provisions is likely to depend on wider efforts to de-stigmatise poor mental health. Furthermore, there is no regulatory body to monitor mental health facilities and impose sanctions on institutions that violate patients' rights.

BEREAVEMENT

Suicide can be a response to a single, triggering event, for which the victim cannot identify an alternative solution with the coping mechanisms at their disposal. One such event is bereavement. The 2008/09 MMM study highlighted cases of suicide victims unable to come to terms with the loss of one or more children. The taboo attached to widows in many Asian societies means that spousal bereavement may have particular implications for the quality of life of the surviving partner in these regions; for example, until 2007 child widows in Nepal were often left without legal identity.

ACADEMIC FAILURE

In many developing countries ***a good education is perceived to be the only means of securing a lucrative position in the future.*** Many individuals feel they have been fortunate to have the opportunity to receive an education and failure is perceived as wasting this precious advantage. The pressure to do well and

shame associated with failure, can lead to suicide. In Asia there is heavy competition for higher education places; considerable media hype associated with final school exam results and financial burdens can result in intense parental pressure. Young people often internalise study-related problems, precluding the engagement of alternative coping strategies. As such ***academic failure may have a disproportionately great impact on suicide amongst the young in Asia.*** Furthermore, young girls may turn to suicide following poor exam results for fear of being married off, instead of being allowed to study and earn their independence. In-depth case studies indicated the pressure from parents to work hard and do well at school.

INTERACTION OF MULTIPLE FACTORS

Rather than just one driver, ***multiple social, clinical and environmental factors often interrelate to determine the suicidal probability of a given individual.*** The relative weight of different underlying factors varies by context. In Nepal, The 2008/09 MMM Study highlighted that family, marital and relationship factors play a key role in contributing to suicides among women of reproductive age, with husbands and GBV being predominant compounding contributors. Similarly, chronic illness is compounded by inability to pay for care and academic failure is compounded by familial pressure and cost of education.

SUMMARY

This study highlights a multitude of drivers and compounding factors that increase suicide risk amongst women in Nepal. Further work is needed to explore policy and programmatic needs whilst recognising that suicide prevention is a complex task that requires a well co-ordinated multi-sectoral approach.

1.0 Introduction

Suicide is increasingly being recognised as a global public health concern. Every year an estimated 800,000 people commit suicide worldwide (Prince et al 2007), putting the global suicide mortality rate at 16 per 100,000 (WHO 2010). Furthermore, whilst many other health indicators, such as those included in the Millennium Development Goals (MDGs), have been slowly, but steadily improving, the global rate of suicide has risen by 60% in the last 45 years (WHO 2010). WHO predict that suicide will account for 2.4% of the total global burden of disease (GBD) by 2020 (Yeh et al 2008), thus is becoming a pressing health concern and funds may need to be redirected to reflect this.

The 2008/09 MMM Study revealed that suicide is the leading cause of death for women of reproductive age in Nepal (Pradhan et al 2010). Suicides therefore pose a considerable obstacle to improving women's health and the wider health agenda. Both attempted and completed suicide can have significant material and emotional consequences that extend beyond the individual to family and friends, particularly dependents (such as offspring, spouses and elderly), and those who have survived suicide are at increased risk of subsequent suicide (Sharma et al 2006). Therefore, in light of the finding from the MMM study, this report reviews the available literature and data on suicide and investigates possible reasons underscoring suicidal tendencies among women in Nepal, taking into account views from key informant interviews (KIIs). The literature primarily focuses on Nepal and nearby countries, and explores the heightened vulnerability of women with a view to informing future policy and programmatic interventions. Findings for men and from other countries are included for comparison, and where evidence from Asia is lacking.

Objectives

The main objectives of this study are:

- To review the available evidence on suicide in Nepal.
- To explore the burden of suicide among women in Nepal
- To explore the means of suicide used by women in Nepal
- To explore the characteristics of female suicide victims in Nepal
- To explore the underlying reasons for suicidal tendencies among women in Nepal and explore the interaction of multiple factors

2.0 Methodology

This report took the following approaches to review the evidence on suicide among women in Nepal:

- Literature Review
- Key Informant Interviews
- Quantitative data analysis
- Qualitative data analysis

2.1 Literature Review

We conducted a comprehensive literature search on suicide, primarily related to Nepal and nearby countries. However, findings for men and from other countries are included for comparison, and where evidence from Asia is lacking. Evidence provided in papers obtained through the initial literature search led to inclusion of other appropriate papers and reports. The review also included grey literature obtained through internet sources and reports from programmes and organisations who had not published through the databases searched.

2.2 Key Informant Interviews (KIIs)

We interviewed a total of 31 key informants working in Nepal with appropriate expertise in a range of fields including mental health, gender based violence, and suicide prevention including policy makers, programme managers, psychiatrists, Non Government Organisation (NGO) workers, human rights activists, general practitioners, paramedics, mental health activists and academics between August and September 2010 (Table 1). This included Psychiatrists working in government, non government and teaching hospitals, in and outside the Kathmandu valley. The general medical practitioners or paramedics included those working in emergency departments at various hospitals, as suicide cases are initially be assessed by this department. Of the 31 study participants 36% were females.

Table 1: Breakdown of Key informants interviewed

	No	%
<i>Profession</i>		
Policy Makers / Programme Managers	6	19.4
Psychiatrists	6	19.4
NGO Workers / Human Rights Activists	7	22.6
General Practitioners / Paramedics	7	22.6
Mental Health Activists	1	3.2
Academics	4	12.9
<i>Sex</i>		
Male	20	64.5
Female	11	35.5
<i>Caste / ethnicity</i>		
Brahmin / Chhetri	22	71.0
Newar	4	12.9
Janajati	4	12.9
Expatriate	1	3.2
	31	100

Interviews were conducted by three members of the study team, using a pre-designed guideline, and all the interviews were tape recorded and key points recorded by a note-taker accompanying the interviewer. The interviews were first transcribed into Nepali and then into English. Various themes were developed linked to the research objectives and a thematic analysis was carried out. Numerous quotes from the KIIs are included throughout the report. It is important to remember that the KII quotes included in this report represent the views of the respondents, and not the authors, and what they reveal may not necessarily be accurate. Names of respondents are not included to protect their identity.

2.3 Quantitative data

Nepal has a dearth of systematic, reliable and nationally representative data on suicide. We identified and were able to access the following sources of quantitative data on suicide in Nepal (the relevant data collection period is presented in brackets), and each of these is described in more detail in sections 2.3.1 – 2.3.5, below:

- 1998 Maternal Mortality and Morbidity Study (14th January 1997 to 13th January 1998)
- 2008/09 Maternal Mortality and Morbidity Study (13th April 2008 to 13th April 09)
- Police Data (June 2006 to July 2010)
- Tribhuvan University Teaching Hospital (TUTH) Burns Unit (13 April 2004 to 20 November 2010)
- End Violence Against Women (EVAW) Baseline Survey 2010 (15 September – 8 October 2010)

In addition we identified, but were unable to access, the following sources: Nepal Burden of Disease Study (conducted across 15 districts); surveillance data from Mother and Infant

Research Activities (MIRA) (located in Makwanpur and Dhanusha); and the Burns Violence Survivors (BVS), Bir Hospital, Kathmandu.

2.3.1 Nepal Maternal Mortality and Morbidity (MMM) Study 1998

The Nepal MMM Study 1998 (Pathak et al 1998) used a prospective surveillance system to identify all deaths to women of reproductive age (15-49 years) over the period of one year across three districts (Kailail, Rupandehi and Okhaldhunga). Verbal autopsies were conducted with relatives / friends / neighbours soon after the death. Of the total 640 deaths identified, 65 were suicide cases.

2.3.2 Nepal Maternal Mortality and Morbidity (MMM) Study 2008/09

The more recent Nepal MMM Study 2008/09 (Pradhan et al 2010) used a similar prospective surveillance system to identify all deaths to women aged 10-50 years over the period of one year (13 April 2008 to 13 April 2009), however this time across eight districts (Kailail, Rupandehi, Okhaldhunga, Surkhet, Jumla, Baglung, Rasuwa, Sunsari). Verbal autopsies were conducted with relatives / friends / neighbours soon after the death. The study identified 256 suicide cases (aged 10-50), of which 239 were to women of reproductive age (aged 15-49).

2.3.3 Police Data

Police data cover all suicidal incidents recorded for men and women of all ages across the whole country from June 2006 to July 2010 (2060-2067). In Nepal, post-mortems are a legal requirement for all suspected unnatural deaths. The police are responsible for taking the bodies of suspected suicide cases to facilities for post-mortem examination and for keeping records of all confirmed completed suicides in Nepal. We accessed suicide data from two sources in the Police Headquarters: the Crime Record System (CRS) and Central Record and Drugs Section (CRDS) under the Crime Investigation Department. The CRDS collects monthly paper based reports from the district police offices that include brief information on the total number of cases, broken down by means, sex, and whether under the age of 16. The CRS stores information on each suicide case electronically. However, districts often fail to send individual reports for all cases to the CRS so the total number of suicide cases reported by these two sources does not match. We accessed the CRS database containing suicide cases recorded from June 2006 to July 2010, and cleaned the data for analysis¹. Police data may under-report suicide cases as some people may unintentionally fail to report unnatural deaths as they are unaware of the legal requirements; furthermore stigma and socio-legal repercussions may influence intentional under-reporting. However, some cases due to other causes, such as homicide, may intentionally be reported as suicide and thus overestimate suicide figures if unnoticed. Fluctuations in the records may also be affected by reporting standards. These issues were highlighted through interviews with some of the KIIs.

¹ The CRS data includes information about age, sex, ethnicity, marital status, occupation, means of suicide and a case description (in Nepali). However, on reviewing the database we noticed the information in the case description did not match the other columns. Following discussions with officials in the CRS, the data has been corrected to reflect the case description. The data also contained duplicate records of the same case, homicide and accidental deaths and thus these cases were deleted, leaving 7916 suicide cases. It should be noted that this number does not match that made public through the Nepal Police's Spokesperson or the media for the same time period.

Police data may under-report suicide cases as some people may unintentionally fail to report unnatural deaths as they are unaware of the legal requirements; furthermore stigma and socio-legal repercussions may influence intentional under-reporting. However, some cases due to other causes, such as homicide, may intentionally be reported as suicide, and thus overestimate suicide figures, if unnoticed. Fluctuations in the records may also be affected by reporting standards. Problems with police records were mentioned in the KIIs:

“All suicide cases are not reported to police. Some people are not aware that suicide cases need to be reported to police and a number of those who know it intentionally don’t do this because they perceive that informing to police puts themselves at problem. There are some practical problems like responding to various questions raised by police and holding the final rituals until the post-mortem is done. Only few people particularly educated person and organisations, if involved somehow, report to police.”

- KII with an NGO Worker

“All suicidal cases attended by any health facility are reported to the police and a post-mortem is done. Any unnatural deaths, including suicide taking place in the community, also need to be reported to the police and dead body taken to an authorized public health facility for post-mortem. However, all suicidal cases taking place in the community are not reported to the police. Generally people prefer to avoid the legal procedures like police visiting the place and inquiring about the death with the family, colleagues, relatives and neighbours. It also results into delay in performing the final rituals. But we have never heard of a person being fined or imprisoned for suicidal attempt.”

- KII with a Policy maker

2.3.4 Tribhuvan University Teaching Hospital (TUTH)

As with other hospitals, despite storing patient records electronically, along with the ICD-10 code for cause of death, suicide data is under-reported. One unit in TUTH that does accurately record suicide data is the burns unit. Despite the nurses working in the burns unit recording whether it is a suicide, homicide or accidental case in their register, this is not recorded in the discharge sheet, and hence not entered in their electronic database. We were able to access the paper register from the Burns Unit at TUTH, that indicates whether a case is a suicide or not, and we entered all suicide data electronically for analysis. TUTH has recorded a total of 413 burn cases from 13 April 2004 to 20 November 2010 (01 Baishakh 2061 to 04 Mangsir 2067), of which 20% (82) of cases were suicide.

2.3.5 End Violence Against Women (EVAW) Baseline Survey 2010

United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF) and United Nations Development Fund for Women (UNIFEM) in collaboration with the Ministry of Women, Children and Social Welfare (MWCSW) have recently initiated the project "Multi-Sectoral Gender Based Violence Response at the District Level in Nepal" across four districts in Nepal, (Mahotari, Kapilbastu, Surkhet and Kanchanpur), with financial assistance from UNIFEM. It is a three-year project aiming to increase the utilisation of gender based violence (GBV) prevention and protection services by women, men and children for the improved protection status of women/girls, as well as supportive attitude by all community members.

A baseline study was conducted in 16 sampled village development committees (VDCs) from the four project districts. The study included a household survey; focus group discussions; interaction meetings with stakeholders; and a review of secondary information. The household survey was conducted among nearly 1060 households and used a structured questionnaire including sections on household information, socio-economic background information, knowledge on GBV and suicidal ideation. For the purpose of this report we accessed data related to suicidal ideation from the household survey from among female respondents aged 15–49 years.

2.4 Qualitative data

2.4.1 In-depth analysis of verbal autopsies, MMM Study 2008/09

To understand how the issues contributing to female suicide in the social, cultural and economic contexts of Nepal, 40 suicide verbal autopsies from the 2008/09 MMM study were studied in-depth. The cases were purposefully selected to include a selection of pregnancy-related cases, various forms of gender-based violence, and examples of mental and chronic illness. The in-depth cases provide rich insight into the factors that contributed to the suicide of individual women and girls; they shed light on the family context and nature of intimate relationships in Nepal and the care-seeking behaviour of families and neighbours in the case of mental illness and at the time of suicide. Many verbal autopsy respondents from the 2008/09 MMMS were re-interviewed between June and July 2010 to collect more comprehensive information for this report. All names used in this report have been changed to maintain confidentiality.

2.5 Ethical Consideration

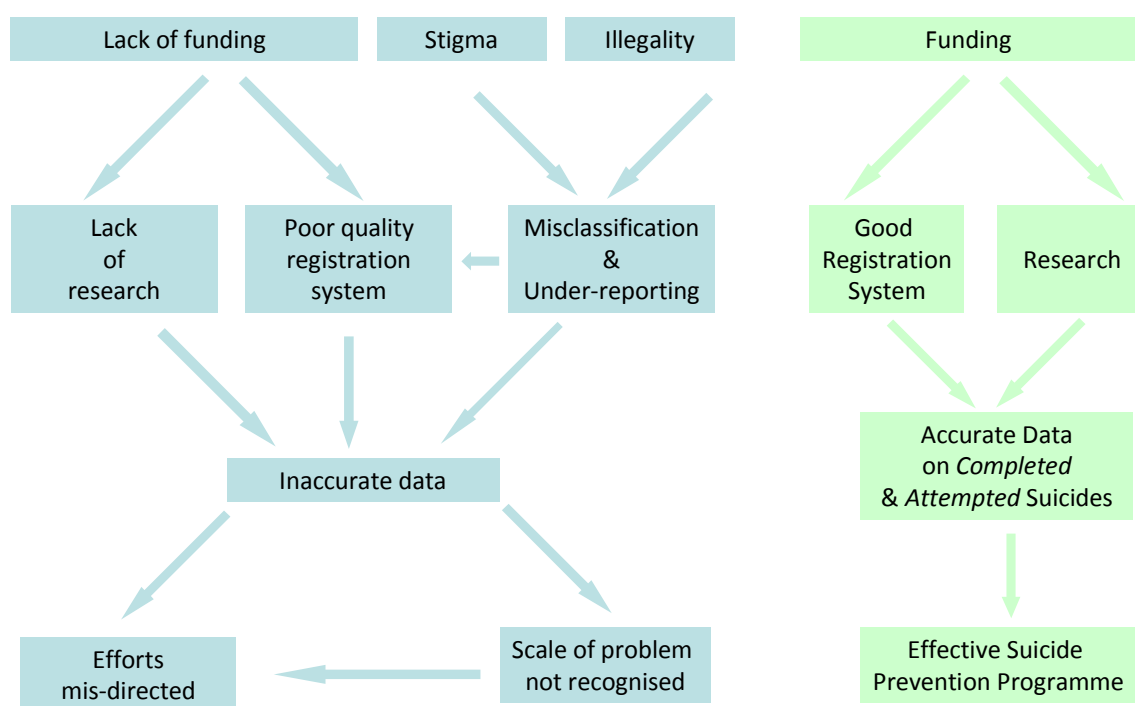
Most of the information used in this report has been sourced via a literature review and secondary data analysis. The key data collection process undertaken for the purpose of this study was the KIIs. Individuals were purposively selected for the KII's from a range of relevant backgrounds. The informed consent for the KIIs is included in Annex 1. The purpose of the study was explained to all participants, along with the expected length of the interview. Participants were informed that they had the right to refuse to be interviewed, to stop the interview at anytime, or to refuse any particular questions. They were given the opportunity to ask any questions at the time of interview and were given contact details in case they had any questions later. Interviewers requested permission to tape record interviews, and assured them that any information provided was strictly confidential. In the report where quotes are included, just the profession of the interviewee is mentioned.

During the 2008/2009 MMM Study verbal autopsies were undertaken for all deaths to women of reproductive age in the study districts. Some of these deaths included suicide deaths, however, as suicide was not the main focus of the MMM report, information describing the factors leading up to suicide was often limited in these verbal autopsies. Therefore, for the purpose of this study a number of suicide cases were re-visited to obtain more detailed information. Informed consent was requested from all verbal autopsy participants invited to participate in the interviews, and confidentiality was assured (form provided in Annex 2).

3.0 Monitoring Suicide & the Scale of the Problem

The collection of accurate statistics relating to the number and means of suicides, as well as to the characteristics of those manifesting suicidal behaviour, through an effective registration system is an essential component in order to determine an effective response for better planning and delivery of suicide prevention programmes as illustrated in Figure 1. Mis- or under- reporting of both attempted and completed suicides can lead to efforts being misdirected. Furthermore, mis-recording of suicide can unduly inflate other mortality categories. Therefore reliable information on suicide mortality will also help to provide a clearer picture of the mortality attributable to other causes (Bertolote et al 2006). Official statistics, if collected at all, often record only *completed* suicides, meaning that the number of *attempted* suicides, indicative of the true need for intervention, goes unacknowledged. WHO estimates that attempted suicides are in fact up to 20 times more frequent than completed suicides (WHO 2010).

Figure 1: Monitoring Suicide



There are often considerable disparities between the official suicide figures collected by government bodies and those captured by independent research. Studies from India, using verbal autopsy to validate national records, have estimated that the actual suicide mortality is likely to be between six and ten times higher than the official national figures suggest (Prince et al 2007; Sanghavi et al 2009). A further study in South Africa, comparing results from an intensive surveillance site to routine data collected by local health authorities, concluded that the latter missed 90% of pesticide poisonings (Bailie 2001). Cross-country comparisons are difficult given the inconsistencies between measuring systems and to date, India, Sri Lanka and the Maldives are the only countries in South Asia to report such figures to WHO (Khan 2002; WHO 2010). It is widely accepted that there is colossal underreporting of suicides worldwide, obscuring the true urgency of the situation.

There are many logistical and socio-cultural barriers to accurate suicide surveillance. On the logistical side, many developing countries have poor quality registration systems which preclude accurate data collection, and suicides are frequently misclassified. This may be accidental, i.e. due to the lack of ability of medical staff, or intentional by family members to avoid the socio-legal consequences which suicide entails in many Asian cultures. First and foremost, attempted and completed suicide remains illegal in many countries (such as Nepal, India, and Pakistan), family members may be fined in case of non-survival; while the victim may be liable for incarceration in the case of survival (Benson & Shakya 2008). Suicide may also lead to the social ostracism of family members, and may jeopardise marriage prospects (Khan 2002; Vijayakumar et al 2005a). It may also carry religious sanctions that alter the victim's funeral rites (Vijayakumar et al 2005a). As such, there is considerable motive to disguise completed suicides; similarly, the same reasons serve to delay and discourage seeking professional help in cases of attempted suicide, thus increasing the likelihood of death. Furthermore, there is the risk of informants intentionally misclassifying homicide cases as suicide, as this key informant expressed:

"I have seen a homicide by husband later claimed as a suicide case just to protect the husband. In Surkhet recently a woman was burnt by husband but later the case was dismissed claiming that it was a suicide."

- KII with an NGO worker

There are methodological weaknesses in retrospective data collection, which is prone to reporter bias, and can at best generate crude estimates. Most suicide research is also cross-sectional, not longitudinal, which leads to difficulties in establishing multiple underlying causes (Ellsberg et al 2008). Given this, qualitative verbal autopsies with the victims' friends and relatives soon after death are gaining currency in suicide research; although not exempt from reporter bias, it allows for an exploration of the factors underlying the victim's decision to take his/her own life and are therefore crucial to informing preventative interventions. Verbal autopsies may capture the influence of multiple factors that have been central to a victim's actions such as intimate partner violence or poor mental health (Yeh et al 2008).

Health Facility Record Keeping

Hospitals in Nepal record the final cause of death and corresponding International Classification of Diseases-10 (ICD-10) code for all patients. This suggests that hospitals should record all 'Intentional self harm' (i.e. suicide) cases under ICD-10 codes X60 to X84, with cases distinguished, where possible, by the type of method. For example, 'intentional self harm by smoke, fire and flames' should be recorded as X76. However, in reality most suicide cases are not coded as 'X60 to X84' in ICD-10 coding (for example burns cases are classified by the proportion and part of the body burnt), and hence are not reported to the Health Management Information System (HMIS) or reflected in the Department of Health Services (DoHS) Annual Report as suicides. Only one case of 'intentional self harm' was reported for both 2005/06 and for 2007/08, and none were reported for year 2008/09. Hence, the current record system in all hospitals is under-reporting suicide as a major cause of death.

Scale of the Problem

Although suicide is a global concern, 86% of completed suicides are estimated to take place in low- and middle-income countries (Prince et al 2007). A ten year study of a community in southern India found rates of suicide 50–70 times higher for girls and about four times higher for boys than rates in the USA and UK (Aaron et al 2004). Central and South East Asia (along with Europe) have been found to have a much higher rate of suicide than other regions (Lopez et al 2006; Jacob et al 2007). Few studies have measured suicide rates in Nepal (Jacob et al 2007 and Thapa et al 2000) and for many providers working in the field the lack of data means they are unaware of the true scale of the problem and trends over time:

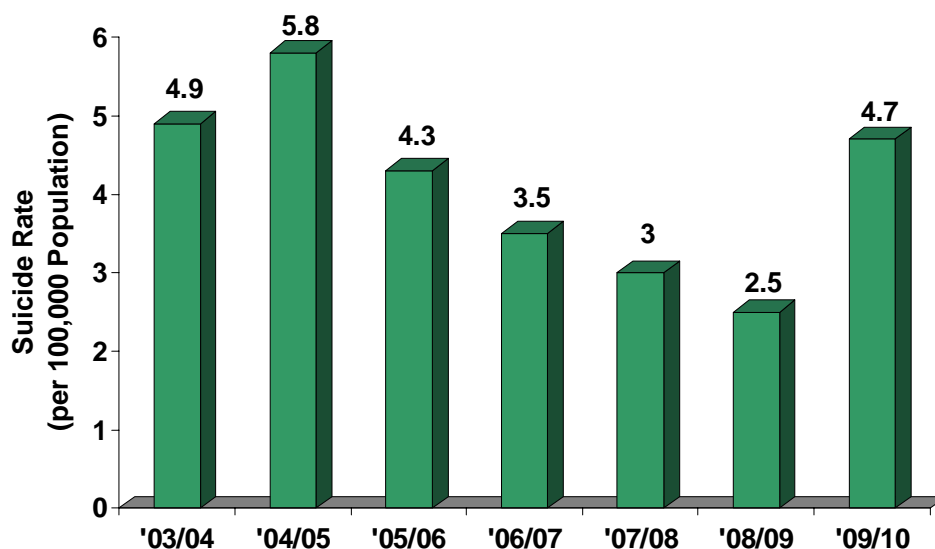
“..... we do not have a national level database on suicide. The report that comes to us is only for the facility level. We do not have the population data. It is very difficult to say whether the trend is increasing or decreasing in absence of actual data.

- *KII with a Psychiatrist*

Men and Women of All Ages

The police data show the overall suicide rate for Nepal from 2003-2011 ranging from 2.5 to 5.8 (Figure 2). A study conducted in Kaski district in 1998 found a suicide rate of 12.4 per 100,000 per year (Upadhyaya & Pol 1998).

Figure 2: Suicide rate (per 100,000) for men and women of all ages across Nepal, by year



Source: Police data 2003-2010 (2060-2066)
(NB Year 2010/11 excluded as data is not for a whole year)

The EVAW baseline survey provides unique data about suicide ideation in Nepal, as respondents in a household survey were asked about suicide ideation (Table 2). Most respondents (over 90%) had never thought of deliberately hurting themselves, tried to deliberately hurt themselves, thought about ending their own life, or tried to end their own life. However, 4% admitted to thinking about ending their life on a regular basis (once a month).

Table 2. Suicide ideation

	Never	Once a month	Once a week	Daily
<u>Have ever ...</u>				
Thought of deliberately hurting self	93.1	5.6	0.9	0.4
Tried to deliberately hurt self	95.4	4.2	0.2	0.2
Thought about ending own life	96.4	3.6		
Tried to end own life	99.5	0.5		

N = 1059

Source: EAW Baseline Survey 2010

Women of Reproductive Age

The Global Burden of Disease Report 2001 found suicide was the third leading cause of death in women aged 15-44 years internationally (Lopez et al 2006). In Nepal the 1998 MMM study showed that suicide was the leading cause of death to women of reproductive age (15-49) Pathak et al 1998), and this finding was repeated in the 2008/2009 MMM study (Pradhan et al 2010) (Table 3). In 1998 suicide accounted for 10% of all deaths among women of reproductive age; however, in 2008/09 the percentage of suicide deaths increased to 16%. The population rate also increased from 21.7 suicide deaths per 100,000 women of reproductive age in 1998 (in an estimated population of 299,072), to 27.7 per 100,000 women of reproductive age (in an estimated population of 861,312). The suicide rate recorded in the police data for women of reproductive age, across the whole country is much lower than those from the study districts in the MMM Studies. It is likely the police data is under-reporting suicide cases.

Table 3. Comparison of overall findings from MMMS 1998 and MMMS 2008/2009

	1998 MMM Study	2008/09 MMM Study	Police data 2008/09
Rank of suicide among individual causes	1 st	1 st	-
% of deaths attributable to suicide	10	16	-
Suicide Rate per 100,000 WRA	22	28	6.1
N	65/640	239/1496	

Source: 1998 and 2008/09 MMM Studies, Police data 2008/09

Table 4 shows the district breakdown from the MMM studies in 1998 where suicide accounted for 11% of deaths in both Kailali and Rupandehi, although the rate in Kailali (32.3 per 100 000 women of reproductive age) was double that of Rupandehi (16.5 per 100,000). The sample size in Okhaldhunga in 1998 is too small to make any inferences. In 2008/09 suicide was the leading cause of death in six out of eight of the study districts. It accounted for the highest percentage of deaths in Surkhet (21%), and the rate was highest in Kailali (41 per 100,000). Where the same districts have been included in both studies, an increase in the suicide rate can be seen over time, the rate in Kailali increased from 32 per 100 000 to 41, and in Rupandehi from 17 to 28. Likewise there has been an increase in the percentage contribution of suicide to all deaths.

Table 4. Contribution of suicide to women of reproductive age, by District

	% of deaths due to suicide	Suicide rate per 100,000 WRA	Rank of suicide deaths
<u>1998</u>			
Kailali	10.6	32.3	
Rupandehi	10.6	16.5	
Okhaldhunga	5.6	8.3	
Total	10.2	21.7	
<u>2008/09</u>			
Surkhet	20.9	35.9	1
Kailali	18.9	41.4	1
Okhaldhunga	18.0	24.8	1
Rupandehi	17.9	28.1	1
Rasuwa	16.7	24.1	1=
Sunsari	12.8	21.1	1
Baglung	7.0	8.4	2
Jumla	3.8	11.6	9=
Total	16	27.6	1

Source: MMM 1998 and 2008/09

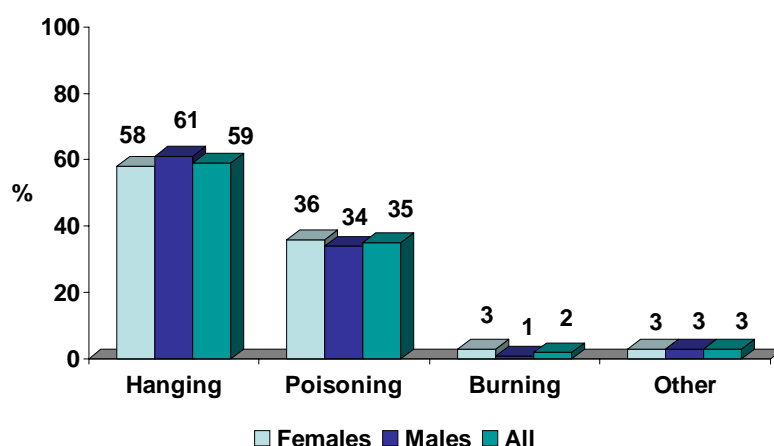
4.0 Means of Suicide

4.1 Choice of Method

A wide variety of methods are used to commit suicide globally and it is crucial to investigate trends in different contexts with a view to targeting prevention. The choice of method is often guided by both logistical and cultural factors, with some methods more lethal than others. Globally, the most popular means for attempting suicide are hanging, firearms, and poisoning (Ajdacic-Gross et al 2008). Research has indicated that the most common method by default is hanging, however, the proportion of hangings decreases as access to pesticides and firearms increases (Ajdacic-Gross et al 2008). This suggests that the accessibility and lethality of a given method is a determining factor in choice of method. Preferences vary significantly by region: in the US firearms are the method of choice, whereas in the Asia-Pacific countries, self-poisoning by pesticides is now the prevalent phenomenon: Gunnell & Eddleston (2003) estimate that this accounts for 300,000 deaths per year in this region. According to South East Asia Regional Office (SEARO) (SEARO 2003), poisoning is now the most common form of suicide in Sri Lanka (70%), Bangladesh (55%) and Indonesia (47%), and although several studies reveal a preference for hanging in India (Kanchan et al 2009; Sauvaget et al 2009; Saddichha et al 2010), the growing popularity of pesticide poisonings is irrefutable. Studies using population data are more accurate as facility based data are biased towards methods that have a greater chance of surviving long enough for a victim to be taken to a facility.

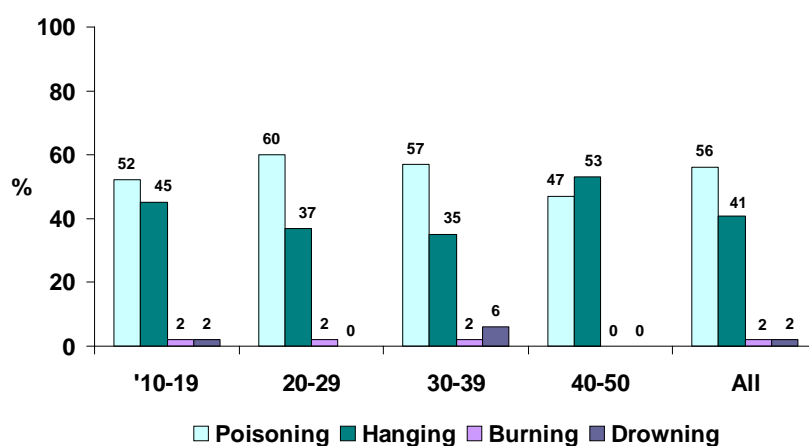
In Nepal hanging and pesticide poisoning consistently emerge as the two most common choices. Records from an emergency department at a hospital in Pokhara found poisoning to be the principal means of suicide among females, accounting for 92% of self harm cases, with 5% for hangings, the second leading means of suicide (Subba et al 2009). Records covering a three-month period at the Kathmandu Autopsy Center, Tribhuvan University found similar levels of hanging and pesticide suicides (Ed. J Nepal Med Assoc authors 2008). Analysis of police data from 2003-2011 revealed that hanging was the most common method (60%), with pesticide next at 35% (Figure 3). The remaining means (burning, drowning, jumping, and use of a sharp weapon) only accounted for 5% of cases. There was little difference in the means used by age-group or over time, although the time period from 2003-2011 is relatively short. For the purpose of this report, we revisited some cases from the 2008/09 MMM study to try to get as complete a picture as possible of the means of suicide for women aged 10-50 years. Poisoning was the main means of suicide among over half of the suicide victims (56%) (Figure 4). This was followed by hanging at 41%, while a minimal number of cases used other methods, with 2% each for burning and drowning. Poisoning was the main means of suicide in all age groups, except the 40-49 year olds, where hanging was the predominant method at 53%, compared to 47% for hanging. The results suggest that younger age groups may be more likely to use pesticides, but it is clearly a common means for all ages and interventions need to be aware of this. Although both the police data and the MMM 2008/09 data reveal that hanging and poisoning are the most common means, the police data revealed that hanging was the most popular means, while the MMM study revealed poisoning to be. We can not be certain of the reason for this, but it may be that hanging cases are more likely to die in the community and be reported to the police, while poisoning cases are more likely to be taken to a facility and less likely to involved the police.

Figure 3: Means of suicide for male and female victims, 2003-2011



Source: Police data 2003-2011

Figure 4: Means of suicide for female victims aged 10-50, by age-group 2008-2009



Source: Maternal Mortality and Morbidity Study 2008/09

As supported by the data from the 2008/09 study, there is a general perception that pesticide ingestion is fast becoming the world's leading suicide method (Bertolote et al 2006). The growing use of pesticides as a means of suicide in Nepal and wider Asia is sometimes attributed to imitation. The contagious character of suicidal behaviour is well-documented in the literature (Kim & Singh 2004; Herrera et al 2006; Beautrais et al 2008) and this may in part explain the increase in use of such a method (Ajdacic-Gross et al 2008; Kanchan et al 2009). However, easy access to pesticides also plays a significant role. Organophosphorous has been found to be the commonest type of poisoning at Dhulikhel hospital in central Nepal (ingested by 74 % of poisoning cases) (Marahatta et al 2009) and thought to be the most common poisoning agent in Nepal (Pokhrel et al 2008). The insecticides are readily available at a low price and they are a popular suicide method among those working in agriculture. They were also raised in the KII's:

“In Nepal organophosphate poisoning is the common method of suicide. Committing suicide using violence means such as Khukuri² is emerging as a means of choice specific to Nepali context. In eastern Nepal most of the suicides are committed by jumping down into the well and Koshi River. Similarly till few years back Rani Pokhari

² A sharp instrument often used in wars and for killing animals.

was a common place for suicide in Kathmandu. This proves that accessibility to means is an important factor in increasing suicidal rate.”

- *KII with a Psychiatrist*

This pesticide is commonly used in animal husbandry and as agricultural insecticides covering the whole range of crop growing and storage (European Commission 1998); as such it is readily available and found in most agrarian households in Nepal. Moreover, an increasing use of this poison has been noticed in young females: a study at Patan Hospital found that female poisonings outnumbered those by males, and almost two-thirds of patients were aged 15-34 years (Poudyal 2005); records for poisoning cases from the Emergency Department of Kathmandu Medical College & Teaching Hospital also found that poisoning was most common in the age group 21-30 years (Thapa et al 2008); and finally, a retrospective study of poisoning cases conducted at several central, zonal and district hospitals across Nepal found young females aged 14-34 account for the majority of admissions (Pokhrel et al 2008). However, from these data it is unclear whether these findings reflect differences in risk of suicide among these groups or differences in regards to choice of methods. The police data above suggest there is little difference in means by age and sex.

Self-immolation is rare in Western culture, but it is seen in South Asia, including Nepal, but more commonly in India (Greenbaum et al 2004). Research often links self-immolation to its religious connotations. In many countries in South Asia the practice of *sati* (where widows are expected to throw themselves on their husband's funeral pyre) has been traditionally widespread, and still continues in some parts of India despite its legal prohibition. Furthermore, many Hindu and Buddhist doctrines, two of the principal religions in South Asia, uphold burning as a means of cleansing the soul; as such people may view suicide by self-immolation as vindication for taking their own life. In spite of these considerations, Subba et al (2009) found that only 1.8% of the female victims in their study in Nepal had deliberately self-harmed by burning, and it only accounted for 3% of female victims in the police data and 2% from the 2008/09 MMM study, compared to a study from India where burns comprised 11.4% of the total fatalities. These disparities suggest that religious affiliation is inadequate to explain burning as a choice of suicide method, given Nepal, like India, is predominantly Hindu. The few incidents of self-immolation reported in the MMM study all occurred in the Terai districts which form the south border with neighbouring India (Pradhan et al 2010), providing support for the imitation theory. However, this may not just be about imitation, as the terai of Nepal is culturally more similar to India than districts in the hill and mountain areas. However, data from the burns unit at TUTH do not indicate that this is just a problem in the Terai areas, as 82% of cases admitted there were from Kathmandu and non-terai districts, and there was no difference between male and female victims (Table 5). However, it should be noted that many patients who usually reside outside of Kathmandu report Kathmandu as their place of residence, and terai cases may go to India rather than Kathmandu for treatment.

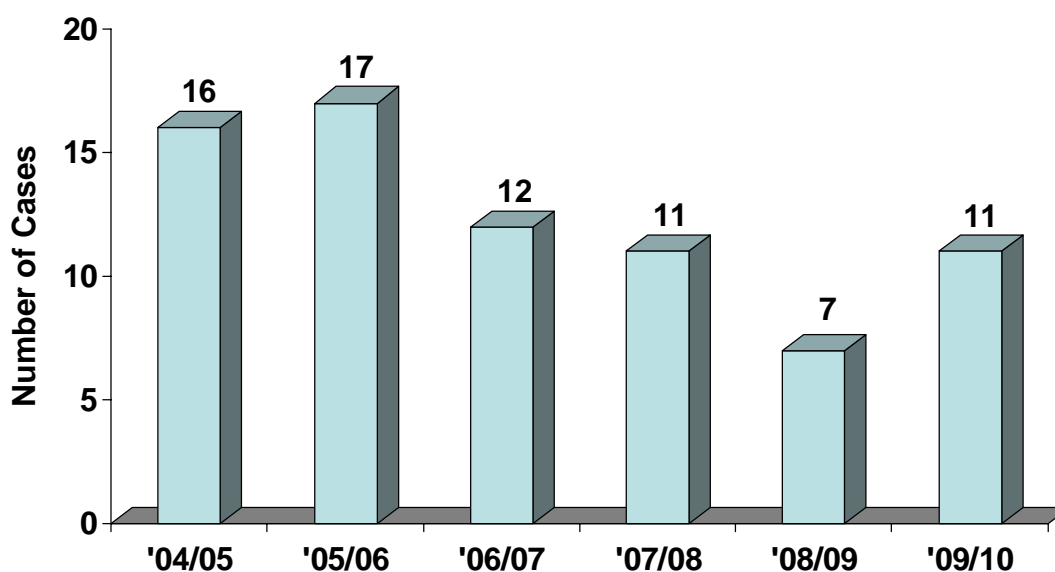
Table 5. Residence of burns suicide victims

	Females		Males		Total	
	No.	%	No.	%	No.	%
Kathmandu	33	51.6	9	50.0	42	51.2
Non Terai Districts	19	29.7	6	33.3	25	30.5
Terai Districts	10	15.6	3	16.7	13	15.9
India	2	3.1	0	0.0	2	2.4
Total	64		18		82	

Source: Burns Unit, TUTH 2004-2010

One fifth of cases admitted to the burns unit at TUTH are suicide cases (79% accident and 2% homicide), and their records show a steady number of cases with an average of 12 (*attempted and completed*) per year between 2004/05 – 2009/10 (Figure 5).

Figure 5: Number of suicide cases (completed and attempted) admitted to the Burns Unit at TUTH



Source: Burns Unit, TUTH 2004 – 2010

The choice of method used in a suicide attempt is determined by the interplay of several factors: access to and availability of a given method, socio-cultural and religious acceptability, and its popularity within a given region (Ajdacic-Gross et al 2008; Kanchan et al 2009). As such, interventions must be tailored according to the motivating factors underlying choice of method within a given context or subgroup of people, such as reducing access to lethal pesticides.

“Nineteen year old Shila was married to an army person. She belongs to a middle class family. She was not having a pleasant relationship with her husband. She frequently used to argue with him and was staying in her parent's home. In Aswin, she again quarrelled with her husband and she committed suicide by setting fire to herself.

Immediately afterwards a member of her parent's family called her husband and collectively they called an ambulance and took her to the Zonal Hospital. She was immediately admitted and medication was started. But after 3 days of medication in the zonal hospital there was no satisfactory improvement in her health and she was referred to Kathmandu. Her husband, being an army person, could admit her to the Army Hospital in Kathmandu where she was provided with the best service available. However, since her body was entirely burnt, she could not recover. In spite of 3 months of tireless efforts made by doctors in the Army Hospital, she ultimately died in the facility. Around Rs. 100,000 was spent on her treatment."

- Respondent for suicide verbal autopsy, MMM Study2008/09

4.2 Lethality of Method

The outcome of a suicide attempt may depend to a large extent on the fatality of the method used. For example, pesticide poisoning can be up to 50 times more fatal higher than paracetamol poisoning, more common method of self-poisoning in developed countries (Gunnell et al 2003). Misinformation and misconceptions surrounding the lethality of particular methods may increase the rate of completed suicides; studies in Sri Lanka and Iran have shown that often women who consumed pesticides or set themselves on fire only had the intention to shock, and were unaware that such actions might cause serious and irreversible damage (Laloë & Ganeson 2002; Ahmadi 2007). The verbal autopsies from the 2008/09 MMM study include examples of women and girls taking poison to threaten their husbands and families, not understanding the lethal nature of their actions, especially in the absence of timely and appropriate care.

"She used to get angry with her husband because of his alcohol intake, and one day in the evening she went to a room saying, 'I am going to die'. A few minutes later she started shouting, 'Save me, Save me'. Hearing her voice all her family member went to see her. She told that she had ingested poison and asked for help."

- Respondent for suicide verbal autopsy, MMM Study2008/09

One victim told her sister as she was transported to hospital that she only took the poison to threaten her husband. She died shortly after arriving in hospital. While a fourteen year old, who came from a poor family and whose mother had died a year earlier, impulsively committed suicide after asking her father for new sandals and being told that he could not afford them. She took an insecticide for killing bed bugs. In hospital she told her elder sister-in-law that she only took the poison to shock, not to kill herself. She died undergoing treatment. The link between impulsive behaviour among the youth was also highlighted during the KII's.

"Another is impulsive act during the young age. Most of the suicidal attempts due to impulsive acts are saved but in some cases they get completed."

- KII with a Psychiatrist

"There are some suicidal cases based on impulsiveness. Here the person reacts immediately and commits suicide without thinking."

- KII with a Psychiatrist

The literature suggests that ratio of attempted to completed suicides is higher among females than males, possibly due to men choosing more lethal methods than women. However, for those admitted to the burns unit at TUTH, females were more likely to have completed suicide than males (Table 6). The data showed that of the 82 cases admitted in the last six years 52% could not be saved. This suggests that for those admitted to the burns unit, there is roughly one attempted suicide for every completed suicide. Not surprisingly, those with a greater percentage of their body burnt were less likely to survive.

Table 6. Breakdown of completed and attempted suicides by burns victims

	Completed		Attempted		Total
	No.	%	No.	%	
<u>% Burn</u>					
<20%	0	0	3	100	3
20-39%	0	0	16	100	16
40-59%	9	40.9	13	59.1	22
60-79%	15	78.9	4	21.1	19
80%+	18	94.7	1	5.3	19
Missing	1	2.3	2	5.4	3
Mean (Min, Max)					56% (9%,100%)
<u>Sex</u>					
Female	37	57.8	27	42.2	64
Male	6	33.3	12	66.7	18
Total	43	52.4	39	47.6	82

Source: Burns Unit, TUTH 2004 – 2010

All suicide attempts should be taken seriously and not just dismissed as attention seeking behaviour. Currently stigma, legal implications, and lack of awareness and access to mental health services mean that most people who attempt suicide do not receive the professional or family help they need to prevent further attempts. Many of those who commit suicide have made previous attempts, as quotes from the MMM case studies and KIIs show:

“One year prior she had tried to commit suicide by having insecticide but she was saved by her step son.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“Generally there is a high possibility of repeated attempts when an attempt is not successful. A suicidal attempt is found to be successfully accomplished in 3rd or 4th attempts. Suicide thus could be prevented if initial signs, symptoms and attempts are well taken care of.”

- KII with a Psychiatrist

One of the most commonly reported gender differentials in suicidal behaviour internationally is the choice of method. Men often choose more violent and lethal methods, such as hanging and firearms, whereas women are more likely to choose self-poisoning, a less lethal method. Sociologically speaking, differences in gender roles and expectations may account for these differences in suicidal behaviour. The gender stereotype of men being

'tough' and 'strong' pushes men to select a more violent and lethal method of suicide; while women go for deliberate self-harm, with or without the intent of suicide, as a means of expressing their desire for attention and assistance. The gender differential in suicidal behaviour can also be influenced by how familiar or easily accessible a method is.

“Generally men get intoxicated before they use drugs with an intention of dying. While intoxicated they don't get the taste of drug easily so go for the whole amount of drug or use any other lethal methods to end their life. Women adopt less lethal methods like making scar marks on the wrist, cutting the vein and taking little poison. This is the reason why completed suicide is higher among men and attempted suicide higher among females.”

- *KII with a Psychiatrist*

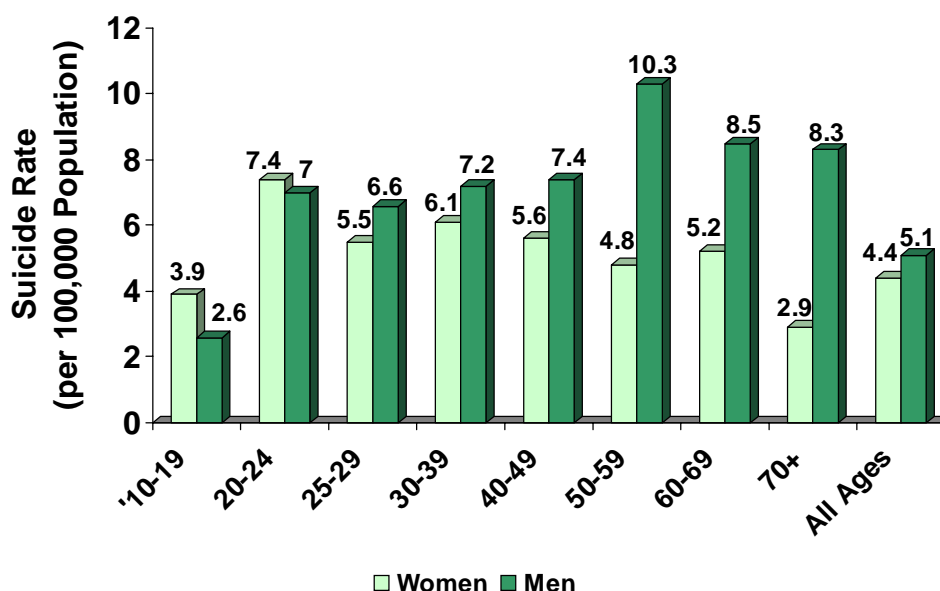
5.0 Profile of Suicide Victims

Given the lack of robust and routine data on suicide in Nepal, it is difficult to compile a profile of suicide victims. This section presents the analysis of the accessible data with the aim of identifying those who may be at greater risk of suicide. However, given the data limitations the findings appear contradictory at times and should be interpreted with caution.

Sex

One study conducted in Kaski district in Nepal in 1998 found a far higher suicide rate among men (18.9) than women (4.8) (Upadhyaya & Pol 1998). The rate for all women of reproductive age, from the 2008/09 MMM Study was 28 per 100,000 (Table 3), i.e. far greater than that reported in the Kaski study for either men or women. Data sources that enabled comparisons by sex were the police data and the burns unit data at TUTH. The police data revealed that from 2003-2010 men accounted for a slightly higher percentage of deaths (55%) than women (45%) (Table 7). We used population projections for 2009/10, the last available full year's worth of police suicide data, to compute rates to provide a more accurate comparison by sex (Figure 6). The results show that, like the Kaski data, men have a higher suicide rate than women, however, the difference was not as stark at 5.1 per 100,000 compared to 4.4 per 100,000. Figure 6 also shows the difference between men and women across the age-groups. Interestingly, the findings suggest that suicide rates are higher for women at younger ages, i.e. between the ages of 10-24. However, after 35 the rates are consistently higher for men, with the gap between the sexes increasing dramatically after the age of 50.

Figure 6: Suicide rates by sex and age-group



Source: Police data 2009-2010 (2066)

The data from the burns unit at TUTH indicate that 3.5 times more women were admitted than men (Table 7). This reflects the police data for the means of suicide presented in Figure

3, which revealed that burning is three times more common as a means of suicide for women than men.

Table 7: Breakdown of suicide data by sex

Sex	Police Data 2003-2011		TUTH Burns Unit 2004-10	
	No. of suicide deaths	%	No. of suicide deaths	%
Female	3556	44.9	64	78.0
Male	4358	55.1	18	22.0
Missing	2	0	-	-

Age

The only sources accessed that collected suicide data for all ages were the police data and TUTH burns unit data. The data highlight that suicide is a problem for all ages, with the police data revealing suicide victims ranged in age from seven to 97, with an average age of 35, and burns unit victims ranged in age from 15 to 70, with an average age of 28 (Table 8). Figure 6 shows the rates broken down by age and sex for 2009/10. For women the rates are lowest at each end of the age spectrum, i.e. before the age of twenty and from seventy onwards. The suicide rate peaks for those aged 20-24 at 7.4 per 100,000, and the risk remains fairly consistent between the ages of 25-69. Although men also have a lower rate before the age of twenty, the pattern after this age differs to women. The rate remains fairly consistent between the ages of 20-49, but the risk of suicide increases substantially after 50 years of age.

Table 8: Breakdown of suicide data by age-group

Age group	Police Data 2003-2011		MMMS Data 1998		MMMS Data 2008/09		TUTH Burns Unit 2004-10	
	No. of suicide deaths	%	No. of suicide deaths	%	No. of suicide deaths	%	No. of suicide deaths	%
<19	1101	13.9	18	27.7	51	21.3	15	18.3
20-24	1197	15.1	19	29.2	52	21.8	21	25.6
25-29	958	12.1	9	13.8	47	19.7	21	25.6
30-34	763	9.6	4	6.2	31	13.0	9	11.0
35-39	726	9.2	6	9.2	21	8.8	8	9.8
40+	2625	33.2	9	13.9	37	15.5	8	9.8
Missing	546	6.9					-	-
Mean	35						28	
(Min, Max)	(7,97)						(15,70)	

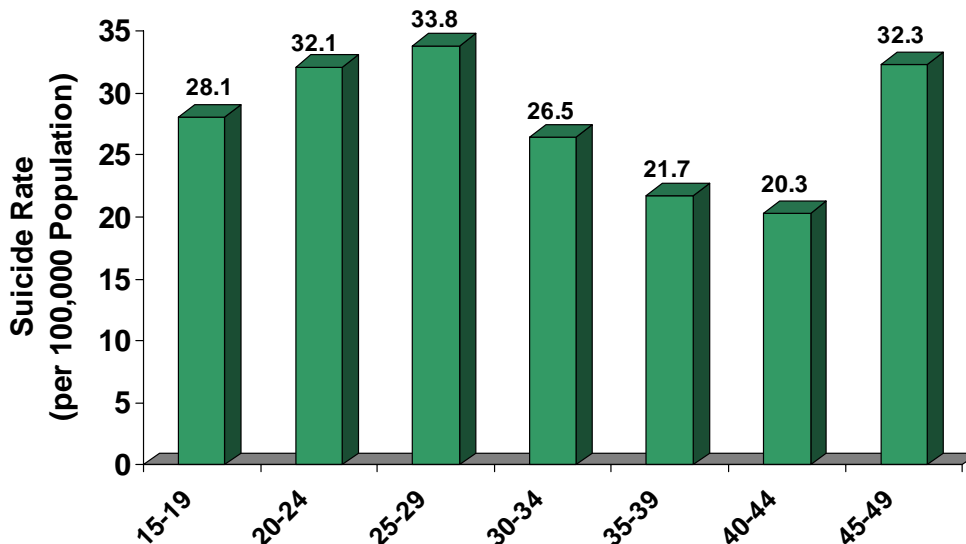
The MMM 1998 and 2008/09 Study data reveals a variation in the proportion of suicide deaths to women of reproductive age by age. In 2008/09 suicide accounted for a higher

proportion of deaths among younger women than older women: accounting for nearly one quarter of deaths for those aged 15-34 (24%) compared to just 8% for 35-49 (Table 9). Furthermore, 63% of suicide deaths to women of reproductive age occurred to women aged 15-29 (Table 8). However, these percentages should be interpreted with caution as they are likely to be influenced by older women being more prone to dying from other causes. Hence for a more accurate comparison we used population data to compute rates (Figure 7). The rates by five year age group range from 20.3 to 33.8, and suggest there may be an increased risk of suicide for ages 15-34, a reduced risk for those aged 35-44, and then an increased risk again after 45. The reduced risk for those under the age of twenty, seen in the police data above, is not reflected here, and it is likely the inclusion of those aged 10-14 in the police data has contributed to this difference.

Table 9: Percentage of deaths due to suicide, by age-group

Age group	MMMS 1998		MMMS 2008/09	
	No. of deaths to WRA	% of deaths to WRA due to suicide	No. of deaths to WRA	% of deaths to WRA due to suicide
15-19	121	14.9	202	25.2
20-24	105	18.1	203	25.6
25-29	90	10.0	202	23.3
30-34	68	5.9	137	22.6
35-39	75	8.0	221	9.5
40-44	89	4.5	194	8.2
45-49	92	5.4	337	6.2

Figure 7: Suicide rates by age-group

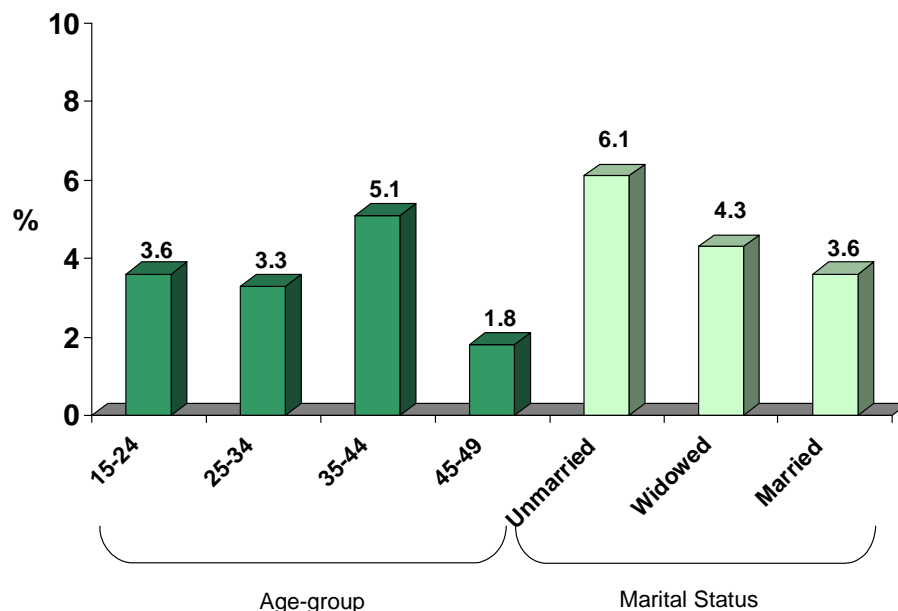


Source: MMMS 2008/09

In the analysis of the EVAW Baseline Survey we looked at the percentage of respondents in each age-group who revealed that they had either contemplated or attempted suicide. It should be noted the sample size is small and caution should be taken in interpreting the results. The findings revealed the highest percentage of suicide ideation among those aged

35-44: where 5% of respondents reported that they had either contemplated or attempted suicide (Figure 8). The percentage was lower for women aged 45-49 (1.8%).

Figure 8: Percentage of respondents contemplated or attempted suicide by age-group and marital status



Source: EVAW Baseline Survey 2010

Marital Status

Both the police data and 2008/09 MMM study show that most suicide victims in Nepal are married (Table 10). This is not surprising, given the high prevalence of marriage. However, the findings from the 2008/09 MMM study also indicated that suicide accounted for a far greater proportion of deaths among the unmarried (25%) than the married (15%) or the separated / divorced / widowed (14%) (Table 10). This suggests a greater risk of suicide among the unmarried, although population data broken down by marital status for this year is unavailable to verify this with rates. However, it is supported by the EVAW Baseline survey, which revealed that 6.1% of unmarried respondents had contemplated or attempted suicide, compared to 4.3% of widowed and 3.6% of married respondents (Figure 8).

Table 10: Breakdown of suicide data by marital status

Marital Status	Police Data 2003-2011		MMMS Data 2008/09			
	No. of suicide deaths	%	No. of suicide deaths	%	No. of deaths to WRA	% of deaths to WRA due to suicide
Married	6660	84.1	174	72.8	1191	14.6
Unmarried	646	8.2	50	20.9	197	25.4
Separated / Divorced / Widowed	610	7.7	15	6.3	108	13.9

Religion

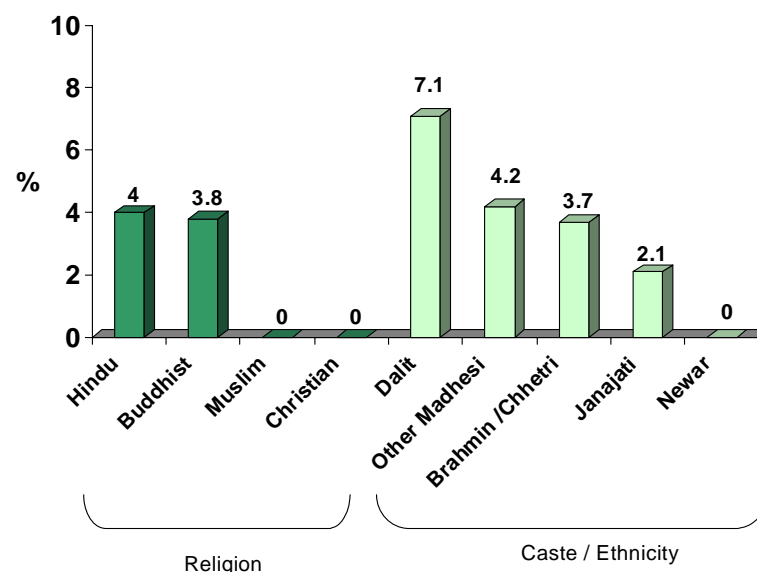
Given that 81% of the population of Nepal are Hindu (CBS, 2001) it is not surprising that most suicide victims in Nepal are Hindu. Therefore, in the 2008/09 MMM study we examined the proportion of deaths suicide accounted for within the different religions. The results showed that, for women of reproductive age, suicide accounted for approximately one third of deaths among Kirants (36%) and Christians (31%), and this was nearly twice that of Buddhists (17%) and Hindus (16%), which in turn were far higher than Muslims, where suicide accounted for just 7% (Table 11). Unfortunately no population data are available broken down by religion to enable rates to be calculated.

Table 11: Breakdown of suicide data by religion

Religion	MMMS Data 2008/09				TUTH Burns Unit 2004-10	
	No.	%	No. of deaths to WRA	% of deaths to WRA due to suicide	No.	%
Hindu	221	92.5	1378	16.0	77	93.9
Buddhist	6	2.5	58	6.9	2	2.4
Muslim	4	1.7	36	16.7	3	3.7
Christian	4	1.7	13	30.8		
Kirant	4	1.7	11	36.4		

The low rate among Muslims is also reflected in the results of the EAW survey: with no Muslims reporting that they had contemplated or attempted suicide (Figure 9). However, there are no similarities between this survey and the 2008/09 MMM data for the other religions, with 4% of Hindus and Buddhists interviewed revealing they had contemplated or attempted suicide, while no Christians had.

Figure 9: Percentage of respondents contemplated or attempted suicide by religion and caste/ethnicity



Source: EAW Baseline Survey 2010

Caste/ethnicity

The distribution of suicide deaths by caste / ethnicity may be influenced by the respective proportions of the different castes / ethnic groups in Nepal (Table 12) and hence need to be interpreted with caution. Likewise looking at the percentage of deaths within these groups attributed to suicide may reflect the fact that some groups, for example Dalits, may be more likely to die due to other causes. Unfortunately no population data are available broken down by caste / ethnicity to enable rates to be calculated. The MMM study 2008/09 revealed the groups with the highest proportion of suicide deaths were Janjati (20%), Brahmin / Chherti (17%), while proportions were far lower for Dalits (9%) (Table 12). This is in contrast to the ERAW survey data (Figure 9) where a higher percentage of Dalits report that they had contemplated or attempted suicide, at 7%, compared to 4% of other Madhesi and Brahmin / Chhetri.

Table 12: Breakdown of suicide data by caste/ethnicity

Caste / Ethnic Group	Police Data 2003-2011		MMMS Data 2008/09				TUTH Burns Unit 2004-10	
	No.	%	No.	%	No. of deaths to WRA	% of deaths to WRA due to suicide	No.	%
Janjati	2482	31.4	109	45.6	548	19.9	14	17.1
Brahmin / Chhetri	2762	34.9	67	28.0	385	17.4	30	36.6
Terai / Madheshi / Other Caste	1019	12.9	29	12.1	188	15.4	10	12.2
Dalits	832	10.5	25	10.5	281	8.9	11	13.4
Muslim	114	1.4	4	1.7	65	6.2	2	2.4
Newar	424	5.4	3	1.3	19	15.8	14	17.1
Other	232	2.9	2	0.8	10	20.0	1	1.2
Missing	51	0.6						

Education

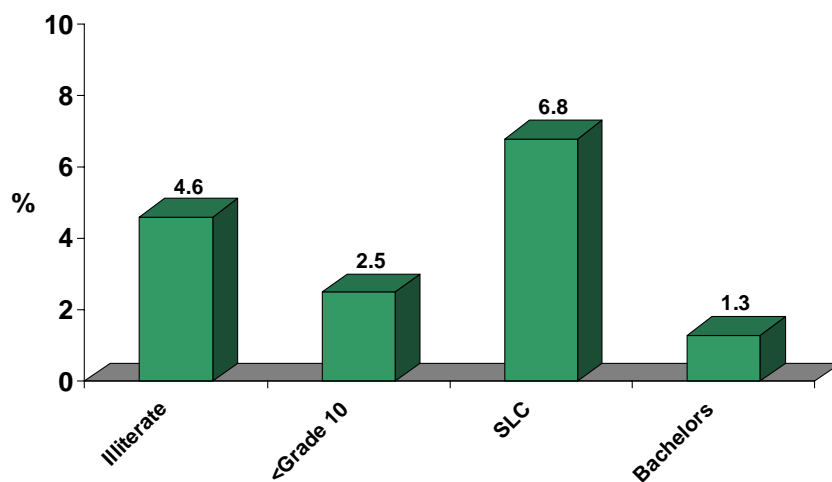
The MMM study 2008/09 revealed that most suicide victims among women of reproductive age received no schooling and are illiterate (44%) (Table 13). Again this is likely to be affected by the higher proportions of the population in these categories. Therefore we looked at the proportion of deaths attributable to suicide within these groups. This analysis revealed that suicide actually accounted for more than double the proportion of deaths among those who went to school (27%) compared to those who did not (12%) (Table 13). It is feasible that those who did not attend school may be more likely to die from other causes, and hence the proportion of suicide deaths may be lower. However, once again population data broken down by education is unavailable for this year and hence it's not possible to calculate rates for a more accurate comparison.

Table 13: Breakdown of suicide data by education

Education	MMMS Data 2008/09			
	No. of suicide deaths	%	No. of deaths to WRA	% of deaths to WRA due to suicide
No schooling illiterate	105	43.9	893	11.8
No schooling literate	31	13.0	210	14.8
Grade 0-5	40	16.7	149	26.8
Grade 6-9	36	15.1	154	23.4
School Leaving Certificate (SLC) passed or higher	27	11.3	84	32.1
Don't know			6	
Total	239		1496	16.0

The EAW survey data (Figure 10) revealed that the education group most likely to report that they had contemplated or attempted suicide, at 6.8%, were those whose highest educational achievement was the School Leaving Certificate (SLC). Next were illiterate respondents, at 4.6%. Interestingly, lower rates were seen for those who either had some education or were literate, but did not reach the SLC, at 2.5%, and for those who progressed beyond the SLC, at 1.3%.

Figure 10 Percentage of respondents contemplated or attempted suicide by education



Source: EAW Baseline Survey 2010

6.0 Underlying Reasons for Suicidal Tendencies

A wealth of international literature explores the underlying reasons for suicidal tendencies, and many determinants have been identified as causal stimuli in victims around the globe (Vijayakumar & Rajkumar 1999; Vijayakumar et al 2005b). However, without understanding why these determinants increase suicide risk in a given context, suicide prevention efforts will be largely reduced to targeting these factors on an *ad hoc* basis, rather than providing any comprehensive strategy to foster the conditions needed to discourage suicide on a wider basis.

A useful model for assessing suicide risk is offered by Herrera et al (2006): the authors note how underlying structural conditions cultivate an environment that is either conducive to or protective against suicide, in which a single precipitating event may cause an individual to consider suicidal behaviour. Before attempting suicide, an individual's decision may be mediated by their personal temperament and the emotions deriving from this, and alternative strategies available to them, such as personal coping mechanisms. Thus, suicide risk entails both idiosyncratic and social elements. This supports the theory put forward by Emile Durkheim in the late 1800s which constructed suicide as a social product resulting from social conditioning (Durkheim 1897); as such, both individual characteristics and the wider societal framework must be considered in an analysis of suicide risk.

This section is divided into four subcomponents: first, the effect of an individual's social and demographic characteristics upon their suicide risk will be considered; second, their clinical status; third, the environmental conditions that may encourage or protect against suicidal behaviour, and finally the effect of recent stressful life events.

6.1 Effect of Demographic and Socio-Economic Characteristics

6.1.1 Age

Historically, elderly men have been shown to be at highest risk of suicide (Durkheim 1897; Vijayakumar et al 2005b; WHO 2010). Vulnerability naturally increases in old age: individuals become less productive, less able to provide for themselves, more likely to suffer health problems and may have reduced access to medical care (Kohrt et al 2009). Suicidal tendencies can be mediated by social transfers, such as healthcare and state pension. Given that life expectancy is improving worldwide and birth rates reducing, there has been an increase in the proportion of elderly people. This has serious implications for social provisioning, as has been the case in Japan and Hong Kong, where the rapid increase in elderly led to insufficient support (Kwon et al 2009).

More recent evidence suggests that younger people have emerged as an additional high risk age group. The combination of developmentally incomplete psychological coping mechanisms at a time when many of life's major stressors are encountered for the first time puts younger people at a unique psychological vulnerability (Farzaneh 2010). The changing suicide demographic with regard to age is reasonably consistent across the globe, and Nepal is no exception: 43% to 60% of suicide deaths to women of reproductive age were aged 15-24 (Pradhan et al 2010; Subba et al 2009). The heightened levels of suicide in younger age groups has significant implications for Nepal, where over 50% of the population is 19 or under (Ministry of Health and Population 2006), and particularly with the high rates amongst

young women, it will impact upon support for dependents. The increased risk at either end of the age spectrum was mentioned in the KIIs:

“A graph showing age of the people who committed suicide looks like a hump of a camel. It is high among the people aged below 20 years and above 35 years,” says a senior psychiatrist.

- *KII with a senior psychiatrist*

While others drew attention to the fact suicide is a problem for all ages:

“Suicidal tendency can be developed in all age group. We have heard of small children committing suicide.”

- *KII with a Mental health activist*

6.1.2 Marital Status

Findings from developed countries support Durkheim’s postulation that a traditional family structure, founded upon marriage and childrearing, does indeed lower suicide risk (Durkheim 1987). Married individuals have been found to be at lower risk of suicide than single persons (Qin et al 2003). This association may be due to a *protective effect* due to the security offered by marriage during times of hardship, or a *selection effect* whereby healthier individuals are more likely to get married and stay married. It has been suggested that family and social integration may be an even more significant factor in suicide risk than marital status (Vijayakumar et al 2005b).

The picture in less developed countries, however, is not the same, and the protective effect of marriage is less evident. Several studies found no difference in suicide risk based on marital status (Vijayakumar et al 2005b). Vulnerabilities suffered by married women in developing countries, particularly by young married women in Asian societies, may outweigh any protective factors afforded by marriage. A case-control study of women of reproductive age in Pakistan, found a positive association between depression and arranged marriage and younger age at marriage (Ali et al 2009). In Nepal, it is not uncommon for women to have forced marriages, marry at a young age, and to have a large age gap between husband and wife. Since divorce is highly stigmatised, there is often social and familial pressure to stay married even in an abusive or unhappy relationship (Laloë & Ganeson 2002; Vijayakumar et al 2008; Yeh et al 2008; Ratnayake & Links 2009). These issues were highlighted in the 2008/09 MMM verbal autopsies:

“Somala had love affair with a boy but her parents got her married to another boy forcefully. So she committed suicide by hanging herself.”

- *Respondent for suicide verbal autopsy, MMM Study2008/09*

“According to the neighbour she had a love affair with a boy. One day she left home giving the reason that she was going to work, but she married that boy and did not return back home. She was taken back by her father, who scolded her. She was also physically assaulted. She could not tolerate that so she committed suicide.”

- *Respondent for suicide verbal autopsy, MMM Study2008/09*

All of these factors can reduce a young woman's bargaining power and household decision-making capacity, increasing her susceptibility to physical and psychological violence and heavy domestic duties. Furthermore, women may suffer from their husband or his family's dissatisfaction with dowry payment; spouse's drinking problem or an increased likelihood of physical and mental health problems due to young age at first parity. In Nepal, suicide accounted for a far greater proportion of deaths to unmarried women of reproductive age (25%), compared to married women (15%) (Pradhan et al 2010).

"She was newly married at the age of 17. After marriage she used to be mentally stressed as she was not happy in her new house. Every morning there used to be frequent quarrelling regarding her dowry, her in-laws always used to ask her about the dowry. Later on her husband also started to listen to his parent's demands and started to neglect her."

- Respondent for suicide verbal autopsy, MMM Study2008/09

The 2008/09 MMM study found that although most suicide deaths were to married women, that reflects the higher proportions of women married in society, and in fact suicide accounted for a far greater proportion of deaths to unmarried women of reproductive age (25%), compared to married women (15%) (Pradhan et al 2010).

In the past, Nepal has had highly conservative and patriarchal views towards marriage, largely derived from the Hindu concept of marriage. Hindu doctrine 'prohibits youth participation in spouse selection and considers the virginity of a bride-to-be the most essential qualification for marriage, therefore encouraging early marriage arranged by parents' (deJong et al 2006). A pattern observed from the KIIs data revealed how the familial pressure placed on young girls to marry according to parental arrangements and how the lack of control they have over their lives can drive them to suicide, and are supported by cases from the verbal autopsy:

"According to her mother, Usha, at the age of 15 was not interested in getting married. But the arrangements had been made and the boy and his family had come to visit her. That day, Usha consumed pesticide and died in hospital."

- Respondent for suicide verbal autopsy, MMM Study2008/09

"Females are at high risk of suicide when they are forced into a marriage."

- KII with Psychiatrist

There has, however, been a noticeable and increasing propensity towards love marriages and choice in arranged marriages in recent years (deJong et al 2006; Puri et al 2010), and more young people being allowed to participate in partner selection. Social norms are becoming more relaxed regarding inter-caste marriage, previously considered unacceptable given the centrality accorded the institution of marriage in forcing alliances with desirable lineages (deJong et al 2006). The GoN announced in July 2009 budget that cash incentives of Rs. 100,000 would be given for marriage between dalits and non-dalits, and the couple must stay together for at least seven months after their marriage is registered to be eligible for the full benefit.

KII respondents believe that these government policies to encourage intercast marriage and re-marriage of widows has helped in reducing society. However, *“there has been much debate about whether this policy improves the status of ... Dalits or contributes to further social stigmatization and humiliation. While the initiative to address these issues through policy is encouraging, implementation risks, such as financially motivated marriages, may be counterproductive and lead to more burdens without effectively achieving attitudinal change”* and it's still considered unacceptable by many in society (ADB, 2010). Women in Nepal may still be rejected by family members for pursuing love marriages, largely when it is inter caste, leaving them isolated if marital problems later occur.

“According to villagers, her family members did not talk to her since she had love marriage.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

Views on divorce and widowhood demonstrate changing perceptions and reduced stigmatisation in Nepal: almost 40% of Nepalis interviewed in Chitwan felt that divorce was better than an unhappy marriage and 61% of respondents felt that a young widow should remarry (deJong et al 2006). Although considerable time may pass before behaviour reflects these views, changing ideals surrounding marital behaviour may impact on suicide rates in Nepal. The government had proposed a scheme to provide incentives of Rs. 50,000 to marry widowers, however, after much debate and criticism this was dropped. Several of the verbal autopsies reported women who found themselves in unhappy, although not necessarily abusive, marriages leading to threatened or attempted suicide and such women often do not receive the professional help they need.

“Anjali had completed her bachelor’s degree, married and eight months pregnant when she committed suicide. Before marriage she had an affair with a boy from a different caste, and was still in love with him. She attempted suicide before her marriage, and threatened suicide shortly after getting married; she wanted a divorce. The week before committing suicide it was believed that she had met her earlier boyfriend in her maternal village, though it was not clear whether they were still having a relationship. She hung herself.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

Affairs or suspected affairs, either on the part of the husband or the wife, were commonly reported in the verbal autopsies. However, in reading the transcripts one needs to consider these accounts may be biased by who reports them. Rumour mongering and anxiety led to suicide in some cases.

“Ramshova lived happily with her husband and independent from his family. When he went to a friend’s wedding, rumours started in the village that he had taken a second wife, which he hadn’t. Unable to cope with the emotional trauma she swallowed insecticide and died in hospital before his return.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

Transcripts referred to affairs or suspected affairs on the part of the wife, as well as the husband:

“One day before her death, in the evening her husband had gone for work and returned back at 10pm. ‘I found her sleeping with other man in my bed and I slapped her 3 times,’ says her husband. After that she dived in the well near her home.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“Her husband was having affair with a girl and because of that they used to quarrel. Her husband would take his girl friend on his motorcycle which she did not like. On 25th Srawan 2065, her husband and his girlfriend went to Kathmandu on motorcycle. When he returned back in the evening, the two quarrelled violently and she left her home. Next morning she was found hanging below the staircase of a hotel in the bazaar.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

In settings where women are expected to marry, the lack of marriage can cause tension among the family. Chronic illness was noted as one reason behind non-marriage related suicide in some transcripts:

“Rita was a tuberculosis patient however, after regular check-ups and medication, she was cured. As she was suffering from tuberculosis (TB) and her treatment continued for a relatively long time, her younger sister got married, overtaking her turn. Though she was having pleasant relationship with her family members, she was mentally stressed from remaining unmarried and her younger sister getting married before her turn. Due to the complex, she took poison.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“Sarita was suffering from Bone T.B and she was undergoing treatment from India. The disease was to some extent treated but the doctor involved in her treatment advised her not to get married.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.1.3 Parental Status

Studies in Denmark found a positive impact of the presence of children on suicide risk (Qin & Mortensen 2003), although the influence may be restricted to younger children (Qin et al 2003). Several reasons for the protective tendency of children were reported: firstly, their presence might augment parents' feelings of self-worth through being needed (particularly relevant when children are young); secondly, children may provide emotional and financial support; and lastly, a *selection effect* means that healthier individuals, both physically and mentally, are more likely to have children. The effect of children was stronger for women than men, leading the authors to conclude that, “being a parent of a young child, rather than being married per se, appeared to explain the apparent protective effect of marriage for women, whereas marriage appeared to be a protective factor in its own right for men” (Qin et al 2003). Involving widowed or never married women in raising their siblings' children or their own grandchildren may help to maintain emotional linkages that protect them from suicidal tendencies (Yeh et al 2008).

In developing countries, the protective effect of children appears to be weaker such as Nepal, where all women are expected to bear children. Case studies from the MMM study showed that most suicide victims had children, but also, and perhaps more shocking, that young children often witnessed the tragic event; that mothers threatened their children that they would commit suicide; or that children were the first to find their mother's body.

"After hearing her daughter crying continuously, and no any attempt being made to make her quiet, her neighbour approached and found Radha hanging in the same room."

- Respondent for suicide verbal autopsy, MMM Study2008/09

"Her maternal home was in India, and she used to live there with her husband and five children. However, one year ago they moved to her husband's home in Nepal although her husband remained in India for work. She had to manage food and education for her children, and no one was there for her support. She was usually tense. Sometime she used to threaten her children by saying "look I am dying by hanging" said her mother in law. On the day of her death she quarrelled with her own daughter and hit her with metal water jug. She was also physically assaulted by her daughter. She hanged herself in her room with her own shawl."

- Respondent for suicide verbal autopsy, MMM Study2008/09

Some of these children would not only be left without a mother, but also a father:

"The child was taken away to the maternal home and no one knows where the husband is."

- Respondent for suicide verbal autopsy, MMM Study2008/09

"Poonam married around seven year ago. Her husband died around one and half years ago. She had a small child. Mental stress due to death of her husband, she also committed suicide by taking poison."

- Respondent for suicide verbal autopsy, MMM Study2008/09

The literature shows that having children reduces risk of suicide (Qin & Mortensen 2003). Infertility may contribute to the risk of suicide; in Nepali culture, there are a number of stigmas and taboos associated with infertility, and infertile women are often subject to different forms of abuse, which may increase their suicide risk.

"Ganga was her husband's second wife. He already had three children from his first wife, but she had fled away with another man so he married Ganga. However, after three years of marriage Ganga had still not conceived so her husband used to mentally torture her, asking why she could not conceive."

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.1.4 Religion

Durkheim saw religion as protective against suicide in its provision of social solidarity and integration (Durkheim 1912). Research does suggest that a belief system may impact upon suicide, however, while it may indeed have a beneficial effect when suicide is viewed negatively, it can equally increase suicidal tendencies in contexts where belief systems sanction it (Vijayakumar et al 2005b).

Religious conventions regarding suicide were reviewed by Vijayakumar et al (2008), who observe that suicide is forbidden by the Qur'an and Islam prohibits the use of alcohol, which is a risk factor in suicidal behaviour (discussed further below). The authors note that countries with Muslim majorities, such as Pakistan and Malaysia, have lower rates of suicide. Conversely, it has been suggested that traditional Muslim practices such as *pardah* (discussed below), which socially isolate women, may indirectly lead to increased suicide risk through their effect on women's status.

Hinduism is more ambiguous regarding suicide: whilst ostensibly condemning self-harming behaviour, it may be sanctioned for religious purposes (Vijayakumar et al 2008). Suicide has been both commended and condemned in Hindu literature and there has been mention of suicide in various Hindu holy books. For instance, *Swasthani* mentions suicide committed by 'Sati Devi' by throwing herself into the fire when she could not tolerate the insulting words about her husband from her own parents. The practice of *sati* is closely associated with Hindu beliefs, and in fact means 'virtuous' or 'pure' in Hindi (Greenbaum et al 2004).

Self-immolation is the only suicidal practice that can be directly related with all of the main religions. As Ahmadi summarises: "the Judeo-Christian traditions have imagery of fire as cleansing and purifying. Buddhists have used self-immolation as a form of protest. The ritual death of Sati is closely associated with Hindu beliefs; there is also secular imagery associating fire with images of condemnation and evil. Finally, the Muslim traditions have imagery of fire as the most violent punishment (Ahmadi and Ytterstad 2007). However, in practice self-immolation has not gained significant currency as a means of suicide, with the exceptions of India, Iran, Zimbabwe and Brazil (Greenbaum et al 2004).

Buddhist doctrines venerate human life and therefore view suicide negatively. The relatively high number of suicides in some predominantly Buddhist countries, such as Japan, the Republic of Korea and Sri Lanka, can therefore not be attributed to religious motives (Vijayakumar et al 2008). *Prima facie*, Christianity also prohibits suicide, but as Vijayakumar et al note: "there are a number of examples of suicide in the Bible, and Christian teachings do not explicitly preclude a person who dies by suicide from entering Heaven, providing he or she has faith in God" (Vijayakumar et al 2008). It is therefore possible for a Christian wishing to complete suicide to construe the religious texts so as to avoid sanction.

6.1.5 Ethnicity / Caste

Nepal's rich social tapestry comprises 103 social groups³ including a variety of castes, ethnic and religious groups speaking many different languages spread across the three ecological belts of the country. . Three major population groups make up over 94% of the population:

³ This number is likely to increase in the 2011 Census as more social groups seek recognition from the Government.

(i) *Adivasi Janajatis* who are indigenous people belonging to approximately 85 different ethnic groups (Bennett and Parajuli 2011) (ii) Nepali-speaking *Parbatiya* Hindu castes traditionally from the hills and are divided into two main groups, higher caste Brahmins and Chhetris, and lower, occupational caste Dalits. (iii) *Madhesis* Hindu castes from the plains that include a larger number of castes than in the Hills, and speak a variety of Indo-Aryan languages.

For hundreds of years, political and economic power has been consolidated through the caste system which has in turn framed Nepal's social hierarchy. This classification of peoples into varying levels of purity is a feature of Hindu and non-Hindu groups with, for example, Janajatis who follow animist beliefs and fall between higher castes and untouchables. The 1854 Muluki Ain or National Legal Code set out what was acceptable inter-caste behaviour and was one of the foundations of the structural and social discrimination that persists in modern day Nepal.

Disaggregated caste and ethnicity data has only been collected by the Census since 1990 providing irrefutable evidence of social exclusion based on gender, caste, ethnicity and region. Poverty incidence is higher among more disadvantaged groups, such as Dalits than for the less disadvantaged, such as Brahmins, Chhetris and Newars (CBS 2005). The latter have better access and use of health services and lower rates of infant mortality, better schooling and higher literacy rates, and higher life expectancy (UNDP 2009). The most recent multidimensional analysis of social exclusion based on indicators of income, health, education and influence provides further evidence of who the most excluded groups in the country are: namely, all Madhesis and Hill Dalit groups, Muslims, 9 out of 31 Hill Janajati groups, and 6 out of 38 Madhesis Other Castes⁴ (Bennett and Parajuli 2011).

While enhanced poverty and social exclusion among Dalits, vulnerable Janajatis, Muslims, and disadvantaged Madhesis exposes them to greater risk of physical and mental ill-health, the evidence is ambiguous as to whether they also have an increased risk of suicide compared to others. Kohrt's ethnographic and epidemiological study in Jumla found that although Dalits had the highest prevalence of depression and anxiety, the direct effect of caste on mental health was insignificant after the impact of exposure to stressful life events, number of livestock, and household income had all been discounted (Kohrt, 2009).

The 2008/09 MMM study in fact found that Dalits and Muslims had one of the smallest percentages of deaths to women of reproductive age attributable to suicide 8.9% and 6.2% respectively, compared to Brahmin/Chhetri at 17.4% and Newars at 15.8%; the latter two social groups being relatively advantaged in the Nepal context. These findings appear to run counter to the hypothesis that more socially excluded groups would be at greater risk of suicide. Although we should note that the low proportion of suicide deaths for Dalits and Muslims may reflect their greater propensity of dying from other causes (Pradhan et al, 2010)⁵. The MMM study findings for Madhesis Other Castes and Janajatis are more problematic to interpreting because they data does not disaggregate people from advantaged and excluded social groups that fall into these broader classifications.

The 2008/09 MMM study did reveal, however, that suicide accounted for one fifth of deaths to all Janajati women of reproductive age, higher than among any other social group (Pradhan et al, 2010). The verbal autopsy data highlight a number of suicide cases where

⁴ Sometimes referred to as Other Backward Castes.

⁵ No population data is available to enable rates to be calculated.

social injustice, extreme poverty and social exclusion were considered to have contributed to suicide along with other factors.

“Durpati was an 18 year old girl from a lower caste who had dropped out of school in Year 8. She had an arranged marriage, but wasn’t happy as her husband was older than her. Soon after her marriage, she had an extra marital relation with a boy who belonged to an upper caste. She left her first husband and married that boy. Her mother had to pay ten thousand rupees to her first husband as fine. She did not tell her current husband’s family members, including her husband, about her low caste before the marriage, out of fear. She was living happily with her husband and his family members, but after some time, her mother in-law found out that she was from a lower caste and started to insult her, and other family members also avoided her. Even her husband was not supportive, and was sometimes violent towards her. She was alone and isolated. Her mother in-law wanted her and her husband to separate and sent her son to work abroad. At home, she was living alone with her mother in-law who always used to scold her. Her economic condition was very poor and she did not have the control over the family assets. She used to talk to the neighbours about it, and say “There is very poor condition in my home. So I will die.” One month after her husband went abroad, ...her mother in-law found her in the goat shed, she had hung herself.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

As is common with suicide, such social factors interplay with other precipitating events to trigger suicide, and teasing out the relative weight of social exclusion due to caste and ethnicity is not possible with the current datasets. Further research is needed to understand the relationship between female suicide and caste and ethnicity, to identify if specific social groups are at greater risk of committing suicide, and to inform suicide prevention strategies.

6.1.6 Education

The impact of education on suicide is not clear. A study in 33 European countries found that high literacy rates predicted high suicide rates even where gross domestic product (GDP) and age were controlled for (Marusic et al 2002). Conversely, an analysis conducted in ten European populations found an elevated suicide mortality in every male population of lower education, whilst the pattern was less significant and even reversed in some female populations (Lorant et al 2005). Research from low and middle income countries is similarly inconclusive: two studies from Iran failed to find a significant difference in literacy among suicide burns victims (Ahmadi & Ytterstad 2007; Alaghebandan et al 2010). The MMM study showed suicide accounted for a higher proportion of deaths among educated women of reproductive age than uneducated but this may be due to a lower risk of dying from other causes (Pradhan et al 2010).

In spite of the rather tenuous link, suggestions have been put forward as to why education may impact suicidal tendency. Education might enable impoverished individuals to better appreciate their adverse social circumstances, create unfulfilled expectations, and produce frustration at being unable to realise modern aspirations, prompting depression and suicide. (Marusic et al 2002; Baudelot & Establet 2008). On the other hand, Ahmadi (2007) suggests that education might enable troubled women to consider positive alternatives to suicide.

“I think illiterate people have a very small world and low ambitions - like working their field, growing crops, getting cattle, feeding them, preparing for receiving their daughters during festivals - things like this. Educated people have big ambitions in their life. Their ambitions and expectations grow with advancement in education. The worst part is that when a well educated person does not get appropriate job the society takes it as a shameful act and s/he develops frustrations. This leads to depression and then to suicide.”

- KII with an Academic

6.1.7 Employment

Studies in developed and developing countries alike have found an unequivocal link between employment and suicide independent of other factors (Blakely et al 2003), with unemployed individuals at an extremely heightened risk of self-harming (Blakely et al 2003; Lin 2006). However, there are also layers of other issues that link unemployment and poor mental health, depressive symptoms and subsequent suicide: the stress of looking for work; reduced self esteem and confidence; the inability to afford the same lifestyle; family tensions; less social contact and severing of social ties (Preti 2003). Studies in Denmark and in seven Asia-Pacific countries found the correlation was limited to men (Qin et al 2003; Lin 2006). In contrast, the lack of economic opportunities for women in developing countries may affect their mental health wellbeing and thus impact female suicide risk as employment often has a beneficial effect on psychological health (Niaz & Hassan 2006).

Suicide rates for men under the age of 45 nearly doubled between 1950 and 1998 in England and Wales, and this has been attributed to social circumstances, such as high unemployment and divorce rates, declining marriage, and increased substance abuse and (Gunnell et al 2003) to reduced unemployment (Kwon et al 2009).

In Nepal, from the results of the 2008/09 MMM Study, there was no evidence of a link between employment and suicide. However, The KII’s raised the issues of specific occupations increasing the risk of suicide, and of having the access to means and knowledge to ensure it is successful, associated with different occupations. Others, however, cautioned against the generalisation of suicide among certain occupations.

“When a well running business collapses there is a risk that the persons involved commit suicide. It is believed that persons involved in tourism sector are more prone to have drinking habit and drug addictions and this puts them at high risk of suicide. Veterinary doctors, medical doctors particularly the psychiatrists are at more risk of suicide as they know the effect of different medicines on their body. When they attempt they complete it.”

- KII with a Psychiatrist

“In the context of Nepal a large number of farmers are found attempting suicide due to easy access to pesticides and insecticides at the local level.”

- KII with a Psychiatrist

6.2 Clinical Contributing Factors

6.2.1 Chronic Illness

Chronic illness is associated with a lower quality of life; poorer physical health; an increased risk of developing depression (Tang & Crane 2006); and is a risk factor for suicide; specifically, chronic pain has been identified as a motivating factor in a quarter of all suicides with risk increasing with age (Fisher et al 2001). Half of individuals with chronic, non-malignant pain conditions in one study revealed that they had, at some point, seriously considered suicide (Fisher et al 2001). The impact of chronic illness on suicide may also occur indirectly by increasing the propensity to depression (Fisher et al 2001). Prince et al (2007) suggest multiple factors may lead to the development of additional psychiatric morbidities, such as 'the acute trauma of the diagnosis, the difficulty of living with the illness, the long-term threat of decline and shortened life expectancy, necessary lifestyle changes, complicated therapeutic regimens, aversive symptoms such as pain, and stigma, which can lead to guilt, loss of social support, or breakdown of key relationships'. However, other studies suggest that chronic pain may impact risk of suicide directly and *independently* of depression (Magni et al 1998; Ratcliffe et al 2008).

Most research exploring the link between suicide and chronic illness has been conducted in developed countries. However, a study from India, found ongoing stress and chronic pain caused an elevated risk of suicide (Manoranjitham et al 2010). This was reflected in Nepal where the 2008/09 MMM study found chronic illness to be the second most common underlying factor for suicide among women of reproductive age (Pradhan et al 2010). The risk of suicide due to chronic illness may be elevated in developing countries given the increased likelihood of experiencing a chronic illness; the poorer access to healthcare and treatment; the cost of healthcare; and the 'culture of silence' in Asian countries putting pressure on people, especially women, to suppress negative emotions and pain / discomfort experienced as a result of illness (Klainin & Arthur 2009). Women may avoid expressing suffering or seeking help, and finally reach a stage where they see suicide as their only option.

A common theme running through the chronic illness case studies from the 2008/09 MMM study is the resultant financial burden on the family, many of whom are poor, and women's anxieties related to the cost of their treatment, their reduced economic contribution to the household and the implications for the well-being of the family:

"Monika was 32 years old when she died. She was happily married with two young sons and had a supportive husband. For four years before she committed suicide she suffered from severe headaches which caused her to sleep for two to three days. Her husband took her to various doctors, who performed many investigations. Different diagnoses were made by doctors in Siliguri and Kathmandu. Monika was told that she would never be cured, but that her condition could be managed with daily medication. Her husband believes that after she heard this she became more tense, she lost hope, and feared the negative implications for the family. He was never forewarned by any of the many doctors they saw that she may be at risk of suicide. She committed suicide by taking poison."

- Respondent for suicide verbal autopsy, MMM Study 2008/09

“Dhanarupa, was married with two sons and a daughter. Her family were economically comfortable and could manage their living for a year. For many years she suffered from different health problems, including a ‘growing bone’ which she had surgery for. After the surgery she became anxious, her body would tremble, and she seemed frightened. Various dhamis were consulted but she was not cured. An astrologer pronounced that ‘her days were not in her favour’ which increased her tension. Once she shared her concerns with her husband that there was not enough money for the children and her treatment, and it would be better for her to die. On the 5th of Baisakh while her family went to Puja and her son was watching TV (Television) at the neighbour’s house she hung herself at home.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

It’s not just one’s own chronic illness, and the link to high costs of care that leads people to commit suicide, but also the responsibility for paying for the cost of treating relatives:

“Last week we heard that a man committed suicide in Manipal Hospital, Pokhara because he could not afford the cost of his wife’s treatment. Today, in one of the national daily newspaper there was news of a mother who committed suicide for not being able to treat her newborn baby. All these examples illustrate that there is a close linkage between poverty, illness and suicide.”

- KII with Policy Maker

As with mental illness, women who suffer from some chronic illnesses, such as recurring headaches or epilepsy, are often believed to have been attacked by evil spirits and witches; care seeking includes both doctors for physical symptoms and traditional healers for the spiritual beliefs.

“Geeta suffered from epilepsy and was regularly taking medication which she had received from a nearby health facility. Her family had taken her to various hospitals but she was never cured. Neighbours described her as normal. She never took alcohol, [she] did her housework, cared for her children, worked on her farm, and made food for the family. Her father-in-law reported that in addition to the epilepsy she also suffered from evil spirits that caused her to shiver and fear people. When she showed such signs, the traditional healer was called to worship the bad evil, sacrifice a chicken in the name of god, chant some mantras and sprinkle rice grains over Geeta’s body. This helped her to recover from the attack. Without a precipitating event, on 8th of Ashoj in the morning when everyone was working in the field she ingested a large amount of pesticide which had been bought for the crops. She died on the way to the sub-health post.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.2.2 Mental Illness

Poor mental health can be both a cause and consequence of the same social determinants as suicide, such as poverty, social exclusion and marital problems (Prince et al 2007: 11). A wealth of literature investigates the link between mental health and increased suicide risk. According to WHO, 90% of suicide cases relate to a mental disorder (Lamichhane 2010) and some studies have found the link to be stronger in females (Qin et al 2003).

The 2008/09 MMM study in Nepal found underlying mental health problems in many suicides to women of reproductive age in Nepal, often as a consequence of social determinants (Pradhan et al 2010). The case histories illustrate the complexity of mental health in its social context and how social norms, poverty and poor access to healthcare overlap with mental ill-health. Examples of women suffering from some form of mental illness or perceived mental illness by her family and neighbours illustrate the:

- lack of accessible, quality care for mental health conditions in Nepal
- lack of knowledge and understanding of mental health conditions in the community
- Underlying social and family conditions that in many cases appear to contribute to poor mental health.

Some case studies highlighted issues related to marriage preceding depression, such as being married off at a young age, or being prevented from marrying the person they love:

“Umakali was 48 when she committed suicide, she had had a history of depression and had been taken to India by her husband for treatment. Her elder daughter was also suffering from mental illness. Umakali was married at the age of 12. She became a second wife, her husband married her because his first wife was unable to have children. Her daughter said, ‘when we were small father used to drink and beat my mother. My mummy has faced so many problems and she lived her life in sorrow. I have heard that one time she left the home with rope to hang. ...She used to say ‘I am fat, can not work, all did not get a happy life because of me’’. On the day of her death, her husband gave her Rs 3000 but she immediately gave it to her daughter. When her children had gone to study she hanged herself in the roof.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“Purnima, at 25, became depressed after her boyfriend’s marriage proposal was rejected by her father. She remained unhappy and sad even while taking medication for a year and her father decided to relent and approached the boy’s father. By this time the boy was already engaged to someone else, although it was reported that he loved Purnima, he could not go against the wishes of his father. Feeling betrayed, Purnima took insecticide and died two days before the boy married.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

Many of the psychiatrists interviewed regarded mental illness as the main contributory factor behind suicides. However, many also failed to acknowledge that mental illness is often a consequence of social determinants and that interventions need to target these underlying social determinants, as well as improving mental health care.

“Most people are found committing suicide due to depression. Depression is a curable state of mental illness. We can treat almost 95% of the depression patients and patients of other mental illnesses. After treatment, suicide risk goes very low. Due to the lack of proper diagnosis, patients are sent home without treatment and as an effect of other underlying causes these patients commit suicide.”

- KII with Psychiatrist

The lack of care seeking for the mentally ill was evident. Even when a wife tried to kill her husband and was imprisoned, no care was sought for her.

“Juni, 43, had married twice and had 2 children from her first husband. Her second husband explained that she had a history of mental illness over the past 9 years, which had included violence towards family members, destroying household utensils, and locking herself away in a room. Her husband took her to a doctor in Kathmandu who prescribed medicine and advised her to stop drinking alcohol, which she didn’t. She had attempted suicide before by cutting her wrists and attempted hanging. A week before she committed suicide she tried to kill her husband and was locked in prison for a day and then released. Her husband moved out of the house and lived in his shop. One of her nephews slept in the house with Juni so that she was not alone; one night she poisoned herself and died. Her husband said, ‘I couldn’t tolerate her behavior. I thought that it is worthless to discuss with her and if she will not see me she will calm down. If I had not left her alone her in home she could have been saved but we all were worried about that she may attack others because she was senseless and aggressive in nature’.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

There has been a recent and positive change in global attitudes towards mental health, recognising it as ‘an essential and inseparable component of health’ (Chisholm et al 2007). This all-inclusive approach to health and wellbeing is encapsulated by the WHO slogan ‘there is no health without mental health’ (WHO 2005b). Interventions are beginning to encompass preventative as well as curative strategies. The first WHO Global Burden of Disease report conducted in 1990 emphasised for the first time the burden of non-fatal diseases, particularly mental disorders (Lopez et al 2006). Subsequent GBD reports have found that mental illnesses make up three of the ten leading causes of disease burden in low- and middle-income countries (WHO 2008). Depression is the leading cause of disease burden for women of reproductive age in countries of all income bands, and globally the burden of depression is 50% higher for females than males (WHO 2008). In South East Asia, unipolar depression was the fourth leading cause of disease burden. The strong association between suicide and depression in developed (Fisher et al 2001), may have serious implications for suicide rates in a setting like South East Asia region, where depression is common (?).

In spite of the change in attitudes towards mental health, programmatic priorities and funding have been slow to respond. In 2001 the United Nations (UN) Secretary General requested all countries make mental health a priority on their national agenda (Trivedi et al 2007). However, in 2004 WHO reported a treatment gap of 76–85% for low- and middle-income countries (Saxena et al 2007) indicating that the importance of mental health is still grossly under-acknowledged. No doubt many governments simply lack the necessary resources to make demonstrable progress. Critics argue that donor preferences for projects misdirect resources away from areas of true need in favour of those that receive more public attention.

There has been criticism of the omission of mental health from the Millennium Development Goals (Miranda & Patel 2005). However, it is argued that the achievement of many of the goals is not possible without efforts to improve mental health (Chisholm et al 2007; UNFPA/WHO 2007). Therefore, in spite of the advances in the perception of mental health, the ground reality in many countries is lagging behind: many developing country governments continue to afford physical health primacy over mental health, often in order

to attract more funding (Tausig & Subedi 1997). The director of Nepal's only mental health hospital stated that: "Though Nepal is a member country of World Health Organization (WHO), it has not acknowledged the absolute definition of WHO's health definition in its law. In Nepal, people understand health as only physical illness while as per WHO, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (People Daily 2010).

Estimates of the prevalence of mental disorders in middle and low-income countries vary widely and research is lacking (Chisholm et al 2007). Deva (2002) postulates that about 10% of the population in Asia suffer from some kind of neurological dysfunction. The median lifetime rate of depression has been estimated at 3.7% for the Asia-Pacific region (Chiu, 2004). There are no national statistics on the prevalence of mental disorders in Nepal and this demonstrates the need for future research and better record keeping in order to determine the true demand for mental healthcare.

Even when reliable statistics are available to reflect mental health needs, financing mental health care is extremely difficult in low-income countries. The poorest countries typically spend the smallest proportion of their health budget on mental healthcare (Saxena et al 2007). In Nepal, government provision is hugely wanting: there is no official office representing mental health (Jordans et al 2010); no regulatory body to ensure the quality of care provided (Jha & Adhikari 2009); and of the 3% of gross domestic product spent on the health system, a meagre 0.02% is allocated to mental health (Jha & Adhikari 2009). WHO reports show that there was no increase in mental health spending in Nepal between 2001 and 2005 (WHO 2001; WHO 2005a), and there were only minor improvements to infrastructure and health personnel.

In many developing countries, like Nepal, the absence of mechanisms such as health insurance, social funds and tax-based systems, places the burden of mental healthcare payments almost entirely on family members (Regmi et al 2004), often forcing them to make out-of-pocket payments on an *ad hoc* basis. These usually disproportionately disadvantage the poor (Saxena et al 2007). It is estimated that the family of a mentally ill individual could spend USD (United States Dollars) 320 in direct service costs on an annual basis (WHO 2005a; Jha 2007), and given gross national income is put at USD 400 per capita (World Bank 2009) it is highly likely that many of those in need of medical attention are forced to go without treatment

The benefits of effective preventative strategies in the field of mental health have been well documented. One intervention targeting depression in China, concluded that 50% coverage would achieve a 10% reduction in the number of suicides, saving 580,000 productive life years or USD 1 billion per year (Prince et al 2007). Another study predicted that the cost of a basic mental health package would cost USD 3-4 in sub-Saharan Africa and South Asia; this would require a ten-fold increase in health spending in countries such as Nepal (Chisholm et al 2007). The cost-effectiveness and potential benefits of mental health interventions seem preferable to the economic consequences of non-investment. If left unaddressed, mental health-related problems have the potential to incur significant direct and indirect costs: including costs to the health system for related illnesses; expenditure on treatment outside the formal health system, such as traditional healers; lost production; and premature mortality (Patel et al 2007). Mental health disorders can preclude or delay detection and help-seeking behaviour in relation to other health issues, thereby exacerbating existing conditions (Prince et al 2007). Hence it is in policy-makers' interests to promote the use of proven strategies.

In Nepal mental health problems are widely perceived to be related to evil spirits, and thus the need for medical attention is rarely appreciated; care is often sought from traditional faith healers instead. Many other barriers also prevent those in need from seeking formal mental health services (where they exist) and include stigma, poverty and long distances. Stigma remains a principal obstacle to the effective treatment of mental disorders in many Asian societies, materialising in the form of health provider discrimination or social and familial ostracism (Regmi et al 2004). In Nepal, people with psychological disorders may be abandoned by families unable to cope with the social and financial burdens (Aryal 2007). Stigma has particularly been identified as a barrier for young people, who may be more reluctant to discuss their condition and seek help (Saxena et al 2007). 'Discrimination against people with mental disorders is widespread, often formalised, and sometimes even codified in law' (Saxena et al 2007); for example, a man may divorce his wife on the grounds of mental incapacity (Chapter 9, Malaki Ain 1963). Furthermore, stigmatisation of mental health is embedded in the medical discourse by the words they use, how they speak to the affected person, or their refusal to treat those with mental illness (Sartorius 2007). These interviews highlighted the stigma towards mental health, including by those in health professions.

"I have seen mentally ill rich persons kept locked inside their house and even kept in a chain. Because of stigma they never come out and we have to provide the services confidentially disguising our identity as people working in psycho-social counselling organization. Mental illness affects females more than males, as females lose everything once they get mental illness. Once diagnosed, she never gets ownership of land, house and any other assets. Sometimes she even gets accused of being a witch. She also has to suffer sexual exploitation. All these sufferings lead her to suicide."

- KII with an NGO worker

"Once, an employee was fired from the job when the employer came to know that he was treating for the mental illness though he was equally qualified and competent compared to other staff."

- KII with a Policy Maker

"Even health professionals working at tertiary level hospitals do not refer psychiatric patients to a psychiatrist. I see this as another form of stigma prevailing in educated people. ... Once I had gone to a tertiary level hospital in Kathmandu and asked staff about the psychiatric OPD ward. Two of the staff ridiculed and laughed at me. Visiting a psychiatric department does not mean the person is mentally ill, and if so, what's there to laugh on it. I felt very sorry for them."

- KII with a Psychiatrist

Writing on Nepal, Tausig & Subedi suggest that mental healthcare systems are 'carriers of modernity' (Tausig & Subedi 1997) attracting external funding; and merely serve a symbolic purpose, while actual functionality is a lesser consideration. In many low-income countries NGOs are the principal providers of mental health services, so long-term planning and sustainability are uncertain (Jordans et al 2010). There are few incentives for professionals to enter the controversial field of mental health, particularly in rural areas (Saraceno et al 2007). As such, the proportion of mental health staff to patients is negligible and there is

only one mental and psychiatric hospital in the country. The interviews with key informants highlighted the lack of mental health care in Nepal:

“There is a gap in both curative and preventive field of mental health. We are developing mental health experts from post graduate MD programme but the number is still very inadequate and there is a lack of counsellor i.e. one mental health expert in the current organizational structure. We have only one specialised hospital, and this is also not functioning well. Though there is provision of psychiatric services in zonal hospitals many of the hospitals do not have a psychiatrist. We do not have any specific services below this level. Currently some NGOs are undertaking some interventions on psycho-social counselling and domestic violence but the governmental efforts are not sufficient. In current five year health sector plan we have incorporated mental health as one of the main agenda.”

- KII with Policy Maker

Centralisation is a further obstacle to the provision of equitable mental healthcare since this usually leads to the concentration of mental health resources in or near large urban centres and hence there is considerable geographical discrimination (Saraceno et al 2007). The proposed federal plan to devolve powers within the health field to the country’s 75 districts, and to integrate mental health into primary health care (WHO 2005a) will hopefully allow stricter control of resources appropriate to local need (Solberg 2010), and a shift in focus to community and individual-based care and treatment, entailing ‘a wider range of services, coordinated treatment programmes, services closer to home, ambulatory care, and partnership with caregivers’ (Trivedi et al 2007).

Training is a notable fallacy of the mental healthcare system in low-income countries, where approaches to teaching tend to perpetuate stigma and focus mainly on theory, with little practical component (Saraceno et al 2007). Psychiatry was late to be introduced as a subject in many Asian countries and often teaching is geared to severe mental illnesses rather than primary care (Deva 2002). Even as psychiatry syllabi improve, interest in these courses remains low: only four new psychiatrists graduate from Nepal’s two main teaching institutions each year (Aryal 2007). Furthermore, human rights are still absent from teaching agendas in most developing contexts (WHO 2006).

The case studies highlighted the reluctance to see a psychiatrist, even when referred by a physician.

“When physicians examine patients they diagnose psychiatric illness and refer the case to a psychiatrist. But when the patient comes to me [psychiatrist] he would have already wasted 2 years. This is so because when they are referred to a psychiatrist, they try other means first and then come to me only when the case gets worst.”

- KII with a Psychiatrist

Whilst attitudes towards mental health in countries like Nepal are slowly shifting, it is important that efforts in suicide prevention recognise the impact of physical and cultural barriers on treatment and help-seeking behaviour and strive to overcome these; by providing alternative solutions and coping strategies, effective mental healthcare has the potential to prevent many of the growing number of suicide attempts.

Nearly half of the respondents in the EAW baseline survey revealed that they felt sad / depressed or hopeless at least once a month, while 28% reported feeling helpless and 19% felt worthless at least once a month (Table 14). For those who had at least one of these symptoms at least once a month, 28% felt unable to express one's own feelings, and more than one in five (22%) had strong feelings of helplessness (Table 15). Despite feeling like this, 41% had not shared this with anyone (Table 15). Thirteen percent of those interviewed had experienced an event that made them feel unable to cope, but over half of these had not shared this with anyone (53%) (Table 16). Only 4% of those interviewed had ever had a consultation for a mental health problem, and most of these (71%) had visited a hospital for their consultation (Table 17). The main reason given for never having a mental health consultation was that it wasn't felt necessary (81%), although a few did report that they had been prevented by stigma (4%), lack of money (6%) or prevented by a family member (4%) (Table 17). These findings suggest that many women in Nepal may be suffering from depression, but they feel uncomfortable talking about how they feel to others and very few have had a mental health consultation. The latter may be because that they don't see depression as a mental illness.

Table 14. Frequency of depressive symptoms

	Never	Once a month	Once a week	Daily	Missing
<u>How often do you feel ...</u>					
Sad / Depressed	53.4	34.5	7.4	0.8	3.9
Hopeless	53.8	32.9	5.5	3.0	4.8
Helpless	66.7	23.1	2.5	2.3	5.4
Worthless	73.6	15.5	1.7	2.2	7.1

N = 1059

Source: EAW Baseline Survey 2010

Table 15. Reasons attributed for depressive symptoms

	No.	%
<u>If ever feel sad, depressed, hopeless, helpless or worthless ...</u>		
<u>Reason for feeling like this</u>		
Cannot express one's own feelings	133	27.5
Strong feeling of helplessness	105	21.7
Discriminatory practices	71	14.7
Lack of justice	43	8.9
Other	39	8.1
(N = 484)		
<u>Shared feelings with</u>		
Friends	100	20.7
Neighbours	93	19.2
Relatives	93	19.2
Women's Groups	9	1.9
Other	39	8.1
No one	196	40.5
(N = 484)		

Source: EAW Baseline Survey 2010

Table 16. Experience of events (or just events) contributing to depressive symptoms

	No.	%
<u>Ever experienced a past or present event / incident that has made you feel unable to cope</u>	135	12.7
N = 1059		
<u>Reason for feeling unable to cope</u>		
Cannot express one's own feelings	71	52.6
Discriminatory practices	67	49.6
Strong feeling of helplessness	45	33.3
Lack of justice	43	31.9
Other	13	9.6
N = 135		
<u>Shared feelings with someone</u>	64	47.4
N = 135		
<u>Shared feelings with</u>		
Relatives	42	65.6
Neighbours	25	39.1
Friends	18	28.1
Women's Groups	3	4.7
Other	9	14.1
N = 64		
<u>Received Support from</u>		
Relatives	37	57.8
Neighbours	12	18.8
Friends	9	14.1
Women's Groups	1	1.6
Other	17	26.6
N = 64		

Source: EAW Baseline Survey 2010

Table 17. Experience of mental health services / care

	No.	%
<u>Ever had a consultation for a mental health problem</u>	42	4.0
N=1059		
<u>Place(s) visited for mental health consultation (multiple response)</u>		
Hospital	30	71.4
PHCC	7	16.7
Pvt. nursing home	3	7.1
Private clinic	2	4.8
Health camp	5	11.9
N=42		
<u>Reason for never having a mental health consultation</u>		
Stigma by others	43	4.2
Could not afford	58	5.7
Did not get approval from household member	44	4.3
Other	59	5.8
Not necessary	825	81.1
N=1017		

Source: EVAW Baseline Survey 2010

Maternal Mental Health

WHO defines maternal mental health as ‘a state of well-being in which a mother realises her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community’ (Engle 2009). Poor maternal mental health has far-reaching adverse effects for the infant and well as the mother because depressed mothers are:

- more likely to express negative emotions,
- more likely to show less physical affection,
- more likely to have less positive verbal communication with their infants,
- less likely to take preventative measures for their infants, such as medical visits and vaccinations,
- less likely to breastfeed or concern themselves with their child's nutrition which could affect their infant’s growth (Klainin & Arthur 2009; Miranda & Patel 2005).

In terms of maternal health, maternal depression is associated with increased maternal disability and use of health services (Patel et al 2002). Women suffering from antenatal depression are more likely to contract postnatal depression, which may then lead to a chronic disorder (Patel et al 2002). Studies have shown that whilst pregnant women have a low rate of suicide in general (Oates 2003), those who develop severe mental conditions during the postpartum period may be at high risk, particularly during the first year and a half following childbirth (Babu et al 2008). As such, poor maternal health serves as an independent risk factor for suicide.

To date, women's health in Asia has largely been linked to reproductive health, while mental health has been relatively neglected (Niaz & Hassan 2006). However, depression, particularly during and after pregnancy, is being increasingly recognised among mothers worldwide. It is estimated that between one in three to one in five pregnant and postpartum women in developing countries suffer from mental health problems such as depression and anxiety (UNFPA/WHO 2007). The 2008/09 MMM study found suicide accounted for 3% of pregnancy related deaths in Nepal (Pradhan et al 2010).

Traditional childbirth practices in many Asian cultures are regarded by some as protecting women against pregnancy-related mental disorders. It is not uncommon for postpartum women to have a period of convalescence, during which they follow a prescribed diet and activities are restricted (Klainin & Arthur 2009). They are cared for by family members, principally husbands, mothers, and mother-in-laws, and usually confined to a place of rest. However, several Asian studies have found that in practice these rituals conferred no significant psychological benefits for mothers, as existing domestic tensions may be exacerbated by long-term confinement, along with the frustration of limited activity and freedom.

Whilst one study in Nepal found no difference in the with the level of depression between a group of recently delivered women and a control group (Regmi et al 2002), other research has found tentative support for postnatal convalescence practices (Dørheim Ho-Yen et al 2006; Dørheim Ho-Yen et al 2007). A cross-sectional study among postnatal women in Kathmandu found a relatively low prevalence of postnatal depression (4.9%) (Dørheim Ho-Yen et al 2006). The authors noted that in general those included in the study sample were relatively well educated with good access to health services, which might influence levels of mental health. x Other research has demonstrated much higher levels of depression, particularly during pregnancy: a cross-sectional study of women attending antenatal care in hospitals in the eastern region of Nepal found about half of the women to be experiencing some kind of depression (Shakya et al 2008).

"She had delivered a live baby at Family Planning Centre, Itahari two months prior to her death. The delivery was normal and she did not have any complications after delivery but she used to be angry most of the time."

- Respondent for suicide verbal autopsy, MMM Study2008/09

Further research is required to support or refute associations between pregnancy-related depression and suicide, and context-appropriate tools to screen for depression are required. There is a cultural tendency to internalise pain and suffering (Niaz & Hassan 2006), and this may render conventional Western screening tools identify maternal depression void in developing countries, where women may be more likely to express their health issues as somatic complaints (Klainin & Arthur 2009).

Studies in Nepal and Bangladesh have found common risk factors for postnatal depression, which include intimate partner violence, unsupportive husband or mother-in-law, son preference, husband's alcoholism, and multiparity (Dørheim Ho-Yen et al 2007; Gausia et al 2009). Hence, suicidal tendencies resulting from gender-based risk factors may constitute an even greater burden among pregnant women in Asian countries. Some of the suicide cases from the records at the Burns Unit, TUTH mentioned that the patient was pregnant, however, this information is not collected on a routine basis.

6.2.3 Previous Suicide Attempt, Family History and Imitation

Evidence regarding the role of family history of suicide is limited (Marusic & Farmer 2001), although many studies have found family history of mental disorder to be an important factor (Vijayakumar & Rajkumar 1999; Agerbo et al 2002; Qin et al 2003; Tang & Crane 2006). Previous suicide attempts in the family, increase the likelihood of future attempted and completed suicidal behaviour (Fisher et al 2001; Tang & Crane 2006).

Some case studies from the 2008/09 MMM study mentioned suicides by others in the community, highlighting that suicide is not a rare event, and possibly indicate an imitation effect.

“Three other people had earlier committed suicide from the same village that Mayadevi committed suicide. Pulti’s grandfather had committed suicide and her younger sister attempted suicide but was saved. Purnima’s boyfriend who was engaged to marry another woman committed suicide after Purnima did so.”

- Respondent for suicide verbal autopsy, MMM Study 2008/09

“Six days before Ashima’s committed suicide, her friend Jubeda committed suicide. Altogether four girls of the same age committed suicide within one year in that area. Two other girls were saved when their parents saw them attempting to commit suicide. They all had the same sign and symptoms and all went to the river before committing suicide.”

- Respondent for suicide verbal autopsy, MMM Study 2008/09

Referring to evidence of children committing and attempting suicide, psychiatrists argued that children may act out the imitation effect of the suicidal death of their close ones, particularly close friends. This could also be the effect of ‘mass hysteria’, or an ‘illusion/fantasy’, a psychological disorder in a group of people, they claim. It is yet to be scientifically confirmed how valid these claims are.

6.3 Social & Situational Conditions

6.3.1 Poverty, Social Exclusion and Inequality

The association between poverty and suicide is widely acknowledged in the international literature, with many studies reporting it to be one of the main motivating factors (Lorant et al 2005; Vijayakumar et al 2005b; Ahmadi 2007). Poverty may serve both as a conditioning and a precipitating factor in suicide. Enduring poverty has strong links with poor mental and physical health (Harpham et al 2005; Miranda & Patel 2005; Jha & Adhikari 2009); as such, it may serve as an *indirect* cause of suicide, operating through multiple proximal factors. Similarly, financial vulnerability may constitute a *direct* cause, for example through the loss of job. Women may face additional financial pressure if their husband is deceased or has migrated in search of work. Furthermore, poor individuals may resort to suicide in the belief that they are unable to move up from the economic position that they were born into (Ratnayake & Links 2009).

“The youths are now passing through a severe unemployment situation. The daily wage labourers do not make sufficient money to run their family. Sometimes they do not get work so do not make earnings to provide food, clothes and shelter to their kids. They do not see any hopes for the betterment and find themselves unable to be a good parent. This feeling may lead them to suicide. We have also heard that in India a large number of farmers committed suicide as they were not able to pay back their loan”.

- NGO worker, male

“Mother of five, Phurma, 45, was from a poor family. Her husband was a rickshaw puller. The Dalit couple used to quarrel with each other frequently. On one morning, there was a quarrel between the couple. She was sick and tired with the struggle in her life and the extreme poverty. Having seen no hope to overcome the poverty she took a poison named Sulfas and took her own life.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

The international suicide literature focuses on the economic aspects of poverty rather than the multidimensional factors, including for example, empowerment and influence which impact on access to opportunities and realisation of rights. Given the depth of social exclusion in Nepal, as discussed earlier, the interplay between income poverty, social exclusion and suicide will need country specific unpacking. High levels of inequality in Nepal, with a gini-coefficient of 4.1 (2005), lead some to suggest that this will ‘provide a perfect breeding ground for antisocial activities, substance abuse, and common mental health problems including rising suicide rate’ (Jha & Adhikari 2009).

As we discussed earlier, several cases from the MMM study show that income poverty and social exclusion are contributing factors to female suicide. However, at a disaggregated level, the data from the MMM study does not support the hypothesis that the more income poor are necessarily at higher risk of suicide; female suicide among Dalits as a proportion of all female deaths to women of reproductive age (WRA) is notably lower than for better off groups. Again, limitations of the data must be noted. The picture presented by the MMM study is of suicide driven by multiple and complex personal and social factors, including poverty and social exclusion, but more sophisticated research is needed to identify the factors, understand how they interrelate, and therefore the most appropriate prevention strategies.

6.3.2 Gender & Women’s Status

Gender is an independent and confounding factor in suicide, not only in terms of differentials in vulnerabilities outlined above (e.g. through parental and marital status), but also in terms of disadvantages inherent in socially constructed notions of gender. An important disparity is repeatedly noted with regard to gender, whereby males are more susceptible to suicide in developed countries, whilst females seem to be at increased risk of suicide in developing countries (Vijayakumar & Rajkumar 1999). For example, Qin et al (2000) found the male:female suicide ratio for Denmark to be just over 2:1, while Aaron et al (2004) found the average suicide rate for young women to be more than double that for young men in a southern Indian community, and in Nepal, Subba et al (2009) found two-thirds of suicide cases to be females. Many explanations have been offered for this divergence. Vulnerabilities for young females in developing countries, such as childbearing, child marriage and husband’s alcohol consumption (Kohrt et al 2009), restrictions on partner choice, dowry expectations and reduced earning capacity (Vijayakumar & Rajkumar 1999)

may increase suicidal tendencies. These will be explored further below. Furthermore, Kushner argues that suicide is usually defined as *completed* suicide, thus excluding *attempted* suicides, and given that it is widely accepted that women *attempt* more but *complete* less suicides due to their preference for less violent methods, it is likely that female suicidal tendencies are under-reported by conventional mechanisms (Steen & Mayer 2004).

Whilst gender equality has been on the international agenda for some time, it has not been readily accepted by many developing world cultures, in spite of their governments' legal and moral commitments to modern gender values. Women in Asia are generally afforded subordinate social standing increasing their vulnerability to violence, injury and suicide. From birth, Asian cultures conventionally attach greater primordial value to male infants than female ones. Sons are viewed as more desirable for economic reasons (their greater productivity and the wealth they may bring a family through a dowry) and many ritual ceremonies (namely funeral rites) can only be conducted by males (Cameron 1998). Son preference plays a key role in perpetuating women's low status: a girl child is just a "visitor" in the house where she is born and will eventually go to her "real" or married home (Niaz 2003), hence she has no rights and is considered the most unimportant part of the household, thus education and other opportunities are unnecessary. At her husband's house, her role is housekeeper and child bearer. Women are considered men's property, their sexuality, fertility and labour are systematically controlled (Pradhananga & Shrestha, accessed June 2010).

The widespread perception of women as inferior beings is sustained by traditional beliefs, institutions, and practices that are widely accepted by both sexes. Even in modern times local proverbs retain significant gender bias (Bhusal 2008), for example the South Asian saying that "girls are born to be fed throughout their lives" (Niaz & Hassan 2006: 118). Representation in modern media and outdated school textbooks preserve the notion of women as subservient, thus instilling these views into younger generations. Accordingly, women become trapped in a perennial cycle of dependence, which may lead some to consider suicide as their only option.

Son preference, and the consequences for wives who do not produce sons was apparent in the 2008/09 MMM Study, in this case the wife also suffered from a chronic illness:

"Hirakali was 47. ... She had no son from her current second, husband. So, her husband always tortured her for not being able to deliver a son. There used to be frequent quarrels between husband and wife on this issue. He used to scold Hirakali and used to throw bad words to her. He was so passionate to have a son he had an extra marital relation with another woman for this purpose. Because of this, Hirakali used to be tense and frustrated most of the time. Also, her physical condition was deteriorating day by day because of her illness. One day prior to her death, she had intense discussion with her husband. Her husband said, 'I have spent lots of money for your treatment. Neither you have ever been cured nor been able to give me a son. I do not know why I married you'. ... She hanged herself.."

- Respondent for suicide verbal autopsy, MMM Study2008/09

Women's realm has traditionally been that of the household, including domestic chores and undertaking agricultural labour delegated by their husbands. In spite of their substantial material and non-material contributions to the household wellbeing and income, women's activities are not granted any economic value or reward, leaving them economically

dependent on their husbands. Economic power is a complex issue in terms of gender roles. In Nepalese culture men “providing economically for the family affirms and supports men's dominance. Conversely, the inability to provide adequately for the family can threaten a man's sense of masculinity and his feelings of worth (Jack and Ali 2010)”. In spite of the legal provisions allowing females equal access to property ownership (Interim Constitution of Nepal 2007), only 6% of households and 11% of land are owned by females (UNDP 2009). Archaic views, coupled with barriers blocking women’s access to means of production, continue to enforce women’s economic dependence and social subordination.

In Asia, women often have very little control over their marriage and reproductive rights. Arranged marriage is common, sometimes with young girls often having little or no say in the choice of future partner. Women are married young, sometimes pre-pubescent, and may be immediately forced into sexual relations to prove their fertility, which will establish their acceptance and security in the marital home (Puri et al 2010). Inevitably mothers are young at the birth of their first child, with no opportunity to develop outside the maternal realm. Early marriage increases the likelihood of a large age gap between the bride and groom, further weakening newly married women’s bargaining power and increasing the risk of maltreatment by in-laws, who are more likely to victimise young brides.

In Nepal, the minimum legal age at marriage is 18 years without parental consent, but the 2006 Nepal Demographic and Health Survey (NDHS) shows that 60% of female respondents were married before the age of 18. The cultural taboo surrounding openly discussing sex; the lack of access to and use of contraception; and the fact that sexual and reproductive decision-making remains firmly in the hands of the male, means that women may have more children than they wish. Early marriage, early childbearing, high parity and pregnancy are recognised risk factors for depression and poor maternal health, and have serious implications for risk of suicide (Ali et al 2009).

Several cultural and religious practices still prevalent in South Asia are extremely demeaning, hazardous to women’s health, show no sanctity for women’s life or freedom, and socialise women to behave with subservience from an early age. Although now prohibited in many Asian countries, such as India and Bangladesh, the institution of the dowry means that women are valued in monetary terms, and is still commonplace. Nepal's Prime Minister announced a ban on the dowry system in 2009, but this is yet to be codified in legislation (One World South Asia 2010).

Within the household, women’s nutritional wellbeing is threatened by norms that dictate that she must eat less than and after her husband and family (Paudel 2007). The cultural practice of *chhaupadi* precludes contact with women during menstruation and a prescribed period following childbirth, often forcing confinement within a small, unventilated room. It is believed that menstrual blood is impure and that any contact with women during this period may pollute the rest of the household (Kandel et al, accessed July 2010). The customs of *deuki* and *kumari pratha* involve the offering of a pre-pubescent girl to a temple where she is considered a living goddess until she reaches puberty. After puberty, she is replaced, but expected to remain a virgin throughout her life; however, in practice, owing to their lack of skills and resources such girls are often forced into prostitution to earn a living (Joshi & Kharel 2008). The social UN Committee on the Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW) has raised concern with the continuing practice in Nepal (UNHCHR 2004). The tradition of *pardah*, practiced in many Muslim and Hindu communities, represents control over a woman’s body and spatial mobility (Ghosh, accessed June 2010) by requiring them to be completely covered by a veil and isolated from contact

with males outside the family. The Hindu custom of *sati*, whereby a widow immolates herself on her husband's funeral pyre, implies the worthlessness of a woman's life and the likelihood of her destitution following her husband's decease.

Many religious doctrines present women as intrinsically inferior to men. South Asia is home to a mixture of Hindu, Muslim, Buddhist, Christian, and Confucian populations, each of which has its own views on women's role in the home and in society. Niaz (2003) describes the influence of these religions on women's status. Hinduism conceives women as having lower value than men, and traditionally discouraged their education; furthermore it dictates that women remain faithful to their husbands irrespective of maltreatment. Buddhism similarly expects women to demonstrate subservience to men, and sees them as an obstacle to men's attainment of purity. Both religions view women's realm as that of the family, as demonstrated by their veneration of Seeta, who represents perfection and purity as a wife and mother. Conversely, Islam traditionally granted women a much higher status that allowed her to own property and marry and divorce at will, however, over time Islam has changed its view of women's status (Niaz, 2003) and as such, women in predominantly Muslim territories today enjoy less freedom than their Hindu and Buddhist counterparts. Whilst adultery carries severe sanctions for women in certain Asian societies, the practice of polygamy is widely accepted for men, and formally endorsed by Hindu and Buddhist doctrines (Niaz 2003).

In Nepal, polygamy is officially illegal, however the NDHS 2006 recorded 2% of men aged 15-59 reporting have two or more wives. One study indicated that nearly two-thirds of respondents believed a man should not have more than one wife at a time (deJong et al 2006).

Polygamous marriage was an underlying factor in some of the 2008/09 MMM study verbal autopsies:

"She divorced her first husband and re-married someone who was already married and had children as his second wife. She had two children from her first husband, but left him as she was suspicious her husband was having an affair with another woman. She did not have any children from her current husband as she had already done permanent family planning. There used to be frequent quarrelling between the two wives. She did not allow her husband to speak with her co-wife and used to argue with her husband. Her sons were in her own village. Their economic condition was strong, but when she used to see them they ignored her as she left them in childhood. She was worried about her future, about her old age as there were no children to take care of her."

- Respondent for suicide verbal autopsy, MMM Study 2008/09

"Manjita married five years ago, at the age of 25, as a second wife. Her husband's first wife already had two daughters and the doctor had advised that she shouldn't have another caesarean section so her husband married Manjita for a son. After two years of marriage Manjita also had a daughter. There was an age difference between Manjita and her husband. She did not have a good relation with her family and frequently went to her mother's home. She was the youngest daughter and two years earlier her elder sister also committed suicide. Her husband said she used to say to me, 'You married me for a son but you will never get one'."

As a sign of its commitment to values espoused in the 1994 International Conference on Population and Development, the Nepalese government established the Ministry for Women, Children and Social Welfare. It is responsible for promoting women's empowerment and equality by mainstreaming gender into the national agenda, and initiating measures to remove socio-cultural, structural, and behavioural obstacles to women's full and equal participation in national development (UNFPA 2007).

In spite of the government's prohibition of discrimination against women (Interim Constitution 2007), Nepal ranks low for the gender inequality index within Asia (Tol et al 2010). Legally 150 discriminatory provisions are still in force, restricting women's access to and control over resources and granting women low representation in decision-making positions in civil services, politics and public sectors (Joshi & Kharel 2008). The increasing employment and education opportunities that have been entailed in the country's economic growth and liberalisation, have been largely limited to men (APROSC 2003). Female literacy rates are almost half those of their male counterparts (69.7%: 38.4%), with men enjoying a mean of 4.1 years' schooling compared to 2.5 for women (UNDP 2009). Gender disparities often preclude women from entering the non-agricultural sector and deny them positions of power, and women continue to be systematically excluded from public services and government.

Research suggests that Nepalese attitudes towards women are slowly changing, as are attitudes towards the beliefs and practices that maintain their low status. For example, deJong et al's 2006 study found that three-quarters of respondents disagreed with marriage before menstruation, and the NDHS 2006 found that only one in ten women reported that their husband alone decided how earnings should be used. However, even as younger family members are exposed to and take up modern notions of gender equality, there is little room for activating change when gender bias is so institutionalised among older generations. Politically, the Maoist government took visible steps to improve women's status and reduce their marginalisation from development and executive processes. In accordance with the Interim Constitution 2007, which provides for proportional representation in the state machinery, the HDR 2009 showed a female representation of 32.4% in the 2008 Constituent Assembly. Improved access to positions of power and public office is expected to yield significant benefits for women, since 'male domination in the public sphere ... in turn influences the nature of gender hierarchy in the private sphere (Pradhananga & Shrestha, accessed June 2010)'.

Gender based violence in Nepal

Legal reforms, government commitments and NGO response

Constitutional and legal reforms against GBV in Nepal

- The Civil Code (Muluki Ain, 1963) Eleventh Amendment Act, 2002, gives a woman the right to seek divorce from her husband on various grounds, from psychological harassment to husband's infection with a sexually transmitted disease.
- The Interim Constitution of Nepal, 2007, prohibits physical, mental or any other form of Violence Against Women; declares such acts shall be punishable by law (Article 20 [3]); and provides all citizens are equal before law (Article 20 [1]), (GoN, 2007).
- The Domestic Violence Act, 2009, contains provisions for a domestic violence case to be resolved through quasi-judicial bodies or mutual understanding; if these are unsuccessful, the victim can file a case directly to the courts. Ensuring interim relief to the victim, the Act has made provisions to the Court to order protective measures for the entire duration of case proceedings (GoN 2009).
- The Supreme Court has issued orders prohibiting different malpractices that contribute to GBV. Directive orders such as to enact a law to end *Chhaupadi* have helped stop such malpractices (AFN 2010).
- Other important legislation include: The Gender Equality Act, 2006; The Comprehensive Peace Accord, 2006 (CPA); and The Human Trafficking Act (2007)

Government commitments against GBV

- Nepal is party to 16 international human rights instruments committing the GoN to gender equality in all spheres of their lives.
- The Police have established Women and Children Service Centers to investigate crimes against women and children in all 75 districts.
- 2010 was the "Year Against GBV". It focused on the prevention and protection from GBV. A campaign was launched; a unit has been established monitoring GBV-related complaints and subsequent government action; a special hotline has been set up.
- The GoN and donors are including paralegal committees that comprise of women from different backgrounds and deal with a broad range of cases, including domestic violence, early marriage, and property disputes, in their programmes. (AFN 2010).
- The current GoN Three-Year Interim Plan (2008-2011) has identified the end of GBV as a key objective
- The Ministry of Women, Children and Social Welfare (MWCSW) is playing a lead role in developing a conducive policy environment to prevent and respond to gender-based violence and to ensure multisectoral services are provided for survivors (AFN 2010).

I/NGO response against GBV in Nepal

- Many I/NGOs have adopted a number of interventions focusing on violence against women. The areas of work include domestic violence, women's rights, and capacity building. However, these interventions to combat GBV are generally small in scale, widely dispersed, narrow in scope (mostly addressing only physical violence) and experimental in nature (AFN 2010).

6.3.3 Gender Based Violence

Gender-based violence (GBV), intimate partner violence, domestic violence and a multitude of other terms encapsulate a global occurrence: violence against women. GBV transcends purely physical abuse, encompassing (but not exclusive to) sexual abuse; psychological abuse; neglect; deprivation of food, money or healthcare (Paudel 2007). Acts include battering, (marital) rape, verbal abuse, threats, *chhaupadi*, and dowry-related abuse. Forms of violence vary by socio-cultural context. For example, dowry-related violence is more common in the Terai regions of Nepal due to the close proximity to India, where the practice is widespread (Joshi & Kharel 2008; US Department of State 2009). Witchcraft still exists in Nepal, with reports of women being fed human excrement (US Department of State 2009). In fact many of the Asian customs which perpetuate women's low status can be viewed as

violence. It's not just men who are reported as abusing women, and the role of other women is highlighted in the quote below:

"In Terai there are many gender based violence cases related to dowry. We have seen involvement of women in almost all the cases like verbal abuse, beating, hitting and putting fire. We can see at least 3-5 persons' involvement while killing a woman and generally three are females. This proportion is seen very clearly in most of the cases. I am surprised to see greater involvement of women with more than 4-5 children in such activities. They are found more aggressive than others."

- KII with a Human Rights Activist

GBV has important consequences for physical and mental health. When women do not have control over their own bodies they are at greater risk of health problems, including gynaecological and reproductive disorders; Sexually Transmitted Infections (STIs), including Human Immunodeficiency Virus (HIV); unwanted pregnancy; vaginal bleeding and infection; irritable bowel syndrome; urinary tract infections; chronic pain or illness; sleeping and eating disorders; and sexual dysfunction (Vizcarra et al 2004; Ellsberg et al 2008; Puri et al 2010). Furthermore, women's mental wellbeing is affected, leading to psychiatric disorders such as depression, anxiety, post-traumatic stress disorder, substance abuse, and suicidal thoughts and/or behaviours (Vizcarra et al 2004; Ellsberg et al 2008; Chowdhary & Patel 2008; Ali et al 2009). As such, GBV poses not only a direct health risk in terms of injury and mortality, but threatens to substantially increase the overall burden of disease in its impact on a wide range of health issues (Ellsberg et al 2008) and can be seen as a direct and indirect factor in suicide risk.

There are many factors that contribute to GBV in South Asian countries, and these include: the importance of aggression to the male profile; the perception of males as indispensable to women; the threat of female progression and independence through improved education; an outlet for frustration at events occurring inside and outside the household (Niaz 2003); the perception of women as men's property; and the importance of female chastity and obedience. Violence against women and the underlying determinants are mutually reinforcing. Women's poor health, low status, lack of education and autonomy, political exclusion and economic dependence all increase their vulnerability to GBV. Poverty and violence are found to 'interact in complex cycles of causality (Terry 2004)'. Violence against women is particularly insidious due to its self-perpetuating nature (Terry 2004; Pradhananga & Shrestha, accessed June 2010). Boys who witness GBV against their mothers are more likely to use violence to exert social control over others, while girls who do are more likely to become victims of GBV (Terry 2004). The inter-generational effect is likely to increase its acceptance and incidence.

"Gender based violence is something that you learn from others, elder people like mother and in-law or from culture. No one is born with a violent nature. We always see people fighting and torturing wife, that is normal in our society. Women don't have any other options; they have to stay with husband. So they are under extreme pressure and often it pushes them to commit suicide."

- KII with NGO worker

GBV is both a cause and consequence of women's low status, hence, it is common in countries with poor gender equality. It is estimated that a third of women worldwide have

been beaten, coerced into sex or otherwise abused during their lifetime (Paudel 2007). Underreporting is common, due to the cultural silence surrounding women's suffering, fear of reprisals, stigmatisation, discrimination, and damaging the family reputation (Joshi 2009). Furthermore, healthcare providers and public officials are often unsympathetic to victims of abuse, especially domestic abuse, and may view them as responsible for any injuries sustained, while poor legal and social protection mechanisms, such as interim relief, compensation, and equitable criminal investigation, preclude faith in the justice system. These factors discourage help-seeking behaviour and provide a facilitating environment for violence against women (Joshi & Kharel 2008). Despite most societies prohibiting GBV the reality is that many violations against women's human rights are sanctioned under cultural practices and norms, and misinterpretation of religious tenets (Joshi & Kharel 2008). Moreover, when violation takes place within the home, as is often the case, the tacit silence and the passivity displayed by the state and law-enforcers effectively condones the abuse. The below quote shows some of the social norms expected of women:

"From a mental health perspective some women have the habit of tolerating suppression and some cannot control their emotions and react immediately. As a female, there are certain social roles and obligations that a woman should follow. Generally a woman is expected not to answer back immediately, even at the time of their disagreement. This puts them at risk of mental illness like depression, anxiety and irritation. As a result she cannot work and play her roles properly then she is accused of being a bad woman. This leads her towards a threshold of violence and this may further deteriorate her mental state and develop suicidal tendency."

- KII with Psychiatrist

There is a dearth of research on GBV in Nepal, resulting in a range of prevalence estimates. The Nepal National Women's Commission estimated that domestic violence comprised 80% of all GBV (Dhakal 2008). A study conducted at the Women's Rehabilitation Centre found 50% had experienced non-consensual sex during their marriage (Puri et al 2010), while another study found that over 35% had experienced some form of gender-based violence in their home, putting Nepal at the top end of the range for 35 countries (Paudel 2007). The most illuminating research in Nepal on sexual violence within marriage was carried out by Puri et al (2010) and formed the basis of a WHO policy brief (WHO 2009b). The study revealed that in addition to the lack of female bargaining power and inability to negotiate safe sex arising from early marriage, younger newlyweds (often underage) are less informed about sex, increasing the likelihood of sex by force. Even when age is not a factor, the persisting taboo surrounding sex prevents open communication between couples, and whilst sexual education does now feature on the national syllabus, in practice it is rarely and poorly taught within schools, leading to widespread misinformation and misconceptions regarding sex. Hence, many women are not mentally prepared for sex when they get married (Puri et al 2010).

Arranged marriage has been found to increase vulnerability to sexual violence, since newlyweds have not had time to get to know and understand one another. Equally, it has been reported in love marriages, since brides may be abandoned by their families, economically and socially dependent upon their husbands, and sexual intercourse may be viewed as a husband's right given the lack of dowry (Puri et al 2010). Son-preference, dependence on husbands due to lack of economic autonomy, compounded with the perception of sex as a natural male entitlement may result in non-consensual sex (Puri et al

2010). Furthermore, men may use physical and psychological threats to secure sexual submission, such as threatening to take a second wife (Puri et al 2010).

Alcohol increases the risk of perpetration as does the husband's education; Puri et al suggest that this may be due to the widened gap between the education of husband and wife, much as a greater age difference is recognised to diminish female bargaining capacity (Puri et al 2010). Accordingly, females are socialised to be submissive to male desires.

“In most of the female suicide cases in Nepal husband is found to have played a major role. Husband is found a drunkard and/or beating her mercilessly and/or keeping extra marital relationships. The woman faces extreme physical and mental torture and finds it very difficult to satisfy her family. The hopeless woman finds no option other than committing suicide to release her from this suffering.”

- KII with Health Professional

Women from lower castes are thought to be at increased risk of GBV (Paudel 2007; WHO 2009a). Castes that traditionally accord women higher status generally boast better female literacy and economic independence. For example, Newars allow women a good degree of economic and household freedom in terms of managing money and decision making and female literacy is high. Thirteen per cent of Newar women reported experiencing GBV at home (Paudel 2007). The Tharu largely work in agriculture, many are poor and landless and employed under bonded labour (under which women may be physically and sexually exploited), female literacy is low, and 47% of Tharu women reported experiencing GBV at home (Paudel 2007). Dalit women are often poor and illiterate with limited employment prospects, and experience high levels of GBV: 54% of Dalit women reported exposure to violence in the home. Some lower castes are even reliant on sexual exploitation as a means of survival: the Badi community, a landless Dalit tribe, is dependent on the prostitution of its female members as a means of sustenance (Mollah 2008; APROSC 2003). Other factors found to increase women's susceptibility to violence include women's education, and the socioeconomic development of a given region (Paudel 2007).

“In Rai/Limbu community women are highly empowered and mostly they are head of the family with the power to punish their husbands. In certain Terai communities women are highly suppressed with many restrictions like speaking to other males and exposing their faces without veil. These practices lead to mental illness. Sometimes guardians come to us to get proved that s/he is mentally ill. With this validation they sometimes outcast her/him from home or claim compensation.”

- KII with Psychiatrist

“Gender based violence is high among poor, uneducated and Dalit women. It is said that 20 percent of the women are being beaten by their husband. There is high prevalence of sexual harassment at workplace and at public sites; at times they are even raped. Both government and non-government agencies have initiated some activities to protect women against gender based violence but their effects have been limited due to problem in coordination, cultural values and traditions prevailing in the society.”

- KII with Policy Maker

Women experiencing violence in developing countries often face significant barriers to seeking a solution. Despite today's political climate of gender equality, GBV commonly goes un-reprimanded. In 1978, most countries signed up to the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), an international covenant that imposes legal obligations to eliminate violence in both the public *and* private domain (Pradhananga & Shrestha, accessed June 2010; Mollah 2008). However, GBV commonly occurs within the home, and despite CEDAW, the home is usually viewed as outside the realm of public intervention.

Most Asian cultures disapprove of domestic issues being discussed outside the family realm, hence women are discouraged from reporting mistreatment for fear of public censure, shame and further retaliation from the husband (Puri et al 2010). In countries such as Nepal, self-silencing behaviour serves as a manifestation of the 'good woman' in line with conventional gender norms and role expectations (Jack & Ali 2010: 153). Thus, despite modernist legal frameworks to prohibit GBV, cultural norms are more resistant to change, and hence the practice often continues unabated.

GBV is so commonplace in many Asian countries that it is widely accepted by both men and women of all generations. Studies have shown many women believe a woman does not have a right to refuse sex to her husband under any circumstances and that beating is justified where a woman had made such a refusal, while men openly admit to having had non-consensual sex with their wives (Ali et al 2009). In Nepal, the NDHS 2006 revealed that men and women reported wife beating as acceptable under certain circumstances, but the figures were generally substantially lower than those found in neighbouring countries, with 3% of men and women submitting refusal to have sex as one of these permissible situations. This is a significant improvement on the results of the 2001 Census.

“For married women husband is the main abuser followed by in-laws but unmarried girls are abused by parents and brothers in the name of maintaining family discipline. Girls are not allowed to go out alone and they are subject to punishment in non-compliance to this. In many cases such ‘punishment’ takes the shape of ‘violence’. Relatives also play key role in abusing both married and unmarried women. In workplace particularly in urban areas women are abused by the employers.”

- KII with NGO worker

Ignorance regarding GBV and women's rights is systematic among health and public officials in many countries. In Nepal, one study found good knowledge among health service providers, community counsellors, police personnel and lawyers regarding different forms of violence against women and the impact it may have on woman's health, with health service providers and counsellors having higher levels of knowledge than police and the lawyers (Paudel 2007). However, around 10% of interviewees (including women) expressed the view that wife-beating was acceptable if a woman refuses to have sex with her husband; is unfaithful; disobeys her husband; or fails to perform domestic duties (such as cooking, cleaning, looking after the children and livestock, or collecting firewood) (Paudel 2007). With a lack of awareness of women's rights so heavily institutionalised in the public realm this indicates an urgent need for gender-sensitivity training within Nepal's public sector. Given this it is hardly surprising that such attitudes persist at grassroots level. With a lack of access to efficient social and legal protection in Nepal, many sufferers of GBV are likely to opt for informal coping mechanisms, such as confiding in friends and maternal family members (Paudel 2007) in order to mitigate its consequences and incidence. Even consulting with the

local Women's Group is considered an extreme strategy. Since changes in the law have had little impact in reality many women who are victims of GBV may see no alternative to suicide.

"Generally a woman conceals the fact that she is being abused. She tells it to someone else only when she cannot tolerate the mental or the physical sufferings. Most of the cases come out only when she gets severely injured and seeks medical assistance. In most of the instances she reports as she had an accident somewhere. A large [amount] depends on dealing of the medical persons as well. Women expose their sufferings only when they feel secured and confident. Generally she shares with the doctor only after 4-5 visits/interactions."

- *KII with Medical Professional*

"Higher the tendency to tolerate sufferings more is the risk of being victimized. One cannot dare to victimize who is defensive. Silent nature women get victimized more."

- *KII with Human Rights Activist*

The cases of gender based violence from the 2008/09 MMM study include a range of abuse; physical, psychological, sexual, and the deprivation of essential goods. In some of the cases physical and psychological abuse by the husband is played out in the context of extreme poverty. Alcohol use and abuse by husbands and wives is common, and tends to fuel the beating and verbal abuse levied by the men. The resultant verbal abuse by women was also reported.

"27 year old Prerna ... married a teacher. ... They had four children ... Her husband was an alcoholic. When he was not drunk, he used to be polite and humble. But after he got drunk, he was a totally different character. He became a violent and cruel person. Once drunk, he invariably used to intimidate Prerna. He used to abuse her. He used to be mad and used to beat her with firewood and sometimes with sharp tools. He used to threaten to kill her. After such ferocious events, Prerna used to go to her maternal home for emotional support but there she was scolded for coming. She was helpless. In the meantime, her husband involved himself in the Maoist war and left the teaching job. He became a Maoist commander. He used to carry a gun and fight in the war. Their economic condition deteriorated. Their family life became miserable. Prerna was also not supported by her maternal home because they were poor too. Her husband was addicted to alcohol, he quarreled with known and unknown persons in the village. Back home, he used to show the same cruel behavior towards his wife and children. On the day of her death, her husband took lots of alcohol and came home. She was preparing for food. Without any reason he started to beat her with wood and locked her in a room. After two hours, her husband asked her brother to see what was wrong with her. When her brother opened the door, she was dead. According to her neighbours, she had ingested insecticide, and died of poisoning but her body was badly beaten and she had wounds on her chest and forehead. Her mother said that her daughter had only that life and she had to die like that, no one could save her."

- *Verbal autopsy of suicide victim, MMM Study2008/09*

There is often a pattern of husbands working away from home, typically in India. The implications of long-term separation are wide-ranging for both the spouses, children and

larger family. Women are often left to bear all household livelihood and caring responsibilities, often living with their in-laws. Although outside the boundaries of this study to investigate, one can expect that in such a situation with relationships under extreme pressure, extra-marital affairs may be more likely on the part of both husband and wife.

“Mayadevi was 40 when she committed suicide. Her first husband had died and she was married to her second husband with whom she had 4 children. They were economically very poor. They had a miserable life and lived on daily wages. They could not think of missing even one day of work. So her husband and her brother-in-law (Jethaju) went to India to work while she took care of their four children by doing labor work. While her husband was away, her sister in law had an extra marital relationship with a man from the same village. When the brothers returned home from India there was rumor of her sister in law’s extra marital affair in the village. Hearing the rumor, Mayadevi’s husband suspected her and warned her not to keep a relationship with her sister-in-law. But she convinced her husband that she was not like her sister in law and she had not had a relationship with another man. Her husband was not convinced and continued to suspect her. He started to scold her. There used to be frequent quarrelling between husband and wife. Gradually, he also started to torture her, misbehaving and beating her. According to her elder son, his father used to abuse his mother verbally and used to slap and beat her most of the time. Consequently, she felt isolated and humiliated. Whenever she used to visit her maternal home, she used to share her pain with her family members. She also threatened them that she would commit suicide if she had to live such a stressed life. Four days before her death Mayadevi and her sister in law were made to prove themselves innocent as per their traditional rules. At 26th of Kartik, while none of the other family members were in her house, she locked the door and hanged herself.” Reported by the husband, elder son and Maternal and Child Health Worker (MCHW).

- Verbal autopsy of suicide victim, MMM Study2008/09

The pervasiveness of violence and abuse in some women’s lives carries across from one relationship and marriage to another. Many of the 40 in-depth cases reviewed report women and men being married more than once in their lives, and having more than one spouse at a time. No mention is made of divorce.

“Chanda, a married woman of 20 years of age from a rural village of Kailali, was living with her second husband. Her first husband was an alcoholic, used to intimidate, humiliate and beat her; so she left him, and got married to another person who was also already married. Her current husband’s first wife left him and married another person. For a few years, they lived together happily and had one child. Her economic condition was very poor. Her husband used to do labour work in India while she used to work for daily wages. She also used to make local wine at home. Her husband was a drunkard and a very aggressive person. Whenever he came home drunk, he used to scold her and quarrel with her. According to Chanda’s maternal uncle, there used to be frequent quarrelling between husband and wife, and her husband was savage. Because of the lack of income to meet family needs, she was often gloomy and depressed and used to sleep most of the time. Whenever her husband returned from India, he never gave her any money. Even if she asked for money, he used to rebuke her and they used to quarrel.”

- Verbal autopsy of suicide victim, MMM Study2008/09

The vulnerability of women who married into being second wives comes across clearly from the case of Janaki.

“At 18, Janaki was married to a man twice her age. He took a second wife because his first wife had not borne any children, but he continued to live with the first wife and shared her bed. Janaki delivered two children. Her husband neglected her and they quarrelled frequently. The husband used to beat Janaki. A neighbour reported how ‘she was not loved and cared for by her husband. She had to do very hard work to earn money and to feed both her children’. The day before her death, her husband scolded her for no reason, they quarrelled and Janaki went to her maternal home. The next day her husband collected her and she returned with him. That evening while her husband slept with his first wife, Janaki hanged herself in a tree.”

- Verbal autopsy of suicide victim, MMM Study2008/09

There are few reports of sexual abuse in the case histories compared to physical and psychological abuse, though this may be related to the taboo surrounding sexual abuse. However, in the case of Rita, below, it was perceived to be a factor contributing to her suicide.

“Himali, 21, illiterate mother of two children, was pregnant with her third child when she committed suicide. Although no history of spousal abuse was reported in the case history, the FCHV (Female Community Health Volunteer) and the MCHW of her community reported that ‘she was a hysteric patient and she had an illicit relationship with her father-in-law. After treatment, she recovered from hysteria but her in-law used to force her to continue the relation so she was in tension most of the times. Her in-law’s behavior towards her could be the reason she committed suicide’.”

- Verbal autopsy of suicide victim, MMM Study2008/09

Several cases of gender based violence illustrate how underlying social norms related to the choice of marital partner, including caste, underpin women’s psychological abuse and neglect by her family and/or in-laws, and contribute to the decision to commit suicide.

Despite frequent reference to domestic violence few cases report police involvement. Even in the case of Prerna, when her battered body was found, no police inquiry was launched.

“I don’t think that GBV has decreased so we are planning targeted Programmes and coordination from various sectors. We have incorporated this in NHSP II (Nepal Health Sector Programme-II). Violence is an outcome of mental instability. One cannot tolerate it and becomes violent. GBV is high among alcohol and drug addict groups. Dowry system is also promoting GBV. Women are both physically and verbally abused. They are often abused in workplace like factories and even in big business houses but those cases do not come out in public.”

- KII with Policy Maker

Trafficking

One element of GBV is trafficking. Trafficking usually exploits women and children, and trafficked women are often regularly exposed to sexual and physical violence, and face

particular health risks such as HIV and reproductive problems. Consequently, they are likely to experience poor physical and mental health, which may lead to increased risk of suicide.

In Nepal many women and girls face the threat of being trafficked internally and outside the country for forced labour or sexual exploitation (US Department of State 2009). Trafficking commonly occurs from districts to Kathmandu and from Nepal to nearby countries, particularly India; given the long open border between Nepal and other countries, this is easily achieved (Joshi 2009). Many of the victims of trafficking are promised work in the Middle East or Gulf countries, but are in fact sold into sexual slavery or bonded labour. Additionally there have been many reports of parents or relatives selling young girls into the commercial sex trade or as domestic servants out of poverty (US Department of State 2009). Estimates for the number of Nepalese girls that have been sold to Indian brothels begin at 5,000 (Niaz 2003) and reach 12,000 (US Department of State 2009); additionally, 5,000 to 7,000 girls are estimated to have been brought to Kathmandu from Nepal's rural areas in order to meet the capital's growing commercial sex demand (Joshi 2009). The upheaval caused by the Maoist insurgency meant that security was severely compromised during this period, with the result that even higher numbers of females are likely to have been trafficked.

Awareness of the issue is increasing and steps have been taken to try to reduce trafficking and support victims. The government has taken legislative action: in 2007, the Trafficking in Persons and Transportation (Control) Act was passed, which prohibits all forms of human trafficking, with penalties ranging from 10 to 20 years' imprisonment (US Department of State 2008); and the Foreign Employment Act made it a criminal offence for individuals or agencies to send workers abroad on false promises - punishable by up to seven years' incarceration. The MWCSW sponsors training programmes in areas with high numbers of women trafficked to India, and the government provides funding to NGOs for rehabilitation, medical and legal assistance (US Department of State 2009). However, legislation has been poorly implemented to date and hence is unlikely to reduce the number of traffickings. There are large discrepancies between the instances of trafficking reported by independent organisations and those actually brought to court (UNHCHR 2004). Corruption means that officials may facilitate rather than prosecute incidences of trafficking, and public sector employees may need more training. More is needed to monitor agencies recruiting Nepali nationals to work abroad (US Department of State 2009).

Even where victims of human trafficking are recovered and able to return home, they receive limited support and are often rejected by friends and family, particularly when HIV positive. Furthermore, widespread stigma prevents support for victims of sexual violence, and hence there is limited protection against suicidal behaviour. The Nepal 2008/09 MMM study identified a case of a rescued victim of human trafficking and, despite being supported by a rehabilitation centre, she still committed suicide:

"In this area women usually go to a foreign country at least once to earn money. Pasang's husband had died and she was staying with her in-laws. She had previously worked in Kuwait. According to villagers she again intended to go Kuwait but was left in Mumbai, India. Maiti Nepal found her there and brought her to the Maiti Nepal Rehabilitation Center in Kathmantu. However, after that incident, her mental condition deteriorated. On 8th Magh 2065 she was found hanging from the staircase of Maiti Nepal."

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.3.4 Pregnancy outside Marriage

In contexts such as Nepal, pregnancy outside of marriage is often frowned upon. In-depth cases from the 2008/09 MMM Study depict a strong sense of shame felt by girls and women when they become pregnant outside of marriage. This shame exists irrespective of age, for example, a widow aged 40 with four children who committed suicide was reported to have lost her self-respect when the father of her unborn child took no responsibility and fled to India. The lover of a 15-year-old also fled to India on learning of her pregnancy. Shanti's story below, which included attempting abortion at home, not seeking care from a clinic due to lack of money, and the mother's unsuccessful search to find her a husband illustrates the desperation, her lack of control over her life options, and the social pressure on pregnant women to be married. As her mother says:

"By this time she was almost five months pregnant and had lost all her optimism. She quit eating, started getting weaker and weaker, she constantly used to say that it was a matter of shame to her family and no one is going to marry her, thus began to torture herself mentally."

- Respondent for suicide verbal autopsy, MMM Study2008/09

Studies have shown how the social norms surrounding pregnancy discourage discussion of pregnancy and the needs of the woman. In such a social environment disclosing pregnancy outside of marriage magnifies the shame women feel. One 23 year old unmarried woman worked in a brick factory to support her parents and six siblings. She lied to conceal her increased appetite and growing abdomen from her family. The post-mortem showed that she was seven months pregnant when she committed suicide. Her family suspect she may have been pregnant once before and also concealed her previous pregnancy. In neither incident did the family directly confront Gita and ask if she was pregnant. Her parents said:

"Pregnancy was the main cause to commit suicide. She was not raped, but we suspect something might have gone wrong in the place where she used to go for work."

- Respondent for suicide verbal autopsy, MMM Study2008/09

"If an unmarried girl is pregnant, society raises questions on her character though male is also equally responsible for that. No one supports her and she has to suffer alone. Having seen no support mechanism in the family and society she simply chooses to commit suicide. If someone counsels her and shows hope in the future she can be saved."

- KII with a Health professional

6.3.5 Modernisation, Urbanisation and Societal Change

Modernisation undoubtedly brings many benefits, such as improving health and reducing poverty, that are accepted as lowering suicide risk, however, some of the knock-on effects can be less positive. Rapid modernisation challenges cultural structures and institutions that determine individuals' aspirations and conduct. Whereas modernisation has been occurring incrementally for over two hundred years in the West, the sudden post-colonial interest in the development of low-income countries has often lead to increased exposure to external

values, which have not been endogenously created and accepted. This influx of values through technology and media leads to the integration of these ideas into conventional norms and practices, with implications for traditional institutions such as the household and family (Caldwell 1978). As such, many authors suspect that the upheaval caused by rapid modernisation has serious implications for individual wellbeing, and increases suicidal vulnerability.

Urban and rural lifestyles can both increase the likelihood of exposure to suicide risk factors, albeit different ones. Risks associated with urbanisation include social exclusion, alienation (Vijayakumar et al 2005b), substance abuse, and increased job competition (Qin 2005). In rural areas there is frequently increased vocational insecurity and increased access to means of suicide, such as pesticides (Vijayakumar et al 2005b). Likewise, both locations can convene certain benefits: rural dwellers may receive more familial and social support, whilst urban areas provide increased access to health services and job opportunities (Qin 2005). Hence it is not surprising that study findings are contradictory.

In China (Qin 2005), India and Sri Lanka rural living seems to be the greater risk factor for both sexes (Vijayakumar et al 2008). Those left behind as a result of the migration of family members may be at increased suicidal risk due to poverty and reduced family support (Vijayakumar et al 2008) and there may be a *selection effect*, with healthier individuals being more likely to migrate. Conversely, a study conducted in two rapidly developing towns in Nepal's western region found high levels of psychiatric morbidity, which the authors suggest could be due to the weak social structures in larger urban developments (Upadhyaya & Pol 2003).

Weaknesses in data collection preclude an accurate assessment of the impact of urbanisation on suicide in the developing world: firstly, the lack of a universal definition of urbanisation (Qin 2005); and secondly, official suicide data, if available at all, is rarely split by urban / rural location (Vijayakumar et al 2005b). It would appear that urbanisation and rural living could both impact upon suicide risk and incidence, but in different ways. The KII's showed a slight predisposition towards sensing higher suicide rates in urban areas, but this may reflect those selected for interview are largely from urban areas and as above, quotes reflect the opinions of KIIs and are not necessarily factually correct.

"There are no studies to prove it statistically, but from observations it appears that more suicide cases are heard of from urban areas. This could be due to media coverage. But there are suicide cases in rural populations too."

- KII with Policy Maker

"The urban population faces higher stress, mental illness and has greater access to means so this population is at more risk than the rural population."

- KII with Academic

Rapid societal change has profound effects, particularly for the most vulnerable populations. Although economic growth improves the quality of life for many, which may be expected to reduce suicide rates, the gulf between the richest and poorest frequently widens, which can lead to "increased marginalisation, unemployment, erosion of job security, increased poverty, reduced access to health care and education, and reduced social provision for people who are ill or unemployed" (Bhugra & Minas 2007). Furthermore, the disruptive effect of periods of growth upon stable structures and

institutions can have a negative effect on individuals which may lead to depression and suicide (Vijayakumar et al 2005a; Baudelot & Establet 2008).

Evidence from industrialised countries demonstrate that in spite of growing prosperity, the *instability* of sudden growth can cause particular upheaval to vulnerable individuals which may increase suicides. Suicide rates rose steeply during both the construction of socialism in Russia (Kwon et al 2009) and the construction of capitalism in Europe in the nineteenth century (Baudelot & Establet 2008: 180). Baudelot & Establet (2008) observe that 'India, China and Russia are the only countries to have experienced a rise in suicide rates comparable to that experienced under nineteenth-century capitalism'. In South Korea the suicide rate increased following unprecedented economic growth during the 1970s (Kwon et al 2009). Indeed Vijayakumar et al (2008) found suicide rates to be higher in Asia-Pacific countries that attained a high Human Development Index (HDI) relatively rapidly (Hong Kong, China; Japan; and the Republic of Korea) than in those which had achieved this at a more gradual pace (Australia, New Zealand and Singapore). What appears to be common in the countries that had increasing suicide rates is the socio-cultural upheaval brought about by changes in the political and economic system (Kim & Singh 2004: 1090). Yeh et al (2008) observe that working practices often adapt before more rigid social and familial practices. In contrast to the above, Nepal's growth rate has been slower than neighbouring countries, such as India, at 2.4% per annum. Its growth trajectory has also been uncertain, with periods of economic growth often followed by crisis (such as high food prices) and an unstable political situation which hampers the fragile economy. As such, any societal transformation so far has been largely limited to urban areas. Hence, to date, Nepal has not undergone the kind of rapid transition that has affected suicide trends elsewhere.

6.3.6 Displacement

Displacement may be caused by a variety of reasons, with the underlying cause determining which members of the family go and which, if any, stay behind. For example, if the aim is to find work, it is likely that the male breadwinner will go alone, whereas in the case of conflict, the whole family may be uprooted. Nepal's population is at particular risk of experiencing some form of displacement due to its heightened vulnerability to natural disasters such as floods, landslides and earthquakes, compounded by its recent civil unrest (Acharya et al 2006) and high levels of economic migration.

Displacement, either forced or voluntary, has serious implications for personal health and wellbeing. It entails divergence from one's customary environment, and the resources and coping mechanisms available to an individual will determine how easily they can adapt to their new surroundings and circumstances. The effects of displacement are widely felt, affecting the mobile individuals, those left behind, and those in the host community; as such, the impact of displacement on suicide may be varied and far-reaching. Displaced persons may be unable to work or access services, and may face an identity crisis should their views and beliefs differ from those of their host community (Khatiwada 2008). This may lead to feelings of exclusion which can precipitate in poor mental health and suicidal behaviour.

Migration

The impact of migration on the mental and physical health of those affected varies, and as such the effect of migration on suicide risk and behaviours must be considered with reference to the context. Migration has conventionally been a common strategy worldwide in response to lack of job opportunities, resulting in voluntary displacement. It is a common practice in Nepal for husbands to migrate overseas to work for long periods and leave their

wives behind. However, migration is increasingly occurring due to resource depletion, such as food and water scarcity. The Himalayan regions, upon which many have traditionally depended for their livelihood, are undergoing extensive deforestation and soil erosion. The decline of arable land and living resources, coupled with population increase, and the turbulent political and economic situation throughout the Maoist insurgency have forced many men to search for work elsewhere, both within and outside the country (Massey et al 2007; Bohra & Massey 2009).

According to the International Centre for Integrated Mountain Development (ICIMOD) (2009), almost half of all hill households receive remittances from abroad that represent close to 35% of their income. The NDHS (2006) reports that in 37% of households at least one person had travelled away within the 12 months before the study, on average at least two family members were likely to have migrated, and men were nearly three times as likely to migrate as women. Of these migrants, the vast majority (85.9%) had travelled within Nepal, with 11.6% migrating to India and 2.5% travelling to other countries, including the Gulf (NDHS 2006). As Bohra & Massey (2009) note, international migration increased significantly after the liberalisation and restoration of multi-party democracy in 1990 and the trend is likely to develop further as the government strengthens ties with foreign powers.

“Migration and foreign employment are also crucial reasons for suicide. We had internal conflict for a decade and this has created an intensive unemployment situation in our country. Numbers of people in a family have now migrated for employment and the people in the family feel unsecured and unsupported. This increases mental pressure on them and this leads to depression or other forms of mental illness. We are unable to make sufficient provision of primary care for mental health problems at the community level.”

- *KII with Policy Maker*

In Nepal, the number of female-headed rural households rose by 49% between 2001 and 2006 (NDHS 2006). The bulk of migration literature in developing countries refers to the health of wives left behind when husbands migrate. Wives left behind may have to assume farming and economic duties in addition to domestic tasks. In some cases this doubles their physical activities and requires daughters to drop out of school to assist at home (International Fund for Agricultural Development (IFAD) 1999). The increased time needed to complete tasks reduces women's spatial mobility. Despite these increasing responsibilities, socio-cultural norms in Nepal still limit economic and social opportunities (Lokshin & Glinskaya 2009); this means that their husbands' absence may reduce their market access and autonomy. Additionally certain agricultural tasks, such as ploughing, are taboo for women, making duties hard to fulfil (IFAD 1999; Lokshin & Glinskaya 2009).

The literature on husband migration shows a varying impact on wives left behind. Some studies have shown females enjoy greater social and economic autonomy and decision-making capacity from increased responsibilities relating to employment and household management, however, others have shown male migration reinforced orthodox gender roles as women became more dependent on extended family members (Desai & Banerji 2008). Benefits relating to autonomy may be limited to situations where the wife does not live in an extended household, although, other studies suggest that those living in a nuclear family are more vulnerable than those living in an extended family due to the significant increase in their workload (Lamichhane, accessed June 2010).

Desertion or non-transferral of funds by husbands is not uncommon, as highlighted in the 2008/09 MMM study. As such, male migration may have adverse consequences for women's physical and mental health; indeed, Kohrt et al (2009) found that the migration of Dalit men to India in search of work increased the propensity to depression of those left behind due to the decline in material social support, with implications for suicide risk. Transcripts from the 2008/09 MMM Study highlighted the impact of spousal separation, due to economic migration, on relationships:

“Twenty five year old Bindu had an extra marital affair while her husband was overseas for employment. It was known to the locality and when her husband returned back to Nepal, eventually he also came to know about the relationship. The reason was enough to get the couple divorced. They had a son. Under the condition that their son will stay with his father and in return, Bindu received Rs. 100,000 from her husband, the couple separated. After getting separated, she was staying in her parent’s home. Few days after getting separated, she informed her parents that she is going to her former husband’s home to meet her son. As informed, she went to her husband’s home, met her son and engulfed the poison that she had carried along with her.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“Chepa's husband lived in India and she had extra marital affair. When society, in-laws and her own daughter knew about the affair, her daughter scolded her. She could not tolerate the embarrassment and committed suicide in India where her husband lived. The principal respondent said ... ‘she could have been saved if she was forgiven by family members’.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

The treatment by extended family members of wives left behind by migrant workers can also be challenging and contribute to suicidal thoughts and/or behaviours.

“Ambika was a 45 year old widow living with her 4 sons and 2 daughter-in-laws. The 2 married sons were working in India. When her sons were in India, her daughter in-laws abused and neglected her. They did not give her proper food. She used to remain without food for days. Her daughter in-laws quarreled with her and scolded her. They did not care for her. According to one neighbor, she had not taken anything for the last ten days as her daughter in-laws did not give her food. She was becoming weak day by day and had not any strength to work. She was alone, depressed and remained gloomy. On the day of her death she went to the market and bought alcohol. At night she took alcohol and said, ‘Stay happy I am going to next place’ but no one noticed her words. When all her family members went to sleep at night she went to a nearby nursery and hanged herself.” Reported by the woman’s mother-in-law and Auxiliary Nurse Midwife (ANM).

- Verbal autopsy of suicide victim, MMM Study2008/09

The case studies from the 2008/09 MMM study highlighted instances where husbands emigrated for work, but failed to send money home to support their families, even for essential medical care and school fees, and the subsequent strain on the wives left behind:

“She was sick from last one and half years. She used to develop fever and cough. Her husband went abroad after that she was living with her son and was carrying out all the responsibility. She did not have enough money so she took medicine from medical shop and later on her parents took her to Lumbini Zonal Hospital and TB was diagnosed. After that she used to be tense. ‘Father did not send any money so we had a lot of loan’ says her son..... One day she was taken to for check-up by her parents and returned back. In the evening she started to show unusual behaviour like moving here and there. She was worried about something but no one asked her about that. All of us went to sleep. Next day her dead body was found in the pond near home.”

- Verbal autopsy of suicide victim, MMM Study2008/09

In contrast, cases were seen where husbands sent sizeable amounts of money home to families, expecting to see it on their return, and the consequences when wives were found to have squandered it.

“Husband ... was back to home after staying 3 years overseas for earning. During his stay there in abroad, he had sent around Rs.300.000 to his wife. The couple had an argument when he tried to know the status of the money.”

- Verbal autopsy of suicide victim, MMM Study2008/09

“In some cases migrant workers living abroad for a long period, on their return, ask for all the details of the money they had sent from abroad. Many women have been abused in different forms in the name of not providing the satisfactory financial statements to the husbands. These kinds of cases are found in city area like Butwal, Pokhara and Dharan. It indicates that financial management is also one of the main reasons behind GBV; and in many instances it has led to suicide.”

- KII with NGO Worker

One case study highlighted the extent to which families come to depend on the wages of those working overseas, and the repercussions when this wage is no longer available:

“Mother of four children, Juna was from a financially weak family setting. In search of earning, her husband went to India. He was doing quite well and was earning satisfactorily. His family were enjoying quite a prosperous life. Unfortunately, while on an office assignment, he had a road accident. Though his life could be saved he became mentally abnormal. For this reason, the company send him back to his home in Nepal. As his entire family was financially reliable on him, when he became unfit physically, the financial status of his family was getting poorer day by day. Gradually, their neighbours and people in their community stopped any financial loan/support. The family atmosphere started becoming unpleasant; there often used to be quarrel between husband and wife. Even the community intervened between them thrice and avoided them from getting separated. But, there was no improvement in their relationship. Being disappointed from her life Juna finally decided to commit suicide. Within a month time, 5 members from the same family committed suicide.”

- Verbal autopsy of suicide victim, MMM Study2008/09

Conflict

Forced displacement due to conflict is a common and growing phenomenon in many parts of the world. With the huge potential for violations of physical and mental wellbeing, the impact of political violence and forced migration are likely to increase suicidal tendencies. For example, growing suicide rates in many Latin American countries are attributed to political volatility (Herrera et al 2006).

Internal conflicts have been frequent in Nepal (Tol et al 2010). In 1996, Maoist rebels began the People's War and by the time a Comprehensive Peace Agreement was reached in 2006, the conflict had left more than 10,000 dead (Thapa & Hauff 2005). The number of persons still displaced by the conflict is estimated to be between 50,000 and 70,000 (International Displacement Monitoring Centre (IDMC) 2010). Figures for the total number displaced throughout the conflict would have been much higher, with Kathmandu alone estimated to have hosted more than 100,000 people during the ten-year period (Bohra & Massey 2009). Many of those displaced were forced to flee without documentation, putting them at a significant disadvantage when looking for work, forcing them to take lower-paid, menial jobs and rendering them economically and socially vulnerable. Tol et al (2010) explain that in those areas affected by the conflict, the Maoists' presence drastically changed the norms and institutions upon which people made their daily decisions and lives; as discussed above, rapid societal change can have implications for depression and suicidal risk in its impact upon social capital and relations. Additionally, many families were separated with no means of communication, and young boys were recruited as child soldiers. Given the centrality of familial solidarity to sound mental health (discussed above), such separation may cultivate suicidal tendencies in those affected. The loss of property such as land and resources also compromised individuals' ability to maintain a livelihood, and increased the chances of poverty.

"..... the decade long conflict led to displacement and migration of a large number of people from villages to cities. The city areas got over populated with limited employment opportunities. People could not meet their expectations and as a result some of them choose to take their own life. Poverty aggravated by unemployment has led to increase in suicide in Nepal."

- *KII with a Police Officer*

Conflict in Nepal has had particular consequences for women, given both their heightened vulnerability and lower position within society. Firstly, conflict places women at greater risk of sexual and physical violence, such as rape, assault and torture, thereby increasing their vulnerability to HIV and unwanted pregnancy. Women are more easily kidnapped and trafficked when separated from their families and have no male protection. They were reportedly forced to work in the service of the insurgents and have sex with militia (Ward & Marsh 2006). Similarly, it is reported that those forced to resettle elsewhere often had to resort to prostitution due to their lack of skills and documentation. HIV risk is particularly high amongst displaced girls and women (IDMC 2010). Nonetheless, some Maoist doctrines support modern notions of gender and caste equality, advocating against gambling, drinking and domestic violence (Tol et al 2010). As such, many women support the Maoist cause and were mobilised in roles traditionally undertaken by men. However, challenges to orthodox gender roles can damage social relations and place stress on families (Tol et al 2010).

Conflict-induced displacement can have an independent impact on mental and physical wellbeing. Many aspects of the recent conflict in Nepal can increase suicidal tendencies.

Psychological distress was widely reported during the conflict, and often presented as physical complaints, such as headaches (Tol et al 2010). One survey found that almost all subjects reported trauma and 53.4% had post-traumatic stress disorder (Thapsa & Hauff 2005).

Mental disorders are frequently reported in populations following conflicts and complex emergencies, even where there has been no direct exposure to violence (Prince et al 2007). As such effects of conflict and violence on suicidal ideation are likely to sustain long after formal resolution, irrespective of the success of rehabilitation efforts. In Nepal there is no coordinated mental health strategy for disaster response (Acharya et al 2006). Furthermore, although in 2005 the Inter-Agency Standing Committee established a global Task Force to set guidance for organising such support in emergency settings (Jordans et al 2010), the preceding section outlining Nepal's mental health personnel and infrastructure to date suggests that little has been done to meet these guidelines. As such, displacement caused by the People's War may be strongly influential in suicide risk in Nepal.

In 2006, the Maoists and the royal government signed a formal commitment to encourage displaced persons to return to their homes and be reunited with surviving family members. However, to date, no adequate provisions have been made for those displaced by the insurgency, and those who have managed to return home have received no state support (IDMC 2010). There is yet to be a coordinated effort at rehabilitation (Khatiwada 2008), and although in 2007 the government adopted a national policy to identify displaced persons, the logistical difficulties posed by the registration process has largely undermined progress, and awareness of the programme remains low (IDMC 2010).

Refugees

Refugees suffer similar social and economic prejudices and disadvantages as displaced persons, but are seldom able to return to their place of origin. Since most refugees are forced to flee without prior warning, few are able to provide proof of identity that would secure a work permit in their place of resettlement. More than 20,000 Tibetan refugees and over 100,000 Bhutanese refugees in Nepal have sought asylum in Nepal in order to escape political persecution in their own countries (Pandey 2006). A tacit agreement reached between the Nepalese government and the United Nations High Commissioner for Refugees (UNHCR) in 1990 accords Tibetan refugees safe transit through Nepal to India, however, this often results in many Tibetans establishing themselves within Nepal. It is estimated that between 2,500 and 3,000 Tibetans continue to enter Nepal on an annual basis, however, due to political pressure inflicted by China, those crossing the border after 1989 are deemed illegal aliens by Nepalese law and subject to deportation (Tibet Justice Center 2002). Sometimes the Nepalese government hands over Tibetan refugees to the Chinese, where they face the possibility of imprisonment and grave human rights abuses. Nepal's Bhutanese refugee population comprises Nepali-speaking Lhotsampas who were legally excluded by their government who revoked their Bhutanese citizenship if they could not prove that they had been resident in the country in 1958 (Cultural Orientation Resource Centre (COR) 2007).

Nepal is not party to the UN Refugee Convention or Protocol and refugees are not recognised by national legislation (Ruiz & Berg 2004). As such, refugees and their children lack nationality and official legal status and rights, and remain largely isolated from Nepalese society. Within Nepal, there has been little effort to find permanent solutions for refugees. The Bhutanese still live in make-shift camps in eastern Nepal. The restricted access to basic needs such as water, sanitation and medical services, along with poor diet means that refugee health status is invariably low, and their exclusion from employment and education

makes them economically and socially vulnerable. Sustained exposure to these pressures mean that Bhutanese refugees living in these conditions are at increased risk of both physical and mental disorders which may induce suicidal behaviour. Ruiz & Berg (2004) report that suicide rates in the Bhutanese camps are more than four times higher than that of the surrounding areas; similarly, Tol et al (2010) review a study of tortured Bhutanese refugees in Nepal which finds a 'consistent long-term impact on the mental health of the refugee population (40)'. Moreover, whilst the Tibetan refugees are ostensibly more integrated with the Nepalese, most nationals continue to see them as foreigners, and as such they face widespread exclusion and xenophobia (Tibet Justice Center 2002); it is therefore likely that Tibetan refugees also face this heightened risk of suicide.

6.3.7 Alcohol & Substance Abuse

There is a well-established link between alcohol and/or substance abuse and increased vulnerability to suicidal tendencies, and this also extends to family history of substance abuse (Fisher et al 2001). In Asia, alcohol and substance abuse is increasing, especially among men (Patel et al 2007), and studies in India and Taiwan have found a positive correlation between alcoholism and suicide (Vijayakumar et al 2005b). In developing countries it is thought to be largely the impact of a husband's alcohol / substance abuse that leads to an increased suicide risk in female counterparts, often due to the increased risk of GBV. Studies in Uganda have shown that women whose partners drink alcohol on a regular basis are at four times the risk of physical and sexual violence than those women whose partners do not consume alcohol (Puri et al 2010). Alcohol and substance abuse are recognised as increasing aggression and impulsiveness, which are both implicated in suicidal behaviour (Sher 2006).

Street children are also particularly vulnerable to substance abuse. In Nepal, there is huge variation between estimates, but local organisations approximate there are between 800 and 1,500 street children, with around 1,200 living in Kathmandu. Street children are exposed to violence, exploitation, and discrimination on a daily basis. They are highly stigmatised and abused, even by public authorities. Extreme poverty and miserable living conditions often force them into delinquency, and many turn to drugs and alcohol consumption as coping mechanisms. Ill-health, unwanted pregnancies and HIV/AIDS (Acquired Immune Deficiency Syndrome) are all heightened risks amongst street children. All of these factors contribute to poorer mental and physical health, greater risk of injury and murder, and a greater propensity to suicidal behaviour owing to their frustrating life conditions (Kenyon Densley & Joss 2000; Panter-Brick 2002; Ali et al 2004). Substance abuse was mentioned in the KII's, and largely seen as linked to behaviour among the lower caste (see Section 5.1.4). In case studies from the MMM 2008/09 study, substance abuse was mentioned frequently, and interestingly in reference to the wife, just as much as the husband:

“Sunita only got married a year ago. Her husband was an alcoholic and the couple frequently quarrelled with each other. Sunita was the only child of her parents and her own father and mother were no more. She was left with no one to share her pain. She heard a rumour from the villagers that her home was being sold by her husband. This made her frustrated with her life and she committed suicide.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“She was an alcoholic and used to take alcohol daily. She frequently quarrelled with her husband about her drinking habit. Whenever her family members asked her to stop

drinking she used to quarrel with them. Because of the frequent quarrelling, she was separated from her children and she started to stay in a field nearby the jungle with her husband. She did not stop her drinking habit. One day before her death, she lost her ox in the jungle and she was intense as she did not find it. Next day when others were in the field she took alcohol and went to the jungle, and hanged herself in a tree.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.4 Environmental Factors

6.4.1 Access to Means

Easy access to suicide means, such as firearms or poison, may increase the likelihood of both attempted and completed suicide. In particular, it is likely to have an impact in facilitating impulsive suicides (Ajdacic-Gross et al 2008). It is becoming increasingly common for countries to restrict access to materials that are capable of causing death, either directly or indirectly. Legal measures controlling the ownership of firearms and sale of alcohol to minors are in place in most countries worldwide. In developing countries, preventative initiatives have tended to target access to pesticides as the most important factor in suicide prevention. Studies that have monitored suicide rates before and after the introduction of restrictions regarding access to pesticides have observed a reduction in suicide rates, hence providing evidence that access increases risk (Vijayakumar et al 2005).

6.4.2 Role of the Media

Many studies have suggested a link between improved access to modern technology, such as the internet and media, and an elevated risk of suicide (Kwon et al 2009) due to the availability of information and imagery which may prompt self-harming behaviour.

The media is often the source of information regarding victims' profiles and circumstances, and as such, holds enormous power and responsibility in its presentation of suicide to the public. It plays an important role in influencing attitudes and opinion towards public health issues, such as GBV, and mental illness (Miller 2007). As such, accurate reporting is essential to garner public support for policies targeting risk factors relating to suicide. However, the media often misinform readers, tending to simplify the underlying factors and focus on immediate individual motives rather than highlighting ingrained cultural and societal practices (Beautrais et al 2008). A study conducted in Israel compared national statistics regarding suicide motives with those reported in the press (Fishman & Weimann 1997). The researchers found significant discrepancies and public understanding of suicide patterns was deeply flawed due to media misrepresentation. The media indicated that male suicides were usually induced by economic hardship, while female victims were usually triggered by failed romantic endeavours. National statistics showed the reverse to be true. Mental illness was also grossly under-represented in suicide risk and underscored the continuing stigma attached to mental health in the press and its reluctance to take the lead in changing prevalent perceptions. The resultant danger is that the real issues that social policies need to address are often overlooked.

A further concern relating to the portrayal of suicide by the media is the suggestible nature of self-harming behaviour, particularly amongst younger people and in smaller communities (Kim & Singh 2004; Herrera et al 2006; Beautrais et al 2008). In addition to the trauma

rendered to the victim's family as a result of the often graphic accounts and photos common to the Asian press (Pradhananga & Shrestha, accessed June 2010; Beautrais et al 2008), print media can enhance socio-cultural acceptability by spreading opinion widely and rapidly, and media portrayal of suicides has been linked to copycat suicides (Beautrais et al 2008). The introduction of media guidelines in countries such as the Republic of Korea has been found to increase the likelihood of responsible reporting and inclusion of information about warning signs and treatment in coverage of a suicide. Such considerations would be extremely relevant in Nepal. Furthermore, as highlighted in the KII's, the media can play a key direct role in influencing the suicide:

“Laxmi had failed the same class (SLC) for the last two years. She found out she had failed for the third time in the result published in the newspaper on 11th of Baishak. She could not tolerate her sorrow and took the pesticide.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.4.3 Nepal's Legal System

Suicide risk is often reduced by protective measures operating within legislation outlawing practices and products encouraging or facilitating suicide. For example, restricting access to lethal materials and criminalising gender-based discrimination and substance abuse often form the basis of national suicide prevention programmes. This section describes the history of Nepal's legal context. Nepal's first unified Country Code, the *Muluki Ain*, has been in force since 1854 and continues to form the basis of the legal system today, with the provision that, where no new statute supersedes it, it remains the supreme legal authority (Pradhananga & Shrestha, accessed June 2010). The relationships set out by the legal system were based on kin group, family lineage, caste and sex, hence many of the inequalities rife in Nepal at the time based on these, supposedly, immutable aspects of identity were given legal backing.

The long-standing gender inequality in Nepal is therefore firmly rooted in legal doctrine. For example, the legal system institutionalised the Hindu perception of women and children as the property of the father, thereby denying women property rights in inheritance (Pradhananga & Shrestha, accessed June 2010). Nepal has made substantial efforts to prioritise the wellbeing and perception of women in its national agenda in order to adhere to global paradigms, with increasing recognition of women as citizens who should have equal legal and political rights (Joshi & Kharel 2008).

Nepal is party to all of the international conventions relating to the rights of women, however, these conventions are often a sharp contrast to the reality of life for many women (Niaz 2003). Tangible steps are being made towards eliminating gender-based discrimination and violence. It is strongly rejected in the Interim Constitution 2007, which also enshrines women's reproductive rights. In the previous Code, the only recognition of violence was as grounds for divorce, and women could only litigate under general assault and verbal abuse legislation (Pradhananga & Shrestha, accessed June 2010). The Domestic Violence (Crime and Punishment) Act 2008 defines 'domestic violence' broadly as 'any form of physical, mental, sexual and economic abuse...acts of reprimand or emotional abuse'. Furthermore, the perpetrators of domestic violence are those with whom the victim has a 'family relationship', defined as anyone currently or previously living in a shared household; as such, this also encompasses violence by family members such as in-laws.

The Nepalese government is also trying to improve women's status through other legal initiatives. In 2006 sexual harassment was prohibited under the Gender Equality Bill, and the government criminalised marital rape under the Gender Equality Amendment Act, expanding the definition to include forced sex by a husband (WHO 2009a). This put Nepal ahead of its South Asian neighbours: as marital rape is exempt from punishment in India, Pakistan and Bangladesh. The original 1854 text of the *Muluki Ain* outlawed the practice of *sati*, but this has also been enhanced by subsequent legislation. In 2005, the Supreme Court banned the practice of *chhaupadi*, and the government has subsequently issued a protocol for its eradication (Sharma 2010). Similarly, in 2009 Nepal's Prime Minister made the practice of dowry a criminal offence. The practices of *deuki* and *badi* have also been outlawed in Nepal, however certain customs, such as *kumari pratha*, remain legal since they are ordained by Buddhist beliefs; as such they are seen as outside the proper purview of the law (Chhetri 2001).

Whilst such measures have been applauded by women's organisations worldwide, many are quick to caution that the mere existence of a legal remedy is no guarantee of corresponding improvement in quality of life; as Niaz (2003) observes such advances have been met with substantial cultural resistance in some regions, where traditions and customs are so rigid that they do not allow a woman to seek justice even when she has the legal right. Puri (2010) adds that in practice, laws protecting women from violence are rarely invoked as authorities are more likely to sympathise with the perpetrator than the victim; in many cases law enforcement agencies will therefore try to settle disputes without pressing charges (Dhakal 2008). A report by the US Department of State (2009) concluded that 'the law provides an independent judiciary, but courts remain vulnerable to political pressure, bribery, and intimidation'. Awareness of the laws relating to women's rights remains low, with most people still ignorant of their existence (Puri et al 2010).

In spite of its considerable progress to improve the legal status of women, Nepal has been criticised by the CEDAW Committee for failing to fulfil its obligations to take sufficient action to repeal its discriminatory laws (UNHCR 2004). The Human Development Report (HDR) 2009 notes that a study conducted for Gender and Social Exclusion Assessment in 2005 found 32 provisions that discriminate on the basis of religion, caste and ethnicity, and 176 provisions that discriminate against women (UNDP 2009). For example, although bigamy was officially outlawed along with child marriage in 1963, a man is permitted to remarry without divorcing his current wife where she becomes mentally or physically incapacitated, blind, lame or infertile (Pradhananga & Shrestha, accessed June 2010). As such, a change in attitudes and behaviour towards gender-based discrimination and violence must supplement further legal advances if meaningful progress is to be made.

Another essential legal domain for suicide prevention efforts is mental health legislation. This is particularly important for those in involuntary treatment (Saxena et al 2007) and when mental illness is heavily stigmatised. Globally, although most countries have mental health policies and legislation (Jacob et al 2007), Saxena et al (2007) observe that most were in place before mental disorders received adequate attention, and have not been revised since 1990. As such, many policies do not incorporate recent developments.

Nepal formulated a National Mental Health Policy in 1997, but took many years to fully operationalise it in active legislation. In 2006 the parliament passed the Mental Health (Treatment and Protection) Act, which sets out the provisions for the establishment and operation of Nepal's National Mental Health Centre, as well as safeguarding the rights and treatment of the mentally ill. Crucially, it outlaws discrimination and maltreatment of

individuals with mental disorders, although the effectiveness will also depend on wider efforts to destigmatise poor mental health. Therefore, although Nepal's mental healthcare budget remains low, the issue is at least receiving increasing attention.

As Trivedi et al (2007) note, although Nepal has the lowest Gross National Product per capita of the SAARC countries, it is one of just four with a national mental health policy (and now law) along with India, Bhutan and Pakistan. However, Saraceno et al (2007) suggest that mental health legislation has been devised by government bureaucrats without the involvement of essential mental health stakeholders, such as service providers, NGOs, and patients; as such, the content and comprehensiveness of national policies may not accurately reflect the needs of the mentally ill. Further, there is no regulatory body to monitor mental health facilities and impose sanctions on institutions which violate patients' rights (Jha & Adhikari 2009). However, it is hoped that the political will demonstrated by the Nepalese government with regard to mental health will prove as effective as in improving maternal health.

6.5 Precipitating Factors: Recent Stressful Life Events

The social, clinical and environmental factors outlined in the preceding sections interrelate to determine the suicidal risk of a given individual. However, attempted suicide may be a response to a single, triggering event, for which the victim cannot identify an alternative or reparative solution with the coping mechanisms at his/her disposal. Stressful life events cited in the literature include: interpersonal loss, conflict, or rejection; loss of employment; economic problems; incarceration or legal troubles; eviction; and being diagnosed with a terminal illness (Vijayakumar et al 2005b). Some of these have been discussed above; below bereavement and academic failure are discussed in more detail as they are common to the suicide literature from Nepal.

6.5.1 Bereavement

Studies investigating the impact of bereavement on mental health and suicide risk have found a positive association (Qin & Mortensen 2003; Agerbo 2005). The loss of a spouse or a child, especially a younger one, has been linked to increased suicide risk (Qin & Mortensen 2003; Agerbo 2005), and bereavement may be more indicative of suicide in men than in women (Agerbo 2005). The loss of a relative can also have an economic as well as emotional impact (particularly in contexts such as Nepal where women are often financially dependant on men). Bereavement as a suicide risk is particularly pertinent in Nepal, where neonatal and infant mortality stand high at 33 and 48 per 1,000 live births respectively, and life expectancy remains low at just over 60 years (NDHS 2006). Whilst these figures are improving, bereavement is clearly a much more frequent risk factor in developing countries. Furthermore the taboo attached to widows in many Asian societies means that spousal bereavement may have particular implications for the quality of life of the surviving partner; for example, until the passage of the Interim Constitution 2007 in Nepal, citizenship was only conferred upon reaching the age of 18 through a father, husband or brother, meaning that child widows were often left without legal identity. Bereavement, particularly the loss of children, was apparent as an underlying factor in the 2008/09 MMM case studies:

“After she lost her seven month baby she used to be tense. She started showing unusual behaviour like crying, shouting, singing songs remembering her son, dancing, talking about her baby. She used to grieve where her child was buried. She didn't listen

to others. Often she used to sit where her baby had been placed for the last time and talk alone. She used to say, 'take me with you' and 'I will hang myself'. She was not taken to any health facility because she was not suffering from any illness. Since she was mentally disturbed due to that incidence we thought that we can convince her by providing our emotional support but suddenly she took the poison."

- Respondent for suicide verbal autopsy, MMM Study2008/09

"We had three daughters and two sons. One daughter had already died and one son died in Magh. Then my wife started being tense. It was first week of Falgun when a medical personnel came to my village and I was called there, since my nine years old son could not walk properly because of a tumour in his fibula. I took my son for check up and the medical personnel told me that he will only survive till he is 12 years old. My brother-in-law was also there and he heard all these things. Later when we went back home, he told everything to my wife. She then started saying I have just lost my one son and another son is at risk of dying, how can I see all my sons dying and cried a lot. Though I tried to convince her, she used to cry, remain quiet, get angry and stay alone. I was unable to calm her down. But all of the sudden on 14th of Falgun when I went to serve food to her I found her hanging and she had already died by the time I reached there."

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.5.2 Academic Failure

In many developing countries a good education is perceived to be the only means of securing lucrative employment. Many are fortunate just to have the opportunity to receive an education in the first place, therefore failure means losing this precious advantage. The pressure to do well in exams, and the shame associated with failure, has been cited as causes for suicide among young people. There is strong competition for college/university places, and considerable media hype associated with final school exam results (Vijayakumar et al 2008). Parental pressure on children to succeed at school can derive from the financial burden entailed in pursuing education (Ratnayake & Links 2009).

In many Asian societies young people often internalise study-related problems (Arun & Chavan 2009) and as such can impact on suicidal thoughts and/or behaviours. The impact may differ for girls and boys. Niaz (2003) reports that young girls may turn to suicide following poor exam results for fear of being married off, instead of being allowed to study and earn their independence. Academic failure has emerged as a factor contributing to suicidal behaviour amongst young people in Nepal. Many youth have taken their own life after realising their educational achievement was not in line with the huge investment and expectations from their parents. Being successful in studies is often seen as social prestige.

The Police records show that suicide among youths is higher during the SLC examination and immediately after publication of its result. Hospital staff report that the number of emergency admissions is higher during the week the SLC result is out and a large number of cases are suicide attempts by the students. The records show that a large proportion of students who take the SLC fail (40-50%). Psychosocial experts argue that adolescents are more prestige-conscious, and lose self-esteem when they fail academically and when they perceive that they are losing love and care from their beloved ones. It can lead to depression

and suicide. Suicide notes from young people often indicate the mental stress resulting from educational failure and concern for the amount of money their parents spent on their education. The case studies from the 2008/09 MMM Study included cases of young women who consumed poison after failing academically:

“She was poor in her study. She failed in mathematics and was going through severe mental stress. For the same reason, to commit suicide, she took metacide.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“As soon as she heard that she had failed in the SLC exam for the second time she took the poison.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

6.5.3 Interaction of Multiple Factors

The sections above have highlighted a multitude of underlying determinants of suicide and explained how they may increase risk of suicide. It is clear, both from the literature and the analysis of cases from the 2008/09 MMM Study, that there is usually an interaction of multiple factors, rather than just one driver, behind an individual suicide case. Furthermore, the relative weight of different underlying factors varies by context (and individual).

We analysed all of the verbal autopsies from the 256 suicide cases identified for the 2008/09 MMM Study (age 10-50), and assigned multiple underlying causes to get a better understanding of the relative importance of different factors (Table 18, Figure 11). Unfortunately this information was not available from the 1998 study for comparison.

The findings highlighted the key role that family, marital and relationship factors play in contributing to suicides among women in Nepal, as observed in nearly two thirds of cases (65%), with husbands being by far the predominant contributor (35%). Furthermore, this may be an underestimate given the husband was often the respondent for the verbal autopsies. However, it is also clear that a wide variety of family and non-family members, and sometimes more than one individual, played a key role in the lead up to the victim's deaths including unrelated males; parents; in-laws; children; siblings; and second wives. Likewise the predicaments that victims had with these individuals varied. In over a third (38%) of suicide cases intimate partner relationships played a role, namely in the form of unhappy marriages (24%). This may be a more common underlying factor in a context, such as Nepal, where divorce is frowned upon, and women are financially dependent on men. There were also reports of women who were involved in socially unacceptable relationships (10%) and frequent reports of extra-marital affairs, surprisingly equally reported on the part of the wife and the husband. Affairs on the part of the husband may be less likely to be reported, especially if the husband was overseas (and hence unnoticed by his community) or if he was the main respondent for the verbal autopsy. Affairs on the part of the wife were sometimes linked to husbands working overseas for long periods of time and leading to suicide once the husband returned home and found out about it, or a pregnancy entailed. It is very common in Nepal for men to migrate for work, reported in 11% of suicide cases, and from reading the transcripts it is clear this is having a detrimental impact on relationships with spouses. Polygamous relationships were mentioned in 5% of the case studies. There were often links between polygamous marriages and pressure to have children, with men sometimes taking a second wife if the first fails to bear children or a son, and this can

produce tension between wives. Second wives may be particularly vulnerable if they are young and a big age gap persists.

“Yatimaya, 21 years of age, was in a love relationship with a boy from her village. Her parents opposed the relationship and when they found out about it beat and locked Yatimaya in her room. Yatimaya threatened that she would commit suicide by hanging if her parents prevented her from marrying the boy. She went on to marry the boy and lost the support of her family. After marriage, she started to live with her husband nearby her maternal home. Her parents used to say, ‘It was your choice so you do your own job. It’s not our concern’. Her economic condition was poor. She used to work in the agricultural field. Her husband was also not supportive in work. He was completely unaware of agriculture work and house work so she had to manage everything. In the meantime, she lost her first child four days after delivery. She had another child (a daughter) of four month for whom she used to worry about her future. She always used to think about the economic condition of her family. Not being able to cope with the burden of isolation from the parents and her family’s economic condition, one day she tried to hang herself; but her husband saved her. Her maternal parents used to insult her. They used to abuse her verbally whenever she came across them. They never accepted her marriage. She was tense and disturbed. On 5th of Ashoj, there was a death ritual at her mother’s home and both of them were invited. Her husband went alone to attend the ritual but she stayed at home. In the evening, her husband returned home and saw her daughter crying. When he opened the door, he found Yatimaya hanging. She had killed herself. Reported by her husband. Her father-in-law believes she couldn’t tolerate the pain of being rejected by her maternal parents and having to perform a heavy work load while mothering a small child.”

- Verbal autopsy of suicide victim, MMM Study2008/09

As noted above, GBV takes on many forms and was mentioned in over one third of cases (35%). It is likely to be under-reported in the transcripts, especially physical or sexual abuse by family members. Non-family members, such as neighbours, were more willing to report instances of GBV than the family members themselves. Although it was still common for husbands to openly report scolding their wives, indicating that this is seen as acceptable behaviour. Psychological abuse was reported in over one quarter of cases (29%). Alcohol or substance abuse was reported in 13% of cases, again equally on the part of the wife as much as the husband, although, the husband’s alcohol consumption may be under-reported. Alcohol consumption had links to many other factors including poverty, migration, GBV, and extra-marital affairs.

“Sima, 25, was an illiterate mother of one child. She had a pleasant relationship with her husband. After two years of marriage her husband went to Malaysia and returned back after two years. On his return he started to drink alcohol and misbehave towards his wife. He was aggressive in nature, and used to fight with villagers and family members too. They often quarreled with each other and her husband used to beat her. He had extra-marital affairs. He never gave her money even for household expenses, and did not care for his son. ‘Whenever we tried to solve problem or save Sima, he started to beat us. Once we called the police and they kept him in prison for 3 days but we did not find any changes in his behavior,’ said her sister. After Sima’s death the husband married within 2 months and beat his new wife too. Reported by Sima’s sister, Rupendehi..”

- Verbal autopsy of suicide victim, MMM Study2008/09

“Pramila married ten years before her death and had one child. Although it was a love marriage she left her husband for another man after 4 years of being married. Later her family returned her to her husband. She had a drinking habit, and she and her husband drank alcohol together at night. Pramila usually used to invite boys from the village to join the drinking and this caused conflict between her and her husband. Pramila and her husband labored in the same place along with their female neighbour. Her husband and the neighbour had an illicit relationship. On the day of her death, her husband did not return from work with Pramila because of some extra work. When he returned home at night he found her drinking alcohol together with some villagers. He scolded the boys and Pramila. She mixed the poison with alcohol and took it. When her husband knew what had happened he beat her severely so she ran away and stayed in a neighbour’s home. Her condition deteriorated but her husband was drunk. He did not go after her.”

- Verbal autopsy of suicide victim, MMM Study2008/09

Mental health was mentioned less commonly than other studies have found, and in most cases where it was apparent, an underlying social cause, such as intimate partner relationship issues or poverty, or a chronic health problem was mentioned. This may be a result of lack of awareness of mental health problems, and very few specified the type of condition, with depression being the only type of mental illness specified. It was difficult to assign cases directly to maternal depression, although it was clear in some cases the victim was pregnant or had delivered a child in the last one year, suggesting maternal depression could have been a factor. Chronic illness was often linked with other underlying factors. Women were commonly concerned about the cost of their treatment and hence the burden on their family. There is also a link to women’s status in that women are expected to suffer in silence, which may lead many to the point where they see suicide as their only way out. Chronic illness also affected some unmarried women’s opportunity for marriage. Again this is more likely to be an issue in contexts such as Nepal, where women are expected to marry, to marry at a relatively young age, and to marry before younger sisters. Suffering from a chronic illness may prevent marriage altogether, or affect the timing of marriage.

“Sushila was 28 and the mother of 3 children. She was a chronic alcoholic and suffered from severe stomach pain. Her husband worked as a labourer, and sometimes they fought about the children’s future and their economic condition. She had been to Dhanagadhi and Paliya Hospitals for treatment and recovered after taking medication. But once she stopped taking medicine, her problem started to make her life worse. She could not work due to the pain. Several times, she was taken to dhamijhankri, a traditional faith healer as well but she could not recover completely. Her family spent lots of money for her treatment but her illness was never treated successfully. Not being able to recover from the problem, Sushila used to be frustrated with herself. She always thought about her husband and her children. She used to feel guilty for not being able to help her husband. On last day of Shrawan, she went to spray the insecticide in the wheat field and kept three tablets with her. Later in the evening at home, while her husband and children were watching television in one room, she went to other room and took all the three tablets. It was around 6 pm. Only at 7 pm, her husband knew about this when she was vomiting. Immediately, husband arranged a motorcycle from the village and took her to the nearest health facility. She was referred to the Seti Zonal Hospital in Dhanagadhi where she was admitted

immediately and treatment was started. At night, she was recovering well. Her condition was better and she was able to talk to her husband. But the next day in the very early morning, her condition started to deteriorate. She became unconscious. Despite the concerted effort of the doctors, she breathed her last at around 11 am. Her husband said, she used to threaten me, telling that she would commit suicide. He felt she might have committed suicide as she could not bear the pain due to gastritis.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

Financial issues were specifically mentioned in 19% of suicide cases with poverty adding to women’s general burden and suicide risk. These issues were often linked to economic migration or being from a low caste and hence having limited employment opportunities. However, poverty was the context for many women, which likely contributed to their suicide risk.

Notably, two key stressful life events influenced some women’s suicide: bereavement (largely due to the loss of one or more children) and academic failure. The links between academic failure, the publishing of exam results in the newspaper, and pressure from parents were very apparent. In some instances, it was parental pressure to study, rather than specifically academic failure, and the arguments that ensued when children did not spend enough time studying that contributed to suicide. Often arguments about study involved more than one sibling, with parental expectations for older ones to support younger ones.

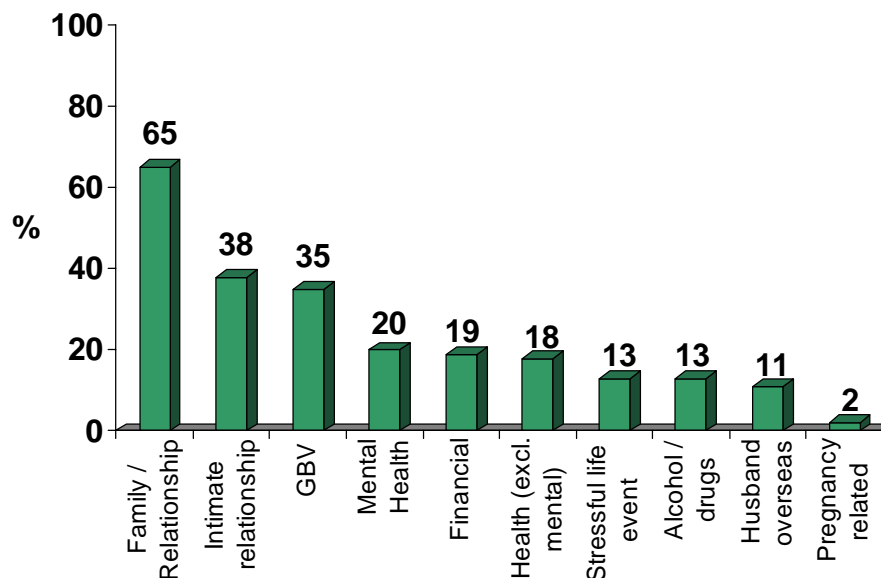
Table 18. Underlying factors related to suicide of women in Nepal aged 10-50

Underlying Factors	No.	%
<u>Family / Marital / Relationship</u>	166	64.8
- Husband	90	35.2
- Male (non-relative)	27	10.5
- Parents	23	9.0
- In-laws	20	7.8
- Son / Daughter	17	6.6
- Brother / Sister	7	2.7
- Second wife	3	1.2
- Family member (un-specified)	6	2.3
- Other	4	1.6
<u>Intimate Relationships</u>	97	37.9
- Unhappy marriage	61	23.8
- Socially unacceptable relationship	26	10.2
- Extra-marital affair - husband	14	5.5
- Extra-marital affair – wife	14	5.5
- Polygamous relationship	13	5.1
- Not able to be with man she loved	12	4.7
- Opposed to arranged / forced marriage	5	2.0
- Pressure to produce a child / son	4	1.6
- Concern about being unmarried	2	0.8
<u>Gender-Based Violence</u>	90	35.2
- Psychological abuse	74	28.9
- Frequent quarrelling	41	16.0
- One-off argument	38	14.8
- Physical abuse	28	10.9
- Deprived resources	14	5.5

- Sexual abuse	8	3.1
- Treated as a commodity	7	2.7
<u>Mental Health</u>	50	19.5
- Depression	12	4.7
- Un-specified	38	14.8
<u>Financial</u>	48	18.8
<u>Other Health Problem</u>	46	18.0
- Chronic illness	33	12.9
- Acute illness	2	0.8
- Infertile	1	0.4
- Un-specified	11	4.3
<u>Stressful Life Event</u>	34	13.3
- Bereavement	10	3.9
- Academic study	9	3.5
- Quarrel with employer	1	0.4
- Other	17	6.6
<u>Alcohol / Substance abuse</u>	32	12.5
- Self	20	7.8
- Other	17	6.6
<u>Husband working overseas</u>	27	10.5
<u>Pregnancy-related</u>	5	2.0

Source: 2008/09 MMM Study

Figure 11: Underlying factors related to suicide of women in Nepal aged 10-50



Source: 2008/09 MMM Study

The sample size from the EAW study for those who had either thought about or attempted suicide was too small to draw conclusions about the relative weight of underlying reasons (Table 19). However, this data is interesting in that it is the person themselves reporting. A range of reasons were given, and reflected those highlighted above, although depression emerged as a main reason.

Table 19. Reason for thinking about or attempting to commit suicide

	No.	%
Depression	3	7.7
Financial reason	2	5.1
Tension / quarrel at home	2	5.1
Domestic violence	1	2.6
Scolding	1	2.6
Alcoholic Husband	1	2.6
Other	1	2.6
N = 39		

Source: EAW Baseline Survey 2010

7.0 Care Seeking Behaviour for Suicide Victims

In many cases from the 2008/09 MMM study, the family took immediate action on finding the victim, often taking them to a health facility or in the case of poisoning, initiating home treatment first, followed by seeking medical care. In some instances, delays were incurred while the family found money to pay for transportation. In other cases, the family did not seek medical help as the victim was already dead. Some respondents reported the cost of seeking care for the suicide victim, with costs going as high as Rs. 50,000 in one case. The case studies highlighted the inability of some health facilities to successfully treat victims of poisoning, and the lack of awareness of relatives to take any evidence of the type of poison consumed to aid treatment.

“... After three hours she was taken to Inaruwa Hospital and she was attended by doctor. She was induced for vomit and provided IV fluid. She was admitted there for two days and then she was referred to BPKIHS and admitted there in ICU for three days. It had cost about 10,000 in Inaruwa and 40,000 in BPKIHS for her treatment. We didn't have enough money so we mortgage our field to save her life.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“... We took her to BPKIHS but before treatment the doctor asked about the poison she had taken, I returned home to check and found an empty bottle in her room. She died on the sixth day when the treatment was on going. If we had identified the poison she could have been saved,” says her husband.

- Respondent for suicide verbal autopsy, MMM Study2008/09

At times both mental and physical illness are explained by evil spirits, and sometimes evil spirits are perceived to attack women suffering from illness, which can lead to more care-seeking in the traditional rather than formal sector.

“According to her relative once she had suffered from possession of evil spirits. During that attack, she used to tremble and she was cured when she consulted with traditional healer.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

Cultural explanations of illness and evil spirits and witches need better understanding. The case of Jareem is also an example of what seems a wave of suicide.

“Jareem was 12 years old when she committed suicide. ... Her uncle's explanation for her death was an evil spirit in the village. Six days after Jareem took her life by hanging her friend Saniya also committed suicide. Then another two girls of the same age took their lives. Two other girls attempted suicide. The common symptoms among all the girls was reported to be going to the river and crying before the suicide or its attempt.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

“Kalika was 13 when she committed suicide. The post-mortem showed she died from poisoning but this is refuted by her family who believe she was killed by a witch. Kalika suffered from a headache the day of her death. Her father called the traditional healer

who chanted some mantras which seemed to help. When her state deteriorated again the family called a second traditional healer but by this time she had consumed poison and became unconscious, so the family decided to take her to hospital; she died on the way.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

There are cases of women who have a history of mental illness and intermittent treatment from a practitioner, but often they lack the level of care and support they need to prevent suicide, and sometimes to prevent harm to others. Within the same families there are reports of seeking care from both the formal and informal sector. Seeking care from a traditional healer for perceived mental illness, sometimes parallel to allopathic care, appears common. Commonly care is sought from the traditional healer for symptoms of mental illness, and it is only once physical symptoms are seen, such as after attempting suicide, that care from the formal sector is sought. The case studies highlighted the poor quality of care received both for mental and physical illnesses and sometimes this seemed to push women towards choosing suicide.

“Tulasi died at the age of 25. Her maternal family and in-laws felt that she showed symptoms of mental illness for some time. Before her gauna she tried to hang herself 3 times in her maternal home. At this time a traditional healer was called and he attributed the cause to an aggrieved god (deuta bigriyeko). ... Three days before her death, Tulasi suffered from fever, vomiting and fatigue. Her in-laws took her to Lumbini PHC but she did not get better. The next day she poisoned herself and though she was immediately taken to Bhim hospital for treatment she died within 24 hours.”

- Respondent for suicide verbal autopsy, MMM Study2008/09

8.0 Discussion

Suicide is a major hidden public health problem in Nepal. It was the leading individual cause of death for women of reproductive age in the 1998 MMM Study. However, since being identified as a problem in 1998 it has received little attention and not only was it still the leading cause in the 2008/09 MMM study, but it also increased from accounting for 10% to 16% of deaths, and was the leading cause of death in six out of eight of the study districts (Pradhan et al 2010). The rates computed from these data give an indication of the severity of the problem, at 22 per 100,000 in 1998 and 28 per 100,000 in 2007/08.

The lack of robust routine data on suicide in Nepal makes it difficult to determine national and sub-national rates; to identify at risk groups; to assess trends over time; and to monitor the impact of interventions. It means policy makers and the public are unaware of the true picture, and increases the power and influence of inaccurate media coverage, even among specialists working in the area. Hence, there is an urgent need to improve accurate recording of *completed* suicides at hospitals, and reporting to the health management information system (HMIS). There is also scope to develop mechanisms for hospital monitoring of *attempted* suicides. At present police data is the only source of national level suicide data. However, there is scope for improvement in police data collection, reporting and analysis. As well as improving the quality of hospital and police record keeping, the data generated need to be analysed and used effectively as an evidence base for appropriate policy formulation.

Hanging and poisoning are the main means of suicide in Nepal. The police data showed hanging is more prevalent. There may be a bias in police data in regards to deaths as some methods may be more likely to be reported to police than others, given that victims of hanging may be less likely to be taken to health facilities. Verbal autopsies from the 2008/09 MMM study revealed that victims of poisoning are frequently taken to health facilities and hence police may be less likely to be informed as the cause of death is recorded in the hospital. Our exploration of hospital records revealed that many suicide cases are not recorded as such.

The 2008/09 MMM Study found poisoning to be the main means of death in all but the oldest age-group (40-50 year olds). In the poisoning cases respondents frequently mentioned pesticides, highlighting the need for interventions to place legal restrictions on accessing and storing pesticides, as one of the most successful suicide prevention strategies globally is to reduce access to means of suicide. In Sri Lanka, the number of suicide deaths fell by 50% from 1995-2005 after banning Class I pesticides and endosulfan (Gunnell et al 2007). There is a need to review the potential for introducing legislation to regulate the production, importation, transportation, storage and sale of pesticides. Various strategies could be implemented to discourage the ingestion of pesticides (e.g. warning labels on products; adding stanching agents or emetics; creating solid or diluted forms) (WHO 2008).

Whilst the cure rate for organophosphates poisoning can be relatively high (Pokhrel et al 2008; Saddichha et al 2010), in many developing countries, the inability of health facilities to treat cases coupled with the delay in victims reaching services can be fatal. The verbal autopsies from the 2008/09 MMM study highlighted the inability of many facilities to successfully treat these patients. Hence health facilities in Nepal need to be better equipped to handle such cases in an emergency and better training on the clinical management of poisoning is needed. The creation of poisoning management units in the larger hospitals, and awareness of these units, would ultimately help in significantly reducing the mortality due to poisoning.

International literature has suggested there are differences in the means of suicide by sex, however, the police data analysed for this report showed strong similarities between men and women in the choice of means in Nepal, with the main difference being that burning was three times more likely among female victims than men. This finding is supported by data from the burns unit at TUTH, where females are 3.5 times more likely to be admitted than males. The lack of differences may be due to limited access to more lethal means in Nepal, such as guns, or bias by the type of method used in the cases reported to and recorded by police.

From our analysis of verbal autopsies from the MMM Study 2008/9 it is clear that there is rarely one driver behind an individual suicide case, but rather an interaction of a multitude of underlying determinants. Furthermore, the underlying factors, and their relative weight varies by context. In Nepal, family, marital and relationship factors are clearly major contributors to suicides among women, as observed in nearly two thirds of cases (65%), with husbands being by far the predominant contributor (35%), and unhappy marriages being mentioned in nearly a quarter of suicide cases (24%).

Many problems linked to the family, marital and relationship factors are related to women's status and gender based violence. Gender norms are an important contributor to the social environment in Nepal that increases women's risk of suicidal behaviour. In this environment, social pressures on girls and women are so strong that the inability or failure to conform, such as pregnancy outside of marriage, places them under intense social pressure. This is often without any support from family or community members, and places them at greater risk of suicidal behaviour.

Gender inequality increases the risk of gender based violence. Various forms of GBV were raised in the case studies from the 2008/09 MMM Study. Often husbands openly acknowledged what they inflicted on their wives prior to their suicide, with that in itself being a sign of the social acceptance of GBV. In countries such as Nepal, self-silencing behaviour serves as a manifestation of the 'good woman' in line with conventional gender norms and role expectations, and furthermore, GBV commonly goes un-reprimanded. Given the links between GBV and suicide risk among females in Nepal, and the Prime Minister's multi-sectoral initiative to tackle GBV, opportunities to synergise efforts are a priority.

Some variables appear unquestioningly as risk factors, while others are more ambiguous. Contrary to the international literature, being married or being a parent does not appear to be a strong protective factor for Nepalese women. This may be due to the expectation in the Nepali context that all women should marry and bear children and women's lack of empowerment and say in the family. Arranged or forced marriages; restrictions on appropriate marriage partners (e.g. caste); young age at marriage and first parity; large age gaps between spouses; dowry payments; and second marriages (particularly when the first wife fails to produce a child or a son) are not uncommon in the Nepalese context. Furthermore, divorce is stigmatised, and there is often social and familial pressure to stay married even in an abusive or unhappy relationship. The verbal autopsies from the 2008/09 MMM Study highlighted how common extra-marital affairs are in Nepal, both on the part of the husband and the wife and how this often reinforced women's subordination and vulnerability.

It is common in Nepal for men to migrate for work, and this was reported in 11% of suicide cases, and from the interviews it is clear this is having a detrimental impact on relationships with spouses.

Being married may not provide much protection in this context, however, being unmarried can undoubtedly cause tension for individuals and their relatives. The 2008/09 MMM study indicated that suicide accounted for a far greater proportion of deaths among the unmarried (25%) than the married (15%) or the separated / divorced / widowed (14%), which is cause for concern. This may be due to unmarried women being less likely to die from other causes, such as maternal causes. The verbal autopsies highlighted the upset that being unmarried caused women, and showed how it is often linked to chronic illness.

Likewise, poverty and caste status do not appear to have straightforward relationships with suicide risk. Suicide accounts for a lower proportion of deaths among Dalits than some other caste/ethnic groups. However, the lower proportion of deaths may be due to an increased risk of dying from other causes. Due to the lack of a denominator, rates could not be calculated to enable a more accurate assessment of risks by caste/ethnicity.

Despite the extensive conflict in Nepal, the anticipated increased risk of suicide resulting from the violent conflict over the past fifteen years is not something that has come out of the analysis for this report. It may be that this was not specifically probed for in discussions and that people are more likely to mention the more immediate pressures than underlying issues, or that people choose to bury the past conflict and possible consequences. More in-depth work is needed to really understand the impact of conflict on suicide in Nepal.

Poor mental health can be both a cause and consequence of social determinants leading to suicide (Prince et al 2007). According to WHO, 90% of suicide cases relate to a mental disorder (Lamichhane 2010). In Nepal it is likely that mental health problems are under-reported due to lack of awareness and stigma. Depression was the only disorder that was specified in the 2008/09 MMM Study. In most cases where mental illness was apparent it was largely as a consequence of social determinants. It illustrated the complexity of mental health in its social context, and how social norms, poverty and poor access to health care overlap with mental ill-health. The interviews illustrate the lack of accessible, quality care for mental health conditions in Nepal; lack of knowledge and understanding of mental health conditions in the community and underlying social and family conditions that, in many cases, appear to contribute to poor mental health. Mental health problems are widely perceived to be related to evil spirits, hence the need for medical attention is rarely appreciated, and care is often sought from traditional faith healers instead. In spite of a recent change in global attitudes towards mental health, programmatic priorities and funding have been slow to respond in many countries. There have been many positive steps taken towards improving mental health care in Nepal, including the National Mental Health Policy in 1997, and Mental Health Act in 2006. However, despite commendable steps there is still scope for significant improvement and these gaps would benefit from further exploration.

Mental health is a low priority on the national health agenda in Nepal, with less than one per cent of the total health budget allocated for mental health. For effective provision of mental health services additional budget allocation from the government and donors is required (Benson et al 2008). Mental illness often requires long-term medical care, which patients are often unable to afford, and places the poor at increased risk of suicide (Desjarlais et al 1995). One solution would be an appropriate health financing system to protect the poor. One study estimates that a basic mental health package would cost USD 3-4 per person per year in South Asia and sub-Saharan Africa. However, this would require a ten-fold increase in health spending in Nepal (Chisholm et al 2007). Despite this, the cost-effectiveness and potential benefits of these mental health interventions seem preferable to the economic

consequences of non-investment. If left unaddressed, mental health-related problems have the potential to incur significant direct and indirect costs: including costs to the health system for related illnesses; expenditure on treatment outside the formal health system, such as traditional healers; lost production; and premature mortality (Patel et al 2007). Mental health disorders can preclude or delay detection and help-seeking behaviour in relation to other health issues, thereby exacerbating existing conditions (Prince et al 2007).

Mental health services in Nepal are largely restricted to hospitals in urban areas and only accessed by a small proportion of those who need them. Mental health needs to be integrated into general health services where primary care providers are trained to detect and treat mental health disorders. This is a cost-effective approach due to decreased morbidity, co-morbidity and mortality, combined with the preventive nature of primary care interventions and hence the reduced need for expensive inpatient care (WHO 2008). The integration also has the benefits of less stigmatisation, increased detection rates for patients presenting with vague physical complaints, and improved treatment of the physical problems for those suffering from mental illness (Benson et al 2008).

Acknowledging and adopting mental health into policy and practice and integrating psychosocial and mental health care in the primary health care system would help in making mental health a national agenda. Early detection and treatment of mental disorders substantially contribute in decreasing the number of suicides (Upadhyaya et al 1998). Mental health investment in primary care is unlikely to be sustained unless community mental health services allow for training, supervision, and continuous support for primary care workers. Training health post staff on diagnosis and basic medical treatment of major mental disorders such as depression, psychosis, and epilepsy would help people get adequate and timely medical care at the grassroots level.

Media is a powerful source of information for the general public. However, the media have been criticised for misinforming readers about suicide, largely by just highlighting immediate individual drivers rather than focusing on contributory ingrained cultural and societal practices (Beautrais et al 2008). In Nepal, coverage of suicide events, mental health issues and gender issues in the media has increased in recent years (Lamichhane 2009) and it is important to acknowledge that the power of the media, if used correctly, can be beneficial in awareness raising and suicide prevention strategies. In the Republic of Korea, the inclusion of information about warning signs and treatment was successful in reducing the incidence of suicide.

Given the stigma associated with suicide and mental health in Nepal, there is a need to work with journalists to ensure coverage is beneficial and not detrimental to prevention measures. Further work would be needed to ensure appropriate responses in the Nepali context. However, this could potentially include better media coverage to inform the public of the dangers and impact of poisoning; more responsible reporting of SLC exam results (evidence suggests this fuels impulsive behaviour in adolescents and increases the risk of suicide); and the development of guidelines on responsible reporting. Ultimately the media needs to be sensitised to protect people from suicide rather than fuel self harming behaviour.

Suicide risk is often supported by protective measures operating within legislation outlawing practices and products encouraging or facilitating suicide. For example, restricting access to means or criminalising contributory factors. Nepal's legal system is based on principles set out in 1854 and is entrenched with many discriminations on the basis of religion, caste / ethnicity and gender. Nepal has been criticised for taking insufficient action to repeal these

discriminations. However, Nepal is party to international conventions relating to the rights of women, and is taking steps towards eliminating GBV: criminalising sexual harassment and marital rape. Another essential legal domain for suicide prevention efforts is mental health legislation. Most countries have mental health legislation that was in place before mental disorders received adequate attention, and have not been revised to incorporate important recent developments. Nepal is one of the few exceptions, formulating a National Mental Health Policy in 1997. It outlaws the discrimination and maltreatment of individuals with mental disorders. Although Nepal has the lowest gross national product (GNP) per capita of the SAARC countries, it is one of the only four with a national mental health policy / law.

Further work is needed to explore policy and programmatic needs. Suicide prevention is a complex task that requires a well co-ordinated multi-sectoral approach. Both state and non-state agencies (such as civil society organisations) need to work together to integrate various strategies involving awareness raising and preventative measures, and targeting of at risk groups and functioning at the individual, family, community and societal levels. Prevention programmes need to be locally relevant, culturally appropriate and cost effective, and require social and public health approaches. Improved evidence gathering and government leadership on reducing suicide will be essential to building the momentum to save lives of the many women, mothers and girls that commit suicide each year.

REFERENCES

- Aaron, R., Joseph, A., Abraham, S., Muliylil, J., George, K., Prasad, J., Minz, S., Abraham, V. J. & Bose, A. (2004) 'Suicides in young people in rural southern India', *The Lancet* 363(9415): 1117-1118
- Acharya, L., Upadhyaya, K. D. & Kortmann, F. (2006) 'Mental health and psychosocial support aspects in disaster preparedness: Nepal', *International Review of Psychiatry* 18(6): 587-592
- ADB (Asian Development Bank) (2010) 'Overview of Gender Equality and Social Inclusion in Nepal', Mandaluyong City, Philippines: Asian Development Bank, 2010
- Asia Foundation Nepal (AFN) (2010) Preliminary Mapping of Gender Based Violence, The Asia Foundation
- Agerbo, E. (2005) 'Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: a gender specific study', *Journal of Epidemiological and Community Health* 59(5): 407-412
- Agerbo, E., Nordentoft, M. & Mortensen, P. B. (2002) 'Familial, psychiatric, and socioeconomic risk factors for suicide in young people: nested case-control study', *British Medical Journal* 325(7355): 74
- Ahmadi, A. (2007) 'Suicide by Self-Immolation: Comprehensive Overview, Experiences and Suggestions', *Journal of Burn Care and Research* 28(1): 30-41
- Ahmadi, A. & Ytterstad, B. (2007) 'Prevention of self-immolation by community-based intervention', *Burns* 33(8): 1032-1040
- Ajdacic-Gross, V., Weiss, M. G., Ring, M., Hepp, U., Bopp, M., Gutzwiller, F. & Rössler, W. (2008) 'Methods of suicide: international suicide patterns derived from the WHO mortality database', *Bulletin of the World Health Organization* 86(9): 657-736
- Alaghebandan, R., Rastegar Lari, A., Joghataei, M. and Islami, A. (2010) A prospective population-based study of suicidal behavior by burns in the province of Ilam, Iran *Burns* 2011 Feb; 37(1):164-9. Epub 2010 Jul 14.
- Ali, F. A., Israr, S. M., Ali, B. S. & Janjua, N. Z. (2009) 'Association of various reproductive rights, domestic violence and marital rape with depression among Pakistani women', *BMC Psychiatry* 9: 77
- Ali, M., Shahab, S., Ushijima, H. & de Muynck, A. (2004) 'Street children in Pakistan: A situational analysis of social conditions and nutritional status', *Social Science & Medicine* 59(8): 1707-1717
- APROSC (Agricultural Projects Services Centre for the Gender Planning Network) (2003) 'Economic Reform and the Status of Women in Nepal', from Tracking Gender Equity under Economic Reforms: Continuity and Change in South Asia, ed. Mukhopadhyay, S. & Sudarshan, R. M. (accessed 16/06/10), available at: http://www.idrc.ca/en/ev-58036-201-1-DO_TOPIC.html

Arun, P., & Chavan, B. (2009) 'Stress and suicidal ideas in adolescent students in Chandigarh', *Indian Journal of Medical Sciences* 63(7): 281-287

Aryal, M. (2007) 'Stigma therapy: Removing discrimination against mental illness is a bigger challenge than treatment', *Nepali Times Issue 372* (accessed 14/06/10) available at: <http://www.nepalitimes.com/issue/372/Nation/14138>

Babu, G. N., Subbakrishna, D. K. & Chandra, P. S. (2008) 'Prevalence and correlates of suicidality among Indian women with post-partum psychosis in an inpatient setting', *Australian and New Zealand Journal of Psychiatry* 42(11): 976-980

Bailie, R. (2001) 'Challenges for improving surveillance for pesticide poisoning: policy implications for developing countries', *International Journal of Epidemiology* 30(3): 564-570

Baudelot, C. & Establet, R. (2008) 'Suicide: The hidden side of modernity', Cambridge: Polity Press

Beautrais, A., Hendin, H., Yip, P., Takahashi, Y., Chia, B. H., Schmidtke, A. & Pirkis, J. (2008) 'Improving Portrayal of Suicide in the Media in Asia', *Suicide and Suicide Prevention in Asia*, Department of Mental Health and Substance Abuse, World Health Organization

Bennett, L and Parajuli, D. (2010) *Nepal Multidimensional Exclusion Measure: Methodology, First Round Findings and Implications for Action (Draft)*. A Paper Prepared for the World Bank, Kathmandu.

Benson, J. & Shakya, R. (2008) 'Suicide Prevention in Nepal: a comparison to Australia: a personal view', *Mental Health in Family Medicine* 2008;5:177-182, Radcliffe Publishing

Bertolote, J. M., Fleischmann, A., Butchart, A. & Besbelli, N. (2006) 'Suicide, suicide attempts and pesticides: a major hidden public health problem', *Bulletin of the World Health Organization* 84(4): 260-261

Bhugra, D. & Minas, I. H. (2007) 'Mental health and global movement of people', *The Lancet* 370(9593): 1109-1111

Bhusal, S. (2008) 'Women's access to food and land rights', *All Nepal Women's Association (ANWA)* (accessed 10/06/10), available at: www.asianruralwomen.net/themes/land_001.doc

Blakely, T. A., Collings, S. C. D. & Atkinson, J. (2003) 'Unemployment and Suicide: Evidence for a Causal Association?', *Journal of Epidemiology and Community Health* 57(8): 594-600

Bohra, P. & Massey, D. S. (2009) 'Processes of Internal and International Migration from Chitwan, Nepal', *International Migration Review* 43(3): 621-651

Caldwell, J. (1978) 'A Theory of Fertility: From High Plateau to Destabilisation', *Population & Development Review* 4(4): 553-577

Cameron, M. (1998) 'On the Edge of the Auspicious: Gender and Caste in Nepal', University of Illinois Press

CBS (2002) Population Census of Nepal, 2001: Village Development Committee/ Municipality (Central Development Region). Kathmandu: Central Bureau of Statistics

CBS (2005) Poverty Trends in Nepal (1995-96 and 2003-04). Kathmandu: Central Bureau of Statistics

Chhetri, A. (2001) 'Tracing the shape of violence against women in Nepali media' (accessed 19/07/10), available at: http://www.asmita.org.np/Women_Subject_Category/vaw.htm

Chisholm, D., Flisher, A. J., Lund, C., Patel, V., Saxena, S., Thornicroft, G. & Tomlinson, M. (2007) 'Scale up services for mental disorders: a call for action', *The Lancet* 370(9594): 1241-1252

Chiu, E. (2004) 'Epidemiology of depression in the Asia Pacific region', *Australasian Psychiatry* 12(Supplement): S4-S10

Chowdhary, N. & Patel, V. (2008) 'The effect of spousal violence on women's health: Findings from the Stree Arogya Shodh in Goa, India', *Journal of Postgraduate Medicine* 54(4): 306-312

COR (2007) 'Bhutanese Refugees in Nepal' (accessed 15/07/10), available at: www.cal.org/co/pdf/files/backgrounder_bhutanese.pdf

DeJong, J., Ghimire, D., Thornton, A. & Pearce, L. (2006) 'Developmental idealism and changing models of marriage', Population Studies Centre Research Report 06-609, Population Studies Centre: Michigan

Desai, S. & Banerji, M. (2008) 'Negotiated identities: male migration and left-behind wives in India', *Journal of Population Research* 25(3): 337-355

Deva, P. (2002) 'Mental health and mental health care in Asia', *World Psychiatry* 1(2): 118-120

Dhakal, S. (2008) 'Nepalese women under the shadow of domestic violence', *The Lancet* 371(9612): 547-548

Dørheim Ho-Yen, S. D., Bondevik, G. T., Eberhard-Gran, M. & Bjorvatn, B. (2006) 'The prevalence of depressive symptoms in the postnatal period in Lalitpur district, Nepal', *Acta Obstetrica et Gynecologica Scandinavica* 85(10): 1186-1192

Dørheim Ho-Yen, S. K., Bondevik, G. T., Eberhard-Gran, M. & Bjorvatn, B. (2007) 'Factors associated with depressive symptoms among postnatal women in Nepal', *Acta Obstetrica et Gynecologica* 86(3): 291-297

Durkheim, E. (1897) 'Suicide: A study in sociology', New York: The Free Press

Durkheim, E. (1912) 'The Elementary Forms of Religious Life', Oxford University Press

Ed. J Nepal Med Assoc (2008) 'On the present crisis of confidence between health professionals and the public and on some largely preventable unnatural deaths in the country', *Journal of the Nepal Medical Association* 47(170): I-II

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H. & García-Moreno, C., on behalf of the WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team (2008) 'Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study', *The Lancet* 371(9619):1165-1172

Engle, P. (2009) 'Maternal mental health: program and policy implications', *American Journal of Clinical Nutrition* 89(Supplement): 963S–966S

European Commission (1998) 'Opinion on possible links between BSE and Organophosphates used as pesticides against ecto- and endoparasites in cattle' Report and opinion adopted at the Scientific Steering Committee meeting of 25-26 June 1998 (accessed 07/07/10), available at: http://ec.europa.eu/food/fs/sc/ssc/out18_en.html

Farzaneh, E., Mehrpour, O., Alfred, S., Moghaddam, H. H., Behnoush, B. & Seghatoleslam, T. (2010) 'Self-poisoning suicide attempts among students in Tehran, Iran', *Psychiatria Danubina* 22(1): 34-38

Fisher, B. J., Haythornthwaite, J. A., Heinberg, L. J., Clark, M. & Reed, J. (2001). Suicidal intent in patients with chronic pain. *Pain* 89, 199–206

Fishman, G. & Weimann, G. (1997) 'Motives to commit suicide: Statistical versus mass-mediated reality', *Archives of Suicide Research* 3(3): 199-212

Gausia, K., Fisher, C., Ali, M., & Oosthuizen, J. (2009) 'Antenatal depression and suicidal ideation among rural Bangladeshi women: a community based study', *Archives of Women's Mental Health* 12(5): 351-358

Ghosh, M. (unpublished) 'Social capital and postnatal depression among South Asian women: How culture defines how people will experience the symptoms of "postnatal depression"?' (accessed 07/06/10), available at: www.sasnet.lu.se/EASASpapers/20ManonitaGhosh.pdf

Government of Nepal (2006) Comprehensive Peace Accord, GoN

Government of Nepal (2006) Gender Equality Act, GoN

Government of Nepal (2007) Human Trafficking Act, GoN

Government of Nepal (2007) Interim Constitution of Nepal 2063, GoN available at: lawcommission.gov.np/index.php/ne/consitution/doc/163/raw

Government of Nepal (2009) Domestic Violence (Crime and Punishment) Act, GoN

Government on Nepal National Planning Commission (2007) Three Year Interim Plan, GoN available at: <http://www.unpei.org/PDF/Nepal-3-year-interim-plan-eng.pdf>

- Greenbaum, A. R., Donne, J., Wilson, D. & Dunn, K. W. (2004) 'Intentional burn injury: an evidence-based, clinical and forensic review', *Burns* 30(7): 628-642
- Gunnell, D. & Eddleston, M. (2003) 'Suicide by intentional ingestion of pesticides: A continuing tragedy in developing countries', *International Journal of Epidemiology* 32(6): 902-909
- Gunnell D, Eddleston M, Phillips M, Konradsen F. (2007) The global burden of fatal pesticide self-poisoning: Systematic review. *BMC Public Health*, 7:357
- Harpham, T., Snoxell, S., Grant, E. & Rodriguez, C. (2005) 'Common mental disorders in a young urban population in Colombia', *British Journal of Psychiatry* 187: 161-167
- Herrera, H. Dahlblom, K., Dahlgren, L. & Kullgren, G. (2006) 'Pathways to suicidal behaviour among adolescent girls in Nicaragua', *Social Science & Medicine* 62(4): 805-814
- ICIMOD (International Centre for Integrated Mountain Development) (2009) 'Labour migration in the Hindu Kush-Himalayas – a core livelihood strategy', available at: <http://books.icimod.org/index.php/search/publication/594>
- IDMC (Internal Displacement Monitoring Centre) (2010) 'Nepal: failed implementation of IDP policy leaves many unassisted' (accessed 19/07/10), available at: [http://www.internal-displacement.org/8025708F004CE90B/\(httpCountries\)/CC2C3C0FBDAD8F03C125746D002F61D9?opendocument&count=10000](http://www.internal-displacement.org/8025708F004CE90B/(httpCountries)/CC2C3C0FBDAD8F03C125746D002F61D9?opendocument&count=10000)
- IFAD (International Fund for Agricultural Development) (1999) 'Nepal: Factors that increase women's workloads' (accessed 10/06/10), available at: <http://www.ifad.org/gender/learning/role/workload/24.htm>
- Jack, D. C. & Ali, A. (2010) 'Silencing the Self Across Cultures: Depression and Gender in the Social World', Oxford University Press
- Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., Sreenivas, V., Saxena, S. (2007) 'Mental health systems in countries: where are we now?', *The Lancet* 370(9592): 1061-1077
- Jha, A. (2007) 'Nepalese psychiatrists' struggle for evolution', *Psychiatric Bulletin* 31(9): 348-350
- Jha, A. & Adhikari, S. R. (2009) 'Mental Health Services in New Nepal – Observations, Objections and Outlooks for the Future', *Journal of the Nepal Medical Association* 48(174): 185-190
- Jordans, M., Upadhaya, N., Tol, W., Shrestha, P., Doucet, J., Gurung, R., Aguetant, J., Mahate, P., Shah, S., Shrestha, K. P., Sherchan, S., Maharjani, R., Kunwar, A., Regmi, I. R., Shyangwal, P., Melville, A. & van Ommeren, M. (2010) 'Introducing the IASC Mental Health and Psychosocial Support Guidelines in emergencies in Nepal: a process description', *Intervention* 8(1): 52-63
- Joshi, S. K. (2009) 'Violence against Women (VAW) in Nepal: Role of health care workers', *Kathmandu University Medical Journal* 7(2): 89-91

Joshi, S. K. & Kharel, J. (2008) 'Violence against Women in Nepal – An Overview', *The Free Library* (accessed 10/06/10), available at: <http://www.thefreelibrary.com/Violence+Against+Women+in+Nepal+---+An+Overview-a01073875052>

Kanchan, T., Menon, A., & Menezes, R. (2009) 'Methods of choice in completed suicides: Gender differences and review of the literature', *Journal of Forensic Sciences* 54(4): 938-942

Kandel, N., Bandhari, A. R. & Lamichhane, J. (unpublished) "'Chhue, Chhaupadi and Chueekula Pratha" – Menstrual Sheds: Examples of Discriminatory Practices against Women in the Mid- and Far-Western Regions of Nepal: Considering Women as "Impure" or "Unclean" During Menstruation and Post-Partum Periods' (accessed 18/07/10), available at: <http://drnirmal.tripod.com/Journal1.pdf>

Kenyon Densley, M. & Joss, D. M. (2000) 'Street children: Causes, consequences and innovative treatment approaches', *Work* 15(3): 217-225

Khan, M. (2002) 'Suicide on the Indian Subcontinent', *Crisis* 23(3): 104-107

Khatiwada, P. P. (2008) 'Conflict Induced Migration in Nepal (A Social Inclusion Perspective)' (accessed 11/07/10), available at: <http://www.socialinclusion.org.np/researchdetail-220.html>

Kim, W. J. & Singh, T. (2004) 'Trends and dynamics of youth suicides in developing countries', *The Lancet* 363(9415): 1090

Klainin, P. & Arthur, D. G. (2009) 'Postpartum depression in Asian cultures: A literature review', *International Journal of Nursing Studies* 46(10): 1355-1373

Kohrt, B., Speckman, R. A., Kunz, R. D., Baldwin, J. L., Upadhaya, N., Acharya, N. R., Sharma, V. D., Nepal, M. K. & Worthman, C. M. (2009) 'Culture in psychiatric epidemiology: Using ethnography and multiple mediator models to assess the relationship of caste with depression and anxiety in Nepal', *Annals of Human Biology* 36(3): 261-280

Kwon, J. W., Chun, H. & Cho, S. (2009) 'A closer look at the increase in suicide rates in South Korea from 1986–2005', *BMC Public Health* 9: 72

Laloë, V. & Ganesan, M. (2002) 'Self-immolation a common suicidal behaviour in eastern Sri Lanka', *Burns* 28(5): 475-480

Lamichhane, A. R. (unpublished) 'Coping strategies of rural women in the context of male out-migration' (accessed 10/06/10), available at: http://ifwf2.org/addons/download_presentation.php?fid=1010

Lamichhane, J. (2010) 'South Asia needs to root out mental health stigmas' (accessed 14/06/10), available at: <http://www.guardian.co.uk/commentisfree/2010/may/20/south-asia-mental-health-stigmas>

Lin, S. J. (2006) 'Unemployment and suicide: Panel data analyses', *The Social Science Journal* 43(4): 727-732

Lokshin, M. & Glinskaya, E. (2009) 'The Effect of Male Migration on Employment: Patterns of Women in Nepal', *The World Bank Economic Review* 23(3): 481-507

London, L. & Bailie, R. (2001) 'Challenges for improving surveillance for pesticide poisoning: policy implications for developing countries', *International Journal of Epidemiology* 30(3): 564-570

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T. & Murray, C. J. L. (2006) 'Global Burden of Disease and Risk Factors', a co-publication of Oxford University Press and the World Bank

Lorant, V., Kunst, A. E., Huisman, M., Costa, G. & Mackenbach, J. (2005) 'Socio-economic inequalities in suicide: a European comparative study', *British Journal of Psychiatry* 187: 49-54

Magni, G., Rigatti-Luchini, S., Fracca, F. & Merskey, H. (1998) 'Suicidality in chronic abdominal pain: an analysis of the Hispanic Health and Nutrition Examination Survey (HHANES)', *Pain* 76(1-2): 137-144

Manoranjitham, S. D., Rajkumar, A. P., Thangadurai, P., Prasad, J., Jayakaran, R. & Jacob, K. S. (2010) 'Risk factors for suicide in rural south India', *The British Journal of Psychiatry* 196: 26-30

Marahatta, S., Singh, J., Shrestha, R., Koju, R. (2009) 'Poisoning cases attending emergency department in Dhulikhel Hospital-Kathmandu University Teaching Hospital', *Kathmandu University Medical Journal* 7(26): 152-156

Marusic, A. & Farmer, A. (2001) 'Genetic risk factors as possible causes of the variation in European suicide rates', *The British Journal of Psychiatry* 179: 194-196

Marusic, A., Khan, M. & Farmer, A. (2002) 'Can the interaction of poverty and literacy explain some variability of suicide rates in Europe?', *European Journal of Psychiatry* 16(2): 103-107

Massey, D., Axinn, W. & Ghimire, D. (2007) 'Environmental Change and Out-Migration: Evidence from Nepal', Population Studies Center Research Report

Miller, G. (2007) 'Mental health and the mass media: room for improvement', *The Lancet* 370(9592): 1015-1016

Miranda, J. J. & Patel, V. (2005) 'Achieving the Millennium Development Goals: Does Mental Health Play a Role?', *PLoS Medicine* 2(10): e291

Mollah, A. H. (2008) 'Combating Violence against Women in South Asia: An Overview of Bangladesh' (accessed 10/06/06), available at:
<http://www.unpan.org/Library/SearchDocuments/tabid/1111/language/en-US/Default.aspx>

Muluki Ain (General Code) (1963)

Muluki Ain Eleventh Amendment Act (2002), Government of Nepal

- Ministry of Health and Population (2007) Nepal Demographic and Health Survey 2006, Ministry of Health and Population
- Niaz, U. (2003) 'Violence against women in South Asian countries', *Archives of Women's Mental Health* 6(3): 173-184
- Niaz, U. & Hassan, S. (2006) 'Culture and mental health of women in South-East Asia', *World Psychiatry* 5(2): 118-120
- Oates, M. (2003) 'Suicide: the leading cause of maternal death', *British Journal of Psychiatry* 183: 279-281
- One World South Asia (2009) 'Nepal bans dowry, caste-discrimination' (accessed 19/07/10), available at: <http://southasia.oneworld.net/todaysheadlines/nepal-bans-dowry-caste-based-discrimination>
- Packard, R. (1997) 'Visions of Postwar Health and Development and their Impact on Public Health Interventions in the Developing World', from *International development and the Social Sciences* by Cooper, F. & Packard, R.: 93-115, London: University of California Press
- Pandey, N. N. (2006) 'Bhutanese and Tibetan refugees in Nepal: Implications for regional security', ISAS (Institute of South Asian Studies) Insights No. 17 (accessed 15/07/10), available at: <http://www.isas.nus.edu.sg/PublicationByCategory.aspx>
- Panter-Brick, C. (2002) 'Street Children, Human Rights, and Public Health: A Critique and Future Directions', *Annual Review of Anthropology* 31: 147-171
- Patel, V., Rogridues, M. & DeSouza, N. (2002) 'Gender, Poverty, and Postnatal Depression: A Study of Mothers in Goa, India', *American Journal of Psychiatry* 159(1):43-47
- Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., Hosman, C., McGuire, H., Rojas, G. & van Ommeren, M. (2007) 'Treatment and prevention of mental disorders in low-income and middle-income countries', *The Lancet* 370(9591): 991-1005
- Pathak LK, Malla D, Pradhan A, Rajlawat R. (1998) *Maternal mortality and morbidity study*. Kathmandu, Nepal: Family Health Division, Department of Health Services
- Paudel, G. S. (2007) 'Domestic Violence against Women in Nepal', *Gender Technology and Development* 11(2): 199-233
- People Daily (2010) 'Experts seek rights to mental health in Nepal' (accessed 14/06/10), available at: <http://english.peopledaily.com.cn/90001/90782/90880/6997510.html#>
- Pokhrel, D., Pant, S., Pradhan, A. & Mansoor, S. (2008) 'A comparative retrospective study of poisoning cases in central, zonal and district hospitals', *Kathmandu University Journal of Science, Engineering and Technology* 1: 5(40): 40-48
- Poudyal, B. (2005) 'Poisoning: pattern and profile of admitted cases in a hospital in central Nepal', *Journal of the Nepal Medical Association* 44(159): 92-96

Pradhan A, Suvedi BK, Barnett S, Sharma S, Puri M, Poudel P, Rai Chitrakar S, Pratap NKC, Hulton L. (2010) Nepal Maternal Mortality and Morbidity Study 2008/2009. Family Health Division, Department of Health Services, Ministry of Health and Population, Government of Nepal, Kathmandu, Nepal.

Pradhananga, R. B. & Shrestha, P (unpublished) 'Domestic Violence against Women in Nepal: Concept, History and Existing Laws', Forum for Women, Law and Development (accessed 10/06/10), available at: <http://www.fwld.org/article.php>

Preti, A. (2003) 'Unemployment and Suicide', *Journal of Epidemiology and Community Health* 57(8): 557-558

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R. & Rahman, A. (2007) 'No health without mental health', *The Lancet* 370(9590): 859-877

Puri, M., Shah, I. & Tamang, J. (2010) 'Exploring the Nature and Reason for Sexual Violence Within Marriage Among Young Women in Nepal', *Journal of Interpersonal Violence* Feb 5. [Epub ahead of print]

Qin, P. (2005) 'Suicide risk in relation to level of urbanicity—a population-based linkage study', *International Journal of Epidemiology* 34(4): 846-852

Qin, P., Agerbo, E., Westergård-Nielson, N., Eriksson, T. & Mortensen, P. B. (2000) 'Gender differences in risk factors for suicide in Denmark', *British Journal of Psychiatry* 177(6): 546-550

Qin, P. & Mortensen, P. B. (2003) 'The Impact of Parental Status on the Risk of Completed Suicide', *Archives of General Psychiatry* 60(8): 797-802

Qin, P., Agerbo, E. & Mortensen, P. B. (2003) 'Suicide Risk in Relation to Socioeconomic, Demographic, Psychiatric, and Familial Factors: A National Register-Based Study of All Suicides in Denmark, 1981–1997', *American Journal of Psychiatry* 160(4): 765-772

Ratcliffe, G. E., Enns, M. W., Belik, S. L. & Sareen, J. (2008) 'Chronic Pain Conditions and Suicidal Ideation and Suicide Attempts: An Epidemiologic Perspective', *Clinical Journal of Pain* 24(3): 204-210

Ratnayake, R. & Links, P. (2009) 'Examining student perspectives on suicidal behaviour and its prevention in Sri Lanka', *International Journal of Social Psychiatry* 55(5): 387-400.

Regmi, S., Sligl, W., Carter, D., Grut, W. & Seear, M. (2002) 'A controlled study of postpartum depression among Nepalese women: validation of the Edinburgh Postpartum Depression Scale in Kathmandu', *Tropical Medicine and International Health* 7(4): 378-382

Regmi, S. K., Pokharel, A., Ojha, S. P., Pradhan, S. N. & Chapagain, G. (2004) 'Nepal mental health country profile', *International Review of Psychiatry* 16(1–2): 142-149

Ruiz, H. A. & Berg, M. (2004) 'Unending Limbo: Warehousing Bhutanese Refugees in Nepal', World Refugee Survey

- Saddichha, S., Prasad, M., & Saxena, M. (2010) 'Attempted suicides in India: a comprehensive look', *Archives of Suicide Research* 14(1): 56-65
- Sanghavi, P., Bhalla, K. & Das, V. (2009) 'Fire-related deaths in India in 2001: a retrospective analysis of data', *The Lancet* 373(9671):1282-1288
- Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D. & Underhill, C. (2007) 'Barriers to improvement of mental health services in low-income and middle-income countries', *The Lancet* 370 (9593): 1164-1174
- Sartorius, N. (2007) 'Stigma and mental health', *The Lancet* 390(9590): 810-811
- Sauvaget, C., Pamadas, K., Fayette, J., Thomas, G., Thara, S., & Sankaranarayanan, R. (2009) 'Completed suicide in adults of rural Kerala: rates and determinants', *National Medical Journal of India* 22(5): 228-233
- Saxena, S., Thornicroft, G., Knapp, M. & Whiteford, H. (2007) 'Resources for mental health: scarcity, inequity, and inefficiency', *The Lancet* 370(9590): 878-889
- SEARO (WHO South East Asia Regional Office) (2003) 'Self-Directed Violence' from 'Violence Prevention in South-East Asia: A Challenge for Public Health (accessed 14/06/10), available at:
www.searo.who.int/LinkFiles/Disability,_Injury_Prevention_&_Rehabilitation_directed.pdf
- Shakya, R., Situala, S. & Shyangwa, P. M. (2008) 'Depression during Pregnancy in a Tertiary Care Center of Eastern Nepal', *Journal of the Nepal Medical Association* 47(171): 128-131
- Sharma, R. (2010) 'Chhaupadi' (accessed 20/07/10), available at:
<http://blog.nyayahealth.org/2010/03/26/chhaupadi/>
- Sharma, G., Shrestha, P. K., Wasti, H., Kadel, T., Ghimire, P. & Dhungana, S. (2006) 'A review of violent and traumatic deaths in Kathmandu, Nepal', *International Journal of Injury Control and Safety Promotion* 13(3): 197-199
- Sheikholeslami, H., Kani, C. & Ziaee, A. (2008) 'Attempted Suicide Among Iranian Population', *Suicide and Life-Threatening Behavior* 38(4): 456-466
- Sher, L. (2006) 'Alcohol consumption and suicide', *Quarterly Journal of Medicine* 99(1): 57-61
- Solberg, K. E. (2010) 'New laws could improve women's health in Pakistan', *The Lancet* 375(9730): 1956
- Steen, D. M. & Mayer, P. (2004) 'Modernization and the Male-Female Suicide Ratio in India 1967-1997: Divergence or Convergence?', *Suicide and Life-Threatening Behavior* 34(2): 147-159
- Subba, S. H., Binu, V. S., Menezes, R. G., Kanchan, T., Arun, M., Patil, R., Pant, S., Saha, A., De, A. & Rana, M. S. (2009) 'Pattern and Trend of Deliberate Self-Harm in Western Nepal', *Journal of Forensic Sciences* 54(3): 704-707

- Tang, N. K. & Crane, C. (2006) 'Suicidality in chronic pain: a review of the prevalence, risk factors and psychological links', *Psychological Medicine* 36(5): 575-586
- Tausig, M. & Subedi, S. (1997) 'The modern mental health system in Nepal: organizational persistence in the absence of legitimating myths', *Social Science & Medicine* 45(3): 441-447
- Terry, G. (2004) 'Poverty Reduction and Violence against Women: Exploring Links, Assessing Impact', *Development in Practice* 14(4): 469-480
- Thapa, S. B. & Hauff, E. (2005) 'Psychological distress among displaced persons during an armed conflict in Nepal', *Social Psychiatry & Psychiatric Epidemiology* 40(8): 672-679
- Thapa, B and Carlough M. (2000) Suicide incidence in the Lalitpur district of Central Nepal *Tropical Doctor* 30:200-3.
- Thapa, S., Lama, P., Karki, N., Khadka, S. (2008) 'Pattern of poisoning cases in Emergency Department of Kathmandu Medical College Teaching Hospital', *Kathmandu University Medical Journal* 6(2): 209-213
- Tibet Justice Center (2002) *Tibet's Stateless Nationals: Tibetan Refugees in Nepal*, Tibet Justice Center
- Tol, W. A., Kohrt, B. A., Jordans, M. J. D., Thapa, S. B., Pettigrew, J., Upadhaya, N. & de Jong, J. T. V. M. (2010) 'Political violence and mental health: A multi-disciplinary review of the literature on Nepal', *Social Science & Medicine* 70(1): 35-44
- Trivedi, J. K., Goel, D., Kallivayalil, R. A., Isaac, M., Shrestha, D. M., Gambheera, H. C. (2007) 'Regional cooperation in South Asia in the field of mental health', *World Psychiatry* 6(1): 57-59
- UNDP (United Nations Development Programme) (2009) 'Nepal Human Development Report 2009: State Transformation and Human Development' UNDP Nepal
- UNDP (2010) 'Gender Issues likely to get prominence in the Constitution' (accessed 01/07/10), available at: <http://www.undp.org.np/news/latestnews.php?NewsID=1247&showNews=1>
- UNFPA (2007) 'Gender Equality and Empowerment of Women in Nepal' available at: nepal.unfpa.org/pdf/Gender%20Equality.pdf
- UNFPA/WHO (2007) 'Maternal mental health and child health and development in resource-constrained settings', Report of a UNFPA/WHO international expert meeting: the interface between reproductive health and mental health
- UNHCHR (United Nations Human Rights Office of the High Commissioner for Human Rights) CEDAW (Committee on the Elimination of Discrimination against Women) (2004) Concluding Observations (accessed 10/06/10), available at: <http://www.unhcr.ch/tbs/doc.nsf/%28Symbol%29/A.59.38,paras.189-225.En?Opendocument>
- Upadhaya K. D. & Pol K. (1998) Suicide in Kaski District, *Journal of the Institute of Medicine* 1998: 20:137-145

Upadhyaya, K. D. & Pol, K. (2003) 'A mental health prevalence survey in two developing towns of western region', *Journal of Nepal Medical Association* 42(150): 328-330

US Department of State (2008) 'Trafficking in Persons Report: Nepal' (accessed 19/07/10), available at: <http://www.unhcr.org/refworld/docid/484f9a2fc.html>

US Department of State (2009) 'Human Rights Report: Nepal', 2008 Country Reports on Human Rights Practices, Bureau of Democracy, Human Rights, and Labor (accessed 22/06/10), available at: <http://www.state.gov/g/drl/rls/hrrpt/2008/sca/119138.htm>

Vijayakumar, L. & Rajkumar, S. (1999) 'Are risk factors for suicide universal? A case-control study in India', *Acta Psychiatrica Scandinavica* 99(6): 407-441

Vijayakumar, L., Nagaraj, K., Pirkis, J. & Whiteford, H (2005a) 'Suicide in Developing Countries (1): Frequency, Distribution, and Association with Socioeconomic Indicators', *Crisis: Journal of Crisis Intervention & Suicide* 26(3): 104-111

Vijayakumar, L., John, S., Pirkis, J. & Whiteford, H. (2005b) 'Suicide in Developing Countries (2): Risk Factors', *Crisis: Journal of Crisis Intervention & Suicide* 26(3): 112-119

Vijayakumar, L., Pirkis, J., Huong, T. T., Yip, P., Seneviratne, R. D. A. & Hendin, H. (2008) 'Socio-economic, Cultural and Religious Factors Affecting Suicide Prevention in Asia', *Suicide and Suicide Prevention in Asia*, Department of Mental Health and Substance Abuse, World Health Organization

Vizcarra, B., Hassan, F., Hunter, W. M., Muñoz, S., Ramiro, L. & de Paula, C. S. (2004) 'Partner violence as a risk factor for mental health among women from communities in the Philippines, Egypt, Chile, and India', *International Journal of Injury Control and Safety Promotion* 11(2): 125-129

Ward, J. & Marsh, M. (2006) 'Sexual Violence Against Women and Girls in War and Its Aftermath: Realities, Responses, and Required Resources' A Briefing Paper Prepared for Symposium on Sexual Violence in Conflict and Beyond

WHO (2001) The world health report. Geneva: World Health Organization WHO (2005a) Mental Health Atlas, available at: http://www.who.int/mental_health/evidence/mhatlas05/en/index.html

WHO (2005b) 'Mental Health: facing the challenges, building solutions', Report from the WHO European Ministerial Conference available at: http://www.euro.who.int/__data/assets/pdf_file/0008/96452/E87301.pdf

WHO (2006) WHO-AIMS Report on Mental Health System in Nepal available at: http://www.searo.who.int/LinkFiles/Mental_Health_Resources_WHO-AIMS_Report_MHS_Nep.pdf

WHO (2008) 'The global burden of disease: 2004 update' available at: www.who.int/.../global_burden_disease/GBD_report_2004update_full.pdf

WHO (2009) Suicide prevention and special programmes: Country reports and charts (accessed 23/06/10), available at:
http://www.who.int/mental_health/prevention/suicide/country_reports/en/index.html

WHO (2009b) 'Perspectives on sexual violence during early years of marriage in Nepal: findings from a qualitative study', Policy Brief available at:
http://www.who.int/reproductivehealth/publications/violence/rhr_hrp_09_01/en/index.html

WHO (2010) Suicide Prevention, available at:
http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/index.html
(accessed on 02/07/10)

World Bank (2009) 'Nepal at a glance' (accessed 14/07/10), available at:
<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/NEPALEXTN/0,,menuPK:148707~pagePK:141159~piPK:141110~theSitePK:223555,00.html>

Yeh, J. Y., Xirasagar, S., Liu, T. C., Li, C. Y. & Lin, H. C. (2008) 'Does Marital Status Predict the Odds of Suicidal Death in Taiwan? A Seven-Year Population-Based Study', *Suicide and Life-Threatening Behaviour* 38(3): 302-310

ANNEX 1: ORAL INFORMED CONSENT FOR KEY INFORMANT INTERVIEW

Namaste! My name is _____ and I am working on a UNFPA / DFID funded study looking at suicide in Nepal. The main objective of this study is to gather as much information as possible to assess current gaps in knowledge, and to identify programmatically useful information to inform future investment and interventions. As part of the study, we are interviewing key stakeholders from government departments, NGOs, hospitals, research institutes/universities, police etc. The interviews will focus on factors that may contribute to suicide. We will be interviewing about 30 people like yourself.

You have been selected since you are working in **xxxx**. You have every right to choose not to participate in this study, and if you do participate you may choose not to answer any of the questions posed during the interview, and I will move on to the next question. Please be assured that the information that you provide during the interview will be kept confidential. Only the interviewer and researchers associated with the study will have access to the information. This interview will take about an hour of your time.

If you have any questions, please feel free to ask them now. If you wish to ask questions later, you may contact Mr. Ajit Pradhan, Monitoring and Evaluation Advisor of Options at Teku, Kathmandu (Tel: 426-2110) or Mr Suresh Tiwari, SDIP Adviser Options at Teku, Kathmandu (Tel: 426-2110).

Do you have any questions about what I have just told you?

YES [Interviewer, please answer any questions to the best of your ability]

NO [Interviewer, go to the next question]

Do you clearly understand the purpose of the interview I have just described?

YES [Interviewer, go to the next question]

NO [Interviewer, repeat the section on the purpose of the study and make sure that the interviewee understands it]

Do you agree to give an interview?

YES [Interviewer, ask the respondent to sign the form (or an acceptable equivalent)]

NO [Interviewer, thank the interviewee and terminate the interview]

Consent for Tape Recording

We would like to tape record this interview. Once we have reviewed the tape it will be destroyed. Your name will not be placed on the tape, or specified in the transcribed document. Would it be alright with you if we recorded this interview?

___ Yes, my interview may be tape recorded.

___ No, please do NOT tape record my interview

At this time, do you want to ask me anything about the purpose or content of this interview?
May I begin the interview now?

Signature of the Interviewer: _____

Date: ____/____/____

Respondent agrees to be interviewed..... 1

ANNEX 2: ORAL INFORMED CONSENT FOR VERBAL AUTOPSY

Namaskar! My name is _____ and I am working on a study looking at suicide in Nepal, funded by UNFPA / DFID. Our colleagues visited you previously as part of a study working with the MINISTRY OF HEALTH AND POPULATION collecting information on deaths to all women aged 10-50, where you kindly gave your time to provide us with information about the loss of your loved one. That study revealed that suicide is one of the main causes of death to women in this age-group in Nepal. Therefore we are interested in understanding why some many women are committing suicide in Nepal, and are revisiting some of the suicide cases identified in the first study. We appreciate that you have given information regarding the death of your loved one previously, but we would be grateful if you could explain again the events leading up to the death and the care sought. We would very much appreciate your participation in this study and the information you provide will be very important.

This should take about half an hour to complete. Whatever information you provide will be kept strictly confidential and no information identifying you or the deceased will be released to anyone outside of study team. Participation in this study is voluntary, and you can choose not to answer any individual question or all of the questions. You may stop the interview at any time.

If you have any questions, please feel free to ask them now. If you wish to ask questions later, you may contact Mr. Ajit Pradhan, Monitoring and Evaluation Advisor of Options at Teku, Kathmandu (Tel: 426-2110) or Mr Suresh Tiwari, SDIP Adviser Options at Teku, Kathmandu (Tel: 426-2110).

Do you have any questions about what I have just told you?

YES [Interviewer, please answer any questions to the best of your ability]

NO [Interviewer, go to the next question]

Do you clearly understand the purpose of the interview I have just described?

YES [Interviewer, go to the next question]

NO [Interviewer, repeat the section on the purpose of the study and ensure that the interviewee understands it]

Do you agree to give an interview?

YES [Interviewer, ask the respondent to sign the form (or an acceptable equivalent)]

NO [Interviewer, thank the interviewee and terminate the interview]

At this time, do you want to ask me anything about the purpose or content of this interview?
May I begin the interview now?

Signature of the Interviewer: _____

Date: ____/____/____

Respondent agrees to be interviewed..... 1

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