স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
গণপ্রজাতন্ত্রী বাংলাদেশ সরকার

Epidemiology of Suicide and Suicidal Behavior Among Youth and Adolescent in Bangladesh

REPORT

নন কমিউনিকেবল ডিজিজ কন্ট্রোল
স্বাস্থ্য অধিদপ্তর

জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট
শের-ই-বাংলা নগর, ঢাকা।

World Health Organization
Bangladesh

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CONTENTS

Senior Secretary
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MESSAGE

Suicide is becoming a major health problem throughout the World particularly among young age group. In Bangladesh it is a public health concern also. It is certain, suicide is a complicated action that is mired in a multiplicity of causal variables, and it is preventable. With the visionary leadership of H.E. Sheikh Hasina, Honorable Prime Minister of Bangladesh, we are on the right track to achieve the SDGs. I strongly believe, in the journey to reach SDGs, we will decrease the rate of suicide within 2030 as per direction of SDG 3.4.2.

To prevent suicide, we need to address the causes and risk factors of suicide. By engaging in research, all the stakeholders can work toward understanding suicidal behavior and thereby uncover the risks and pursue the best ways to prevent it. The evidences gathered from any research can create awareness and give the right directions to the policy makers.

I am congratulating National Institute of Mental Health Team for successful conduction of the survey titled **'Epidemiology of suicide and suicidal behavior amongyouth and adults in Bangladesh'**. I express my thanks to Non-Communicable Disease Control Program of DGHS for the initiative of this essential survey. I also express my heartfelt thanks to WHO, Bangladesh and other stakeholders who contributed to the survey.

I believe, if all of us work together, we can increase public awareness to prevent suicide. The evidences generated from this research work will also play a pivotal role in this regard. I wish every success of the survey team.

Lokman Hossain Miah

Director General
Directorate General of Health Services
Government of People's Republic of Bangladesh

MESSAGE

Suicide is one of the leading causes of death among the adolescents and youth worldwide. Approximately 1.5% of all deaths worldwide are by suicide. In a given year, this is roughly 12 per 100,000 people. In Bangladesh, Suicide is a public health concern also. Suicide is preventable, but to prevent suicide, we need to identify the warning signs and risk factors of suicide. Only research can identify these.

National Institute of Mental Health, Dhaka with financial support from Non-Communicable Diseases Control Program of DGHS and technical support of WHO Bangladesh conducted survey titled **'Epidemiology of suicide and suicidal behavior among youth and adults in Bangladesh'**. My heartful congratulations to National Institute of Mental Health and all the stake holders for successful conduction this time demanding survey.

I hope, findings of this study will help to identify the epidemiology of suicide and suicidal behavior among adolescents and youths and provide a right direction to the policy makers.

Professor Dr. Abul Bashar Mohammad Khurshid Alam

Line Director
Non-Communicable Diseases Control Program
Directorate General of Health Services
Ministry of Health & Family Welfare
Government of the People's Republic of Bangladesh

MESSAGE

Suicide is one of the leading cause of death among young adolescents and adults. It has already been recognized as a major health issue and addressed in the SDG goal 3.4.2 as a target to 'reduce suicide mortality rate' by 2030. It is found that in every 40 seconds, one person commits suicide in the world. Bangladesh is also sharing the burden of this unwanted event. As there is no well-established surveillance system for suicide in our country, national level research like this is the key tool for generation of substantial evidence for policy adoption, program design and suicide prevention. This multicentered stratified nationwide study sheds a light on the suicidal behavior of our context. Special attention should be given to the suicidal tendency and thoughts among the adolescents and young population as this is the triggering factor for the problem. An evidence-based strategy is needed to reduce the number of suicidal death. This study conducted by a group of dedicated, skillful and hardworking psychiatrist, psychologist and social workers will lay the path for the above mentioned policy level advocacy, formulating evidence based strategy and help reducing the suicidal mortality in the country and thus achieving the SDG goal by 2030. I wish all the success of the study and the researchers and persons involved with it.

Professor Md Robed Amin

Director-cum-Professor
National Institute of Mental Health & Hospital
Sher-e-Bangla Nagar, Dhaka-1207

MESSAGE

In Bangladesh, suicide is becoming a major mental health problem particularly among young and adolescent group of people. Suicide is also a major public health problem around the world. For this reason, Sustainable Development Goal (SDG) indicator 3.4.2 emphasized the issue of suicide prevention. To formulate policy and programs for prevention of suicide, it is mandatory to have adequate evidences generated through population studies. The survey 'Epidemiology of suicide and suicidal behavior among youth and adults in Bangladesh' is such a piece of work that would be an effective instrument in terms of policy context and evidence generation. For the first time, such a national level population based survey on suicide was conducted in Bangladesh. An expert group of researchers, physicians and experts of National Institute of Mental Health, Dhaka was involved with this survey. I think this is a commendable work in this field. I wish proper application of all the evidences generated from this research work.

Professor Dr. Bidhan Ranjan Roy Podder

Associate Professor
National Institute of Mental Health & Hospital
Sher-e-Bangla Nagar, Dhaka-1207
&
Principal Investigator (PI)

MESSAGE

As a part of global problem, suicide appeared to be one of the major mental health issues in recent times, particularly among young and adolescent group of people in Bangladesh. This group of people is particularly vulnerable for suicide due to multidimensional causes like emotional and social stresses, impulsive behavior and peer pressure. Unfortunately, there was no national level data on suicide epidemiology till date in Bangladesh. This is the first time a nationwide population-based survey was conducted to see the prevalence and epidemiological aspect of suicide in Bangladesh. The study was conducted by National Institute of Mental Health, Dhaka with the involvement of a group of experts, young psychiatrists, doctors and many more. Undoubtedly, without their help, dedication and hard work it would have been impossible to conduct the study. Despite many limitations, evidences generated from this study hopefully will play an important role in formulating policy and programs on suicide which ultimately will contribute to achieve the sustainable development goals by 2030.

Dr. Helal Uddin Ahmed

Contributors to the Report

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Survey on Epidemiology of suicide and suicidal behavior among youth and adolescent in Bangladesh was undertaken by National Institute of Mental Health, Dhaka around the whole country with the active involvement of many individuals during the period of 2019. The project was funded by Non-Communicable Disease Control (NCDC) of Directorate General of Health services (DGHS) under Ministry of Health & Family Welfare (MOH&FW) of the Government of People's Republic of Bangladesh.

National Institute of Mental Health, Dhaka would like to acknowledge supports of all individuals contributing to the activities at different levels of the survey.

We express our gratitude to honorable members of NCDC of DGHS and WHO Team.

নন কমিউনিকেবল ডিজিজ কন্ট্রোল
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We are deeply indebted to Research Psychiatrists who had to go door to door for diagnosis.

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Dr Md Anowar Hossain

Dr Hasibur Rahman

Our heartfelt thanks to all the data collectors who approached house to house for collecting survey data.

Epidemiology of suicide & suicidal behaviour among youth and adolescent in Bangladesh, 2019
National Institute of Mental Health & Hospital
Sher E Banglanagar, Dhaka
Movement plan with team combination

Team	Team combination	Mobile no.	Psu no	Division	District	Upazila	Union	Vill/Mouza	Working date	Movement	PSU Sts	Sl no
01	Meratul Islam	01776861042	4	Barishal	Barguna	Barguan Sadar	Ward-07	Bazarpara	June 13-14, 2019		Urban	1
	Dilruba Sharmin	01818730360	5	Barishal	Barguna	Barguan Sadar	Gaurichhanna	Khajurtola	June 15-16, 2019		Rural	3
			21	Barishal	Barishal	Barishal sadar	Ward-29	Ichhakati	June 17-18, 2019	19/06/2019	Urban	2
			11	Barishal	Barishal	Bakerganj	Rangashree	Birangal	June 20-21, 2019		Rural	7
			26	Barishal	Barishal	Wajirpur	Zalla	Karfa	June 22-23, 2019	24/06/2019	Rural	12
			34	Barishal	Bhola	Char fassion	Neelkamal	Char Nurulamin	June 25-26, 2019	26/06/2019	Rural	16
02	Md. Abul Hasnat	01767173607	47	Barishal	Patuakhali	Galachipa	Ward-01	Natunbazar	June 13-14, 2019		Urban	3
	Moina boidya	01740673218	49	Barishal	Patuakhali	Galachipa	Ratandi Taltola	C. chouddakani	June 15-16, 2019	June 17, 2019	Rural	25
			41	Barishal	Jhalokathy	Kanthalia	Analbunia	Analbunia	June 18-19, 2019		Rural	20
			59	Barishal	Pirojpur	Nazirpur	Sheikhmatia	Ragunathpur	June 20-21, 2019	22/06/2019	Rural	30
			191	Khulna	Bagherhat	Morrelganj	Panchakaran	Chak kharaikhali	June 23-24, 2019		Rural	3
			200	Khulna	Jessore	Chaugacha	Pashapole	Palua	June 25-26, 2019	26/06/2019	Rural	7
03	Md. Ibrahim	01713522891	190	Khulna	Bagherhat	Mongla	Ward-07	Purbo selabunia	June 13-14, 2019		Urban	10
	Johora Khatun	01751728747	218	Khulna	Khulna	Dumuria	Ragunathpur	Thukura	June 15-16, 2019	June 17, 2019	Rural	16
			209	Khulna	Jhenaidah	Harinakunda	Ward-09	Harinakunda	June 18-19, 2019		Urban	11
			211	Khulna	Jhenaidah	Jhenaidah Sadar	Chanduali	Bagimara	June 20-21, 2019	June 22, 2019	Rural	12
			230	Khulna	Kushtia	Khoksha	Dhokrakul	Ambaria	June 23-24, 2019		Rural	20
			238	Khulna	Meherpur	Gangni	Roypur	Kariagachhi	June 25-26, 2019	26/06/2019	Rural	25
04	Apon chandra	01713522891	226	Khulna	Khulna	Sonadanga	Ward-17	Purbo sonadanga	June 13-14, 2019		Urban	12
	Tripti Halder	01763905428	244	Khulna	Satkhira	Kaliganj	Dhalbaria	Dhamrail	June 15-16, 2019	17/06/2019	Rural	29
			159	Dhaka	Gopalganj	Kotalipara	Amtoli	Unasia	June 18-19, 2019		Rural	11
			151	Dhaka	Faridpur	Madhukhali upz	Dumain union	Laxmipur	June 20-21, 2019	22/06/2019	Rural	6
			164	Dhaka	Madaripur	Kalkini	Enayetnagar	Enayetnagar	June 23-24, 2019		Rural	15
			169	Dhaka	Munshiganj	Sirajdi khan	Malkhanagar	Nateshwar	June 25-26, 2019	26/06/2019	Rural	19
05	Md. Nazrul Islam	01714537508	136	Dhaka	Dhaka	Keraniganj	Subadhya	Begunbari	June 13-14, 2019		Rural	2
	Sheikh Sharmin	01828173431	126	Dhaka	Dhaka	Bangshal Thana	Ward-67	KM Azam Lane	June 15-16, 2020		Urban	7
			138	Dhaka	Dhaka	Mirpur thana	Ward-13	Borobag	June 17-18, 2019	19/06/2019	Urban	8
			152	Dhaka	Gazipur	Gazipur Sadar	Ward-03	Auchpara	June 20-21, 2019		Urban	9
			182	Dhaka	Tangail	Dhanbari upz	Baniajan	Baniajan	June 22-23, 2019	24/06/2019	Rural	28
			177	Dhaka	Narsingdi	Roypur upz	Miraznagar	Hoglakandi	June 25-26, 2019	26/06/2019	Rural	24
06	Anamul Haque**	01841603837	65	Chattogram	Brahmonbaria	B.baria sadar	Ward-12	South badhughar	June 13-14, 2019		Urban	4
	Lutfun Nahar	01918138962	68	Chattogram	Brahmonbaria	Sarail	Chunta	Lopara	June 15-16, 2019	17/06/2019	Rural	4
			76	Chattogram	Chattogram	Banshkhali	Khankhanabad	Khankhanabad	June 18-19, 2019		Rural	8
			94	Chattogram	Chattogram	Satkania	Khagaria	Khagaria	June 20-21, 2019	22/06/2019	Rural	13
			108	Chattogram	Cox's Bazar	Ramu	Kauwarkhup	Manirjheel	June 23-24, 2019	24/06/2019	Rural	22

07	Azmul Hasan**	01865169024	101	Chattogram	Cumilla	Cumilla Sasdar	Ward-13	South Charta	June 13-14, 2019		Urban	6
	Reena parvin**	01906219723	100	Chattogram	Cumilla	Debidwar	Dhamti	Dhamti	June 15-16, 2019	17/06/2019	Rural	17
			110	Chattogram	Feni	Dagunbhuiyan	Samaspur	Mahadipur	June 18-19, 2019		Rural	26
			119	Chattogram	Noakhali	Chatkhil	Shahapur	Prosadpur	June 20-21, 2019	22/06/2019	Rural	31
			83	Chattogram	Chattogram	Halishahar	Ward-24	Anandipur	June 23-24, 2019	24/06/2019	Urban	5
08	Iqbal Hossain	01747 524474	455	Sylhet	Moulabibazar	Rajnagar	Fatehpur	Sonaloha	June 13-14, 2019	15/06/2019	Rural	12
	Samsun Nahar Luna	01716940477	485	Sylhet	Sylhet	Sylhet Sadar	Ward-07	Subid Bazar	June 16-17, 2019	18/06/2019	Urban	24
			439	Sylhet	Habiganj	Chunarughat	Mirahi	Himalia	June 19-20, 2019		Rural	3
			438	Sylhet	Habiganj	Chunarughat	Ward-06	North bazar	June 21-22, 2019		Urban	22
			446	Sylhet	Habiganj	Nabiganj	Kurshi	Samargaon	June 23-24, 2019	24/06/2019	Rural	7
09	Mahabubur Rahman	01718154034	462	Sylhet	Sunamganj	Dherai	Ward-08	Anwarpur uttar	June 13-14, 2019		Urban	23
	Josna Begum	01751496510	467	Sylhet	Sunamganj	Jamalganj	Sachna bazar	Mafij nagar	June 15-16, 2019	17/06/2019	Rural	20
			471	Sylhet	Sylhet	Balaganj	Balaganj	Hasampur	June 18-19, 2019		Rural	16
			476	Sylhet	Sylhet	Dakshin Surma	Daudpur	Daudpur	June 20-21, 2019	22/06/2019	Rural	25
			482	Sylhet	Sylhet	Kanaighat	Laxmi prosad	Sonatonpunji	June 23-24, 2019	24/06/219	Rural	29
10	Mustafijur Rahman	01704423533	251	Mymensingh	Jamalpur	Dewanganj upz	Ward-07	Char babshur	June 13-14, 2019		Urban	13
	Syeda Rabeya	01913441746	250	Mymensingh	Jamalpur	Bakshiganj upz	Nilxima	Sajimara	June 15-16, 2019	17/06/2019	Rural	1
			259	Mymensingh	Jamalpur	Madarganj upz	Karaichara up	Ilshamari	June 18-19, 2019	20/06/2019	Rural	5
			269	Mymensingh	Mymensingh	Fulbaria upz	Putijana up	Beribari	June 21-22, 2019		Rural	10
			275	Mymensingh	Mymensingh	Ishwarganj upz	Mogtola up	Chatiantola	June 23-24, 2019	24/06/2019	Rural	14
11	Obayedul Haque	01771038610	271	Mymensingh	Mymensingh	Gaffargaon upz	Saltia up	Silasi	June 13-14, 2019	15/06/2019	Urban	14
	Humaira Hasin	01817757725	286	Mymensingh	Mymensingh	Nandail upz	Achargaon	Goichkali	June 16-17, 2019		Urban	15
			288	Mymensingh	Mymensingh	Nandail upz	Sherpur up	Sherpur	June 18-19, 2019	20/06/2019	Rural	18
			295	Mymensingh	Netrokona	Kalmakanda upz	Boro kharpan up	Joynagar	June 21-22, 2019		Rural	23
			302	Mymensingh	Netrokona	Purbodhala upz	Khalishaur up	Bandsarpara	June 23-24, 2019	24/06/2019	Rural	27
12	Md. Ramjan Ali	01773517391	326	Rajshahi	Joypurhat	Panchbibi	Ramchandrapur N	Ramchandrapur N	June 13-14, 2019	15/06/2019	Rural	8
	Mahabuba Khatun	01737476293	312	Rajshahi	Bogura	Bagura Sadar	Ward-09	Sutrapur	June 16-17, 2019		Urban	16
			331	Rajshahi	Naogaon	Naogaon Sadar	Chandipur	Chuniaghari	June 18-19, 2019	20/06/2019	Rural	4
			333	Rajshahi	Naogaon	Sapahar	Goala	Hindupara	June 21-22, 2019		Rural	13
			336	Rajshahi	Natore	Natore Sadar	Ward-02	Patua para	June 23-24, 2019	24/06/2019	Urban	17
13	Joy Roy	01773517391	340	Rajshahi	Chapai N ganj	Nachole	Nachole	Hulaspur	June 13-14, 2019	15/06/2019	Rural	17
	Shapna Begum-**	01701921412	355	Rajshahi	Rajshahi	Boalia	Ward-26	Jamalpur	June 16-17, 2019		Urban	18
			361	Rajshahi	Rajshahi	Puthia	Nandanpur	Uttarpara	June 18-19, 2019	20/06/219	Rural	26
			349	Rajshahi	Pabna	Pabna Sadar	Bharar	Shreerampur	June 21-22, 2019		Rural	21
			370	Rajshahi	Sirajganj	Sirajganj Sadar	Ratankandi	Harina	June 23-24, 2019	24/06/2019	Rural	30

14	Md. Abdul Hakim	01712603978	375	Rangpur	Dinajpur	Bochaganj	Ward-07	Railcolony para	June 13-14, 2019		Urban	19
	Shajeda Khatun	01866288325	376	Rangpur	Dinajpur	Bochaganj	Ishania	Khanpur	June 15-16, 2019	17/06/2019	Rural	2
			385	Rangpur	Dinajpur	Parbotipur	Palashbari	Durgapur east	June 18-19, 2019		Rural	6
			396	Rangpur	Kurigram	Phulbari Sadar	Chandrakhana	Chandrakhana	June 20-21, 2019	22/06/2019	Urban	20
			393	Rangpur	Gaibandha	Sundarganj	Kismat sarban.	Sarbananda	June 23-24, 2019	24/06/2019	Rural	11
15	Md. Lavlu Miah	01773 289642	415	Rangpur	Panchaghar	Debiganj	Upen Chaukibanji	Upen Chaukibanji	June 13-14, 2019	15/06/2019	Urban	21
	Mst Umme Kulsum	01722231472	402	Rangpur	Kurigram	Ulipur	Hatia bhabes	Balarchar	June 16-17, 2019		Rural	15
			409	Rangpur	Nilphamary	Jhaldhaka	Kaimary	Gabrol	June 18-19, 2019	20/06/2019	Rural	19
			419	Rangpur	Rangpur	Gangachhara	Khalia	Beerabari	June 21-22, 2019		Rural	24
			428	Rangpur	Rangpur	Peerganj	Madankhali	Madankhali	June 23-24, 2019	24/06/2019	Rural	28

Note: Revised as instruction of Mukul Bhai & Dr. Nyem sir 11/06/2019 13:20

*The movement plan has prepared based on experience from previous survey: GATS-2017, Steps survey-2018 & NMHS-2019

*First 05 team will perform for 06 psu each and next 10 team will complete 05 psu each

** Taken from waiting list

We are Indebted to members of office team of NIMH whose support was essential for successful completion of the survey.

NIMH Office Team

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The survey activities could not be completed without the support of office secretary Qamruzzaman Mukul.

Computer Operator (Current Assistant Programmer)

Computer Support was provided by Anwar Hossain whose service was essential for survey activities.

Office Staffs of NIMH, Dhaka

Office Staffs of NIMH, Dhaka supported the survey activities from their respective position.

People of Bangladesh

Our sincere thanks to all people of Bangladesh who have taken all the troubles to participate in the survey.

Funding and Conflict of Interest

This survey has been funded by NCDC of DGHS under Ministry of Health & Family Welfare of the Government of People's Republic of Bangladesh. National Institute of Mental Health, Dhaka has conducted the survey as a designated institute of the Government for the purpose. The persons involved with the survey are responsible for the views expressed in this document which do not necessarily represent the views or policies of the institutions with which they are affiliated.

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Dr Helal Uddin Ahmed

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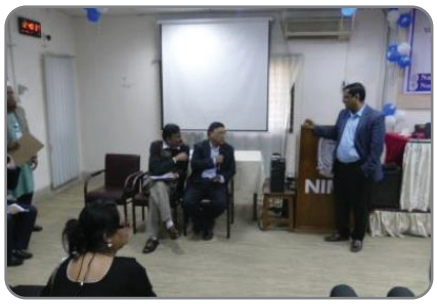
PICTORIAL PRESENTATION OF SURVEY ACTIVITIES













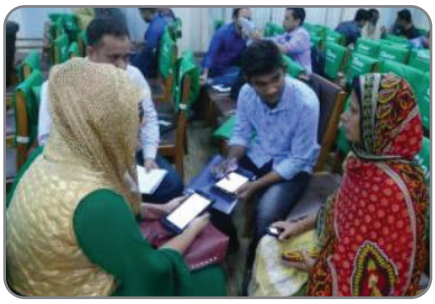











Summary

Suicide is one of the leading causes of death among adolescents and youths. Successful prediction and timely intervention is of utmost importance as within every 40 second a person is committing suicide. Among the various warning signs and precipitating factor, suicidal related behavior are important predictors of suicide. Hence, adequate culture and community specific information is necessary to prepare a holistic plan and successful implementation of this plan in the country. Though every year suicide is cost thousands of lives in Bangladesh, a large-scale community level national study was missing.

This is the first population-based nationwide study that explored suicidal behavior in Bangladesh.

This study was a multi-centric, representative, stratified nationwide survey conducted on randomly selected 1744 adolescents and youths (10-24 years) of either sex in Bangladesh. Adapted version of the instrument WHO Multisite Intervention Study on Suicidal Behavior (SUPRE-MISS) was used for data collection, in addition to sociodemographic questions. This household survey was conducted from October 2018 to June 2019.

The survey revealed 4.7% of adolescent and youth population had suicidal thought and 1.5% had suicidal plans and attempted suicide at least once. Female had more serious suicidal thought than male (2.6% vs 6.6%) and suicide related thoughts were more frequent among urban people than rural people (8.2% vs 3.7%). The mean age of first attempted suicide was 17 years. It was also observed 49.1 % household members had a history of suicidal behavior and suicidality.

The suicidal tendency and thoughts among the adolescents and young population of Bangladesh needs special attention from the health policy makers. We need to develop an evidence-based strategy to reduce the number of death every year due to suicide and this study will help in designing and implementing the strategies.

Introduction

Self-harm in adolescent is a major public health concern, eventually which may end up by suicidal attempts (1). Suicidal behaviors are enlisted as leading causes of death worldwide, especially among adolescents and young adults (2). The World Health Organization (WHO) marked suicide as the second leading cause of death for the youths aged between 15 to 29 (3). Although international variation exists, 10% of adolescents irrespective of socio-demographic level reported self-harmed from community-based studies (4). Worldwide 804,000 suicidal deaths occurred globally in 2012, representing age-standardized suicide rate of 11.4 per 100000 population (15.0 for males and 8.0 for females) (5). In developed countries, three times as many men die of suicide than women do, but in developing countries the male-to-female ratio is much lower at 1.5 men to each woman (5). However, due to social and cultural stigma, actual rate of suicide is believed to be under-reported in developing country. Despite the scope and seriousness of the problem, relatively little is known about the prevalence, correlates, or treatment of suicidal behavior (ie, suicidal ideation, plans, and attempts) in developing country like Bangladesh.

Suicide takes approximately 10,000 lives each year, and is one of the major causes of death in young adult females in Bangladesh (6). Although the overall estimated average rate of suicide in Bangladesh is 7.3 per 100,000 of the population per year, the rate in adolescents (15 - 18 years) is much higher, at 17.1 in males, and 22.7 per 100,000 in females (7). The estimation of suicide attempts made by adolescents is 100-200 for each completed suicide (8). A prior suicide attempt is considered as a risk factor for death by suicide (9). Persons who have attempted suicide before are at risk of dying by suicide than those who have not attempted before (10). However, the suicide related problems not only kill the person but also leave a life-long trauma towards the family members. The factors that provoke or precipitate suicide may arise from the family, society or community level. Being a religious country, suicide is stigmatized; therefore, suicide deaths might be hidden by the family (11,12). Nevertheless, in rural areas, adolescent females were found to be most vulnerable to commit suicide (6). The prevalence of suicide varies widely in different age, sex, socioeconomic and geographic contexts. Besides, some other problems including physical health problems, mental disorders, interpersonal difficulties, harming others and greater treatment service utilization (13–15).

South East Asian countries account for nearly 40 % of global suicides and 8 countries contribute for highest number of suicides at national and global levels. Suicide rates have been

increasing and are an established public health problem in recent years in India, Nepal, Thailand, Myanmar, Bangladesh and other countries. Suicide affects the young population and the region is affected significantly in all countries. The spectrum of suicides varies and includes those with suicides, suicidal attempts and suicidal ideations. There is an urban–rural variation and risk factors are several, both within and outside an individual. Many social, economic, cultural, and environmental related risk factors contribute significantly to suicide apart from health status and conditions of an individual for driving an individual to a stage of helplessness, hopelessness, and worthlessness. Among mental health conditions, depression, alcohol, other mental health conditions contribute to a greater extent. Childhood adversities history of abuse, neglect, growing up in dysfunctional families increases the risk for suicidal attempts and suicidal ideation among the youth and adolescents (16–18). In an addition to that, through various studies it is evident that, the adolescents who are prone to suicide have marked psychosocial deficit including low self-esteem, impulsivity and hopelessness (19–23). The world Health assembly has set a global target of reducing suicides by 10% by 2020 and suicide prevention is included under SDG goals to be achieved by 2030. Suicide is a major public health problem in South East Asian Region that is unrecognized and hidden amidst socio-cultural, economic and political complexities. Even though, suicides are recognized as a public health problem in many HICs, the recent recognition of the same in South East Asia Region is a noticeable feature. Undoubtedly, suicides are a societal problem and is often referred as the pulse of society. While the debate continues on the multidimensional nature of suicides, they are intricately linked to social and mental health of populations. Some mental health conditions like depression, schizophrenia, substance use disorders are major recognized risk factors for suicides and addressing these risk factors will result in suicide reduction. Good quality and robust data on suicides is very much essential to develop a comprehensive understanding of the problem for developing policies and programmes that address prevention, care and related services.

The main objective of this study was to determine the prevalence of suicide and pattern of suicidal behaviors among adolescents and youth in Bangladesh. Besides, by understanding the familial, social and environmental factors related to suicidal behavior in youth and adolescents, this study also tried to find out the prevalence of suicidal behaviors among them. The survey on **"Epidemiology of suicide and suicidal behavior among youth and adolescent Bangladesh"** was conducted successfully by National Institute of Mental Health, Dhaka and

by the financial and technical assistance of the Non-Communicable Disease Control (NCDC), Director General of Health Service (DGHS) and technical support of World Health Organization (WHO).

What is suicidal behaviour?

Suicidal behaviors include ideation (thinking about killing oneself), planning suicide, attempting suicide and suicide itself. Thoughts about suicide and suicide attempts can be seen as preliminary stages of completed suicide. This means that there is a development from thoughts or ideas about suicide to attempted suicide and from attempted suicide to completed suicide. Completed suicide includes all deaths in which a willful, self-inflicted, life-threatening act has been performed which results in death. This act with fatal outcome was deliberately initiated and performed. The person knew or expected the fatal outcome. Through this act the person aimed at achieving changes he or she desired. However, the intention might be vague or ambiguous. This means that in most cases the person does not want to die and does not see death as the goal, but the person wants to stop living or the person wants to stop being conscious. Suicide attempt includes those situations in which a person has performed a life-threatening act with the intent of putting his or her life into danger or giving the appearance of such intent. However, the life-threatening act might not result in death. Attempted suicide has to be seen as a cry for help. The person wants to provoke changes which should make life bearable for him or her. It includes interruptions by others before the actual self-harm occurs.

Rationale

The extreme despair which drives the individual to self-killing may be linked to unrecognized or untreated endogenous illnesses; or it may have psychosocial causes within the social system. Several factors have been identified, such as poor education, early marriage, unemployment, early motherhood, domestic violence etc. (24) but more researches are needed to be performed to address the issue in depth. There is a need for recent population-based data that could be used to define the burden and epidemiology of suicide in Bangladesh, and to consequently address interventions for reducing rates of fatal and non-fatal suicidal behavior in Bangladesh. In recent years, global experience has shown that suicides are predictable and preventable. Many High-Income Countries have reduced the number of suicides while countries like Bhutan and Sri Lanka in SEAR have strengthened their existing programs or developed new activities. A strong national policy in close coordination with mental health or suicide prevention integrated into other sectors policies and programs is the need of the hour. Implementation of alcohol control policies, restricting access to means like control of easy availability of pesticides and drugs, positive media reporting, strengthening information systems are urgently required in the region. In addition, scaling up mental health services in terms of availability and accessibility and reduction of stigmatization will greatly support those with suicidal behavior. Decriminalization of both completed and attempted suicides will help people to seek help, reduce stigma and promote better understanding of suicides. Including suicide prevention in all welfare and economic policies will benefit region where more than 40% live in low-income households. However, all SEAR countries have very weak and fragmented policies and programs. The much required intersectoral approaches, skilled human and financial resources are often found lacking. The easy availability of pesticides/ drugs and alcohol is a major cause for suicides in the region. The poor awareness combined with stigma towards suicides in a criminalizing environment is one of the major contributors in the absence of strong advocacy and awareness programs. Mental health services, especially in peripheral and rural areas, are deficient to a large extent. Considering all these deficiencies, it becomes vital to initiate working on developing a strong national policy that addresses suicide prevention policy and for this massive task to be accomplished, prerequisite steps such as gathering nation-wide data should be undertaken.

Methodology

i. Study Design

The design of the present study was multi-centric, representative, stratified (male and female, urban and rural population), which was based on Population Proportionate to Size (PPS strategy) of population in randomly selected samples. This study was principally quantitative in nature with a qualitative part to look for specific risk factors for suicidal behavior.

The participants of the study consisted of 1744 individuals. Adolescents and youth aged 10-24 years residing in Bangladesh were selected randomly. The research team of National institute of Mental Health completed randomly selected household survey in both rural and urban areas in the country. This nationally representative, population-based and cross-sectional household survey was conducted from October 2018 to June 2019.

Sample Size:

The sample size was calculated using the formula: $n = (Z^2pq)/d^2.$ $n = (Z^2pq)/d^2.$

Here, Z^2 = standard normal deviate set at 3.8416 corresponding to 95% confidence level,

p = the estimated prevalence within the target population taken as 7% = 0.07[12] q = 1 - 0.07 = 0.03,

d = margin of error (the expected half-width of the confidence interval and here recommended value is 0.035)[16].

The initial sample size was 204. After adjustment for design effect (3.0), sex or residence groups (2) and response rate of 80%, the final minimum sample size was 1 530 which was rounded to 1 600 for equal allocation by sex in a Primary Sampling Unit (PSU) to ensure minimum numbers for each domain. Finally, data were collected from 1744 respondents.

Selection criteria

Following criteria were considered during selecting the participants.

Inclusion Criteria

a. All youth between 10 to 24 years of age residing in Bangladesh during the study period.
b. Those who were Bangladeshi citizens by birth.

Exclusion Criteria

a. Those who were unable to give verbal and written consent.
b. Those who were in terminal illness (Ex. Last stage of Cancer).
c. Those who were under 10 years and above 24 years old.

ii. Study period

The survey was conducted from October, 2018 to June, 2019. The field work was done within February to June, 2019. It included preparatory activities, protocol and research instrument development, pretesting, field preparation, data collection, data processing and analysis, quality control check followed by report writing and dissemination of survey findings. Time period of the conducted study is given below:
Training: 26 and 27 May, 2019
Piloting and debriefing: 28 May 2019
Question finalization: 29 May, 2019
Field operation: 10-20 June, 2019

iii. Instruments

WHO Multisite Intervention Study on Suicidal Behaviors (SUPRE-MISS).

The adapted version of the WHO Multisite Intervention Study on Suicidal Behaviors (SUPRE-MISS) was used as the data collection tool. This tool has been used in all the six WHO regions in the early 2000s in the community surveys based on the European Parasuicide Study Interview Schedule (EPSIS; Kerkhof et al. 1999). It had also been applied in the WHO/EURO multicenter study on suicidal behavior. In a meeting of experts, the SUPREMISS instrument

was discussed and refined. The final instrument (WHO, 2002) covered sociodemographic information, the history of suicidal behavior, family data, physical health, contact with health services, mental health, questions related to substance use, and to community stress and problems. Two questions were added to this community survey questionnaire about method and perceived cause of suicidal behavior which was added by technical advisory committee based on literature review of Bangladeshi context.

iv. Development and Adaptation of Questionnaires

At first, the questionnaire was translated into Bangla by researchers whom mother tongue is Bengali but have well knowledge in English and the terminology covered by the questionnaire.

The translated questionnaire was presented to the judges to identify and resolve the inappropriate expressions/concepts of the translation. Professional senior psychiatrists, psychologists and public health specialists served as the judges. They found very few discrepancies of some words between the forward translation and the English versions and then suggest alternatives. After completing judge evaluation, from the comments of the judges, accumulated possible Bengali option and prepared the first draft of the questionnaire which was presented for back translation. The first draft of the scale was translated back to the English by a senior psychiatrist who had no orientation of the questionnaire. In the back-translation emphasis was given on conceptual and cultural context and not linguistic equivalence. After translated back to English compared with the original version and found no contributory discrepancies. So, prepared the final scale.

v. Piloting and Development of Master Protocol

A pilot study was conducted among population in different PSU from urban and rural. Necessary modifications made based on feedback from the pretest and prepared Master Protocol.

vi. Study Procedure

National Institute of Mental Health (NIMH), Dhaka, conducted the multi-centric community-based study. The study was supervised and monitored by the Technical advisory committee, working group committee and NIMH core committee. **A pilot study** following a scientific protocol has undertaken in the urban and rural areas among people outside the study area. Then necessary modification has made depending on the findings of the pilot study. The **Master Protocol** of the study has drafted based on the results from the pilot study and finalized after presentation and approval of the technical advisory committee.

vii. Project Management

a. **Technical Advisory Committee:** A committee was formed to coordinate and supervise the survey. The committee members arranged total 10 meetings during the survey period.
b. **Supervision and monitoring teams:** Eight number of experts was constituted a team to coordinate and supervise the survey especially in their respective study area.
c. **Field workers:** total number of field workers was=40
    1. As our total PSU are 80 in number so every field worker should cover 2 PSU
    2. Day per PSU for each field worker = 3 days
    3. So, covering 2 PSUs will take = 6 days
    4. Inter district travelling time = 1 day
    5. So total day for data collection= 7 days
    6. Training period= 2 days
    7. So total days of involvement of field workers= 11 days

d. Terms of Reference for the activity

1. Technical Advisory Committee supervised the whole survey process.
2. Supervision and monitoring Team coordinated and supervised the survey activities in their respective area.
3. The core National Institute of Mental Health (NIMH) Team comprising of psychiatrists and epidemiologists with extensive experience in conducting population-based surveys. Training was provided for use of other instruments.

4. Core NIMH Team and Persons received TOTs trained the field data enumerators (DEs) and other related personnel following guidelines laid out in the master protocol.
5. Guidelines for field data enumerators (DEs) and guidelines for research psychiatrists was developed by core NIMH expert team
6. Supervision and monitoring team received multiple extensive training at NIMH which was conducted by core NIMH team.
7. Prior to training, study protocol was provided to all members of core NIMH team and supervision and monitoring team. At first, Outline was presented by core NIMH team to all other members. Presentation was also made on Suicide and suicidal behavior.
8. 'Record keeping' was maintained by field data enumerators (DEs), coordinator of DEs, monitoring and supervision team and core NIMH team through different forms / checklists which was designed at different levels.
9. Continuous monitoring was done by investigators, supervision and monitoring team, core NIMH Team and national technical advisory committee.

viii. Data Management

Face to face interview was conducted for the data collection in the study. Collected data was processed and analyzed by using Microsoft Excel, Epi Info/SPSS software. All data were stored on a secure database. The lead researcher team have overall responsibility for data management over the course of the research project and monitor compliance with the plan.

ix. Monitoring, Supervision of Data Collection

The members of the Technical Committee frequently visited data collection field to ensure the valid data collection. The representatives of NCDC, DGHS and WHO were involved in monitoring field activities.

x. Ethical Consideration

1. All possible ethical considerations were maintained in the survey. The ethical approval for the study was obtained from Bangladesh Medical Research Council (BMRC). The survey protocol, instruments and consent forms for this survey was approved by the ethical review board of Bangladesh Medical Research Council (BMRC). Informed written consent form was taken from all the participants before collection of survey data or specimens.

2. The participation was voluntary. Detailed explanatory information was read out and explained to the participants in the local language from a printed handout. Objectives, methods of the study, duration and frequency was included on the Informed consent form. Consent was taken in Bengali and interview was conducted in Bengali. Finger impressions was obtained from the participant who was unable to sign.

3. Confidentiality of the data was maintained with highest priority. Privacy of the respondents was maintained during the data collection.

4. There was no physical harm or risk on the study population as no hazardous procedure was involved with the study participants. There was no loss of working hours of the studied population.

5. Before data collection, formal permission was taken from the respective community leader.

6. The study didn't create any injustice to the participants and it didn't create any emotional, financial, social or professional problem to the participants.

7. The participants were offered with due respect and they had the right to withdraw from the study at any time.

8. Collected data was used only for this study. Data of the study was analysed and presented anonymously.

Results

Table 1. Number and percent of households and persons interviewed and response rates by residence and sex.

Household status	Residence				Sex				All	
	Urban		Rural		Man		Woman			
	n	%	n	%	n	%	n	%	n	%
Household level										
Roster completed (RC)	485	35.9	1307	41.4	878	38.7	914	40.7	1792	39.7
No one eligible*	720	53.3	1635	51.8	1208	53.4	1147	51.0	2355	52.2
Locked house (LH)	77	5.7	142	4.5	104	4.6	115	5.1	219	4.9
Broken house (BH)	15	0.0	33	1.0	22	1.0	26	1.2	48	1.1
Vacant house (VH)	35	2.6	30	0.9	37	1.6	28	1.2	65	1.4
House not found*	4	0.0	4	0.1	4	0.2	4	0.2	8	0.2
Refused interview (HHR)	4	0.3	4	0.1	4	0.2	4	0.2	8	0.2
Group accommodation*	9	0.7	6	0.2	7	0.3	8	0.4	15	0.3
Not HH*	2	0.1	0	-	1	0.0	1	0.0	2	0.0
Total	1351	100.0	3161	100.0	2265	100.0	2247	100.0	4512	100.0
Household response rate (HRR)†		**78.7**		**86.2**		**84.0**		**84.1**		**84.1**
Individual level										
Completed (C)	475	97.9	1269	97.1	850	97.0	894	97.6	1744	97.3
Unavailable (U)	10	2.1	38	2.9	26	3.0	22	2.4	48	2.7
Refused (R)	0	-	0	-	0	-	0	-	0	-
Total	485	100.0	1307	100.0	876	100.0	916	100.0	1792	100.0
Individual response rate (IRR)‡		**97.9**		**97.1**		**97.0**		**97.6**		**97.3**
Total response rate§		**77.1**		**83.7**		**81.5**		**82.1**		**81.8**

* These persons were not included as sample as they do not qualify[1] as sample for the Survey.

† Household response rate (%)=[RCx100]/[RC+LH+BH+VH+HHR]=91.0%

‡ Individual response rate
(%)=[Cx100]/[C+U+R]=99.3%
§ Total response rate
(%)=HRR*IRR/100=90.4
1 The American Association for Public Opinion Research. 2016. Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys. 9th edition. AAPOR. Available from: https://www.aapor.org/AAPOR_Main/media/publications/Standard-Definitions20169theditionfinal.pdf (Accessed on 3 September 2019).

Figure 1. Response rates of the Survey.

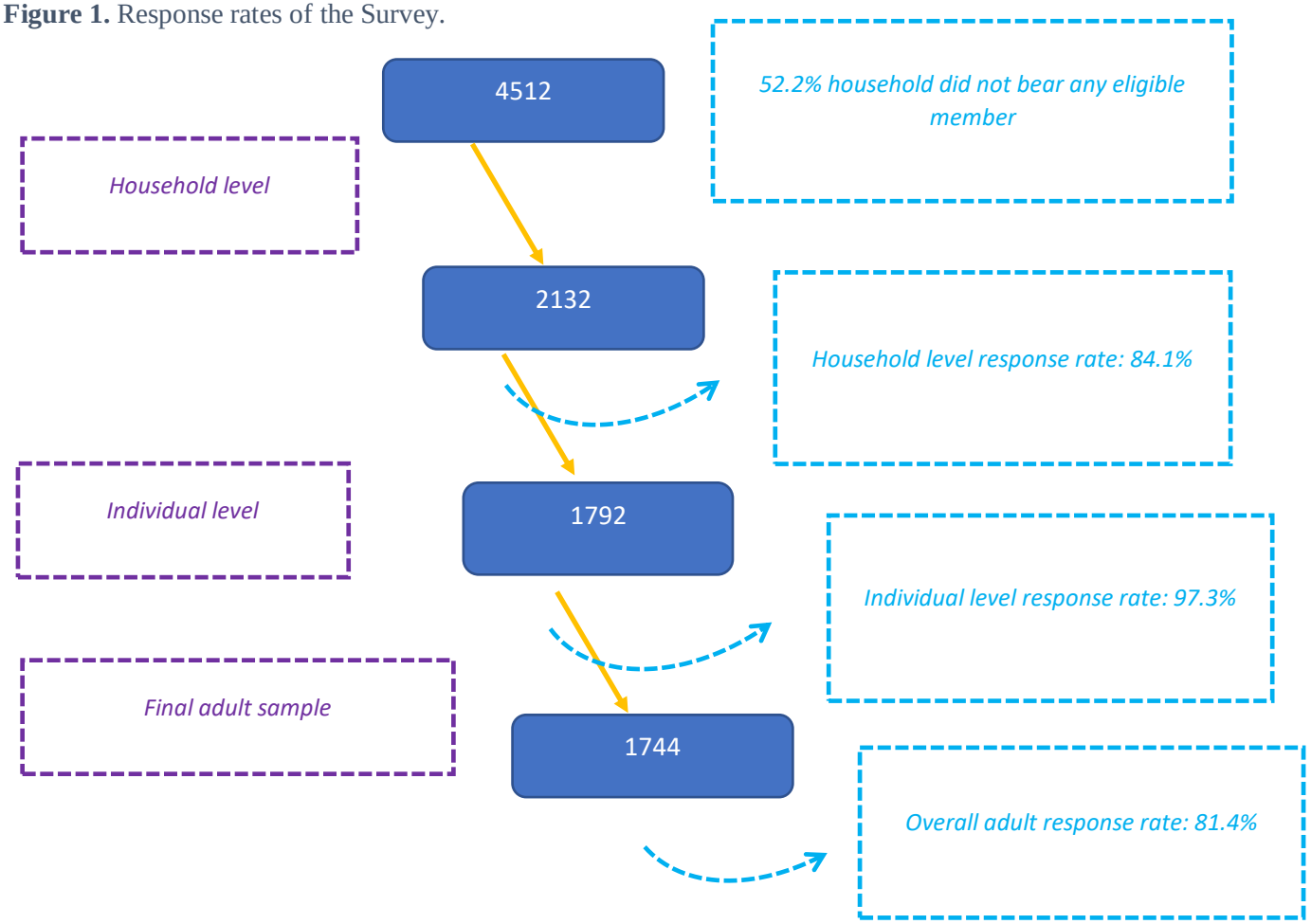


Figure 2: Total household response rate (n = 4512)

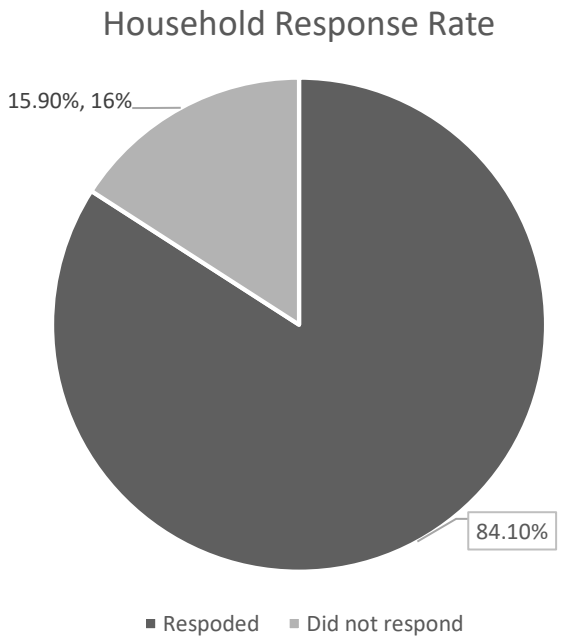


Figure 3. Map of Bangladesh showing areas of data collection as urban and rural primary sampling units.

Table 2. Distribution of unweighted and weighted sample by age and sex.

Age Group (year)	Unweighted									
	Men		**Women**		**Urban**		**Rural**		**All**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
10 – 19	603	70.8	631	70.7	334	70.3	900	70.9	1234	70.8
20 – 24	249	29.2	261	29.3	141	29.7	369	29.1	510	29.2
10 - 24	**852**	**100.0**	**892**	**100.0**	**475**	**100.0**	**1269**	**100.0**	**1744**	**100.0**
	Weighted*†									
10 – 19	15453289	72.4	15829200	65.9	6717863	66.1	24564627	69.8	31282490	69.0
20 – 24	5897599	27.6	8188897	34.1	3448508	33.9	10637988	30.2	14086496	31.1
10 - 24	**21350889**	**100.0**	**24018097**	**100.0**	**10166371**	**100.0**	**35202615**	**100.0**	**45368986**	**100.0**

* Sample number weighted to projected Bangladeshi population aged 10-24 years upto June 2019 based on growth rates and population counts of Housing and Population Census Bangladesh 2011

† weight trimmed beyond 2.5 times the median value and fixed at that value.

Figure 4: Distribution of respondents by Residency and Age group (n = 1744)

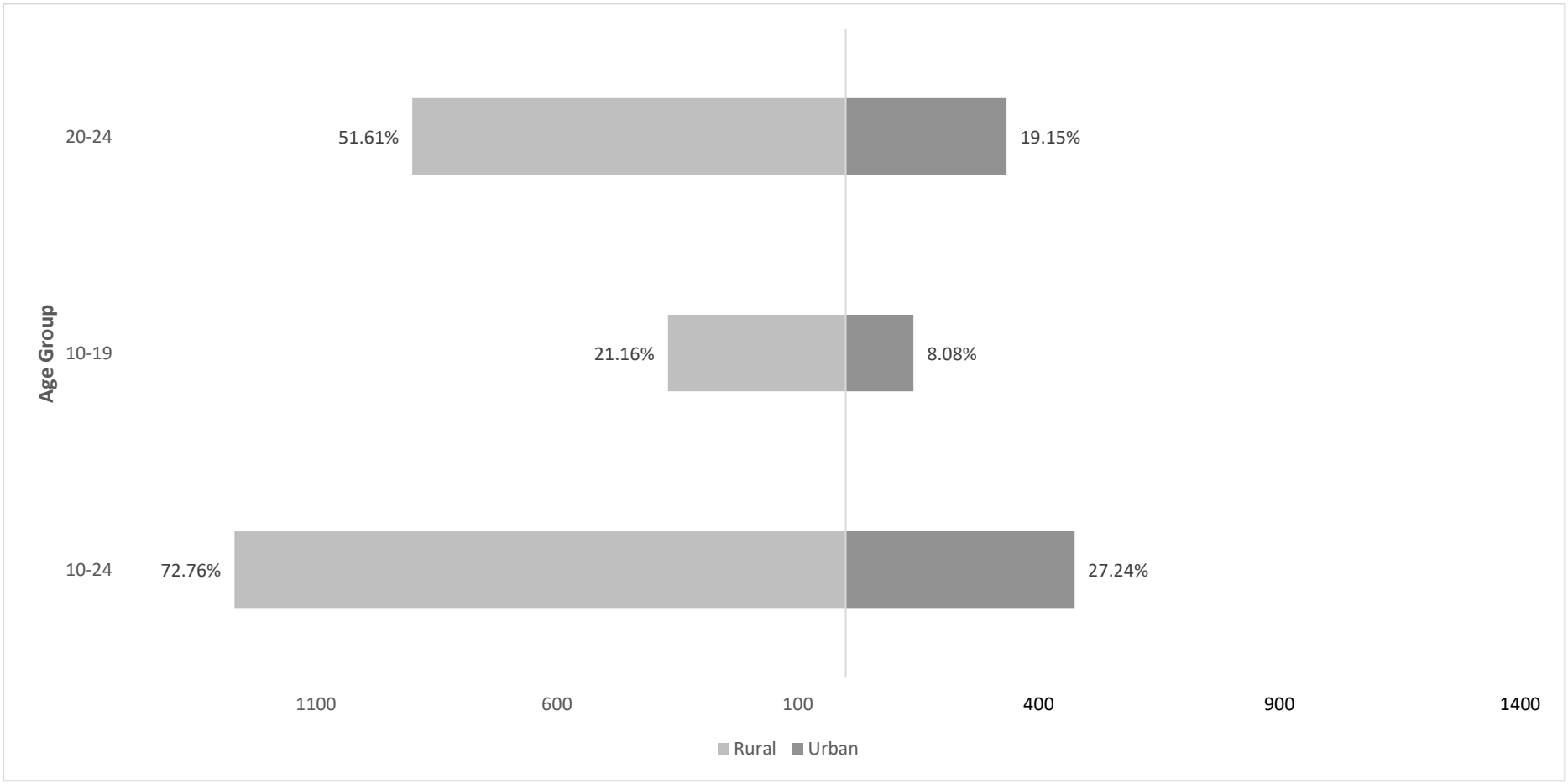


Table 3: Distribution of respondents by demographic background. (n = 1744)

Demographic characteristics	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Education level										
Graduation and above	6.5	4.4 - 8.5	5.5	3.3 - 7.6	7.2	4.9 - 9.5	5.6	3.6 - 7.5	5.9	4.3 - 7.6
Higher secondary	13.8	10.1 - 17.5	12.2	9.3 - 15.1	15.0	12.4 - 17.6	47.6	9.0 - 15.6	12.9	10.2 - 15.6
Secondary	38.7	34.1 - 43.3	54.7	49.7 - 59.8	45.7	40.4 - 51.1	47.6	42.8 - 52.4	47.2	43.3 - 51.1
Primary	39.3	33.6 -45.1	27.3	23.1 - 31.6	31.0	25.0 - 36.9	33.5	28.7 - 38.4	33.0	29.0 - 37.0
No education	1.7	-	0.3	-	1.0	-	1.0	-	1.0	0.4 - 1.6
Religion										
Islam	89.2	82.4 - 96.1	92.7	86.923	93.5	89.8 - 97.1	90.4	82.5 - 98.2	91.0	84.9 - 97.2
Hinduism	10.8	3.9 - 17.6	7.1	1.343	6.0	2.5 - 9.5	9.6	1.8 - 17.5	8.8	2.7 - 15.0
Christianity	-	-	0.2	-	0.5	-	-	-	0.1	-
Marital Status										
Unmarried	93.9	91.6 - 96.1	71.6	66.0 - 77.1	81.5	74.8 - 88.2	82.2	78.2- 86.3	82.1	78.6 - 85.6
Married	6.0	3.7 - 8.3	27.9	22.6 - 33.2	17.8	11.6 - 24.1	17.6	13.5 - 21.6	17.6	14.2 - 21.0
Others*	0.1	-	0.5	-	0.7	-	0.3	-	0.4	-

* 95% confidence interval

- Unweighted numbers are < 25

Table 4: Distribution of respondents by occupation (n = 1744)

Demographic characteristics	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Occupation										
Service*	3.6	1.6 - 5.6	3.8	-	6.9	-	2.8	0.5 - 5.0	3.7	1.4 - 6.0
Business†	6.2	3.9 - 8.5	-	-	4.3	-	2.5	1.4 - 3.6	2.9	1.8 - 4.0
Farming‡	5.6	1.8 - 9.3	-	-	0.3	-	3.3	1.0 - 5.6	2.6	0.8 - 4.4
Daily worker§	9.0	5.8 -12.2	1.3	-	4.1	-	5.1	3.3	4.9	3.4 - 6.4
Driver**	1.5	0.5 - 2.5	-	-	0.6	-	0.7	-	0.7	-
Student	71.7	66.7 - 76.6	63.0	57.4 - 68.5	66.8	60.6 - 73.1	67.1	62.1 - 72.2	67.0	62.9 - 71.2
Household work	0.6	-	30.4	24.6 - 36.2	13.8	8.5 - 19.0	17.2	13.4 - 20.9	16.4	13.2 - 19.6
Retired	-	-	0.1	-	-	-	0.0	-	0.0	-
Unemployed††	1.9	-	1.6	0.2 - 2.9	3.3	-	1.3	0.3 - 2.3	1.7	0.8

* 95% confidence interval
- Unweighted numbers are < 25
* Service: Government/private/autonomous/self-employment
† Business: small and large
‡ Farming: with or without owned land
§ Daily worker: factory/labourer/paid household/blacksmith/potter/weaver/fisherman
** Driver: transport driver and other transport worker/rickshaw puller/ rickshaw van puller/push cart driver/private car driver
†† Unemployed: retired/unemployed but capable/unemployed and incapable

Table 5: Distribution of respondents by socioeconomic background. (n = 1744)

Demographic characteristics	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Household members currently living together										
Husband and wife	1.0	-	2.6	-	2.6	-	1.6	-	1.8	0.4 - 3.2
Husband, wife and children	2.4	-	12.1	8.2 - 16.0	9.8	4.3 -15.3	6.9	4.5 - 9.2	7.5	5.3 - 9.8
With children	4.3	0.5 - 8.1	0.5	-	0.8	-	2.7	0.0 - 5.5	2.3	0.1 - 4.5
Parents or father- and mother-in-law	89.5	84.6 - 94.5	82.2	76.5 - 87.8	83.2	76.2 - 90.2	86.3	81.0 - 91.7	85.6	81.2 - 90.1
Relatives or friends	1.8	-	0.8	-	1.4	-	1.2	-	1.3	0.5 - 2.1
Visit to place of worship										
Once a week	39.5	29.3 - 49.8	21.2	14.0 - 28.4	26.6	11.6 - 41.6	30.8	22.9 - 38.7	29.8	22.8 - 36.9
More than once a week	53.8	43.3 - 64.3	37.2	28.2 - 46.1	40.4	28.6 - 52.2	46.3	37.1 - 55.6	45.0	37.3 - 52.7
Once a month	3.5	1.3 - 5.6	7.7	4.4 - 11.0	4.4	1.1 - 7.8	6.1	3.7 - 8.4	5.7	3.7 - 7.7
Once a year	1.5	-	1.5	-	1.6	-	1.5	-	1.5	0.6 - 2.4
2 - 3 times a year	0.4	-	2.4	-	0.5	-	1.7	-	1.5	-
Never	1.2	-	30.1	17.7 - 42.4	26.5	10.6 - 42.4	13.6	6.6 - 20.7	16.5	9.7 - 23.3
Considers oneself as pious	90.0	85.5 - 94.4	81.6	74.0 - 89.2	82.9	72.4 - 93.4	86.3	80.4 - 92.2	85.6	80.4 - 90.7
Sexual orientation										
Heterosexual	79.6	69.2 - 89.9	68.9	57.9 - 79.8	86.9	76.6 - 97.2	69.7	58.8 - 80.7	73.8	64.7 - 82.9
Homosexual	1.6	-	9.5	3.9 - 15.2	4.7	-	6.3	2.3 - 10.2	5.9	2.6 - 9.2
Bisexual	8.3	0.9 - 15.7	11.8	4.0 - 19.7	2.8	-	12.5	3.5 - 21.6	10.2	3.1 - 17.3
Unsure of sexual orientation	10.5	2.7 - 18.3	9.7	4.9 - 14.6	5.6	1.0 - 10.2	11.5	5.5 - 17.5	10.1	5.3 - 14.8

* 95% confidence interval

- Unweighted numbers are < 25

Table 6: Distribution of respondents by socioeconomic background and social media use (n = 1744)

Demographic characteristics	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Household asset: has…										
Mobile/ smart phone	93.9	-	97.1	-	93.4	-	96.2	-	95.6	-
Television	55.1	-	55.4	-	73.7	-	49.9	-	55.2	-
Computer/ laptop/ tablet computer	53.8	-	46.2	-	17.2	-	5.4	-	8.0	-
Roof of main house										
Thatched	8.0	1.9 - 14.1	2.2	-	0.4	-	6.3	2.4 - 10.1	5.0	1.9 - 8.0
Tin/ asbestos/ clay tile/ similar	70.5	62.2 - 78.8	80.7	73.3 - 88.0	61.0	45.6 - 76.4	80.2	74.2 - 86.2	75.9	69.5 - 82.3
Cement/ concrete/ cement tile	21.5	14.5 - 28.5	17.1	10.0 - 24.1	38.6	23.1 - 54.1	13.6	8.4 - 18.7	19.2	12.8 - 25.5
Social media use										
Facebook/ other social media	32.3	25.6 - 39.1	14.5	10.8 - 18.2	33.6	28.0 - 39.2	19.8	14.8 - 24.8	22.9	18.4 - 27.4
YouTube	27.7	20.7 - 34.7	14.7	9.8 - 19.7	34.0	24.3 - 73.8	17.0	11.7 - 22.4	20.8	15.5 - 26.1

* 95% confidence interval

- Unweighted numbers are < 25

Table 7. Distribution of respondents who had suicidal thoughts (n=1744)

Variables	Sex			Residence				All	
	Man	Woman		Urban		Rural			
	%	%	95% CI*	%	95% CI*	%	95% CI*	%	95% CI*
Had suicidal thoughts…(n=82)									
Seriously though about suicide	2.6	6.6	3.5 - 9.6	8.2	4.2 - 12.2	3.7	1.4 - 5.9	4.7	2.6 - 6.8
Thought of suicide was within past 12 months	64.4	48.6	-	52.4	-	52.8	37.8 - 67.8	52.7	36.7 - 68.6

* 95% confidence interval
- Unweighted numbers are < 25

Table 8. Distribution of respondents who had planned and attempted suicide. (n=1744)

Variables	Sex		Residence		All
	Man	Woman	Urban	Rural	
	%	%	%	%	
Had planned for suicide…(n=21)					
Ever planned for suicide	0.7	2.3	2.8	1.2	1.5
Planned for suicide within past 12 months	45.6	24.8	47.2	17.0	29.4
Attempted suicide…(n=21)					
Attempted suicide in lifetime	0.8	2.1	2.0	1.4	1.5
Number of attempts (mean)	1.3	3.2	6.5	1.2	2.7
Attempted at least once in past 12 months	15.6	13.6	4.5	18.1	14.1

Table No 9. Distribution of respondents who had planned and attempted suicide depending on first and last attempt of suicide. (n=1744)

Variables	Sex		Residence		All
	Man	Woman	Urban	Rural	
First attempt of suicide					
Age of first attempt (mean, years)	16.0	17.3	15.5	17.6	17.0
Statement regarding the attempt					
Tried to suicide but is lucky to have failed	89.6	55.3	93.5	51.7	64.0
Tried but knew that the effort is not sufficient	10.4	20.0	-	24.9	17.6
Tried to gain compassion by attempting	-	24.6	6.5	23.4	18.4
Method					
Ingestion of poison	32.6	15.6	6.5	25.4	19.9
Hanging by the rope	53.8	32.2	61.9	27.5	37.6
Drowning	8.4	-	-	3.0	2.1
Sever arms/ other places of body	5.2	50.5	31.6	42.2	39.1
Other method	-	1.7	-	1.8	1.3
Injury/ poisoning due to suicide attempt	62.7	55.6	28.4	68.8	57.3
Any treatment† required	24.6	27.4	-	37.0	26.7
Admission needed once or more	100.0	49.1	-	61.2	61.2
Last attempt of suicide					
Age at last attempt (mean, years)	16.4	17.3	15.5	17.8	17.1
Statement regarding the attempt					
Tried to suicide but is lucky to have failed	100.0	54.5	93.5	54.6	66.1
Tried but knew that the effort is not sufficient	-	20.4	-	21.6	15.2
Tried to gain compassion by attempting	-	25.1	6.5	23.8	18.7

* 95% confidence interval

- Unweighted numbers are < 25

Table 10. History of suicide of household members. (n=18)

Variables	Sex		Residence		All
	Man	Woman	Urban	Rural	
	%	%	%	%	%
Had thoughts, planned, attempted or committed suicide	74.6	41.0	28.4	58.2	49.1
Method					
By ingesting poison†	15.7	-	-	7.0	5.7
Hanging by the rope	84.3	36.9	-	65.9	54.3
Sever arms/ other places of body	-	63.1	100.0	27.2	40.0
Suicide attempt or suicide was a…					
Preplanned event	13.0	-	-	5.8	4.8
Instant event	87.0	100.0	100.0	94.2	95.2
Reason					
Family conflict	60.1	16.3	-	39.2	32.3
Unable to tame anger	-	56.0	-	43	35.5
Sleep disorder	-	27.7	100	-	17.6
Poverty	15.7	-	-	6.97	5.7
Failure in exam	24.2	-	-	10.8	8.9
History of suicide in married women household member (n=231)	-	1.4	0.9	1.6	1.4
Age of marriage (mean, years)	-	17.7	16	18	17.7
Number of children (mean)	-	1.4	1.0	1.5	1.4
Number of children borne before 18 years (mean)	-	0.6	1.0	0.5	0.6
Age when first child was born (mean, years)	-	17.4	17.0	17.5	17.4

* 95% confidence interval

- Unweighted numbers are < 25

† Type of poison: sedative medication

Table 11. History of suicide or attempted suicide of family members. (n=815)

Variables	Sex		Residence		All
	Man	Woman	Urban	Rural	
	%	%	%	%	%
Family member having suicidal death	0.8	1.0	2.474	0.38	0.9
Relationship with respondent…					
Brother	85.4	45.0	52.4	81.1	61.3
Sister	-	55.0	47.6	-	32.8
Grand father	14.6	-	-	18.9	5.9
Reason for last episode of suicide…					
Family cause	14.6	-	-	18.9	5.9
Brother-/ sister-in-law	10.5	-	-	13.6	4.2
Failure in exam	52.0	-	-	67.5	21.0
Marital disharmony	-	45.0	39.0	-	26.9
Abuse by father-in-law	-	55.0	47.6	-	32.8
Others	23.0	-	13.5	-	9.3
Family member attempting suicide	0.2	1.9	2.2	0.8	1.1
Relationship with respondent…					
Brother	100.0	37.9	44.2	42.0	43.7
Sister	-	62.1	55.8	58.0	56.3
Reason for last episode of suicide…					
Family cause	100.0	8.5	-	26.9	13.8
Addiction	-	16.9	-	30.9	15.9
Marital disharmony	-	22.7	44.2	-	21.4
Personal relationship issue	-	51.8	55.8	42.2	48.8

* 95% confidence interval - Unweighted numbers are < 25

Table 12. Health status and health seeking behavior of respondents. (n=1742)

Variables	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	%	95% CI*	%	95% CI*	%	95% CI*	%	95% CI*	%	95% CI*
Long term sickness or incapability for at least 1 year	2.8	1.3 - 4.2	4.8	2.5 - 7.1	5.4	2.0 - 4.9	3.4	1.9 - 4.9	3.8	2.4 - 5.3
Sickness or incapability is…										
Hypertension	3.4	-	7.6	-	12.2	-	3.4	-	6.2	-
Incapability†	-	-	1.3	-	2.8	-	-	-	0.9	-
Diabetes	4.2	-	-	-	-	-	2.1	-	1.4	-
Asthma, breathing difficulty	41.2	11.3 - 18.3	33.2	-	23.1	-	41.8		35.9	22.9 - 49.0
Cancer	2.4	-	-	-	-	-	1.2	-	0.8	-
Thyroid problem	-	-	5.3	-	-	-	5.1	-	3.5	-
Arthritis	21.7	-	23.3	-	17.4	-	25.2	-	22.8	-
Blood disorders (Thalassemia/ Hemophilia)	-	-	0.8	-	-	-	0.8	-	0.5	-
Epilepsy	3.0	-	-	-	-	-	1.5	-	1.0	-
Others	24.0	-	28.5	-	44.5	-	18.9	-	27.0	-
Duration (mean, year)	4.7	3.1 - 6.2	4.1	2.7 - 5.6	3.8	-	4.5	3.1 - 6.0	4.3	3.1 - 5.5
Times of seeking health service										
Never	96.8	94.9 - 98.7	99.0	97.8 - 100.1	98.2	-	97.9	-	97.9	-
Once	2.8	-	0.7	-	1.6	-	1.8	-	1.7	-
2-3 times	0.1	-	-	-	-	-	0.1	-	0.0	-
4 times	0.3	-	0.3	-	0.2	-	0.3	-	0.3	-

* 95% confidence interval

- Unweighted numbers are < 25

†Incapability: paralysis due to stroke, loss of limb due to accident etc.

Table 13. Point of seeking health care service for mental health. (n=1688)

Variables	Sex		Residence		All
	Man	Woman	Urban	Rural	
	%	%	%	%	%
Service sought from…					
Polyclinic, hospital indoor	1.1	0.2	0.6	0.6	0.6
Day-care, outpatient	1.3	0.5	0.6	1.0	0.9
Private chamber of psychiatrist	0.4	0.2	0.5	0.2	0.3
Private chamber of psychologist	0.8	0.1	-	0.5	0.4
Alcohol and substance abuse treatment center	0.3	-	-	0.2	0.2
Personal relationship and sexual problems treatment center	0.6	0.1	0.2	0.3	0.3

* 95% confidence interval

- Unweighted numbers are < 25

Table 14. Health seeking behavior for emotional disorders (n=1732)

Variables	Sex		Residence		All
	Man	Woman	Urban	Rural	
	%	%	%	%	%
Sought help from someone	0.8	6.0	5.34	3.0	3.5
Problem occurred that disrupts routine life	1.1	1.3	1.4	1.2	1.2
Type of problem…					
Fear of going out of own home	21.3	-	2.12	11.72	9.2
Undue fear of people	30.2	15.1	17.4	23.14	21.7
Very upset mentally	35.1	81.4	65.7	59.84	61.4
Others	13.3	3.5	14.7	5.297	7.7

* 95% confidence interval

- Unweighted numbers are < 25

Table 15. Distribution of respondents according to Tobacco, alcohol and amphetamine abuse. (n=1740)

Ever used these…	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	%	95% CI*	%	95% CI*	%	95% CI*	%	95% CI*	%	95% CI*
Tobacco products†	18.7	14.2 - 23.3	8.0	4.0 - 12.0	15.8	11.0 - 20.7	12.2	1.7 - 8.8	13.0	10.1 - 16.0
Times used in past 3 months…										
Never	5.9	-	19.0	-	17.3	-	7.5	-	10.2	-
1-2 times	17.7	9.6 - 25.8	26.1	-	17.5	-	21.5	-	20.4	12.9 - 28.0
Once a month	2.9	-	24.3	-	16.3	-	7.4	-	9.8	4.7 - 15.0
Several times in a month	15.0	-	9.3	-	9.2	-	14.6	-	13.1	5.3 - 21.0
Once a week	2.2	-	1.0	-	0.8	-	2.1	-	1.8	0.2 - 3.4
Daily/ almost daily	56.4	42.2 - 70.6	20.3	-	38.9	13.8 - 64.0	46.8	32.8 - 60.8	44.7	32.3 - 57.0
Alcoholic beverage‡	7.0	3.6 - 10.5	0.6		3.2	0.5 - 5.9	3.8	1.7 - 5.8	3.6	2.0 - 5.3
Times used in past 3 months…										
Never	4.1	-	63.7	-	21.7	-	6.4	-	9.4	-
1-2 times	64.1	39.4 - 88.7	-	-	53.8	-	59.5	31.3 - 87.6	58.4	33.3 - 83.4
Once a month	7.9	-	36.3	-	22.7	-	7.4	-	10.5	-
Several times in a month	11.4	-	-	-	1.8	-	12.5	-	10.4	-
Once a week	3.8	-	-	-	-	-	4.4	-	3.5	-
Daily/ almost daily	8.7	-	-	-	-	-	9.8	-	7.9	-
Stimulant: Yabba, amphetamine	0.7	-	0.2	-	0.5	-	0.4	-	0.4	-
Times used in past 3 months…										
Never	42.7	-	64.4	-	37.9	-	50.9	-	47.0	-
1-2 times	52.2	-	-	-	38.7	-	43.1	-	41.8	-
Once a month	-	-	35.6	-	23.3	-	-	-	7.1	-
Several times in a month	5.2	-	-	-	-	-	6.0	-	4.2	-

* 95% confidence interval

- Unweighted numbers are < 25

† Tobacco products: cigarette, *bidi,* tobacco containing *paan masala,* chewing tobacco, *sada, gul* etc.

‡ Alcoholic beverages: beer, wine, alcohol, local alcohol

Table 16. Distribution of respondents according to Marijuana and other substance abuse. (n=1740)

Ever used these…	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	%	95% CI*	%	95% CI*	%	95% CI*	%	95% CI*	%	95% CI*
Marijuana§	3.1	1.4 - 4.7	-	-	0.3	-	1.8	-	1.4	0.6 - 2.2
Times used in past 3 months…										
Never	13.2	-	-	-	57.6	-	10.7	-	13.2	-
1-2 times	52.6	-	-	-	25.5	-	54.1	-	52.6	-
Once a month	14.1	-	-	-	8.5	-	14.4	-	14.1	-
Several times in a month	20.2	-	-	-	8.5	-	20.8	-	20.2	-
Cocaine/ crack	0.4	-	-	-	0.1	-	0.2	-	0.2	-
Times used in past 3 months…										
Never	63.2	-	-	-	100.0	-	58.9	-	63.2	-
1-2 times	28.4	-	-	-	-	-	31.7	-	28.4	-
Once a week	8.4	-	-	-	-	-	9.3	-	8.4	-
Sleep inducing or sleep medication	2.0	-	0.7	-	1.3	-	1.4	-	1.3	-
Times used in past 3 months…										
Never	23.2	-	81.5	-	100.0	-	23.7	-	40.3	-
1-2 times	73.2	-	4.9	-	-	-	68.0	-	53.2	-
Once a month	3.6	-	13.6	-	-	-	8.3	-	6.5	-
Heroin, morphine, methadone, phensedyl or pain medication	0.6	-	0.1	-	0.2	-	0.4	-	0.3	-
Times used in past 3 months…										
Never	-	-	39.2	-	-	-	6.2	-	5.3	-
1-2 times	88.5	-	-	-	100.0	-	72.4	-	76.6	-
Once a month	11.5	-	60.8	-	-	-	21.4	-	18.1	-
Others	0.3	-	0.1	-	0.3	-	0.1	-	0.2	-
Times used in past 3 months…										
Never	52.3	-	100.0	-	6.2	-	100.0	-	62.1	-
1-2 times	47.7	-	-	-	93.8	-	-	-	37.9	-

* 95% confidence interval

- Unweighted numbers are < 25

§ Marijuana: pot, weed, hashish, *ganja*

Table 17. Opinion of the respondents on social pressures and problems. (n=1744)

Issues	Sex				Residence				All	
	Man		Woman		Urban		Rural			
	Mean†‡§	95% CI*	Mean†‡§	95% CI*	Mean†‡§	95% CI*	Mean†‡§	95% CI*	Mean†‡§	95% CI*
Social problems†…										
Accommodation	2.5	2.3 - 2.6	2.5	2.3 - 2.8	2.6	2.4 - 2.8	2.5	2.3 - 2.7	2.5	2.4 - 2.7
Crime	2.8	2.6 - 2.9	3.0	2.8 - 3.3	3.1	2.8 - 3.3	2.9	2.7 - 3.1	2.9	2.7 - 3.1
Poverty	3.0	2.8 - 3.1	3.3	3.2 - 3.5	3.0	2.8 - 3.2	3.2	3.1 - 3.3	3.2	3.0 - 3.3
Education	2.8	2.7 - 2.9	2.8	2.7 - 2.9	2.6	2.5 - 2.8	2.9	2.7 - 3.0	2.8	2.7 - 2.9
Government/ administration	2.8	2.6 - 3.0	3.2	3.1 - 3.4	2.8	2.6 - 3.0	3.1	2.9 - 3.2	3.0	2.9 - 3.1
Family life	2.7	2.6 - 2.8	2.8	2.7 - 3.0	2.7	2.5 - 3.9	2.8	2.6 - 2.9	2.8	2.7 - 2.9
Transportation	2.7	2.6 - 2.9	2.8	2.6 - 3.0	2.7	2.5 - 2.9	2.8	2.6 - 3.0	2.8	2.6 - 2.9
Healthcare	2.8	2.7 - 3.0	3.0	2.9 - 3.1	2.7	2.5 - 2.9	3.0	2.8 - 3.1	2.9	2.8 - 3.0
Job security	3.1	2.9 - 3.2	3.3	3.2 - 3.5	3.0	2.8 - 3.2	3.3	3.1 - 3.4	3.2	3.1 - 3.4
Racial prejudice	2.8	2.6 - 2.9	2.8	2.7 - 3.0	2.8	2.6 - 3.0	2.8	2.6 - 3.0	2.8	2.6 - 2.9
Pollution	2.8	2.6 - 2.9	2.9	2.7 - 3.2	3.1	2.8 - 3.4	2.8	2.6 - 3.0	2.9	2.7 - 3.0
Substance abuse	2.9	2.7 - 3.2	3.2	2.9 - 3.5	3.2	2.9 - 3.5	3.0	2.7 - 3.3	3.0	2.8 - 3.3
Alcohol abuse	2.8	2.5 - 3.0	3.0	2.6 - 3.3	3.1	2.8 - 3.4	2.8	2.5 - 3.1	2.9	2.6 - 3.1
Violence against children and women	2.7	2.5 - 2.9	3.0	2.7- 3.2	3.0	2.7 - 3.4	2.8	2.5 - 3.0	2.8	2.6 - 3.0
Quality of life	2.7	2.5 - 2.8	2.9	2.7 - 3.0	2.7	2.5 - 2.9	2.8	2.6 - 3.0	2.8	2.6 - 2.9
Personal security	2.7	2.5 - 2.8	2.8	2.6 - 3.0	2.8	2.6 - 3.0	2.7	2.6 - 2.9	2.8	2.6 - 2.9
Closeness and compassion among people of‡…										
Neighborhood	3.2	3.0 - 3.4	3.7	3.5 - 4.0	3.4	3.1 - 3.7	3.5	3.3 - 3.7	3.5	3.3 - 3.7
City	2.9	2.7 - 3.0	3.1	2.9 - 3.3	3.1	2.9 - 3.3	2.9	2.8 - 3.1	3.0	2.8 - 3.1
Region	3.0	2.9 - 3.2	3.2	3.0 - 3.3	3.2	3.0 - 3.4	3.0	2.9 - 3.2	3.1	2.9 - 3.2
Nation	2.9	2.7 - 3.0	3.1	2.9 - 3.3	3.2	3.0 - 3.4	3.0	2.8 - 3.1	3.0	2.9 - 3.2
***Optimism among people of* §…**										
Neighborhood	3.2	3.0 - 3.5	3.6	3.4 - 3.9	3.4	3.1 - 3.7	3.5	3.2 - 3.7	3.4	3.2 - 3.6
City	2.9	2.8 - 3.0	3.1	2.9 - 3.3	3.1	2.9 - 3.3	3.0	2.8 - 3.1	3.0	2.9 - 3.1
Region	3.0	2.9 - 3.2	3.1	2.9 - 3.3	3.2	3.0 - 3.4	3.0	2.9 - 3.2	3.1	2.9 - 3.2
Nation	2.9	2.8 - 3.0	3.1	2.9 - 3.3	3.2	2.9 - 3.4	3.0	2.8 - 3.1	3.0	2.9 - 3.2

* 95% confidence interval
\- Unweighted numbers are < 25
† score range 1 - 5: 1=not severe; 5=severe
‡ score range 1 - 5: 1=not compassionate; 5=compassionate
§ score range 1 - 5: 1=not hopeful; 5=hopeful

Table 18. Distribution (percent) of the respondents on scores of opinion*†‡ on social pressures and problems. (n=1744)

Issues	Man					Woman					Urban					Rural					All				
	Likert scale value†					Likert scale value†					Likert scale value†					Likert scale value†					Likert scale value†				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Issues related to…																									
Accommodation	12.7	45.7	29.1	7.8	4.6	22.2	25.2	34.9	11.6	6.1	13.9	31.8	39.8	8.9	5.6	18.8	35.7	29.9	10.1	5.4	17.7	34.9	32.2	9.8	5.4
Crime	5.1	37.4	37.6	14.3	5.6	14.4	19.6	28.8	21.8	15.5	7.6	24.3	36.7	16.1	15.3	10.7	29.0	31.8	18.9	9.6	10.0	28.0	32.9	18.3	10.8
Poverty	2.1	28.9	43.3	20.0	5.7	3.9	13.7	41.0	29.7	11.8	3.9	22.7	45.6	21.2	6.6	2.8	20.3	41.0	26.2	9.6	3.1	20.8	42.1	25.1	8.9
Education	5.6	30.7	45.6	14.5	3.6	8.8	26.8	43.6	15.4	5.4	10.6	33.2	43.5	9.9	2.8	6.4	27.3	44.9	16.5	5.0	7.3	28.6	44.6	15.0	4.5
Government/ administration	6.1	30.0	43.5	17.9	2.5	5.2	15.7	45.8	20.1	13.2	6.7	26.1	48.8	13.0	5.4	5.3	21.4	43.6	20.8	9.0	5.6	22.4	44.8	19.1	8.2
Family life	6.3	33.7	48.1	9.8	2.0	11.3	19.9	49.0	14.7	5.1	10.4	24.8	51.6	10.5	2.7	8.6	26.8	47.7	13.0	3.9	9.0	26.4	48.6	12.4	3.7
Transportation	7.5	34.8	41.9	10.0	5.7	12.9	25.1	38.6	15.1	8.3	10.7	32.5	38.1	14.8	3.8	10.3	28.8	40.7	12.1	8.0	10.4	29.7	40.2	12.7	7.1
Healthcare	4.6	32.1	43.4	17.5	2.5	6.7	18.5	51.6	15.1	8.1	8.9	27.1	50.9	10.5	2.6	4.8	24.3	46.8	17.9	6.3	5.7	24.9	47.7	16.2	5.4
Job security	2.0	26.9	41.0	21.4	8.7	4.2	14.7	42.7	20.0	18.3	5.2	20.8	52.5	10.2	11.4	2.6	20.3	38.8	23.7	14.5	3.2	20.4	41.9	20.7	13.8
Racial prejudice	7.2	36.1	33.6	19.8	3.3	12.2	21.3	44.3	16.2	6.0	8.6	27.3	46.0	13.3	4.8	10.3	28.5	37.3	19.2	4.7	9.9	28.2	39.3	17.9	4.7
Pollution	5.8	35.7	38.6	14.7	5.2	15.2	16.1	41.0	14.7	13.0	8.0	25.8	35.4	9.6	21.2	11.6	25.2	41.2	16.2	5.9	10.8	25.3	39.9	14.7	9.3
Substance abuse	8.3	37.0	25.1	15.1	14.5	18.2	15.8	23.6	17.0	25.4	6.7	29.8	24.0	12.2	27.2	15.5	24.6	24.4	17.2	18.3	13.5	25.8	24.3	16.1	20.2
Alcohol abuse	14.0	30.8	31.5	9.4	14.3	21.9	16.3	26.2	16.0	19.6	12.4	22.9	30.3	10.3	24.0	19.9	23.2	28.2	13.7	15.1	18.2	23.1	28.7	12.9	17.1
Violence against children and women	10.8	35.7	34.3	12.1	7.1	16.4	22.0	26.6	18.9	16.1	14.7	29.7	28.8	17.2	9.6	10.5	24.2	35.0	10.6	19.7	13.8	28.4	30.2	15.7	11.9
Quality of life	5.9	35.7	44.2	12.4	1.9	10.4	17.8	52.6	13.9	5.4	8.2	26.2	48.6	13.2	3.7	8.1	25.4	48.9	13.8	3.9	8.2	26.2	48.6	13.2	3.7
Personal security	6.0	34.9	46.5	11.2	1.4	13.5	18.1	45.6	15.6	7.2	7.9	23.6	51.0	13.8	3.7	10.6	26.7	44.5	13.5	4.7	10.0	26.0	46.0	13.6	4.5

† score range 1 - 5: 1=not compassionate; 5=compassionate

Table 19. Distribution (percent) of the respondents on scores of opinion*†‡ on social pressures and problems. (n=1744)

Issues	Man					Woman					Urban					Rural					All				
	Likert scale value‡					Likert scale value‡					Likert scale value‡					Likert scale value‡					Likert scale value‡				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Closeness and compassion among people of…																									
Neighborhood	2.4	26.7	33.6	21.8	15.5	7.3	7.1	24.6	27.3	33.7	3.4	16.3	34.4	26.0	19.9	5.4	16.3	27.2	24.4	26.7	5.0	16.3	28.8	24.7	25.2
City	2.7	31.3	45.0	18.0	3.0	9.0	16.2	42.1	22.9	9.9	3.4	18.8	48.8	21.8	7.2	6.8	24.6	41.9	20.2	6.4	6.0	23.3	43.5	20.6	6.6
Region	1.6	27.9	45.1	22.3	3.1	7.6	12.0	47.7	22.6	10.2	1.8	13.5	53.8	24.1	6.8	5.7	21.2	44.4	21.9	6.8	4.8	19.5	46.5	22.4	6.8
Nation	2.5	30.1	48.1	16.7	2.6	9.3	13.0	43.9	22.9	11.0	2.5	17.1	48.1	22.6	9.7	7.1	22.2	45.2	19.2	6.2	6.1	21.0	45.9	20.0	7.0

‡ score range 1 - 5: 1=not hopeful; 5=hopeful

Table 20. Distribution (percent) of the respondents on scores of opinion*†‡ on social pressures and problems. (n=1744)

Issues	Man					Woman					Urban					Rural					All				
	Likert scale value*					Likert scale value*					Likert scale value*					Likert scale value*					Likert scale value*				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Optimism among people of …																									
Neighborhood	1.0	28.2	34.5	18.8	17.5	8.1	5.8	30.1	27.6	28.3	2.6	15.5	40.8	22.1	19.1	5.4	16.6	29.7	23.9	24.5	4.8	16.4	32.2	23.5	23.2
City	2.0	26.9	51.7	15.7	3.7	9.9	13.8	45.1	21.9	9.3	3.1	18.3	50.7	19.8	8.1	7.0	20.5	47.5	18.8	6.3	6.2	20.0	48.2	19.0	6.7
Region	1.7	28.4	42.6	21.1	6.3	9.0	11.2	47.4	23.5	9.0	3.5	14.6	51.5	20.3	10.2	6.1	20.6	43.3	23.0	7.0	5.5	19.3	45.1	22.4	7.7
Nation	2.0	29.3	47.3	18.2	3.3	10.3	12.7	43.6	23.1	10.3	2.9	20.8	44.2	21.6	10.5	7.4	20.4	45.7	20.6	6.0	6.4	20.5	45.3	20.8	7.0

* score range 1 - 5: 1=not severe; 5=severe

Discussion

Suicide is a serious mental health concern and one of the leading causes of premature death, however, most suicides are preventable. Young people, age between 15 to 24 years are in great risk for self-harm and the second leading cause of death among these population is suicide[1]. Around 10% of the world's suicide (more than 100,000 people) take place in just three countries on the Indian subcontinent including India, Sri Lanka, and Pakistan (khan, 2002).

Information on suicide in other south Asian countries such as Bangladesh, Nepal, Bhutan, and Afghanistan are rare. In Bangladesh, data on the prevalence of suicidal ideation, suicide attempts, and direct self-injurious behavior in adolescents and young adults are scarce. Though the absolute efficiency of suicide prediction is a questionable (Carter et al., 2017), being acquainted with the prevalence of suicidal behavior is essential for suicide risk assessment. Therefore, the wellbeing of the vast population of a nation largely depends on an understanding of suicidal behavior into the youngest population. The present study aimed to investigate the epidemiology of self-injurious behavior, suicidal ideation, and suicidal attempt among adolescent and youth in Bangladesh. Specific focus was to find out the prevalence of suicidal behaviors among male and female as well as determining the familial, social and environmental factors related to suicidal behavior in youth and adolescents in Bangladesh.

The present study was a nationally representative, population-based, cross-sectional household survey of Bangladeshi population on 1744 respondents aged 10–24 years from October 2018 to June 2019. We selected the respondents by a probability based, multistage and geographically clustered sampling technique. The reporting domains were sex (male/ female) and residence (urban/ rural) at national level. A total of eight teams were assembled with four enumerators and one supervisor in each team. The field team members had bachelor's degree and were all selected from a pool of field staff who participated in field work of National Mental Health Survey conducted by the same Institute a few weeks before.

We trained the field team members before the pre-test for 3 days using a manual and hands on exercise with programmed tablet computers with mock scenarios. Pretest was conducted followed by experience sharing by field teams and monitoring teams. After necessary modifications in tools a brief post pre-test training was conducted to update the changes to the field staff. The training was held on roles and responsibilities of field staffs, face-to-face interview techniques, general handling of tablet computers, finding the PSUs and HHs, recording the interview responses using tablet computer and sending data to server, mock

interviews and administrative briefing including field movement. We conducted a final assessment before sending the teams to the field so that they score at least 80% marks. The survey was conducted by National Institute of Mental Health (NIMH) funded by Non-Communicable Disease Control programme, Director General of Health Service with technical support from World Health Organization (WHO) Bangladesh.

The mean age of the participants was 16.9 years and the majority of them completed secondary education (47.2%) followed by primary education (33%). Majority of the population belonged from nuclear family (78.1%) where most of them were unmarried (82.1%) and student (67%).

Results revealed that 4.7% of population had suicidal thought, and 1.5% had suicidal plans and attempted suicide at least once. Severing arms/other parts of the body was the commonest (39.1%) method of suicide followed by hanging (37.6%). The mean age of first attempted suicide was 17 years.

The present study revealed some interesting patterns about suicide and related behaviors among male-female and urban-rural clusters. Women had more serious suicidal thought than men (2.6% vs 6.6%) and suicide related thoughts were more frequent among urban people than rural people (8.2% vs 3.7%). Although, women more seriously thought about suicide than men, within the past 12 months suicidal thoughts were more frequent among men than women (64.4% vs 48.6%). Similarly, even though, women were more prone to plan for suicide then men, within the past 12 months male outnumbered planning for suicide than men. In addition, more urban people planned for suicide within past 12 months than rural people.

The findings of the present study clearly indicate a pattern that all the suicidal behaviors were more common in females and in urban areas. Several psychosocial factors might play an important role for the variation of revealed suicide related behavioral pattern. Normally, in our sociopolitical culture, women are more repressed than men and women are not always welcomed to express their opinion, feelings and thoughts as well as making a decision. Consequently, women in our society are more emotionally vulnerable than men that somehow contributes to keep them in a state of constant stress most leading to suicidal thoughts, ideations, and attempts.

The present research indicates cultural and lifestyle related factors might play an important contributing factor for this variation. In urban areas, people live a very mechanical and busy life where the family structure is more like a nuclear one and the bonding and support systems are not as much stronger as seen in an extended family. Moreover, the education system in

urban areas is predominantly academic and achievement focus at the same time stressful which fling the students in a state of depression resulting frequent suicidal thoughts, attempts, and behaviors. Overall, cultural beliefs and values related to suicide are quite different in urban and rural areas. From religious perspective, suicide is considered as an act of sin and rural people strongly value the religious sentiment than urban people. Perhaps, this pro-religious value could play the role of a protective factor against suicidal behaviors among people in rural areas.

Findings of the present study also revealed that 49.1 % household members had a history of suicidal behavior and suicidality was more common among males and in rural areas. Majority of the suicide attempt was an instant event (95.2%) and not a planned one (4.8%). Previous studies found a higher rate of suicide among females than males (Mashreky et al., 2013). This apparently contradictory finding demand further extensive research to find out true effect of gender on suicidal behavior. The Report of first Global School-based Student Health Survey (GSHS) Bangladesh, 2014 describes that 4.9% of 13–17-year-old students in Bangladesh seriously considered attempting suicide in the last 12 months (WHO, 2017). In a six months newspaper content analysis in Bangladesh, 61% of the reported cases were below 30 years of age and hanging was found to be the commonest method (82.29%) (Shah et al., 2018). In another study poisoning was identified as the most frequent method for attempting or committing suicide, followed by hanging. Thus, the findings about method of suicide attempt resonate with the previous study and claims that poisoning and hangings are the most common method of suicide among young people in Bangladesh.

Though the absolute efficiency of suicide prediction is a questionable (Carter et al., 2017), being acquainted with the prevalence of suicidal behavior is essential for suicide risk assessment. But there are very few population-based data on suicide behavior in Bangladesh and this study aimed to explore credible data on suicidal behavior, suicide risk and related factors among youths which ultimately contributes to future planning and policy making for suicide prevention. The present study thus adds intensive information in our literature which will definitely help our policymakers to take necessary steps in preventing suicide. Furthermore, since suicide is a criminal offence in our country (Soron, 2018), the punishable offence might resist the sufferers to seek help when needed. Therefore, decriminalizing suicide might empower the intended persons to step forward for assistance which probably will reduce suicidal behaviors. Therefore, to find out accurate cause of suicide as well as effective prevention strategy more research is needed to understand suicide and its associated sociocultural factors.

This study is the first to investigate the epidemiology of suicide related behaviors among adolescent and youth in a nationally representative Bangladeshi sample. In addition, the participants were selected by random sampling in the surveillance areas. Also, data collection was done by highly trained research assistants. The striking findings of the present study stresses the need for specific public health interventions and other policy changes for better prevention of suicide in young adults. Specifically, in mental health care related bills there should have some special facilities for women. Similarly, decriminalization of suicide might improve help-seeking and service provision for people in need of psychological care. Our policy makers also need to consider high urban suicide rates in order to design specific measures to improve emergency psychiatric services and greater accessibility to community mental health care. Moreover, the present study largely contributes to understand the suicide related behaviors in adolescents and young adults which might guide to implement a national strategy to prevent it from happening.

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Appendix: Questionnaire

বাংলাদেশের কিশোর এবং তরুণদের মধ্যে আত্মহত্যা ও আত্মঘাতী আচরণের মহামারী সম্পর্কিত জরিপ ২০১৯

A Survey on epidemiology of suicide and suicidal behavior among youth and adolescent Bangladesh 2019

Questionnaire (Bangla)

প্রশ্নাবলী (বাংলা)

কেইস সম্পর্কিত তথ্যাবলী

নির্দেশনা: এই অংশটি সাক্ষাৎকার গ্রহণকারী খানায় প্রবেশের পূর্বে নিজে পূরণ করবে।

Questions	Answer	Code
সাক্ষাৎকারের তারিখ এবং সময়	ট্যাবলেট স্বয়ংক্রিয়ভাবে সাক্ষাৎকারের তারিখ এবং সময় নির্বাচন করবে।	datetime
বাংলাদেশের কিশোর এবং তরুণদের মধ্যে আত্মহত্যা ও আত্মঘাতী আচরণের মহামারী সম্পর্কিত জরিপ ২০১৯ এ আপনাকে স্বাগতম। পরবর্তী প্রশ্নে প্রদর্শিত "ট্যাবলেট আইডি","পিএসইউ আইডি", এবং "নির্বাচিত খানার ক্রম নম্বর " অত্যন্ত সতর্কতার সাথে পূরণ করুন। ফলে ট্যাবলেট আপনাকে একটি স্বয়ংক্রিয় "কেইস আইডি" তৈরি করে দিবে। [এই "কেইস আইডি" টি ও সতর্কতার সাথে আপনার 'ইন্টারভিউ ট্রেকিং ফর্মে" লিখে রাখুন।]		intro
ট্যাবলেট আইডি *আপনার ট্যাবলেটের কাভারের উপর আই ডি টি লিখুন. ট্যাবলেট আই ডি ১১ থেকে ৪০ এর মধ্যে হবে।*	__	i1
পিএসইউ আইডি *আপনার বর্তমান পিএসইউ নম্বর লিখুন।পিএসইউ আইডি '৩' সংখ্যার হবে।যদি পিএসইউ আইডি '১' সংখ্যার হয় (যেমন: ১ থেকে ৯) তাহলে পূর্বে '০০' যোগ করুন; যদি পিএসইউ আইডি '২' সংখ্যার হয় (যেমন: ১০ থেকে ৯৯) তাহলে পূর্বে '০' যোগ করুন।* *[যেমন: ২ এর জন্য '০০২' এবং ১৫ এর জন্য '০১৫' লিখুন]*	___	i2
খানা তালিকার বই থেকে নির্বাচিত খানার ক্রম টি লিখুন *খানার ক্রম '৩' সংখ্যায় লিখতে হবে। যদি খানার ক্রম '১' সংখ্যার হয় (যেমন: ১ থেকে ৯) তাহলে পূর্বে '০০' যোগ করুন; যদি খানার ক্রম '২' সংখ্যার হয় (যেমন: ১০ থেকে ৯৯) তাহলে পূর্বে '০' যোগ করুন।*	___	i3
ফেইস আইডি [স্বয়ংক্রিয়ভাবে প্রদর্শন করবে।]	0 0 - 0 0 0 - 0 0 0	pid
পিএসইউ আইডি *আপনার বর্তমান পিএসইউ নাম্বারটি লিখুন*	___	i2a
ইউনিয়ন/ ওয়ার্ড	*এই অংশগুলো স্বয়ংক্রিয়ভাবে আসবে*	i7
উপজেলা		i4
জেলা		i5
বিভাগ		i6

ক - বিভাগ: খানা সম্পর্কিত তথ্যাবলী

1 . খানার ধরণ/ অবস্থা

Questions	Answer	Code
এটি একটি পুরুষ/মহিলা খানা। *ট্যাবলেট আইডি 'বিজোড়' হলে "পুরুষ" হবে ট্যাবলেট আইডি 'জোড়' হলে "মহিলা" হবে।*	পুরুষ 1 মহিলা 2	h1
এই খানার অবস্থা কি? *উত্তর এক হলে পরবর্তী প্রশ্ন যান অন্যথায় সাক্ষাৎকার শেষ করুন।*	এটি একটি খানা এবং সাক্ষাৎকার নেয়া সম্ভব হবে 1 খানা কিন্তু কোন উপযুক্ত সদস্য নেই 2 মেস/হোস্টেল ইত্যাদি 3 খানা নয় (যেমন: ব্যাংক, বীমা, সামরিক বাহিনীর ঘাঁটি, বৃদ্ধাশ্রম ইত্যাদি) 4 খানা কিন্তু তালাবদ্ধ বাড়ি 5 ভেঙেপড়া বাড়ি 6 খালি বাড়ি 7 খানা খুঁজে পাওয়া যায়নি 8 খানা কিন্তু কোনপ্রকার তথ্য দিতে অসম্মতি 8 8	h2
খানা তালিকায় লিপিবদ্ধ ব্যক্তিরাই কি বর্তমানে এই খানায় বসবাস করছেন। ?	হ্যাঁ 1 না 0	h2_find
এই খানায় মোট কতজন বাস করেন?	_____	h3
এই খানার কতজন পুরুষ/ মহিলা বাস করেন?	_____	h4
এই খানার কতজন (বালক/ বালিকা) -এর বয়স ১০ থেকে ২৪ বছরের মধ্যে?	_____	h5

2 . খানার উপজযুক্ত সদস্যদের তথ্য লিপিবদ্ধকরণ

খানায় উপযুক্ত বালক/বালিকার নাম, বয়স ও লিঙ্গ (h5 অনুসারে) লিপিবদ্ধ করুন।
List the name, age and sex of all male/female eligible member's according to their seniority.

Questions	Answer	Code
খানায় বসবাসরত ১০ থেকে ২৪ বছর বয়সের উপযুক্ত পুরুষ /মহিলার নাম	.....	
তার বয়স	_____	
এই অংশটি h5এর উত্তরের সাথে সামঞ্জস্য রেখে পুনরাবৃত্ত হবে		
যার ব্যক্তিগত সাক্ষাৎকার গ্রহণ করতে হবে তিনি হলেন: *ট্যাবলেট একজন উপজযুক্ত সদস্যকে নির্বাচন করবে যার কাছথেকে ব্যক্তিগত স্বাক্ষাৎকার গ্রহণ করতে হবে।*	.....	

Recall status

Questions	Answer	Code
নির্বাচিত ব্যক্তির উপস্থিতি	নির্বাচিত ব্যক্তিকে পাওয়া গেছে. 1 একাধিকবার পরিদর্শনের পরেও নির্বাচিত ব্যক্তিকে খানায় পাওয়া যায়নি 0	R_availability

সম্মতি

কাগজে প্রিন্ট করা সম্মতি পত্রে উত্তরদাতার স্বাক্ষর/ টিপসই গ্রহণ করার পর সাক্ষাৎকার শুরু করুন।

Serial	Questions	Answer		Code
1 1	সম্মতির অবস্থা *[সম্মতি প্রদান না করলে সাক্ষাৎকার শেষ করুন]*	নির্বাচিত ব্যক্তির সম্মতি সম্মতি প্রদান করেননি	1 0	h6

খ - বিভাগ: ব্যক্তিগত সাক্ষাৎকার

Questions	Answer	Code
উত্তরদাতার পূর্ণনাম	.....	c1
উত্তরদাতার জন্ম তারিখ *জানি না হলে দিন = 7 7 , মাস = 7 7 , সাল = 7 7 7 7*	দিন ..... মাস ..... সাল	c3.1 c3.2 c3.3
আপনার আনুমানিক বয়স কত? *[যারা জন্ম তারিখ বলতে পেরেছেন হিসাব করে তাদের বয়স লিখুন, আর যারা বলতে পারেননি তাদের প্রশ্ন করুন]*	____ ____	c4
উত্তরদাতার মোবাইল নম্বর *[জানা না থাকলে 7 7 লিখুন]*	☐☐☐☐☐☐☐☐☐☐☐	c5
এটি একটি একক, নাকি যৌথ খানা ?	একক 1 যৌথ 2	c6
আপনি সর্বমোট কত বছর প্রাতিষ্ঠানিক শিক্ষা গ্রহণ করেছেন? [উত্তরদাতার প্রাতিষ্ঠানিক শিক্ষাকাল হিসেব করে তিনি সর্বমোট কত বছর প্রাতিষ্ঠানিক শিক্ষা গ্রহণ করেছেন তা লিখুন] (প্রথম শ্রেণীর নিচে এবং উপানুষ্ঠানিক শিক্ষা অন্তর্ভুক্ত হবে না)	____ ____	c7
আপনি কোন ধর্মের অনুসারী?	ইসলাম 1 সনাতন /হিন্দু 2 খ্রিষ্টান 3 বৌদ্ধ 4 অন্যান্য 5 অসম্মতি 8 8	c8
আপনার বৈবাহিক অবস্থা কি?	অবিবাহিত 1 বিবাহিত 2 পৃথক 3 তালাকপ্রাপ্ত 4 বিপত্নিক/ বিধবা 5 অসম্মতি 8 8	c9
আপনি কত দিন ধরে বিবাহিত/ পৃথক/ তালাকপ্রাপ্ত/ বিপত্নিক/ বিধবা অবস্থায় আছেন।	দিন ..... মাস ..... বছর	c9.1 c9.2 c9.3
গত ১২ মাসে আপনার প্রধান পেশা কি ছিল?	সরকারী কর্মচারী 1 বেসরকারী কর্মচারী 2 স্বায়ত্তস্বাসিত কর্মচারী 3 ব্যবসা (ছোট) 4 ব্যবসা (বড়) 5 কৃষি কাজ (নিজস্ব জমি 6 আছে এমন কৃষক) 7	c10

	ক্ষেত মজুর 8 কারখানার শ্রমিক 9 দিনমজুর 10 ড্রাইভার ও অন্যান্য 11 পরিবহন শ্রমিক 12 ভ্যান, ঠেলা ও রিকশা 13 চালক 14 ব্যক্তিগত গাড়ির চালক 15 স্ব-নিয়োগ 16 ছাত্র/ছাত্রী 17 গৃহ-কর্ম 18 অবসরপ্রাপ্ত 19 বেকার, কমর্ক্ষম বেকার, কর্মক্ষম নন 20 পারিশ্রমিক প্রাপ্ত গৃহকর্মী C10others কামার/কুমার/তাঁতী/ 88 জেলে অন্যান্য অসম্মতি	
আপনি কতদিন ধরে বেকার আছেন?	..... দিন ..... মাস ..... বছর	c11

Questions	Answer	Code
বর্তমানে আপনি কাদের সাথে বসবাস করেন (খানার সদস্যবৃন্দ)	একা থাকেন 1 শুধুমাত্র স্বামী/স্ত্রী/সঙ্গীর সাথে থাকেন 2 স্বামী/স্ত্রী ও সন্তানদের সাথে থাকেন 3 শুধুমাত্র সন্তানদের সাথে একা থাকেন 4 পিতা মাতার সাথে থাকেন 5 আত্মীয়/ বন্ধু বান্ধবদের সাথে থাকেন 6 অন্যান্য 7 অন্যান্য নির্দিষ্ট করুন m4Other	c12
আপনি কতদিন পরপর উপশনালয়ে (মসজিদ, মন্দির,গিজা ইত্যাদি) যান?	সপ্তাহে ১ বার 1 মাসে ১ বার 2 বছরে ২-৩ বার 3 বছওে প্রায় ১বার 4 প্রায় কখনই না 5	c13
আপনি কি নিজেকে ধার্মিক মনে করেন?	না 0 হ্যাঁ 1 অসম্মতি 88	c14
যৌনতা সম্পর্কে আপনার পছন্দনীয় ধারণা / ঝোক কি?	বিপরীত কামীতা 1 সমকামীতা 2 উভকামীতা 3 অনিশ্চিত 4 অসম্মতি 88	c15

খানার সম্পদের তালিকা:

আপনার কি নিম্নলিখিত সম্পদগুলো আছে?

Questions	Answer	Code
মোবাইল/স্মার্ট ফোন	হ্যাঁ 1 না 0	c16.1
টেলিভিশন	হ্যাঁ 1 না 0	c16.2
কম্পিউটার/লেপটপ/ট্যাব	হ্যাঁ 1 না 0	c16.3
[প্রধান ঘরের ছাদ/চাল মূলত কি দিয়ে নির্মিত? (পর্যবেক্ষণ করে লিখুন)	কাঁচা (বাঁশ/তালপাতা/খড়/চট) টিন/ এসবেস্টস সীট/ মাটির টালি/ অনুরূপ সামগ্রী 1 সিমেন্ট/কনক্রিট/সিমেন্টের টালি 2 3	c17

সোশ্যাল মিডিয়ার ব্যবহার

Questions	Answer	Code
আপনি কি ফেইসবুক বা অন্যকোন সোশ্যাল মিডিয়া ব্যবহার করেন?	হ্যাঁ 1 না 0	c16.5
যদি করে থাকেন তাহলে কতবছর বয়স থেকে?	..... বছর	c16.6
আপনি কি ইউটিউব ব্যবহার করেন?	হ্যাঁ 1 না 0	c16.7
যদি করে থাকেন তাহলে কতবছর বয়স থেকে?	..... বছর	c16.8

আত্মহত্যা চেষ্টার ইতিহাস

Questions	Answer	Code
আত্মহত্যার চিন্তা		
আপনি কি কখনও আত্মহত্যার কথা গভীরভাবে **চিন্তা** করেছেন ? [উত্তর না হলে প্রশ্নের বাকী অংশ উপেক্ষা করে ------ নং প্রশ্নে যান]	না 0 হ্যাঁ 1 অসম্মতি 88	s1
কত বছর বয়সে প্রথম এই আত্মহত্যার চিন্তা এসেছিল? [S1 হ্যাঁ হলে]	..... বছর বয়সে	s2
গত বার মাসের মধ্যে কি এই আত্মহত্যার চিন্তা এসেছিল?	না 0 হ্যাঁ 1 অসম্মতি 88	s3
শেষবার যখন আত্মহত্যার চিন্তা এসেছিল তখন আপনার বয়স কত ছিল ?	..... বছর বয়সে	s4
আত্মহত্যার পরিকল্পনা		
আপনি কি কখনও আত্মহত্যার কোন **পরিকল্পনা** করেছিলেন ? [উত্তর না হলে প্রশ্নের বাকী অংশ উপেক্ষা করে ..... নং প্রশ্নে চলে যান]	না 0 হ্যাঁ 1 অসম্মতি 8 8	s5
কত বছর বয়সে প্রথম আত্মহত্যার **পরিকল্পনা** করেছিলেন?	..... বছর বয়সে	s6
গত বারমাসের মধ্যে কি আত্মহত্যার **পরিকল্পনা** করেছিলেন?	না 0 হ্যাঁ 1 অসম্মতি 8 8	s7
শেষবার যখন আত্মহত্যার **পরিকল্পনা** করেছিলেন তখন আপনার বয়স কত ছিল?	..... বছর বয়সে	s8
আত্মহত্যার চেষ্টা		
আপনি কি কখনও আত্মহত্যার **চেষ্টা** করেছিলেন? না হলে প্রশ্নের বাকী অংশ উপেক্ষা করে ..... নং প্রশ্নে চলে যান	না 0 হ্যাঁ 1 অসম্মতি 88	s9
সারা জীবনে মোট কতবার আপনি আত্মহত্যার চেষ্টা করেছেন?	..... বার	s10
কত বছর বয়সে প্রথম আত্মহত্যার **চেষ্টা** করেছিলেন?	..... বছর বয়সে	s11
শেষবার যখন আত্মহত্যার **চেষ্টা** করেছিলেন তখন আপনার বয়স কত ছিল?	..... বছর বয়সে	s12
গত বার মাসের মধ্যে আপনি কি অন্তত একবারও আত্মহত্যার চেষ্টা করেছিলেন ?	না 0 হ্যাঁ 1 অসম্মতি 88	s13
প্রথম বার আত্মহত্যা চেষ্টা করার বিষয়ে চিন্তা করলে নিচের কোন বর্ণনা ঐ অবস্থা সঠিকভাবে তুলে ধরে ?	আমি নিজেকে হত্যা করার একটি কঠিন চেষ্টা করেছিলাম এবং আমার ভাগ্য ভালো যে আমি সফল হইনি। 1 আমি নিজেকে হত্যা করার চেষ্টা করেছিলাম কিন্তু জানতাম যে, এটি 2	s14

	পুরোপুরি কার্যকর ছিল না। 3 আমি সহানুভূতি আদায়ের জন্য চেষ্টা করেছিলাম। আমি মরতে চাইনি। আমি জানি না। 4	
এ প্রথমবার আত্মহত্যা প্রচেষ্টার পদ্ধতি কি ছিল? (আপনি কিভাবে নিজেকে হত্যাকরতেচেয়েছিলেন?)		s15
এ প্রথমবার আত্মহত্যা প্রচেষ্টার ফলে কি কোন জখম অথবা বিষক্রীয়া হয়েছিল?	না 0 হ্যাঁ 1 অসম্মতি 8 8	s16
এ প্রথমবার আত্মহত্যা প্রচেষ্টার ফলে কি কোন ধরণের চিকিৎসার প্রয়োজন হয়েছিল?	না 0 হ্যাঁ 1 অসম্মতি 8 8	s17
এ প্রথমবার এই আত্মহত্যা প্রচেষ্টার ফলে কি হাসপাতালে একবার কিংবা তার চেয়ে বেশি সময় ভর্তি থাকার প্রয়োজন ছিল?	না 0 হ্যাঁ 1 অসম্মতি 8 8	s18
শেষবার আত্মহত্যা চেষ্টা করার বিষয়ে চিন্তা করলে নিচের কোন বর্ণনা ঐ অবস্থা সঠিকভাবে তুলে ধরে ?	আমি নিজেকে হত্যা করার একটি আন্তরিক চেষ্টা করেছিলাম এবং আমার ভাগ্য ভালো যে, আমি সফল হই নি। 1 আমি নিজেকে হত্যা করার চেষ্টা করেছিলাম কিন্তু জানতাম যে, একটি পুরোপুরি কার্যকর নয়। 2 আমি সহানুভূতি আদায়ের জন্য চেষ্টা করেছিলাম। 3 আমি মরতে চাইনি। 4 আমি জানি না।	s19
আত্মহত্যা বা আত্মহত্যা চেষ্টার পদ্ধতি কি ছিল? **তাদের জন্য যারা আত্মহত্যার চিন্তা, চেষ্টা এবং আত্মহত্যা করেছিলেন।আত্মহত্যাকারীদের আত্মীয়দের কাছে থেকে তথ্য সংগ্রহ করতে হবে।**		

বিষের ধরণ	ঔষধ (সাধারণ) 1 ঘুমের ঔষধ 2 ফেনল 3 সেভলন 4 বিøচিং পাউডার 5 ওপিসি (কীটনাশক) 6 এসিড 7 ধূতুরা 8 অন্যান্য উল্লেখ করুন ….	s20
গলায় ফাস দিয়ে	না 0 হ্যাঁ 1	s21

	অসম্মতি 8 8	
ট্রেন বা গাড়ীর সামনে ঝাপ দিয়ে	না 0 হ্যাঁ 1 অসম্মতি 8 8	s22
পানিতে ডুবে	না 0 হ্যাঁ 1 অসম্মতি 8 8	s23
হাত বা শরীরের অন্যান্য অংশ কেটে	না 0 হ্যাঁ 1 অসম্মতি 8 8	s24
আত্মহত্যা বা আত্মহত্যা চেষ্টার ধরন কি ছিল?	পরিকল্পিতভাবে 1 তাৎক্ষনিকভাবে সিদ্ধান্ত নিয়ে 2	s25
আত্মহত্যা বা আত্মহত্যা চেষ্টার কারণ	পারিবারিক ঝগড়া 1 বৈবাহিক অশান্তি 2 দারিদ্রতা 3 সম্পর্কজনিত সমস্যা 4 স্বামী কর্তৃক নির্যাতন 5 শ্বশুর বাড়ীতে নির্যাতনঃ শ্বশুর / শাশুড়ী / ননদ / ননস / দেবর / ভাসুর 6 যৌতুক 7 প্রেমে ব্যর্থতা 8 পরীক্ষায় ব্যর্থতা 9 বেকারত্ব 1 0 অনৈতিক যৌন সম্পর্ক 1 1 অবৈধ গর্ভ ধারণ 1 2 যৌন হয়রানি 1 3 ইন্টারনেট / মোবাইলে আসক্তি 1 4 লেখাপড়ায় অতিরিক্ত চাপ 1 5 নিকটাত্মীয়ের আত্মহত্যা 1 6 নিকটাত্মীয়ের আত্মহত্যার চেষ্টা 2 7 অপরাধের ইতিহাস 1 8 সামাজিক সুবিধা বঞ্চিত 1 9 ভবিষ্যতে সম্পর্কে অনিশ্চয়তা 2 0 দত্তক সন্তান / পালিত সন্তান 2 1 রাগ নিয়ন্ত্রণে অক্ষমতা 2 2 আত্মীয়ের সাথে সমস্যা 2 3 পরীক্ষায় খারাপ করা 2 4 ঘুমের সমস্যা 2 5 সাম্প্রতিক সময় বাচ্চা প্রসব 2 6 সমকামিতা 2 7 ইচ্ছার বিরুদ্ধে / জোরপূর্বক বিবাহ দেয়া 2 8	s26

শেষবার এ আত্মহত্যার প্রচেষ্টার ফলে কি কোন জখম অথবা বিষক্রীয়া হয়েছিল?	না 0 হ্যাঁ 1 অসম্মতি 8 8	s27
শেষবার এ আত্মহত্যা প্রচেষ্টার ফলে কি কোন ধরণের চিকিৎসার প্রয়োজন হয়েছিল?	না 0 হ্যাঁ 1 অসম্মতি 8 8	s28
শেষবার এ আত্মহত্যার প্রচেষ্টার ফলে কি হাসপাতালে একরাত কিংবা তার চেয়ে বেশি সময় ভর্তি থাকার প্রয়োজন ছিল?	না 0 হ্যাঁ 1 অসম্মতি 8 8	s29

বিবাহিত নারীর ক্ষেত্রেঃ		
কত বছর বয়সে বিয়ে হয়েছিল?	..... বছর	s30
সন্তান সংখ্যা কতজন?	..... জন	s31
১৮ বৎসর বয়সের পূর্বে কতজন সন্তান হয়েছিল?	..... জন	s32
প্রথম সন্তান জন্মের সময় আপনার বয়স কত ছিল?	..... বছর	s33

আত্মহত্যার আচরণের পারিবারিক ইতিহাস:

আপনার নিজ খানার (জন্মসূত্রে সম্পর্কিত) নিম্নলিখিত কোন সদস্য কি আত্মহত্যার মাধ্যমে মৃত্যুবরণ করেছিল অথবা আত্মহত্যার চেষ্টা করেছিলেন?

Questions	Answer	Code
আপনার নিজ খানার (জন্মসূত্রে সম্পর্কিত) কোন সদস্য কি আত্মহত্যার মাধ্যমে মৃত্যুবরণ করেছিলেন? [একাধিক উত্তর হতে পারে।]	না 0 হ্যাঁ 1 জানি না 77 অসম্মতি 88	f1
যদি হ্যাঁ হয় তাহলে তিনি কে?	মাতা 1 পিতা 2 ভাই 3 বোন 4 সন্তান 5 দাদা 6 দাদী 7 নানা 8 নানী 9 অন্যান্য 10 অন্যান্য নির্দিষ্ট করুন Othrs জানি না 77 অসম্মতি 88	f2
তাঁর আত্মহত্যার বা আত্মহত্যা চেষ্টার পদ্ধতি কি ছিল?		f3

তাঁর আত্মহত্যার বা আত্মহত্যা চেষ্টার কারন কি ছিল?		f4
আপনার নিজ খানার (জন্মসূত্রে সম্পর্কিত) কোন সদস্য কি আত্মহত্যার চেষ্টা করেছিলেন?	না 0 হ্যাঁ 1 জানি না 77 অসম্মতি 88	f5
যদি হ্যাঁ হয় তাহলে তিনি কে?	মাতা 1 পিতা 2 ভাই 3 বোন 4 সন্তান 5 দাদা 6 দাদী 7 নানা 8 নানী 9 অন্যান্য 10 অন্যান্য নির্দিষ্ট করুন Othrs জানি না 77 অসম্মতি 88	f6
আত্মহত্যার বা আত্মহত্যা চেষ্টার পদ্ধুতি কি ছিল?		f7
আত্মহত্যার বা আত্মহত্যা চেষ্টার কারন কি ছিল?		f8

শারীরিক স্বাস্থ্য, স্বাস্থ্য সেবা প্রদানকারী সংস্থার সাথে যোগাযোগ, মানসিক স্বাস্থ্য

Questions	Answer	Code
আপনার কি দীর্ঘমেয়াদী কোন শারীরিক অসুস্থতা কিংবা অক্ষমতা আছে যা কমপক্ষে এক বছর ধরে আপনাকে ভোগাচ্ছে?	না 0 হ্যাঁ 1 অসম্মতি 8 8	t1
উত্তর হ্যাঁ হলে, আপনার বিষয়টি কি ?	----------	t2
কত দিন ধরে আপনার এ বিষয়টি আছে?	---------- দিন	t3
যদি কখনও আপনি মানসিক হাসপাতালে কিংবা জেনারেল হাসপাতালের মানসিকরোগ বিভাগে অথবা অন্য কোন প্রতিষ্ঠানের অন্তবিভাগ যেখানে মানসিক সমস্যার চিকিৎসা দেয়া হয়, সেখানে চিকিৎসা নিয়ে থাকলে তা কতবার ? (নিশ্চিত হউন যে অন্তবিভাগ	কখনও না 1 ২---১ 2 বার 3 ২-৩ বার 4	t4

বলতে বুঝাচ্ছে 'আপনি হাসপাতালে দিন এবং রাতে অবস্থান করেছিলেন'। আত্মহত্যার চেষ্টার পরবর্তী অন্তবিভাগের চিকিৎসা এর অন্তভর্‌ক্ত নয়) উত্তর কখনও না (১-) হলেঃ বহিঃবিভাগে মানসিক রোগের চিকিৎসা এবং ডে-কেয়ার সম্পর্কিত প্রশ্নে যান	৪ বার বা তার বেশী 5	

মানসিক বহিঃবিভাগে চিকিৎসা এবং ডে কেয়ার

আপনি কি কখনও নিম্নের কোন পেশাগত সংস্থার সাথে চিকিৎসা কিংবা পরামর্শের জন্য যোগাযোগ করেছেন?

Questions	Answer	Code
মনোরোগ সেবা, পলিক্লিনিক সেবা হাসপাতালের অন্তরবিভাগ	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t5
মনোরোগ সেবা, ডে-কেয়ার বহিবিভাগ	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t6
বেসরকারী মনোরোগ বিশেষজ্ঞ	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t7
বেসরকারী মনোবিজ্ঞানী	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t8
মদ ও মাদক বিষয়ক চিকিৎসা কেন্দ্র	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t9
সম্পর্ক জনিত এবং যৌন সমস্যার চিকিৎসা কেন্দ্র	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t10

আবেগ জনিত সমস্যার জন্য অন্যান্য চিকিৎসা ব্যবস্থা

Questions	Answer	Code
আবেগ জনিত সমস্যার জন্য আপনি কি কখনও কারো কাছ থেকে সহায়তা নিয়েছেন?	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t11
দীর্ঘ সময়ের জন্য (অন্তত এক বছরের জন্য) আপনার কি নিজের মধ্যে এমন কোন সমস্যা হয়েছে বা হয়েছিল, যা আপনার স্বাভাবিক কাজকর্মে বাধা সৃষ্টি করছে বা করেছিল? (কাউন্সেলিং সেন্টার/বন্ধু-বান্ধব, আত্নীয়, ১।নিজ বাড়ী থেকে দূরে যাবার ভয় ২।মানুষের মাঝে গেলে অতিরিক্ত / অস্বাভাবিক ভয় ৩।অতিরিক্ত মন খারাপ ৪।মাত্রাতিরিক্ত পরিষ্কার পরিচ্ছন্নতা	না 0 হ্যাঁ 1 অসম্মতি ৪ ৪	t12
উত্তর হ্যাঁ হলে, আপনার ক্ষেত্রে কি ঘটেছিল?	…….	t13
এটি আপনার কতদিন ধরে ছিল?	…….	t14

মাদকদ্রব্য এবং মদ্যপান (এ্যালকোহল) বিষয়ক প্রশ্নাবলী

Questions	Answer	Code
আপনার জীবনে আপনি কখনও নিম্নলিখিত জিনিসগুলো গ্রহন করেছেন? (ঔষধের কার্ড দেখুন)		
তামাকজাত দ্রব্যাদি (সিগেরেট, পান, গুল ইত্যাদি)	না 0 হ্যাঁ 1 অসম্মতি 8 8	a1
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না 1 একবার দুইবার 2 মাসে একবার 3 সপ্তাহে একবার 4 প্রতিদিন অথবা প্রায় প্রতিদিন 5	a2
মদ (এ্যালকোহল) জাতীয় পানীয় (বিয়ার, ওয়াইন মদ ইত্যাদি)	না 0 হ্যাঁ 1 অসম্মতি 8 8	a3
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না 1 একবার দুইবার 2 মাসে একবার 3 সপ্তাহে একবার 4 প্রতিদিন অথবা প্রায় প্রতিদিন 5	a4
মারিজুয়ানা (পট, গ্রাস হাসিস ইত্যাদি)	না 0 হ্যাঁ 1 অসম্মতি 8 8	a5
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না 1 একবার দুইবার 2 মাসে একবার 3 সপ্তাহে একবার 4 প্রতিদিন অথবা প্রায় প্রতিদিন 5	a6
কোকেইন বা ক্রাক	না 0 হ্যাঁ 1 অসম্মতি 8 8	a7
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না 1 একবার দুইবার 2 মাসে একবার 3 সপ্তাহে একবার 4 প্রতিদিন অথবা প্রায় প্রতিদিন 5	a8
উত্তেজক বা ইয়াবা , এমফিটামিন (স্পীড, ডায়েট, এক্সটেসি)	না 0 হ্যাঁ 1 অসম্মতি 8 8	a9
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না 1 একবার দুইবার 2 মাসে একবার 3	a10

	সপ্তাহে একবার প্রতিদিন অথবা প্রায় প্রতিদিন	4 5	
ইনহেলেন্ট (নাইট্রাস গ্যাস, জুতার আঠা, স্প্রে রং গ্যাসোলিন, রং এর থিনার)	না হ্যাঁ অসম্মতি	0 1 8 8	a11
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না একবার দুইবার মাসে একবার সপ্তাহে একবার প্রতিদিন অথবা প্রায় প্রতিদিন	1 2 3 4 5	a12
ঘুমউদ্রেগকারী অথবা গুমের বড়ি, (সেডিল, রিভোট্রিল, মাইলাম, রিলাক্সেন ইত্যাদি)	না হ্যাঁ অসম্মতি	0 1 8 8	a13
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না একবার দুইবার মাসে একবার সপ্তাহে একবার প্রতিদিন অথবা প্রায় প্রতিদিন	1 2 3 4 5	a14
ভ্রম সৃষ্টিকারী (এলএসডি, এসিড, মাসরুম, পিডিপি, স্পেশালকে ইত্যাদি)	না হ্যাঁ অসম্মতি	0 1 8 8	a15
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না একবার দুইবার মাসে একবার সপ্তাহে একবার প্রতিদিন অথবা প্রায় প্রতিদিন	1 2 3 4 5	a16
হেরোইন, মরফিন, মেথাডন, ফেনসিডিল অথবা ব্যাথানাসক ঔষধ(কোডেইন, ডাইলোডিড, ডারভন, ডেমোরাল, পারকোডেন, ফাইয়োরিনাল ইত্যাদি)	না হ্যাঁ অসম্মতি	0 1 8 8	a17
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না একবার দুইবার মাসে একবার সপ্তাহে একবার প্রতিদিন অথবা প্রায় প্রতিদিন	1 2 3 4 5	a18
অন্যান্য উল্লেখ করুন		,……..	a19
গত তিন মাসের মধ্যে কতবার আপনি তা ব্যবহার করেছেন?	কখনও না একবার দুইবার মাসে একবার সপ্তাহে একবার প্রতিদিন অথবা প্রায় প্রতিদিন	1 2 3 4 5	a20

সামাজিক চাপ এবং সমস্যা

Questions	Answer					Code
আপনার সামাজ বর্তমানে কোন ধরণের প্রধান সমস্যার সম্মূখীন হচ্ছে বলে আপনি মনে করেন? (নিজের ভাষা ব্যবহার করুন) -						
নি¤œলিখিত সমস্যাগুলো আপনার সামাজে কতটা মারাত্মক বলে আপনি মনে করেন (১=মারাত্মক নয় থেকে ৫=অত্যান্ত মারাত্মক)						
a . আবাসন	1	2	3	4	5	p1
b . অপরাধ	1	2	3	4	5	p2
c . দারিদ্রতা	1	2	3	4	5	p3
d . শিক্ষা	1	2	3	4	5	p4
e . সরকার/প্রশাসন	1	2	3	4	5	p5
f . পারিবারিক জীবন	1	2	3	4	5	p6
g . যাতায়াত	1	2	3	4	5	p7
h . স্বাস্থ্য সেবা	1	2	3	4	5	p8
i . চাকুরীর নিরাপত্তা	1	2	3	4	5	p9
j . জাতিগত কুসংস্কার	1	2	3	4	5	p10
k . দূষণগত সমস্যা	1	2	3	4	5	p11
l . মাদকের অপব্যবহার	1	2	3	4	5	p12
m. এ্যালাকাহলের অপব্যবহার	1	2	3	4	5	p13
n . শিশু এবং স্ত্রী নির্যাতন	1	2	3	4	5	p14
o . জীবন যাত্রার মান	1	2	3	4	5	p15
p . শারীরিক নিরাপত্তা এবং সাবধানতা	1	2	3	4	5	p16
আপনার মতে এই ---------- লোকজন একে অপরের কতটা ঘনিষ্ট এবং কতটা সহানুভূতিশীল? (১= ঘনিষ্ট / সহানুভূতিশীল নয় থেকে ৫= খুব ঘনিষ্ট/সহানুভ'তিশীল)						
a . পাড়া/প্রতিবেশীগণ	1	2	3	4	5	p17
b . শহর	1	2	3	4	5	p18
c . অঞ্চল	1	2	3	4	5	p19
d . জাতি	1	2	3	4	5	p20
আপনার মতে এই ---------- লোকজন ভবিষ্যিত সম্পর্কে কতটা আশান্বিত এবং আশাবাদী? (১= আশান্বিত / আশাবাদী নয় থেকে ৫=আশান্বিত / আশাবাদী)						
a . পাড়া প্রতিবেশীগণ	1	2	3	4	5	p21
b . শহর	1	2	3	4	5	p22
c . অঞ্চল	1	2	3	4	5	p23
d . জাতি	1	2	3	4	5	p24

ধন্যবাদ দিয়ে সাক্ষাৎকার শেষ করুন।

Report on
Epidemiology of Suicide and Suicidal Behavior Among Youth and Adolescent in Bangladesh

Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

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