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Original Research Article

Prevalence of suicide over a decade in Nepal

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ABSTRACT

Background: When developing suicide prevention strategies and programs, accurate data on suicide deaths, method and its pattern is crucial. There is still a lack of information on the techniques used and their variance across the nations. This study described the pattern of suicidal deaths and the suicide rates in Nepal.
Methods: We conducted a review of records of suicide data in Nepal from 2009 to 2020 to determine the pattern of suicidal deaths in Nepal. This study includes a sample size of 42,136 suicidal deaths. For statistical analysis, R software version 4.0 was used. Parametric numerical variables were presented with mean and standard deviation, whereas categorical variables were presented as frequency and percentage.
Results: From April 2009 to March 2020, a total of 42,136 suicidal deaths were recorded in Nepal. The mean age of suicide victims was 43.4 years, and the majority were male (45.7%). The average yearly suicide rate in Nepal was found to be 14.8 per 100,000 people. Hanging (69.5%) was the common method and depression (31.1%), becoming the leading causes of suicide. Suicidal attempts were found to be highest in the morning (58.4%) from 5 a.m. to 12 p.m.
Conclusions: The average rate of suicide was high in comparison with other countries in Southeast Asia. The increase in the rate was mostly after a major geographical, economic, political, or health disaster. Given the importance of policies in determining a country's progress, it's time to consider suicide as a "sleeping pandemic.

Keywords: Decade, Nepal, Review, Suicide

INTRODUCTION

Suicide is a worldwide epidemic that affects all parts of the world, not only high-income nations. In fact, more than half of the total suicides that occur globally are in low-and middle-income countries.[1] Nepal has an estimated 6,840 suicides per year, or 8.2 suicides per 100,000 people, according to a study by World Health Organization study (2015), ranking it 126th in the world.[2]

WHO calculated an age-standardized suicide rate for the country in 2012, placing it seventh in the world at 24.9 per 100,000.[3] According to the findings, harm to oneself or loved ones, destruction of one's property, or the death of family members as a result of the earthquake increase suicide inclinations.[4,5]

There is a scarcity of comprehensive, accurate, and nationally representative suicide statistics.[6] It is mostly due to a lack of a strong vital registration system, a lack of reliable data collection methods by responsible authorities, and underreporting of suicide to police because it is still an illegal issue in Nepal.[7]

In this context, we aimed to analyze the pattern of suicidal deaths and the suicide rate in Nepal.

METHODS

A retrospective chart review of records of suicide data from April 2009 to March 2020 was conducted in Nepal to determine the pattern of suicidal deaths. Research ethics approval was obtained for the secondary data analysis by the Nepal Health Research Council (Ref no: 2794). All data was kept on password-protected computers accessible to researchers only. Confidentiality and anonymity of all suicide victims were maintained.

The sample size was determined by using following formula.

Sample size (n) = z^2pq/d^2

$= (2.58)^2 0.5*0.5/ (0.01)^2$

$= 16641$

Where,

Prevalence (p) = 0.5 (50% prevalence was taken as there wasn't any relevant study done in Nepal)

q= 1-p = 1-0.5 = 0.5

Confidence Interval (CI) =99%, Z= 2.58

Margin of error (d) = 1% =0.01

The sample size for the study was 16641.

Data source

We collected the data from Nepal Police, the nodal institution for recording the data on suicide across Nepal. Nepal Police (NP) functions under the Ministry of Home Affairs, Government of Nepal. For this study, we have collected data on suicide for a period of 10 years (2009-2020) from different institution of Nepal Police. The Nepal Police, who are under governmental body of the Ministry of Home Affairs, are tasked with determining suicide death and reporting them. As per investigation procedure in Nepal, local police intake individual reports and relay those to the district police office (Figure 1). District police investigate, document, request a post mortem, and send information to the central headquarters in a standard format. In the context of Kathmandu Valley (Kathmandu, Bhaktapur and Lalitpur) local police take individual reports and relay them to metropolitan offices and PHQs Crime Investigations Department as well. District and national police officers depicted the informational chain as originating with a family or community report of a death followed by the initiation of formal procedures to collect evidence (both physical and verbal). Police then complete several reports (an initial brief inspection report detailing the day, time, location, and individuals involved, a subsequent longer report, a request for a post-mortem report from a certified hospital, and a full report with complete case details that can only be completed after the case is closed). Reports are transcribed at the district office and sent via post or email to the National Police Headquarters in Kathmandu. Districts may vary in documentation sharing processes, whereby some are hand-written and hand delivered and others must travel through the post.

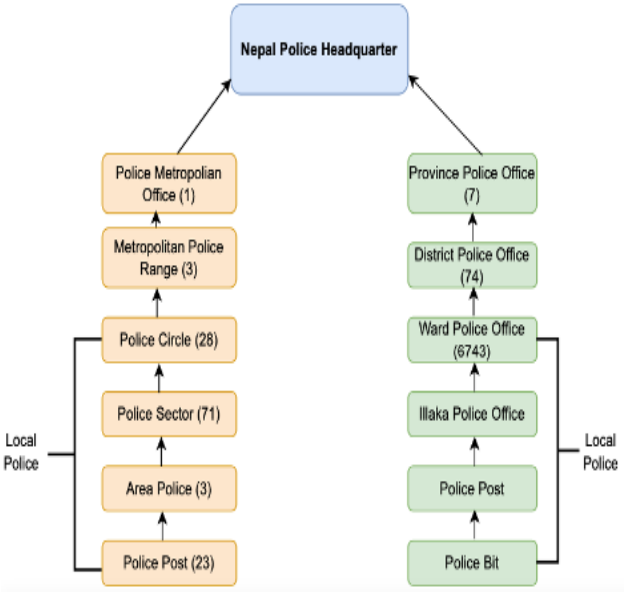

Figure 1: Suicides case reporting flow from Nepal police.

Data extraction

We collected and compiled records of all suicidal deaths reported to District Police Headquarters located in 77 districts of Nepal from April 15th, 2009 to March 14th, 2020 as a part of a larger surveillance study. There are seven provinces and 77 districts in Nepal. A team of police officers consisting of 5–10 members in each province (a member of each district of the province) was created according to geographical and population density. We provided a one-day online orientation session to the members on the extraction of data. Nepal Police Officers entered the data into a Microsoft Excel 2010 spreadsheet.

The following variables were set for the extraction of data from each case

Socio-demographic characteristics

This included age (in years), sex (Male/Female), ethnicity (Brahmin,Chhetri/ Dalit/ Janajati/ Madhesi/ Tharu,satar/ Other), Province (Province-1/ Province-2 (Madhesh)/ Bagmati/ Gandaki/ Lumbini/ Karnali/ Sudurpaschim), marital status (Married/Not married), family type (Joint/ Nuclear), education (Illiterate/Literate with formal education/ Primary/ Secondary/ Higher secondary and above) and occupation (agriculture/ Housewife/ Labor/ Student/Unemployed/ Others)

Suicide-related characteristics

Suicide-related characteristics were based on documents prepared by police officers during the investigation of the victims' family, friends, and community witness. This included suicide method (Hanging/Poison/Fire/ Weapon/Jump/Others), suicide reason (Depression/Poverty/Family dispute/Alcohol use/Diseased/Love failure/ Others), and suicide date and time.

Statistical analysis

We cleaned data in Google Sheets, and the cleaned data was exported to R software version 4.0.1 for pre-analytical processes and statistical analysis. We presented numerical variables as mean and standard deviation, whereas categorical variables as frequency and percentage. The time trend of suicide from April 2009 to March 2020 stratified by sex was reflected through the line graph. We used QGIS 3.10 to display the distribution of the district-wise average yearly suicide rate (per 100,000 population).

RESULTS

A total of 42,136 suicidal deaths were recorded from April 2009 to March 2020 in Nepal. (Table 1) represents the characteristics of people who attempted suicide. The ages of individuals attempting suicide were categorized as child, youth, adult, and senior, where more than two-thirds of respondents (71%) were adults and the majority of them were male (73%) and married (75.3%). About one-third of them belonged to Brahmin/chhetri (30.6%) and Janajati ethnic groups (30.5%) each. Province 1 (22.2%) and Lumbini province (22.9%) reported the majority of suicides. Nearly half of the participants were found to be living in joint families (48.3%). Data on educational status revealed that more than half (53.4%) were without formal education but could read and write. Similarly, agriculture was the most common occupation (40%).

Table 1: Sociodemographic characteristics of suicide cases in Nepal from April 2009 to 14th March 2020.

Characteristics	Female (n=19072)	Male (n=22810)	Overall (n=42136)
Age in years, Mean SD, N (%)	40.6±16.9 [2.0, 98.0]	45.7±16.7 [3.0, 102.0]	43.4±17.0 [2.0, 102.0]
Child (<14)	280.0 (1.5%)	182.0 (0.8%)	462.0 (1.1%)
Youth (14-25)	3,657.0 (19.3%)	2,534.0 (11.1%)	6,191.0 (14.8%)
Adult (26-64)	13,031.0 (68.7%)	16,676.0 (73.0%)	29,707.0 (71.0%)
Senior (65 and above)	2,007.0 (10.6%)	3,448.0 (15.1%)	5,455.0 (13.0%)
Missing	163 (0.9)	158 (0.7)	321 (0.8)
Ethnicity N (%)			
Brahmin/Chhetri	5512 (28.9)	7364 (32.3)	12876 (30.6)
Dalit	2944 (15.4)	3399 (14.9)	6343 (15.1)
Janajati	5938 (31.1)	6897 (30.2)	12835 (30.5)
Madheshi	1748 (9.2)	1671 (7.3)	3419 (8.1)
Tharu Sataar	1141 (6.0)	1102 (4.8)	2243 (5.3)
Other (Muslim, Giri, Puri, Sanyasi)	1789 (9.4)	2377 (10.4)	4166 (9.9)
Province			
Province 1	4012 (21.0)	5346 (23.2)	9358 (22.2)
Province 2	2103 (11.0)	1897 (8.2)	4000 (9.5)
Bagmati	3180 (16.6)	4209 (18.3)	7389 (17.5)
Gandaki	2069 (10.8)	2957 (12.9)	5026 (11.9)
Lumbini	4345 (22.7)	5314 (23.1)	9659 (22.9)
Karnali	865 (4.5)	1120 (4.9)	1985 (4.7)
Sudurpaschim	2564 (13.4)	2155 (9.4)	4719 (11.2)
Marital status N (%)			
Married	13439 (74.4)	16770 (76.2)	30209 (75.3)
Not married	4624 (25.6)	5208 (23.8)	9832 (24.6)
Missing	1075	1020	2095
Type of family N (%)			
Joint	9438 (49.3)	11119 (48.3)	20557 (48.8)
Nuclear	2541 (13.3)	2727 (11.9)	5268 (12.5)
Missing	7159	9152	16311 (38.7)
Education level N (%)			
Illiterate	949 (6.7)	970 (5.8)	1919 (4.6)
Literate without formal	10044 (70.8)	12457 (74.6)	22501 (53.4)

Continued.

Characteristics	Female (n=19072)	Male (n=22810)	Overall (n=42136)
education			
Primary	397 (2.8)	517 (3.1)	914 (2.2)
Secondary	2350 (16.6)	2209 (13.2)	4559 (10.8)
Higher secondary and above	450 (3.2)	536 (3.2)	986 (2.3)
Missing	4948	6309	11257
Occupation N (%)			
Agriculture	6863 (41.0)	9988 (51.0)	16851 (40.0)
Housewife	3663 (21.9)	0 (0.0)	3663 (8.7)
Labor	658 (3.9)	2553 (13.0)	3211 (7.6)
Student	2417 (14.4)	1678 (8.6)	4095 (9.7)
Unemployed	1094 (6.5)	2072 (10.6)	3166 (7.5)
Others	2032 (12.1)	3300 (16.8)	5332 (12.7)
Missing	2411	3407	5818

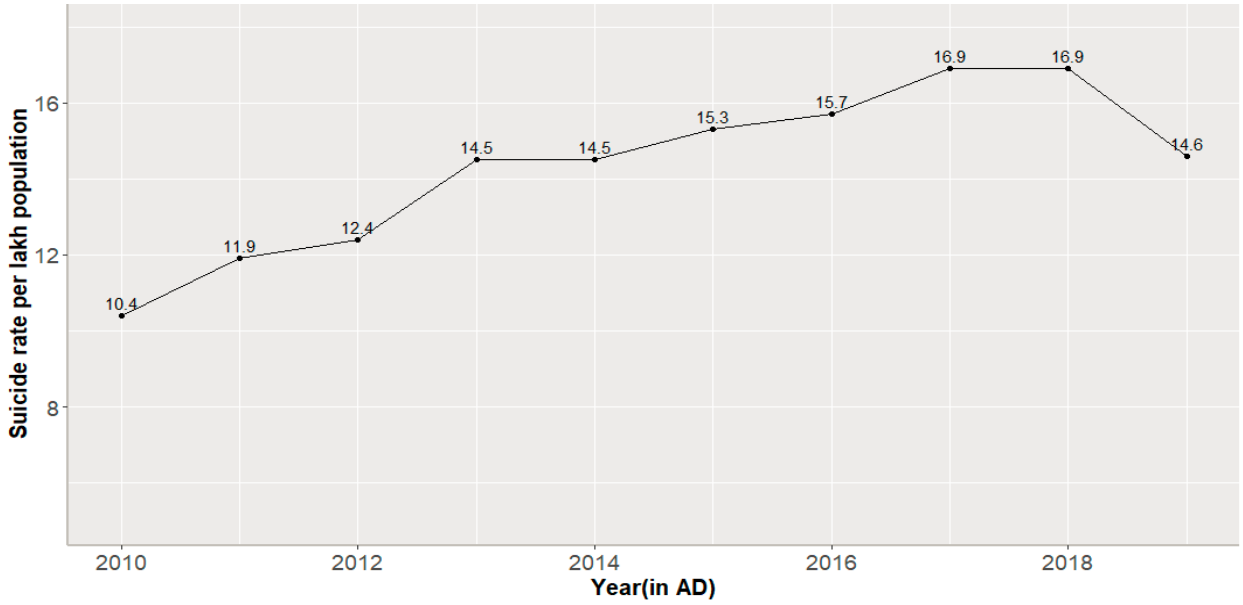

Figure 2: Time trend of suicide in Nepal from 2010 to 2020.

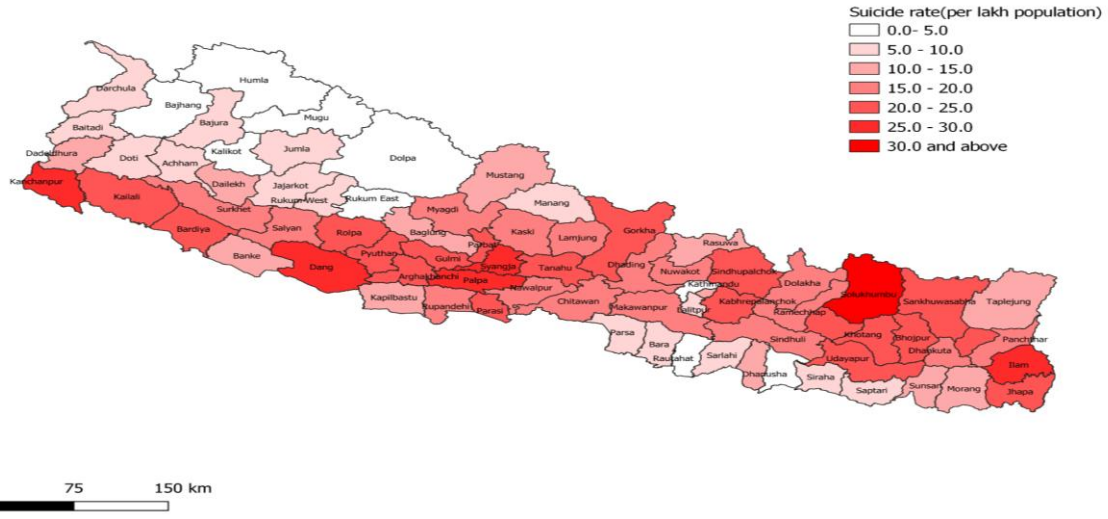

Figure 3: District wise average yearly suicide rate.

Table 2: Method, reason, time and month of suicide.

Method/ reason/ time/ month of suicide	Gender		Overall, N (%)
Methods	**Female, N (%)**	**Male, N (%)**	
Hanging	12902 (67.4)	16382 (71.2)	29284 (69.5)
Poison	5466 (28.6)	5525 (24.0)	10991 (26.1)
Fire	92 (0.5)	50 (0.2)	142 (0.3)
Weapon	131 (0.7)	227 (1.0)	358 (0.8)
Jump	278 (1.5)	271 (1.2)	549 (1.3)
Other (Electric current in hand, overuse of medicinal drugs)	269 (1.4)	543 (2.4)	812 (1.9)
Reasons			
Depression	2304 (30.9)	2802 (31.2)	5106 (31.1)
Poverty	958 (12.9)	1398 (15.6)	2356 (14.3)
Family dispute	2090 (28.0)	2152(24.0)	4242 (25.8)
Alcohol use	164 (2.2)	385 (4.3)	549 (3.3)
Diseased	438 (5.9)	738 (8.2)	1176 (7.2)
Love failure	646 (8.7)	461 (5.1)	1107 (6.7)
Other	852 (11.4)	1034 (11.5)	1886 (11.5)
Missing	11686	14028	25714
Parts of a day			
Night (9pm-5am)	4712 (26.2)	5276 (24.6)	9988 (25.3)
Morning (5am-12pm)	10388 (57.7)	12639 (58.9)	23027 (58.4)
Afternoon (12pm-5pm)	1392 (7.7)	1644 (7.7)	3036 (7.7)
Evening (5pm-9pm)	1505 (8.4)	1885 (8.8)	3390 (8.6)
Missing	1141	1554	2695
Month of suicide occurrence			
Baishak (April)	1818 (9.6)	2180 (9.5)	3998 ((9.6)
Jestha (May)	1805 (9.5)	2131 (9.3)	3936(9.4)
Ashad (June)	1745 (9.2)	1992 (8.7)	3737(8.9)
Shrawan (July)	1720 (9.1)	1958 (8.6)	3678 (8.8)
Bhadra (August)	1639 (8.6)	1942 (8.5)	3564 (8.5)
Aswin (September)	1535 (8.1)	1991 (8,7)	3630 (8.7)
Kartik (October)	1441 (7.6)	1889 (8.3)	3424 (8.2)
Mangsir (November)	1221 (6.4)	1687 (7.4)	3128 (7.5)
Poush (December)	1223 (6.4)	1487 (6.5)	2708 (6.5)
Magh (January)	1317 (6.9)	1679 (7.4)	2996 (7.2)
Falgun (February)	1443 (7.6)	1848 (8.1)	3281 ((7.9)
Chaitra (March)	1680 (8.8)	2045 (9.0)	3725 (8.9)
Missing	152	169	321
Suicide notes			
Present	2995 (22.3)	3326 (21.1)	6321 (21.7)
Absent	10442 (77.7)	12412 (78.9)	22854 (78.3)
Missing	5701	7260	12961

On an average, 3919.2 suicidal deaths per year take place in Nepal. (Figure 2) shows that the average yearly suicide rate in Nepal was 14.8 per 100,000 population. Between 2010 and 2019, the highest suicide rate was recorded in 2017 and 2018, with 16.9 per 100,000 population.

As shown in (Figure 3), the district with the highest suicide rate was found to be Solukhumbu (36.7 per 100,000 population), followed by Kanchanpur (29.8 per 100,000 population). With 0.2 per 100,000 population, Kathmandu ranked last when it came to the lowest suicide rate. Similarly, Dhanusha, after Kathmandu, had the lowest suicide rate (1.8 per 100,000 population).

In addition, Palpa (26.5), Ilam (25.4), Dang (25.2), Syangja (25.1), and Jhapa (24.9) were among the districts with the highest suicide rates after Solukhumbu and Kanchanpur.

Method, reason, time and month of suicide of suicide

As shown in (Table 2), known discrepancies in preferred suicide methods were found for both males and females. Both groups of victims attempted to commit suicide by hanging (69.5%), whereas suicide due to poisoning (26.1%) was the second most common method followed by both groups. Likewise, in context to the reasons for suicide, depression (31.1%) was determined to be the leading cause of both male and female suicides, followed by family conflict (25.8%) and poverty (14.3%). An individual's diseased state (7.2%) also contributed to the total suicide rate.

Analyzing suicides by part or time of the day, we found that suicide rates varied significantly by time of day for both sexes. Suicide occurrences were lowest in the afternoon (7.7%) from 12 p.m. to 5 p.m., whereas suicidal attempts were highest in the morning (58.4%) from 5 a.m. to 12 p.m. for both males and females, followed by the night (25.3%) and evening hours (8.6%). Additionally, the overall suicide rate was somehow similar in all the months. However, the suicide rate was found to be slightly higher among both male and female groups in the month of Baishak, making up a total of 9.6%, whereas the month of Poush accounted for a comparatively lower number of suicides (6.5%). Similarly, a suicide note was found only in 21.7% of victims.

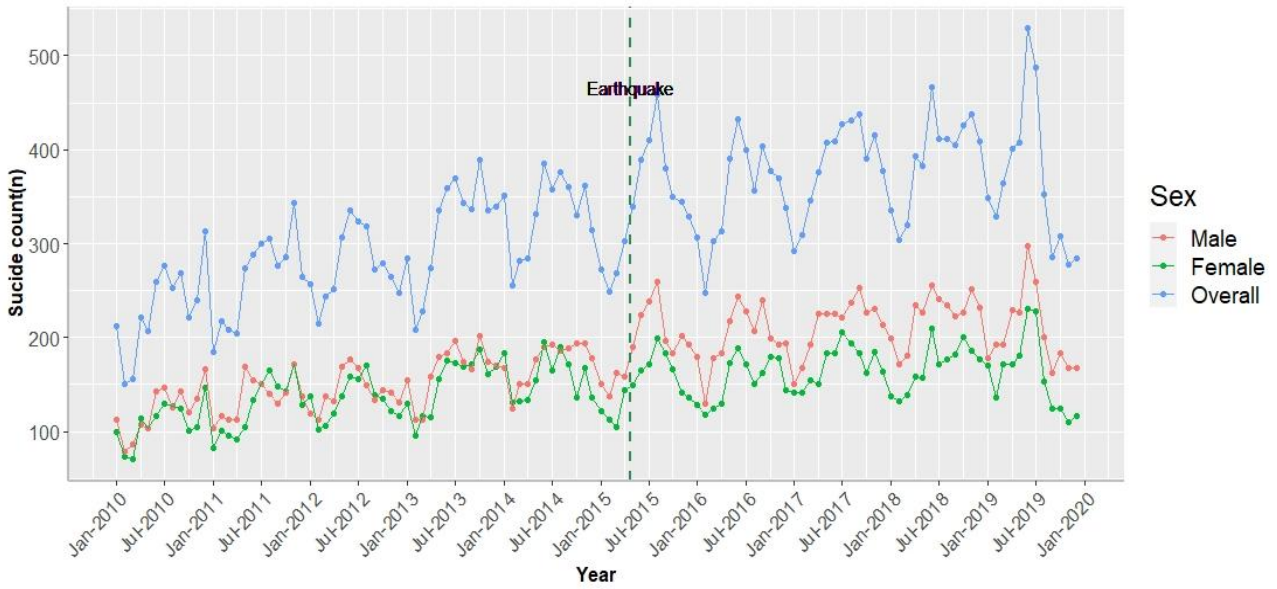

Figure 4: Time trend of suicide from 2010 to 2020 stratified by sex.

(Figure 4) shows suicide deaths in both male and female groups since 2010. As can be seen from the figure, the total number of deaths among both male and female groups as of January 2010 was about 100, but the male group showed a gradual increase. A total of about 150 people have died in the male group since January 2011. This trend continued to fluctuate until July 2013, when the death toll rose sharply, about 200 more deaths compared to January 2010. The numbers dropped significantly after that until January 2015, reaching less than 150 in males and 100 in females. Unfortunately, the death toll increased significantly after the massive earthquake that hit Nepal in July 2015, reaching almost 300 and 150 death counts in male and female, respectively, showing some fluctuation until January 2020.

DISCUSSION

This study examined the pattern of suicidal deaths and the suicide rate in Nepal by time trend, location, and sex. The study used national data from 2009-2020, documented by the District Police Headquarters. Suicide-related characteristics such as method, reason, time, and month of suicide were segregated by gender.

In the present study, the average yearly suicide rate was 14.8 per 100,000 population per year. A review published in Nepal in the year 2017 has quoted that the calculated suicide rate for the years 2015 and 2016 was 16.4/100,000.[8] Between 2009 and 2011, a survey found that China, which borders Nepal to the north, had a suicide rate of 9.8 per 100,000 population.[9] Suicide rates in neighboring countries like India, which shares an east-west-south border with Nepal, were also estimated to be between 13.5 and 14.0 per 100,000 from 2001 to 2013.[10] Our results were in line with those of other studies done in Nepal and the neighboring country, with whom we share an open border (India) and a similar culture. In 2012, WHO modeled an age-standardized suicide rate, where Nepal ranked seventh in the world with a suicide rate of 24.91 per 100,000 population.[11] From 2009 to 2020, we looked at the suicide rate and found that it was highest in the years 2017 and 2018 with 16.9 suicides per 100,000 people. However, in the year 2019, the rate dropped to 14.6.

A mental health survey conducted in 21 countries showed a yearly suicide attempt prevalence of 0.3% in developed countries and 0.4% in developing countries.[12] Similarly, another study that included data from 91 countries calculated the prevalence of suicide as per the human development index (HDI). The country having a medium HDI that is between 0.5 and 0.8 had a suicide rate prevalence of 13.94/100,000; with a HDI between 0.8-0.9 had 7.93/100,000; and with a HDI greater than 0.9 had 11.64/100,000.[9] Nepal being a low and middle-income country (LMIC) with a HDI of 0.602, our findings were consistent with the preceding study.

The mean age of the suicide victims in the present study was 43.4±17.0 years, with the majority of the victims being in the age group of 26-64 years. Our study also showed an increasing trend of suicides in this age group. However, the age group of 10-19 and the age group 20-65 years remained persistently low over the year, with a slight rise from the year 2011. Previously published studies in Nepal highlighted an increasing trend of suicidal deaths in the age group of less than 40 years.[13,14] Because these studies were cross-sectional and based on a small sample from a single institution, they may have simply mirrored the local scenario. Contrary to our findings, in a study done in China, the suicide rate was higher in the age group of above 65 years.[15] This study has stated that rapid changes in socioeconomic conditions could have increased stress levels, causing more suicides in the elderly.

In our study, the male population was slightly higher (54.1%) than the female. A similar pattern was seen in the population above 26 years, but female predominance was observed in the age group less than 26 years. The trend of males and females remained parallel throughout the study period (Figure 2). A 5-year data set from India showed similar findings where the male to female ratio was 2.5:1 and the rate was more in the males in the age group of 30-44 years, while in the age group of 15-29 years it was more in females.[16] A study from Bharatpur hospital stated an equal ratio of males and females. However, this was based on 170 autopsies performed at the hospital.[14] As per the WHO data on suicide in Nepal, the completed suicide rate among men (30.1/100,000) remains higher in Nepal compared to women (20.0/100,000). However, Nepal is ranked 17th for male suicide rates but 3rd for female suicide rates (WHO suicide data).[8,17] Males and females differ in their roles, responsibilities, physical characteristics, and biological characteristics, which contribute to suicidal behavior.[17,18] A study reviewing a publication on suicide in Nepal from 2000 to 2014 suggested the causes of suicide in women included partner violence, alcoholism, polygamy, the culture of silence, early age marriage, prolonged childbearing, and dependency on men for financial security.[19]

There are six major groups of people residing in Nepal: the Hill caste group, Adibasi and Janajati, Newars, Madheshi, Others, Unidentified, and Foreigners.[20] Of these ethnic groups, the Hill caste group and the Adibasi-Janajati group comprise 70% of the population. Suicidal death was common in the upper hill castes (Brahmin/Chettri) followed by Janajati. The proportion of suicides combined in these two groups comprised 61.1% in this study. A study done in eastern Nepal showed 18.3% of suicidal deaths in disadvantaged HillJanajati (e.g. Magar, Tamang, Rai, Limbu, Sherpa, etc.) and 18.3% in upper hill castes (e.g. Brahmin, Chhetri, Thakuri, etc).[21] The ten-year trend has been seen to be persistent, with the upper hill group and janajati dominating the trend. There are no studies suggesting why suicide is common in these groups. However, due to migration for work, being away from family and the work environment could be one of the reasons which needs to be explored. The number of deaths of migrants in the years 2008 to 2014 showed that there were a total of 451 (10%). Suicides nearly tenfold increased over a seven-year period.[8]

Nepal is divided into seven provinces and each province has several districts. Therefore, there are a total of 77 districts in Nepal. The Lumbini Province had the highest rate of suicidal death 9358 (22.2%) followed by Province one. District wise, the highest suicidal rate was in Solukhumbu district (36.7%), which is in Province 1, followed by Kanchanpur district (29.8%), which is in Sudurpacchim province. We do not have data on whether the same ethnic group is predominant in the province that has a high rate of suicidal deaths. Therefore, it could be an area for research in the future. Moreover, Province 1 and Lumbini are in medium HDI areas while Sudurpaschim is in a low HDI area.[22] Therefore, there was no relation seen in our study about HDI and suicide.

In our study, suicidal death was seen more among married people (75.3%). This finding was similar to a review done in Nepal which also had a similar finding.[23] However, a study done in Finland showed that suicides were more common among the never-married, divorced, and widowed.[24] Yet another study showed a higher suicide risk among unmarried individuals younger than 65 years of age than those who are older than 65 years of age. The same study also showed that unmarried men had a greater risk of suicide than their married counterparts.[25] Though several studies have demonstrated the protective effect of marriage against suicide, not all marriages are equal: unhappy marriages provide fewer benefits than happy ones.[26] Cultural differences and financial and social responsibilities may be the factors contributing to more suicidal deaths amongst the married population in this study. Our study also demonstrated that suicidal death occurs more in joint families than in nuclear families (48.8%). In contrast, in another study, suicidal ideation and attempts were more common in nuclear families.[27,28] Similar findings were observed in studies from Malaysia and Gujrat.[29,30] The study from Gujrat stated the cause of suicide was more in the nuclear family due to educational challenges, economic status, and health factors that are otherwise supported by the family

in a joint family. Educational challenges can be one of the triggers in our study as 53.4% of suicidal deaths were in those who were literate without formal education. However, there is no literature published from Nepal to prove this hypothesis. In contrast to common findings, our study showed more suicidal deaths in a joint family. This can be because of missing data. We did not analyze 13311 (38.7%) of the data in this area as it was missing.

In our study, 40% of the deaths had agriculture as their profession, and hanging was the most common modality, 69.5%, followed by poisoning (261%). Males were seen to choose hanging as a means of suicide compared to females. In a study looking at 91 cases of autopsy death due to hanging, 57 (63%) were males and 34 (37%) were females.[30] The national police data of completed suicide cases from 2010 to 2015 showed that there is a rising trend of hanging cases in Nepal whereas there is a slight decrease in the trend of pesticide poisoning.[8]

The common driving factors for suicide included: lack of education, poverty, violence, migrant labor, and family disputes.[31] In industrialized countries, limited social connectivity is associated with suicidal ideation, non-fatal suicidal behavior, and suicide in later life.[32] A study in Nepal suggested intimate partner violence as an independent risk factor for committing suicide (OR=5.33; 95% CI: 1.41–20.10; P=0.013). The other two strong factors were depression (OR=10.53; 95% CI: 3.11–35.66; P<0.001) and substance dependence (OR=16.38; 95% CI: 4.23–63.35; P<0.001).[33]

Therefore, suicide is a complex public health problem with various medical, social, and cultural factors contributing to it. The rising trend of suicidal deaths in our study, along with the persistence of the same age group, ethnic group, and gender in the last ten years, strongly shows that there have been fragmented efforts to prevent suicide in the last ten years, but we lacked consolidated effort. A multi sector approach under government leadership, policy, and participatory community engagement is believed to be helpful.[6] As a result, it appears that a strong policy, as well as public ownership and support, are required to reduce this rising trend of suicidal deaths.

To the best of our knowledge, this is the first study to analyze the pattern of suicide over a decade in Nepal. This study is one of the first to use real-world administrative data nationwide from Nepal police officials. However, it has some limitations. Since the Nepal Police record was employed as a secondary source of information, the results are subject to issues such as under-reporting. During data acquisition, we found some major drawbacks. The non-academic actors who were actively engaged and were the first ones to interact in the suicidal scene lacked knowledge and training in handling suicide cases. Non-academic actors, such as ground-level police officers, saw suicide only from a criminological and legislative standpoint, and did not see it as a mental health issue.

CONCLUSION

The average suicide rate was high compared to other Southeast Asian nations. The majority of the rate rise occurred after a big geographic, economic, political, or health catastrophe. What is documented herein might only be the tip of the iceberg. The reality of suicide in Nepal might be deeply buried due to the stigmatization and work-related priorities of the non-academic actors who are frontliners of suicide intervention. A multi-disciplinary integrated model should be incorporated for the decrement of the suicide rate. Considering policies are the foundations of every country's progress, it's time to consider suicide as a "sleeping pandemic." Making a policy of mandatory inclusion of a checklist for risk factors of suicide and incorporating it with suicide case documentation would help to address the problem with future research. Also, an electronic continuous data entry and monitoring system would give us the "real time" issues that need to be considered for prevention.

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