# A Study of
# Risk Factors of Suicide in Survivors of Gender-Based Violence

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# EXECUTIVE SUMMARY

The study team conducted research on suicidal risk factors among GBV survivors of Nepal using cross sectional study design. The sample size was 300 based on convenient sampling. There were 300 respondents altogether from five different districts; Kathmandu, Lalitpur, Bhaktapur, Sindhuli and Udaypur. There were 60 respondents from each district who were interviewed between July and September 2020. These GBV survivors were receiving services from One-Stop Crisis Management Centres (OCMC), safe homes and women cell from their respective districts. The major findings of this study are listed below:

## MAJOR FINDINGS

- The study found that GBV is prevalent mostly in Janjati ethnicity (both hill and terai accounted for 54%), followed by Chhetri, Dalit and Brahmin. Alcohol abuse was found as a significant contributing factor for violence.
- GBV is more common in 19-30 and 31-50 age categories than other age groups. Thus, prevention and response interventions should consider it when planning.
- GBV phenomena is found to be common in a nuclear family, partners having low level of education, low level of income (less than NRS 5,000 per month) and who have experienced multiple types of violence and multiple reasons to face the GBV.
- GBV and suicide is increasing in rural area than in urban as the result showed highly prevalent of GBV in rural areas (Sindhuli and Udaypur).
- The study found that depression has increasingly become common among the GBV survivors (88.7%) with 16.7% suffering from severe depression. Suicide risk is also found very high (56.3%) among GBV survivors with 7.3% displaying severe level.
- Depression is increasingly common in GBV survivors (88.7%) and it is contributed by age, sex, family environment, type of family, marital status, social discrimination (caste, sex, economic status), income status, low level of education, experience of violence from multiple perpetrators and experience multiple violence in Nepalese context. Women were experiencing GBV mostly from their husband (40%).

## RECOMMENDATIONS

- As GBV survivors are experiencing very high level of depression and suicidal thoughts, there is huge gap in mental health and psychosocial support services to tackle this situation. It is imperative to develop mental health and psychosocial support services to GBV survivors and need to create supportive environment for rehabilitation and reintegration of survivors into their own family and community. Both response and prevention mechanism need to be placed to address it.
- Since the prevalence of GBV is high among participants with low economic access and low-income level (monthly income less than NRS 5,000), activities to improve access to economic resources by GBV survivors is necessary to integrate into all GBV response and prevention

programs. As economic empowerment and better access to earning source improves women health and mental health condition as well. We strongly recommend entrepreneurial activities for better income source in GBV survivors.

- GBV is observed very high in certain ethnic groups such as Janjati, Dalit and Chhetri/ Thakuri . Use of alcohol was also reported high by the perpetrator which acts as precursor to induce violence act to the perpetrator. Prevention strategy needs to focus on reducing easy availability of alcohols and other stimulant substances as well. Further alcohol rehabilitation and counselling therapy can be provided to the alcoholic members of the family to reduce the GBV effectively in a family.
- Service provider and duty bearers' responsibility should be punctuate with legal provisions and active implementation of laws to reduce violence act and also for the prevention of such act. Training on GBV issues, its impact to survivors and other members of the family and community, available of effective services to the survivor is necessary in GBV prevention and response program activities. Capacity building is also equally necessary for health service providers and psychosocial workers to provide effective services to the survivors.
- Mental health and psychosocial support service to GBV survivor is a key to address increased depression and suicide in GBV survivors. Thus, response program at community level and health facilities play greater role to reduce both depression and suicide. GBV survivors mostly have no access to resources. Any service developed for them need to create access at individual level and at community following client centered approach.
- Severe form of suicidal risk cases are found comparatively higher in Sindhuli and Udaypur than in Kathmandu valley, thus this study recommend to establish a well equipped and efficient center to provide mental health and psychosocial services promptly.
- It is important to deliver psychosocial support services in the community through well trained community psychosocial workers (CPSW). CPSWs model has been already tested and has produced good result at community level. They are effective in addressing immediate emotional support needs and refer or link clients to other higher levels services in the One-Stop Crisis Management Centre (OCMC) for psychosocial counseling, mental health treatment, medical treatment, legal and protection support. This reduced chronicity of mental health condition of the survivors can reduce suicidal risk as well.
- Safe Houses that are providing shelter to the GBV survivors should also provide effective psychological counseling to them and should facilitate them in accessing mental health treatment if necessary.
- GBV survivors are vulnerable and need social as well as legal protection. These GBV survivors need easy and affordable access for their justice. Therefore there should be advocacy at the policy level emphasizing the need for the government's attention and investment to establish a responsive and effective mechanism to address the GBV problem.
- There should be maximum efforts for coordination among multi-stakeholders of different issues such as Health treatment, protection, care, education, reintegration, etc. to address the GBV survivors' needs.

# ACRONYMS

| | |
|---|---|
| CMCS | Centre for Mental Health and Counseling Service Nepal |
| CPSW | Community Psychosocial Workers |
| COVID 19 | Corona Virus Disease -19 |
| GBV | Gender Based Violence |
| NHRC | National Health Research Council |
| OCMC | One Stop Crisis Management Centre |
| PHQ-9 | Patient Health Questionnaire 9 items |
| RAs | Research Assistants |
| WCWC | Women and Children Welfare Centre |
| WHO DAS-II | WHO Disability Assessment Scale |

# ACKNOWLEDGEMENTS

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**Dr. Pashupati Mahat**

# INTRODUCTION

## 1.2 BACKGROUND

Millions of people die every year globally due to various reasons such as health problems, wars, homicides and natural disasters. But suicide is one of the top twenty prominent reasons for deaths as nearly 800,000 people commit suicide annually (WHO, 2019). People worldwide are at risk for suicide. It is a critical issue and in future it could be even alarming if effective and massive prevention measures are not implemented from global to local level. However the international documents such as Sustainable Development Goals (SDGs) and WHO Mental Health Action Plan 2013-2030 have started to include it (WHO, 2019).

Southeast Asian countries are estimated to account for 39% of all global suicides, however none have a comprehensive vital registration system (Vijayakumar L. 2016). Most of the studies have been carried out by west on the suicides that occur in Asia. In Southeast Asia suicide rates are more than double the homicide rates (NHRC 2009).

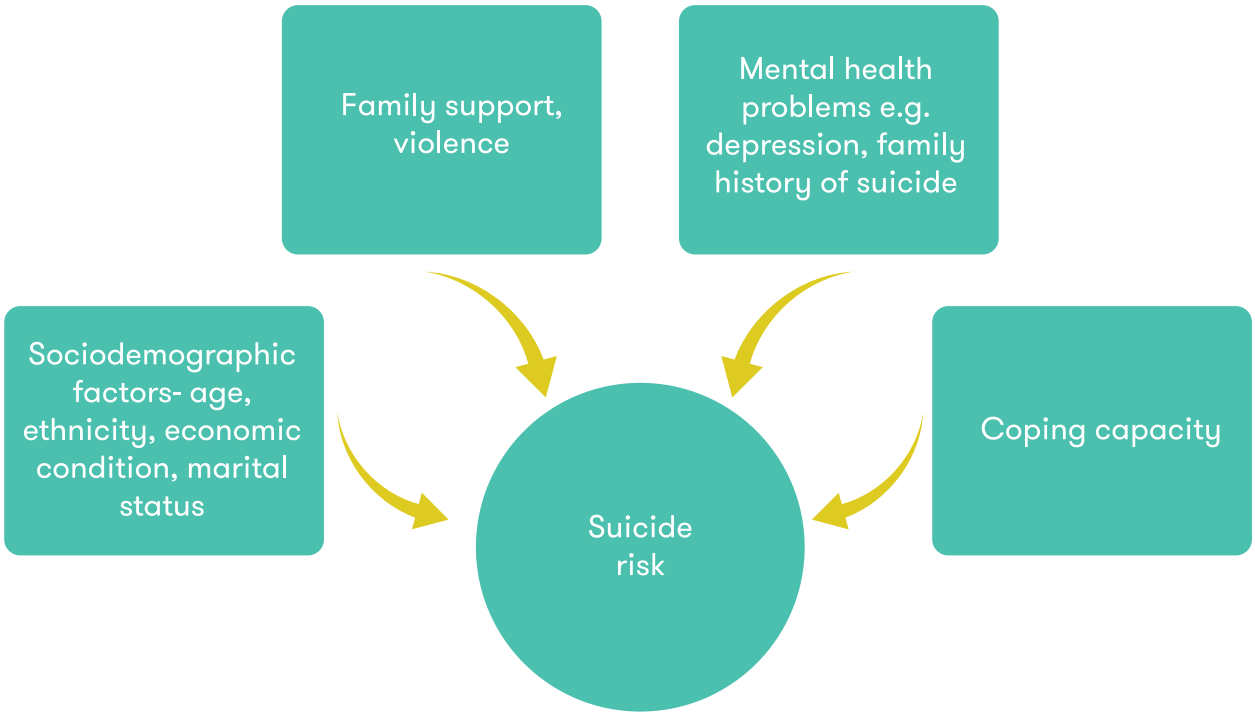
In low- and-middle income countries suicide is largely correlated with gender-based violence and oppression of women in general (Sayani, 2019). The leading cause of maternal mortality is due to intentional self-harm (suicide) which accounts for 16% of deaths (Pradhan, et. al, 2009). Systematic review of published articles on suicide identified that the most common risk factors for women to suicide is marital abuse in a family by their husbands (27%), and family members (27%). The other risk factors (7%) reported were family conflict, forced marriage, and negative rumors (Sayani, 2019). The same study found 11 specific risk factors focused on marital, family violence and gender-based oppression.

Community based mental health service at primary health care facilities implemented by an NGO (CMC-Nepal 2018) found that a large number of service recipients were female (68%) who were experiencing mental health problems. A study on school adolescents (studying in 7-11 grades) in Nepal showed 14% had suicidal ideation while 10.33% attempted suicide (Pandey, et. al., 2019). The same study further showed factors associated with suicidal ideation were food insecurity, anxiety, loneliness, and gender as risk factors of suicidal attempts. Having three or more close friends was found to have protective effect against suicide attempt. Recent national mental health survey has shown suicide prevalence 6.5% (Nepal Health Research Council, 2020). Suicide is one of the leading causes of death for women of a reproductive age in Nepal. Scoping review study of available literature to identify the causes of suicide among women in Nepal brought number of explanations for high rate of suicide among women including: partner violence, alcoholism and polygamy, the culture of silence, early age marriage and prolonged childbearing and dependency on men for financial security (Simkhada, et. al., 2015). There is a gender difference in suicide rates in Nepal. For women the most at-risk group is those aged between10 to 24 years, whereas for men it is those over the age of 35 (Pradhan A. et. at, 2011)). There are higher rates of suicide in unmarried women compared to those who are married, this is likely to be because of the social pressure on women to marry. Suicide often caused by depression and severe form of mental illness which can be treated and prevented from death if there is awareness that treatment will help to cope with suicidal thoughts.

As suicide in young age and unmarried women is increased every year, there has not much

studied on the risk factors of suicide in gender-based violence survivors in Nepal. Further information on potential risk factors will help to design prevention activities mainly in the development of awareness materials to prevent suicide. Result of the study will contribute not only in designing suicide prevention strategy also risk factors can be ranked out so that focused prevention and service development strategy can be framed out by all level of government and other stakeholders involved in GBV prevention. Present study aims to explore the suicidal risk factors among GBV survivors of Kathmandu valley, Sindhuli and Udaypur districts so that prevention strategies can be built to reduce the major risk factors.

### FIGURE 1.1: CONCEPTUAL FRAMEWORK




## 1.2 OBJECTIVE OF THE STUDY

This study explored the suicidal risk factors among GBV survivors of Kathmandu valley, Sindhuli and Udaypur districts so that prevention strategies can be built to reduce the major risk factors.

### SPECIFIC OBJECTIVES OF THE STUDY

- Assess the prevalence and trends of suicide risk in GBV survivors.
- Assess and correlate the suicidal risk and prevention factors in GBV survivors.
- Compare suicidal risk factors between urban and rural populations

# METHODOLOGY

## 2.1 RESEARCH DESIGN

It is a cross sectional study design, where GBV survivors were interviewed using standard questionnaire in one to one basis. Interview took place one time maintaining COVDI 19 safety i.e. interviewer maintained at least two meters physical distance with participants, use of face mask and use of sanitization as necessary.

### DESCRIPTION OF RESEARCH DESIGN

Cross sectional study design used in the study to assess suicidal risk factors among GBV survivors in prospective GBV survivor cases in service centers such as hospital based One Stop Crisis Management Centre (OCMC), safe houses, women shell of Nepal Police etc. Participants were first asked for consent to participate in the interview and those who consented were interviewed by research assistants in privacy assured room. Study focused independent variables are age, gender, socio-economic condition, experience of violence, marital status, family relation, perceived support and dependent variables is the experience of gender based violence.

### SAMPLE POPULATION

Female GBV survivors of 15-60 years, further the age of participant is put in three groups such as 15-19, 20-24, 25-60 respectively.

Sample size/ number of participants and justification - A convenient sample of 300 GBV survivors were selected with representation of 60 participants from Sindhuli and same number in Udaypur and 180 participants were selected from service centers in Kathmandu valley (Bhaktapur, Lalitpur and Kathmandu) from July to September. All prospective cases visited in service centre were approached by research assistants and interviewed during July to September. Sample size of 300 can be considered adequate for descriptive (quantitative) analysis. The size is further decided by the flow of survivor data in service centres such as OCMC and women police shell and time factors available for the data collection (3 months). There were 15-25 cases visited for service in OCMC and women shell per month with average of 20 case per month. We have decided data collection duration of three months considering it to reach required number of participants for the research i.e. 60 from each district at least.

### STUDY SITES AND JUSTIFICATION

This study is conducted in Kathmandu, Bhaktapur, Lalitpur, Sindhuli and Udaypur district where there are more GBV case flow in OCMC of district hospitals of Sindhuli and Udaypur and safe houses. We want to compare suicidal risk and contributing factors between urban and rural population so that result will direct us to develop contextual advocacy materials and messages for the prevention of suicide in GBV survivors. GBV survivors were tracked from first service point which is OCMC, women shell of Nepal Police and then safe houses.

### INCLUSION CRITERIA

- GBV survivors of 15- 60 years old.
- Survivor who agreed and provide consent to participate in the study.

### EXCLUSION CRITERIA

- Survivors who are below 15 years and above 60 years of old.
- Survivor who does not want to give consent to participate in the study.
- Survivors suffering with severe mental illness (psychosis) or are in hospital for medical health conditions.

## 2.2 RESEARCH TOOL

Following tools are used to assess suicidal risk in GBV survivors:

- Semi-structured sociodemographic questionnaire for demographic and other risk factor related information.
- Patient Health Questionnaire (PHQ-9). Nepali adopted version has been used in this study.
- WHO-II DAS (WHO-II disability assessment scale). Nepali adopted version has been used in this study.
- Suicide screening questionnaire

## 2.3 DATA COLLECTION PROCESS

Ethical approval was sought from NHRC before starting field work. Research Assistants (RA) were recruited having academic qualification of Bachelor in public health science. Research assistant were provided training on methodology of the study such as sample selection process, study sites, data collection process including process of getting informed consent from participants. It also includes taking consent from minor GBV survivors (age 15-18). The safety of data and process of transferring filled questionnaire. They further learned on administration of research tools through practice pair. They were further trained in communication skills on how to build trust with GBV survivors who are participating in this research. Research coordinator supervised and monitored during field testing of research tools and main data collection process. Learning from field testing were incorporated in the tools before proceeding to main data collection process. Mainly consent presentation has to be restructured to some survivors who has difficulty to better understand Nepali language. Because of having local RAs the process of data collection became easier as she asked all research questions in the local language of survivor. It was experienced in Sindhuli and Udaypur than in Kathmandu valley. Suicide screening and questionnaire and PHQ 9 questionnaire were further simplified based on field testing findings. We have tested all questionnaires in small sample of 5 GBV survivors in Maternity Hospital, Kathmandu and five

in OCMC of Udaypur. Researcher has further discussed and trained to all RAs and coordinator about the finding of field test, informed about changes in sentences of some of the items of sociodemographic questionnaires, PHQ 9 and suicide screening questionnaire.

## 2.4 VALIDITY OF THE TOOL

A socio-demographic questionnaire adapted from the already practiced tool in Nepalese contexts such as WHO-DAS II and PHQ-9. WHO DAS II has been validated in the Nepalese context (10, 11) and used widely in various published and unpublished studies. PHQ-9 measures the severity of depression and suicide risk, so it has been used in the present study as well. It is shorter and simple to understand and administer. The suicide risk assessment questionnaire has been used globally in clinical settings, we have translated it into Nepali and tested it in the field before using it in the main research. As it has only four questions pertaining to suicide risk and severity, was found easier by both RAs and participant to the response. Further, it also provided measures to verify the suicide prevalence with PHQ 9.

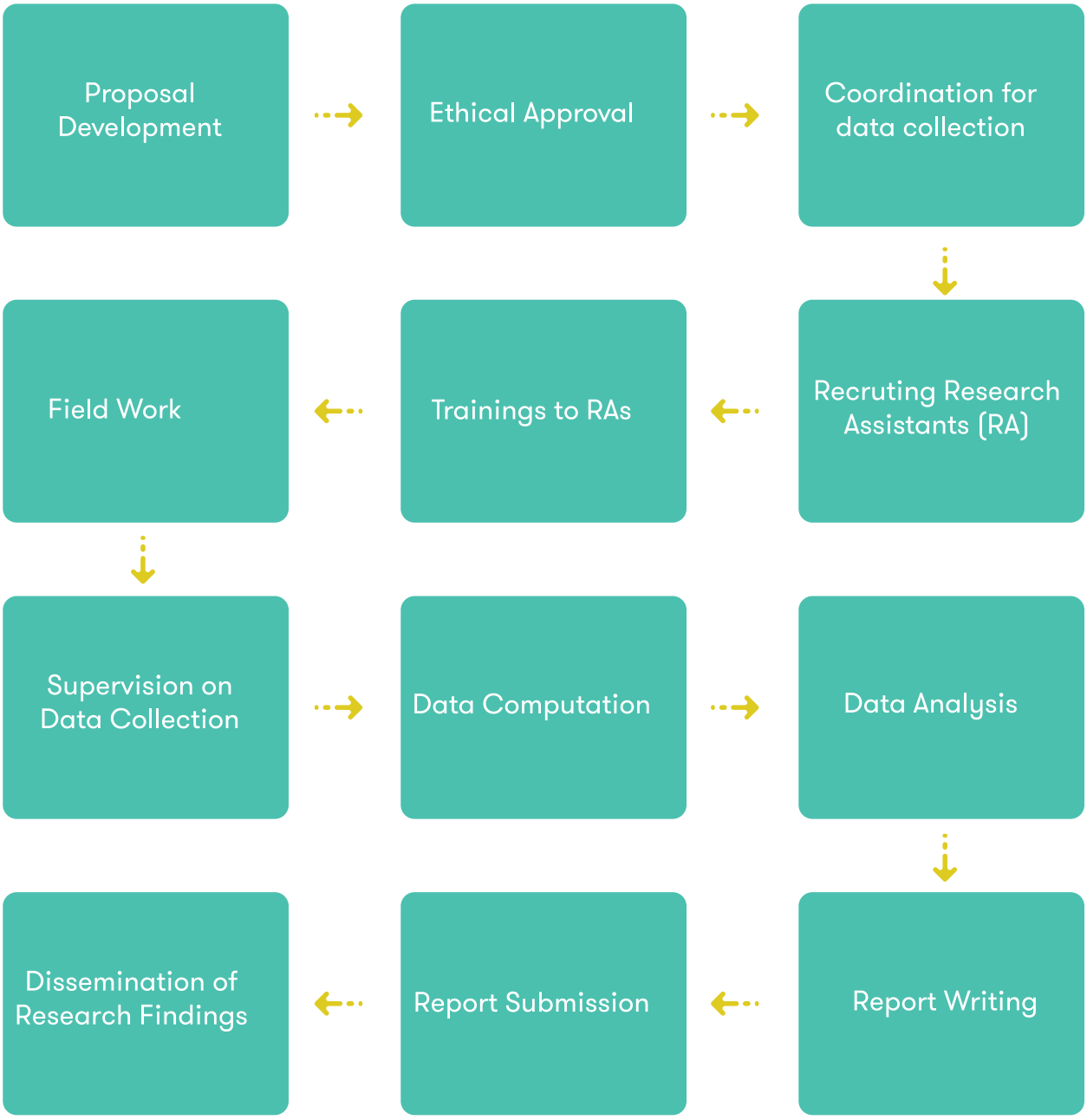
## 2.5 POTENTIAL BIAS

As GBV survivors experience social stigma and receive threats from perpetrators, they may not reveal true information if there is not adequate rapport with RAs. Thus, RAs were supervised frequently by the researcher, they were also trained in communication skills during the training. In some cases, RAs had to talk to participants more than one time especially when the survivor was in high emotional distress to make information less influenced by an overwhelmed emotional reaction. Recall bias from participants might affect GBV survivor response reliability. We expect the rapport of RAs' reduces such bias. In selected cases coordinator who is also a counselor, did an independent interview on the same questionnaire to retest such bias and found less effect of recalling bias. As RAs have spent some time, in the beginning, to establish rapport with each respondent, has played a role to make interview survivor friendly and reduce reluctant feeling.

## 2.6 ETHICAL CONSIDERATION

Since GBV survivors are more vulnerable to mental health problems, any survivor who expressed a high level of suicidal thoughts during the interview was referred to CMC-N mental health and psychosocial service centers for psychiatrist consultation and psychologist intervention. We have provided treatment and counseling to 107 research participants who display a high rate of depression and suicidal ideation. Ethical approval was sought from NHRC before starting fieldwork. Before an interview, the written consent was taken from all the research participants by RAs which was verified by the coordinator and researcher before entering into the computer. The interview was taken in a privacy assured room.

FIGURE 2.1: FLOWCHART OF RESEARCH WORK




## 2.7 LIMITATION OF THE STUDY

This study used prospective sample of three months attending service centers such as OCMC and police cell from five districts only. Further research is necessary from other districts population as well as to have better understanding on prevalence of depression and suicide risk in GBV survivors.

# DATA ANALYSIS AND PRESENTATION

## 3.1 DEMOGRAPHIC PROFILE OF THE STUDY POPULATION

There were altogether 300 participants in this study. All of them (100%) were female survivors as GBV is highly prevailed in women globally and even high in South East Asia including Nepal. The age distribution of the GBV survivors showed the highest prevalence of GBV (47%) in the age group of 19-30 years, followed by 39.3% in 31-50 years of age and 8.7% at 15-18 years age group. This showed females aged between 19-50 are more at risk for GBV while adolescent girls also increasingly experienced GBV. The mean age of the participants was 30 years. Married women (67.3%) are more prone to GBV. However, about one-fifth of the participants are unmarried (20.3%) who have also experienced GBV. Comparatively, there were fewer single, widow, and divorced women as GBV survivors. The mean age of the participant was about approximately 11 (10.8) years GBV survivors are found mostly in a nuclear family (73.3%). It shows women are safer when they live in a joint and extended family. The mean size of the family was about 5 members. Likewise, they had more than one child (1.55) on average.

### TABLE 3.1: DEMOGRAPHIC PROFILE

| Demographic Characteristics | Percent | n |
|---|---|---|
| **Age Group** | | |
| 15 – 18 years | 8.7 | 26 |
| 19 – 30 years | 47.0 | 141 |
| 31 – 50 years | 39.3 | 118 |
| 51 – 60 years | 5.0 | 15 |
| **Total** | **100.0** | **300** |
| **Mean Age** | **30 years** | |
| **Marital Status** | | |
| Married | 67.3 | 202 |
| Unmarried | 20.3 | 61 |
| Single | 8.0 | 24 |
| Widow | 2.0 | 6 |
| Divorced | 2.3 | 7 |
| **Total** | **100** | **300** |
| **Mean years of Marriage period** | **10.8 years** | |
| **Type of Family** | | |
| Nuclear Family | 73.3 | 220 |
| Joint Family | 24.3 | 73 |
| Extended Family | 2.3 | 7 |

| | | |
|---|---|---|
| **Total** | **100** | **300** |
| **Mean size of family members** | **4.74** | |
| **Mean number of children** | **1.55** | |

## 3.2 SOCIO-ECONOMIC CHARACTERISTICS

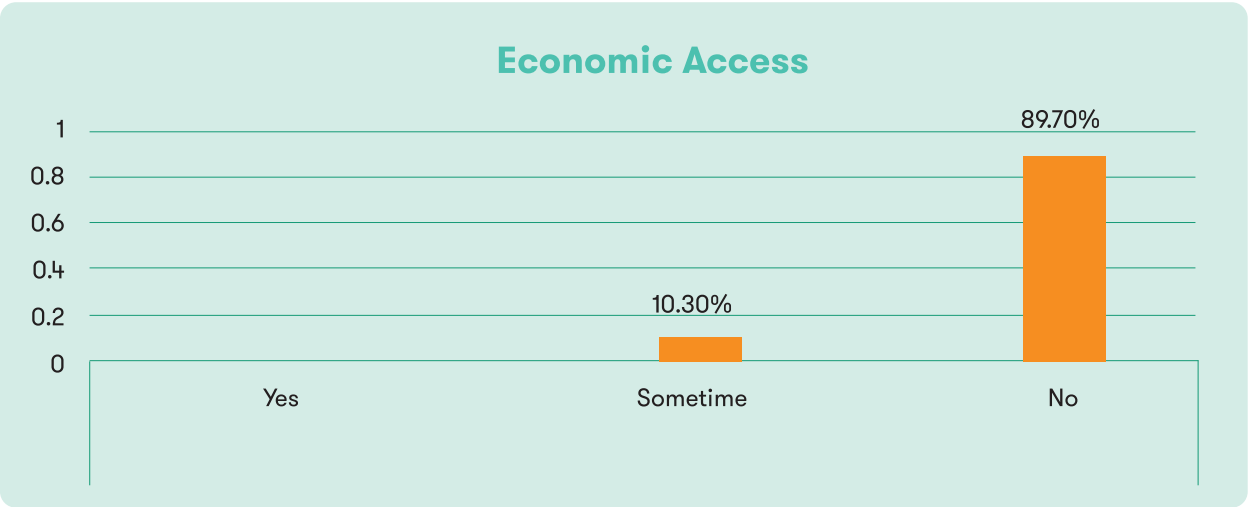
GBV highly prevailed in Janjati ethnic group followed by Chhetri/Thakuri, Dalit and Brahmin Similarly, GBV is found higher among the research participants who had a less low level of education i.e. who were unable to read and write (28.7%) and only primary level (38.3%). So lower the education level of the participant, more will be their increase in vulnerability towards GBV. Regarding religion, GBV is highly prevalent among Hindus (63.7%). Mostly the GBV survivors are unemployed (23.3%), farmers (22.7%), and house managers (18.3%). It indicates that if women are involved in economic activities, there are more chances of not experiencing GBV. More than seventy percent of women who have less than 5000 rupees monthly income have experienced violence in their lifetime. And the fact is that the average income of these GBV survivors is Rs. 5775. It showed that GBV survivors have a low-income source which is a risk factor to be dependent on perpetrators and maintain the cycle of violence in the family. This further increases the risk in the mental health condition of the survivors. It has been further supported by the chart below where nearly 90% of survivors reported they have no access to economic sources while only 10% mentioned they have such access only sometimes.

### TABLE 3.2: SOCIO-ECONOMIC CHARACTERISTICS

| Demographic Characteristics | Percent | n |
|---|---|---|
| **Caste/Ethnicity** | | |
| Brahmin | 10.0 | 30 |
| Chettri/Thakuri | 21.3 | 64 |
| Janjati | 54.0 | 162 |
| Dalit | 13.0 | 39 |
| **Others** | **1.6** | **5** |
| **Total** | **100** | **300** |
| **Education Level** | | |
| Not able to read and write | 28.7 | 86 |
| Primary level (1 – 8 grade) | 38.3 | 115 |
| Secondary education (9-12 grade) | 19.0 | 57 |
| Bachelor degree | 4.0 | 12 |
| **Total** | **100** | **300** |
| **Religion** | | |

| | | |
|---|---|---|
| Hinduism | 63.7 | 191 |
| Buddhism | 23.0 | 69 |
| Christianity | 13.0 | 39 |
| Others | 0.3 | 1 |
| **Total** | **100.0** | **300** |
| **Occupation** | | |
| Farmer | 22.7 | 68 |
| Self-Employed | 9.7 | 29 |
| Job/Service | 13.3 | 40 |
| Labor/Daily wage | 12.7 | 38 |
| House Manager | 18.3 | 55 |
| Fully Unemployed | 23.3 | 70 |
| **Total** | **100.0** | **300** |
| **Monthly Income (NRs.)** | | |
| 1000 – 5000 | 70.3 | 211 |
| 5000 – 10000 | 25.3 | 76 |
| 10000- 15000 | 2.0 | 6 |
| 15000 – 20000 | 1.0 | 3 |
| Above 20000 | 1.4 | 4 |
| **Total** | **100.0** | **300** |
| **Average Monthly income** | **5775** | |

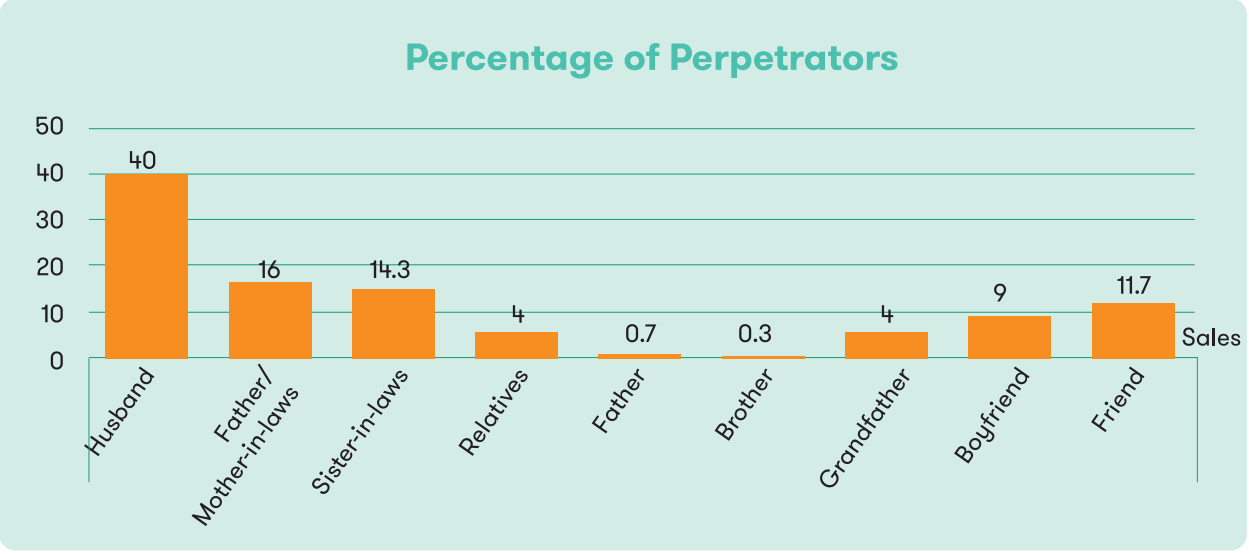
## FIGURE 3.1: ECONOMIC ACCESS



## 3.3 TYPES, ACTOR AND, CAUSES OF GBV

Gender-based violence in society is carried out by the people inside and outside the house. The study found out that the most common perpetrator is the husband (40%) in the family, then the in-laws, friends, and their boyfriend. Comparatively, there were fewer GBV survivors whose father and brother were involved in such violence at home. It shows more than 75% of survivors experienced violence from their family members, thus the family is not as secured as it should be for the survivors (women and girls).

### FIGURE 3.2: VIOLENCE ACTOR




GBV survivors have experienced various types of violence from their partner. GBV survivors mostly experienced emotional or mental violence (78.7%) followed by physical violence (44.7%), neglect (37%), sexual abuse (21%), social blame (9.7%) and rape (9.3%) respectively. Similarly, 65% survivors experienced more than one type of violence which is really damaging to mental, physical and social health of the survivor. Likewise the result showed that family, economic, relationship, social and alcohol abuse were reported frequently by the GBV survivors as the causes of the violence. Since the most of the perpetrators were family members, the family causes was reported by as the major cause by the majority of the survivors (70.3%) in this study. Similarly, more than 62% survivor reported they experienced violence because of more than one causes.

### TABLE 3.3: TYPES AND CAUSES OF VIOLENCE EXPERIENCED

| Type of violence | Yes | No | Total Per-cent | No. of violence types experi-enced | Total Percent |
|---|---|---|---|---|---|
| Physical violence | 44.7 | 55.3 | 100 | 1 | 35 |
| Emotional / mental violence | 78.7 | 21.3 | 100 | 2 | 39 |

| | | | | | |
|---|---|---|---|---|---|
| Sexual abuse | 21 | 79 | 100 | 3 | 18.7 |
| Rape | 9.3 | 90.7 | 100 | 4 | 6 |
| Neglect | 37 | 63 | 100 | 5 | 1.3 |
| Social blame | 9.7 | 90.3 | 100 | Total | 100% |
| **Causes of GBV** | | | | **No of Causes** | |
| Economic | 47.7 | 52.3 | 100 | 1 | 37.8 |
| Family | 70.3 | 29.7 | 100 | 2 | 33.1 |
| Social | 27 | 73 | 100 | 3 | 21.1 |
| Relationship | 43 | 57 | 100 | 4 | 6.4 |
| Job/Work | 8.0 | 92.9 | 100 | 5 | 1.7 |
| Alcohol Abuse | 32.0 | 68 | 100 | Total | 100% |

## 3.4 SUPPORT AND COPING STYLES OF GBV SURVIVORS

Receiving support is very important for GBV survivors to cope with the problems caused by GBV. The study found that the perpetrators of GBV are mostly found in the family itself. In such case, the GBV survivors can seek support from their neighbors. If they have good relationships with their neighbors, they will get support to fight against the violence. Half of the research participants said that they neither had a good nor bad relationship with them. However, they had better support from their neighbors (27%) than their family. The family members of the GBV survivors (15%) had gone for foreign employment and only 12% used to send remittance to them. However, it was received by the other members of their family so they had no access to it. Again the GBV survivors were not able to access it. Having good relations with neighbors and accessing economic resources is one of the copying styles of GBV survivors. While assessing the GBV survivors, the study found that they had various coping styles. Most of them blamed themselves for whatever happened. They also seek help from their other family members and neighbors. They tried to cope by listening to the music and crying too. Very few of them fought with the perpetrators, got counselor's help, and reported to the government authorities at the local level.

### TABLE 3.4: COPYING STYLES OF GBV SURVIVORS

| Coping style of GBV survivors | Percent Distribution |
|---|---|
| Self-blaming | 96 |
| Get the help of family/ relatives | 71.7 |
| Get the help of a neighbor | 35.3 |
| Get the help of a friend | 20.3 |
| Hoping situation to improve | 24.0 |
| Pray to god | 32.3 |

| | |
|---|---|
| Crying | 60.0 |
| Listening music | 72.0 |
| Staying alone | 26.3 |
| Fight with perpetrator | 44.3 |
| Report to municipality | 18.7 |
| Get the help of a counselor | 19.3 |

Note: It is a multiple response question

## 3.5 DEPRESSION IN GBV SURVIVORS

Depression and its severity were assessed using PHQ-9 in GBV survivors. The study showed that 88.7% of GBV survivors experienced depression with mild to a severe level, among them 44.3% were having depression symptoms to moderate degrees and 16.7% were having severe form depression. Both categories needed immediate attention from mental health professionals for both psychiatric treatment and psychosocial counseling service. Counseling support is equally valuable to survivors experiencing a mild level of depression (27.7%) as it helps quick recovery and prevents them from getting a severe form of depression. GBV resulted in high depression symptoms in the survivors and has affected 42.7% of survivors. GBV survivors' experience most of the symptoms.

### FIGURE 3.3: DEPRESSION LEVEL IN GBV SURVIVORS

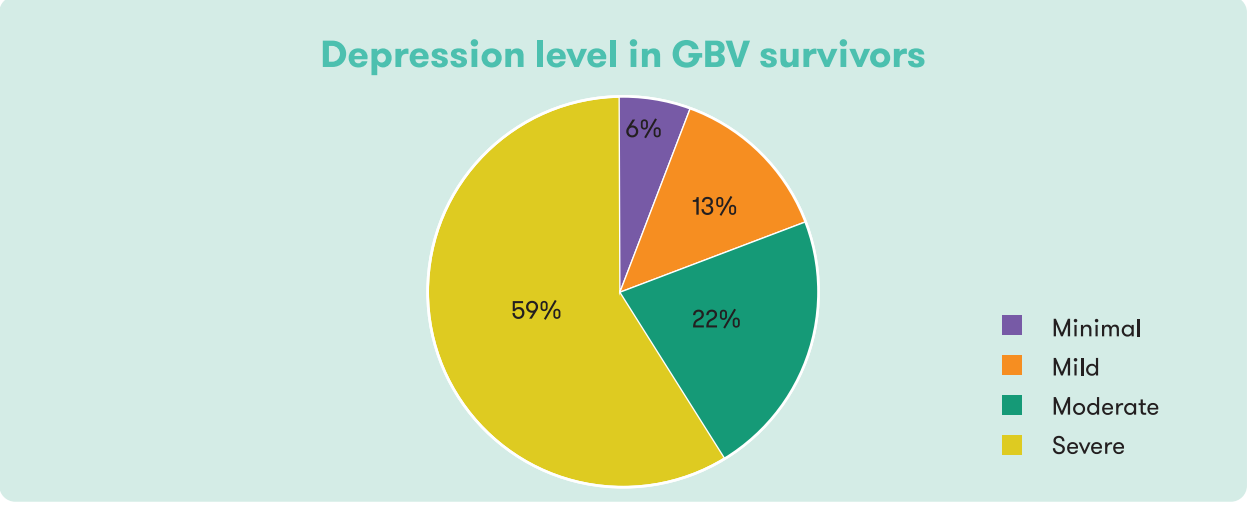


TABLE 3.5: DEPRESSION SCALE ITEM WISE ANALYSIS IN PHQ 9

| PHQ items | Not at all | Seldom | Often | Always | Total Percent |
|---|---|---|---|---|---|
| Feeling happy/joy | 11.70 | 45.0 | 34.7 | 8.7 | 100.0 |
| Feeling sad/helpless | 11.7 | 44.3 | 32.7 | 11.3 | 100.0 |
| Problem in sleep | 19.0 | 43.7 | 29.3 | 8.0 | 100.0 |
| Feeling tiredness | 24.3 | 38.3 | 28.7 | 8.7 | 100.0 |
| Disturbed appetite | 28.0 | 41.0 | 25.7 | 5.3 | 100.0 |
| Self-blaming of being failure | 21.0 | 41.7 | 23.7 | 13.7 | 100.0 |
| Difficulty in concentration | 22.3 | 42.3 | 26.7 | 8.7 | 100.0 |
| Slowness in walking and talking | 33.0 | 33.7 | 22.0 | 11.3 | 100.0 |
| Suicidal feelings | 46.3 | 24.7 | 21.7 | 7.3 | 100.0 |
| Affect the functioning in daily life | 12.3 | 45.0 | 34.7 | 8.0 | 100.0 |

## 3.6 SUICIDAL THOUGHTS IN GBV SURVIVORS

The prevalence of suicidal ideations among the GBV survivors were at the range of 53-58% (item 1, 2 and 3) while suicide attempt in last one week was reported by 34.7% and idea of self-killing occurs all the time was reported by 7.3% which is high for the suicidal attempt at any point of time. It has indicated that high level of suicidal risk prevails in GBV survivors. It also indicates that there is increasing suicidal risk among GBV survivors due to their experience of violence. Thus, adequate mental health support is very much necessary to save the life of the survivors.

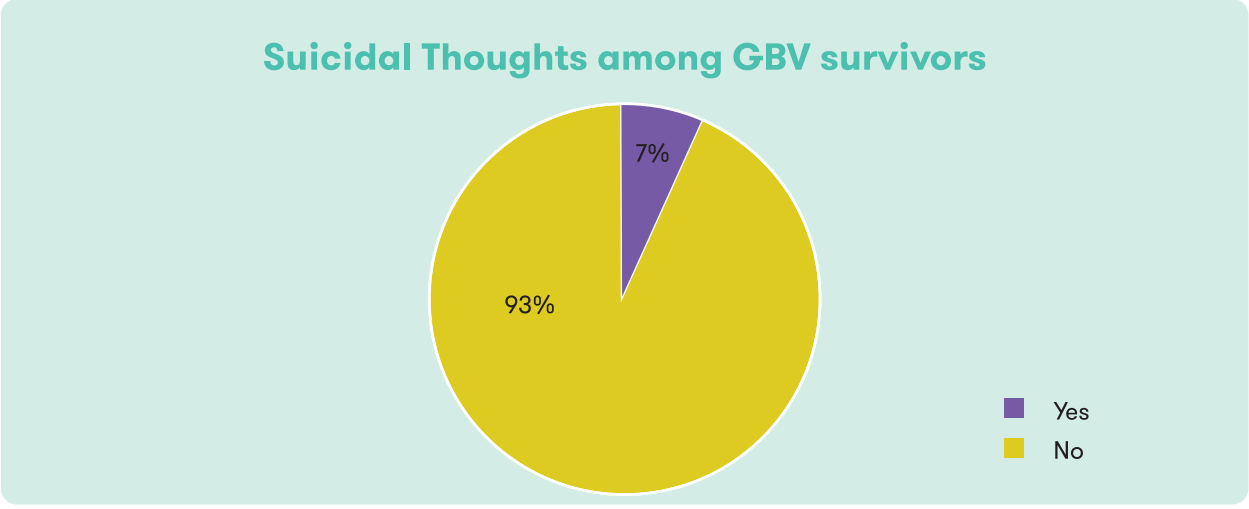
TABLE 3.6: SUICIDE SCREENING ITEM WISE ANALYSIS

| Suicide screening checklist items | Yes | No | Total |
|---|---|---|---|
| Last week did you feel would be better to die. | 58.30% | 41.70% | 100% |
| Last week did you have idea it would be good to family if you die | 56.3% | 43.7% | 100% |
| Last week did you think you will kill yourself | 53.3% | 46.7% | 100% |
| Last week did you ever try to commit suicide | 34.7% | 65.3% | 100% |
| Do you have self-killing thoughts right now? | 7.3% | 92.7% | 100.% |

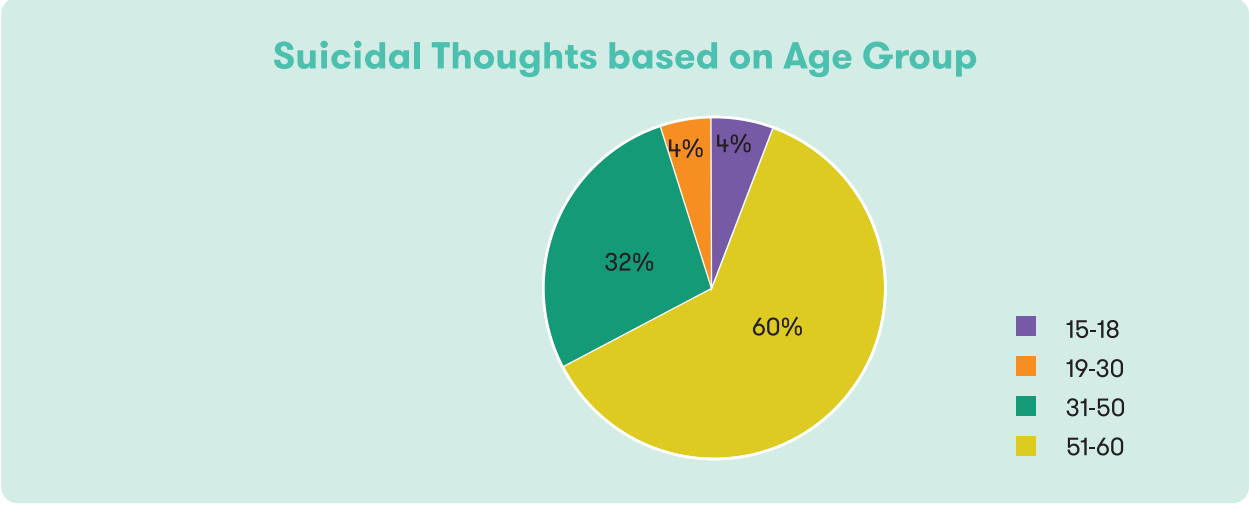
Among the GBV survivors in the study during interview, 22 of them (7.3%) reported that they had the thoughts of committing suicide at that particular time (Figure 3.5). This study showed suicide risk according to age category It revealed suicide has highly prevailed in the age group

of 19-30 (4.3%) then at 31-50 years (2.3%) than other age categories (Figure 3.6). Both age group belongs to highly productive age and loss of life impacts not only death person but entire family members and society as well. Thus, mental health and psychosocial counseling service should be made accessible to women and girls to prevent increasing suicidal incidents. Depression and suicidal risk study tool consistently showing GBV is a high-risk factor for suicide in young women.

## FIGURE 3.4: SUICIDAL THOUGHTS AMONG GBV SURVIVORS



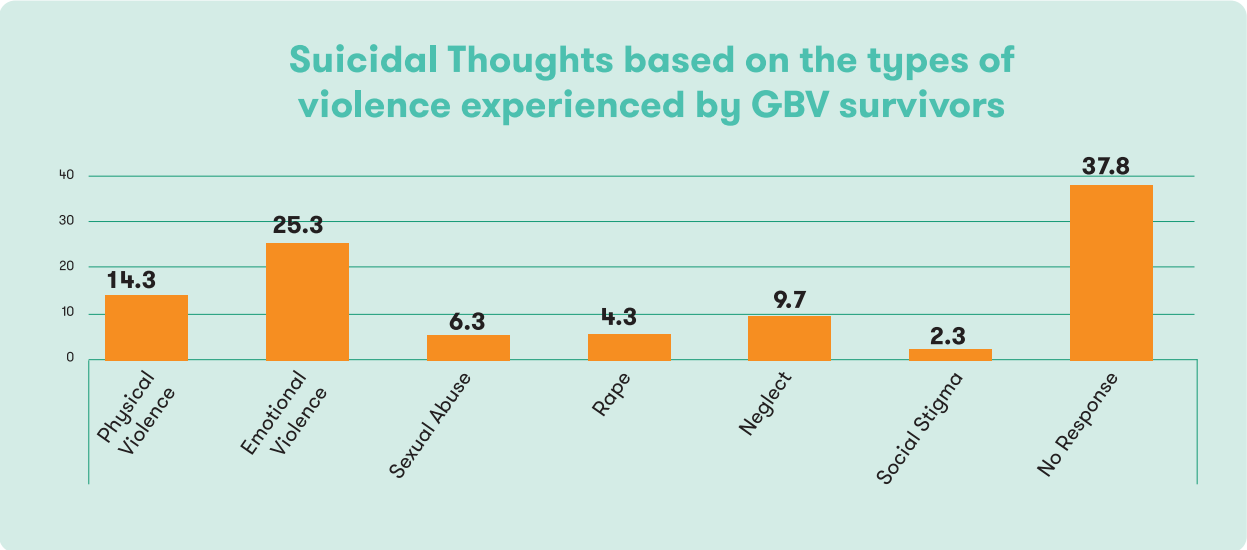

## FIGURE 3.5: SUICIDAL THOUGHTS BASED ON AGE GROUP




The GBV survivors have faced different types of violence. Their suicidal thoughts are also contingent on the types of violence they go experience. The study found that those who experience emotional violence from the perpetrator have a high prevalence of suicidal thoughts (25.3%) followed by physical violence (14.3). However other violence types too have an impact on their suicidal thoughts even though it is in less number. Because of less number of survivors in sexual abuse (n=63) and rape (n=28), it is hard to predict that sexual and rape survivors have

less suicidal risk. It needs to be explored in a larger population of GBV survivors. More than one-third of the participants didn't respond to this question.

FIGURE 3.6: SUICIDAL THOUGHTS BASED ON VIOLENCE TYPES




## 3.7 SUICIDAL ATTEMPTS

Whenever we are depressed due to the experience of violence, many victims might think of committing suicide. And some of the GBV survivors (32%, n=96) actually attempted to commit suicide. The GBV survivors of the study too had attempted suicide in their lifetime. About 30 percent had attempted suicide once, 2 percent twice and 0.3% multiple times.

TABLE 3.7: SUICIDAL ATTEMPT

| Suicide Attempt | Percent | n |
|---|---|---|
| Single | 29.6 | 89 |
| Twice | 2.0 | 6 |
| Multiple | 0.3 | 1 |
| No attempt | 68.1 | 204 |
| Total | 100 | 300 |

## 3.8 MEANS OF SUICIDE

96 (32%) research participants who reported that they had attempted suicide were further asked about various means for suicide they had applied. Table 3.8 presents the actual (n=96) and cumulative figures (n=300). The table showed that most of the attempters used the hanging method (44.8%) for suicide followed by ingesting poison (31.3%). It indicates the picture that the attempters are using the easily available tool (rope and pesticide. The two were the usual method applied by the suicide attempters in Nepal. However, the attempters also tried other means of attempting suicide. When the GBV victims attempt suicide, they may not succeed. Instead, the survivors may face serious long term health problems (both physical and mental).

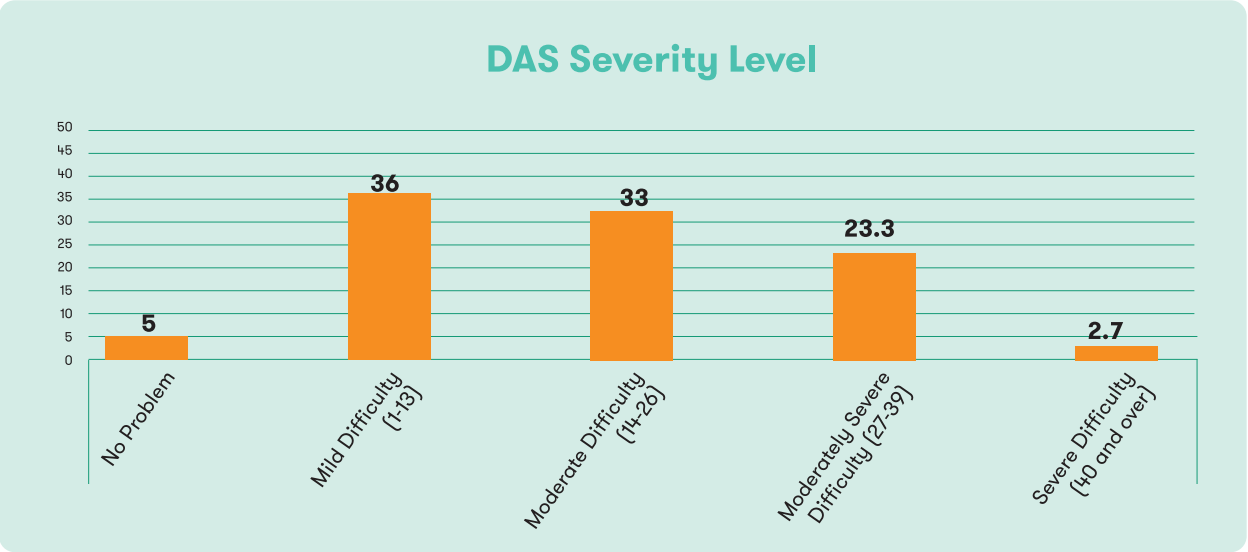
### TABLE 3.8: MEANS OF SUICIDE

| Means of Suicide | Percent | n=96 | Percent | n=300 |
|---|---|---|---|---|
| Hanging | 44.8 | 43 | 14.3 | 43 |
| Ingesting poison | 31.3 | 30 | 10.0 | 30 |
| Wrist cutting | 10.4 | 10 | 3.3 | 10 |
| Banging Head | 3.1 | 3 | 1.0 | 3 |
| Jumping from a height | 3.1 | 3 | 1.0 | 3 |
| Jumping into the river | 3.1 | 3 | 1.0 | 3 |
| Medicine Overdose | 2.1 | 2 | 0.7 | 2 |
| Putting fire on the body | 1.0 | 1 | 0.3 | 1 |
| Lying on the highway road | 1.0 | 1 | 0.3 | 1 |
| **Total** | 100.% | 96 | --- | --- |
| No response | | | 68.0 | 204 |
| **Total** | | | **100%** | **300** |

## 3.9 IMPACT OF GBV IN DAILY LIFE OF SURVIVORS

Table 3.8 below showed the impact of violence on survivors and ranged from mild to severe. Disability because of mental health distress due to GBV is assessed using WHO-Disability Assessment Scale-II in this study. This tool has been validated and used in the Nepalese context in other studies already. The last two categories implied increasing difficulty in the life of GBV survivors that accounts for 26% of survivors' experienced severe difficulty due to psychological distresses.

## FIGURE 3.7: DAS SEVERITY LEVEL




## TABLE 3.9: CORRELATION OF DEPRESSION AND DEMOGRAPHIC VARIABLES

| Variables | | Depression category | Suicidal Thoughts | DAS category |
|---|---|---|---|---|
| Easy access to the economic source | Pearson Correlation | .009 | -.115 | .087 |
| | Sig. (2-tailed) | .874 | .047 | .135 |
| Relation with family | Pearson Correlation | -.012 | .049 | .051 |
| | Sig. (2-tailed) | .842 | .399 | .379 |
| Relation with neighbor | Pearson Correlation | -.127 | .126 | -.113 |
| | Sig. (2-tailed) | .028 | .030 | .050 |
| Violence Experienced | Pearson Correlation | .112 | -.028 | .089 |
| | Sig. (2-tailed) | .053 | .626 | .124 |
| Sexual abuse | Pearson Correlation | .054 | -.043 | .096 |
| | Sig. (2-tailed) | .352 | .455 | .098 |
| Rape | Pearson Correlation | -.055 | .090 | -.039 |
| | Sig. (2-tailed) | .338 | .119 | .505 |
| Emotional / Mental violence | Pearson Correlation | .108 | .010 | .139 |
| | Sig. (2-tailed) | .061 | .869 | .016 |
| Age category | Pearson Correlation | .169 | .017 | .240 |
| | Sig. (2-tailed) | .003 | .771 | .000 |
| Education | Pearson Correlation | -.075 | .062 | -.042 |
| | Sig. (2-tailed) | .194 | .283 | .467 |

| | | | | |
|---|---|---|---|---|
| Marital status | Pearson Correlation | .082 | -.022 | .110 |
| | Sig. (2-tailed) | .154 | .706 | .057 |
| Duration of marriage | Pearson Correlation | .180 | -.034 | .207 |
| | Sig. (2-tailed) | .002 | .555 | .000 |
| Type of marriage | Pearson Correlation | .034 | .081 | -.082 |
| | Sig. (2-tailed) | .554 | .160 | .155 |
| Type of family | Pearson Correlation | .128 | -.092 | .242 |
| | Sig. (2-tailed) | .026 | .111 | .000 |
| Size of a family | Pearson Correlation | .177 | -.126 | .246 |
| | Sig. (2-tailed) | .002 | .029 | .000 |
| Occupation | Pearson Correlation | -.144 | .042 | -.191 |
| | Sig. (2-tailed) | .013 | .471 | .001 |
| Income category | Pearson Correlation | .025 | -.148 | .101 |
| | Sig. (2-tailed) | .670 | .010 | .081 |
| Family member migrated | Pearson Correlation | -.021 | .013 | .029 |
| | Sig. (2-tailed) | .712 | .819 | .611 |
| Number of perpetrators | Pearson Correlation | .085 | -.007 | .165 |
| | Sig. (2-tailed) | .270 | .932 | .032 |
| Physical violence | Pearson Correlation | .071 | -.004 | .030 |
| | Sig. (2-tailed) | .217 | .939 | .600 |
| Neglect | Pearson Correlation | -.020 | .004 | -.065 |
| | Sig. (2-tailed) | .735 | .949 | .263 |
| Social blame | Pearson Correlation | .052 | .049 | -.024 |
| | Sig. (2-tailed) | .374 | .400 | .681 |
| Number of violent | Pearson Correlation | .090 | .040 | .052 |
| | experiences | .120 | .495 | .368 |

Table 3.9 above estimates the correlation of depression, suicide risk, and Disability category with demographic variables of GBV survivors. Results showed relationships with neighbors and the size of family members are significantly correlated with depression, suicidal thoughts, and disability feelings. Emotional violence is significantly correlated with psychosocial disability. Age category, duration of the marriage, family type, occupation are significantly correlated with depression and psychosocial disability Income category is significantly correlated with suicidal thought. Other variables are not correlated significantly.

## 3.10 RURAL-URBAN COMPARISON

As per the third objective of the study to compare the suicidal risk factors between rural and urban populations, the study showed that there is a difference. The suicidal risk is high among the research participants from rural districts (Sindhuli and Udaypur). The cumulative percentage of the research participants who seldom, often, and always had the thought of suicide was high in Sindhuli (15.4%) and Udaypur (13.0%). Comparatively the urban area from three districts (Bhaktapur-4.0%, Kathmandu-9.0%, and Lalitpur – 12.7% had suicidal feelings. District-wise distribution of suicide feelings analysis revealed GBV survivors from Bhaktapur has the lowest rate of suicide feelings while highest in Sindhuli (15.4%) and Udaypur has the second-highest prevalence of suicidal ideation (13%).

### TABLE 3.10: DISTRICT WISE SUICIDE IDEATION AMONG GBV SURVIVORS

| Districts | Suicidal feelings | | | | Total |
|---|---|---|---|---|---|
| | Not at all | Seldom | Often | Always | |
| **Urban** | | | | | |
| Bhaktapur | 15.7% | 3.3% | 1.0% | 0.0% | 20.0% |
| Kathmandu | 11.0% | 3.0% | 4.3% | 1.7% | 20.0% |
| Lalitpur | 8.0% | 4.0% | 4.3% | 3.7% | 20.0% |
| **Rural** | | | | | |
| Sindhuli | 4.7% | 5.7% | 8.0% | 1.7% | 20.0% |
| Udaypur | 7.0% | 8.7% | 4.0% | 0.3% | 20.0% |
| **Total** | **46.3%** | **24.7%** | **21.7%** | **7.3%** | **100.0%** |

Depression is one of the major causes of suicidal thoughts. Like the suicidal ideation (Table 3.10), the depression level is observed higher in the rural districts than in urban districts. The moderate depression level is highest in Udhaypur (13.7%) and second highest in Sindhuli (13.3%), both representing the rural area. The depression level of the participants in these two districts starts from mild depression to severe depression. Therefore it shows the depression is more prevalent in rural areas. The prevalence of depression is lowest in Bhaktapur with moderate (5.0%) and severe (0.3%).

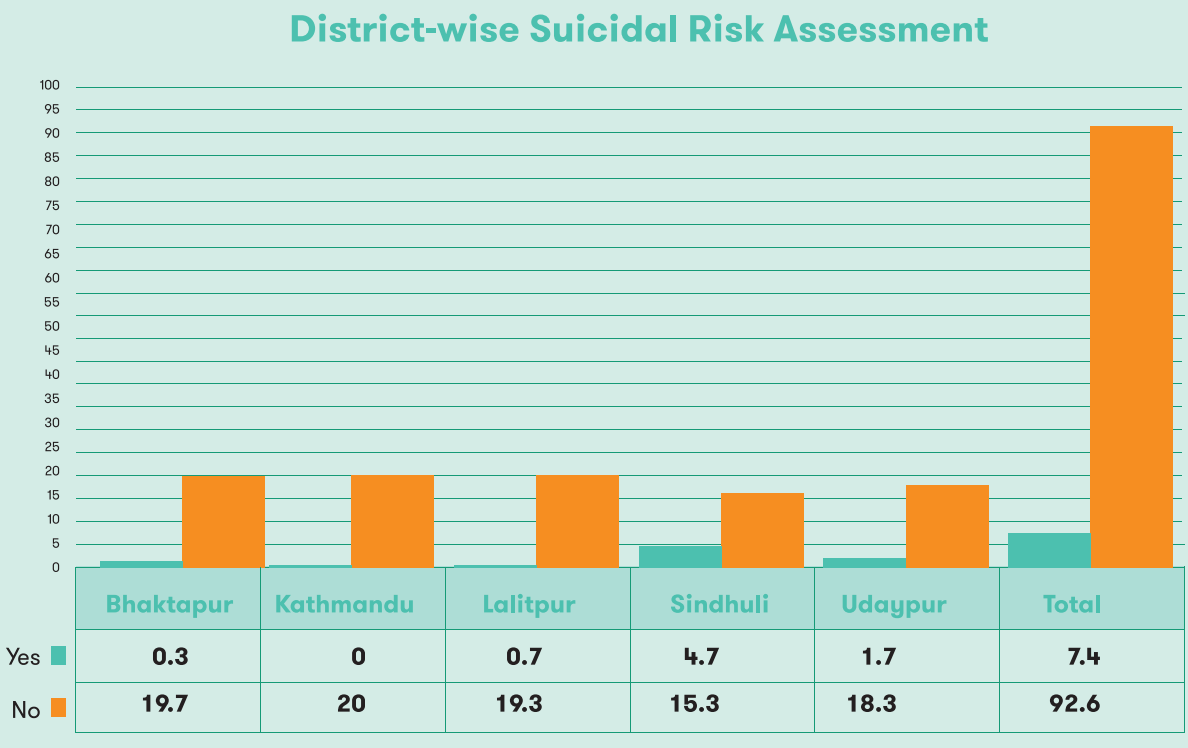
### TABLE 3.11: DISTRICT WISE DEPRESSION AMONG GBV SURVIVORS

| Districts | Depression category | | | | Total |
|---|---|---|---|---|---|
| | Minimal depression (1-4) | Mild depression (5-9) | Moderate depression (10-19) | Severe depression (20-27) | |
| **Urban** | | | | | |
| Bhaktapur | 4.7% | 10.0% | 5.0% | .3% | 20.0% |
| Kathmandu | 4.7% | 6.0% | 5.0% | 4.3% | 20.0% |

| | | | | | |
|---|---|---|---|---|---|
| Lalitpur | 2.3% | 5.0% | 7.3% | 5.3% | 20.0% |
| **Rural** | | | | | |
| Sindhuli | 0.0% | 1.7% | 13.3% | 5.0% | 20.0% |
| Udaypur | 0.0% | 5.0% | 13.7% | 1.3% | 20.0% |
| **Total** | **11.7%** | **27.7%** | **44.3%** | **16.3%** | **100.0%** |

The severe suicidal risk was further assessed in the suicide screening questionnaire and result showed the higher suicidal risk in Sidhuli (4.7%) followed by Udaypur (1.7%). The three urban districts had comparatively less suicidal risk (Bhaktapur-0.3%, Kathmandu-0.0% and Lalitpur-0.7%).

## FIGURE 3.8: DISTRICT WISE SUICIDAL RISK ASSESSMENT




| | Bhaktapur | Kathmandu | Lalitpur | Sindhuli | Udaypur | Total |
|---|---|---|---|---|---|---|
| Yes | 0.3 | 0 | 0.7 | 4.7 | 1.7 | 7.4 |
| No | 19.7 | 20 | 19.3 | 15.3 | 18.3 | 92.6 |

# FINDINGS, DISCUSSION, CONCLUSION AND RECOMMENDATION

## 4.1 RESEARCH FINDINGS

- GBV survivors were experiencing depression to 88.7% (mild to severe level) with 16.7% suffering from severe depression. Similarly, suicide risk was also found very high in GBV survivors as 56.3% showing moderate to severe suicidal risk while 7.3% displaying the severe level.
- This research result showed GBV is increasingly prevailed in Janjati ethnicity (both hill and terai accounts 54%), followed by Chhetri, Dalit and Brahmin. Alcohol found significant contributing factors for violence.
- GBV is common in 19-30 and 31-50 age categories than other age groups. Thus, prevention and response interventions should consider it when planning.
- GBV phenomena is common in a nuclear family, young age group (19-30), low level of income (less than 5000), low level of education, the experience of multiple types of violence and, multiple causes.
- Depression is increasingly common in GBV survivors (88.7%) and it is contributed by age, sex, family environment, type of family, married, social discrimination (caste, sex, economic status), income status, low level of education, the experience of violence from multiple perpetrators and experience multiple violence in Nepalese context.
- Prevalence of suicidal thought is also very high in GBV survivors (56.3%) with a severe level of suicidal risk to 7.3%.
- Depression and suicidal feelings were observed higher in Sidhuli and Udaypur districts than in three districts of Kathmandu. Thus, women and girls from rural areas are more at risk for GBV and mental health consequences such as depression and suicide.

## 4.2 DISCUSSION

Suicide risk in GBV survivors has been claimed higher in the literature because violence disrupts healthy ways of coping that lead to mental health problems such as depression and suicide. We have conducted a study on the suicidal risk factor in GBV survivors from age 15-60 years as there was not much research focusing on the survivors in the context of Nepal. So the present study is the first of its kind in revealing the psychological status and leading risk factors to suicide. Socio-demographic factors were found to play a significant role to moderate the mental health conditions of the survivors. Results of this study showed the high rate of GBV in Janjati ethnic groups as their representation is 54%. Janjati includes both hill and terai ethnicity in this study. One of the reasons for high prevalence of GBV in Janjati can be because of use of alcohol as it has been easily available and used for religious purposes and in most of social activities. Alcohol as a cause of violence has been reported by 32% of participants which also supports the above explanation.

GBV is more common among women of lower education level, low income (income less than Rs

5,000 per month, low access to economic resources, among married women, nuclear family, occupation wise unemployed status, house managers and farmers. Similarly, it increases suicide risk accordingly. Results showed more than 62% of survivors reported they experienced violence because of more than one causes. It causes a direct impact on the mental health status of survivors hence increases the risk of suicide. This study showed self commonly used coping mechanism by GBV survivors, result showed self-blaming is highly prevalent in GBV survivors (96%), which is likely to increase vulnerability to depression and suicide as well. Prevalence of depression is very high among GBV survivors (88.7%), out of which 16.7% were suffering with a severe form of depression that warrants the immediate need of treatment support both mental health and psychological counseling. Similarly, the prevalence of suicide was found 56.3% with severe suicidal risk in 7.3%. Results showed a very high level of suicidal risk among GBV survivors particularly severe suicidal risk population needs urgent mental health treatment including psychological intervention. The suicidal risk was observed very high in the young age group 19-30 years and then 31-50 years old. Thus, it further indicates prevention and curative measures to build in primary healthcare facilities and community for needful support to affected person. Similarly, another 22% of survivors were experiencing suicidal thoughts often and it may be likely to increase suicidal risk at any time to the person. Similarly, emotional and physical violence resulted from a higher prevalence of suicidal thoughts in GBV survivors. This result also warns us why mental health and psychological intervention is necessary to build in our health care system to have easy access to GBV survivors and others. There is a huge gap of services to address mental health distress including suicidal feelings. Most of the survivors are even lacking access to support resources. In the study, 90% of the survivors reported that they have no access to support. This will further increase their risk to suicide. Thus, poor economic condition contributed experience of GBV as reported in this study. Economic entrepreneur and skill empowerment to GBV survivors should give priority while rehabilitating the GBV survivors. The present study strongly revealed less chance of experience of GBV by women having good access to economic sources, as most of the survivors were earning a very less amount of money which is not even sufficient for their daily living. It further increased dependency on males, and become subservient to the males in the family.

The support system also includes family, social support, support in livelihood, support in easy treatment, protection support, and prevention of violence. In many cases, survivors feel very much debilitating when she is unable to find any source of support that perpetuates mental health distresses. It can worsen the situation of survivors having suicidal thoughts. In our study, means of suicide commonly reported were hanging (14.6%) followed by the use of pesticides (11.3%). It is determined based on easy access of means as rope and pesticides are available everywhere in Nepal. This finding needs to consider for the prevention of suicide as such means need to be restricted from easy access. Psychosocial disability (WHO DAS) was experienced by 33 percent at a moderate level, 23.3 percent moderately severe and, severe to 2.7 percent. It indicates increasing disability feelings among the GBV survivors. Correlation results showed easy access to the economic source, relation with a neighbor, emotional violence experience, age category (19-30 and 31-50), marriage duration, family type, occupation and income source were significantly correlated with depression and disability feelings. It needs to be well considered while we are planning prevention activities for focused intervention. Particularly, need to consider the active involvement of young age married women from a nuclear family, unemployment, house manager and farmer in occupation and low-income source women in both prevention and interventions to GBV survivors. Depression and suicidal ideation when compared across districts, high level of depression and suicide observed in Sindhuli (20% depression and 15.4% suicidal feelings) and Udaypur (20 depression and 13% suicidal feelings.

It showed depression and suicidal thoughts are have highly prevailed in a rural area than urban. More prevention and psychosocial intervention program need to design and implement in rural areas. The mental health and psychosocial services in the primary health care system are highly necessary for timely addressing the depression and suicidal risk.

## 4.3 CONCLUSION

The study findings showed increasing suicidal risk in GBV survivors as in studies in other countries. Both depression and suicidal thoughts were observed very high in GBV survivors of 15-60 years old. The prevalence of depression and suicidal thoughts observed higher in young age and middle age. This finding supports that GBV occurs age group 19-45 years globally and most common in low-income countries like Nepal. The result of this study indicates the high need for mental health and psychosocial support services for GBV survivors. Thus, it is emphasized for the placement of mental health and psychosocial support service in the existing health care system. Similarly, activities targeting the economic empowerment of women is also an important part of the social intervention for the prevention of both GBV and associated mental health conditions. Multi-stake holder coordination is essential to address the complex needs of the survivors. Future research is necessary for larger samples representing more districts for a clear estimation of depression and suicide risk and service gap.

## 4.4 RECOMMENDATION

- As GBV survivors are experiencing a very high level of depression and suicidal thoughts, there is a huge gap in mental health and psychosocial support services to tackle this situation. It is imperative to develop mental health and psychosocial support services for GBV survivors and need to create a supportive environment for the rehabilitation and reintegration of survivors into their own families and community. Both response and prevention mechanisms need to be placed to address it.
- Since the prevalence of GBV is high among low economic access and have low income, activities to improve access in economic resources to GBV survivors are necessary to build in all GBV response and prevention programs. As economic empowerment and better access to earning sources improve women's health and mental health conditions as well. We strongly recommend building entrepreneur activities for better income source in GBV survivors.
- GBV is observed very high in certain ethnic groups such as Janjati, Dalit and, high caste Chhetri and Brahmin. There is the use of alcohol also reported high by the perpetrator which acts as a precursor to induce violence act to the perpetrator. Prevention strategy needs to focus on reducing the easy availability of alcohol and other stimulant substances as well.
- Service provider and duty bearers' responsibility should be interrogated with legal provisions and active implementation of laws to reduce violence acts and also for the prevention of such act. Training on GBV issues, its' impact on survivors and other members of the family and community, availability of effective services to the survivor is necessary for GBV prevention and response program activities. Capacity building in mental health is also equally necessary

for health service providers and psychosocial workers to provide effective services to the survivors.

- Mental health and psychosocial support service to GBV survivors is a key to address increased depression and suicide risk in GBV survivors. Thus, response programs at a community level and health facilities play a greater role to reduce both. GBV survivors mostly have no access to resources, any service build for them needs to create access in an individual level at the community following a client-centered approach.
- Severe form of suicidal risk cases was higher in number in Sindhuli and Udaypur than in Kathmandu valley, thus this study indicates higher-level mental health and psychosocial services to be established in these districts and other rural parts as well because the study finding showed higher depression and suicidal thoughts in women and girls in rural area.
- It is important to develop community-level psychosocial support services in all communities through establishing community psychosocial workers (CPSW) and capacitating them. CPSWs model has been already tested and produced a good result at a community level, they are effective in addressing immediate emotional support need and referring or linking client to other higher levels services in One Stop Crisis Management Centre (OCMC) for psychosocial counseling, mental health treatment, medical treatment, legal and protection support. This reduced chronicity of the mental health condition of the survivor and reduce suicide risk as well.
- Since we have collected data from GBV survivors who were in safe houses as well, effective psychological counselling services should be built in safe houses and have an easy link for mental health treatment to the survivors.
- It is important to lobby at the policy level to create a necessary legal action for the protection of survivors and prevention of GBV largely. It is also important to create easy access for justice to the survivors in a timely and cost-effective way. Policy level lobby is also important to increases investment to establish effective response mechanisms in GBV.
- Coordinated effort among multi-stakeholders is key to address GBV survivors' needs in areas such as health treatment, protection, care, education, reintegration, etc.

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# APPENDICES

## ANNEX 1

### TIME LINE OF THE RESEARCH WORK

| Activities | Apr 2020 | May 2020 | Jun 2020 | Jul 2020 | Aug 2020 | Sep 2020 | Oct 2020 | Nov 2020 | Dec 2020 |
|---|---|---|---|---|---|---|---|---|---|
| Agreement Signed | ✓ | | | | | | | | |
| Literature Review | ✓ | ✓ | | | | | | | |
| Research Planning | | ✓ | | | | | | | |
| Finalized Planning after reviewer's comment | | ✓ | | | | | | | |
| Ethical Approval for Data Collection | | ✓ | | | | | | | |
| Recruitment of Research Assistants (RAs) | | | ✓ | | | | | | |
| Trainings to RAs | | | ✓ | | | | | | |
| Developed, printed and distributed Suicidal Prevention Leaflets | | | ✓ | | | | | | |
| Developed Data collection tool | | | ✓ | | | | | | |
| Pilot-testing of research tool | | | | ✓ | | ✓ | | | |
| Data Collection | | | | ✓ | ✓ | ✓ | | | |
| Data Management | | | | | | | ✓ | | |
| Dissemination of preliminary findings of research to the multi-stake holders | | | | | | | ✓ | | ✓ |
| Report Writing | | | | | | | ✓ | ✓ | ✓ |
| Report Submission | | | | | | | | | ✓ |
| Feedback on Report<br>Editing and Final Report Submission | | | | | | | | | ✓ |

**Alleviate Poverty Empowerment women In Rural areas Of Nepal (APEIRON)** is a Non-Governmental Organization established in 2013 with the DAO registration number 223. It is also affiliated with Social Welfare Council (SWC) with the number 38100. Currently, APEIRON has operations in 14 districts of Nepal. APEIRON's vision is an equal world for a better future. Women's empowerment is APEIRON's ultimate goal.


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**Centre for Mental Health and Counselling Service – Nepal (CMCS-Nepal)** is a registered organization by complying the rules and regulation of the Government of Nepal. It is registered in the Office of the Company Registrar in Asoj 2076 (October 2019). The vision of the CMCS-Nepal is "Satisfaction of clients and quality mental health service" and the mission is "work, research and publication in the promotion of mental health"


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