Suicide Trends in Bhutan from 2009 to 2013

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Abstract

This paper focuses on the increasing trend of suicide in Bhutan over a period of five years from 2009-2013, and argues that there is a need of immediate attention from the government or any other relevant organization to set up a helpline, or to put in place any strategy to prevent/reduce it. For a small country like Bhutan, an average annual suicide growth rate of 9.4 percent is an alarmingly high one. A descriptive analysis of this time series data is used to generate comparison of suicide cases by region, gender, occupation and age group to identify which of the groups need the most attention.

Introduction

Using the definition of suicide by Emile Durkheim (1897), which states suicide as cases of death that is a result of the act of the victim himself/herself, imposed with the full knowledge of what the result will be, this paper attempts to analyse suicide in Bhutan using the records maintained by the Royal Bhutan Police from 2009 to 2013. Though there is a general feeling among the Bhutanese population that suicide has been increasing over the years at a noticeable rate, especially among youth, there is no research work carried out to substantiate this belief. There is also no strategy put in place, either by the government or by relevant organizations, in preventing it and helping out those with suicidal ideation.

Bhutan is a small country with strong social fabric and family relationships; however, from general observation, this trend of strong social support is declining. As per the 2010 GNH Survey, 14.7% and 9.1% of the people said that there is no

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one to help during financial problems and emotional problems respectively as shown in Table 17. It will be interesting to observe the change in a few years time from now. Taking into account factors such as opening up to the modern world, its effect on Bhutan's culture of extended family and social cohesion, the author attempts to make a deduction of suicide cases by gender, region, age, and occupation to argue that Bhutan must give immediate attention to address the suicide problem.

Except for sporadic news coverage ('Suicide case on the rise in the country' by The Bhutanese on July 3 2013; '11 year old commits suicide' by Kuensel on August 19 2013; 'Who says youth are happy?' by Bhutan Observer on July 18 2013), no in-depth analysis has been done on suicide cases in Bhutan until now due to limited access to case files[1], which is understandable due to sensitivities involved[2]. Furthermore, in Bhutan, it wasn't until recently that people reported mental illness as a form of sickness that was diagnosed and treated in the hospitals.

However, in 2015 the government commanded that an extensive research must be carried out on suicide. It has already started with the appointment of Department of Public Health in the Ministry of Health as the lead agency. Using the same data used for this paper, they plan to carry out a survey using structured questionnaire involving the family members of the suicide victims. Looking at this scenario, there may be successive research on it, for which this paper may serve as a starting point. Moreover, it hopes to help combat this issue by at least identifying vulnerable groups in terms of gender, age, occupation, and region. It also takes note of the social factors such as family relationship and social support in terms of

[1] When a research on suicide was carried out for all the countries in the Indian Subcontinent, Bhutan was excluded on the basis of lack of data (Khan 2006).

[2] Therefore, I would like to thank the RBP for allowing me to have an access to the annonymised dataset on suicide cases in Bhutan for the current study.

social isolation and feeling of helplessness to help understand causes of suicide in a broader sense.

The rest of the paper is divided into four parts: Literature review; Results showing the analysis of the suicide data from 2005 to 2009; Conclusion discussing the results and recommendations; and Limitations and what similar future research should focus on.

Literature Review

Several research (Lie & Liou 2012; Pool 2009; Lewinson et al. 2001) showed that social factors play an important role as a trigger, especially for adolescents in committing suicide. It means that the family members and all members of the society have a role to play in how it can be prevented. Furthermore, it shows that suicide rates are continuously increasing. It is the second leading cause of death worldwide for people aged 15 to 24 with 1.5% of deaths accounted to suicide (Pool 2009), the first leading cause of death being vehicle accidents. Analysis of the worldwide trend of suicide rates from 1950 to 2009 by WHO (2008) showed that 782 thousand deaths in year 2008 were attributed to suicide and the rate of suicide for the whole world is 11.6 per 100,000 inhabitants. Lithuania is the country with the highest suicide rate in the world with 34.1 per 100,000 inhabitants, but it is increasingly becoming common in Asia; already, female suicide rate is highest in South Korea with 22.1 in 100,000 inhabitants (Varnik 2012). Asia alone accounts for 60% of suicides in the world (Beautrais 2006) affecting a minimum of 60 million people yearly. For example, it is predicted that 60 people die every month in Malaysia (National Registry Malaysia 2011).

According to the above research works, majority of people who commit suicide have some form of mental disorder such as anorexia, bipolar disorder, and schizophrenia. They are also people who suffer from social isolation, have no close friends, and have communication problems with family and friends, and lack a sense of belongingness. Out of the

different mental problems, Robert Pool (2009) argues that people suffering from anorexia are more likely to commit suicide, which in his view is because they are more likely accustomed to pain and do not fear death as others. This supports the theory that Joiner (2005) proposed explaining why some people kill themselves; he claims that they must meet two conditions besides feeling depressed and hopeless: First they must have a serious feeling of wanting to die and second they must be capable of doing it. He justifies that despite the serious desire to die, it is not an easy thing to do and therefore, people who have a serious desire to die attempt to kill themselves a few times, in order to develop themselves up to it. It also explains why people suffering from anorexia are the ones who mostly commit suicide. He further explains that people who had painful or scary experiences are daring in taking their own lives, such as soldiers and police. But what is worrying is his statement that there will be suicide in our society as long as people feel isolated and feel that they are a burden to others. It means there is a need to keep a continuous watch by individuals, as a family member or a friend on those who are at risk; furthermore, it means there must be an active social helpline put in place by the government, checking continuously on groups of people who are prone to suicide.

Studies by Stein et al. (1992) and Zemaitiene and Zaborskis (2005) showed that it is those who think it is their right and therefore okay to kill themselves that have suicidal thoughts, and therefore, it is important to assess the attitudes towards suicide. Moreover, according to Zemaitiene and Zaborskis (2005), suicide has become more accepted in the society than before. For example, there is no strong belief system in the society that taking one's life is punishable or sinful. Though Bhutan is largely a Buddhist country and Buddhists believe that human body is the most precious form of life because it is only in this form that there is an opportunity to pursue dharma and therefore get enlightened, there is no social stigma pertained to it. The research on Japan's high suicide rates by Ozawa-de Silva (2008) supports this idea as he

shows that the high rates of suicide in Japan is due to its culture of tolerance and acceptance of suicide. From the point of view of preventing suicide, before this attitude spreads to others, it is very important that this attitude is identified and treated (Stack & Kposowa 2008). The society's value system, belief and attitudes are important (Clearly and Brannick 2007), and therefore, one of the things that Bhutan could do to help in bringing down suicide rate is to maintain this belief system and keep the community intact. In a way, Bhutan seems to have an accepting attitude in general for suicide. For example, the Penal Code of Bhutan mentions only the 'Complicity in suicide' whereby it states that:

> A defendant shall be guilty of the offence of complicity in suicide, if the defendant aids, abets, counsels or procures the suicide of another person.

This raises the question, 'will considering suicide a crime under the court of law help bring it down?' This is not in any way a suggestion to stigmatize it to the extent where family members of the culprit will be shunned and looked down by the society, such as the case in India where families are ostracized and viewed with suspicion and therefore have implications such as on the 'marriage prospects of the girls in the family' (Khan 2002, p. 105). However, if there were such a law, there would be less number of suicide attempters and therefore, less suicide cases. In fact, National Registry Malaysia (2011) has found that Buddhist college students had higher acceptance of suicide as compared to Malay and Muslim college students. It suggests that Buddhists have an accepting nature of social phenomena, or that Bhutanese society is losing the strong social system of volunteerism, of helping strangers, and taking other's suffering as a concern. In other words, it seems to suggest that Bhutanese are becoming more individualistic, though compared to many developed countries, Bhutan still has so many social norms intact because of its vision of Gross National Happiness. More action-oriented solution would be to set up a 24 hours helpline where a professional counselor is appointed to help

those in suicide risk. But it must be advertised and promoted nationwide by making everyone understand that it takes calls anonymously and there is no need to show one's identity. This can be a start in combating this fatal social sickness, and later on more systematic and better institutes can be established.

Results

This study used the suicide record from the Royal Bhutan Police from 2009 to 2013. The different variables available for analysis were 'name of the police station', 'date', 'time of occurrence', 'place of occurrence', 'dzongkhag', 'age', 'gender' and 'occupation'. However, some information were missing for some variables, and therefore, there is a varying number of cases for different variables. The result of the study is presented by: (i) Gender, (ii) Age, (iii) Economy, (iv) Occupation, and (v) Region.

i) Gender

Self-reported suicide attempts are higher for females than males but completed suicides are higher for males than females (Schmidtke et al. 1996; Vijayakumar et al. 2004; Helliwell 2006). Wichstrom and Rossow (2002) showed that in Norway, though female suicide attempts were higher than male, in the same year, in fact number of male committing suicide was three times more than female. Similarly, in Sri Lanka suicide data for the years 1991-1995 shows that number of males was three times more than females (Ratnayeke 1998). However, in India the available literature reported different trends. For instance, Sarma and Sawang (1993) reported that there is no such gender difference in the suicide cases in India. Others reported that there is a male majority (Sarma and Sawang, 1993) and some others reported female majority (Bannerjee et al. 1990). Since there is no recent study to refer to, no conclusion can be drawn but Khan (2002) argues that despite the inconsistent reporting, the male to female ratio does not seem to be higher than 3:1, which in his opinion is because the men are seen as a role model upon which the family's prestige is judged. Even in the

case of Bhutan suicide case is higher for male compared to female. Out of a total of 378 cases of suicide, 254 are male and 124 are female with a male to female ratio of 2:1 as shown in Table 1.

Table 1. Suicide case by gender

Gender	Frequency	Percent
Female	124	32.8
Male	254	67.2
Total	378	100.0

ii) Age

While it is found that suicide is higher among the elderly people in the West (Khan, 2002), it is not the case in the Indian subcontinent, at least not in Sri Lanka, India and Pakistan; in fact, one-fourth of suicides are by people under the age of 30 years (Ratnayeke 1998; Venkoba 1983; Khan and Reza 2000). The current study shows that in Bhutan, out of 365 cases, 184 are under the age of 30 years. A detailed result is shown in Table 2. According to Khan (2002), this could be because of the lower average life expectancy in the Indian Subcontinent compared to the West, and the culture of elderly being treated with a position of privilege and respect, cared for and looked after by their families. It could be true in the case of Bhutan as well. The elderly in Bhutan remain active throughout their lives, largely devoting their time in practicing dharma. They see retirement as a time for spiritual pursuit, much waited for in the lifetime. Out of the total of 356 suicides from 2009 to 2013, only 10 are above the age of 70.

Table 2. Suicide by age category

agecat	Freq.	Percent
<20	76	20.82
21-25	60	16.44
26-30	48	13.15
31-35	47	12.88

36-40	33	9.04
41-45	19	5.21
46-50	19	5.21
51-55	15	4.11
56-60	13	3.56
>61	35	9.59

Table 3. Suicide by age and gender

	Gender		
agecat	F	M	Total
<20	40	36	76
21-25	16	44	60
26-30	10	38	48
31-35	14	33	47
36-40	12	21	33
41-45	7	12	19
46-50	4	15	19
51-55	4	11	15
56-60	4	9	13
>61	8	27	35
Total	119	246	365

Research shows that youth suicide rates have been increasing in many industrial countries over the last 50 years; for example, the youth suicide rate in the U.S. tripled (Cutlet et al. 2000), especially between the mid 1950s and mid 1970s, which according to them is due to the increasing divorce rate. Putnam (2000) argues that since 1960, trust and sense of belonging in the U.S. decreased mainly due to the influence of television in that era. The population at most risk in Malaysia as well as for the whole world are those in the age group of 16-25 years (Ng 2011), which means it is mostly the college students. Westefeld et al. (2006) and Glover (2000) argue that

college students are at higher risk because they are in a transition in life, either in the midst of making a career choice or life's decisions apart from the academic pressures. Moreover, it is also at this age that individuals go through traumatic emotional pressures of romance and relationships resulting into loneliness and hopelessness making them feel suicidal (Tam et al. 2011).

iii) Economy

There is positive association between unemployment and suicide (Lewis and Sloggett 1998; Jin et al. 1994; Gunnell et al. 1999; Aihara and Iki, 2002). For example, the longitudinal study carried out in the U.S. by Kposowa (2001) shows that the unemployment increases the risk of suicide, more for male than female. Similarly the study on Italian suicide rates shows that the effect of unemployment is higher on male than females (Preti & Miotto 1999). Another study carried out in Denmark found that it is an important factor for males but not for females (Qin et al. 2000). A study carried out in Japan using the prefecture based data for the years 1993 to 2009 showed that unemployment is a significant factor but the effect is stronger for men by a factor of three (Schaede 2013). Aside from these varying findings, there does seem to exist a positive association between economic factor (especially unemployment) and suicide. Several research have found that it increases the suicide risks significantly. For example, a Swedish study by Johansson and Sundquist (1997) empirically shows that unemployment increases the risks of suicide substantially. Similarly, the report on mental health (World Health Organization 2003) states that the risk of mental disorders, and therefore, the risk of suicide is higher among the poor, homeless and unemployed, as well as persons with a lower educational background. This is true in the context of Bhutan. The data shows that the majority of the victims were of the lower occupational rung such as cook, driver, mechanic etc. which could mean that they had stress related to financial problems or social stress as a result of not having resources to 'achieve desired goals or maintain the current level of social functioning' (Yur'yev et al. 2011, p.236).

iv) Occupation

The classification of occupation is done based on the different occupations of the victims as listed in the records maintained by the Royal Bhutan Police. It is not the same as the occupational groups classified for the Labour Force Survey (published by the Ministry of Labour and Human Resource) and the Statistical Yearbook (published by National Statistics Bureau) because they have classified the different categories of jobs into broad categories that will not give a detailed picture of the occupation of the victims. Out of 208 people from 2009 to 2013, taking into account two ambiguous occupations, which only mentions the organizations they worked for and does not mention their specific job titles, it is fair to mention that only one officer level individual has committed suicide and it is worth noting that all others are drivers, labourers, housewives, farmers, students etc. However, no investigation was carried out to check the suicide risk associated with an occupation group by controlling other factors such as age and gender. A detailed classification of the data is shown in Table 4 and Table 15. Stack (2001) notes that there is no clear relationship between occupation and suicide because of the lack of data for many occupations but states that the stress associated with the different kinds of occupations may contribute to the suicide risk. However, this does not seem to hold true in the case of Bhutan. In the case of Bhutan the suicide risk seems more associated with poverty and financial problems than with the occupational stress.

Table 4. Suicide by occupation

Occupation	Freq.	Percent
Farmer	64	30.77
Student	57	27.40
Private employee	23	11.06
Labourer	15	7.21
ESP and driver	10	4.81

RBP/RBA	10	4.81
Civil servant	7	3.37
Corporate employee	7	3.37
Housewife	6	2.88
Unemployed	5	2.40
Monk/nun/gomchen	4	1.92
Total	208	100.00

v) Region

Many research (Bhui, Dinos and McKenzie 2012; McKenzie 2012; Borges, Orozco, Rafful, Miller, and Breslau 2012; Liu, Liao, Lee, Kao, Jenkins, and Cheng 2011) have hypothesized that the race, ethnicity and religious background have a big role to play in an individual's suicide ideation, his/her attitude towards it, and therefore the suicide risk associated with people of different ethnicity. For this paper, Bhutan is divided into four different regions: East, West, South, and Central. It is divided depending on the different languages spoken by the people in these different areas. People in the East speak Sharchop, those in the West speak Ngalop (Dzongkha), those in the central speak Bumthapkha/Mangdepkha and those in the South speak Lhotshamkha and are mostly of Nepalese origin. And by dzongkhag wise, the highest number of suicide cases is in Samtse (with 8.75 suicide rate in 10,000 population), which is the southern part of Bhutan. However, when this result was crosschecked using the data from Gross National Happiness Survey 2010, it shows that the highest number of people with suicidal ideation and suicidal attempts are not from this dzongkhag (see Table 12).

Table 5. Suicide by region

Dzongkhag	Freq.	Percent
South	170	44.97
East	107	28.31

West	81	21.43
Central	20	5.29
Total	378	100

Table 6. Suicide by dzongkhag

Dzongkhag	Frequency
Samtse	60
Chukha	41
Sarpang	38
Thimphu	38
Tashigang	34
Mongar	22
Paro	16
Tashiyangtse	16
Tsirang	16
Dagana	15
Pemagatshel	15
Samdrupjongkhar	14
Punakha	13
Wangduephodrang	12
Zhemgang	10
Lhuentse	6
Bumthang	5
Trongsa	5
Haa	2
Gasa	0
Total	378

Table 7. Number of suicide per 10,000 populations in each dzongkhag

Sl. No.	Dzongkhag	Suicide case per 10,000 population
1	Samtse	8.75
2	Sarpang	8.65
3	Trashiyangtse	7.89
4	Tsirang	7.54
5	Trashigang	6.21
6	Pemagatshel	6.09
7	Dagana	5.65
8	Mongar	5.14
9	Punakha	4.82
10	Chhukha	4.79
11	Zhemgang	4.77
12	Paro	3.82
13	Samdrupjongkhar	3.55
14	Lhuentse	3.49
15	Thimphu	3.41
16	Wangdue	3.31
17	Trongsa	3.23
18	Bumthang	2.72
19	Haa	1.52
20	Gasa	0.00

Table 8. Suicide in different years

Year	Freq.	Percent
2009	72	19.05
2010	57	15.08
2011	65	17.2
2012	88	23.28

2013	96	25.4
Total	378	100

Table 9. Number of respondents who said that they had seriously thought of committing suicide in their lifetime

Ever seriously thought of committing suicide	Freq.
Yes	359
No	6,778
Total	7,137

Source: GNH Survey 2010

Table 10. Number of respondents who said that they had seriously thought of committing suicide in the past 12 months

Seriously thought of committing suicide in last 12 months	Freq.
Yes	224
No	122
Total	346

Source: GNH Survey 2010

Table 11. Number of respondents who said that they had attempted suicide in their lifetime

Ever attempted to commit suicide	Freq.
Yes	59
No	278
Total	337

Source: GNH Survey 2010

Table 12. Number of respondents from different dzongkhags who said that they had thought of committing suicide in the past 12 months

Dzongkhag	Freq.	Percent
SamdrupJongkhar	26	11.61
Chukha	20	8.93
PemaGatshel	20	8.93
Bumthang	19	8.48
Trongsa	18	8.04
Tashigang	17	7.59
WangduePhodrang	16	7.14
Punakha	15	6.70
Dagana	11	4.91
Mongar	11	4.91
Zhemgang	11	4.91
Samtse	9	4.02
Paro	6	2.68
Thimphu	6	2.68
Lhuntse	5	2.23
Haa	4	1.79
Sarpang	4	1.79
Tsirang	4	1.79
TashiYangtse	2	0.89
Total	224	100

Source: GNH Survey 2010

Table 13. Suicide in 100,000 population

Year	Suicide in 100,000
2009	11
2010	8
2011	9
2012	12
2013	13

Conclusion and future research

More than billion people live in the Indian subcontinent sharing similar values of culture and tradition and the fact that 100,000 people kill themselves in these countries every year is a tragedy that needs urgent attention (Khan 2002). In line with his argument, Bhutan must give priority to the suicide prevention, both by mental health professionals, individuals, policy makers and the government.

According to WHO research, the problem of suicide has shifted from Western Europe to Eastern Europe and now it is shifting to Asia. This seems to have caught on Bhutan too with a continuous increase of suicides every year. The average annual growth rate of suicide in Bhutan is 9.4 and suicide in 100,000 population is 11 in 2009, 8 in 2010, 9 in 2011, 12 in 2012, and 13 in 2013 (as shown in Table 13). For each year the number of suicide for male is more than female, and by age category, it is highest for youth below the age of 25 years. By occupation, the highest is farmer followed by students, and, by region, the highest is in the South, followed by the East. The data suggests that there is a positive association between economy and suicide, where most of the victims are people who had been working in lower rung of the government, corporate or private organisations. Therefore, even though there may be need for further analysis in the future to check the validity of these findings, it will serve as a start for research in this area. The findings from this paper suggests that the attention on prevention of suicide must first be given to those who are economically

poor, those having low social support, low self esteem with feeling of hopelessness and people with mental stress and, taken all these factors together, males are more at risk and they need more attention.

The world over, suicide rate is reported to be higher in urban centers than in rural areas due to crowding and social isolation, which can vary with age and sex of individuals across countries (Vijayakumar et al. 2004). But this is contrasted by the studies in India, China, Sri Lanka and Taiwan which shows that suicide rates in rural area is higher than urban areas with suicide in rural areas in China as high as three times that of urban areas (Philips et al. 1999). For this paper, no separate analysis was carried out for urban and rural areas and it could be an interesting future research. Despite the importance of social factors (especially family members' support and trust) in the suicidal risk, the data collected by the Royal Bhutan Police, used for this paper, did not have the marital status of the victims and this could be another area of research for future.

Method employed to commit suicide could have been another area of analysis, but it was omitted in this paper deliberately with the thought that it could be read as a way of encouragement by giving ideas on how to commit suicide. However, if this would help in the prevention of suicide by identifying the different methods and how best to conceal or make them unavailable to those in risk, it could be studied in the future.

Appendix

Table 14. Classification of dzongkhags into different regions

Sl. No.	East	West	Central	South
1	Tashigang	Haa	Bumthang	Samtse
2	Tashiyangtse	Paro	Trongsa	Tsirang
3	Samdrupjongkhar	Thimphu	Zhemgang	Sarpang
4	Pemagatshel	Wangdue		Dagana
5	Mongar	Gasa		Chukha
6	Lhuentse	Punakha		

Table 15. Classification of occupation

Occupation	Category
Accountant	Civil servant
Employee of National Land Commission	Civil servant
Employee of NRDCL	Civil servant
Teacher (Tsebar LSS)	Civil servant
VHW (Village Health Worker)	Civil servant
Ward boy, Punakha Hospital	Civil servant
Mess boy	Civil servant
BPC Staff	Corporate employee
Foreman, KHPC	Corporate employee
Mechanical Technician, Operator Division, Power house	Corporate employee
Care taker (Dungna LSS)	ESP and driver
Care taker (Royal guest house)	ESP and driver
Cook	ESP and driver
Driver	ESP and driver
Driver	ESP and driver

Driver	ESP and driver
Driver (Municipal of Mongar)	ESP and driver
Driver of PHPA	ESP and driver
Driver, National Land Commission	ESP and driver
Driver, Haa Court	ESP and driver
Driver, Karma feed	ESP and driver
Driver, Nima Construction at Yurung	ESP and driver
Driver, PHPA-I	ESP and driver
Dry sweeper, Samtse College of Education	ESP and driver
Excavator operator, DANTAK	ESP and driver
School cook	ESP and driver
Cow herder	Farmer
Farmer	Farmer
Tshogpa	Farmer
H/wife	Housewife
Daily wage worker	Labourer
labourer	labourer
PWD labour	Labourer
PWD labour	Labourer
Gomchen	Monk/nun/gomchen
Monk	Monk/nun/gomchen
Monk of Tashichhodzong	Monk/nun/gomchen
Nun, Wangsisina	Monk/nun/gomchen
Accountant, K.C. Hotel	Private employee
Baby sitter	Private employee
Business, Druk Photo Shop, Gelephu	Private employee
Cook NT Hotel, Thimphu	Private employee

Cook of IMTRAT Hospital	Private employee
Electrician	Private employee
Employee of Bhutan Ply Wood	Private employee
Employee of PCAL	Private employee
HRO, Bhutan Silicon, Tashi Head Office, Pling	Private employee
Janka Resort (House keeping)	Private employee
Pipe fitter of PCAL	Private employee
Private employee of Naksel Hotel	Private employee
Security guard, KK steel	Private employee
SonamYarphel Automobile, Rurichu	Private employee
Staff, BFAL, Pasakha	Private employee
Store keepr, BOD, Tashi Commercial Corporation	Private employee
Taxi driver	Private employee
Teacher at Daycare Centre	Private employee
Waitress	Private employee
Masson, Dorji construction Babesa, Thimphu	Private employee
Ex RBA	RBP/RBA
Ex-RBA	RBP/RBA
Ex-RBA	RBP/RBA
RBA	RBP/RBA
RBA	RBP/RBA
RBP	RBP/RBA
RBP	RBP/RBA
RBP	RBP/RBA
RBP, Paro Division	RBP/RBA
RBP, WT operator	RBP/RBA
CE student Sherabling HSS	Student

Class VII, Woochu LSS, Paro	Student
Ex student Damphu HSS	Student
Ex-student, Nima HSS	Student
PGDE, Samtse College of Education	Student
Student	STUDENT
Teacher (Teaching practice at Gonpa Singma LSS)	Student
Trainee of Civil Engineering, Final year	Student
Trainee, VTI, Sershong	Student
Jobless	Unemployed
Jobless (class 12 pass out from Kelki HSS and looking for job)	Unemployed
School dropout	Unemployed
Unemployed	Unemployed

Table 16. Suicide in 100,000 populations in different Asian countries per year

Country	Year	Rate (per 100,000)	Reference
Australia	2010	10.5	Australian Bureau of Statistics
China	1999	13.9	Värnik, P. (2012). Suicide in the world. *International journal of environmental research and public health*, *9*(3), 760-771.
India	2009	10.6	Radhakrishnan, R., & Andrade, C. (2012). Suicide: an Indian perspective. Indian journal of psychiatry, 54(4), 304-319.
Japan	2009	19.85	OECD (2011), "Suicide",

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New Zealand	2007	11.7	Värnik, P. (2012). Suicide in the world. *International journal of environmental research and public health*, *9*(3), 760-771.
Singapore	2006	10.3	Värnik, P. (2012). Suicide in the world. *International journal of environmental research and public health*, *9*(3), 760-771.
Sri Lanka	2009	19.6	de Silva, V., Hanwella, R., & Senanayake, M. (2013). Age and sex specific suicide rates in Sri Lanka from 1995-2011. *Sri Lanka Journal of Psychiatry*,*3*(2), 7-11.
Thailand	2002	7.8	Värnik, P. (2012). Suicide in the world. *International journal of environmental research and public health*, *9*(3), 760-771.

Table 17. Number of people available for help during financial and emotional problems

Have financial problems	Percent
None	14.74
1 to 2	27.4
3 to 5	30.5
6 to 8	13.22
More than 8	13.05
Don't know	1.09

Have emotional problems	Percent
None	9.13
1 to 2	21.63
3 to 5	23.89
6 to 8	17.02
More than 8	27.38
Don't know	0.94

Source: GNH Survey 2010

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