CHAPTER 9

Suicide Prevention in Bangladesh: Current Status and Way Forward

Mohima Benojir Hoque

Abstract Suicide is a public health problem for both the developed and developing world. Like many other developing countries, it is a problem with less focus in Bangladesh. A few initiatives are taken to prevent suicide in the country such as two *Suicide Prevention Clinic*s, *Kaan Pete Roi*, a helpline, *Society for Voluntary Activities, Brighter Tomorrow Foundation* and *Society for Suicide Prevention Bangladesh*. However, the current prevention strategies lag behind when compared to the World Health Organization proposed components for a national suicide prevention strategy. More empirical studies, responsible media reporting, crisis intervention, the national database for suicide, raising awareness, adequate mental health support, means restriction, decriminalization, national suicide prevention strategy, and comprehensive and integrated efforts are warranted among different sectors of society for the prevention of suicide in Bangladesh. The chapter discusses the current scenario and future way outs for suicide prevention in the country.

Keywords Suicide in Bangladesh · Suicide prevention · Responsible media reporting · Suicide prevention clinic · Risk factors · Decriminalization

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1 Introduction

Globally, more than 700,000 people died by suicide in 2019. It is a serious public health problem in high-income countries (HICs) as well as predominantly in lower and middle-income (LMICs) countries where 77% of the suicides occurred worldwide in 2019 (WHO, 2021a). One person dies in every 40 s because of suicide, and many more attempt to suicide all over the world (WHO, 2014). It is the top twenty leading causes of death worldwide which is more than malaria, breast cancer, war, and homicide. It is the fourth leading cause of death among the individual with 15-to-29-year of age. Globally, suicides among young people account for nearly 25% of all suicides (WHO, 2021a). Although suicide is a sensitive issue, it is under-reported in some countries. Even the countries which have good data record, suicide have often been classified differently such as an accident or other reasons of death. Suicide registration is a difficult process comprising a number of different persons including law enforcement authorities. This chapter begins with the global context of suicide and encompasses how suicide prevention gets global attention, strategic approaches of suicide prevention, the risk factors of suicide in Bangladesh, overview of current situation of suicide prevention in Bangladesh, the readiness of national suicide prevention strategies, challenges of suicide prevention in Bangladesh and future way outs for suicide prevention in Bangladesh.

2 How Suicide Prevention Gets Global Attention

In the early 1990s, an imperative document entitled "*Prevention of suicide: guidelines for the formulation and implementation of national strategies*" was published by the *United Nations* (UN) following consultation with a variety of experts and with technical support from the World Health Organization (2018). It is emphasized the need for intersectoral collaboration, multidisciplinary approaches, and continued evaluation and review, and also identified key elements as a necessary means of increasing the effectiveness of suicide prevention strategies (WHO, 2018). In 2014, WHO published its first-ever world suicide prevention report "*Preventing suicide: a global imperative*" (WHO, 2014). In this report, WHO made a call to action for countries to employ a multisectoral approach which addresses suicide in a comprehensive manner. Currently, some forty countries at every income level have incorporated a state suicide prevention policy and only a few LMICs have accepted a national suicide prevention strategy, although 77% of suicides happen in these countries (WHO, 2021a).

The WHO MiNDbank online platform was created to provide easy and rapid access to global resources, national and regional-level strategies, services, and laws for improving mental health and related areas such as suicide, substance abuse, disability, general health, and human rights. Another global effort to address suicide is the creation of *World Suicide Prevention Day*,

organized by the *International Association for Suicide Prevention (IASP)*. This day is observed worldwide on 10 September each year providing a vital opportunity to raise awareness about suicide prevention (WHO, 2018).

The *WHO Mental Health Action Plan* 2013–2020 was approved by the *World Health Assembly* in 2013 (WHO, 2013). The action plan labels suicide prevention as a priority by reducing suicide rate by 10% within 2020. It is also highlighting suicide as a serious public health problem worldwide and will be prevented with appropriate efforts. National responses to suicide with comprehensive multisectoral suicide prevention strategies are essential to achieving this target. In 2015, the *Sustainable Development Goals* (SDGs), also focused on agenda adopted by the UN General Assembly. The third goal of the SDGs is to safeguard healthy lives and uphold well-being for people of all ages. Again, the target of SDG 3.4.2 is to decrease suicide by 33% through enhanced intervention and prevention in 2030 (Naghavi and Global Burden of Disease Self-Harm Collaborators, 2019; WHO, 2018; Khan et al., 2020).

3 Strategic Approaches of Suicide Prevention

Numerous strategic approaches are suggested for suicide prevention and classified as universal, selected, and indicated (WHO, 2014; Mann et al., 2005; Zalsman et al., 2016; Arafat and Kabir, 2017). Universal suicide prevention strategies are designed to reach the total population with a view to take full advantage of health and reduce suicide risk by eliminating barriers to health care and increasing protective measures for example, societal support and altering the environment (Table 1). Selective strategies mark vulnerable groups of people based on features like age, occupation, sex, or family history. Indicated strategies target another vulnerable group of individuals who have displayed initial signs of suicide potential (WHO, 2014).

Table 1 Strategic Approaches for Suicide Prevention adapted from WHO, 2014

Name of the strategy	*Category*
Mental health policies	UNIVERSAL
Policies to reduce harmful use of alcohol	
Access to health care	
Restriction of access to means	
Responsible media reporting	
Raising awareness about mental health, substance use disorders and suicide	
Interventions for vulnerable groups	SELECTIVE
Gatekeeper training	
Crisis helplines	
Follow-up and community support	INDICATED
Assessment and management of suicidal behaviors	
Assessment and management of mental and substance use disorders	

WHO launched awide-ranging '*Mental Health Action Plan 2013–2020*' in 2013 which persuade the countries to work on the way of their own mental health policies. The plan highlighted some points such as strengthening effective leadership and mental health governance; providing complete, unified, and amicable mental health and participatory community care services; implementing policies for prevention and promotion of mental health and support information systems, evidence-based research for mental health. WHO's Global strategy published a policy and interventions to reduce harmful use of alcohol. And it also provides measures for effective suicide prevention through proper guidance, mindfulness, and potentials, health services' response, community accomplishment, alcohol availability, drink-driving policies, and countermeasures, marketing of alcoholic drinks, minimizing the negative consequences of harmful-drinking and alcohol intoxication, and informally produced alcohol, monitoring, and surveillance. Available treatment for mental and substance use disorders can reduce the risk of suicidal behavior and executing health literacy policies and practices throughout health systems and institutions, and especially at community health centers are the main way to improve access to health-care services in general and mental health care in particular. Pesticide self-poisoning is the most common method of suicide worldwide. So, to prevent suicide limiting access to the means of suicide is effective. The main interventions in restricting access to the means of suicide are access to pesticides, access to firearms, bridges, buildings and railroads, accessibility of poisonous gases, and access to pharmacological agents. Study shows that responsible media reporting of suicide helps to reduce suicide rates. It may play a significant role by avoiding exaggeration and glamorization, using responsible language, avoiding detailed descriptions of suicidal acts, providing educative materials to the public, and mentioning information about suicide prevention services. Awareness raising on mental health, substance use disorders, and suicide may help to condense stigma and negative attitudes among people with a mental disorder. The selected strategic approach includes interventions for vulnerable groups, gatekeeper training, and crisis helplines. A number of vulnerable groups have been identified as having a higher risk of suicide such as persons who have experienced abuse, trauma, conflict or disaster, refugees and migrants, indigenous peoples, prisoners, lesbian, gay, bisexual, transgender, and intersex persons. Sometimes people who are at risk of suicide may not seek help. A "*gatekeeper*" is anyone who is in a position to identify whether someone may be contemplating suicide and the potential gatekeepers are primary, mental, and emergency health service providers, teachers and community leaders, other school staff, police officers, firefighters, and other first responders, spiritual and religious leaders or traditional healers, human resource staff and managers. Crisis helplines are a kind of public call centres which people can turn to when other social support or professional care is unavailable or not preferred. The indicated approach includes community support and follow-up, assessment and management of suicidal behaviours,

and mental and substance use disorders (Zalsman et al., 2016; WHO, 2014; Mann et al., 2005; Arafat and Kabir, 2017).

In 2021, WHO declared an implementation guide for suicide prevention which is known as 'LIVE LIFE' where, LIVE stands for leadership, interventions, vision and evaluation and builds the pillars of LIFE—i.e., the core interventions, which are less means, communication with the media for accountable reporting, life skills development to the younger and primary identification, management and follow-up. The core pillars of LIVE LIFE are situation analysis, multisectoral collaboration, raising awareness and promotion, capacity-building, funding, investigation, monitoring, and assessment (WHO, 2021b).

4 Risk Factors for Suicide in Bangladesh

The foundation of any effective response to prevent suicide is to find out the appropriate risk factors and their mitigation by implementing appropriate interventions. Suicidal behaviors are multifaceted and no single factor is adequate to elucidate a suicidal act. There are various contributing factors and underlying pathways to suicide and a range of options for its prevention. Protective factors are equally important and have been identified as improving resilience. Therefore, to mitigate the identified risk factors is imperative for effective interventions. Consequently, enhancing protective factors is also an important aim of any comprehensive suicide prevention response (WHO, 2018). An ecological model is used to best describe the both risk and protective factors of suicide which can help to take effective measures (WHO, 2014). As, it is multi-factorial, driven by a series of socio-cultural, psychological, economic, biological, and environmental issues, such as financial loss, interpersonal conflict, loneliness, chronic illness, mental health and substance abuse problems, discrimination, and difficulties accessing health care. Given the interplay of factors, multi-sectoral action is essential (WHO, 2014).

We discussed the risk factors for suicide in Bangladesh in Chaps. 1 and 3 of this book (Kabir et al., 2023). In Bangladesh, though the health sector extensively works on different domains of health with the existing resources but still suicide is less focused public health issue (Shah et al., 2017; Arafat, 2017; Arafat et al., 2018). In the country, majority of the suicide cases are found in their early adulthood and the significant risk factors are psychiatric disorder, sexual abuse, previous attempt, immediate life event, unemployment, social isolation, physical abuse, and physical disorder. Other risk factors are emotional issue, relationship events, rape, eve-teasing, and sexual relationship. The study reveals that among the total respondents 61% have psychiatric disorder such as axis I disorder—major depressive disorder (MDD), personality disorder, schizophrenia, and substance misuse. A total 91% have experienced life events such as academic failure, arguments with family member, arguments with spouse, broken engagement, extramarital affair, taking a large loan, spousal

extramarital affair, sexual assault, major personal physical illness, marital separation, business failure, child married, divorce and moving to another city (Arafat, 2019; Arafat, Khan et al., 2021; Arafat, Mohit et al., 2021).

Moreover, it is customarily predominating issue among married women who are young and come from subordinate socio-economic division living in the rural part of the country (Feroz et al., 2012; Shahnaz et al., 2017; Khan et al., 2022; Sharmin Salam et al., 2017). Evidences from several studies reveal that the effects of patriarchal society, early marriage, forced marriage, lower socio-economic status of women, lower female education, divorce, threat to divorce, conflicts with in-laws, forced childbearing, in-fertility, and various forms of exploitation and coercion are significantly linked with suicide and suicidal behaviors among women and girls in the country (Feroz et al., 2012; Arafat, 2019; Sharmin Salam et al., 2017; Khan, Ratele, et al., 2020). Again, people reside in the countryside particularly in *Chuadanga, Jenaidah, Kustia, Meherpur, Jashore, and Chandpur* were more vulnerable to suicide in Bangladesh (Feroz et al., 2012; Shahnaz et al., 2017; Chowdhury et al., 2018; Arafat, 2017, 2019). It is also found that in Bangladesh, the common approaches for suicide and attempt to suicide are hanging and pesticide ingestion (Mashreky et al., 2013; Shahnaz et al., 2017; Arafat et al., 2018; Arafat, 2019; Khan, Ratele, et al., 2020).

5 Overview of Current Situation of Suicide Prevention in Bangladesh

Bangladesh is a densely populated south-east Asian country containing about 171 million inhabitants (World Population Review, 2022). Evidence from a current systematic review showed that the country lacks comprehensive data base of suicide, national suicide surveillance system, strategy for suicide prevention, and experimental study on suicide (Arafat, 2019). Besides, suicide and parasuicide are considered as illegal and social, religious and legal consequences hamper the suicide disclosures (Arafat, 2017; Khan et al., 2020). In Bangladesh, there are a few but sporadic activities on suicide prevention interventions are initiated in different levels with limited resources following variable methods (Arafat, 2018; Khan et al., 2020).

5.1 Mental Health Support—Suicide Prevention Clinics

At present there are two clinics working on suicide prevention in Bangladesh. In 2016, the first *Suicide Prevention Clinic (SPC)* was launched at *Bangabandhu Sheikh Mujib Medical University* (BSMMU) under the *Department of Psychiatry*. The clinic runs on Saturdays and provides psychotherapy for two hours only (Arafat, 2018). It is the only public sector facility to provide treatment to patients with suicidal behavior (Arafat, 2018; Khan et al., 2020). But most of the people are unfamiliar with the existing facility due to insufficient promotional activities and media coverage. The website of the BSMMU

also does not deliver any message about the services of the clinic (Arafat, 2018; Khan et al., 2020). A recent study on the clinic data reveals that about 73% of the respondents were under the age of 25 and approximately 70% were females with depression followed by personality disorder was the most common psychiatric disorder (Shah et al., 2018).

Another *SPC* was started in October 2021 under the department of psychiatry of *Enam Medical College and Hospital (EMCH)* is a private medical college in Dhaka. Here the provision of services from 9 a.m. to 5 p.m. in every working day. There are no other specialized clinical services for suicide prevention in the country. The maximum patients who come to the SPC at BSMMU are referred by the psychiatry outpatient department where as in EMCH the picture is different. Here they receive self-reports because of awareness materials, banner with information of suicide and self-harm. In the country, outpatient departments for mental health services are existent in 72 hospitals but it cannot go without question regarding the availability of any specialist on mental health in all centres apart from medical college hospitals (WHO, 2022). The general physicians who are trained on mental health also not available in all the centres at primary health care facilities of Bangladesh. Consequently, it is difficult to accept that these centres can efficiently handle suicidal behaviour and suicide in the country. It is also to note that none of these individuals in the SPCs has any official training on suicide prevention rather than their inadequate theoretical knowledge.

5.2 Means Restriction–Category 1 Pesticides Ban

The main reason behind the declining of suicide rate globally is to reduce access to exceedingly harmful pesticides (HHPs) byreducing the agricultural use, harmless use and packing, and mainly due to legislation and prohibition of HHPs (Chowdhury et al., 2018). Bangladesh is an agrarian country where pesticide self-poisoning is extremely prevalent for both suicide deaths and attempt to suicide. The government of the country has proclaimed pesticide regulation and banned extremely hazardous pesticides (HHPs) from their use in agriculture over the last two decades (Chowdhury et al., 2018). The regulatory body of the country partially or totally banned 21 hazardous pesticides (WHO class I) during the period from 1996 to 2007 and move towards less harmful WHO toxicity class II, III, and U pesticides. By the year 2000 all kinds of WHO Class I toxicity HHPs were prohibited. During the post–ban period (2001–2014), suicide due to pesticide were decreased to 35,071 in comparison with pre-ban period from 1996 to 2000. It was also evidenced that the decline of unnatural death after banned the HHPs and the number was 76,642. It is found that there is an impact of pesticide legislation on pesticide suicide and unnatural deaths without any detrimental consequence on agricultural output (Chowdhury et al., 2018). So, the country should extremely

consider limited access to pesticides and other deadly means. Also, to ban toxic pesticides used for suicidal ingestion (Chowdhury et al., 2018; Khan et al., 2020).

5.3 Helpline—Kan Pete Roi and National Helpline (999)

In Bangladesh, the only telephonic helpline '*KAAN PETE ROI*' (my ears wait to listen) is established in 2013. It is also known as Bangladesh–Befrienders, an initiative IASP. Nonetheless, the mobile numbers are not widely distributed and unique one, unable to reach 24 h in every day(Iqbal et al., 2019; Arafat, 2018; Khan et al., 2020). The contact numbers used for the hotline seem like a personal number. Again, the services are not available for 24 h in every day as because the activities of this platform are run by volunteers. *SAJIDA Foundation*, a non-government organization works together with this helpline through the *WhatsApp* platform during the COVID-19 pandemic.

The national crisis hotline (999) was launched in December 2017. It is accomplished by the home ministry of Bangladesh and plays a significant role in suicide prevention by saving endangered individuals.

5.4 NGO-SOVA, BTF

There are few organizations that aim to work in preventing suicide in Bangladesh. *Society for Voluntary Activities* (SOVA), a non-government organization, is actively involved with suicide prevention activities in *Jhenaidah*, a suicide-prone district in Bangladesh (Khan et al., 2020). This organization extensively worked in mitigating and resolving the causes related to suicide and attempts to suicide in *Jhenaidah* from 2005 to 2017 under the direct financial backing of *Manuser Jonno Foundation* (foundation for man). In recognition of its highly impressive activities, SOVA achieved an international award (known as Lee Award) from the IASP. Currently, it is not functioning because of not being able to assemble funds from any donor organization for being instrumental (Khan et al., 2020).

Brighter Tomorrow Foundation (BTF) is another NGO established in 2015 with a view to work for public mobilization against suicide, sensitization of reporting in media, celebrating international suicidal prevention day and mental health day (Khan et al., 2020).

5.5 Academic Society—SSPB

The Society for Suicide Prevention Bangladesh (SSPB), an association was founded in 2016 with the ambition to enhance suicide prevention in Bangladesh. Unfortunately, it is struggling to demonstrate noticeable suicide prevention activities. Also, it could not make any national and international collaboration for increasing its activities (Arafat, 2018; Khan et al., 2020).

6 Readiness of National Suicide Prevention Strategies

WHO widely explored the importance of developing a national suicide prevention strategy that has numerous benefits such as helps to outlines the scope and magnitude of the problem as well as momentously recognizes that suicidal behavior is a major public health problem. It is also an indicator of the commitment of a government to addressing the issue. It recommends a structural framework incorporating various aspects of suicide prevention and provides authoritative guidance on key evidence-based suicide prevention activities. It helps to identify key stakeholders and allocate specific responsibilities to them. Moreover, it outlines the necessary coordination among these various groups and identifies vital gaps in existing legislation, service provision, and data collection and indicates the human and financial resources required for interventions. It shapes advocacy, awareness-raising and media communications and proposes a robust framework of monitoring and evaluation, thereby instilling a sense of accountability among those in charge of interventions as well as provides a context for a research agenda on suicidal behaviors (WHO, 2018).

According to Arafat (2021), Bangladesh has not formulated a central suicide database and national suicide prevention strategies until now. This section aims to focus on the current status of Bangladesh with regard to establishing national suicide prevention strategies based on 12 components suggested by WHO. Responsible media reporting is a key element of the national suicide prevention strategy but it is poor in quality and unresponsive to Bangladesh. It has no concrete guideline which is obligatory to improve the current status. To sustain nationwide suicide prevention program and awareness raising is an important component. However, few periodic activities are done by some NGOs and from the government level. There is also a lack of structured policies which is necessary to raise awareness among mass population at a satisfactory level. To develop skilled manpower through training and education is a key to articulate suicide prevention strategies but is not outlined yet in Bangladesh. The available treatment facilities for suicide patients are drastically insufficient and as it is an illegal offense the individual with suicide referred to a police case. There is also a lack of fund and political motivation for research on suicide and activities for suicide prevention. The services available for crisis intervention are inadequate according to demand. There is also lacking of institutional support to create a leader for the promotion and prevention of suicide. The government of Bangladesh has banned WHO class I pesticides but policy regarding other methods of means restriction is ignored. As an element of national suicide prevention strategies, it is recommended to take care of the postvention but they are not interested due to the legal status of the society and stigma. Again, stigma, inadequate services and avoidance of the providers may hinder the accessibility of the individual who are vulnerable. To establish a national suicide surveillance is challenging for underreporting and poor quality of data. So, Bangladesh is far off from the components of national suicide prevention strategies suggested by WHO.

7 Challenges of Suicide Prevention in Bangladesh

A well-designed suicide prevention strategy may threaten its success and sustainability due to barriers. So, overcoming barriers is crucial and actions need to be well-defined and structured, taking into account the stakeholders involved, the resources available, and the characteristics of the national and local contexts. Considering this in advance may help to avoid barriers and reduce their consequences (WHO, 2018). According to WHO, potential barriers to consider when implementing national suicide prevention strategies are management and logistics to understanding the problem and for actions and interventions, stakeholders for leadership and management, teamwork and collaboration and legislation and policies, financial resources, human resources, multisectoral involvement, data and stigma (WHO, 2018).

From the previous section, it gives an impression that Bangladesh may not rapidly moving forward toward suicide prevention because of the lack effective and comprehensive policy measures to fight suicide and suicidal behavior. Again, the prevention intervention which is available is isolated, segmented, mostly under-performing, under-funded, or not funded. So, there is no visible societal impact. In such a circumstance, it is not surprising for LMICs like Bangladesh to have obstructing factors and challenges (Khan et al., 2020). The significant challenges for suicide prevention in Bangladesh are as follows:

7.1 Criminal Legal Status

According to the Penal Code (1860) section 309, Suicide is considered as criminal offence in Bangladesh. Any person attempts to suicide and activities related with this will be punishable through imprisonment and fine. The member of law enforcement agency has the right to arrest people who endeavoring suicide. In addition, to avoid legal procedure and harassments patient cannot complete treatment and leave the hospital without any prior notice. It is also a stigmatized and discriminated issue in the country (Soron, 2019). However, modification of the legal situation of suicide might be advantageous to decrease societal stigma, unnecessary legal harassment, anxiety to take health services after suicidal comportment (Arafat, 2019; Arafat and Khan, 2019). Decriminalization may help to destigmatize the problem and increase the proper help-seeking behaviors for suicidality as well as demolish the undue legal harassments (Arafat, 2019).

7.2 Poor Quality of Media Reporting

An accountable media reporting is key to a potential national suicide prevention strategy for mass population (WHO, 2017; Zalsman et al., 2016; Niederkrotenthaler et al., 2020). Media play a noteworthy role to raise awareness among the people and change their attitude on suicide and prevention

of suicide. In Bangladesh, there is a lack of enquiry of suicide reporting by media. Thus, general people are misunderstood and misguided of this issue. As suicide is a criminal offence in Bangladesh, media broadcasting of suicide events is undertaken by crime journalists (Arafat, 2019). A study conducted reveals that report of suicide news is placed on the first page of the newspaper and majority reported the methods of suicide with details. About fifty percent of the articles provide monocausal description of suicide incident. Few articles report the place of suicide and suicide note in details and also the impacts of suicide on person with bereaved. It also noted that tremendous lack of supportive reporting features on suicide and views of mental health experts (Arafat et al., 2020). Furthermore, media reports from online portal also deliver data in poor quality on suicidal behavior such as mention victim's name with details, methods of suicide including victim's image. There is no report observe with education and prevention approaches of suicide for mass population (Arafat et al., 2019).

7.3 Poor Data Quality

A reliable source of suicide information is a real challenge in the country and actual rate of suicide is yet to be estimated (Arafat, 2019, 2017; Shah et al., 2017). A countrywide epidemiological study has not been conducted in Bangladesh (Arafat, 2019). The absence of a national suicide prevention strategy, nonexistence of central database, surveillance system for suicide, and extreme stigma is a serious challenge for Bangladesh like many other countries of Southeast Asia (Armstrong and Vijayakumar, 2018; Arafat, 2017).

7.4 Poor Awareness and Suicide Literacy Along with High Suicide Stigma

Study reveals that suicide literacy among the university students of Bangladesh is inadequate and they also have poor knowledge on suicidality and depression. The presence of stigma, legal status of suicide as a criminal offence and lacking of mass education among the people could be the key determinants of poor literacy of suicide that is hamper the help-seeking behavior of suicide in the country (Arafat, Menon et al., 2021). However, they have adequate knowledge on suicide prevention and the role of mental health experts (Arafat et al., 2022). For example, the Prime Minister of Bangladesh gave direction to establish a suicide research institution in *Jhenaidah* in 2014, a suicide prone area, was not established until now. It indicates the lack of knowledge, capacity and unenthusiastic to give priority on suicide prevention (Khan et al., 2020).

7.5 *Inadequate Mental Health Services*

In Bangladesh the available mental health services are drastically inadequate according to the need of the people. A few initiatives are taken for suicide prevention in Bangladesh such as two SPCs are established; one is public with limited hours of service provision and the other is private. The extreme lacking of mental health services are a significant challenge for the national suicide prevention strategy in the country (Arafat, Menon et al., 2021; Arafat et al., 2019; Arafat, 2018).

7.6 *Negligible Budget*

The fund availability for suicide prevention activities, research on suicide, and the mental health services are undoubtedly inadequate. Normally, the budget for mental health is approximately 0.5% of health budgets. There is also a lack of political motivation to introduce a suicide prevention policy which is a timely demand for the country (Arafat, 2021).

8 Suicide Prevention in Bangladesh: Way Forward

'*National suicide prevention strategies: Progress' examples and indicators*' a report launched by WHO in 2018 to support countries with their continued progress in suicide prevention, whilst inspiring others to establish or revise their national suicide prevention strategies. In this situation, Bangladesh should pay attention to global call and formulate a national suicide prevention action plan (Khan et al., 2020). A national suicide database and suicide surveillance is an imperative considerations of Bangladesh. Changes in the legal system to decriminalize suicide in the country should be considered as instantaneous priority, which has been already done in some other parts of the world (Soron, 2019; Arafat, 2019). Decriminalisation may help to destigmatize the problem and increase the proper help-seeking behaviours for suicidality as well as demolish the undue legal harassments (Arafat, 2019). It is an immediate obligation for the country to construct appropriate prevention strategy to formulate, initiate, implement and evaluate its effectiveness. Multisectoral collaboration such as clinicians, social scientist, researchers, funders, media professionals, social workers, voluntary organisations, non-governmental organisation, government, and/or any organisation connected with suicidality is also a key action for the country. International organisations should come forward to cooperate with the country in this regard (Arafat, 2019).

Bangladesh may consult with Bhutan and Sri Lanka as they have effective national prevention strategy and have similar socio-economic and cultural context (Khan et al., 2020; WHO, 2018). In 2015, Bhutan adopted three years action plan from 2015 to 2018 for suicide prevention (Vijayakumar

et al., 2020). This multifaceted action plan necessitates diverse cross-sectoral key stakeholders, sectors, and organizations. A Suicide Prevention Steering Committee (NSPSC) was created under the Ministry of Health to maintain governance and active operation of the plan (WHO, 2018).

8.1 Decriminalization

In many countries decriminalization of suicide is considered as a part of suicide prevention strategy (Suryadevara and Tandon, 2018). The issue is also raised by some other Asian countries (Suryadevara and Tandon, 2018). At present, the decriminaliztion of suicide is a rising issue pronounced by the academicians in Bangladesh. In the country, it is a vital prerequisite for confirming suitable suicide prevention environment (Soron, 2019). However, only decriminalization will not provide any positive impact on suicide prevention in Bangladesh without addressing the other vital issues related to suicide like trustworthy reporting of media on suicidal behavior, suicide surveillance system, national database of suicide, national suicide prevention strategies, empirical research and appropriate policy implementation. This may lead to change the attitude of mass people to suicidality by reducing legal restriction, social stigma and also increase the accessibility to health care.

On the contrary, the recently endorsed *Bangladesh Mental Health Act 2018* does not suggest any clear provision to approach decriminalization of suicide or attempt to suicide but the matter of decriminalization must be prioritized in order that suicidal populations can have their access to treatment instead of punishment (Soron, 2019; Vijayakumar et al., 2020; Khan et al., 2020). Again, Bangladesh is on the way to articulate an inclusive suicide prevention policy or an essential database for suicide prevention in line with the call of WHO (Arafat, 2021). Bangladesh highly needs an inclusive and vigorous mental health strategy that integrates suicide prevention (Khan et al., 2020).

8.2 Media Monitoring

Responsible media reporting of suicide is one of the four pillars of the WHO's *Live Life* suicide prevention framework. Detrimental media reporting transmits contagion risks for people vulnerable to suicide. There is an opportunity to implement media reporting approaches that may have protective effects on the population (WHO, 2021b).

8.3 Intersectoral Collaboration

It is necessary since the risk factors for suicide are linked with many areas. A whole-of-society approach works across government sectors or departments and includes nongovernmental and community groups and facilitates knowledge-sharing, exchange of methodologies and lessons learned, and

sharing of suicide-related data and research under the leadership of government (WHO, 2014). Intersectoral collaborators such as clinicians, social workers, researchers, media professionals, social scientists, voluntary organisations, government and non-governmental organisations connected with suicidality are a keyactorin the country. International organisations should come forward to cooperate with the country in this regard (Arafat, 2019).

8.4 More Funds in Suicide Research

Financing for suicide prevention is often inadequate because of factors such as poor economic conditions, lack of prioritization of suicide as a serious issue, and lack of recognition that suicides are preventable. So, that requests for funds should include a focus on the development and implementation of policies, strategies, and plans (WHO, 2014).

8.5 Raising Awareness

It depends on targets a public audience and an organized process of communication through which draws people's attention to the facts such as suicide is a serious public health issue. Advocacy aims to bring about changes such as decriminalization or a national suicide prevention strategy. Both the strategies can range from a single community to nationwide public communication campaigns such as 'World Suicide Prevention Day'. It may also help to decrease stigma and negative attitudes among people with a mental disorder (WHO, 2014).

8.6 Gate Keeper Training

Sometimes people who are at risk of suicide may not seek help. A "*gatekeeper*" can be useful in such cases to identify the risky individuals and to refer them to mental health services based on it's accessibility and availability (WHO, 2014).

8.7 Improved Quality Data

National suicide database and suicide surveillance is an imperative consideration of Bangladesh to improve the quality of suicide data in Bangladesh. Changes in the legal system to decriminalize suicide in the country should be considered as instantaneous priority to ensure better suicide reporting which in turn will improve the suicide data quality in the country (Arafat, 2019; Suryadevara and Tandon, 2018).

8.8 National Suicide Surveillance System

It can provide data on suicide and self-harm to guide LIVE LIFE interventions and the source of data such as civil registration and vital statistics, health and police records, verbal autopsies, and population-based surveys.

8.9 National Suicide Prevention Strategy

'*National suicide prevention strategies: Progress' examples and indicators*' a report launched by WHO in 2018 to support the countries in suicide prevention with their continued progress, whilst inspiring others to launch or revise their national suicide prevention strategies. In this situation, Bangladesh should pay attention to global call and articulate a national suicide prevention action plan (Khan et al., 2020). It is an immediate obligation for the country to construct appropriate prevention strategy to formulate, initiate, implement and evaluate its effectiveness.

8.9.1 Increased Psychiatric Services

Generally, in the primary care setting depression and other forms of psychiatric disorders are under-treated and under-predictable. Studies from several developed countries revealed that there is a significant association educating of primary care provider and reducing suicide by early identification of depression, substance abuse, and other risk factors for suicide. For example, in Australia, to implement a training program for physician of the primary care level help to increase the diagnosis rate by 130% of suicidal patients. Subsequently, educating physician of the primary health care level for appropriate assessment of depression and evaluation of the risk of suicide is an element of suicide prevention (Mann et al., 2005; Zalsman et al., 2016).

8.9.2 Religious or Spiritual Beliefs

Religious beliefs and spirituality give mental happiness. They inspire people to endure in any kind of difficulties. Generally, people commit suicide when they cannot accept something contrary to their expectation. Most religions prohibit committing suicide and consider it a great sin. Suicide is forbidden in both Judaism and Christianity. It is also forbidden in Islam. Again, spirituality gives mental satisfaction which is very important in abstaining from any kind of harmfulness including suicide. Thus, religion and spirituality can play a vital role in preventing all sorts of destruction including one's own. So, by maintaining religious obligation and spirituality, a society can prevent suicide.

9 Conclusion

In Bangladesh, suicide is a neglected public health issue. The key risk factors are triumphed within the family and the common methods are hanging and poisoning. The criminal legal status, poor quality data, lack of awareness, actual suicide rate, poor quality media reporting, inadequate mental health services, social stigma, negligible budget, and poor coordination among the sectors are real challenge for this part. The mortality rate by suicide was higher among women than men in their productive age and hindered the economic development of the country. Effective and encompassing policy interventions though obtaining a promise from the policymakers is a daunting task. Preventive measures have been in progress but yet to make tracks. Finally, empirical studies, increased psychiatric services through primary care physician education in different levels of health sector, decriminalization and national suicide surveillance are the priority list for the country.

References

Arafat, S. M. Y. (2017). Suicide in Bangladesh: A mini review. *Journal of Behavioral Health, 6*(1), 66–69. https://doi.org/10.5455/jbh.20160904090206

Arafat, S. M. Y. (2018). Suicide prevention activities in Bangladesh. *Asian Journal of Psychiatry, 36*, 38. https://doi.org/10.1016/j.ajp.2018.06.009

Arafat, S. M. Y. (2019). Current challenges of suicide and future directions of management in Bangladesh: A systematic review. *Global Psychiatry, 2*(1), 9–20. https://doi.org/10.2478/gp-2019-0001

Arafat, S. M. Y. (2021). Formulation of national suicide prevention strategy of Bangladesh: The readiness assessment. *Journal of Public Health (Oxford, England), 43*(1), e131–e132. https://doi.org/10.1093/pubmed/fdaa117

Arafat, S. M. Y., & Kabir, R. (2017). Suicide prevention strategies: Which one to consider? *South East Asia Journal of Public Health, 7*(1), 1–5. https://doi.org/10.3329/seajph.v7i1.34671

Arafat, S. M. Y., & Khan, S. T. (2019). Suicide prevention in Bangladesh: Only decriminalization would not be beneficial in an expected fashion. *Asian Journal of Psychiatry, 36*, 22–23. https://doi.org/10.1016/j.ajp.2019.03.027

Arafat, S. M. Y., Khan, M. M., Niederkrotenthaler, T., Ueda, M., & Armstrong, G. (2020). Assessing the quality of media reporting of suicide deaths in Bangladesh against world health organization guidelines. *Crisis, 41*(1), 47–53. https://doi.org/10.1027/0227-5910/a000603

Arafat, S. M. Y., Mali, B., & Akter, H. (2018). Demography and risk factors of suicidal behavior in Bangladesh: A retrospective online news content analysis. *Asian Journal of Psychiatry, 36*(July), 96–99. https://doi.org/10.1016/j.ajp.2018.07.008

Arafat, S., Hussain, F., Hossain, M. F., Islam, M. A., & Menon, V. (2022). Literacy and stigma of suicide in Bangladesh: Scales validation and status assessment among university students. *Brain and Behavior, 12*(1), e2432. https://doi.org/10.1002/brb3.2432

Arafat, S., Khan, M., Knipe, D., & Khan, M. M. (2021). Population attributable fractions of clinical and social risk factors for suicide in Bangladesh: Finding from

a case-control psychological autopsy study. *Brain and Behavior, 11*(12), e2409. https://doi.org/10.1002/brb3.2409

Arafat, S. M. Y., Mali, B., & Akter, H. (2019). Quality of online news reporting of suicidal behavior in Bangladesh against World Health Organization guidelines. *Asian Journal of Psychiatry, 40*, 126–129. https://doi.org/10.1016/j.ajp.2018.10.010

Arafat, S., Menon, V., & Kar, S. K. (2021). Media and suicide prevention in Southeast Asia: Challenges and directions. *Journal of Public Health (Oxford, England), 43*(1), e123–e124. https://doi.org/10.1093/pubmed/fdaa084

Arafat, S., Mohit, M. A., Mullick, M., Kabir, R., & Khan, M. M. (2021). Risk factors for suicide in Bangladesh: Case-control psychological autopsy study. *BJPsych Open, 7*(1), e18. https://doi.org/10.1192/bjo.2020.152

Armstrong, G., & Vijayakumar, L. (2018). Suicide in India: A complex public health tragedy in need of a plan. *The Lancet. Public Health, 3*(10), e459–e460. https://doi.org/10.1016/S2468-2667(18)30142-7

Chowdhury, F. R., Dewan, G., Verma, V. R., Knipe, D. W., Isha, I. T., Faiz, M. A., Gunnell, D. J., & Eddleston, M. (2018). Bans of WHO class I pesticides in Bangladesh-suicide prevention without hampering agricultural output. *International Journal of Epidemiology, 47*(1), 175–184. https://doi.org/10.1093/ije/dyx157

Feroz, A., Islam, S. N., Reza, S., Rahman, A. M., Sen, J., Mowla, M., & Rahman, M. R. (2012). A community survey on the prevalence of suicidal attempts and deaths in a selected rural area of Bangladesh. *Journal of Medicine, 13*(1), 3–9. https://doi.org/10.3329/jom.v13i1.10042

Iqbal, Y., Jahan, R., & Matin, M. R. (2019). Descriptive characteristics of callers to an emotional support and suicide prevention helpline in Bangladesh (first five years). *Asian Journal of Psychiatry, 45*, 63–65. https://doi.org/10.1016/j.ajp.2019.09.005

Kabir, R., Hasan, M. R., & Arafat, S. M. Y. (2023). Epidemiology of suicide and data quality in Bangladesh. In S. Y. Arafat & M. M. Khan (Eds.), *Suicide in Bangladesh* (pp. 1–16). Springer. https://doi.org/10.1007/978-981-99-0289-7_1.

Khan, A. R., Arendse, N., & Ratele, K. (2020). Suicide prevention in Bangladesh: The current state and the way forward. *Asian Social Work and Policy Review, 15*(1), 15–23. https://doi.org/10.1111/aswp.12214

Khan, A. R., Ratele, K., Arendse, N., Islam, M. Z., & Dery, I. (2020). Suicide and attempted suicide in Jhenaidah district, Bangladesh, 2010–2018. *Crisis, 41*(4), 304–312. https://doi.org/10.1027/0227-5910/a000631

Khan, A. R., Ratele, K., Helman, R., Dlamini, S., & Makama, R. (2022). Masculinity and suicide in Bangladesh. *Omega, 86*(1), 218–240. https://doi.org/10.1177/0030222820966239

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mehlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schmidtke, A., Shaffer, D., Silverman, M., Takahashi, Y., Hendin, H. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association, 294*, 2064–2074. https://doi.org/10.1001/jama.294.16.2064

Mashreky, S. R., Rahman, F., & Rahman, A. (2013). Suicide kills more than 10,000 people every year in Bangladesh. *Archives of Suicide Research, 17*, 387–396. https://doi.org/10.1080/13811118.2013.801809

Naghavi, M., & Global Burden of Disease Self-Harm Collaborators. (2019). Global, regional, and national burden of suicide mortality 1990 to 2016: Systematic analysis

for the Global Burden of Disease Study 2016. *BMJ, 364*, l94. https://doi.org/10.1136/bmj.l94

Niederkrotenthaler, T., Braun, M., Pirkis, J., et al. (2020). Association between suicide reporting in the media and suicide: Systematic review and meta-analysis. *BMJ, 368*, m575. https://doi.org/10.1136/bmj.m575

Shah, M., Sajib, M., & Arafat, S. (2018). Demography and risk factor of suicidal behavior in Bangladesh: A cross-sectional observation from patients attending a suicide prevention clinic of Bangladesh. *Asian Journal of Psychiatry, 35*, 4–5. https://doi.org/10.1016/j.ajp.2018.04.035

Shah, M. M. A., Ahmed, S., & Arafat, S. M. Y. (2017). Demography and risk factors of suicide in Bangladesh: A six-month paper content analysis. *Psychiatry Journal, 2017*, 3047025. https://doi.org/10.1155/2017/3047025

Shahnaz, A., Bagley, C., Simkhada, P., & Kadri, S. (2017). Suicidal behavior in Bangladesh: A scoping literature review and a proposed public health prevention model. *Open Journal of Social Sciences, 5*, 254–282. https://doi.org/10.4236/jss.2017.57016

Sharmin Salam, S., Alonge, O., Islam, M. D., Hoque, D., Wadhwaniya, S., Ul Baset, M. D., Mashreky, S., & El Arifeen, S. (2017). The burden of suicide in rural Bangladesh: Magnitude and risk factors. *International Journal of Environmental Research and Public Health, 14*(9), 1032. https://doi.org/10.3390/ijerph14091032.

Soron, T. R. (2019). Decriminalising suicide in Bangladesh. *Asian Journal of Psychiatry, 39*, 91–92. https://doi.org/10.1016/j.ajp.2018.12.012

Suryadevara, U., & Tandon, R. (2018). Decriminalization of attempted suicide across Asia—It matters! *Asian Journal of Psychiatry, 35*, A2–A3. https://doi.org/10.1016/j.ajp.2018.06.001

Vijayakumar, L., Daly, C., Arafat, Y., & Arensman, E. (2020). Suicide prevention in the Southeast Asia region. *Crisis, 41*(Suppl 1), S21–S29. https://doi.org/10.1027/0227-5910/a000666

WHO. (2013). *Mental health action plan 2013–2020*. Geneva: World Health Organization. https://www.who.int/publications/i/item/9789241506021 (accessed on July 25, 2022)

WHO. (2014). *Preventing suicide: A global imperative*. Geneva: World Health Organization. https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/ (accessed on July 25, 2022).

WHO. (2017). *Preventing suicide: A resource for media professionals Update 2017*. Geneva: International Association for Suicide Prevention (IASP): World Health Organization. Department of Mental Health and Substance Abuse. https://apps.who.int/iris/handle/10665/258814 (accessed on July 15, 2022)

WHO. (2018). *National suicide prevention strategies: Progress, examples and indicators*. Geneva: World Health Organization. https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/ (accessed on September5, 2022).

WHO. (2021a). *Suicide worldwide in 2019: Global health estimates*. Geneva: World Health Organization (accessed on September 1, 2022).

WHO. (2021b). *LIVE LIFE: An implementation guide for suicide prevention in countries*. Geneva: World Health Organization (accessed on September 5, 2022).

WHO. (2022). Mental Health Atlas 2020 country profile: Bangladesh. https://www.who.int/publications/m/item/mental-health-atlas-bgd-2020-country-profile (accessed on July 15, 2022)

World Population Review. (2022). Bangladesh Population 2022 (Live). https://worldpopulationreview.com/countries/bangladesh-population (accessed on September 16, 2022)

Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Höschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J. P., Sáiz, P. A., Lipsicas, C. B., Bobes, J., Cozman, D., Hegerl, U., & Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. *The Lancet. Psychiatry, 3*(7), 646–659. https://doi.org/10.1016/S2215-0366(16)30030-X