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Five-Year Trends and Patterns of Suicide in Karnali Province, Nepal: A Descriptive Analysis

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Abstract

Suicide remains a major global public health concern, with Nepal experiencing a substantial burden in recent years. This study examines five-year suicide trends in Karnali Province, Nepal, using a descriptive research design and secondary data. The findings reveal 1,517 reported suicide cases, of which young people accounted for 38.6%. Hanging was the most common method (83.9%), while domestic violence was the leading reported cause (31.4%). Married individuals constituted 73.3% of the cases. Geographically, Surkhet, Dailekh, and Salyan together accounted for 70% of reported suicides across the province's 10 districts. These findings highlight the need for comprehensive, multidimensional suicide prevention strategies, including accessible community-based mental health services, livelihood support, domestic violence prevention and response, and youth-focused psychosocial counselling.

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<https://muodgshss.edu.np>**Keywords:** Determinants of suicide, Socio-economic determinants of suicide, Suicide prevention, Suicide rate, Suicide trend

Introduction

Globally, suicide is emerging as a major challenging issue even in the 21st century. Every year, many lives are lost due to it. Black's Law Dictionary defines suicide as the act or an instance of taking one's own life voluntarily and intentionally. It further notes that the act is also termed "self-killing, self-destruction, self-slaughter, self-murder, or death by one's own hand. The WHO defines suicide as the deliberate act of ending one's own life, emphasizing its multidimensional nature. Durkheim (1987) led the understanding of suicide with social factors, before that people defined suicide as a personal health issue. Durkheim claimed that all suicidal behavior is influenced by levels of social integration and regulation. Durkheim divided suicide in egoistic, altruistic, anomic, and fatalistic four types which show how social forces shape individuals to take their own life. Besides that, psychological perspectives focus on deliberate, self-directed act of injury intended to cause one's own death. Freud's (1917) and Shneidman (1985) viewed suicide not simply as a physical act, but as a complex psychological coping mechanism used to escape overwhelming emotional pain, unbearable psychological distress and hopelessness (Bist & Kandel, 2026).

According to (WHO 2025), nearly 727,000 individuals take their own life by suicide in 2021. Nearly 73% of all these suicide cases occurred in the low and middle-income countries. Adults among 15-29 years are the most vulnerable age group of suicide worldwide, reflecting an alarming youth mental health crisis. Analyzing the South Asian context suicide rates are consistently overtaking global averages, with significant variations across countries from 0.43 per 100,000 in Pakistan to over 58 per 100,000 in parts of Bangladesh (Arafat, 2018). In South Asia the dense populations, entrenched social hierarchies, limited mental health facilities and worse financial condition lead to the stress and self-harm. In Nepal past five years, it has facing large scale of historic increases in suicide cases. Nepal Police (2024) data show that suicide rates rose by an average of 7.2% annually over the past five years, with a 14% increase in 2021 alone. The fiscal year 2023/24 recorded 7,223 suicides the highest single-year figure in Nepal's history, accounting for around 20 deaths daily. This data humiliates the commitment of our country to Sustainable Development Goal 3.4, which aims to reduce premature mortality from non-communicable diseases and promote mental health, including a target suicide rate of 4.7 per 100,000 populations by 2030. The National Mental Health Survey (2020) revealed that nearly 80% of Nepal's requiring mental health care do not receive it, highlighting critical service gaps and the concern on mental health issue.

Karnali Province, one of the largest and most scattered population and lack of infrastructure development, low education level, geographically remote, worse financial condition, lack of health care facilities leads this province to the

vicious circle of suicide. Among other six provinces these unique features make Karnali more vulnerable for suicide. According to Nepal Police (2024) the Province Police record a total of 1,211 people take their life by suicide over four years (2019–2023) in Karnali. Overall suicide prevention methods may not useful to address the recent issues and trends of suicide in Karnali. Understanding province-specific dynamics is essential for developing targeted, evidence-based prevention strategies. This study will fill the gap by analyzing five years of suicide data from 2020–2025 BS. Therefore, this study aims to examine trends, compare socioeconomic, demographic, and regional variations and analyzing the primary causes and methods of suicide. This study seeks to inform policy and programmatic made to fit specific needs to Karnali's unique context.

Literature Review

The word “suicide” derives from the Latinized term *suicidium*, referring to the act of killing oneself, and entered the English language in the seventeenth century (Barraclough & Shepherd, 1994). In early modern England, self-killing was treated as a serious legal and religious offence, and individuals who died by suicide could be subjected to degrading burial practices (MacDonald & Murphy, 1990). In Hindu traditions, suicide has generally been viewed negatively, with beliefs concerning karma and rebirth suggesting that self-killing may have adverse spiritual and karmic consequences and may impede the progression toward liberation (Mohanty, 2018). In the 18th century Durkheim presented sociological theory to understand suicide. He defines suicide as a social phenomenon and argues that society plays a significant role in shaping suicidal behavior. He addressed suicide vary based on levels of social integration and social regulation and category suicide into four main types i.e., egoistic, altruistic, anomic and fatalistic, (Durkheim, 1897). After Durkheim's ideology suicide is defined by different scholars from very dimensions. Freud (1917) defines suicide as an unconscious act of aggression or a murder wish turned inward against the self. He theorized suicide driven by two main psychological concepts i.e., aggression turned inwards and the death drive. Likewise, another scholar Menninger (1938) defines suicide not just a single act but as a spectrum of self-aggression and three unconscious wishes: the wish to kill, the wish to be killed, and the wish to die.

In modern society suicide is consider as the international act of causing one's own death. The contemporary understanding on suicide has shifted as a complex public health challenge influenced by mental health disorders, severe stress and social factors, WHO (2026). Suicide does not just occur in a high-level income country but is a global phenomenon in all regions of the world. Every suicide is a tragedy that affects family, communities and entire countries. With timely, evidence based and often low-cost intervention, suicide can be prevented. For national response to be effective, a comprehensive multi-sectoral suicide prevention strategy is essential (WHO 2021).

Despite having one-quarter of world's population South Asia is facing a high suicide burden around one-third of global suicide deaths (Patel, 2012). In this region some common factors of suicide are identified by the researchers as poverty, debt, unemployment, domestic violence, marital conflict, social marginalization and limited mental health facilities (Arafat, 2018; Niaz, 2012). Another vulnerable fact in this region is increasing in the farmer's suicide rates which is closely linked to lack of irrigation, agriculture disaster, crop failure, indebtedness and worse agriculture policy (Mishra, 2014; Debnath, 2019). Pesticide poisoning is common in agricultural regions of Asia, including India, Sri Lanka and China, easy access to toxic chemicals increases suicide acts (Gunnell, 2007). In South Asia female suicide rate is higher while males outnumber female globally (Canetto & Sakinofsky, 1998). Some major causes of suicide are gender-based violence, early marriage, dowry conflicts, restricted autonomy, and limited socioeconomic opportunities for women (Arafat, 2024) lead to increase suicide rate in South Asia.

Nepal is also not out of the risk zone increasing trends of suicide. 13.6% adolescents committed suicide who were studying between grades 7 to 11, for same grades 10.3% were reported to attempts suicide (Aryal, 2021). Easy availability of pesticide leads a major poisoning method of suicide in Southern Nepal, where among 116 suicide attempt survivors, 78.4% used pesticide poisoning, 82.7% of attempts were impulsive and 60% had diagnosable mental illness primarily depressive disorders (Jordan, 2017). In compared to urban area rural residence are facing more challenges: geographical isolation, limited healthcare access, pervasive stigma, and socioeconomic marginalization which leads to attempt suicide (Singh, 2020).

Methodology

This study employed quantitative research methodology. Descriptive research method for the qualitative data analysis and analytical research design for quantitative data analysis. Descriptive research interpretation and describe all the secondary data which are related to socioeconomic distribution, trends, methods and causes of suicide in Karnali Province. Likewise, analytical component focuses on the comparative analysis of socioeconomic, demographic and cultural frameworks of suicide in Karnali Province.

Data Collection and Analysis

The major sources of this research are based on the secondary data. This study is fully depended on the provided secondary data from the Karnali Province Police Office database. The office provided all raw data are available as soft copy through email. The five-year data which are officially recorded and only officially registered, include 1,517 cases are recorded between July 16, 2020, and August 16, 2025 (Nepali fiscal years 2077/78–2081/82). In this research, the data are rearranged and analyzed without manipulating the raw data.

Ethical Considerations

The data were provided by the Karnali Province Police Office in response to a formal written request. All the secondary data available as raw materials remain original, analysis and rearrange them without modifying them. Personal identifiers included in the raw data were not included in this analysis. This research fully obeyed all the ethical principles of privacy and lawful use of data.

Limitations of the study

This study has several limitations. First of all, this study based on secondary data by Nepal Police which may minimize the actual suicide incidence during reporting, collection and real information. The recorded data are based on the police investigation process rather than psychological and community health-based aspects. Suicide is often underreported due to different cultural stigma, religious prohibition and legal burden. Despite these limitations, this study provides the most comprehensive analysis of suicide in Karnali Province for five years.

Results

A total 1,517 suicide cases were officially registered over the five years (2020/21 to 2024/25) in Karnali Province. Annual number of suicides remained comparatively stable from 271 to 326 cases, each year ranging around 18 to 22% of the total suicide cases. The largest suicide cases registered in 2020/21 (326 cases, 21.5%), nearly followed by 2023/24 (324 cases, 21.4%). The minimum cases were registered in 2022/23 (273 cases, 18.0%). Continuous decreasing in 2021/22 and 2022/23, suicide cases rebounded in 2023/24 before a slight decrease in 2024/024 (305 cases, 20.1%). The overall suicide pattern in Karnali province in five fiscal year shows the pattern fluctuates, decreasing for two years, increasing in 2023/24, and decreasing again in 2024/25.

District-wise Distribution of Suicide

In Karnali Province, among the 10 districts Surkhet is in the leading position with 2 to 3 times higher suicide number (36.5%) of overall suicide cases, which is so far from Dailekh (17.2%) and Salyan (17.1%). Only these 3 districts occupy 70% of all suicide cases in Karnali Province. Compared to those the five districts Kalikot, Jumla, Mugu, Humla, and Dolpa all together registered only 11.8% of total suicide cases.

Table 1: District-wise Distribution of Suicide Cases in Karnali Province (2020/21–2024/25)

District Name	Fiscal Year					Total
	2020/ 21	2021/22	2022/23	2023/24	2024/ 25	
Surkhet	118	101	109	112	114	554
Dailekh	53	56	44	59	49	261
Jajarkot	26	18	19	31	20	114
Rukum	30	26	28	26	40	150
Salyan	65	53	45	54	42	259
Kalikot	13	17	12	16	15	73
Jumla	14	7	6	14	12	53
Mugu	4	8	4	5	9	30
Humla	3	1	6	5	2	17
Dolpa	0	2	0	2	2	6
Total	326	289	273	324	305	1517

Source: Karnali Province Police Office, Surkhet.

Distribution of Suicide by Rural/Urban Area

The suicide occurrences in rural municipalities are considered rural areas and municipalities are urban areas. Rural areas consistently reported 2 to 3 times higher suicide cases than municipalities. Overall analysis show that rural suicide occupies 70% of the total suicide cases in Karnali Province. One of the interesting facts in this research suicide is in increasing order every single fiscal year.

Methods of Committing Suicide

In Karnali Province, hanging is found as the primarily method of suicide in the five-year study period. In total 1517 studied cases hanging only covered 84% of overall suicide method. Likewise, poisoning was the second most common suicide method, with 14.4% in Karnali province. Other methods like drowning, jumping, used of weapon and self-immolation totally accounted for 1.7% nominal in total cases. This pattern clearly shows the highly vulnerable suicide method used by the people in Karnali province.

Socioeconomic Distribution of Suicide

In five-year, period agriculture is the most vulnerable group, 57% agricultural workers commit suicide in Karnali province, which is more than half of the total number of recorded suicide deaths. Students and unemployed individuals are in critical condition where business and public service employees are considered low level of suicide. Another socioeconomic distribution in educational sector is also showing surprising result in this research i.e., literate and educated people are committing more suicide than illiterate individuals in Karnali province. Increase of literate individuals (68.6%)

in suicide doubt in our educational system and pattern suggest that only literacy cannot help to reduce suicide in the setting like Karnali province of Nepal.

In Karnali province, Chhetri community individuals have the highest involvement in suicide. It only occupies 38.7% of the total suicide cases. Simultaneously Dalit and Janajati communities are also in critical condition, these three communities all together contribute 90% of suicide in Karnali Province. Brahmin and Madeshi community reflect nominal presence in suicide.

Table 2: Socioeconomic Distribution of Suicide Cases in Karnali Province

Socio-economic Variants		Fiscal Year					Total
		2020/21	2021/22	2022/23	2023/24	2024/25	
Occupation	Agriculture	174	172	157	182	180	865
	Public Service	32	5	3	4	2	46
	Business	21	23	21	24	44	133
	Study	63	46	45	72	56	282
	Unemployed	36	43	47	42	23	191
Education	Literate	186	215	200	225	214	1040
	Illiterate	77	21	21	46	52	217
	Ab. Grade 10	63	53	52	53	39	260
Caste	Brahmin	35	21	21	49	25	151
	Chhetri	78	140	124	115	131	588
	Janajati	112	62	62	79	67	382
	Dalit	99	66	66	72	82	385
	Madheshi	2	0	0	9	0	11

Source: Karnali Province Police Office, Surkhet.

Police-recorded reported circumstances associated with suicide

This study identified domestic violence as the predominant causes lead to suicide in Karnali province. Domestic violation contributed 31.4% of the overall suicide cases and closely flowed by another notorious casus of suicide depression as 26.7%. Poverty is the third most common causes of suicide in Karnali, while foreign employment-related stress is also in increasing as an emerging challenge of suicide in this province. Other causes included tragedy/accident, mental disease and fatal disease also have played vital role in suicide.

Demographic Distribution of Suicide

The research result show that young adults aged 19-30 years are the most affected and vulnerable group in Karnali province. This age group only occupied 37% of total suicide which is similar to the global pattern of suicide. Another notable part of suicide in Karnali is involvement of adolescents below the age of 18 is also in increasing order, over the five years these age group has 16% involvement with sharp increase in 2023/24. The gender pattern of suicide shows 5% more male are involved in suicide then the females in Karnali province. In 1517 total cases 55% male and 45% female committed suicide in five years. This is the overall majority, however a notable gender shift occurred in 2024/25, when female suicides (178 cases, 58.4%) went beyond male suicides (127 cases, 41.6%). Talking about the marital status, 73.3% married individual involvement in suicide is quite similar with global suicide pattern. The unmarried individuals comprised 26.7% overall but suicides increased notably in 2024/25 (121 cases, 39.7%), suggesting emerging vulnerabilities among unmarried populations.

Table 3: Demographic Distribution of Suicide Cases in Karnali Province

Demographic Variants		Fiscal Year					Total
		2020/21	2021/22	2022/23	2023/24	2024/25	
Age (years)	Below 18	36	34	35	96	38	239
	18 – 30	149	121	103	100	113	586
	31 - 41	97	74	75	74	82	402
	42 – 59	29	46	48	40	56	219
	60 & above	15	14	12	14	16	71
Gender	Female	133	118	105	148	178	682
	Male	193	171	168	176	127	835
Marital status	Married	225	254	200	249	184	1112
	Unmarried	101	35	73	75	121	405

Source: Karnali Province Police Office, Surkhet.

Discussion

This study finds out the pattern of suicide is fluctuating in five study periods in Karnali province. Despite the fluctuations in annual number of recorded suicide deaths overall pattern indicate an alarming public health crisis in this province. Public health crisis is shaped by complex socioeconomic, demographic and geographic determinants in Karnali province. Victims of suicide increase in agricultural sector, literate individuals, adolescent and adult age group, students, and married individuals bring unique challenge to prevent suicide in this province. The leading causes of suicide like domestic violence, depression, poverty, foreign employment related stress and mental disease indicates that existing prevention efforts have been insufficient to address the trends of suicide in Karnali. The global common methods of suicide are also in leading position in this province. Maximum findings in this research align with the previous global and regional evidence although we need local level target oriented specific suicide prevention initiatives.

Demographic Vulnerability

Finding of this research show 37% young adults aged 19-30 as the high-risk population align with the report of (WHO, 2025) Adults among 15-29 years are the most vulnerable age group of suicide worldwide, reflecting an alarming youth mental health crisis. In the South Asian region this crisis is further strengthened by the family expectations, education pressure, unemployment and limited mental health facilities (Kandel, 2023; Patel 2012). The sharp increase in adolescent suicide by 96 cases in 2023/24 linked to post-pandemic stressors, academic pressure, and social media influences (WHO, 2023) need an alarming intervention. These findings reveal some urgent need to school-level mental health programs, youth-friendly counseling services, and family interventions targeting adolescent wellbeing.

The overall findings of suicide pattern in Karnali shows in compared to female male have 5% more suicide rate. In 2024/25 an emerging gender shift with female suicides overtaking males demanded careful attention. While males traditionally predominate in suicide statistics globally (WHO, 2025), South Asian suicide pattern show narrower gender gaps because of the women facing domestic violence, marital conflict and other many socioeconomic statuses (Arafat, 2024). Some major causes of suicide are gender-based violence, early marriage, dowry conflicts, restricted autonomy, and limited socioeconomic opportunities for women (Arafat, 2024) lead to increase suicide rate in South Asia. The majority of married individuals (73.3%) and domestic violence as the leading cause (31.4%) of suicide also provide evidence to this interpretation. In Karnali, alarming interventions must address gender-based violence through legal enforcement and community-based prevention programs.

Socioeconomic Determinants

Findings shows that the agricultural workers cover more than half (57%) of the all-suicide cases take their own life in Karnali. In South Asian region increasing in the farmer's suicide rates which is closely linked to lack of irrigation, agriculture disaster, crop failure, indebtedness and worse agriculture policy (Mishra, 2014; Debnath, 2019). Pesticide poisoning is common in agricultural regions of Asia, including India, Sri Lanka and China, easy access to toxic chemicals increases suicide acts (Gunnell, 2007). In Karnali's context of subsistence agriculture, limited market access bust to increase suicide. Agricultural support programs, debt relief mechanisms, crop insurance and easy access to market are necessary intervention actions to reduce farmer's suicide in Karnali province. The critical condition of student's suicide rate 18.6% and unemployed individual's 12.6% facing educational pressure and joblessness. The similar finding from previous studies reported that academic stress, competitive examination pressure, and uncertain employment pressure the youth to take their own life (Panday, 2019).

Educational pattern in Karnali shows surprising result that the literate and educated people are committing more suicide than illiterate individuals. The majority 68.6% literate individuals suicide doubt in our educational system and pattern and suggest that only literacy cannot help to reduce suicide. This finding is consistent with research indicating that education may increase ambitions without guaranteeing parallel opportunities, generating frustration and psychological distress (Phillips, 2002; Stack, 2000). Education must be applied as the wonderful tool of living happy and healthy life. In Karnali province, Chhetri community individuals have the highest involvement in suicide besides having average livelihood in compare to Dalit and Janajati. Dalit and Janajati communities together occupied 51% of the total suicide cases in Karnali province. Dalit and Janajati communities are facing social inequalities, low financial condition and historical marginalization. The global research evidence agrees with the finding with social exclusion, discrimination and limited opportunity structures promote suicide risk (WHO, 2014). In Nepal, mainly in rural and remote area caste-based discrimination affecting access to education, employment, healthcare, and social participation (Thapa, 2018; Magarati & Bist 2025). Despite legal prohibitions, interventions must address structural inequalities bottom-up approach and community empowerment programs targeting remote areas and marginalized groups (Oli & Kandel, 2025). All these social disparities have also influenced the life-or-death decisions of the victims.

Geographic Disparities

The suicide rate is excessive higher in Surkhet, Dailekh, and Salyan districts (71%) in compared to other seven districts. These three districts have higher population density, maximum migrant citizens, multiple economic activity and diverse community level may lead individuals to common stressors competition, debt, struggle, family conflict, foreign employment related stress without corresponding mental health infrastructure. Districts like Kalikot, Jumla, Humla, Mugu, Dolpa, Jajarkot and Rukum altogether have 29% suicide beside remote area, they lack of infrastructure development and

occupy maximum rural areas. Rural areas consistently reported 2 to 3 times higher suicide cases than municipalities. Overall analysis show that rural suicide accounts for 70% of the total suicide cases in Karnali Province.

In compared to urban area rural residence are facing more challenges: geographical isolation, limited healthcare access, pervasive stigma, and socioeconomic marginalization, which leads to attempt suicide (Singh, 2020). District-wise specific suicide prevention plans, mobile mental health services, tele-counseling, and mobilize community health worker are essential to address geographic suicide trends in Karnali province.

Conclusion

This study identifies patterns among officially recorded suicide deaths and highlights areas requiring targeted investigation and prevention rather than establishing causal determinants. This is a brief analysis of 1,517 suicide cases based on three main sectors: socioeconomic, demographic and geographic disparities. Socio economic stressors include domestic violence, economic instability, untreated mental health conditions, and migration-related pressures rather than purely medical determinants. Young adults, agricultural workers, students, married individuals, and socially marginalized communities face large scale of risk in this province. Geographic inequalities burden in specific districts and rural areas, where limited mental healthcare access, geographical isolation, poverty and stigma surrounding mental illness push individuals into the vicious circle of suicide. Demographic stressors academic pressure, social media influences, marital conflict, domestic violence, unemployment and family pressure make young adults, adolescents, and married individuals more vulnerable. Addressing this serious issue in Karnali, it is essential to implement a comprehensive, multi-sectoral strategies to enhance livelihood support, domestic violence prevention, educational interventions and social protection for vulnerable groups. A future research statement recommends population-based suicide mortality rates, analytical studies of associated factors, and qualitative investigation of context-specific pathways to suicide in Karnali.

About Authors

Upendra Prasad Acharya has completed an MA in Conflict and Peace Studies (CAPS) from Mid-West University. He is a police officer at the City Police Office, Kathmandu, Nepal. He has long experience of working in crime investigation and police operations in different parts of Nepal.

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Disclosure Statements

No potential conflict of interest was reported by the author(s). The authors read and reviewed the final version and agreed to consent for publication. All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

References

- Arafat, S. M. Y. (2018). Patterns of suicide in South Asian countries: Evidence from India, Sri Lanka, and Bangladesh. *Asian Journal of Psychiatry*, 34, 12–19.
- Arafat, S. M. Y., et al. (2024). Risk factors for attempted suicide and suicide death among South-East Asian women: A scoping review. *International Journal of Environmental Research and Public Health*, 21(12), 1658.
- Barracough, B. M., & Shepherd, D. (1994). A necessary neologism: The origin and uses of suicide. *Suicide and Life-Threatening Behavior*, 24(2), 113–126.
- Bist, R. B., & Kandel, R. K. (2026). From Suffering to Self-Realization: Spiritual Transformation in Hesse's Journey to the East. *The Outlook: Journal of English Studies*, 17, 34-47. <https://doi.org/10.3126/ojes.v17i1.97238>
- Camus, A. (1991). *The myth of Sisyphus* (J. O'Brien, Trans.). Vintage International.
- Canetto, S. S., & Sakinofsky, I. (1998). The gender paradox in suicide. *Suicide and Life-Threatening Behavior*, 28(1), 1–23.
- Cavanagh, J. T. O. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine*, 33(3), 395–405.
- Debnath, P. (2019). Farmer suicides and mental health vulnerability in rural South Asia. *International Journal of Rural Studies*, 26(1), 55–69.
- Devries, K. M. (2011). Intimate partner violence and women's physical and mental health: Findings from the WHO multi-country study. *The Lancet*, 37, 123–138.
- Durkheim, É. (1897). *Suicide: A study in sociology* (J. A. Spaulding & G. Simpson, Trans.). Free Press.
- Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 237–258). Hogarth Press.
- Gunnell, D. (2007). Prevention of suicide in rural areas of South Asia. *The Lancet Psychiatry*, 4, 132–139.
- Jordan, L. (2017). Self-harm and suicide attempt in southern Nepal. *BMC Psychiatry*.

- Kandel, R. K. (2023). Impact of underage marriage of females on their higher education attainment. In C. P. Rijal (Ed.), *Policy prospects in Karnali: Policy briefs* (pp. 60-67). Mid-West University, MU Policy Lab, Karnali Province, Birendranagar, Surkhet, Nepal. https://api.mupolicylab.edu.np//media/file/Policy_Briefs_Final_AntiCopy.pdf
- Knipe, D. W. (2019). Means restriction for suicide prevention in low- and middle-income countries. *International Journal of Epidemiology*, 48(3), 765–778.
- MacDonald, M., & Murphy, T. R. (1990). *Sleepless souls: Suicide in early modern England*. Oxford University Press.
- Magarati, S. L., & Bist, R. B. (2025). Discrimination and resistance: An analysis of discourse and counter-discourse in an anthology of Nepali poetry. *Contemporary Research: An Interdisciplinary Academic Journal*, 8(1), 203-218. <https://doi.org/10.3126/craiaj.v8i1.79903>
- Menninger, K. (1938). *Man against himself*. Harcourt, Brace and Company.
- Mishra, S. (2014). Agricultural stress and farmer suicides in rural India. *Economic and Political Weekly*, 49(10), 34–42.
- Mohanty, S., & others. (2018). Is Hinduism ambivalent about suicide? *International Journal of Social Psychiatry*, 64(6), 575–582.
- National Mental Health Survey Nepal. (2020). *National mental health survey Nepal*. Ministry of Health and Population.
- Nepal Police. (2024). *Annual factsheet on suicide & cyber-crime: Fiscal year 2080/81 (Shrawan to Ashad)*. Crime Investigation Department, Police Headquarters.
- Niaz, U. (2012). Marital conflict, domestic abuse, and suicide risk in South Asia. *Asian Journal of Social Psychology*, 23(1), 22–36.
- Oli, P., & Kandel, R. K. (2025). Reflection, resistance, and reconstruction: Professional identity development among basic-level Nepali female English teachers. *GS Spark: Journal of Applied Academic Discourse*, 3(1), 82-93. <https://doi.org/10.5281/zenodo.18448040>
- Pandey, A. R., Bista, B., Dhungana, R. R., Aryal, K. K., Chalise, B., & Dhimal, M. (2019). Factors associated with suicidal ideation and suicidal attempts among adolescent students in Nepal: Findings from Global School-based Students Health Survey. *PLOS ONE*, 14(4)
- Patel, V. (2012). Mental health of young people in South Asia: Suicide as a major public health concern. *The Lancet*, 379, 413–428.
- Phillips, M. R. (2002). *Suicide in China: Epidemiology, risk factors, and prevention*. University Press.
- Pradhan, S. N., & Adhikary, S. R. (2009). A study of severity of intention of suicide in various psychiatric diagnoses. *Kathmandu University Medical Journal*, 7(1), 63–66.
- Regmi, P. R., Aryal, N., van Teijlingen, E., Simkhada, P., & Adhikary, P. (2020). Nepali migrant workers and the need for pre-departure training on mental health: A qualitative study. *Journal of Immigrant and Minority Health*, 22, 973–981.
- Shneidman, E. S. (1985). *Suicide as psychache: A clinical approach to self-destructive behavior*. Jason Aronson.
- Singh, A. (2020). Mental health disparities in rural South Asia. *Rural and Remote Health*, 20, 1–10.
- Stack, S. (2000). *Suicide: A sociological study*. AltaMira Press.
- Thapa, R., van Teijlingen, E., Regmi, P., & Heaslip, V. (2018). Uptake of health services by people from the Dalit community. *Journal of BP Koirala Institute of Health Sciences*, 1(2), 1–6.
- World Health Organization. (2014). *Preventing suicide: A global imperative*. World Health Organization.
- World Health Organization. (2021). *Live Life: An implementation guide for suicide prevention in countries*.
- World Health Organization. (2023, September 12). *Preventing suicide: A resource for media professionals, update 2023*.
- World Health Organization. (2025). *Suicide worldwide in 2021: Global health estimates*.
- World Health Organization. (2026, August 28). *Suicide*. <https://www.who.int/news-room/fact-sheets/detail/suicide>