SITUATION ANALYSIS
ON ADOLESCENT AND YOUTH SUICIDES
AND ATTEMPTED SUICIDES
IN KYRGYZSTAN

Bishkek 2020
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The views expressed in this publication are those of the authors and do not necessarily reflect the official views of UNICEF and the European Union. The designations employed in this publication and the presentation of the material do not imply on the part of UNICEF the expression of any opinion whatsoever concerning the legal status of children in Kyrgyzstan, any country or territory, or of its authorities, or the delimitation of its frontiers.
# Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CIS</td>
<td>Commonwealth of Independent States</td>
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<tr>
<td>DDSD</td>
<td>District Department for Social Development</td>
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<tr>
<td>DSD</td>
<td>Department for Social Development</td>
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<tr>
<td>FCSD</td>
<td>Family and Child Support Department</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>KR</td>
<td>Kyrgyz Republic</td>
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<tr>
<td>LSA</td>
<td>Local State Administration</td>
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<td>MES</td>
<td>Ministry of Education and Science</td>
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<td>MH</td>
<td>Ministry of Health</td>
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<td>MLSD</td>
<td>Ministry of Labour and Social Development</td>
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<td>MIA</td>
<td>Ministry of Internal Affairs</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NSC</td>
<td>National Statistical Committee</td>
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<tr>
<td>PAP</td>
<td>Paramedic and obstetric point</td>
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<tr>
<td>SALSGIR</td>
<td>State Agency on Local Self-Governance and Interethnic Relations</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>URCM</td>
<td>Unified Register of Crimes and Misconducts</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1. Executive summary

Suicide and attempted suicide among youth and adolescents remain a growing problem in the Kyrgyz Republic and the Central Asian region. According to statistical information obtained from the Ministry of Internal Affairs of the Kyrgyz Republic, the number of suicides throughout the country from 2008 to 2018 has reached 1,080 cases among adolescents aged from 10 to 18 years old. Despite this, there is a lack of quantitative statistical data and qualitative evidence on the subject. To fill this gap, UNICEF Kyrgyzstan has commissioned a study to analyse the situation with regards to suicides and attempted suicides among adolescents and youth in Kyrgyzstan.

The study was built around achieving the following major objectives:

1. To identify the main service providers, examine the range of services and assistance provided to adolescents and youth with suicidal behaviour, as well as to their families;

2. To examine the root causes as well as the risk and protective factors in the field of suicidal behaviour of adolescents and youth who have attempted suicide or died by suicide.

The methods of the study included a literature review, in-depth interviews and focus group discussions. The review of literature and analysis of statistical data were aimed at determining the prevalence of suicide among adolescents and youth. In-depth interviews were conducted with 49 adolescents and youth (aged from 12 to 29 years old) who attempted suicide as well as with 35 family members and close friends of adolescents and youth who died by suicide. The interviews have provided the needed data to analyse the causes of suicide and suicide attempts among the aforementioned target group. The study has also involved the conduct of in-depth interviews and focus group discussions with service providers at national and local levels to identify problem areas in the service delivery system and develop proposals and recommendations. However, the statistical data analysed in this study may not fully cover the full extent of suicides due to their underreporting. The data collected from interviews should not be considered as statistically representative.

A review of approaches at the national level indicated the presence of institutional implementation mechanisms and an integrated approach to tackling suicide and suicide attempts. There are relevant Government Orders in place, including the Order No. 120 “On the prevention of suicides, offences and crimes among children and youth”, issued on March 22, 2016. The Order also approved an Interministerial Action Plan to prevent suicides, offences and crimes among children and youth in the Kyrgyz Republic for 2016-2018.¹ The Ministry of Labour and Social Development of

the Kyrgyz Republic was appointed to monitor and execute the order. Notably, the study has also revealed the availability of clinical guidelines and protocols to provide psychological support to the children in need.\(^2\) They are available on the website on the Ministry of Health of the Kyrgyz Republic, and the degree of their efficiency needs to be evaluated.

The mapping of service providers has shown that they can be divided into three main groups, including the primary level, the secondary level as well as tertiary level. The primary level is represented by school psychologists, social pedagogues\(^3\) and social workers, who are responsible for the identification of those in need of psychosocial support. The study has revealed a lack of common standards in the work of the school psychologists that prevents them from rendering coherent and comprehensive services to the children in need. The school psychologists and other service providers have also noted prevalent stigma and discrimination in obtaining psychological support among adolescents as well as lack of family attention to children with depression symptoms. This requires immediate actions in the form of explanatory works among children and adolescents as well as among the population at large as well as overall improvement in the quality of the services rendered and their availability.

The secondary level of service providers is represented by specialized organizations, such as the Child Support Centre in Bishkek. This level is not well developed in the villages where there are stronger neighbourly and kinship ties that make it easier to identify suicide concerns, unlike in the cities with a greater estrangement of people from one another. The problem with the lack of specialized support centres at the village level requires issues to be directed to NGOs or rehabilitation centres based in district centres and in the cities.

A tertiary level of service providers includes specialized medical or other qualified organizations - mental health and rehabilitation centres that focus on the provision of psychiatric services, as well as helplines, for example, child helpline 111 established by the Ministry of Labour and Social Development of the KR.

The study has also included a survey of adolescents and youth who have experienced a suicide attempt to determine underlying causes, risks and protective factors. A total of 49 respondents (59.2% men and 40.8% women) have participated in the survey. Moreover, 45% of these respondents were school children, and the remaining 55% were of working age. Interpersonal conflicts with family members, friends, partners, colleagues or classmates were noted by many respondents to be the main reason for a suicide attempt. Importantly, 71.4% of respondents (45.7% women and 54.3% men) lived with their parents at the time of the suicide attempt. This speaks of the fact that the physical presence of parents is not enough to prevent a suicide attempt, but a deeper connection, trust and sensitivity is required to understand the mood and inner experiences of the child.

Suicide attempts did not pass unnoticed, both in physiological and psychological terms. The most common consequences were strangulation or rope marks, grooves on the neck (in 38.8% of cases). A fifth of respondents noted colic in the liver and lower back, rash and itching due to self-poisoning (22.4%), and the same number indicated the presence of scars on the wrist due to the cutting of veins. The suicide attempt has also required respondents to seek medical help, in particular from general practitioners (40.6% of respondents), as non-psychiatric patients with somatic problems (3.1%), or from emergency medical services (20.3%). Many noted that after receiving medical assistance, they were recommended to turn to the services of psychiatric and psychotherapeutic care, and 26.6% of respondents did approach such centres.

\(^2\) Clinical guidelines for the provision of psychological assistance to child survivors of violence, Ministry of Health of the Kyrgyz Republic, Kyrgyz psychiatric association, Institute of Behavioral Health of the American University of Central Asia (2017).

\(^3\) According to the Order 1033/1 issued by the Ministry of Education and Science on 30 August 2019, a Social Pedagogue is “an employee of a general educational institution who carries out a set of measures for social protection, upbringing and development of students by establishing networks and partnerships between the family and the school. The (main) target group that is provided with support from the social pedagogues are children in difficult life situations.
In addition to the aforementioned survey, the study has also included interviews with 35 close relatives and friends of adolescents and youth who died by suicide. According to the findings, some of the deceased had expressed verbally for some time that they did not want to live, most likely to the close people around them. A total of 7 girls had expressed that they were tired, that their family members did not understand them, and that they did not have a meaning of life. However, none of the relatives has indicated family reasons as a suicide factor pointing rather to the conflict with peers and other students. In general, the study showed that a quarter of the deceased had a history of previous suicide attempts (22.8% had one attempt, 5.7% had at least two attempts).

Notably, none of the respondents indicated migration of one or both parents as a reason triggering the suicide attempt. However, the data collected from respondents shows that half of the 25 adolescents aged 12-18 years who attempted suicide had one or both parents in migration at the time of the suicide attempt. Accordingly, adolescents lived either with only one parent and in the case when both parents were in migration, they remained in the care of relatives. It can be therefore assumed that the migration of parents can increase the vulnerability of children who may experience emotional or psychological difficulties following the separation from one or both parents: according to 2018 data from the National Statistical Committee of the Kyrgyz Republic, children left behind by their parents due to migration are more likely to experience psychological difficulties and anxiety than children who live with both parents. At the local level, in particular, in regions where migration is widespread, families with children left under their care are paid special attention in the process of identification and accompaniment of families and children in difficult life situations.

These major and other findings of the study will be useful for policy development in the area of suicide prevention and can guide the programmes and activities of Ministries and their respective departments, including the strengthening of the work of service providers. The study will also provide new evidence for the programming of relevant UN agencies, international and civil society organizations and maybe also used for advocacy purposes.

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2 Introduction

Suicide and attempted suicide among adolescents and youth is a recognized growing problem worldwide. Suicides have long-lasting effects on the people left behind and constitute a serious public health problem. According to the World Health Organization (WHO), every year close to 800,000 people take their own lives, and for each suicide, there are more than 20 suicide attempts. Suicide was the second leading cause of death among adolescents and youth aged 15-29 years globally in 2016. It accounts for about 6 percent of all deaths among young people, and the rate at which they have become the highest-risk group continues to rise.

WHO statistics show that the suicide mortality rate in Kyrgyzstan is the second highest in the region after Kazakhstan. According to 2012 United Nations Population Fund (UNFPA) data, the suicide mortality rate among people aged 15 to 29 years in Kyrgyzstan was 16.3 for young men for every 100,000 population and up to 6.6 for young women. Among the group of adolescents aged 15-17 years, the number of deaths by suicide was 11.8 for every 100,000 population for boys and 9.2 for girls. However, families may not report suicides due to stigma. In many cases, deaths by suicide are not registered or are disguised as accidents or other causes of death. Therefore, the actual number of suicides may be higher. According to official data provided by the NSC in 2019, the suicide prevalence rate was quiet high from 2011 to 2015 (from to 19 cases per 100,000 population. This was then followed by a slight decrease from 2016 to 2018.

While the link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established, many suicides happen impulsively in moments of crisis. Further risk factors include the experience of loss, loneliness, discrimination in various forms (social status, gender etc), a relationship break-up, financial problems, chronic pain and illness, violence, abuse, and conflict or other humanitarian emergencies. The strongest risk factor for suicide is a previous suicide attempt.

Suicide is directly linked to human rights. Article 3 of the Universal Declaration of Human Rights...
states that “everyone has the right to life”; and Article 25 states that “everyone has the right to a standard of living adequate for the health and well-being (…)”. Investing in strengthening human rights such as equality, children’s rights, non-discrimination, labour rights, and environmental rights are inseparable from the attainment of the right to health.\(^\text{13}\)

In order to prevent suicides, the United Nations Special Rapporteur on the right to health recommended that States adopt human rights-based strategies: “[t]here is evidence that a rights-based approach, in synergy with modern public health approaches, strengthens mental health promotion and suicide prevention. An overall decrease in suicide rates has corresponded with global advances in the reduction of extreme poverty, greater gender equality, reduction of interpersonal violence, trends toward the abolition of child corporal punishment, and through the creation of civic space and public trust.” In line with a human rights approach to suicides, governments should increase access to child abuse prevention and family support, quality physical and mental healthcare and social services, and attempt to lessen the burden of obstacles to health for all.\(^\text{14}\)

In response to the growing number of suicides committed by young people, the Government of the Kyrgyz Republic issued order No. 120 “On the prevention of suicides, offences and crimes among children and youth” on March 22, 2016. The Order also approved the Interdepartmental Action Plan for the prevention of suicides, offences and crimes among children and youth in the Kyrgyz Republic for 2016-2018.\(^\text{15}\)

The Department of Social Development was appointed as the lead agency to implement the aforementioned order.

Suicide is relatively understudied in Central Asia, despite being at a high level.\(^\text{16}\) In order to obtain both quantitative statistical data and qualitative evidence, UNICEF Kyrgyzstan commissioned this study to analyse the situation in suicides and attempted suicides among adolescents and youth in Kyrgyzstan. Previous studies on suicide were commissioned by UNICEF offices in Kazakhstan\(^\text{17}\) (2014) and Tajikistan\(^\text{18}\) (2013). The present study will contribute to the existing literature on suicides in Central Asia by providing up-to-date evidence on Kyrgyzstan with a focus on adolescents and youth.

Its results will be useful for policy development in the field of suicide prevention among adolescents and youth. The Ministry of Labour and Social Development (MLSD) as well as its structural units represented by the Department of Social Development and its Family and Child Support Departments will be able to use the results of this report in their work. In particular, the report presents data on the mapping of service providers, dividing the providers into three levels depending on the age and location of adolescents and youth. The MLSD, as a central authority in charge of child protection and therefore a key institution in the prevention of suicide among adolescents and youth can apply this information in the development of relevant programmes and strategies.

The findings can also be useful for the Ministry of Internal Affairs (MIA) to flesh out their plans for suicide prevention. The Ministry of Education and Science (MES) can use the report findings to develop and introduce standards in the work of school psychologists and social pedagogues. The findings of this report may also be useful for the Ministry of Health (MH) to improve the work of psychotherapists and psychiatrists, in particular in the adaptation of clinical protocols.


\(^{14}\) Ibid


\(^{18}\) United Nations Children’s Fund, Study of Prevalence and Dynamics of Suicide Among Children and Young People (12-24 Years of Age) In Sughd Region, Tajikistan, UNICEF, Dushanbe, 2013.
for the provision of psychosocial assistance to adolescents and youth.

In addition, the study will provide new evidence for the programming of UN agencies, international and civil society organizations and may be useful for advocacy and awareness-raising activities to increase the attention of decision-makers to the importance of suicide prevention.

Strengthening suicide prevention activities in Kyrgyzstan will contribute to achieving Goal 3 of the Sustainable Development Goals, which aims to ensure healthy lives and promote well-being for all at all ages. More specifically, it will contribute to lowering the suicide mortality rate (Indicator 3.4.2) under Target 3.4: “By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.”

1. **Suicide**, like many other models of human behaviour, is a complex phenomenon, manifested under the influence of certain biological, psychological and social factors. Suicide means the act of a person intentionally causing his or her own death.\(^{20}\)

2. **Completed suicide** is a self-injurious behaviour that resulted in a fatality and was associated with at least some intent to die as a result of the act.\(^{21}\)

3. **Suicide attempt** is a potentially self-injurious behaviour, associated with at least some intent to die as a result of the act. Evidence that the individual intended to kill him/herself, at least to some degree, can be explicit or inferred from the behaviour or circumstance. A suicide attempt denotes non-fatal acts or preparations intended to result in death and may or may not result in actual injury. The suicidal act may have been abandoned, interrupted or was unsuccessful.

   The key difference between deliberate self-injury and the suicide attempt is in the intent to end one’s life. For example, a 16-year-old boy has cut his veins, although he did not succeed. This is known as a suicide attempt. Another 14-year-old girl takes a large overdose of medication because she is angry and upset. She did not want to kill herself but tried to reduce a stressful situation. This refers to non-suicidal self-injury. It has to be kept in mind that both forms of self-harm may overlap: individuals with suicide attempts may also show non-suicidal self-injuring behaviour and vice versa.\(^{22}\)

4. **Parasuicide** refers to a non-habitual, potentially life-threatening self-harming behaviour which is performed without the intention to kill oneself. Since the behaviour is non-suicidal, most authors today prefer the term “non-suicidal self-injury”.\(^{23}\)

5. **Suicidal ideation** refers to passive thoughts about wanting to be dead or active thoughts about killing oneself, not accompanied by preparatory behaviour.\(^{24}\)

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\(^{21}\) ibid

\(^{22}\) ibid

\(^{23}\) ibid

\(^{24}\) ibid
4. Research methodology

The goal of this study is to analyse the situation with suicide and attempted suicide among adolescents and youth (12-29 years old) in Kyrgyzstan. It has the following objectives:

- To identify the main service providers, examine the range of services and assistance provided to adolescents and youth with suicidal behaviour, as well as to their families;
- To examine the underlying causes, risk and protective factors in the field of suicidal behaviour of adolescents and youth who attempted suicide or died by suicide;

Stages of the Situation Analysis

The study was conducted in several stages:

1. Development of a research strategy/protocol with a detailed description of the procedure to access the target respondents;
2. Development of tools for collecting information: questionnaires, informed consent forms for all target respondents;
3. Submission of research instruments to the Ethics Review Board, subsequent consideration of all recommendations;
4. Launch of trainings with interviewers, provision of a detailed briefing on tools and strategies for selecting respondents;
5. Identification of service providers, joint work with them to provide assistance as a “bridge” between target respondents and interviewers;
6. Data collection;
7. Data analysis;
8. Preparation of an analytical report.

Methods of data collection

The comprehensiveness of the goals and objectives of the assessment made it necessary to use various methods of data collection.

The methodology included the use of the following instruments:

- Review of literature and analysis of statistical data.
- In-depth interviews with representatives of relevant departments and organizations- 15 interviews.
- In-depth interviews with adolescents and youth (aged 12-29 years) who attempted suicide. Method for the selection of respondents: respondents were selected through service providers. Selection criteria: informed consent. Number of respondents: 49.
- In-depth interviews with relatives and friends
who lost an adolescent or youth (aged 12-29 years) due to suicide. Method for the selection of respondents: respondents were selected through service providers. Selection criteria: informed consent. Number of respondents: 35.

The aforementioned sample size of 49 respondents (adolescents and youth who attempted suicide) and 35 respondents (relatives and friends who lost an adolescent or youth to suicide) is explained by the following factors: 1) these target groups are very closed to contacts and conversations, making access to them difficult; 2) this sample size is acceptable and quite reliable, as it correlates with the objectives of the study to identify underlying causes in the context of suicidal behaviour.

In order to further understand the extent and prevalence of suicide, the study also used data from the National Statistics Committee (NSC) and the MIA of the Kyrgyz Republic.

**Age range:** For qualitative data obtained through interviews with adolescents, youth and family members, the target age range for studied suicide and attempted suicide cases was from 12 to 29 years. The age range for quantitative data on suicide prevalence was from 9 to 29 years since the statistical information provided by the MIA and NSC has specifically covered this age range.

The methods of data collection are explained in more detail in the table below:

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<th>Task 1:</th>
<th>To study the prevalence of suicide cases in Kyrgyzstan over the past 10 years.</th>
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<tr>
<td><strong>Method:</strong></td>
<td>review of literature and relevant statistical data, policies on suicide and suicide attempts among adolescents and youth.</td>
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<tr>
<td><strong>Instruments:</strong></td>
<td>Review of the literature.</td>
</tr>
<tr>
<td><strong>Target group/objects:</strong></td>
<td>All the available literature on the study topic.</td>
</tr>
<tr>
<td><strong>Activities:</strong></td>
<td>All the available literature was reviewed, and information requests were sent to both the NSC and MIA of the Kyrgyz Republic; the MH, MES, MLSD, Ministry of Culture and the Ministry of Emergency Situations of the Kyrgyz Republic; the Defence Committee; the State Agency for Local Self-Government and Inter-Ethnic Relations (SALSGIR); the State Agency for Youth, Physical Culture and Sports of the Kyrgyz Republic; the State Committee for Information Technologies and Communications under the Government of the Kyrgyz Republic; and to the State Committee on Defence under the Government of the Kyrgyz Republic.</td>
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<td><strong>Outcomes:</strong></td>
<td>Replies to letters of inquiry were received from the MIA, the NSC, the Defence Committee, the Ministry of Culture, SALSGIR, and the State Agency for Youth, Physical Culture and Sports of the Kyrgyz Republic. Requests were also sent on the results of action plans in response to the growing number of adolescents and youth who died by suicide. This was requested in view of the relevant Government Decree with an Action Plan for 2019-2020 on the prevention of suicide, offences and crime among adolescents and youth based on the interdepartmental Order of February 19, 2019 No. 20-7203. According to this regulation, each department should have issued its own internal order and action plan. The reviewed literature in the form of research results, reports, publications and clinical protocols is listed in the annex of the report.</td>
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**Task 2:** Identify main service providers, explore the range of services and assistance provided by them to adolescents and youth with suicidal behaviour as well as to their families.

**Method 1:** In-depth interviews.

**Tools:** Semi-structured interviews.

**Target group/objects:** 15 representatives of relevant organizations and departments.

**Activity:** Meetings were held with representatives of the relevant MIA structures, in particular with the Juvenile Police; with a specialist from the MLSD department for family and child support and State benefits; with the staff of territorial units of the MLSD- Family and Child Support Departments; with school psychologists and social pedagogues; with a representative of the Ministry of Emergency Situations; and with a Head of Department of the State Committee for Information Technologies and Communications under the Government of the Kyrgyz Republic.

**Outcome:** Interdepartmental Orders of the MIA and MLSD, as well as plans for the implementation of activities according to the Action Plan for 2019-2020 for the prevention of suicides, offences and crime among adolescents and youth, were received. Questions included in the Expert Survey were discussed in individual meetings.

**Method 2:** Focus group discussion (FGD).

**Tools:** Brainstorming, analysis, development of a mechanism for service provision.

**Target group/objects:** Representatives of departments.

**Activity:** A round table was organized with representatives of various departments at the national level, in particular the MIA, Juvenile Police, the Ministry of Emergency Situations, the District Department for Social Development (DDSD), and the State Committee for Information Technologies and Communications under the Government of the Kyrgyz Republic. At the level of service providers, FGDs were conducted with school psychologists, social pedagogues, Juvenile Police, specialists of the Family and Child Support Department (FCSD), and social workers of the department for labour and social development.

**Outcome:** The brainstorming allowed to determine the existing mechanism of service provision and to identify problems and possible solutions from the participants’ perspective.

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**Task 3:** To study the risks, protective factors and underlying causes in the field of suicidal behaviour among adolescents and youth with previous experience of a suicide attempt.

**Method:** In-depth interviews.

**Instruments:** Questionnaire/guide.

**Target group/objects:** Adolescents and youth with previous experience of suicide attempts.

**Activity and Outcome:** 49 interviews with adolescents and youth who attempted suicide.
**Task 4:** To study the risk and protective factors and underlying causes in the field of suicidal behaviour of adolescents and youth who have died by suicide.

**Method:** In-depth interviews.

**Tools:** Questionnaire/guide.

**Target group/objects:** Relatives and friends of adolescents and youth who died by suicide.

**Activity and Outcome:** 35 interviews with family members and friends of adolescents and youth who died by suicide.

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**Data analysis**

Two methods were used for the analysis of collected information: 1) the Thematic Networks method was applied to analyse the information collected during in-depth interviews and FGDs with stakeholders (employees of ministries and agencies, service providers). This method aimed at analysing the text array by highlighting the main topics contained in qualitative data, which helped to group and display the main topics. This method does not imply a calculation of the frequency of occurrence of different topics or their combinatorics\(^{25}\), although these aspects were taken into account during the text interpretation process. At the same time, topics were also considered that had a profound meaning even though they were mentioned only at least once. 2) The statistical software SPSS was used for the calculation and analysis for data obtained through interviews with adolescents, youth and family members regarding questions of a formalized nature. The Thematic Networks method was used for parts of the questionnaire with qualitative information presented in a text array.

**Ethical aspects**

Before the start of data collection activities, the research instruments, including questionnaires and informed consent forms, were submitted to an external Ethics Review Board (Health Media Lab Institutional Review Board based in Washington). The recommendations from the Ethics Review Board were taken into maximum account during the research and have included the following major aspects:

- **Language use:** due to stigma associated with the use of the term “commit suicide”, the research was recommended to use the simple term “suicide”;

- **On the recommendation of the Ethics Review Board, no interviews were conducted with respondents who have just recently attempted suicide;**

- **Interviewers were recommended to terminate the interview and refer the respondent to service providers in case they have noticed that a subject was at risk of suicide;**

- **Interviewers were also recommended to immediately report to authorities if they became aware of any child abuse cases.**

**Instructing the interviewers:** Understanding of ethical issues was very important. All of the researchers received the necessary instruction and training on the importance of ethical principles in order to avoid potential risks or ethical problems. All the interviewers were trained on solving any ethical concerns if they arise during the survey. The training and instructions included such topics as engaging with children, tools and methods of ethical data collection.

**Inclusion criteria:** The basic principle of respondent selection and their inclusion in the study was their voluntary informed consent and

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\(^{25}\) Combinatorics is an area of mathematics that studies discrete objects, sets (combinations, permutations, placement and enumeration of elements) and relations to them (for example, partial order).
The identification and selection of potential respondents was done through service providers. To identify potential respondents in the target group of family members who lost a child due to suicide, support was mainly provided by village social workers, police officers and local government representatives. In the city, support was mainly provided by law enforcement agents, heads of sub-municipality and social workers as they have a good knowledge of the inhabitants through regular service provision to them. Particular attention was paid to ensuring the confidentiality of the respondents. Information on confidentiality was included in the informed consent form, and each interviewer was obliged to sign a Protocol on data protection.

The research team has also attracted medical personnel (psychotherapist, psychologist, psychiatrist) to identify, contact and conduct interviews with potential respondents in the target group of adolescents and youth who attempted suicide. They were selected based on their previous experience of working with the research target group, their readiness to accept and abide by the research rules, including respect for confidentiality.

Risk assessments were carried out with service representatives prior to including persons affected by suicide in the list of potential respondents. It was important to assess potential respondents’ readiness to get into contact with the interviewers for the purpose of the study.

First contact with respondents: Access to the target groups of adolescents and youth and family members was obtained through service providers - social workers, school psychologists, social pedagogues and doctors of the Republican Centre for Mental Health. They served as a “bridge” between researchers and potential respondents. Medical workers who previously worked and interacted with the respondents were part of the research group and also conducted some interviews. The service providers also shared information about the study with potential respondents, explained its goals and objectives, as well as the respect of confidentiality and anonymity. Interviews were conducted by the researchers in line with all the procedures only after the potential respondents’ agreement to participate in the study. For this, the respondents had to complete and sign an informed consent form.

Informed consent: Interviews and FGDs with respondents of all categories were conducted after the respondents signed the informed consent form. Parents gave informed consent for the participation of their underage children in the study, and the interview could only begin following the informed consent of the parents and the assent of children. The informed consent form provided information about the study, its procedure, goals, objectives, duration, expected results, the voluntary nature of participation as well as possibility to stop the interview at any time. It has consisted of two parts. The first part contained information about the study itself. The second part included a certificate of consent to be signed by the respondent to formally agree to participate in the study. The information sheet also indicated the contact details of the study coordinator, whom the respondent could contact in case of questions or complaints. The form also included information about risks and benefits regarding participation in the study. The risks included stress and emotional difficulties, whereas benefits were a contribution of respondents to the knowledge required for suicide prevention as well as getting advice on available support services.

The informed consent form helped the respondents to feel free and equal with the interviewers. They were given the full rights to leave the interview at any time and request to delete all the information gathered. Prior to the interview, a sequence number (e.g. 0001, 0002, 003, etc.) was assigned by the local research coordinator and was used as an identification code. This code ensured the anonymity and confidentiality of the collected data. The same code also needed to be indicated in the consent
form. The interviewers were advised to act with sensitivity, tact and to assure respondents of the confidentiality and anonymity of the shared information. They also encouraged respondents to ask questions and express their doubts and provided explanations. The interviewers accepted respondents' refusal to participate and minimized their possible feelings of guilt. Therefore, the completion of the aforementioned form gave respondents the opportunity to weigh all the risks and benefits linked to participation in the study.

**Information about the study:** Before the start of each interview, the interviewers presented themselves and briefly talked about their professional activities. They also provided general information about the study, its objectives and explained some of its terms. Prior to the start of each interview, the respondents were also provided with an information sheet to better familiarize themselves with the study.

**Language use:** The term “suicide” was used during the interviews considering the stigma associated with the term “self-murder”.

**Pilot interviews:** The initial version of the questionnaire was pre-tested with several respondents. In general, the pilot questionnaire proved to be operational, and no significant changes were introduced to its content; the research company changed the format of the questionnaire and the font to make it more convenient for the interviewer.

**Interview process:** The interviewers were trained to be flexible and adapt to the psychological state of the respondents. They were also capacitated to use professional but understandable language. All questions included in the questionnaire were filled in, and whenever possible, the interviewer returned to the questions with missing answers. Nevertheless, the respondents always had a choice to discuss or avoid sensitive issues and stop the interview at any time without feeling guilty. At the end of the interview, each respondent was given an opportunity to express his or her opinion regarding the study and offer suggestions to improve psychosocial services. The interview process always ended on a positive note.

**Respondent discomfort:** The interviews were suspended when a respondent felt upset or uncomfortable. They were continued only following respondents’ willingness and readiness to carry on. The interviewers suggested stopping the interview altogether. Interviewers also encouraged respondents to use available support services and shared contacts of available psychosocial services if the respondent was interested.

**Participants at risk of suicide:** The interviewers were instructed to terminate the interview and refer the person to service providers in case they noticed that the respondent was at risk of suicide.

**Plan in case respondents indicate that they still have a suicidal tendency and are at risk of suicide:** In such a case, the interviewers were instructed to stop the interview and refer the respondent to service providers by sharing the list of contacts of available services. During the data collection process, no respondents were identified with a suicidal tendency or who displayed a risk of suicide.

**Child abuse:** The interviewers were required to report any identified child abuse cases to the study coordinator in order to immediately contact authorities.

**Pseudonyms:** As stated in the informed consent forms, FGD participants could also use pseudonyms if they wished to protect their privacy.

**Access to personal information of respondents:** No lists with personal information were used. Interviewers had no access to such information. The main contact person was the service provider who established the initial contact with the respondent.

**The safety and confidentiality of the collected data:** Protection of data was ensured by the interviewer who had to seal all questionnaires and consent forms in an appropriate envelope with a code on it. The code consisted of 6 characters (first two letters of the region; first two letters of the respondent's category; first two letters of the interviewer’s name; date). This code was indicated on the envelope and transferred to the supervisor. The supervisor was responsible for keeping records of all the
envelopes and storing them in a safe in the central office. Access to the safe was given solely to the supervisor. The supervisor handed over the envelope to the data processing specialist who worked on the computer at the central office (he or she had no right to take it home, or to another office). All the processed data was placed in a file on his or her computer protected with a password. Only the analyst had access to this file. The research manager led the entire data moving process, namely from the interviewer to the supervisor, from the supervisor to the data processing specialist and the data processing specialist to the analyst. The staff involved in the study had to sign a standard non-disclosure sheet. All the information collected during the interviews and FGDs was de-identified in order to ensure the respondents’ confidentiality.

The following difficulties were encountered during the data collection process:

1. It was challenging to develop a list of potential respondents among the target groups of family members as well as adolescents and youth;

2. It was difficult to establish contact with the family members who were the most closed target group. Therefore, they had a high refusal rate (nearly 50%) to participate in the interviews.

3. Some respondents complained about the number of questions and their repetitiveness, which caused irritation and a desire to interrupt the interview. The interviewers were trained to follow all the instructions regarding such situations and remembered to put the respondent’s comfort and wishes first. There were two cases when the interviews were stopped.

Management arrangements for the study

The study was conducted by the research company “Izildoo plus” within the framework of the UNICEF programme “Protecting children affected by migration in Southeast, South and Central Asia” which is co-funded by the European Union and UNICEF.

The expert team of Izildoo Plus included the following members:

- A research manager/analyst, who was responsible for designing the research and its methodology, development and testing of research tools, analytical data processing and report preparation;
- A fieldwork coordinator in charge of leading the organization of all the field works, establishing contacts with service providers, arranging meetings for interviews, and monitoring the quality of interviews and FGDs;
- Two analysts/moderators responsible for data analysis and its processing, moderating FGDs and conducting interviews with service providers; and
- Two interviewers responsible for conducting interviews with respondents from both target groups.

The draft study report was reviewed internally by UNICEF Kyrgyzstan before its submission to external quality assurance review conducted by ‘Universalia Management Group’. The study was also shared with project partners and key national stakeholders for feedback and comments. It has also undergone senior management approval of the UNICEF Kyrgyzstan.

Scope and limitations of the study

The study analysed statistical data from 2009 to 2018, and qualitative data collected on suicides and attempted suicides of adolescents and youth from 9 to 29 years old in Kyrgyzstan. While the study attempted to cover a wide geographical area in Kyrgyzstan, no interviews were conducted with adolescents and youth who attempted suicide from Batken region. The potential respondents from Batken region have refused to participate in the study.

The statistical data analysed in this study may not cover the full extent of suicides due to their underreporting. The study applied qualitative methods, including literature review, in-depth interviews, as well as FGDs with limited sample size. The data collected from interviews
should thus not be considered as statistically representative.

Interviews were conducted with adolescents, youth, family members and close friends to gain an understanding of the life circumstances of adolescents and youth who attempted suicide or died by suicide. However, relatives and friends may not have been fully aware of the situation and issues faced by the deceased and might therefore not have provided an accurate picture of their life circumstances. There is also a risk that some of the respondents might have concealed specific aspects in their answers, such as conflicts within the family. Therefore, information provided by them may not fully present the picture of the situation of these adolescents and youth. To address this potential bias, questions were also asked service providers about the possible risk factors contributing to suicidal behaviour.
5. Key results of the study

5.1 Prevalence of suicide cases among adolescents and youth under 29 years in Kyrgyzstan over the last 10 years according to the NSC data

In response to a request letter, the NSC provided data on the number of suicide cases from 2009 to 2018 for the age range from 9 to 29 years in Kyrgyzstan.

Table 1 shows that the suicide prevalence rate was quite high from 2011 to 2015 (from 15 to 19 cases per 100,000 population). This was followed by a slight decrease from 2016 to 2018.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of cases per 100,000 of the population of adolescents and youth (9-29 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>19</td>
</tr>
<tr>
<td>2012</td>
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<td>18</td>
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<td>2016</td>
<td>13</td>
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<tr>
<td>2017</td>
<td>13</td>
</tr>
<tr>
<td>2018</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 1: Suicide prevalence rate per 100,000 of the corresponding population (9-29 years old)

At the time of the analysis, data for the age group from 9 to 29 years was only available starting from 2011, therefore the data on the suicide prevalence is provided here for the period from 2011 to 2018.

Chart 1. Registered cases of suicide for the years 2009-2018 in the age range from 9 to 29 years old disaggregated by sex (n)
Key results of the study

Chart 2. Proportion of male and female adolescents and youth (aged 9-29 years) who died by suicide in 2009-2018 (n)

![Chart showing proportions of male and female suicides](image)

Generally, in Kyrgyzstan, the highest rates of reported suicides among adolescents and youth were found in the following three age groups: 548 cases in 10 years for youth aged 25-29 years; 517 cases for youth aged 20-24 years; and 514 cases for adolescents aged 15-19 years.

Table 2. Prevalence of suicide among adolescents and youth (9-29 years) by age groups and years (n)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9-14 years</td>
<td>12</td>
<td>16</td>
<td>17</td>
<td>21</td>
<td>37</td>
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<td>30</td>
<td>29</td>
<td>25</td>
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<td>228</td>
</tr>
<tr>
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<td>11</td>
<td>12</td>
<td>18</td>
<td>24</td>
<td>17</td>
<td>22</td>
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<td>8</td>
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<td>66</td>
</tr>
<tr>
<td>15-19 years</td>
<td>58</td>
<td>55</td>
<td>80</td>
<td>58</td>
<td>58</td>
<td>47</td>
<td>54</td>
<td>34</td>
<td>33</td>
<td>37</td>
<td>514</td>
</tr>
<tr>
<td>male</td>
<td>35</td>
<td>33</td>
<td>51</td>
<td>34</td>
<td>34</td>
<td>28</td>
<td>31</td>
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<td>23</td>
<td>14</td>
<td>13</td>
<td>10</td>
<td>201</td>
</tr>
<tr>
<td>20-24 years</td>
<td>59</td>
<td>78</td>
<td>51</td>
<td>59</td>
<td>52</td>
<td>50</td>
<td>45</td>
<td>45</td>
<td>39</td>
<td>39</td>
<td>517</td>
</tr>
<tr>
<td>male</td>
<td>45</td>
<td>58</td>
<td>33</td>
<td>42</td>
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<td>39</td>
<td>33</td>
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<td>25</td>
<td>377</td>
</tr>
<tr>
<td>female</td>
<td>14</td>
<td>20</td>
<td>18</td>
<td>17</td>
<td>12</td>
<td>11</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>14</td>
<td>140</td>
</tr>
<tr>
<td>25-29 years</td>
<td>71</td>
<td>67</td>
<td>56</td>
<td>74</td>
<td>54</td>
<td>66</td>
<td>38</td>
<td>36</td>
<td>43</td>
<td>43</td>
<td>548</td>
</tr>
<tr>
<td>male</td>
<td>57</td>
<td>60</td>
<td>47</td>
<td>61</td>
<td>44</td>
<td>53</td>
<td>34</td>
<td>29</td>
<td>30</td>
<td>35</td>
<td>450</td>
</tr>
<tr>
<td>female</td>
<td>14</td>
<td>7</td>
<td>9</td>
<td>13</td>
<td>10</td>
<td>13</td>
<td>4</td>
<td>7</td>
<td>13</td>
<td>8</td>
<td>98</td>
</tr>
</tbody>
</table>

In regard to the regions, the largest number of suicides was recorded in the Chui region with 443 cases in the last 10 years and 398 cases in the Issyk-Kul region for the same time period. The lowest number of suicides was registered in Osh city with 23 recorded cases.
Data on the regions disaggregated by years indicates that the peak years for the Chui region were 2010 and 2012 with 60 cases in each of these years. There were 57 cases in 2009. The peak year for Issyk-Kul region was in 2012 with 50 cases. There were 48 cases in 2010 and also in 2011.

### Table 3. Prevalence of suicide cases among adolescents and youth (9-29 years) by regions and years (n)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyrgyz Republic</td>
<td>200</td>
<td>216</td>
<td>204</td>
<td>212</td>
<td>201</td>
<td>190</td>
<td>167</td>
<td>144</td>
<td>140</td>
<td>133</td>
<td>1807</td>
</tr>
<tr>
<td>Issyk-Kul region</td>
<td>44</td>
<td>48</td>
<td>48</td>
<td>50</td>
<td>41</td>
<td>37</td>
<td>38</td>
<td>32</td>
<td>27</td>
<td>33</td>
<td>398</td>
</tr>
<tr>
<td>Jalal-Abad region</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>14</td>
<td>14</td>
<td>18</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>93</td>
</tr>
<tr>
<td>Naryn region</td>
<td>22</td>
<td>29</td>
<td>22</td>
<td>15</td>
<td>24</td>
<td>28</td>
<td>15</td>
<td>17</td>
<td>15</td>
<td>12</td>
<td>199</td>
</tr>
<tr>
<td>Batken region</td>
<td>19</td>
<td>16</td>
<td>19</td>
<td>24</td>
<td>20</td>
<td>14</td>
<td>23</td>
<td>10</td>
<td>15</td>
<td>19</td>
<td>179</td>
</tr>
<tr>
<td>Osh region</td>
<td>23</td>
<td>23</td>
<td>30</td>
<td>34</td>
<td>45</td>
<td>42</td>
<td>31</td>
<td>23</td>
<td>29</td>
<td>16</td>
<td>296</td>
</tr>
<tr>
<td>Talas region</td>
<td>8</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>19</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>76</td>
</tr>
<tr>
<td>Chui region</td>
<td>57</td>
<td>60</td>
<td>51</td>
<td>60</td>
<td>34</td>
<td>29</td>
<td>37</td>
<td>43</td>
<td>38</td>
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<td>443</td>
</tr>
<tr>
<td>Bishkek city</td>
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<td>21</td>
<td>21</td>
<td>8</td>
<td>3</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Osh city</td>
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<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>23</td>
</tr>
</tbody>
</table>

5.2 Prevalence of suicide cases among adolescents and youth in Kyrgyzstan over the last 10 years, according to data of the MIA

This section provides data from the MIA about the suicide cases among adolescents aged 10 to 18 years for the period between 2008 to 2018 as well as among youth aged 19 to 29 years for the period 2014-2018. The information below was received from the MIA of the Kyrgyz Republic as a response to a written request.

According to official data provided by the MIA of the Kyrgyz Republic, the number of suicides throughout the country from 2008 to 2018 among adolescents (10-18 years old) amounts to a total of 1,080 cases. It should be noted that the cause of death in certain suicide cases is not reported as a suicide, including due to parents’ or relatives’ inclination for various reasons to consider the case as an accident. Therefore, the actual number of suicide cases could be much higher.
Two reporting years were compared to track the rates of increase and decrease of suicide cases among adolescents (aged 10 to 18 years). When comparing the number of cases in 2008 and 2018, there is a significant increase in the total number of suicides (11 cases). A comparison between each region or city shows a significant decrease in the number of suicide cases in Bishkek (-6 cases in 2018 as compared to 2008). On the contrary, most other cities and regions did not observe a decrease. Instead, a significant increase was noted in Jalal-Abad region (+11 cases in 2018).
Table 4. Growth/declines in suicide rates among adolescents (aged 10 to 18 years) by region in 2008 and 2018 (n)

<table>
<thead>
<tr>
<th>Region/city</th>
<th>2008</th>
<th>2018</th>
<th>Difference</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bishkek</td>
<td>10</td>
<td>4</td>
<td>-6</td>
<td>significant decrease</td>
</tr>
<tr>
<td>Osh</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>same level</td>
</tr>
<tr>
<td>Chui</td>
<td>17</td>
<td>19</td>
<td>2</td>
<td>slight increase</td>
</tr>
<tr>
<td>Issyk-Kul</td>
<td>16</td>
<td>13</td>
<td>-3</td>
<td>slight decrease</td>
</tr>
<tr>
<td>Naryn</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>slight increase</td>
</tr>
<tr>
<td>Osh</td>
<td>16</td>
<td>19</td>
<td>3</td>
<td>slight increase</td>
</tr>
<tr>
<td>Jalal-Abad</td>
<td>4</td>
<td>15</td>
<td>11</td>
<td>significant increase</td>
</tr>
<tr>
<td>Talas</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>slight increase</td>
</tr>
<tr>
<td>Batken</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>slight increase</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>88</td>
<td>11</td>
<td>significant increase</td>
</tr>
</tbody>
</table>

Table 5 indicates the pattern of peak years by region of suicides among adolescents (aged 10 to 18 years). The highest number of cases across all the regions was recorded in 2013 with 125 cases (including 25 cases in Jalal-Abad, 18 cases in Batken, 17 cases in Naryn region). Notably, the figures vary by region. For example, over the past 10 years in the Chui region the largest number of suicides was recorded in 2015 with 24 cases, while the highest number of cases in Osh, Issyk-Kul and Talas regions were registered in 2012 (with 20, 19 and 9 cases respectively). Bishkek had the highest number of recorded cases in 2017 with 15 cases. Osh region had the lowest number of cases with an average of 2 cases per year.

Table 5. Pattern of peak years of suicides among adolescents (aged 10 to 18 years) by region for the period of 2008-2018 (n)

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chui</td>
<td>17</td>
<td>22</td>
<td>17</td>
<td>23</td>
<td>20</td>
<td>20</td>
<td>17</td>
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<td>21</td>
<td>13</td>
<td>19</td>
<td>9</td>
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</tr>
<tr>
<td>Osh region</td>
<td>16</td>
<td>7</td>
<td>15</td>
<td>21</td>
<td>20</td>
<td>19</td>
<td>16</td>
<td>15</td>
<td>17</td>
<td>19</td>
<td>19</td>
<td>2</td>
<td>184</td>
</tr>
<tr>
<td>Jalal Abad</td>
<td>4</td>
<td>10</td>
<td>17</td>
<td>16</td>
<td>18</td>
<td>25</td>
<td>25</td>
<td>19</td>
<td>16</td>
<td>16</td>
<td>15</td>
<td>19</td>
<td>181</td>
</tr>
<tr>
<td>Issyk Kul</td>
<td>16</td>
<td>12</td>
<td>17</td>
<td>15</td>
<td>19</td>
<td>10</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>13</td>
<td>14</td>
<td>150</td>
</tr>
<tr>
<td>Bishkek city</td>
<td>10</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>15</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>104</td>
</tr>
<tr>
<td>Batken</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>11</td>
<td>18</td>
<td>11</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>17</td>
<td>95</td>
</tr>
<tr>
<td>Naryn</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>11</td>
<td>17</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>4</td>
<td>16</td>
<td>82</td>
</tr>
<tr>
<td>Osh city</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Talas</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>5</td>
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<tr>
<td>Total</td>
<td>77</td>
<td>76</td>
<td>93</td>
<td>109</td>
<td>121</td>
<td>125</td>
<td>103</td>
<td>96</td>
<td>95</td>
<td>97</td>
<td>88</td>
<td>98</td>
<td>1080</td>
</tr>
</tbody>
</table>

Table 6 below presents data on the total number of suicide cases among youth aged 19-29 by region from 2014 to 2018. In 2016, Chui region recorded the highest number of cases (80 recorded cases), while Talas region recorded 7 cases in the same year. In general, it is worth noting that Chui region had the highest number of suicides for all of these years.
Table 6. Pattern of peak years of suicides among youth (aged 19-29 years) by region for the period of 2014-2018 (n)

<table>
<thead>
<tr>
<th>Region</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Average</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chui</td>
<td>69</td>
<td>68</td>
<td>80</td>
<td>48</td>
<td>49</td>
<td>62,8</td>
<td>314</td>
</tr>
<tr>
<td>Osh region</td>
<td>32</td>
<td>26</td>
<td>35</td>
<td>37</td>
<td>30</td>
<td>32</td>
<td>160</td>
</tr>
<tr>
<td>Jalal-Abad</td>
<td>40</td>
<td>47</td>
<td>37</td>
<td>27</td>
<td>29</td>
<td>36</td>
<td>180</td>
</tr>
<tr>
<td>Issyk-Kul</td>
<td>31</td>
<td>32</td>
<td>12</td>
<td>12</td>
<td>29</td>
<td>23,2</td>
<td>116</td>
</tr>
<tr>
<td>Bishkek city</td>
<td>37</td>
<td>28</td>
<td>31</td>
<td>44</td>
<td>32</td>
<td>34,4</td>
<td>172</td>
</tr>
<tr>
<td>Batken</td>
<td>20</td>
<td>23</td>
<td>19</td>
<td>18</td>
<td>20</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>Naryn</td>
<td>13</td>
<td>13</td>
<td>17</td>
<td>11</td>
<td>10</td>
<td>12,8</td>
<td>64</td>
</tr>
<tr>
<td>Talas</td>
<td>13</td>
<td>3</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>7,8</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>255</td>
<td>240</td>
<td>238</td>
<td>205</td>
<td>207</td>
<td>229</td>
<td>1145</td>
</tr>
</tbody>
</table>

5.3 Difference in the data on the number of suicide cases provided by the NSC and the MIA

It was not possible to compare data from the NSC and the MIA on suicides among adolescents (aged 10-18 years) and youth (aged 19-29 years) for all the years because for youth the MIA only provided data from 2014 to 2018. Therefore, the section below provides a data comparison for adolescents and youth for the period 2014-2018.

Chart 6. Difference between data from the NSC and the MIA on the number of suicide cases among adolescents (10-18 years old) and youth (19-29 years old) by data source and years (2014-2018) (n)

This chart shows the existing discrepancy in the number of suicide cases depending on the source of information. The discrepancy in the data might be due to differences in recording and registration methods, sources and flows of information received. In this regard, effective suicide prevention requires an improvement in the availability and quality of the data on suicides and suicide attempts. Thus, there is a need to improve the recording system itself.

On January 1, 2019, as part of the judicial reform of the Kyrgyz Republic, the “Unified Register of Crimes and Misconducts” (URCM) entered into force. The URCM is an electronic database that contains information such as about the beginning of pre-trial proceedings, procedural actions and criminal proceedings, misconduct as well as suicides cases. The General Prosecutor’s Office of the Kyrgyz Republic is the holder of this registry system and has a key responsibility for its implementation. The system is expected to demonstrate its effectiveness in the near future.

Some differences in suicide rates are also noted in the Programme of the Government of the Kyrgyz Republic for the Protection of Mental Health of the Population. Namely, it states that a high prevalence rate of suicide cases was observed in 2012 with 9.49 cases per 100,000 population, in 2015 this indicator decreased to 6.93 per 100,000 population. A similar trend is observed in suicide attempts – the prevalence rate per 100,000 population amounted to 27.9 in 2012 and decreased to 19.3 in 2015. The number of suicides among children and adolescents in 2015 increased by almost 1.5 times and amounted to 7.19% of the total number. According to data from the MIA of the Kyrgyz Republic, 90 suicide cases among adolescents were registered in 2015; 22.63% of the total number of suicide attempts were made by young persons between 18-22 years. The variability of the prevalence rates of suicides and suicide attempts according to the year, age range and region requires scientifically-based approaches to studying this problem. The actual data of ministries, agencies and services responsible for the registration of suicide cases and suicide attempts differs significantly and calls for a need to create a single registration database.


Key results of the study
6. Policy measures in the area of suicide prevention

This section presents the analysis of activities, services and assistance provided to children and youth with suicidal behaviour as well as their families.

In general, the mapping of service providers has shown awareness of the suicide problem among children, adolescents and youth at the national level and a very clear understanding of the extent and depth of this issue by decision-makers. Moreover, institutional measures (such as Government Orders) have already been undertaken to prevent this phenomenon, although there are some shortcomings and gaps in the implementation of these measures. The national strategies in this area reflect the importance of coordination and collaboration among multiple sectors for suicide prevention efforts since no single approach can impact and solve an issue of such complexity as suicide alone.29

In 2015, the Law of the Kyrgyz Republic No. 185 “On measures to prevent harm to children’s health, their physical, intellectual, mental, spiritual and moral development in the Kyrgyz Republic” was adopted. The law contains measures to prevent cases of suicide among children. Moreover, in 2018 the Government of the Kyrgyz Republic adopted the Programme for the Protection of Mental Health of the Population of the Kyrgyz Republic for 2018-2030. The Programme was approved by the Decree of the Government of the Kyrgyz Republic No. 119 dated 1 March 2018 and focuses on suicide and their prevention (section 5.2). The Programme also outlines the need to strengthen the provision of medical and social services at the local level both by public institutions, NGOs as well as the private sector in line with the Law “On State Social Procurement”. This law also partially regulates the issues of State support to private providers of social services, including the financing of welfare, socio-legal, medico-social, rehabilitation, psychological and other services. The laws of the Kyrgyz Republic “On psychiatric care and guarantees of the rights of citizens in its provision” and “On the licensing system in the Kyrgyz Republic” state that psychiatric care is provided by governmental, non-governmental psychiatric and neuropsychiatric institutions and private psychiatrists with relevant documents giving permission to such activities.

The Programme for the Protection of Mental Health of the Population of the Kyrgyz Republic for 2018-2030 pays special attention to the provision of psychosocial services at the local level, in particular: the provision of comprehensive, integrated health and social care at the local level (section 4); the development of social services in semi-stationary conditions at the local level (section 4.1); the provision of comprehensive, integrated mental health

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services at the primary health care level (Article 4.2); optimization of the activities of healthcare organizations providing psychiatric services and social inpatient facilities (section 4.3); improvement of the organization and conduct of medico-social and forensic examinations of mental health (section 4.6); the creation of conditions for the non-governmental sector providing mental health services, issues of accreditation and licensing (section 4.7); mental health promotion and prevention of mental disorders (section 5.1).

In response to the growing number of suicide cases among youth, the Government of the Kyrgyz Republic issued Order No. 120 “On the prevention of suicides, offences and crimes among children and youth” on March 22, 2016. The Order also approved an Interdepartmental Action Plan to prevent suicides, offences and crimes among children and youth in the Kyrgyz Republic for 2016-2018. The MLSD of the Kyrgyz Republic was appointed to monitor and execute the order.

In 2019, the Government issued an Interministerial Order with a corresponding Action plan for 2019-2020 on the prevention of suicide, offences, and crime prevention among adolescents and youth. This was based on Interministerial Order No. 20-7203 of February 19, 2019. The Order lists a wide range of agencies that need to develop internal orders and relevant implementation plans. There were 10 departments that have issued such orders and action plans, in particular:

- The MIA of the Kyrgyz Republic, Order No. 268 dated March 28, 2019;
- The Ministry of Culture, Information and Tourism of the Kyrgyz Republic, Order No. 135 dated March 28, 2019;
- The MH of the Kyrgyz Republic, Order No. 169 dated March 28, 2019;
- The State Agency for Youth, Physical Culture and Sports under the Government of the Kyrgyz Republic, Order No. 81-4 dated March 28, 2019;
- The SALSGIR of the Kyrgyz Republic, Order No. 01-18 / 22, dated March 28, 2019;
- The MES of the Kyrgyz Republic, Order No. 338/1, dated March 29, 2019;
- The MLSD of the Kyrgyz Republic, Order No. 44, dated March 28, 2019;
- The Ministry of Emergency Situations of the Kyrgyz Republic, Order No. 323, dated March 28, 2019;
- The State Defence Committee of the Kyrgyz Republic, Order No. 127, dated March 28, 2019;
- The State Committee on Information Technologies and Communications of the Kyrgyz Republic, Order No. 78-a, dated March 28, 2019.

The focus of the activities specified in the plans is of a preventive nature. They primarily aim at informing a wide range of people who in one way or another have an impact or can report suicide risks among adolescents and youth to relevant authorities. In practical terms, these activities can be general meetings with the population, conducted with the help of SALSGIR of the Kyrgyz Republic; the Defence Committee to work with soldiers; the MES – at schools and universities; the MLSD to arrange meetings through its structural units in the field; the MH through primary level structures (paramedic and obstetric points (PAP), family doctors group), emergency medical centres and specialized hospitals (mental health centres) etc.

Activities from the interagency plan include the following:

- Analysis of inspection materials on suicides, offences and crimes among children and youth, identification of the causes and conditions for such acts;
- Analysis of suicide cases, offences and crimes among children and youth in the regions, districts, cities and villages of the Kyrgyz Republic;

• Consideration of issues related to the prevention of suicides, offences and crimes among children and youth, taking into account the analysis and operational environment;

• Development of interagency action plans on the prevention of suicides, offences and crimes among children and youth considering the operational environment;

• Implementation of action plans on the prevention of suicides, offences and crimes among children and youth;

• Provision of emergency psychological aid to children to prevent suicide attempts in the framework of the “Helpline for Children”;

• Provision of timely consultations by psychiatrists, drug addiction specialists and psychologists for children with signs of suicidal behaviour and those prone to consuming alcohol and intoxicating substances;

• Organization of meetings with representatives of social services, psychologists, lawyers for minors in custody and children registered with prison inspections to provide them with timely assistance and support;

• Conducting a series of conversations with children aged 7 to 12 years who are undergoing treatment at rehabilitation centres and residential social service institutions on the following topics: “Life is beautiful!”; “Troubles can be fixed”; “Share if it’s difficult for you”; “Learning to build relationships”;

• Development of a programme and conducting a series of talks and trainings with adolescents aged 13 to 18 years, who are undergoing treatment in rehabilitation centres and in residential social services institutions as well as for minors in an educational colony on the topic: “Everything can be corrected in life while you are alive”.

6.1 Mapping of service providers

In general, the process of providing psychosocial services to target groups in the context of suicidal behaviour can be divided into several stages, specifically:

1. Identification of target groups in need of psychosocial support. This point is significant, considering the specificity of the problem which is subject to stigma and is very latent. At the same time, it is also worth taking into account the legacy of the Soviet era, when the practice of using psychosocial services was not widespread or did not exist at all.

2. Provision of psychosocial support or mechanisms to refer persons to appropriate centres.

3. Follow-up (mentor, guidance, supervision) of the support process and completion of the full assistance cycle.

Given that, in general, children, adolescents and youth in the context of suicide problems are between the ages of 9 and 29, they can be identified, supported and also divided by location. For example, children from 9 to 17 years old are school students; children who do not attend school are at home, in shelters, markets, streets etc.; youth aged 18-22 years attend professional educational institutions (university, vocational education) and some are in the army. For youth aged 23-29 years, it is difficult to determine a frequent place of stay, but they can be informed through the media on the availability of psychosocial support. Therefore, the process of identifying target groups and providing them with psychosocial support can in one way or the other occur in their places of frequent stay. In this regard, the location of the target group, depending on the age was taken into account when mapping service providers.
Figure 1. Mapping of service providers according to the age range of the target group

<table>
<thead>
<tr>
<th>Age range</th>
<th>From 9-17 years</th>
<th>From 18-22 years</th>
<th>From 23-29 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location/social</td>
<td>School, home, shelters, markets</td>
<td>Universities, colleges, home, army</td>
<td>Universities, colleges, home, office, army, media</td>
</tr>
<tr>
<td>institution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service providers</td>
<td>Parent/caregiver, pedagogue (school psychologist, social pedagogue), social</td>
<td>Parent/caregiver, pedagogue, social worker, soldier, head of village/</td>
<td>Parent/caregiver, pedagogue, social worker, soldier, head of village/</td>
</tr>
<tr>
<td>active in the</td>
<td>worker, head of village/sub-municipality, neighbours</td>
<td>sub-municipality, neighbours</td>
<td>sub-municipality, neighbours</td>
</tr>
<tr>
<td>identification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of problems or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>service provision</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The mapping above shows that the most common service providers or suppliers are pedagogues, namely school psychologists, social pedagogues) as well as social workers. School psychologists, social pedagogues and social workers constitute the primary level in identifying youth in need of psychosocial support. Children of preschool age were not considered in the mapping because of the low probability of suicidal behaviour in this age group. Therefore, the main emphasis was placed on schools attended by children aged 6-17 years, where school psychologists and social pedagogues play an important role. If a school-aged child does not attend school, the emphasis was placed on social workers from the local social development service, who along with the school psychologist or social pedagogue may be involved in the preparation of a child support plan. According to some stakeholders, it is more likely that suicide problems manifest in families in difficult life situations, families with parents in migration, single-parent families, and families with alcohol/drug addiction issues. Therefore, the researchers paid attention to the functions and capacities of social workers that remain far from meeting the desired standards, especially notable in the regions that continuously experience lack of qualified social workers.

In addition, the primary level also includes the helpline, which can link the customer with the service provider when a call is received. The MLSD operates the Child Helpline “111”. The researchers conducted a small study using the “mystery shopping” method, the essence of which is to understand and evaluate the work of this service by disguising as a customer. The researchers called the hotline introducing themselves as neighbours of a family where a child is allegedly abused. The hotline operators asked for the exact address in order to contact the Family and Child Support Department (FCSD) of the local department for social development and asked to clarify the school of the child so that the school psychologist or social pedagogue could assist that child. In this regard, there is a reason to believe that the mechanism of providing services through the helpline works quite effectively. The helpline can also be effective at the third level – a tertiary-level where more in-depth consultation and support is given.

The secondary level of service providers includes specialized organizations, such as the Child Support Centre in Bishkek. This level is not well developed in the villages where there are stronger neighbourly and kinship ties that make it easier to identify suicide concerns, unlike in the cities with a greater estrangement of people from one another. The problem with a lack of specialized support centres at the village level requires issues to be referred to NGOs or rehabilitation centres in district centers and the cities.

The tertiary level of service providers includes specialized medical or other qualified organizations - mental health and rehabilitation centres that focus on the provision of psychosocial services, as well as helplines.

The following points provide more information about the centres specializing in the provision of psychosocial support services:
• The Centre for Social Adaptation of Children under the Bishkek city administration acts as such a centre, but it has not faced any suicide cases so far and has therefore not worked yet in the area of suicide prevention.

• The Child Support Centre has special mobile groups that include representatives of the city social protection services, healthcare, law enforcement as well as education agencies to work in all districts of Bishkek. When a complaint is received about a threat or fact of violence against a child, they are able to mobilize their resources to provide urgent assistance to the child in the shortest possible time. There are special rooms for children at the centre, including a playroom with a special mirror glass so that the experts may observe the kids without disturbing them and a relaxation room. The centre employs four psychologists, two lawyers and social workers who provide the necessary psychological and legal support as well as work individually with each child and his or her parents/caregivers. In their work, the specialists of the centre place a key emphasis on bringing assistance to the child to a logical conclusion. The task can be considered complete only when they are convinced that the crisis has passed, and the child can continue to cope with certain situations on his or her own. However, it should be noted that there is no possibility of an overnight stay at the centre. Depending on the complexity level of the case, meetings with the child in need of assistance take place together with the parents or caregivers who oftentimes start interrogating them instead of listening and understanding the situation faced by their child. Therefore, the centre also works with parents in order to teach them to listen to their child. Children who have experienced abuse or violence become vulnerable, their perception of the world changes and they are not able to cope with the situation on their own.

• The work of the helplines shall also be noted. One of the helplines operates on the basis of the Child Support Centre, both children and adults can turn for help to protect themselves from violence or receive free qualified consultations of specialists. This centre was established with technical and financial support from UNICEF, the Bishkek Mayor’s Office and the Child Rights Defenders’ League. The Mayor’s Office provided premises for the centre which was renovated and equipped with the support from UNICEF, that in addition also trained the centre’s specialists to provide better services.

• In the case of a more serious mental illness, there is a centre for out-of-hospital psychosocial care in Bishkek, which provides free consultations of psychiatrists and social workers.

Role of the social worker

The social workers interact with many structures including schools, the Juvenile Police, municipal territorial administrations and heads of village/sub-municipality. The key role here belongs to the MLSD with an expanded management structure at the local and district levels. The regulations on the department of social development, the structure and staffing of the MLSD territorial structures were developed according to the standard project and approved by the Ministry’s orders in early 2016.

In 2011 changes were introduced to the structure of city and district departments for social development to further develop mechanisms for the provision of social services to the population at the local level. New subdivisions of the Department for Social Development (DSD) were created, i.e. the Family and Child Support Departments (FCSD) were transferred from the local State administration, and Mayor’s Offices to the MLSD structure and the social workers’ service was transformed.

The review of the Regulation on the activities of the DSD has shown that the functions of the department for the protection of families and children account for around 40% of the whole activity of the territorial department for social development to perform tasks assigned to the DSD. The large volume of work and low salaries in both departments is resulting in high personnel turnover.
Nevertheless, there are social workers who provide services mostly on the identification of families and children who are in need of psychosocial support.

The Department for the protection of families and children has approximately four specialists in addition to four usually younger social workers with high education degrees who are assigned to the Department. These social workers perform functions of department specialists, except for participation in court proceedings. The assignment of social workers to the Department has positive aspects in regard to solving the issue with personnel training in civil service as well as to improving the capacity of social workers.

Among other functions, the social workers are also involved in identifying families and children in difficult life situations.

The interaction between the regional and local MLSD structures looks as follows\(^\text{31}\): Social workers of district departments for social development work in villages, mainly in their own place of residence. In general, each of the social workers is assigned to work with around 8 to 12 people, including elderly, married couples (due to cases of domestic violence) and persons with disabilities.

In the cities, social workers have to fill out the social passports of low-income families to determine their need for social benefits. The service of social workers is a new division in the structure of the DSD, but the work principles, material and technical resources and the level of qualification of social workers remain the same.

Generally, social workers are involved in:

- the process of identifying and supporting families and children in difficult life situations;
- the organization of field visits to determine the living conditions of families in difficult life situations and develop a relevant Act;

\(^{31}\) The results of the following report were used: Suyunalieva B. et al., Анализ взаимодействия социальных служб с отделами по предоставлению социальных услуг лицам с ограниченными возможностями здоровья, пожилым гражданам и по защите семьи и детей, Public Fund “Fund for the Development of Social Services”, Bishkek, 2016.
Policy measures in the area of suicide prevention

• filling out a social passport for low-income families;
• the preparation of the report on the basis of the social passport;
• conducting in-house visits and compiling lists of people in need to provide them with material assistance;
• the organization and conduct of events on significant dates;
• the participation in various raids conducted by the DSD, Juvenile Police and the local administration;
• the support of activities of local administration to mobilize the population;
• the launch of information and explanatory works;
• joint work with social pedagogues on out-of-school children.

If a phone call from neighbours or the head of village/sub-municipality is received, a special act is prepared through joint work of a commission involving the Juvenile Police, social worker and chief specialist of the FCSD. This act can be the basis for the decision to provide support to families. The social worker is also involved in the development of a joint plan with a social pedagogue and uses reliable tools for collecting and identifying problems. Questionnaires are also available to identify families and children in difficult life situations.

Disadvantages: the institution of the social worker is still in its formative stage. Social workers lack motivation, and there is a high probability of emotional burnout due to the interaction with people in difficult life situations. In addition, social workers face a heavy workload and have wide functional responsibilities, working with elderly people, persons with disabilities, poor people and others. The social workers can play a significant role in the context of suicidal behaviour by identifying and referring those in need of psychosocial support. However, they are not qualified to provide psychological assistance.

The school psychosocial service

The psychosocial service in schools was established on the basis of the regulations “On the establishment of psychosocial service” and the recommendations of the City Department of Education of the Bishkek Mayor’s Office “On creating a service to provide psychological and pedagogical assistance to students in educational organizations” (2017). They are also in accordance with the Law of the Kyrgyz Republic “On education,” the UN Convention on the Rights of the Child, the Family Code of the Kyrgyz Republic, school regulations and aim at preserving and strengthening the health of students and teachers and preventing mental health disorders.

The objectives of psychosocial services are the following:

1. To provide social and psychological conditions for the successful education and development of the child’s personality, his or her socialization and professional development;
2. To provide social care and protection of the rights and interests of minors and especially the children in difficult life situations;
3. To study psychosocial problems of educational activities, leadership style of the educational process, identify errors to prevent their negative impact on the work of the institution;
4. To promote mutual understanding and interaction between the subjects of the educational process;
5. To develop children's individual interests and needs, contributing to their moral development as a socially significant and responsible person;
6. To conduct advisory and educational work among students, teachers, and parents;
7. To carry out psychological work and promote a healthy lifestyle among children, teachers and parents.

The main directions in the work of school psychosocial services:

If a phone call from neighbours or the head of village/sub-municipality is received, a special act is prepared through joint work of a commission involving the Juvenile Police, social worker and chief specialist of the FCSD. This act can be the basis for the decision to provide support to families. The social worker is also involved in the development of a joint plan with a social pedagogue and uses reliable tools for collecting and identifying problems. Questionnaires are also available to identify families and children in difficult life situations.

Disadvantages: the institution of the social worker is still in its formative stage. Social workers lack motivation, and there is a high probability of emotional burnout due to the interaction with people in difficult life situations. In addition, social workers face a heavy workload and have wide functional responsibilities, working with elderly people, persons with disabilities, poor people and others. The social workers can play a significant role in the context of suicidal behaviour by identifying and referring those in need of psychosocial support. However, they are not qualified to provide psychological assistance.
Policy measures in the area of suicide prevention

- Assistance to families facing problems related to the upbringing and education of the child;
- Identification of children’s needs and development of measures to help specific students, involving specialists from relevant institutions and organizations;
- Help the child to address the causes that negatively affect his or her performance and school attendance;
- Involvement of children, parents and the public in the organization and conduct of social and pedagogical events and activities;
- Recognition, diagnosis and resolution of conflicts, problems and difficult life situations affecting the interests of the child in the early stages of development in order to prevent serious consequences;
- Individual and group counselling of children and their parents on the resolution of problematic life situations, education of children in the family, conflicts etc.;
- Prevention and correction of mental health and social behaviour;
- Social and pedagogical support of the educational process.

The psychosocial support service includes social pedagogues, school psychologist, and the Juvenile Police. This service is a relatively new direction in the work of the schools. It is mostly present in Bishkek and is not developed in the regions yet. Below is a detailed outline of the role and responsibilities of the school psychologists, social pedagogues and the juvenile police.

**Role of the school psychologist**

Schools, their psychologists and social pedagogues play a significant role in the context of suicide problems. The presence of a school psychologist is already a great achievement, and they are mostly available in Bishkek schools and only rarely in regional centres. They are practically absent in districts and villages. Due to the high overload of schools, there is usually only one psychologist for 3,000 students. In rare and exceptional cases, schools have several psychologists, for example, school No. 26 in Bishkek.

Several meetings with school psychologists in Bishkek made it clear that some of them are highly qualified specialists who understand the essence of their functional duties and have experience in identifying, diagnosing and providing psychosocial services. At the same time, there are specialists who are partially engaged in teaching or some administrative schoolwork in addition to providing psychological services. This relates to the level of understanding of school management on the importance of the work of school psychologists. This lack of understanding leads to the fact that the school psychologist is kept busy with other parallel work that is oftentimes of an administrative and organizational nature (e.g. organization of events, courier services).

There were also problems with the absence of any common standards in the work approaches of the school psychologists who for example, use different scales in diagnosis depending on their competence. When participating in FGDs, some school psychologists mentioned the development of questionnaires and scales as well as approaches using and interpreting drawings as their achievements.

However, many schools have a comprehensive approach to suicide prevention. For example, social and psychological services were established with their own status and composition, which includes the Juvenile Police, a social pedagogue and a school psychologist.

School psychologists are aware of the need for professional development and express a desire to create an Association of School Psychologists where they could discuss and solve professional problems, share experiences and improve their skills.

Some school psychologists shared their practices and cases working with schoolchildren and mentioned a high stigma towards the ones receiving psychological support. Schoolchildren are afraid that they can be “ridiculed” by their
Policy measures in the area of suicide prevention

classmates for visiting the psychologist’s office. It clearly indicates the lack of a widespread practice of receiving psychological services. In this regard, the school psychologist, for example, has to work with all the 30 children in a class just to be able to help one of them without singling him or her out due to high stigma. As highlighted by WHO, the issue of stigma, particularly surrounding mental disorders and suicide, means that many people are prevented from seeking help. Breaking down taboos are important in suicide prevention efforts.22

Given the lack of a widespread practice among schoolchildren to use the services of school psychologists, it is difficult for them to identify the children in need of support. Therefore, school psychologists often use the practice of attending class hours or request teachers to inform them about students who have indirect or direct signs of the need for psychological help. For example, there was a case when a girl came to school in a long-sleeved shirt, and the teacher noticed cuts on the veins of her hands. The teacher informed the school psychologist about this case and the psychologist had to provide a planned consultation for the whole class to discreetly contact the right girl. The psychologist eventually managed to get in touch with that girl, approach her and give the needed support.

Role of the social pedagogue

The position of a social pedagogue was introduced into the school system by the MES of the KR in 2011. The need for social pedagogues was first and foremost dictated by increasing cases of violence in schools and racketeering, that had even deserved attention and was discussed by Kyrgyzstan’s Security Council. UNICEF Kyrgyzstan has and is continuously working with the social pedagogues to increase their capacity to better interact with the school children, reduce violence and conflicts, render psychosocial support to the ones in need as well as on matters of facilitating social adaptation of children and adolescents. Such extensive support was provided by UNICEF within the framework of its project “School without Violence”, implemented in cooperation with the

Public Foundation “League of childrens’ rights defenders”23

In some schools, a social pedagogue is part of the school’s psychosocial service structure, and as a school employee, he/she creates conditions for the social and professional self-development of students, guiding them in choosing the future profession. The role of the social pedagogues also lies in ensuring the harmonious development of children and adolescents during the school education and in helping the ones facing difficulties in the learning process or who have intelligence deficiencies, emotional, behavioural and communication problems. The social pedagogue works in close collaboration with the juvenile police officer in preventing and tackling conflicts, arguments between the schoolchildren and in this regard plays a leading role in creating schools where there is no place for violence.

Role of the Juvenile Police

The Juvenile Police is a structural unit of the MIA. Almost every school in Bishkek has an assigned juvenile police officer or even several officers. The officers are also present in Chui region, especially in its areas located in close proximity to the capital, for example, in Alamedin district. The juvenile police officer is provided with an office and has an opportunity to participate and conduct activities in the school premises. Officers carry out explanatory and information work among schoolchildren on various topics, including suicide, juvenile delinquency and its negative consequences. They also play a very important role in identifying conflicting sides and in raising the legal education and culture of the schoolchildren. Many juvenile police officers noted that such issues as school racketeering and other difficulties in relations both among peers and between seniors and juniors can lead to suicide attempts. In this regard, the joint work between the social pedagogue and the school psychologist is very important.

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23 More info is available at: https://edu.gov.kg/media/files/5425e2d7-945b-459a-8bb6-6ce7c732b871.pdf
Methodological tools in the provision of psychosocial support in communities

Generally, Kyrgyzstan has developed a number of clinical guidelines for the provision of psychological assistance to children in communities, as well as a clinical protocol to help children victims of violence. They include algorithms to assist and redirect cases to the appropriate services.

For example, if a social pedagogue, a school psychologist or a social worker comes across a case where a child in need of assistance, they may use the scheme below:

**Figure 3. Scheme of psychosocial support**

If a child tells about suffering from violence, the following algorithm of actions should be taken by the psychologist:

1. Psychologist informs about the fact of abuse of children to direct supervisor (Chief Psychologist of the Republican Health Center, Head of Multidisciplinary Team)
2. Head of MT informs about the suspicion of abuse of children to the police (102) and the Child Support Center (support to victims of violence) by phone (312 44-25-10). A special registration card is filled in with data about a child (Annex #1)
3. The Child Support Center shall ensure follow-up management and referral of the case
4. Psychologists of the organization providing assistance to children affected by violence can refer a child for further psychological counseling if their resources are limited

It should be noted that this assistance scheme is relevant for urban areas and regional centres and to a lesser extent for district centres. In rural areas, this approach is difficult to practice due to the lack of appropriate services.

Thus, this chapter suggests that, overall, psychosocial service providers have a significant potential to identify, refer and provide appropriate support in the context of suicidal behaviour. However, there are differences in the capacity between the services in urban and rural areas. The specialized psychosocial services are more or less effective in urban settings with qualified personnel, but this level of service provision faces significant barriers in rural areas. However, it is easier to identify those in need of psychosocial support in rural areas due to close contacts between the neighbours compared to the cities. At the decision-making level, there is an understanding of the depth of the problem with suicides and attempted suicides among youth and adolescents and increased attention is being to tackling this problem in recent years. However, many mechanisms are not yet functioning properly in practice. There are namely, difficulties when it comes to the identification, availability and provision of appropriate services.
7. Underlying causes, risk and protective factors in the field of suicidal behaviour

The next two chapters are devoted to studying the underlying causes, risk and protective factors in the field of suicidal behaviour.

Interviews were conducted with respondents from the following two target groups:

1) Adolescents and youth who attempted suicide (or had a series of attempts);

2) Close relatives and friends of adolescents and youth who died by suicide.

7.1 Underlying causes, risk and protective factors in the field of suicidal behaviour through a survey of adolescents and youth who have attempted suicide

A total of 49 interviews were conducted with adolescents and youth who experienced an attempt or a series of suicide attempts.

This chapter covers the following issues:

1. The assessment of sociodemographic characteristics of persons who attempted suicide (including ethnicity, gender, marital status, employment, age, level of education and family composition)

2. The history and circumstances of suicide attempts;

3. Receiving of medical and psychosocial support;

4. Families and environment (support, risks, atmosphere);

5. Situational stressors.

7.1.1 Socio-demographic characteristics

Age. The average age of the 49 respondents was 19 years old (median 18, mode 14). The minimum age of respondents was 12 years old, and the maximum was 29 years old. 24.5% of respondents (41.1% women) were aged from 15 to 17 years old, 22.4% were from 21 to 25 years old (36.3% women). The adolescents accounted for 20.4% (40% women) and were aged from 12 to 14 years old. The other two age groups from 18 to 20 and from 26 to 29 years amounted to 16.3% each.
Gender. The gender ratio of respondents shows a relatively even distribution between the sexes: 59.2% men and 40.8% women.

Ethnicity. 71.4% of respondents were ethnic Kyrgyz, 12.2% were of Tatar ethnicity, 10.2% were Uzbek and 6.1% Russian.

Residence. Almost half of all respondents lived in Chui region and Bishkek (26.5% and 22.4%, respectively). 10.2% lived in Jalal-Abad region, and the same percentage of respondents resided in Issyk-Kul region. Respondents from Naryn and Osh regions accounted for 8.2% each.
Marital status. 44.9% of the respondents were of school age. The family status of the remaining 55.1 % of respondents aged from 18 to 29 years old is as follows: 81% are not married, 10% are currently residing separately from their partners and remaining 9% have not formally registered their marriages.

Education level. 34.7% of respondents (53% women) completed secondary education and another 30.6% have not completed it (26.6% women). 14.3% (57.1% women) were currently attending schools and institutions of secondary education, and 6.1% had higher education.

Religious affiliation. Almost 70% of respondents identified themselves as Muslim, and 8.2% described themselves as Christians, while 22.4% noted that they do not have any religious affiliation and expressed an indifferent attitude, especially notable among adolescents and youth.

Employment. 44.9% of respondents were schoolchildren, and 55.11% were of working age. 16.3% were mainly employed on a temporary basis, and 2% had permanent employment. 20.4% of respondents were mainly young people who were employed in the service sector (cafes, trade, delivery of good and others). 16.4% had no employment. Most of the respondents have stated the low level of satisfaction with their jobs, and a few indicated some satisfaction and only one respondent was quite satisfied.

7.1.2 History and circumstances of suicide attempts

The majority of respondents, namely 65.3% noted that the last suicide attempt took place between 1-3 years ago. About a fourth of respondents attempted suicide recently, from 1 to 6 months ago.

There is evidence that suicide attempts are associated with a person’s psycho-emotional state that also depends on the season of the year. According to data obtained from respondents, the majority of suicide attempts happened in spring. From a total of 18 attempts (7 among school-aged respondents), 8 took place in May (4 among school-aged children). The level of suicide attempts is also relatively high during the summer months. From a total of 17 attempts (9 among school-aged children), 8 have taken place in July (3 among school-aged children).

A total of 10 attempts took place in autumn (3 among school-aged children). 6 attempts took place in November and 1 has involved a school-aged child. There was a total of 4 attempts in winter seasons, 3 of them among school-aged children.

Evening was the most common time of day for suicide attempts (25 out of 49 suicide attempts happened in the evening and 18 attempts in the afternoon). During the interview, many respondents mentioned that most often they attempted suicide when no one was at home, or when their parents were at work and came home late. Most of the suicide attempts took place at home.

Table 7 below shows that the physical presence of a parent or both parents is not enough for suicide prevention. There is a need for a deeper connection, trust and sensitivity to understand the mood and inner experiences of their child. According to the study, 73.5% of respondents lived with their parents in the year before the attempt, and this did not prevent them from attempting suicide.
Table 7. Family composition during the previous year and at the moment of the attempted suicide (N=49) (%)

<table>
<thead>
<tr>
<th>Family composition</th>
<th>During last year %</th>
<th>At the moment of the attempted suicide %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone</td>
<td>18,4</td>
<td>20,4</td>
</tr>
<tr>
<td>Living with parent(s)</td>
<td>73,5</td>
<td>71,4</td>
</tr>
<tr>
<td>Living with partner and children</td>
<td>4,1</td>
<td>-</td>
</tr>
<tr>
<td>One of the parents passed away</td>
<td>-</td>
<td>4,1</td>
</tr>
<tr>
<td>Living with another relative</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Living in a residential institution</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Interpersonal conflicts with family members, friends, partners, colleagues or classmates were the most frequently noted reasons for suicide attempts, namely among 42% of respondents (24.3 women). 14.8% of respondents (21.3% women) cited psychological pain, 11.1% (14.9% women) pointed to the issues of self-hatred and disappointment, and 7.4% (12.8% women) indicated financial difficulties and stress.

Chart 12. Causes of suicide attempts (N=49) (%)

Suicide attempts did not pass without a trace, both physiologically and psychologically. The most common consequences were strangulation or rope marks, grooves on the neck (38.8%). 22.4% of respondents referred to colic in the liver and the lower back, rash and itching due to self-poisoning. Another 22.4% also mentioned the presence of scars on the wrist due to cutting veins. It should be noted that some respondents painfully reacted to the question about the ways and consequences of attempted suicide. They felt uncomfortable answering these questions and interviewers had to stop for some time or skip these types of questions. None of these cases was among minors. Respondents also noted some psychological problems associated with anxiety attacks after the suicide attempt.
Table 8. Consequences of suicide attempts (N=49) (%)

<table>
<thead>
<tr>
<th>Consequences</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strangulation and rope marks</td>
<td>19</td>
<td>38.8</td>
</tr>
<tr>
<td>Colic in the liver, lower back, rash, itching due to drugs self-poisoning</td>
<td>11</td>
<td>22.4</td>
</tr>
<tr>
<td>Scar on the wrist due to the cutting of veins</td>
<td>11</td>
<td>22.4</td>
</tr>
<tr>
<td>Fear of heights due to jumping from height/window</td>
<td>5</td>
<td>10.2</td>
</tr>
<tr>
<td>Lavage procedures, poisoning due to self-poisoning with drugs + under alcohol influence</td>
<td>3</td>
<td>6.1</td>
</tr>
</tbody>
</table>

A third of the respondents (32.6%) indicated that at different times they mentioned their intentions to end their life to friends, family members and classmates. Some respondents noted that they did it in order to draw some attention to them and their personality. Some of them also used suicide as an element of blackmail to achieve their goals.

Some of the respondents said the following:

“I told my partner several times that I did not want to live and stated that I would commit suicide if he will leave me.”

“I told my school friend that I don’t want to live since no one understands me and needs me.”

“I cut the wrists of both hands with a knife, drank a litre of beer, locked myself in the bathroom and waited for my parents to return from work. When they returned home, they had to break the door.”

The vast majority indicated a house as the location of the suicide attempt (80%), while 12.2% of respondents indicated a barn, a building/construction near the house, or a house of acquaintances. Others mentioned a bridge and a rented apartment.

None of the interviewed adolescents and youth turned for help to solve the problems they faced before attempting suicide. This indicates that they do not have a trusting environment, that there is no proper trust in the psychosocial support services in schools or at the place of residence, adolescents and youth may face stigma approaching, for example, the school psychologist or they simply do not know about available support services. There is also no culture of mental health maintenance. These barriers were also in some way or another mentioned by the service providers.

7.1.3 Medical and psychosocial support

The suicide attempt required respondents to seek medical help, in particular from general practitioners (in 40.6% of cases), from emergency medical services (20.3%) or as non-psychiatric patients with somatic problems (3.1%). Many noted that after receiving medical assistance, they were recommended to turn to the services of psychiatric and psychotherapeutic care, and only 26.6% of respondents did approach such centres.
Chart 13 shows that patients received treatment and recommendations from the places where they had to turn for help after a suicide attempt. Many respondents also noted that they were given more attention from relatives and friends following the suicide attempt. Relatives and friends were trying to send them to specialists to receive specialized psychological and psychotherapeutic assistance. Specialists of mental health centres noted that most often relatives and friends approach them with concerns that their relative is at risk of suicide. This points to gaps in the health care system and the field of social development associated with inadequate mechanisms for the identification, referral and treatment of persons with mental health issues. At the same time, the respondents noted that they received sufficient attention from social and child protection services at the local level, represented by a social worker at the place of residence, Juvenile Police, the head of village or employee of the territorial municipal authority. Depending on the capacity, these actors decided more or less comprehensively where to send the adolescent in a difficult situation to receive psychosocial support. In the framework of this study, there was a case when an adolescent was sent to the “SOS Children's Villages” where he was able to get the help of a psychologist, due to psychological and sometimes physical violence he has encountered in the family where one of his parents was not biological.

Chart 14. Recommendations received for follow-up care and treatment (N=49) (%)

<table>
<thead>
<tr>
<th>Recommendations Received</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, from general practitioners</td>
<td>40,0%</td>
</tr>
<tr>
<td>Yes, from emergency doctors</td>
<td>18,5%</td>
</tr>
<tr>
<td>Yes, from a psychiatric hospital</td>
<td>13,8%</td>
</tr>
<tr>
<td>Yes, from the psychotherapeutic outpatient department</td>
<td>9,2%</td>
</tr>
<tr>
<td>Did not go to medical facilities</td>
<td>7,7%</td>
</tr>
<tr>
<td>Yes, from a non-psychiatric (somatic) hospital</td>
<td>6,2%</td>
</tr>
<tr>
<td>Yes, from a psychotherapy hospital</td>
<td>4,6%</td>
</tr>
</tbody>
</table>

Half of the respondents indicated that they have independently initiated an appeal to support services following the first medical and psychological help they have received. The respondents who were at school or in another educational institution contacted a social pedagogue or a social worker at the place of residence (38%). Others turned for help to a specialist in a psychotherapeutic hospital (10%) and in extremely rare cases a psychologist in a private centre (5%).

63.3% of respondents who applied for medical or psychological help were satisfied with the assistance received and noted that it met their needs and helped them to solve their problems. 5% found it difficult to assess the quality of the received services; the rest noted that the services were not effective, most likely because they require much time and financial resources.

Psychological diagnosis. Although many respondents received psychiatric and psychotherapeutic help, they could not name their psychological diagnosis. Some indicated bipolar affective disorder, adjustment disorder, prolonged depressive reaction, behavioural and emotional disorder, adjustment disorder with behaviour and emotional disturbance, mixed behaviour and emotional disorder.

A third of respondents were hospitalized with psychological disorders and received medical

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35 SOS Children’s Villages is a non-governmental charity organization that started working in the Kyrgyz Republic in 1996 to provide support and accommodation for children without parental care.

Underlying causes, risk and protective factors in the field of suicidal behaviour
Underlying causes, risk and protective factors in the field of suicidal behaviour

7.1.4 Family and environment

73.5% of respondents said that they were brought up in a family with both parents, 22.4% indicated that they grew up having only one parent, 2% were brought up under the care of relatives and another 2% in a residential institution.

The family environment, in many ways, prevents psychological problems, gives confidence to the child that his or her family will provide support in any situation and show love no matter what. Therefore, the study included a question on the nature of family relations with 26.5% of respondents noting that they had warm, trusting relations in the family and with family members. At the same time, more than half of respondents (57.1%) indicated that they had a conflict with at least one of the family members, most often with a parent and less often with a sibling. Moreover, 8.2% indicated that the relationship was normal, neutral, and another 8.2% found it difficult to answer this question.

Most likely because of a conflict in the family, 55.2% of respondents noted that they did not discuss problems with their family members, in contrast to only 24.5% who have done so. 12.2% of respondents discussed their problems only occasionally and another 8.2% were unable to answer this question due to difficulties. The discussion process itself is also of situational in nature, for example, some respondents noted that at the time of the attempt and in the presuicidal period, they did not discuss problems with family members. Sometimes, taking into account the situation in the family, they could decide to bring up a problem for discussion.

Some of the respondents noted the following:

“At the time of suicide attempt, I did not discuss it, but in general I try to discuss some things with my mother, sometimes she understands me, and at other times she does not, and we get into a conflict. So, at times I try not to talk about my problems in order not to anger her even more. If you start discussing, more disagreements might follow.”

“I rarely discussed issues with my mother, I was afraid to upset her.”

“My parents love and support me, but do not accept my problem (sexual orientation), so I do not share my problems with them.”

The statements of respondents did not include discussion of problems with their fathers.

Stories of violence: at home, at school or elsewhere. 55.1% of respondents experienced domestic violence from parents, caregivers and other family members (out of the 27 respondents who experienced domestic violence, 14 were female), while 32.7%, on the contrary, did not; 8.2% periodically experienced domestic violence. The rest of the respondents did not answer this question. In addition, psychological pressure by one of the parents was also indicated as a type of violence. There were also cases when respondents were beaten by one of the parents for using snuff, smoking cigarettes and drinking beer.

25% of respondents have also indicated that their parents drink alcohol. One respondent said that his mother has an asocial lifestyle, stating that she consumes alcohol permanently and disappears for a long period of time. The respondents were not aware of any suicide cases or attempts in their families.

Additional 25% of respondents have noted cases of bullying at school or in an educational institution, constant conflicts with classmates, lack of friends in the class, and feeling like an
outcast. Sexual abuse, as well as bullying on the basis of appearance and sexual orientation, were also reported by 6% of respondents.

**Use or abuse of substances (alcohol and others).** 77% of respondents (31.6% women, 34.2% aged 13 to 17 years; 65.8% aged 18 to 29 years) used or abused alcohol and other means of changing consciousness. 43.4% drank beer (21.7% women, 47.8% aged 13 to 17 years and 52.2% aged 19 to 29 year). More than a quarter of respondents (26.4%) indicated abuse of vodka. They were mainly from rural areas, aged 20 to 29 years. Additional 15.1% noted cannabis (mainly from urban areas) and 13.2% mentioned snuff. Moreover, about 2% indicated the consumption of more powerful psychoactive substances. They consumed it with friends or alone, at work, or in other places of entertainment.

The high percentage of alcohol and other substances consumption, which includes beer for the most part (43.4%) among groups of teenagers aged 13 to 17 is most likely due to the lack of proper preventive work both by the family and by the school. According to a representative of the Republican Centre for Narcology, there is no specialized narcological service for adolescents in the country.³⁶

“I can consume at work, at home, in the club or alone up to 0.7 litres of alcohol on Saturday, marijuana up to twice a week. With friends, we smoke and drink alcohol, usually 1 bottle of vodka, 3 litters of beer and tablets;” noted one of the respondents.

```
Chart 15. Consumption of substances (N=49) (%)

<table>
<thead>
<tr>
<th>Substances</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer</td>
<td>43.3%</td>
</tr>
<tr>
<td>Vodka</td>
<td>15.1%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>26.4%</td>
</tr>
<tr>
<td>Snuff</td>
<td>13.2%</td>
</tr>
<tr>
<td>Psychoactive substances</td>
<td>7.1%</td>
</tr>
</tbody>
</table>
```

7.1.5 **Situational stressors**

The following stressful events were most often noted by respondents during the last 6 months:

**Table 9.** Stressful events experienced by respondents in the past 6 months (N=49) (%)

<table>
<thead>
<tr>
<th>Events</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor financial difficulties</td>
<td>71.4%</td>
</tr>
<tr>
<td>Increased conflict between the family members</td>
<td>49.0%</td>
</tr>
<tr>
<td>Threats</td>
<td>32.7%</td>
</tr>
<tr>
<td>Bullying or blackmail</td>
<td>32.7%</td>
</tr>
<tr>
<td>No job</td>
<td>30.6%</td>
</tr>
<tr>
<td>Terminated a long-time relationship (which lasted at least 3 months)</td>
<td>28.6%</td>
</tr>
<tr>
<td>Violence by peers, elders</td>
<td>24.5%</td>
</tr>
<tr>
<td>Dismissal</td>
<td>24.5%</td>
</tr>
<tr>
<td>Minor law violations</td>
<td>24.5%</td>
</tr>
</tbody>
</table>

³⁶https://kaktus.media/doc/372360_kvartiry_snimali_za_800_somov_v_bishkeke_18_podrostkov_ystroili_prilon.html
Such a stressful event as minor financial difficulties is experienced by a significant number of respondents (71.4%), in equal proportions, both in terms of sex and age. More than a third of respondents noted frequent conflicts between family members. This was especially pronounced among female respondents (62.5%) and is more concentrated in the age group from 13 to 17 years old (87.5%). Threats are most common among boys (72%) aged 13 to 17 years (100%). In general, one-third of respondents mentioned bullying as a stressful event in the last 6 months, mostly boys aged 13 to 17 years. Lack of jobs was also mentioned by a third of respondents, mostly by men (76%) aged 18 to 29 years. The termination of a long-time relationship was noted by more than a quarter of respondents, mostly by women (64%) aged from 18 to 29 years. As shown in the Table above, peer violence is experienced by about a quarter of respondents, mostly by boys aged 13 to 17 years. The dismissal was noted as a stressful factor, particularly among men (75%) above 18 years of age. Minor law violations were mentioned by also about a quarter of respondents, mostly by men (86%) in the age group between 18 to 29 years.

7.2 Underlying causes, risk and protective factors of suicidal behaviour through a survey of close relatives of adolescents and youth who died by suicide

For this chapter, work was conducted to obtain a clear and accurate picture of the life situation, personality, mental health status and possible treatment received in medical institutions before the suicide. It is built on data from semi-structured interviews with family members and friends of adolescents and youth who died by suicide. The interviews covered the following aspects:
• socio-demographic data of the informant (interviewee) and the deceased;
• circumstances of death (time, method, causes);
• history of previous suicide attempts;
• medical and psychosocial support;
• personality and lifestyle, family environment.

7.2.1 Socio-demographic data of the informant (interviewee) and the deceased

A total of 35 interviews were conducted with the family members and friends of adolescents and youth who died by suicide. According to the study protocol, it was planned to reach from 30 to 50 respondents. However, in practice, this was difficult to achieve, and it was decided to analyse the 35 interviews collected during the assessment.

A total of 35 interviews included 29 women and 6 men, who were all mainly close relatives: 19 of the interviewed were parents (18 mothers and only 1 father), 6 were grandparents, 3 were spouses of the deceased, 2 respondents were brothers/sisters, 3 of them were friends and 1 was an aunt. These respondents were chosen through service providers, and in their opinion, the lack of male respondents is explained by their refusal and unwillingness to participate in the study and talk about this subject.

The average age was 41 years old; the minimum was 15 years, and the maximum was 68 years. Moreover, the median was 41, while the mode was 39 years.

The age characteristics of the respondents were as follows:

Table 10. Age characteristics of the respondents (N=35)

<table>
<thead>
<tr>
<th>Age range</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>21-25</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>26-35</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>36-45</td>
<td>13</td>
<td>37</td>
</tr>
<tr>
<td>46-55</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>55-68</td>
<td>6</td>
<td>17</td>
</tr>
</tbody>
</table>

All of them lived with the deceased, except two of them, who were a friend and a girlfriend.

Demographics of the deceased. The data is based on 35 suicide cases. The average age of the persons who died by suicide was 18 years old, the youngest was 12, while the oldest was 29 (median 17; mode 14). One third of those who died by suicide (12 suicides) were in the age range from 12 to 15 years old, and another third were aged 16 to 19 years. Eight persons were between the ages from 20 to 25 years, and three were aged 26-29.

24 suicides in the study sample were completed by men and 15 by women. The majority of these persons (26 suicides) were ethnic Kyrgyz, 5 were Russians, and 3 were of other ethnicities. 20 of the deceased lived in urban areas and the remaining 15 in rural areas. Four of them were married, 16 had incomplete secondary education, 15 had full secondary education, and 4 had secondary special education. 12 of the deceased were schoolchildren, while 23 were of working age, however, 17 of them were unemployed. The occupation of the remaining 6 was as follows: 2 had permanent employment; 2 had temporary work; 2 had temporary part-time work, and all of them had a low level of job satisfaction according to their relatives. 30 of the deceased were Muslims, 3 were Christians, and 2 were described as atheists.

7.2.2 Circumstances of the death

The summer months accounted for 6 suicide cases in both July and August, followed by 5 cases in April and 4 in March.

According to some respondents, the period of the year played a role. For example, more suicides were committed in the summer period when parents or adult family members are usually out of the house.

“It was summertime, and we were not at home just like other people who leave the country, go on vacation during the summer... there were no adult family members in the house, so the child was alone; maybe if someone would have been near him, he would have told what he was worried about and would have asked for advice,” stated one of the respondents.

37 9 respondents lived in Bishkek, 5 in Chui region, 6 in Osh region, 3 in Naryn region, 5 in Issyk-Kul region, 3 in Talas and additional 3 in Djalal-Abad region.
The time of day, when the suicide happened also plays a significant role. Four suicides each occurred in the afternoon (between 2pm-3pm), in the evening (between 7 pm-8 pm) and at night (between 10pm-11pm). Three cases happened at night (between 11pm-12pm) and also deep at night (between 2am-3am). Six cases occurred between 4pm and 7pm.

About half of the suicides occurred during the period from 3 months to 1 year ago. The rest happened between 1 and 3 years ago.
In 31 cases the suicide happened at their house, one case each in a shed and an old building near the house, in 2 cases it was a relative’s house.

More than half of the suicides were committed through hanging or strangulation. Some of the cases happened through self-poisoning with drugs, and five cases involved cutting the veins and jumping out of the window.

Some parents indicated that there is a lot of press coverage of suicide cases and that this could have also impacted the origin and progression of suicidal thoughts.

“A lot of newspapers and also web sites write about someone who jumped out of the window or hanged himself. It is obvious that newspapers write this to attract readers; they attract the audience to their newspaper through such messages. Children read about it, and this incident remains in their head, then if something happens in their life, they see suicide as a solution ... It would be more useful to write what a person, especially a teenager, in a difficult psychological situation should do. For example, something happened in their life, and they think there is no way out, that it is the end of their life... just because they do not have any experience in their life. Besides, they are very emotional, spontaneous, they cannot handle the situation. That is why it will be better if the mass media would explain that adolescents should not panic, that they need to think, to turn to someone and ask for help for example from their teacher, psychologist at school or from an adult whom they trust”, noted one of the respondents.

"A lot of newspapers and also web sites write about someone who jumped out of the window or hanged himself. It is obvious that newspapers write this to attract readers; they attract the audience to their newspaper through such messages. Children read about it, and this incident remains in their head, then if something happens in their life, they see suicide as a solution ... It would be more useful to write what a person, especially a teenager, in a difficult psychological situation should do. For example, something happened in their life, and they think there is no way out, that it is the end of their life... just because they do not have any experience in their life. Besides, they are very emotional, spontaneous, they cannot handle the situation. That is why it will be better if the mass media would explain that adolescents should not panic, that they need to think, to turn to someone and ask for help for example from their teacher, psychologist at school or from an adult whom they trust”, noted one of the respondents.
Suicide notes were left only in 4 cases. In 3 cases, the deceased has asked for forgiveness from their mothers and 1 case, and there was a note asking not to blame anyone.

In 13 cases the deceased mentioned once or several times that they did not want to live. These were mostly girls (9 cases). They expressed that they were very tired from life, that nobody understands them, especially their relatives and that they saw no reason to live. The respondents indicated that they did not pay attention to these words and now feel some regret and guilt. In 13 cases, the deceased expressed their intention to end their life by suicide (once or even more often). In 3 cases, they said that life was not worth living. In 4 cases, they indicated that they wanted to die, and in 4 cases, they expressed thoughts about ending their life. Moreover, in the remaining 2 cases (both among girls), they were thinking about ending their lives and have made such plans.

It should be noted that the underlying causes of suicide were more revealed in interviews with service providers as relatives might not provide a complete picture and information about the causes within the family and interpersonal relationships, which are also significant factors contributing to the level of suicidal behaviour among the target group.

Despite the opinion of social pedagogues, school psychologists and social workers that suicide among adolescents is often due to violence or psychological oppression in the family, this was noted only in 6 cases.

Service providers indicated the following factors that may contribute to suicidal behaviour:

- Problems and conflicts in the family, as well as social exclusion, are in the first place;
- Teenagers are painfully affected by the divorce of their parents, especially those who are equally attached to both parents. Children experience a sense of uselessness, abandonment and betrayal;
- Domestic violence, including of a physical, psychological, sexual and economic nature;
- Unhappy love relationships;
- Loss of a loved one;
- Frequent exposure of the child to stressful situations;
- Prolonged depression of a teenager;
- Low self-esteem;
- Difficulties in relationships with peers, school racketeering;
- Game and internet addiction;
- Sexual orientation.

Nevertheless, the predominant circumstance that led to the tragedy is the presence of a conflict, and most often with peers, with other students, where the cause could be threat, ridicule and bullying. See Table for further details.

Table 11. Circumstances that led to the decision to end life by suicide, according to the interviewed relatives and friends (N=35)

<table>
<thead>
<tr>
<th>Circumstances leading to the decision to end their lives</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict with peers, they did not accept him/her. He or she was not like them, did not know how to be like others, did not obey their rules, children are cruel, racketeering, threats, ridicule or bullying</td>
<td>12</td>
</tr>
<tr>
<td>He/she could not cope with life’s difficulties, could not adapt to society and others, was weak in spirit, felt total loneliness, lack of life experience</td>
<td>8</td>
</tr>
<tr>
<td>Problem within the family, constant pressure, tension, humiliation, misunderstanding, rejection</td>
<td>6</td>
</tr>
<tr>
<td>Unrequited love, rejected, misunderstood</td>
<td>5</td>
</tr>
<tr>
<td>Subject to violence</td>
<td>1</td>
</tr>
<tr>
<td>Exposure of something</td>
<td>1</td>
</tr>
<tr>
<td>He/she committed theft or was accused of theft</td>
<td>1</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>1</td>
</tr>
</tbody>
</table>
In support of the above circumstances that led to suicide, 12 of the interviewed relatives noted that the deceased was subject to violence, whether at school, at university, from peers or in the street.

At the same time, 11 of the interviewed relatives denied that the deceased encountered any violence prior to the suicide. A third of respondents indicated that they could not definitely answer anything about the facts of any kind of violence.

One-third of respondents believed that the deceased suffered from all kinds of bullying (in real life or online) and/or from racketeering. Many did not know anything about this situation (20 of the respondents), while others believed that it did not have any impact.

Almost all the respondents, namely 32 of them, indicated that the deceased did not experience discrimination. The remaining 3 noted that the person faced discrimination because he or she was somewhat constrained, quiet, not as assertive as others or “impudent.”

None of the respondents could answer the question on whether they knew if the deceased turned to someone for help to solve his or her problems and what kind of help was received. This indicates that many relatives were not in a trusting relationship and did not pay much attention to somehow understand what was happening in the life of their close person.

Half of the respondents (18) wanted to hide from the public or law enforcement agencies that their relative died by suicide. The reason was a shame. Suicide cases are a very unpleasant phenomenon both from the point of view of public opinion and religion, in particular Islam as well as Christianity.

"When my eldest daughter divorced, I thought that was the worst shame for our family, but it turned out otherwise, and something even worse was awaiting me. Suicide is something unimaginable and unbelievable," noted one of the grieving mothers.

7.2.3 History of previous suicide attempts

In general, the survey showed that a quarter of the deceased had a history of previous suicide attempts (once – 8 persons (2 girls) and twice -2 persons (both boys). The respondents (relatives of the deceased aged 12 to 16 years) indicated the person’s impulsiveness as adolescents, lack of life experience and values that led them to resort to such a “frivolous” step such as suicide. According to their statements, the reasons were unrequited and unhappy love. One respondent indicated difficulties in relationships with peers, secrecy, and a tendency to keep pain and other grievances inside and the decision to end his/her life by suicide was a potential way out.

For the youth who died by suicide (from 24 to 29 years old), respondents indicated that the person could not properly socialize and find a way out of difficult life circumstances, for example, lack of work, money, inability to withstand the opinions and reproaches of others and relatives that he or she is not a lucky person and cannot properly determine his or her life, find a job, build family relationships.

"Young people are now very cruel and can offend with words or actions, saying that my daughter is not like them. Yes, we are poor and could not buy beautiful clothes. It’s not always possible, for example, to take a shower before leaving to school, maybe these reasons influenced the fact that my daughter decided to hang herself, but she was very secretive. I did not know that she wanted to date a young boy since she did not talk about it. It is my fault as well that I could not talk with her for a long time, because I have the same closed character, I also do not like to talk a lot. Therefore, I feel my fault, as well. She did a very unreasonable thing, took medicine because she quarrelled with the boy who rejected her. This is all about her young age and fragile character," noted one of the grieving mothers.

7.2.4 Medical and psychosocial support

The respondents were also asked if they approached a general practitioner with the deceased within a month before he or she passed away. 25 respondents noted that they did not do so, and in the remaining 10 cases, the fact of treatment was not specified.

After the suicide, life-saving measures were undertaken in 23 cases in the form of artificial
respiration and emergency medical treatment to stop the bleeding or to make gastric lavage.

Three respondents believed that the medical personnel did not inform the police about the suicide case, 25 did not know/find it difficult to answer, while 7 confidently believed that the medical staff informed the police.

After the suicide, 30 respondents have noted that they talked to the police who contacted them to clarify the circumstances of the incident.

32 respondents indicated that the deceased did not have any chronic illnesses of a psychiatric nature nor any physical disabilities. They have rather pointed to their individual personality characteristics, such as being intolerant to criticism, lacking patience and being restrained. The respondents did not note any other significant diseases, treatment received, wounds, accidents or hospitalizations.

7.2.5 Personality and lifestyle, family environment

None of the deceased had obvious disciplinary problems at school, i.e. there were no reprimands, detentions, suspensions and exclusions from the school. There were also no particular interpersonal conflicts with the teachers, but interviewees have referred to a lack of trustful relationships with them.

The respondents also did not observe attacks of anger or sudden mood swings (for example, in relation to a particular person). Rather, there was some depression, reticence to talk, standoffishness or detachment.

“He was harsh, rude, but it was not an anger attack. He showed sharpness and rudeness when there were comments or requests to do something around the house. This was most likely due to teenage impulsiveness and intolerance associated with adolescence and hormones.”

“There were no serious conflicts in the family and with friends.”

“Just like all the other children of his age, he could get into fights. Nevertheless, you cannot call it a systematic manifestation.”

There were individual cases of self-in infliction of physical harm, for example, self-harm, head beating or scratching of the face.

“In her childhood, teachers made comments and spoke of caution that the child reacts strangely to criticism or comment. She could start scratching herself, saying she was bad, she wasn’t doing well and was unlucky. In order to avoid any problems, the teachers simply did not make comments and praised her instead,” noted one of the mothers.

Family environment. 15 adolescents and youth who died by suicide grew up in families with both parents, and in 9 cases, one of the parents was in migration, mostly fathers. In 5 cases, there were 1 or more siblings and up to 3 siblings in 21 cases. One person did not have any siblings and the rest had from 4 to 6 siblings.

Despite the fact that many of them lived in families and were surrounded by brothers and sisters, these circumstances did not save them from the tragedy. This directly or indirectly indicates the absence of a more or less trusting atmosphere in the family.

Many relatives indicated that even though there were cases when the deceased expressed his/her desire to end his/her life, nobody took these words seriously enough to pay attention and provide assistance. Many of the individuals did not discuss their problems with family members.

The composition of the household at the end of the lives of the deceased can be described as quite good given the fact that 30 of them were living with their parents (or a parent) and the rest with partners. This indicates that they were not alone and could have potentially turned for help and support.
The results of this section show that it is necessary to work with families and close people surrounding vulnerable persons and with the public, in general, to inform them about the need to react to worrying statements and take appropriate measures to provide qualified psychological assistance, to establish more trustworthy relationships and try to help the persons in need.

7.3 Information about respondents whose parents are in migration

According to family members and friends interviewed, only 2 out of 35 persons who died by suicide had their parents in migration.

From a total of 25 respondents aged between 12 to 18 years who attempted suicide, 12 were living with both parents at the moment of the suicide attempt (see Chart 20 below). In 7 cases, one of the parents was in external migration and in 4 cases in internal migration. In one case, both parents were in internal migration and in the remaining once case the parent has passed away.

**Table 12.** Presence of parents at the moment of the suicide and during the last year of life (N=35)

<table>
<thead>
<tr>
<th>The presence of parents:</th>
<th>during the last year of life</th>
<th>at the moment of the suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived with both parents</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Lived with one parent</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>One parent lived away from home (internal migration)</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Both parents lived away from home (internal migration)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>One parent resided abroad (external migration)</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>One parent died</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

**Chart 21.** Presence of parents at the moment of the attempted suicide among respondents aged between 12-18 (n)
In 8 cases (out of 12) of adolescents aged between 12 to 15 years, both parents lived with them at the moment of attempted suicide, in 3 cases one of the parents was in internal migration and in the remaining case the parent passed away.

In the age group between 16 to 18 years, only 4 respondents out of 13 lived with both parents. In 7 cases, one of the parents lived away in external migration, and in 2 cases, one or both parents were in internal migration.

The data shows that one or both parents of half of the adolescents were in migration when the suicide attempt occurred. Accordingly, adolescents lived either with only one parent and in the case when both parents were in migration, they remained in the care of relatives.

The study showed that 42% of suicide attempts occurred because of a conflict with a partner, friend or a family member. Parental support plays a significant role in preventing suicide. None of the respondents indicated migration of one or both parents as a reason triggering suicide attempt. However, it can be assumed that the migration of parents can increase the vulnerability of children who may experience emotional or psychological difficulties following the separation from one or both parents: according to the data from the NSC for 2018, children left behind by their parents due to migration are more likely to experience psychological difficulties and anxiety than children who live with both parents.\(^\text{38}\) This is also confirmed by the fact that over the course of COVID-19 pandemic (from March till May 2020), the country has registered 13 suicide cases among youth and adolescents, some of these children had one or both parents in external migration.

**Stressful events in the past 6 months**

This section discusses stressful life events over the past 6 months faced by respondents who had one or both parents in migration during the year of the attempted suicide or at the time of the attempt. In total, the respondents affected by migration amounted to 12 respondents (out of 25) in the age group of 12 to 18 years. These 12 respondents gave 28 answers for stressful situations since the questions were multiple in nature, and respondents could indicate several types of stressors.

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Table 13: Stressful life events during the last 6 months among respondents (between 12 to 18 years old) who had one or both parents in migration during the year of the suicide attempt (n)

<table>
<thead>
<tr>
<th>Stressful life event</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate financial difficulties (bothersome but not severe, i.e., increased expenses, trouble from bill collectors)</td>
<td>5</td>
</tr>
<tr>
<td>Increased arguments with a resident family member</td>
<td>5</td>
</tr>
<tr>
<td>Threats from somebody</td>
<td>3</td>
</tr>
<tr>
<td>Death of a close friend</td>
<td>2</td>
</tr>
<tr>
<td>Minor personal physical illness (one that requires physician’s attention)</td>
<td>2</td>
</tr>
</tbody>
</table>

Moderate financial difficulties and disputes with family members were indicated as stressors in the past 6 months by those respondents who had one or both parents in migration during the year of the suicide attempt. The following reasons were indicated once: the death of a close family member, hospitalization of a family member, relationship breakup, arguments with a boss or a co-worker, separation from a significant person (close friend or relative), move to another city, graduation from school/university, academic failure (important exam or course), violence from peers, change in work conditions.

The respondents who had one or both parents in migration at the moment of the suicide attempt indicated the following stressors: increased arguments with a resident family member (5 mentions out of 22) and moderate financial difficulties (3 cases out of 22). The following reasons were indicated twice: the death of a close friend and minor personal physical illness. The remaining stressors were indicated once each: the death of a close family member, hospitalization of a family member, arguments with a boss or a co-worker, graduation from school/university, academic failure, an important exam, violence from peers.

Table 14: Stressful life events during the last 6 months among respondents (between 12 to 18 years old) who had one or both parents in migration at the moment of the suicide attempt (n)

<table>
<thead>
<tr>
<th>Stressful life event</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased arguments with a resident family member</td>
<td>5</td>
</tr>
<tr>
<td>Moderate financial difficulties (bothersome but not severe, i.e., increased expenses, trouble from bill collectors)</td>
<td>3</td>
</tr>
<tr>
<td>Threats from somebody</td>
<td>3</td>
</tr>
<tr>
<td>Death of a close friend</td>
<td>2</td>
</tr>
<tr>
<td>Minor personal physical illness</td>
<td>2</td>
</tr>
</tbody>
</table>

A survey among service providers also showed that families, where children are left in the care of relatives due to the migration of their parents are under special control by local authorities. The social workers keep track of such children and control their well-being in the families with particular emphasis on their school attendance, material wealth, domestic violence and others. School social pedagogues also noted that they are aware of children whose parents are in migration and that they try to keep a record of these children. The Juvenile Police also monitors these families.

At the local level, in particular, in regions where migration is widespread, families with children left under their care are given a special place in the process of identification and accompaniment of families and children in difficult life situations. The interviewed service providers indicated that they are trying to work comprehensively and jointly with the social workers, social pedagogues and Juvenile Police to more effectively prevent and address suicide attempts.
8. Unintended and unexpected findings

The family does not prevent suicide or suicidal behaviour. An unexpected finding was that more than half of the respondents who attempted suicide (57.1%) indicated that they had a conflict with at least one of the family members, most often with a mother or father and less so with a brother or a sister. Most likely, because of this conflict in the family, 55.2% noted that they did not discuss their problems with family members. The finding was unexpected since family is oftentimes associated with a place that gives security and protection to children.

Stigma as a barrier to psychosocial care. The study has shown the presence of high stigma for schoolchildren in regard to receiving psychological services. They are afraid to be “ridiculed” by their classmates for visiting the psychologist’s office. It clearly indicates the lack of a widespread practice of receiving psychological services.

Psychosocial services at schools. It was unexpected to find the presence of psychosocial services in some schools in Bishkek, which include a social pedagogue and a school psychologist. They work closely with the Juvenile Police, which is part of the MIA. Such an integrated approach demonstrates not only efficiency in working with adolescents and youth, but also the coordination of agencies.
9. Lessons learned

- Accessing and establishing contacts with the main respondents of this study, in particular persons who attempted suicide as well as family members of people who died by suicide, was extremely difficult. It is worth noting as a lesson that it is necessary to involve personnel from service providers as the main interviewers for the study. This shall be preceded by the provision of extensive information to them about the study context;

- There is a need to expand psychosocial services at schools at the regional and local levels to more comprehensively and systemically tackle the issues around suicide prevention among schoolchildren. Such services involve joint work of the juvenile police, the school psychologists and the social pedagogues and have proved their effectiveness in Bishkek schools;

- The school psychologists are not actively present in the schools at the regional and local levels. However, these schools have the social pedagogues, whose functions need to be expanded and capacities enhanced to also provide some form of psychological support to the children in need. This can be a temporary measure until the creation of psychosocial services.
10. Findings and recommendations

Findings and corresponding recommendations are placed below by their priority:

Main reasons and risk factors of suicide among adolescents and youth

Finding: Personal conflicts (with family members or friends) are the lead causes of attempting suicide among 42% of adolescents and youth. They leave severe psychological and emotional consequences, calling for an urgent need to provide timely psychological assistance. According to the study findings, half of the adolescents aged 12-18 years who attempted suicide had their parents in migration at the moment of the attempt.

There are risks associated with restrictions in obtaining support, but also opportunities for strengthening suicide prevention mechanisms:

1) According to service providers, stigma and discrimination are significant obstacles in accessing services. Little attention is paid to depression which may also lead to suicides;

2) School psychologists have insufficient qualifications due to the lack of common work standards;

3) The work of the Juvenile Police is important in preventing school racketeering and bullying, which can lead to suicidal behaviour. In Bishkek, the work of many juvenile police officers in schools is integrated with the schools’ psychosocial services and contribute to making their work more child-friendly. However, there is a lack of psychosocial services in regions;

4) The skills and capacities of school psychologists, social workers and social pedagogues need to be strengthened to work with schoolchildren on suicide prevention and detect possible problems at the primary level. Notably, the helplines are not available in the regions.

5) Capacity building activities are needed for primary health care providers to deliver quality services for children and adolescents to cope with mental health issues;

6) Promote collaboration between the family and the service providers to jointly render comprehensive support to children and adolescents at risk of suicide.

Each of these points is described in more detail below:

1. Finding: Strong stigma in receiving psychosocial services and recognizing mental health problems. As a result, children are not referred and fail to receive the needed and timely support.

Recommendation: The programme of the school psychologists and social pedagogues should include measures to overcome the stigma around the topic of suicide in general and in receiving psychosocial services. There has been a taboo since the times of
Findings and recommendations

the Soviet Union to talk about psychological and psychiatric care in class lessons as well as with parents. Therefore, to tackle these issues comprehensively, C4D strategy needs to be elaborated and implemented with inclusion of such activities as awareness raising campaigns, seminars and lectures to parents and schoolchildren about the necessity and effectiveness of approaching psychologists and that there is nothing shameful and harmful in this. The social workers, social pedagogues and school psychologists can also use the meetings of local authorities and village gatherings to raise these issues and reduce stigma around accessing psychosocial services.

2. Finding: the population does not recognize mental health problems and does not consider depression to be a serious problem. As a result, they do not give importance to the symptoms of a child’s depression.

Recommendation: explanatory and informational activities need to be conducted among the population about the importance of family attention to children with symptoms of depression. All these activities can be carried out using the same methods as for reducing stigma in receiving psychosocial services.

3. Finding: The institution of school psychologists proved its effectiveness in solving problems related to suicides.

Recommendation: It is necessary to develop standards to guide the work of school psychologists and pedagogues. Moreover, there are already developed clinical guidelines, including those that are recommended by designated specialists in the field of psychosocial support. It is necessary to introduce common approaches and standards for 1) the identification of students who have problems in the context of suicidal behaviour (scales, questionnaires); 2) the provision of psychosocial support; 3) further support/guidance; 4) processing and interpretation of the results of scales and questionnaires.

4. Finding: Meetings with school psychologists indicated the existence of an initiative group to create an Association of School Psychologists.

Recommendation: The establishment of an Association is necessary, which could promote and implement ideas and activities to develop common approaches in the work of school psychologists. On its basis, it would be possible to organize trainings, coaching, seminars, exchange visits and contribute to the development and further promotion of this occupation. In the beginning, there will be problems with funding the Association’s activities, and one could apply to international organizations for support. Crowdfunding can also be used to seek additional funding. Moreover, the launch of the Association of Social Pedagogues can be considered and applied.

5. Finding: The Juvenile Police needs to work in close cooperation with the school psychologist, social pedagogue, social workers, and members of the neighbourhood committees to prevent suicide. However, the practice of psychosocial service is only available in Bishkek schools and is not developed at the regional level due to a lack of social pedagogues and in most cases, school psychologists.

Recommendation: It is necessary to create psychosocial services in schools in order to expand the practice of providing psychosocial services. Such services imply the availability and joint works between the juvenile police, the school psychologist and the social pedagogue.

6. Finding: It is important to improve the work of primary level service providers to better identify, provide assistance and refer persons in need of support to other relevant organizations for additional assistance.

Recommendation: It is necessary to strengthen the work of centres specialized in providing psychosocial assistance to the target groups. In particular, it is required to focus on a broader and more in-depth training of school psychologists, social workers, and social pedagogues to better work with the schoolchildren for effective suicide prevention.
Findings and recommendations

7. Finding: The helpline is a very effective tool for responding and mobilizing appropriate services to help children, adolescents and youth in need of support.

Recommendation: it is recommended to increase the number of “111” child helpline staff. It is also necessary to carry out informational activities to raise the public’s awareness on the availability of the helpline, such as: 1) appropriate television spots containing information about the helpline to reach not just the parents, but also neighbours, teachers, students and other persons in contact with children who could report any suspected evidence of child abuse and violence and also seek support for adolescents and youth at risk of suicide; 2) development and public dissemination of informational booklets (such as in schools, health centres and markets); 3) local authorities can help with disseminating information about the helpline among the population.

Mechanisms for identifying, recording and resolving suicide cases and attempts

1. Finding: Existing statistics provide information on suicide cases, but there is a lack of data on the number of suicide attempts. The NSC and the MIA are the main sources of statistical data on suicide cases with significant discrepancies in the numbers.

Recommendation: There is a need for both of these agencies to cooperate and improve the registration methods. The MIA has introduced an automated URCM information system that will hopefully help to obtain data reflecting the actual situation with a view to better design suicide prevention activities.

2. Finding: A review of approaches at the national level shows that there is an understanding of the problem from the side of the authorities that work at the policy level to prevent suicide among adolescents and youth. There is also an institutional implementation mechanism and an integrated approach to tackling this issue. Moreover, a review of plans and activities of the agencies on suicide prevention among youth and adolescents indicates a range of ongoing efforts. Additional research is needed to measure the impact and effectiveness of their activities.

Recommendation: It is necessary to develop a clear and joint strategic policy with an action plan, schedule, financial resources, monitoring and evaluation plan to systemically tackle the identified issues and ensure comprehensiveness of efforts between the various stakeholders involved.

Appropriate organizations to work with vulnerable adolescents and young people

A map of service providers was created to identify the most appropriate organizations to provide support to vulnerable adolescents and youth.
in suicide prevention among youth and adolescents.

In general, there is a need for broader and more in-depth research of suicidal behaviour using a quantitative method with a larger sample that will help to identify target groups (risk groups, environment and impact factors) in order to ensure comprehensive assistance to the ones in need and to develop a more targeted communication strategy to raise awareness on the issue.

11.1 Recommendations for the short, medium- and long-term actions to reduce suicidal behaviour, focusing on prevention programmes and communication strategies that may be supported by UNICEF Kyrgyzstan

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<thead>
<tr>
<th>Short-term actions</th>
<th>Medium-term actions</th>
<th>Long-term actions</th>
<th>Methods</th>
<th>Responsible parties</th>
<th>Financing sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance information exchange between the NSC and the MIA to correctly and comprehensively register suicide cases among youth and adolescents</td>
<td>Develop a single data base system to register suicide cases.</td>
<td></td>
<td></td>
<td>MLSD, MIA, NSC</td>
<td>Donors and state budget.</td>
</tr>
<tr>
<td>Strengthening activities to inform a wide range of people about the helpline, which will allow to identify adolescents and youth at risk of suicide</td>
<td>Develop informational videos and flyers about the “111” helpline and disseminate them in public places</td>
<td></td>
<td></td>
<td>MLSD and local authorities</td>
<td>At the first stage, by donors and budget of the Kyrgyz Republic in the future with the financing of beneficiaries.</td>
</tr>
<tr>
<td>Conduct an in-depth situation analysis on the work of school psychologists and social pedagogues</td>
<td>Draft a strategy for the introduction and development of an Association of School Psychologists</td>
<td>Creation of an Association of School Psychologists</td>
<td>MES, MLSD, local authorities</td>
<td>At the first stage, by donors and budget of the Kyrgyz Republic, in future with the financing of beneficiaries.</td>
<td></td>
</tr>
<tr>
<td>Spread/expand the experience of some schools in Bishkek that created the psychosocial service, which includes a social pedagogue, school psychologist, and juvenile police officer</td>
<td>Organize exchange visits between schools in the capital and in the regions</td>
<td>Prepare a media plan to inform all stakeholders on this issue</td>
<td>Distribute information about the psychosocial service among the relevant agencies</td>
<td>MES</td>
<td></td>
</tr>
<tr>
<td>Increase the capacity of school psychologists and social pedagogues</td>
<td>Develop a capacity strengthening programme</td>
<td>Include the capacity strengthening programme into the school development programme</td>
<td>Organize trainings on working with vulnerable adolescents and youth in the context of suicide problems; Develop a continuing education programme</td>
<td>MES</td>
<td></td>
</tr>
<tr>
<td>Improve the capacity of the Juvenile Police in working and establishing trustworthy relations with children and adolescents in relation to suicide</td>
<td></td>
<td></td>
<td>Develop a skills development programme; Provide training on working with vulnerable youth and adolescents in the context of suicide</td>
<td>MIA, school administration, relevant NGOs</td>
<td></td>
</tr>
<tr>
<td>Measures to reduce stigma in regard to receiving psychosocial services</td>
<td></td>
<td></td>
<td>Conduct explanatory work, lectures</td>
<td>School administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the attention of the public to the issue of child depression</td>
<td>Develop a communication programme to raise awareness of depression</td>
<td>MoH, NGOs</td>
<td>Donors</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Strengthen mechanisms to detect, record and address suicide and attempted suicide cases</td>
<td></td>
<td>MIA, NSC</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11.2 Bibliography

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11.3 Informed Consent Form

Informed Consent form

The informed consent form was developed for parents/guardians/family members whose children ended their life participating in a study of the UN Children’s Fund (UNICEF) conducted by the implementing agency Izildoo plus.

Project name: Situation analysis on adolescent and youth who ended life/attempted to end life by suicide in Kyrgyzstan

The Informed Consent form consists of two parts:

1. Information Sheet (provides information on the study)

2. Consent Certificate (needs to be signed if you agree to participate in the study)

Process and purpose of the study: in-depth interviews to be conducted with parents/guardians/family members whose children ended their life.

Results of the analysis will help to develop recommendations and mechanisms to detect, register and manage cases of children, adolescents and youth who ended life/attempted to end life, and will help to identify the stakeholders best placed to work with vulnerable adolescents and youth.

The study will also provide possible realistic short-term, medium-term and long-term measures and policies to decrease the amount of cases of suicide while paying special attention to preventive programmes and communication strategies to be implemented with the support of UNICEF in Kyrgyzstan.

Respondent’s signature and consent to participate in the survey:

____________________________________________________________________________

You will be provided with a copy of the full Informed Consent form.

Part I: Information Sheet

We, Interviewers of the research agency Izildoo plus invite you to take part in the study conducted by us within the above-mentioned project.

Dear Respondent,

The present questionnaire contains questions that may remind you of and make you relive situations associated with your child’s death. We recognize these moments were difficult to you, but we encourage you to help us understand the depth of these problems and find a decision to prevent further cases of children, adolescents and youth ending their life.

You may have a conversation with anyone you feel comfortable to talk to about the study. You can also demand more time to think over your willingness to participate in the study. We want you to be sure that during the interview you may ask us to clarify certain unfamiliar words and expressions, as well as demand more time if necessary. You may also ask follow-up questions during the interview. All questions will be given response immediately or at later time.

Some words in our discussion might be unfamiliar to you. Please, ask me to stop and explain such words to you.
My name is ______________________. We are having a conversation with you only to clarify the problem and to understand the most effective measures in order to prevent children, adolescents and youth from ending life/attempting to end life in the future.

The information received from you will be used in aggregated form. It will not be linked with your name directly. We will use the information received from you in aggregated form and for research purposes only.

**Type of study**

In-depth interview

**Selection of participants**

Authorities or service providers who were familiar with your family or your child’s death contacted you in order to inform you about the study and to invite you to participate. Through this method, we have selected several families.

**Voluntary participation**

You can make your own decision whether or not to participate. In case if you refuse the interview, you will still receive all services that you usually receive. You can take the decision on the participation in the study independently.

We want to remind you that the participation is voluntary. You may ask as many questions as you want, and we have time to answer them.

**Procedure**

We will hold the interview within the house or another comfortable place for you. If you would like to take a break, you should feel free to tell us about it. In this case, we will suspend the interview, and it might be continued at your own request.

You will answer questions listed in our questionnaire, which does not contain your personal data, full name and address. You will answer the questions, and we record the responses received.

If you do not want to answer a particular question during the interview, you can tell us about it. The interviewer will ask the next question. You can also stop participating in the interview at any time without any problems and without penalty: you do not have to answer all questions and/or continue the interview if you do not want to do so. As it is explained above, the interviews will be held within the house or any room you feel safe in. Unless you ask someone’s presence, nobody but us will be participating. The information is confidential, and no one except researchers will have access to the information recorded during our interview. After the results of the study are tallied, the answer sheets will be destroyed.

**Duration:**

Our interview will take around 1.5 hours.

**Risks and discomfort**

Discussing the study topic can create discomfort and may make you feel upset by reviewing the issues your child experienced. In addition, if during the discussion we refer to sensitive and personal problems you experienced in the past, you might experience certain difficulties. In this case, if you do not want to answer some questions, if you want to stop the interview at any point or if you don’t want to participate in the interview, you can refuse, and this is considered as normal. You are not obliged to explain the reason of refusal.
Benefits

Your participation will possibly help us to learn more about the research issues, to understand and develop an effective strategy for preventing children, adolescents and youth from ending their life or attempting to end their life. It will help to develop programmes and activities to support children, adolescents and youth who suffered from such attempts and who require measures for psychological or other rehabilitation or adaptation.

We will not share your personal data, it will be known only to the researchers. The information we gather within the study will remain confidential. The information about you and your child that will be collected during the study will be deleted, and no one but the researchers will be able to see it. The answer sheets containing any information concerning you will have a code number instead of your personal data.

But if you tell us during the interview that children are abused, we will need to report this to authorities according to national legislation, so that authorities can ensure the protection of the child.

Contact person

You can contact the staff of the research agency Izildoo plus by calling: 0557 10 15 39 or 0777 10 15 39 Irina Dzhalbieva.

The present document titled Consent form was developed by the experts of the research agency Izildoo plus and approved by the external ethics committee.

PART II: Consent certificate

I am asked to give my consent to participate in this study, which includes one interview. I have read the information above. I also had an opportunity to ask questions about the study and the interview. I am satisfied with the answers given to my questions concerning the study, the interview and the conversation. I hereby voluntarily consent to participate in the study.

Full name of the parent/guardian/family member:
________________________________________________________________________

Signature of the parent/guardian/family member: __________________________

Date: Day/Month/Year: ______________

Researcher’s Statement/ person taking consent

I have accurately read and given an opportunity to the parent/guardian/family member to read himself/herself the Information Sheet and, to the extent possible, made sure that he/she understands that he/she will do the following:

1. Participate in the interview

2. Sign the Consent form

3. Refuse to respond to certain questions or stop of the interview without penalty, if he/she wishes to do so.
I confirm that the parent/guardian/family member was given the opportunity to ask questions about the study, and all questions were answered correctly to the best of my ability.

I confirm that this person was not forced to give consent, and the consent was given willingly and voluntarily.

The parent/guardian/family member was provided with a copy of this Informed Consent form.

**Full name of researcher/ person taking Consent**

_____________________________________________________________________________

**Signature of researcher/ person taking Consent**

______________________________________________________________________________