REVIEW REPORT ON THE IMPLEMENTATION OF THE SUICIDE PREVENTION PLAN OF BHUTAN (JULY 2015-JUNE 2018)

NATIONAL SUICIDE PREVENTION PROGRAM
DEPARTMENT OF PUBLIC HEALTH
MINISTRY OF HEALTH
JUNE 2018

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EXECUTIVE SUMMARY

- Suicide death in the country is a public health issue. Recognizing the importance of this, A Three Year (June 2015- July 2018) Multi-sectoral National Suicide Prevention Action Plan was endorsed and was directed to be implemented by the Royal Government of Bhutan.
- The action plan was implemented by multiple-sectors through the agency specific focal points. A national suicide prevention program (NSPP) was established at the Department of Public Health of the Ministry of Health to lead the implementation of the action plans.
- The NSPP served as a national coordinating body and secretariat to the National Suicide Prevention Steering Committee (NSPSC) lead by the health minister. The NSPSC functioned as a governance structure to guide the implementation of the multi-sectoral action plan.
- At the district and local government levels, Dzongda's Suicide Response Team was formed to lead the suicide prevention efforts in the districts and communities. The districts were also encouraged to incorporate the suicide indicators in the government performance management system (GPMS) for better implementation.
- After the completion of the implementation of the period, a representative from the relevant agencies review the action plan, assessing the achievements and the implementation status of the action plans.
- The results of the review indicated that of the 41 indicators planned, only 21 indicators were fully achieved while the rest were either not achieved or partially achieved.
- As for the planned activity, there were a total of 65 total activities of which only 26 (40%) activities were fully implemented. 22 (33.8%) activities were partially implemented and 17((26.2%) activities were not implemented.
- Major success of the action plan was in bringing suicide as an issue in the limelight and action plan being adopted by multiple sectors; however resource constraints and coordination issues were pointed out as challenges.
- Several recommendations were made to improve the implementation in the next action plan.

SECTION A: INTRODUCTION

Background

A suicide death in Bhutan is a growing public health concern. In 2014, a review of suicide deaths from 2009 to 2013 indicated that there were 361 documented suicide deaths, most of which (87%) occurred in the most productive age groups of 15-40 years[1]. The World Health Organization (WHO) estimated the complemented suicide rates as 10 per 100,000 populations, which was slightly lower than the global average of 11.4 per 100,000 populations. Annual statistics maintained by the Ministry of Health (MoH) indicated that suicide deaths constituted the top six leading causes of deaths in the country.

The action plan

Owing to this rising burden of suicide cases, the Royal Government of Bhutan (RGoB) initiated the development of a three-year inter-sectoral national suicide prevention action plans to prevent suicidal behaviors in the country. The action plans were approved during the 74th session of the *Lhengye Zhungtshog* and contained time bound activities to be implemented by various agencies. The implementation period was **from** July 2015- to June 2018 and the action plans were strategized to have meaningful impacts on reducing the suicidal tendencies among the Bhutanese population as follows:

1. **Improve leadership, multi-sectoral engagement and partnerships for suicide prevention in the communities**: where the key actions included garnering greater engagement from religious leaders, policy makers, local government leaders and the media. Engagement from schools and institutions in implementing mental health promotion and suicide education was also considered as an important action. This objective was to ensure that there is greater leadership and support including commitment for resources for effective implementation of the action plan.

2. **Strengthen governance and institutional arrangements to effectively implement comprehensive suicide prevention plans:** to have functional institutional arrangements and governance framework for policy planning and implementation of suicide prevention services. The key actions included establishing a National Level Steering Committee, suicide prevention programs at the MoH and Royal Bhutan Police Head quarter; and district level response teams.

3. **Improve access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide (including those with suicidal ideation, history of self-harm or non-fatal suicide attempt):** to identify and reach individuals at high risk of suicide with prevention services. The key actions included improving the access to counselling and prevention services, improving the service standard for care for individuals with suicidal ideation, increasing the information dissemination on suicide and encouraging culturally appropriate community bereavement support system.

4. **Improve the capacity of health services and gate keepers to provide suicide prevention services;** where the key action includes building capacity of service providers from different agencies and improving the referral mechanism. This was to ensure that the improvement in the quality of service provided

[1] Royal Government of Bhutan, A study on reported suicide cases in Bhutan. 2014

5. **Improve community resilience and societal support for suicide prevention in communities including schools and institutions;** where promotion of actions to enhance resiliency, resourcefulness, and respect at the individual, family and community level were considered key actions. Some of the actions included advocating for suicide prevention in schools/institutions, school parenting education programs, youth engagement and community outreaches.

6. **Improve data, evidence and information for suicide prevention planning, and programming;** where some of the key actions included establishing a National registry, encouraging behavioral and risk identification studies and revising existing information databases to improve reporting mechanism for suicide.

The implementation of the national action plan

National Suicide Prevention Steering Committee (NSPSC)

The national action plan for suicide was implemented by multiple agencies from July 2015 to June 2018. In order to include an effective cross sectoral implementation and governance, the National Suicide Prevention Steering Committee (NSPSC) was instituted which consisted of the following members:

I. Minister, Ministry of Health (chairperson)
II. Secretary, Ministry of Health;
III. Secretary, Dratshang Lhentshog;
IV. Chief of Police, RBP;
V. Director/DG, Department of Local Governance;
VI. Director, GNH Commission Secretariat;
VII. DG, Department of Youth and Sports, MoE;
VIII. DG, Bhutan Narcotic Control Agency;
IX. Director, RENEW; and
X. Member Secretary, Choedhey Lhentshog

The committee met once every six months and functioned as a thrust to the multisectoral response in the prevention of suicide cases in Bhutan. The committee kept itself abreast with the challenges, response, issues and progress of the prevention response, while also imparting necessary recommendations to improve the implementation of the action plan.

National Suicide Prevention Program (NSPP)

In order to lead the suicide prevention response in the country, a national level program was established at Ministry of Health under the direction of the Department of Public health. The main purpose of the NSPP was to serve as a secretariat to the NSCP, coordinating the meetings and following up on the directions of the NSCP. The NSPP also served as a national coordination point for suicide prevention while also engaging the stakeholders in delivering the suicide prevention services. The program is currently being manned by two full time program officers

Agency Focal points as a mechanism for implementation at relevant agencies

In all the relevant agencies, a focal point was identified and appointed through an executive order. The main role of the focal point was to network with various units in their respective organization for implementation of the activities of the action plan. The focal point also formed a bridge between the

NSPP and their respective organization; ensuring that the identified actions and the recommendations of the NSCP were implemented by their organization.

Implementation of the action plans at the Dzongkhag/local government levels

The bulk of the activities in the action plan was meant for the dzongkhags and local governments and the dzongdags, thrompons, and gups were given the major responsibility of the implementation of suicide prevention work plans. The action plans in the dzongkhags and local governments occurred through:

I. Mandatory inclusion of the suicide prevention activities in the Government Performance Management System (GPMS)
II. Suicide prevention and rescue efforts operated under the direct notice of Dzongdags through the formation of the Dzongdag's Suicide Prevention Response Team (DSPRT); which functioned as response system to rescue suicide attempts and deliberate self-harm incidents occurring in the communities.

The District Health Office/thromde health office of the Ministry of Health served as the secretariat and the coordinating body for implementing the action plan under the direction of the Dzongdag/thrompon while also ensuring activities are planned and implemented in communities.

SECTION B: THE REVIEW PROCESS

Method

A formal review of performance against achieving the overall strategic plan objectives and targets was conducted during the 7th stakeholders meeting at Paro from 12th-14th June 2018. The review was conducted by key representatives from all the relevant agencies. The attendees of the review meeting consisted of the representatives from the following agencies:

- National Suicide Prevention Program
- PPD, MoH
- DMS, MOH
- JDWNRH
- District health facilities
- JDWNRH
- Bhutan Board of Certified Counselors-RENEW
- Ministry of Education
- BNCA
- HHC

The stakeholders were divided into three random groups lead by a chairperson. Each individual groups were tasked with reviewing the implementation of the individual action plan, and validate the status of the target indicators. The review considered the evaluation from the reports send in by all the stakeholders. The groups were also tasked with commenting on the relevancy of the individual action plan as a carry-over action for the next action plan including suggestion for any new actions. The three groups then presented their finding to the rest of the group for endorsement. The secretariat compiled the review findings and the review report was prepared.

Analysis of Data

In order to understand the trends, data from the National Suicide Registry maintained by the NSPP was analyzed. Only the data of 2016 and 2017 was analyzed since the data for these two years were complete. Descriptive statistics were used to present the data.

SECTION C: THE FINDINGS

Suicide data from the National Suicide Registry

Suicide status

As shown in table 1. There were a total of 191 individuals who has committed suicide and 132 individuals who had attempted suicide in 2016 and 2017. Majority (71.4%) of the male had completed the suicide while in the females 47.9% completed the suicide.

Table 1: Suicide status

			Suicide Status	
Gender	**Year**	**N**	**Completed n(%)**	**Attempted n(%)**
Male	2016	78	50 (64.1%)	28 (35.9%)
	2017	76	60 (78.9%)	16 (21.1%)
	total	154	110 (71.4%)	44 (28.6%)
Female	2016	93	42 (45.2%)	51(54.8%)
	2017	76	39 (51.3%)	37 (48.7%)
	total	169	81(47.9%)	88 (52.1%)
Total]	2016	171	92 (53.8%)	79 (46.2%)
	2017	152	99 (65.1%)	53 (34.9%)
	Total	323	191 (59.1%)	132 (40.9%)

Work Status of the individuals who have either completed or attempted suicide

As shown in table 2, 31.3% of the individuals who has either completed or attempted suicide were farmers and 26% were employed. Students comprised of 17.6% while 11.8% of the house wives either attempted or completed suicide.

Table 2: Work status of the individuals who have either completed or attempted suicide

Year	Status	N	Work Status						
			Employed n(%)	Un-employed n(%)	Farmer n(%)	Student n(%)	Housewife n(%)	Retired n(%)	Unknown n(%)
2016	**Completed**	92	24 (26.1%)	5(5.4%)	34 (37.0%)	10 (10.9%)	12 (13.0%)	7 (7.6%)	0(0.0%)
	Attempted	79	32 (40.5%)	3(3.8%)	13 (16.5%)	14 (17.7%)	17 (21.5%)	0 (0.0%)	0(0.0%)
	Total	171	56 (32.7%)	8 (4.7%)	47 (27.5%)	24 (14.0%)	29 (17.0%)	7 (4.1%)	0(0.0%)
2017	**Completed**	99	15 (15.2%)	10 (10.1%)	43 (43.4%)	17 (17.2%)	1(1.0%)	0 (0.0%)	13 (13.1%)
	Attempted	53	13 (24.5%)	4(7.5%)	11 (20.8%)	16 (30.2%)	8 (15.1%)	0 (0.0%)	1(1.9%)
	Total	152	28 (18.4%)	14 (9.2%)	54 (35.5%)	33 (21.7%)	9(5.9%)	0 (0.0%)	14(9.2%)
Total	**Completed**	191	39 (20.4%)	15 (7.9%)	77 (40.3%)	27 (14.1%)	13 (6.8%)	7 (3.7%)	13 (6.8%)
	Attempted	132	45 (34.1%)	7 (5.3%)	24 (18.2%)	30 (22.7%)	25 (18.9%)	0 (0.0%)	1(0.8%)
	Total	323	84 (26.0%)	22 (6.8%)	101 (31.3%)	57 (17.6%)	38 (11.8%)	7 (2.2%)	14 (4.3%)

Age group of the individuals who had either completed or attempted suicide

As shown in table 3, Ages of most of the individuals (56%) who had either completed or attempted suicide were in the working population category. Youth comprised of 18.6% while adolescent was 20.8%.

Table 3: Age group

Sex	Year	Total N	Age Group			
			Adolescent n(%)	Youth n (%)	Working population n(%)	Senior Citizen n(%)
Male	2016	78	10 (12.8%)	15 (19.2%)	48 (61.5%)	5 (6.4%)
	2017	75	15 (20.0%)	8 (10.7%)	47 (62.7%)	5 (6.7%)
	Total	153	25 (16.3%)	23 (15.0%)	95 (62.1%)	10 (6.5%)
Female	2016	93	22 (23.7%)	22 (23.7%)	48 (51.6%)	1 (1.1%
	2017	76	20 (26.3%)	15 (19.7%)	40 (52.6%)	1(1.3%)

	Total	169	42 (24.9%)	37 921.9%)	88 (52.1%)	2 (1.2%)
Total	2016	171	32 (18.7%)	37 (21.6%)	96 (56.1%)	6 (3.5%)
	2017	151	35 (23.2%)	23(15.2%)	87 (57.6%)	6 (4.0%)
	Total	322	67 (20.8%)	60(18.6%)	183 (56.8%)	12(3.7%)

**Adolescent: 10-19 years; Youth: 15-24 years; working population: 15-60 years; senior citizen >60 years*

Mode of Suicide

As shown in table 4, the commonest mode of suicide was hanging. The other method of suicide comprised of drowning, jumping from height, poisoning, injury and others.

Table 4: Mode of suicide

Sex	**Mode of suicide**	**Total N**	**Year**	
			2016 n(%)	**2017 n(%)**
Male	Hanging	97	48 (49.5%)	49 (50.5%)
	Drowning	3	3 (100.0%)	0 (0.0%)
	Jumping from height	3	3 (100.0%)	0 (0.0%)
	Poisoning	26	17 (65.4%)	9 (34.6%)
	Injury/burning/cutting	6	4 (66.7%)	2 (33.3%)
	others	19	3 (15.8%)	16 (84.2%)
Female	Hanging	71	38 (53.5%)	33 (46.5%)
	Drowning	3	2 (66.7%)	1(33.3%)
	Jumping from height	7	2 (28.6%)	5 (71.4%)
	Poisoning	55	39 (70.9%)	16 (29.1%)
	Injury/burning/cutting	15	9 (60.0%)	6(40.0%)
	others	18	3 (16.7%)	15 (83.3%)
Total	Hanging	168	86 (51.2%)	82 (48.8%)
	Drowning	6	5 (83.3%)	1 (16.7%)
	Jumping from height	10	5 (50.0%)	5 (50.0%)
	Poisoning	81	56 (69.1%)	25 (30.9%)
	Injury/burning/cutting	21	13 (61.9%)	8 (38.1%)
	others	37	6 (16.2%)	31 (83.8%)

Cause of suicide

As shown in table 5. Majority (60.1%) of the cause of suicide was unknown, while 22.4% of the cause was because of social problems. Suicide due to Psychological reason was 15%.

Table 5: Cause of suicide

Year	Gender	N	Causes			
			Psychological n(%)	Social n(%)	Economic n(%)	Unknown n(%)
2016	Male	78	12 (15.4%)	21 (26.9%)	3 (3.8%)	42 (53.8%)
	Female	93	11 (11.8%)	26 (28.0%)	2 (2.2%)	54 (58.1%)
	total	171	23 (13.5%)	47 (27.5%)	5 (2.9%)	96 (56.1%)
2017	Male	76	13 (17.1%)	5 (6.6%)	1 (1.3%)	57 (75.0%)
	Female	74	12 (16.2%)	20 (27.0%)	1 (1.4%)	41 (55.4%)
	total	150	25 (16.7%)	25 (16.7%)	2 (1.3%)	98 (65.3%)
Total	Male	154	25 (16.2%)	26 (16.9%)	4 (2.6%)	99 (64.3%)
	Female	167	23 (13.8%)	46(27.5%)	3(1.8%)	94 (56.3%)
	Total	321	48 (15.0%)	72 (22.4%)	7 (2.2%)	193 (60.1%)

Achievement status of the priority indicators

As shown in table 6, there were a total of 41 indicators in the action plan. Objective 4 and 5 had the most number of indicators with 12 each. In total 21 indicators was fully achieved while the rest were either not achieved or partially achieved. From the six objectives of the action plan, all the indicators of objective number 2 were fully achieved. The details of the priority indicators and its implementation status are given in **Annexure 1.**

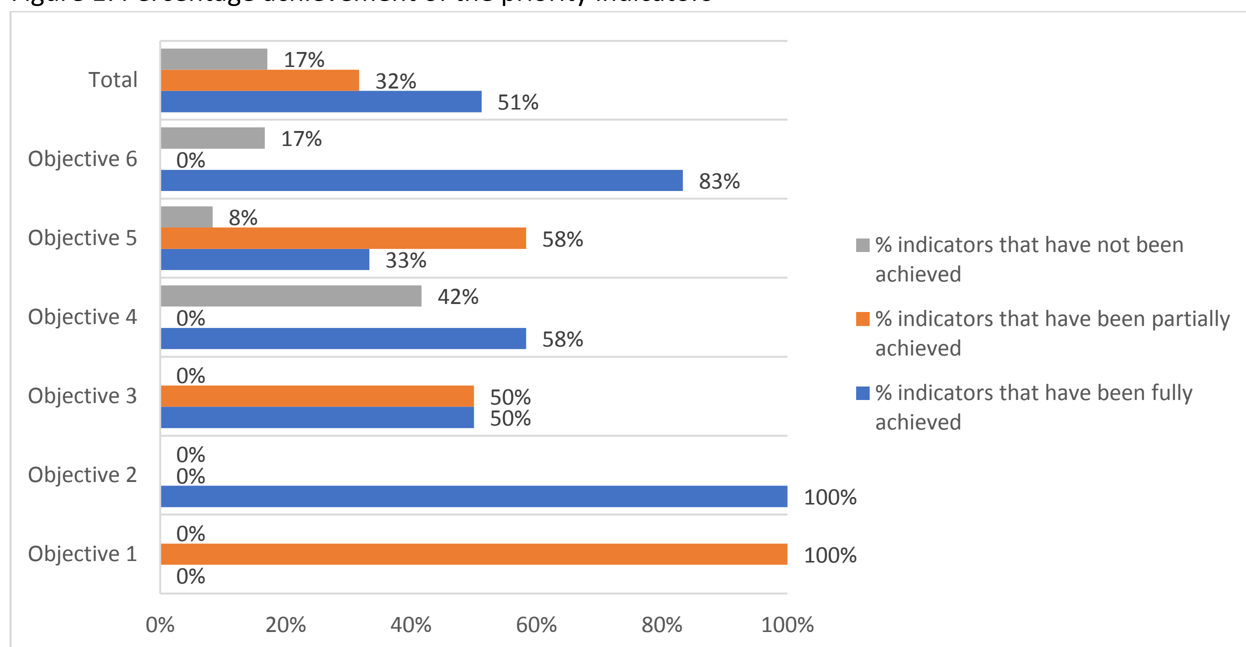
Table 6: Indicator snapshot of the action plan

Objectives	1	2	3	4	5	6	Total
Total number of indicators planned	4	3	4	12	12	6	41
Total number of indicators that have been fully achieved	0	3	2	7	5	5	21
Total number of indicators that have been partially achieved	4	0	2	0	6	0	13
Total number of indicators that have not been achieved	0	0	0	5	1	1	7

Percentage achievement status of the priority indicators

As shown in figure 1, the overall percentage achievement of the indicators was 51%. There was still a lot of work required as most of the objectives had only partially achieved or not achieved the indicators (except for objective 2 which had fully achieved its indicator.

Figure 1: Percentage achievement of the priority indicators



Action Plan implementation status

The review also looked at the implementation of the planned activities. As shown in table 7, of the 65 total activities planned for the 3-year period, only 26 (40%) activities were fully implemented. 22 (33.8%) activities were partially implemented while 17((26.2%) activities were not implemented at all. The details of the planned activity and its implementation statues are given in **Annexure 2**.

Table 7: Activity implementation status

Activity	Number	Percentage
Total number of actions planned	65	-
Total number of activities that have been fully implemented	26	40 %
Total number of activities that have been partially implemented	22	33.8%
Total number of activities that have not been implemented	17	26.2%

The following were the significant achievements that had been achieved as a result of direct implementation of the action plan.

1. Multi-sectoral action plan for suicide prevention was instituted for the first time ever, and the stakeholders were for the most part were taking efforts in implementing the planned activities.
2. A direct result of this action plan was that suicide and mental health was highlighted as a public health menace and prevention efforts were given a national priority.
3. Established functional governance and institutional arrangements with multi-sectoral Participation-National Suicide Prevention Steering Committee (NSPSC), National Suicide Prevention Program (NSPP), Suicide Prevention Unit (SPU) and Suicide response teams and multi-agency focal points
4. Suicide and mental health seen as having multiple causal dimensions; multi-agency inventions are being undertaken at the national, district and community levels. Crisis hotline and counselling services at health centers and schools initiated
5. The need to improve capacity recognized and efforts are underway to improve the capacity for delivering quality services.
6. Data system strengthened to improve evidence based decision making and programming.

There were also challenges when implementing the action plan namely;

1. Resource constraints (capacity and budget) in implementing the action plans
2. Coordination challenges is coordinating and ensuring the implementation of multiagency action plans at the national, district and community levels.

Objective 1: Improve leadership, multi-sectoral engagement and partnerships for suicide prevention in the communities:

As shown in table 8, only 30% out of 10 total planned activities were fully implemented from objective 1. 40 % of the activities were not implemented at all and were carried over to the next plan.

Table 8: Activity implementation status of objective 1

Activity	Number	Percentage
Total number of actions planned	10	-
Total number of activities that have been fully implemented	3	30%
Total number of activities that have been partially implemented	3	30%
Total number of activities that have not been implemented	4	40%

Major achievements:

- Achieved in getting support for suicide prevention and promotion of mental health from the religious leaders from 16 districts of Bhutan as a result of annual advocacy during the conferences for Netens and Shedra Uzins.
- In 16 districts, all the local government (LG) leaders (*dzongdags, thrompons, gups and mangmis*) were sensitized on suicide prevention, identification of vulnerable people and the role of local government administration in suicide prevention during the Dzongkhag and Gewog Tshogdues

Challenges:

- There were still challenges when coordinating with multiple stakeholders. To improve the coordination issues, there is a need for more engaging participation from heads of the relevant agencies and, robust monitoring and supervision by the identified focal persons.
- There are also capacity issues in the districts when officials from non-health sectors need to advocate on mental health and suicide prevention.

Objective 2: Strengthen governance and institutional arrangements to effectively implement comprehensive suicide prevention plans

From objective 2, all the activities were implemented (table 9). This objective was mostly for building the institution and governance structure on suicide prevention and the NSPP were mostly successful in implementing the activities from this objective. However, the need to strengthen the existing structure was pointed out. For the next plan, the need to redefine the roles of some the structure was spelled out by the review team.

Table 9: Activity implementation status of objective 2

Activity	Number	Percentage
Total number of actions planned	5	-
Total number of activities that have been fully implemented	5	100%
Total number of activities that have been partially implemented	0	0 %
Total number of activities that have not been implemented	0	0 %

Major achievements:

- Achieved in establishing functional institutional arrangements and governance framework for policy planning and implementation of suicide prevention services. The National Level Steering Committee, suicide prevention programs at the MoH and Royal Bhutan Police Head quarter; and district level response teams were established.

Challenges:

- There were issues with the roles of certain structures such as the "Dzongda's Suicide Response Team". A need to have clearly defined roles of such organizational structure was felt.

Objective 3: Improve access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide (including those with suicidal ideation, history of self-harm or non-fatal suicide attempt)

Out of 10 total activities planned for objective 3, only 10% of the activities were fully implemented (table 10). 40% of the activities were partially implemented while 50% of the activities were not implemented.

Table 10: Activity implementation status of objective 3

Activity	Number	Percentage
Total number of actions planned	10	-
Total number of activities that have been fully implemented	1	10 %
Total number of activities that have been partially implemented	4	40 %
Total number of activities that have not been implemented	5	50%

Major achievements:

- Successful in establishing 24 hours' crisis helpline services manned by staffs that had basic counselling skills
- Post vention services were also being provide in all the school student survivors by trained school counselors.

Challenges:

- There were issues with reporting the completed/attempted suicide cases from the communities and the need to bring greater awareness on the communities was spelled out.

Objective 4: Improve the capacity of health services and gate keepers to provide suicide prevention services

For the capacity building objective, only 7 activities (41.1%) were fully implemented out of the 17 total activities planned. However, 29.4% of the activities were partially implemented. These activities were continued in the next plan.

Table 11: Activity implementation status of objective 4

Activity	Number	Percentage
Total number of actions planned	17	-
Total number of activities that have been fully implemented	7	41.1%
Total number of activities that have been partially implemented	5	29.4%
Total number of activities that have not been implemented	5	29.4%

Major achievements:

- Counselling courses have been developed and validated by nationally recognized academic institutes
- Suicide risk assessment tools have been developed and health workers trained on the tool

Objective 5: Improve community resilience and societal support for suicide prevention in communities including schools and institutions

For the community based activities of objective 5, 35.7% of the activities were fully achieved out of the 14 panned activities. However, only one activity was not implemented with the rest of the activities being partially implemented (Table 12).

Table 12: Activity implementation status of objective 5

Activity	Number	Percentage
Total number of actions planned	14	-
Total number of activities that have been fully implemented	5	35.7%
Total number of activities that have been partially implemented	8	57.1%
Total number of activities that have not been implemented	1	7.1%

Major achievements:

- Initiated schools to adopt counselling and referral of students with mental illnesses and risk for suicide
- Initiated districts and communities to integrate mental health promotion and suicide prevention activities with focus on screening and identification

Objective 6: Improve data, evidence and information for suicide prevention planning, and programming

For objective 6, a total of 9 activities were planned out of which 5 activities (55.5%) were fully implemented. 2 activities were partially implemented while the other 3 were not implemented.

Table 13: Activity implementation status of objective 6

Activity	Number	Percentage
Total number of actions planned	9	-
Total number of activities that have been fully implemented	5	55.5%
Total number of activities that have been partially implemented	2	22.2%
Total number of activities that have not been implemented	2	22.2%

Major achievements:

- Standard protocols, SOPs and developed for suicide investigation developed and implemented
- Data base of school guidance counsellors maintained and used for decision making
- Suicide data base maintained by the NSPP

Challenges

- Reporting of suicide cases in the country.

RECOMMENDATIONS

The review team after reviewing the action plan came up with the following recommendation to be considered while developing the next action plans:

1. Strengthen the multi-sectoral efforts on suicide prevention by revising/redefining the roles of the National Suicide Prevention Steering Committee. The NSPSC should play an active role in monitoring the implementation of the multi-sectoral action plan.
2. Review the relevance of the Dzongda's suicide prevention response team, as a similar multi-sectoral committee already exists in the districts. The review team recommended exploring the possibility of incorporating the suicide agenda in the already existing multi-sectoral Task Force (MSTF)/ Community Based Support System (CBSS); while also strengthening the role of Department of Local Governance for better community actions for suicide prevention.
3. Simplify the action plans for easy implementation. The current action plan had many activities that were partially implemented, mainly because the activities had complicated measurement targets. The review team recommended for a simpler activity format linked with a measurable target for the next action plan.
4. Strengthen the roles of the National Suicide Prevention Program (NSPP) from that of a coordinating body to also being responsible for taking a lead in the implementation of some of the relevant actions.
5. Impart greater accountability to other non-health sectors in the districts for the implementation of the suicide prevention action plans as currently only the DHOs are perceived as responsible for the implementation of the action plans.
6. Advocate to the high level decision makers on the issues of suicide so that mental health and suicide prevention stays as one of the national priorities.
7. Explore the funding opportunities from development partners and Royal Government of Bhutan through advocacy and partnerships to improve the implementation of the action plan.
8. Improve the suicide surveillance system for quality data collection and management, and for developing evidence based response strategies.

Annexure 1 (indicator)

Annexure 2 (action plan)

Agency wise performance