PERCEIVED CAUSES OF SUICIDE IN KABWE URBAN

A CASE STUDY OF KABWE URBAN

BY

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by

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(201601169)

A Research Report Submitted in Partial Fulfilment of the Requirements for the Masters in Disaster Studies of Mulungushi University

AUGUST 2018

CERTIFICATION

The undersigned hereby certify that they (he/she) have read and recommend the Research Report to be accepted by Mulungushi University in (partial) fulfillment of the requirements for the award of the degree of Mulungushi University.

Prof./Dr.:…….....
(Supervisor 1)
Date:……..

Prof./Dr./.:…….....
(Supervisor 2)
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To the almighty God I give my deepest gratitude for the gift of life. I also wish to thank my parents for building a better foundation of my academic journey. To my wife Martha, my children Nancy, Vivian, Temwani and Deborah for being so wonderful to me. You have been my source of strength throughout my study. My supervisor Mr. Siyanga and Mr. Danny Mwale, I wish to convey my gratitude to your guidance and support.

Last but not the least, to all my course mates and friends too numerous to mention who supported me in one way and the other, I wish to say thank you and may God richly bless you.

DEDICATION

I dedicate this work to my dear daughter Vivian N. Namutengu

DISCLAIMER

ABSTRACT

This study focused on perceived casual factors of suicide in Kabwe urban. The need for the study emanated from an apparent increase of actual and attempted suicides. The phenomena of suicide and suicidal behaviour are global public health concerns, in developed and developing countries alike, and certainly not unique to Zambia. Despite the global and national significance of suicide there is a dearth of information relating to causes and strategies to significantly reduce suicide cases. Thus this study aimed to contribute to the body of knowledge of causes of suicide from perceptions of relevant people. The study attempted to contribute to knowledge relating to strategies that can be employed to significantly reduce its occurrence. The study adopted a mixed-methods approach and was conducted over two main phases to meet its objectives. It relied on an essentially qualitative method to explore the causes of suicide. Qualitative method was utilized to explore perspectives of the causes and strategies needed to reduce suicide cases. Purposive sampling was used to come up with the study sample, which was then subjected to random sampling (quantitative method) to select the 98 respondents.

The findings indicated that family disputes, poverty, drug and alcohol abuse, marital disputes, and mental disorders were the main causes of suicide cases. Males were found to be more likely to commit suicide than, females. The consequences of suicidal behaviour differed depending on whether the suicide act resulted in death or not. In cases of suicide attempts, it was found that victims were left with physical injury, whose extent was dependent on factors which include how serious the intent was and the method used.

The results indicate need for policy interventions to effectively prevent suicide at all levels. One is the adoption of a multi-sectoral approach that allows stakeholders in the education, family, health, social welfare, youth and gender sectors, to share practices and collaborate. In practice this could take the form of a National Platform for the stakeholders to coordinate and work in concert to address this phenomenon and its variants. This approach is important because any loss of life through suicidal acts was found to have significant consequences on the social, economic and health wellbeing of affected people. Further research on causal factor of suicide would complement interventions for reduction of suicide.

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CDC	Centre for Disease Control
CSO	Central Statistical Office
MoH	Ministry of Health
MoHSS	Ministry of Health and Social Services
NGOs	Non-Governmental Organisations
UN	United Nations
WHO	World Health Organization
ZCC	Zambia Counselling Council
ZPCDCR	Zambia Police Central Division Criminal Records
ZP	Zambia Police Service

CHAPTER ONE

1.1 Background of the Study

This study examined the perceived causal factors of suicide cases with a particular reference to Kabwe urban district between the periods 2013 to 2017. According to Webster (2004) "suicide is the act of intentionally causing one's own death. WHO (2014:3) reported that at global level, "in 2014 alone, there were about one million people who died by suicide which accounted for 1.3% of the total global disease burden." In Kabwe, suicide prevalence rates have been escalating during the period 2013 to 2017 from 26 percent to 48 percent (Zambia police records, 2017). In Zambia, despite the increasing of suicide, it is not an offence, except in case of a suicide pact. Suicide pact is when two or more people agree to commit suicide but if one dies while the other(s) remains, then that constitutes an offence.

Yet it is unequivocal that each and every case of suicide or attempted suicide is a case too many. In the last 45 years, suicide rates have increased by 60% worldwide and suicide is now among the three leading causes of death among those aged between 15 and 44 years old, both male and female (Buglow, 2012). According to the World Health Organisation (WHO), official cases of suicide in the world amounted to 782, 000 in the year 2008 (Värnik, 2012). Researchers estimate that each year approximately one million people die from suicide, which represents a global mortality rate of 16 people per 100,000 or one death every 40 seconds and it is predicted that by 2020 the rate of death will increase to one every 20 seconds (Buglow, 2012). One million suicide deaths in the world per year is a high figure that gives a clear indication about the significance of the problem.

It is widely accepted that suicide is a devastating trauma for the surviving family and the lack of sustainable explanations for suicide is a predominant issue in the grief process (Lindqvist et al., 2008). There are various possible explanations for the rising suicide trends. Indeed for some, suicide may appear to be a solution to their problems and stress (Caruso, 2007). Apart from the normal pressures of teen life, specific circumstances can contribute to a person's consideration of suicide. According to (Wasserman, Cheng & Jiang, 2005), it is especially difficult when people are confronted with problems that are out of their control such as loss of social cohesion, breakdown of traditional family structure, growing economic instability and unemployment and rising prevalence of depressive disorders. The consequences of suicide and suicidal behaviour

are not the same in all cases and can be broadly categorized into different aspects namely on the individual himself or herself, on their family as well as the wider community.

In Zambia, the rate of suicide is a matter of concern (Ministry of health, 2015). From the years 2013 to 2017, the number of completed suicide recorded by the Ministry of Health were 1, 971(Central Statistics Office and MoH, 2016). Zambia Counselling Council (2016) observed that, "The number of suicide cases in the country had increased due to perceived negative social, economic and other factors not known". Also, little is known about how far the common causes of suicide as seen elsewhere are pertinent to contemporary Zambia. Scant academic attention has been hitherto given to questions such as whether there are more specific trends and patterns in suicidal behaviour in the local context at present.

This confirms that suicide cases are a significant public concern. In Kabwe urban alone, an average of thirty people died in the past five years by committing suicide, (ZP CDCR 2017), hence the need to conduct a study in order to find out the casual factors of suicide in Kabwe urban

1.2 Statement Of The Problem

WHO (2014) data published in 2014 indicates that suicide rates in Zambia reached 1,346 or 0.99 percent of total deaths every year, ranking it at number 34 in the world. Kabwe is no exception to suicide cases. For instance, according to available official figures from Zambia Police, 182 cases of completed suicide attempts were recorded between 2013 to 2017 (113 males and 69 females) (ZP, 2017). Figures from the Ministry of Health, from 2013 and 2017, indicate that these attempts involved 227 cases respectively (Kabwe District Health Management Board, Vital Statistics, 2018). It is evident that the number of attempted suicides has been increasing consistently over the same period in Kabwe urban. There is so far limited scientific data, particularly from a sociological perspective on what are the causal factors attributable to the phenomenon of suicide as well as what the consequences of these acts are for the victims and survivors of suicide acts. Also, little is known about the types of support offered by various stakeholders in Zambia.

Scant academic attention has been hitherto given to questions such as whether there are more specific trends and patterns in suicidal behaviour in the local context at present. Set against the above background therefore, this study aimed to understand the causes of suicide and attempted suicide as well as to explore its consequences on family and friends of victims/survivors.

1.3 Aim Of The Study

The aim of the study was to identify perceived causal factors of suicide, the impacts and whether there was support for suicide victims and family members in Kabwe urban.

1.4 Objectives.

i) To identify factors responsible for suicide cases in Kabwe urban;

ii) To determine the impact of commission of suicide in Kabwe urban and;

iii) To establish the types of support offered by various stakeholders to both families and victims of suicide cases in Kabwe Urban.

1.5 Research Questions.

1. What are the reasons why people committed suicide in Kabwe urban during the period between 2013 - 2017?
2. What were the impacts of suicide cases in Kabwe Urban?
3. What type of support is offered by various stakeholders to families and victims of suicide to curb the scourge of suicide in Kabwe urban?

1.6 Significance Of The Study

The study is of great significance because it identifies factors influencing the prevalence of suicide cases in Kabwe Urban. The information will benefit affected families, communities and the government on how to prevent people from committing suicide acts.

Studies to ascertain the effects of suicide cases are vital. This is because WHO (2012) reports that suicide is an urgent public concern that requires attention as it involves the loss of lives of people. Suicidal behavior is a major problem worldwide and at the same time has received relatively little attention, (Kimberly. A, et al 2010). Hence the need to conduct a research of this nature especially here in Kabwe urban.

Chanda (2014:1) writes, "Every suicide is a tragedy that impacts on families, friends, communities and has devastating and far reaching consequences, even long after persons dear to them have taken their own lives." In order to establish the key factors that influence people to commit suicide acts, a research on this subject matter is of significant. Suicide acts are disastrous because any single life lost due to suicide acts affects a large number of people's social, economic, health and spiritual well-being. For instance, one loss of life in suicide act can disturb the well-being of a large group of family members, work mates or community members who may lose their productive time to attend the funeral of their loved one.

In contrast to high income countries, studies on the prevalence and determinants of suicide cases in low and middle in-come countries including many countries in sub-Saharan Africa such as Zambia and Kabwe in particular are limited. Despite the recent increase in suicide acts in Kabwe, sparse literature exists on the factors associated with suicide behaviors. Therefore, this study is key as it will probe and bring out a number of issues that are associated to suicide acts a phenomena that puzzles many people whenever it happens.

1.7 Scope of the study

The study was an exploration of the perspectives of the causes of suicide acts in Kabwe urban. It was important to highlight suicide trends and opportunities for curbing the vice, as it can be detrimental to the social well-being of society. It was anticipated that its findings would be of utmost importance for policy-makers to use in the war against the phenomenon by coming up with prevention strategies and enhancing social, economic and political fabrics of Zambia.

1.8 Limitations of the study

The researcher faced a number of challenges including accessibility of the supervisors who were also preoccupied with other national duties. The researcher at two occasions was relocated to three different supervisors a move that brought anxiety on the part of carrying successful research on a specified time frame. The other limitation of the study was difficulties faced to retrieve the questionnaires from respondents and a go ahead signal from the council due to ethical and bureaucratic issues.

In addition to the perceived causes, the researcher acknowledges the importance of knowledge of the actual causes of suicide acts in coming up with more effective preventive interventions. But

the theoretical approach and methodology of this study could not come up with the actual causes and the researcher had to leave this aspect for further research.

1.9 Conceptual and Theoretical Frameworks

1.9.1 Conceptual Framework

There are many theories that have been put fourth which advance the explanations on why people commit suicide acts, (Baumeister 1990). Among the most notable ones are; interpersonal theory of suicide advanced by Emile Durkheim. Other theories are the self-harm and suicide, perceived burdensomeness, suicidal ideation, hope theory, Evolutionary theory, Mathematical model of self-preservation and the unified theoretical framework (de Catanzaro, 2015, Joiner, 2010, wang, 2017, Li, 2014, yang, 2015, and Arat and Wong, 2016). The researcher utilized two theories which were in line with the study matter. These were the Interpersonal and Unified theories advanced by Liljedahl and De Catanzaro (2014). These two theories are interrelated and both explain the key concepts of suicide intentions and acts in totality. The theoretical framework of the study was also premised on the 1996 United Nations (UN) prevention of suicide guidelines and outlines which were adopted by all member states. De Catanzaro (2015) asserted that suicide behaviors are influenced by a complex process that range from suicidal ideation. From the two theories mentioned above, the researcher gave a diagrammatic illustration on the unified theoretical framework of self-harming behavior that was advanced by Liljedahl (2014). In her study on suicide related cases, she, advocated that the theoretical framework of suicide act is seen in self-harm and suicide acts of people that is also known as empirical and theoretical review model.

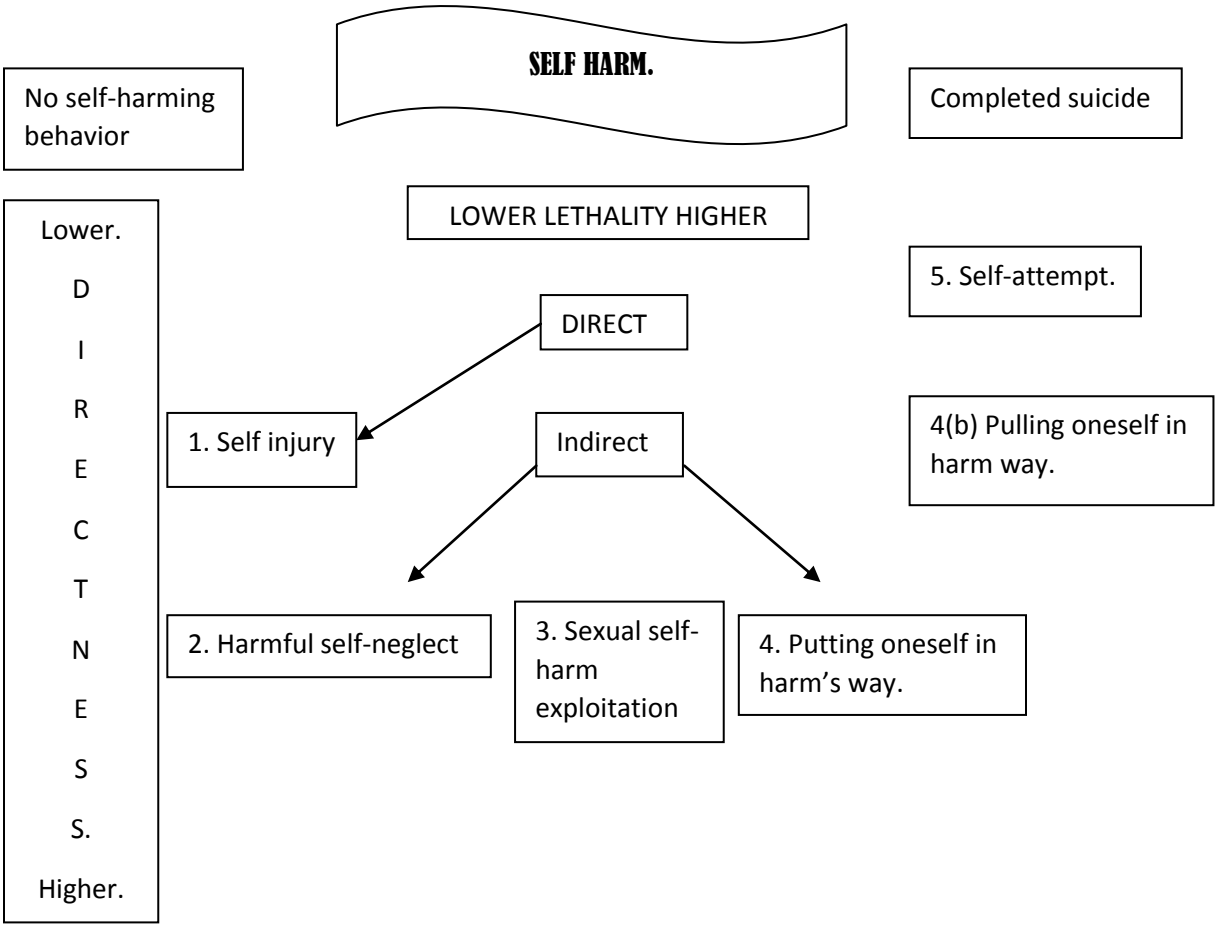

Figure 1 Interpersonal and Unified Theories

Source: Liljedahl, 2014

The researcher also utilized the theory of Emile Durkheim in order to try and investigate the factors influencing high prevalence rate of suicide cases in Kabwe. Durkheim's Structural Functionalism theory best helps to explain why suicide cases are increasing in Kabwe by looking at human society and its social institutions. This theory was ideally picked because the research probed various institutions that are directly linked to suicide cases in Kabwe urban such as the police, the affected families, the local authority, the church, and ministry of health, community groups and the general members of the public. On the other hand, the theoretical model of self-harm advanced by Liljedahl (2014) was picked to form a basis of understanding how various nations through United Nations (UN) council attach their concern on suicide cases. This theory was useful to explore how suicide acts come about. The theory of structural functionalism as

advanced by Durkheim helped to explain how the society is structured and what roles each social group perform in order to continue existing in an orderly manner. This theory helped the researcher to explore how Kabwe urban is interrelated and interdependent and how these structural organs can support prevention of suicide.

1.9.2 Theoretical Framework

The Rational-Suicide Theory, being the most conventional one, describes suicide as "a means of "rationally" ending one's life when the expected value of the future utility of being alive is below the value of death. This theory, originally developed by Hamermesh and Soss (1974), uses the assertion that "suicide is more likely when the variability of happiness is high, when unhappiness is correlated over time, and when people have high discount rates. If there is hyperbolic discounting, then individuals may want to recommit not to kill themselves". As this theory suggests, suicide is closely linked to depression for youths. An increase in discount rate for the youth is possible over time as a result of changes in family structure or social environment that may have impacted on the youth's capacity to regulate his/her impulse. Another possibility is the decrease in the youth's mean utility levels over time or that the variance of utility is greater. As such, the result is that more youth fall below the utility level at which suicide becomes a rational action.

Cutler, Glaeser & Norberg (2001) further explain that the factors leading to depression in people pertain to changes in family relations (divorce, single-parenting, remarriage and conflict), romantic problems and lack of social connections. These events are associated with unhappiness, "they need not be rationally undertaken for the suicide itself to be rational". A person who discounts hyperbolically will prefer to take actions that bring short-term pleasure but long-term costs and he/she will find it more difficult to moderate present pain with the hope for future pleasure. Similarly, he/she will have problems moderating present exuberance with the anticipation of future plan.

The Strategic-Suicide Theory explains that suicidal behaviour in people may be geared not towards death but to signal unhappiness in the hope of shifting the distribution of family resources. As such, this theory is more applicable to attempted suicide than completed ones. The redistribution of resources (time and/or monetary) from the parent(s) to the youth following a suicide attempt may be direct or indirect. Often the signal is only credible when it is repeated and

in cases where parents possess sufficient power, suicidal behaviour might be the only option left for youth. One of the main feature of the strategic-suicide theory is that suicide attempts are more likely in situations where parental resources are greater and thus more available for redistribution. This feature differs for the pure-depression theory where the lack of parental resources is a trigger for unhappiness in youth which eventually leads to suicide attempts.

Contagion Theory. The third suicide theory formulated by Cutler, Glaeser & Norberg (2001) is the contagion theory. It is based on Durkheim explanations for suicides being imitative. In fact, studies have suggested that teen suicidal behaviour bear a stronger contagion factor than suicide behaviour in adults (Gould et al., 1994). Cutler, Glaeser & Norberg (2001) gave two examples of how contagion operates in people. The suicide of a group member causes stress and grief which may affect the ability of other group members to moderate the problems faced by other members of the group. This can in turn make suicide for certain group members more rational. The second example is that a suicide can provide information on how to effectively accomplish such an act. The authors also state that the signal value of the suicide may increase if certain aspects are stylized, such that the receiver is more attentive and sensitive to the signal. For example, a fifteen-year-old boy will be more receptive to the suicide of a boy of the same age. An increase in the sensitivity to the signal reception can lead to the minimum effective signal being less intense. The result may be that social contagion may become more frequent, however, the suicide attempts may decrease in severity.

Another theoretical explanation known in the literature is the instrumentality hypothesis, Contrary to other models, this theory puts more emphasis on the immediate costs and benefits of suicide and not the long-term forward-thinking behaviour. As such, this theory views suicide as an impulsive action whereby suicide occurs with access to the right means at the right time. Most often, the right means pertains to toxic chemical, drugs, medicants and guns. On the other hand lethal means (hanging or jumping from a height) are so widely accessible that a suicidal person will chose a method or substitute form one method to the next depending on which one is more accessible.

The authors finally observe that, in cases where the instrumentality theory is contradicted by statistics, the reasons indicate the presence of a link of this theory with the contagion theory. For instance, in the U.S., the increase in youth suicide in rural areas where guns have always been in high numbers, is in contraction with what the instrumentality hypothesis would have predicted. The latter theory would have assumed that urban areas would have an important rise in youth suicide rate as a result of poverty and the rise in the number of guns. An explanation might be that there has been an increase in non-lethal suicide attempts accentuated by an increase in the availability of nonlethal method such as psychotropic medications. These could have been the result of contagion as the use of those drugs became more popular.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses various theories highlighted by scholars on suicide prevalence. The laws of Zambia on suicide cases are also highlighted to help bring the topic under study on clear perspective of its eminent presence.

2.2 Global, Regional and Local Suicide Related Issues

WHO (2014) reports that suicide is not just a serious public health problem in developed countries, in fact most of its acts occur in low and middle –income countries where resources and services if they do exist, are often scarce and limited for early identification, treatment and support of people in need. Li et al (2014) & Young et al (2015) indicated, "Suicide is a continuous process, starting from suicidal ideation, suicide attempt to suicide completion. In sub-Sahara Africa, about twenty three per cent (23%) of the population is aged between ten (10) and nineteen (19) years old, (WHO 1914B0). "

2.1 Regional Behaviour of Suicide

Table 1 shows the Regional WHO Estimates available for completed suicides/Deaths by Intentional Self-Harm or Injuries for 2000, 2008 and 2012, respectively.

Year	**2000**	**2008**	**2012**
WHO Region	Deaths (000s)	Deaths (000s)	Deaths (000s)
South East Asia Region	287	274	314
Western Pacific Region	287	225	182
European Region	170	125	125
Region Of Americas	66	72	85
African Region	45	51	62
East Mediterranean Region	23	32	31
Global	**883**	**782**	**804**

Table 1 Regional Estimates for Completed Suicide (2000 to 2012) *(Source: WHO, 2002)*

Based on the above, since 2000, a decrease in the total number of completed suicides was observed annually. This represented a decrease in the global suicide rate from 14.4 to 11.4 per

100,000 of the world population from 2000 to 2012. Nonetheless, despite evidence of a steady decline in cases estimated for the South East Region and the Western Pacific Region, the figures presented suggest that these two regions still witness more cases of completed suicides annually than other parts of the world. On the other hand, the African Region and the Americas show a steady annual increase in the number of cases estimated when compared to the European and the Eastern Mediterranean Regions.

As pointed out by the Centre for Disease Control (CDC) (2014), a large body of literature about suicide and suicide prevention exists. However, the accuracy of this information and the resulting interpretations made and, hence, comparability, are often questionable since data on suicidal behaviour is collected and compiled following different definitions. The reliability of statistics on completed suicides is often questioned by most research papers looking at the epidemiology of suicide in one way or the other.

According to Response Ability/Commonwealth of Australia (2005), deaths are classified as suicides following three criteria: the death must be due to unnatural causes, such as injury, poisoning or suffocation rather than an illness; the actions which result in death must be self-inflicted; and the person who injures himself or herself must have had the intention to die.

However, in some cases it can be extremely difficult for the police, coroner or other medical professionals to determine whether some "accidents" or individual acts of self-injury were intended to result in death, especially if mental illness is involved. In some cases where victims survive their attempt, the person themselves may not be able to explain in a rational manner why they performed the act. Besides the misclassification of an intentional death or attempt as an accident because of human error, sometimes, both completed suicides and attempts are intentionally covered up because of the taboo and stigma associated with the suicide act. For instance, Tollefsen, Hem, & Ekeberg (2012) noted that out of 31 studies on completed suicides reviewed during a 46-year period (between 1963 and 2009), inclusive of the US, Europe, Asia and Oceania, 91% of all studies were unreliable. Thus, 52% of the studies included 10% under-reporting, and 39% included more than 30% under-reporting or put simply: poor suicide statistics. Moreover, this is in part the reason why the statistics presented in the present chapter do not include suicide attempts which can be much more frequent than completed suicides (by 10, 20, or more times) according to some studies, as noted by the WHO (2014)

Thus, according to the U.S. Department of Health and Human Services, (2012) survey, out of the nine million Americans who had serious thoughts to commit suicide, 2.7 million made plans. Among these, 1.3 million attempted suicide and 0.3 million made attempts without making plans. While the U.S. may not be the most representative country for international trends, such alarming numbers can lead to the safe inference that existing cross-national data on completed suicides understates the real picture of suicidal behaviour worldwide. According to Nock et al. (2008), the cause of suicidal behaviours is rarely investigated comprehensively.

Chanda (2014) contends, "For some time now, cases of suicide concerning young people around the country have been on the upswing." He further asserts that in the past few years, several cases involving young people ranging from ten (10) years who are taking their lives have been reported although several others, especially in the remote rural areas have not been reported. This situation is a correct picture prevailing in Kabwe. Inquiring on suicide cases in Kabwe through a survey study, has depicted a number of them especially those that do not even reach the police or hospital personnel. The prevalence of suicidal ideation, suicidal plan and attempt among the young population falls within the range of what has been reported in studies from other African countries, (Randall et al 2014).

According to Zambia Counselling Report (2016), suicide reports are on increase while little attention has been paid to the local patterns of distress being experienced and the long term effects this trend leaves to the families or communities affected. This entails that, unfortunately here in Kabwe suicide though too often recorded, fails to be prioritized as a major concern that claims peoples' lives and eludes moral standing in the society. Chan (2014:1) records; "Every single life lost to suicide is one too many." This implies that the impact of suicide acts in Kabwe though not very much published is a tragedy near to disaster phenomena as it causes huge effects to close families, friends and communities around and also far-reaching, even long after persons dear to them have taken their own lives. Zambia Counselling Council (ZCC 2015) observed, the number of suicide cases in Zambia had increased due to negative social, economic and other unknown factors. This situation should be treated with the utmost concern and urgency by all the stakeholders. Chanda and Tembo (2014) also in their assumption highlighted, "For every person who commits suicide, twenty or more might attempt suicide and for families and friends affected by suicide, the emotional impact might last for years. WHO (2015) in their report mentioned that

suicide rates had increased by sixty per cent over the last fifty years and the increase was prominent in developing countries like Zambia.

On the legal part, Zambia has a Law that regulates suicide acts. The suicide act Chapter 89 was enshrined in colonial era and was amended on 27th January 1967. Suicide Act Chapter89 section three states, "The rule of Law whereby it is an offence against the common Law for a person to kill himself is abrogated." This entails that suicide according to Zambian Law is not considered as an offence unless an attempted suicide. The suicide act further in Chapter 89 section seven(7), sub sections(1),(2), and (3) also recognizes suicide pacts as an offence which entails that when a person is in common agreement between two or more other persons having for it's object the death of all of them, whether or not each is to take his/her own life, but nothing done by a person who enters into a suicide pact shall be treated as done by him/ her in pursuance of the pact, unless it is done while he/she has the settled intention of dying in pursuance of the pact. The Act criminalises the complicity in another person's suicide and not the actual person committing the suicide act.

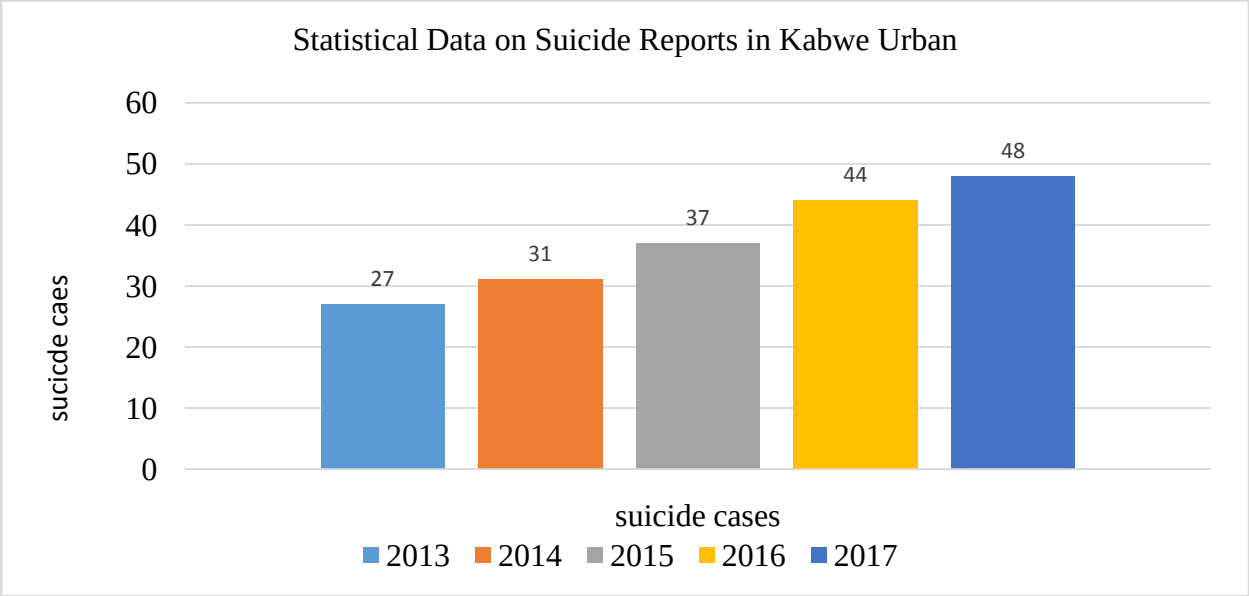

Figure 2 statistical data on suicide reports in Kabwe urban *Source: Zambia police records data, 2017*

The figure 2 shown above depicts that in 2013 to 2017 from 10 percent to 93 percent. The trend shows that there is a significant increase in suicide cases in Kabwe urban. The results are

supported by WHO (2014) , found out that suicide cases in Zambia have increased more than two fold from 2010 to 2013 from 23 percent to 49 percent

CHAPTER THREE

MATERIALS AND METHODS

3.1 Introduction

This chapter outlines various procedures used in order to ensure success of the research. It includes the research design, study area, study population, sampling procedure, instruments of data collection and analysis. In short, both primary and secondary data were used.

3.2 Study Area Location and Description

Kabwe District is a district of Zambia, located in Central Province. The capital lies at Kabwe. As of the 2010 Zambian Census, the district had a population of 208,000 people.

3.2.1 Study Area

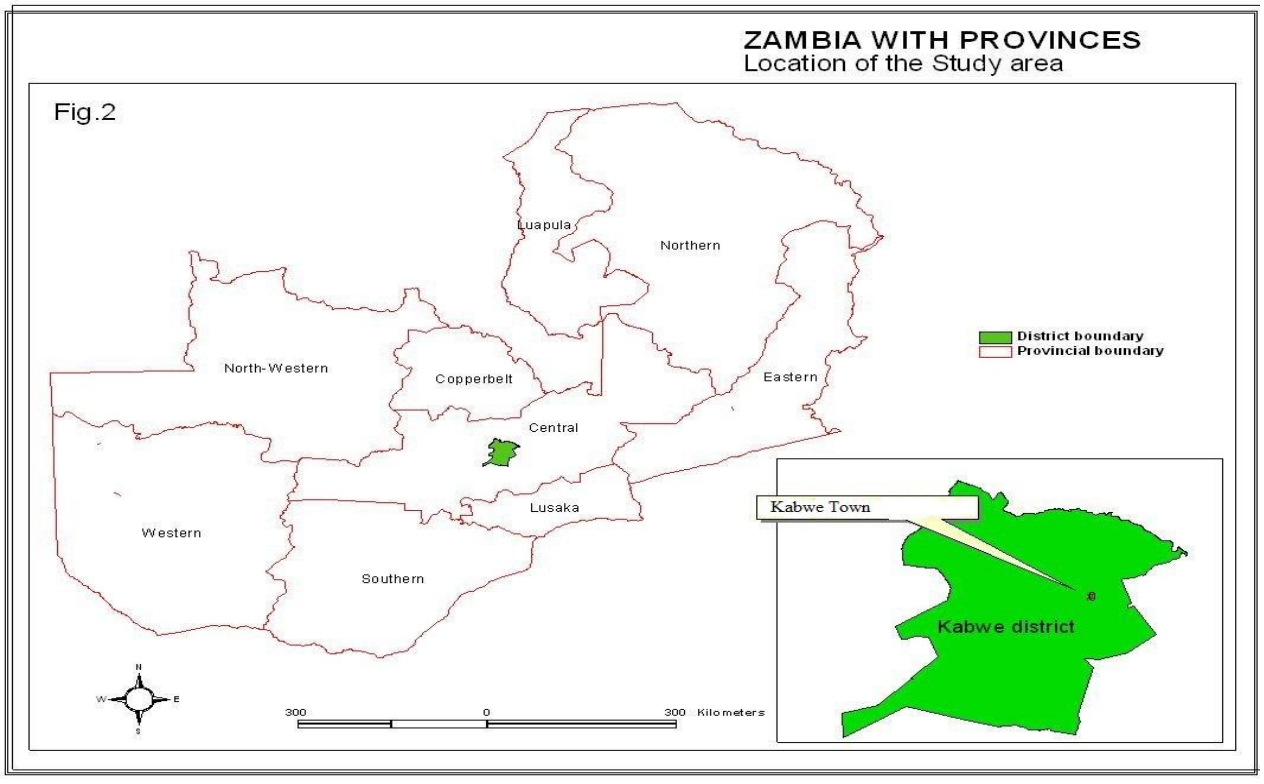

Figure 3 location of Kabwe urban *Source: Ministry of Agriculture, 2015*

3.3 Research Design

This study used a cross-sectional descriptive study involving both quantitative and qualitative methods. The research took the form of an exploratory study. According to Shajahan (2004:50), the design of an exploratory study is characterized by great flexibility. The researcher took advantage of the flexibility and versatility of the study method to explore the problem and assess perceived casual factors of suicide in Kabwe. The study involved collection of data from the Zambia Police Service Kabwe central division offices, pathologists and hospital administrators from Kabwe and Mine hospitals, Kabwe Municipal Council's fire brigade and individual respondents from selected communities of Kabwe urban. The data collected was analyzed for the purpose of establishing perceived causes and identify measures that can be implemented to curb the problem.

3.3.1 Sampling Procedure

Convenience and purposeful sampling methods were used. This was done in view of the fact that only respondents that work with the study subject matter and affected people could provide the required information. After coming up with the study population, the study population was stratified according to different categories of their gender, institutional occupation, education standard, age group and location within Kabwe urban. All the strata were then subjected to random sampling to come up with a representative sample. An interview schedule was utilized to conduct focus group discussions. A questionnaires was administered to individual key informant respondents.

3.3.2 Targeted Population

The population consisted of individuals, groups and institutions that worked with or were affected by suicide. For the purpose of this study the targeted population was considered knowledgeable of the factors influencing the prevalence of suicide cases in Kabwe urban. Kabwe urban was chosen because of its convenience in relation to ease of access and the researchers' mobility and budget constraints. The population of Kabwe District as per 2010 census was estimated at 208,000 people. The researcher sampled a population of 115 people out of 200 study population which is a representative sample (55 percent).

3.3.3 Sample

A sample is a group of subjects or situations selected from a larger population. It can also mean a sub-set of the whole population which is actually being investigated by the researcher and whose characteristics will be generalized to the entire population. The sample size comprised 200 people in Kabwe urban and was broken down as follows; 2 respondents from Kabwe District Police, 2 respondents drawn from Kabwe General and Mine Hospital, and 2 respondents from Kabwe Municipal Council Fire brigade. 94 respondents from six selected communities of Kabwe urban (15 Highridge, 15 pollen, 15 Luangwa, 15 Kasanda mine, 15 Chowa and 15Makululu) and 4 from the churches and from Counseling Institutions.

Initially purposive sampling was utilized to come up with the target/study population which was then subjected to random sampling to come up with the respondents. These sampling strategies are supported because the power and logic of purposive sampling is that a few cases studied in depth yield many insights about the topic, whereas the logic of probability sampling depends on selecting a random or statistically representative sample for generalization to a larger population. The researcher used purposive sampling strategies in order to fully understand the Factors influencing the prevalence of suicide cases in Kabwe urban.

3.3.4 Data Collection Method

In order to come up with a comprehensive data set, the researcher used both primary and secondary sources.

Primary Data

This was collected through the administration of questionnaires. Questionnaires are probably the most widely used research tools because they can be used to cover a wide area. It has a low cost, minimal resource requirements and potentially large sample capturing abilities make it an attractive research method for academics and practitioners alike. The researcher also used an interview guide to conduct focus group discussions.

Secondary Data

The collection of Secondary Data was done through desk research. Most of the secondary data was sourced from; media publications, the internet, manuals, journals, library textbooks and government reports and documents.

Mode of Administration

People have various attitudes towards being interviewed. Others prefer having the interviews conducted in form of a one – to – one interview, while others prefer questionnaires. Therefore, this research used both one – to – one interviews and questionnaires in order to gather data on the factors influencing the prevalence of suicide cases in Kabwe urban. The researcher administered the data collection tools and ensured that the questionnaires were answered and priority in terms of time was given to busy respondents to which data instruments were administered first.

3.4 Data Analysis Method

At data analysis stage, SPSS and Excel were used. Simple t-test and descriptive statistics were used in analyzing the data to come up with answers to the research questions.

3.5 Ethical Considerations

The research topic under study had mainly based on a number of ethical considerations since it involved the lives of people who had died and could not speak for themselves. Therefore, strict measures of respecting people's opinions and views was considered. Both individual and institutional rules and regulations were adhered to accordingly. The study respondents were also expressly, in writing, and verbally assured of confidentially as the information was only intended for academic use.

CHAPTER 4

PRESENTATION OF FINDINGS AND DATA ANALYSIS

4.1 Introduction

This chapter presents finding based on data collected from the selected respondents who participated in answering the questionnaires and interview. The data collection instruments were administered to them regarding perceived factors influencing the prevalence of suicide acts or cases in Kabwe urban. Tables and figures were used to present the results in line with the objectives set by the researcher**.**

4.2 Suicide Cases

The number of suicide cases in Kabwe urban were derived from MoH records and Zambia Police district commanding office. The results are shown in figure 2 below

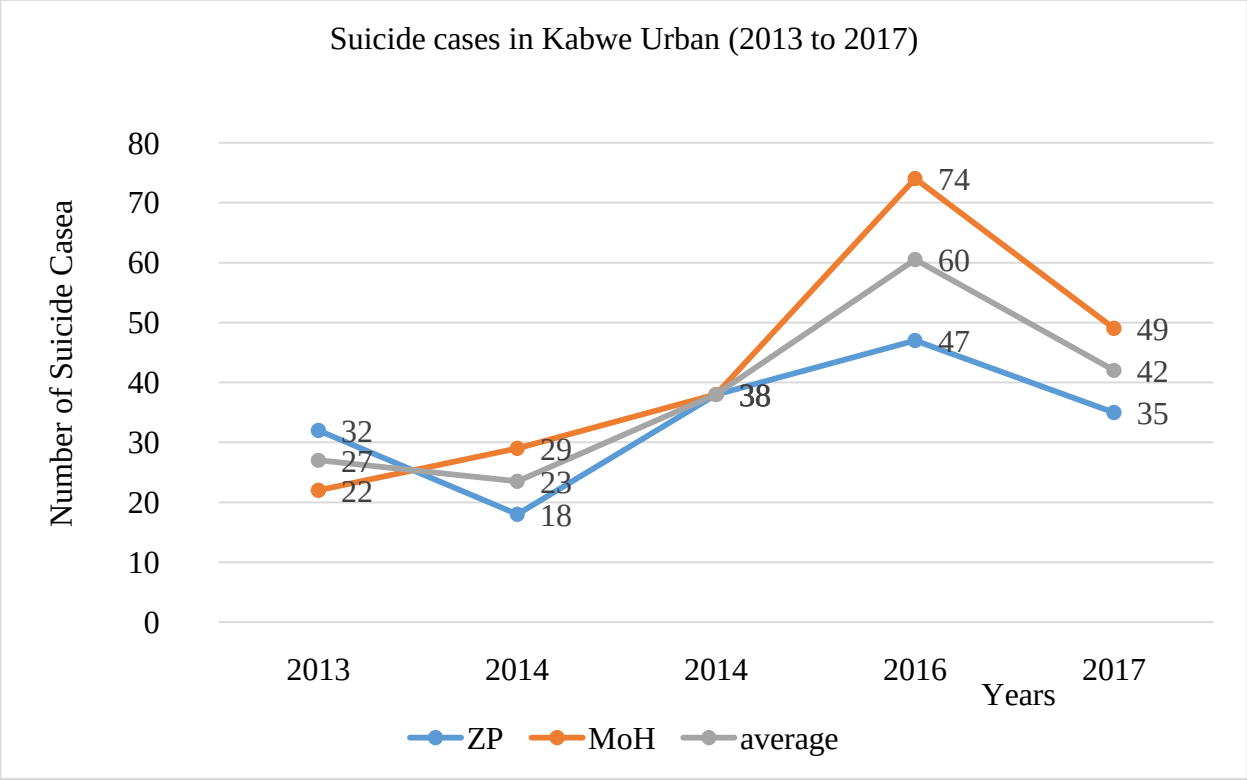

Figure*4* Suicide cases in Kabwe between 2013 to 2017 Source: Field Data

According to the Zambia police and MoH though the suicide rate number between the specified periods do not tally due to various reasons attributed to poor data handling, not following right reporting procedure among others. The research had to find the average of the suicide rate experienced from the two different institutions. It is important to note that the suicide rate were recorded as 191 cases from 2013 to 2017. This trend shows that while there have been some fluctuations, the suicide rate does not appear to be decreasing. The results also indicated that the ratio of male to female suicide rates in Kabwe has been significantly and constantly higher for men than for women over the past five years. An all-time high of 3:1 was recorded in 2014.

Attempted suicides in Kabwe urban (2013 to 2017)

Year/Source	**2013**	**2014**	**2015**	**2016**	**2017**
MoH	57	71	38	62	40
ZP	42	32	17	47	29

Table 2 Attempted Suicide Source: Field Data

Figures on attempted suicide were obtained from the MoH (absolute numbers, disaggregated by sex) and ZP (records disaggregated by age and sex but incomplete) for 2013 to 2017, as seen in Table 3. The differences noted between these two sources (on a ratio of 1:2 at times) are even more striking mainly because significantly less attempted suicides are reported to the police. The researcher also found out that, figures for attempted suicide refer to the number of attempts themselves, not to the number of individuals who make those attempts.

Age Group	**Male Cases**	**Female Cases**	**Total No. of Cases**	**Percentage (%)**
6 to 17	6	5	11	**5.76%**
18 to 40	71	31	102	**53.40%**
41 to 55	32	24	56	**29.32%**
Above 56	12	10	22	**11.52%**
Grand total	**121**	**70**	**191**	100

Table 3 Age group and sex of suicide victims Source: Field data

As it can be seen from table 4.1, the most at risk age groups appear to be those aged 18 to 40 with 53.40 % of all cases recorded, followed by those aged 41 to 55 (29.32%) and above 56 (11.52%) and the least 6 to 17 (5.76%). 57% of all male suicides were found in age group of 18 to 40, implying that males in that particular age-group are potentially more at risk. Among females those in the age group 18 to 40 (57.14 %) and 41 to 55 (26.37 %) were found to be the most at risk. The results also indicated that the ratio of male to female suicide rates in Kabwe has been significantly and constantly higher for men than for women over the past five years. An all-time high of 3:1 was recorded between the ages of 18 to 40.

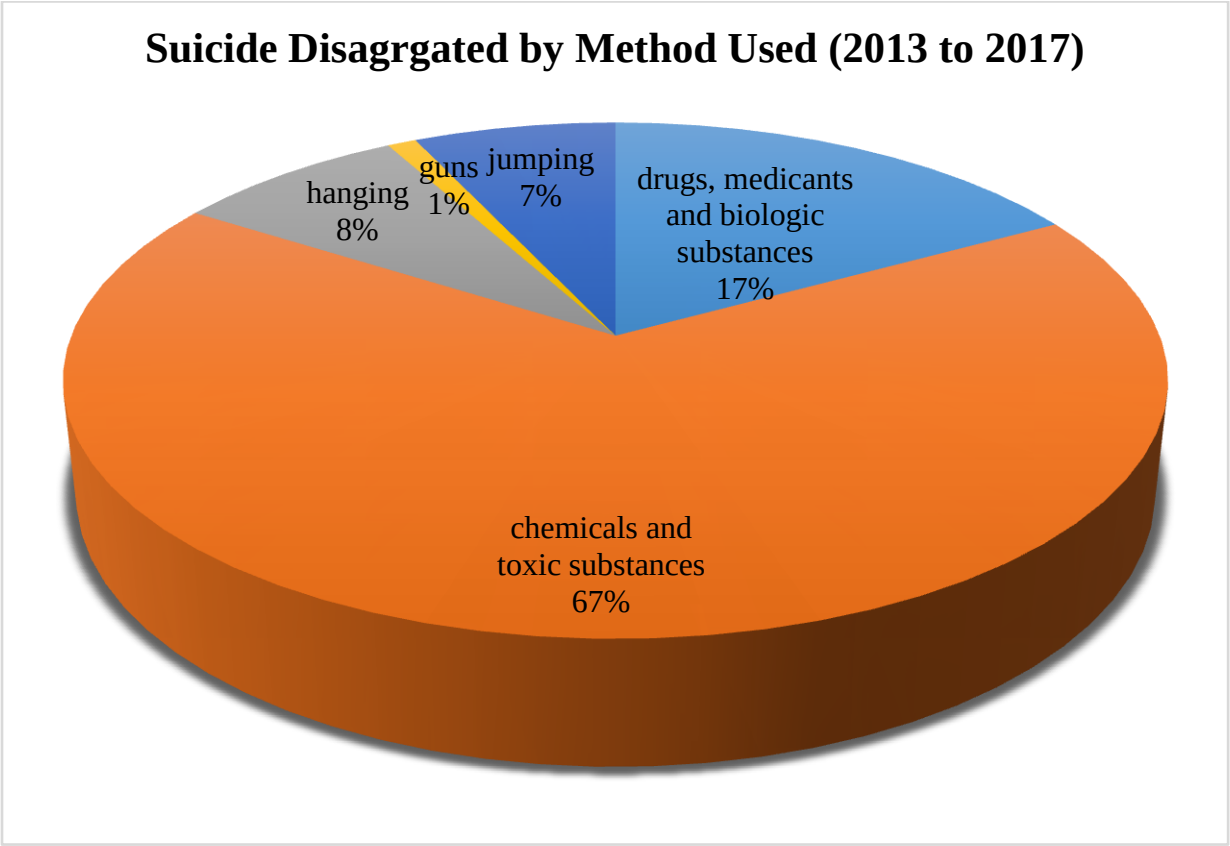

Figure 5 Suicide Method Used

Figure 4 shows suicides disaggregated by the methods used during the 2013-2017 period. Hence, out of the 191 cases of completed suicides recorded, ingestion of chemicals and toxic substance appears to be the most popular method with 127 cases, representing 67% of all cases recorded by

the ZP. Drugs medicants and biological accounted for only 32 cases representing 17% of all cases 191 cases. Death by hanging (8%), was actually preferred to jumping and use of guns.

4.2.1 Perceived Factors Causing Suicides in Kabwe

There are various "perceived" causes of completed suicide since victims cannot answer questions and the information gathered from the respondents cannot be expected to be a 100% objective and accurate. This is in part due to both the retrospective, highly subjective and emotionally charged information being requested.

The researcher wanted to find out the cause of Suicide cases in Kabwe Urban, and the simple t test was use so as to determine the most common perceived casual facto of suicide. The simple t test simply measures the means of the responses. The results indicate that the major casual factors is abuse of drugs with mean of 36, seconded by Poverty 31. Marital disputes was third with mean of 26, lack of counselling services with 15, unemployment 13 and lastly depression at 10 respectively. Substance abuse is on the rampant in the country and there is need to curb the vice.

Perceived causes of suicide in Kabwe (2013 to 2018)

Gender of respondents		Unemployment	Poverty	Depression	lack of counselling services	Abuse of drugs	Luck of family support	Marital disputes
Male	Mean	13	21	08	21	36	21	13
	N	39	39	39	39	39	39	39
2	Mean	14	37	12	12	36	05	34
	N	59	59	59	59	59	59	59
Total	Mean	13	31	10	15	36	11	26
	N	98	98	98	98	98	98	98

Table 4 Perceived Causes of Suicide Cases in Kabwe Urban *Source: field data*

The researcher wanted to find out the perceived causes of suicide cases in Kabwe Urban, and the simple t-test was used to determine the most common perceived casual factors of suicide. The simple t-test simply measures the means of the responses. The results indicate that the major

perceived casual factors are abuse of drugs with mean of 36, seconded by Poverty 31, Marital disputes was third with mean of 26, lack of counseling services with 15, unemployment 13 and lastly depression at 10 respectively.

Suicide causal factors according to MoH and ZP (2013)

	MoH	Zambia Police	
1.	Family disputes	1.	Marital/family disputes
2.	Financial Problem	2.	Depressive illness
3.	Drugs and alcohol	3.	Alcohol and drugs
4.	Unemployment	4.	Poverty
5.	Drunken State	5.	To frighten parents/partners
6.	Epilepsy	6.	Pregnancy (1st attempt)
		7.	Alleged rap
		8.	Lack of hope in a better future/change in current situation

Table 5 Suicide Causes According to MoH and ZP Source: Field data

4.2.2 Impacts of suicide

Impacts of suicide are shown in the table below and descriptive statistics were used.

Impacts of suicide by gender

Gender Of Respondents		Health impairment	Increase In Vulnerability Among Children	Victimization Of Survivor's And Family members	Loss Of Human Resource	Cost Of Burden On Government/Family	Moral Decay
male	Mean	.13	.21	.08	.36	.21	.13
	Std. Deviation	.339	.409	.270	.486	.409	.339
female	Mean	.17	.46	.12	.36	.05	.34
	Std. Deviation	.378	.502	.326	.483	.222	.477
Total	Mean	.15	.36	.10	.36	.11	.26
	Std. Deviation	.362	.482	.304	.482	.317	.438

Table 6 Impact of Suicide Source: Field data

4.2.3 Types of Support offered to Suicide Victims and Family Members

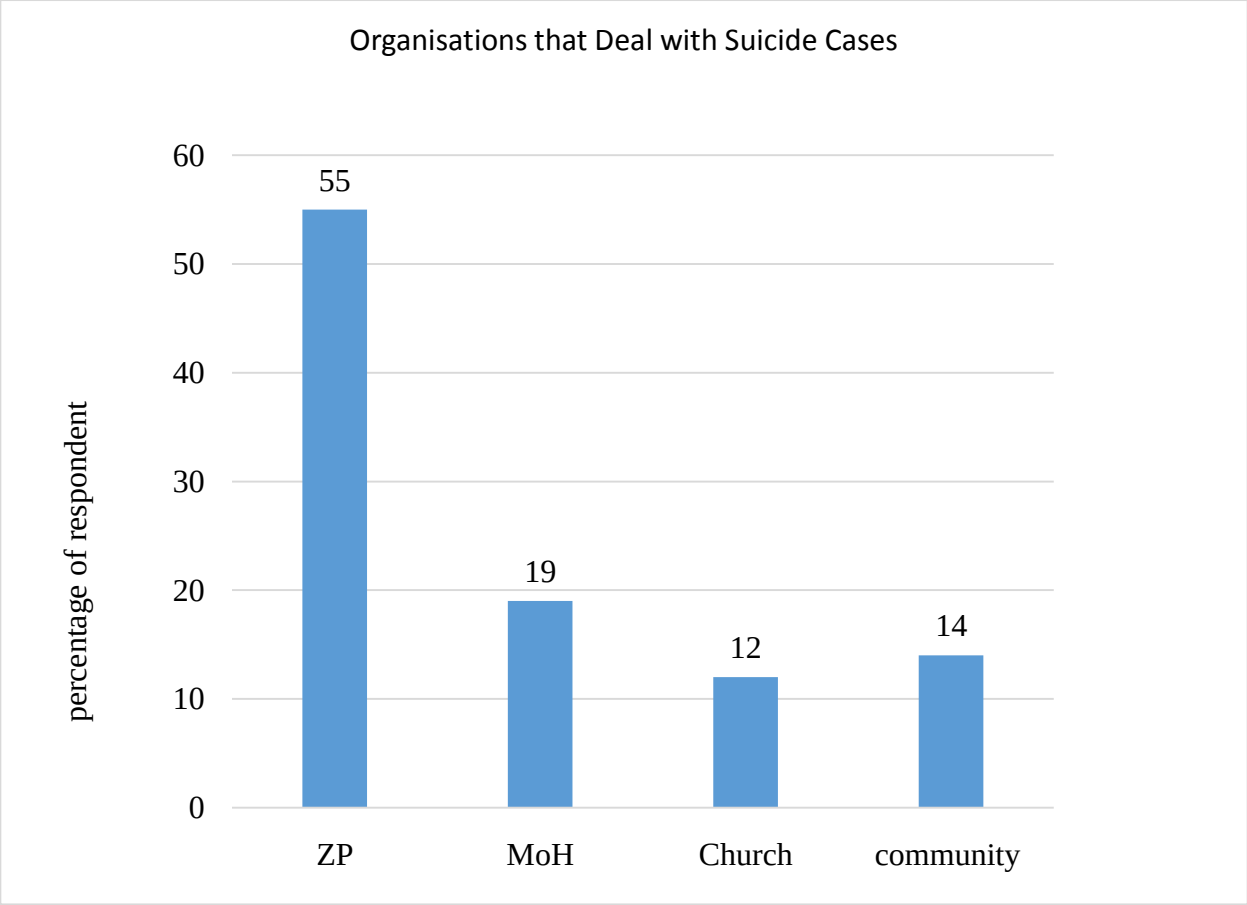

Figure 6 Organisations that deal with suicide Source: field data

Respondents were asked to name the Organizations that deal with suicide cases. The responses show that Zambia Police Services (Victim Support Unit and Criminal Investigations Division sections) were known to handle suicide cases at 55 percent of the total responses, health centers at 19 percent. Both Zambia Police Service and health centers operate within their mandate. Community Leaders like section chairpersons, councilors and elders are some of the people involved and this was represented by 14 percent. Churches were also seen to play an important part and were acknowledged by 12 percent of the respondents.

Respondents were asked if there are any other organizations in their area that offer support to victims of suicide and family members. The results are presented below:

Awareness of institutions that offer support to victims and family members

	Awareness	Respondents	Mean	Std. Deviation	Std. Error Mean
Organisations in your area that offer support to suicide victims , other than government institutions	Yes	39	1.95	.223	.036
	No	59	1.68	.471	.061

Table 7 Organisations that support Suicide Victims other than Govt Institutions Source: Field data

Results indicated that the majority of the respondents (59) with standard deviation of 47 are not aware of Organisations that offer support to suicide victims and family members, other than government institutions. 39 respondents with standard deviation of 22 were aware.

Respondents were asked to name the institutions that offer support to victims and family members:

Organization		Frequency	Percent
	Church	32	82
	Community	20	51

Table 8 Organisations Source: Field data

The church offers support to suicide victims and this was acknowledged by 82 percent of the respondents, and the community by 51 percent. The results indicated that there are few known institutions in Zambia that offer services to suicide victims, thus more stakeholders are required apart from government efforts.

Types of support offered	Count	Percentage
counselling	34	86%
Financial and material help	5	14%

Table 9 services Offered *Source: Field data*

86 percent of the respondents said that counseling services are offered by institutions that handle suicide cases, 14 percent financial and material support. The results imply that churches and community members play a vital role in suicide cases.

Services offered by institutions

Institution	**Services**
Zambia Police	1. Transportation of victims body
	2. investigations
	3. counselling
Ministry of Health (health centres)	1. counselling
	2. treatment
	3. postmortem
Churches	1. counselling 2. financial and material help
community	1. counselling 2. financial and material help (where possible)

Table 10 Support Rendered by the Institutions Source: Field data

Each institution has its role to play in commissioning of suicide. The common support rendered by the institutions is counseling mainly to survivors, and those contemplating suicide. On the other hand there are very few known institutions that offer services to suicide victims. Chainama clinic is the only psychiatric clinic in Zambia that offers treatment of suicide victims. Some of

the types of psychiatric illnesses treated at this institution include: depression, nevrosis, anxiety and psychomatic disorders, organic illnesses (including epilepsy); schizophrenia and other personality disorders, as well as substance abuse which this study found to be significantly correlated to perceived suicide causes.

CHAPTER 5

DISCUSSION OF THE RESULTS

5.1 Introduction

This chapter provides a discussion of the results of the analysis with respect to the theoretical framework of the study, draws conclusions based on these findings, and offers recommendations for application of the research and further study. The discussion is organized into three sections. Each of the first three sections addresses a research question or group of research questions.

5.2 Suicide Cases

Suicide cases were recorded as 191 cases from 2013 to 2017 in Kabwe Urban. This trend shows that while there have been some fluctuations, the suicide rate did decrease but increased. The results confer with findings from WHO (2014) data published in 2014 indicates that suicide rates in Zambia reached 1,346 or 0.99 percent of total deaths every year, ranking it at number 34 in the world. Majority of the victims (58 %) are in their productive age (18 to 55) and the majority were males (53 %). Wasserman and Jiang, (2005) carried out a study and revealed that Suicide occurs throughout the lifespan and is the second leading cause of death among 15-29 year olds globally," According to Arat and Wong, (2016). Males engage in much more serious methods of suicide than females, leading to a higher completed suicide rate.

5.3 Perceived Causes of Suicide in Kabwe Urban

Family and marital disputes were leading causes of suicide in Kabwe urban. Family and martial disputes according to Larson (2002) makes victims experienced feelings of rejection by their partners and their immediate environment, as well as feelings of loneliness, unloved and unwanted. Results are supported by Mclean (2003) who found out that Frequent quarrels in the family often associated with verbal and physical violence, alcoholism, separation of parents, divorce leading to dissolution of the family, were seen as playing an important role in suicide.

Poverty, appeared to contribute to suicidal behaviour in Kabwe and this may be due to economic hardships of Kabwe since the closure of the mine in 1994. Larson et al. (2002) state that increasing economic stratification serves to further hinder disadvantaged people in securing equal access to resources and opportunities in preparing themselves especially for young people.

According to Diekstra and Garnefski (1995) unemployment of parents, especially fathers, is significantly related to the occurrence of depression and suicidal behaviour.

The abuse of alcohol and other substances was listed as a risk factor in suicidal behaviour, which indirectly predisposes the people towards self-destructive behaviours (Gilliland and James, 2001). Results from the research indicated that alcohol and drug use were causes of suicide in Kabwe urban. A national youth risk survey established that Zambia registered the highest percentage of youths (71.5%) that had previously used alcohol (Reddy et al., 2012). Another survey, the Global School based Student Health Survey carried out by WHO (2013), using a sample of 2, 278 youths from Zambia, showed the prevalence of lifetime drug use (i.e. using drugs, such as Marijuana and Glue, one or more times during their life) was 6.4%. Male (9.3%) were found to be significantly more likely than female students (3.7%) to report lifetime drug use. Of those students who reported lifetime drug use, 44.8% did so for the first time, before the age of 18.

One of the major health risks at present among the younger population group is HIV/AIDS. Although the direct effects of HIV/AIDS have a much smaller impact on adolescents, this impact is projected to significantly rise (Wilburn and Smith, 2005). The research indicated that most people in Kabwe when they test HIV positive, they tend to think life is not worth living and end up committing suicide. Officers from counseling sections of Kabwe health centres noted that most people tend to say they will hang themselves once found with the HIV virus.

5.4 Impacts of suicide cases in Kabwe urban.

The consequences of suicidal behaviour may differ depending on whether the attempt made resulted in death or not. In broad terms, the consequences of attempted suicide appear to be more concentrated on the surviving victim. The consequences of successful attempts, or completed suicides, on the other hand, affected survivors the most.

The substantial economic burden of suicide attempts significantly affects any society. The research revealed that it was costly for government in commission of suicide. The cost burden can be in the form of investigation, transport, treatment and others. For example, Butchart, (2008) reveals that the direct economic costs to society may include cost of police or coroner investigations. He further adds on that Suicide costs the United States of America approximately

$34.6 billion a year in combined medical and work loss costs. For this reason, the costs associated with suicide and suicide attempts cannot be ignored (Platt et al., 2006). Direct costs to society are health care costs, in instances where these costs are incurred by the government. Indirect costs to society are productivity losses as a result of disability or premature death of those who committed suicide.

In the cases of completed suicides direct costs incurred by survivors are usually limited to the price of a funeral. On the other hand, post suicidal attempt treatments are associated with low to high costs depending on the severity of the uncompleted act and would usually be incurred by family and relatives as opposed to the victims of the attempt. As pointed by the MRC (2011) This would not be enough to cover direct medical and pharmaceutical costs, as well as indirect costs, such as loss in quality of life of relatives, parents as a result of having to look after someone in need of constant care.

While information on the extent of the stigmatization and shame experienced by those associated with suicide cannot be found for the Zambian context, its presence can be felt in the statistics on completed suicides and attempted suicides. Rejection and avoidance by friends and by the society is feared, since victims of suicide attempt are often regarded as weak and selfish individuals instead of an individual in need of medical care. Family members and close friends of the victims are deeply impacted by the tragic event, and experience a range of complex grief reactions including, guilt, anger, abandonment, denial, helplessness, and shock (Jordan, 2001; AAS, 2008), which often lead to psychological stress. Cerel (2008) also reveals that Survivors may face the added psychological stress of societal blame and reduced social support (Cerel et al., 2008). During the bereavement process which is often painful, psychological help and support are highly recommended. Stigmatization, thus, instigates a feeling of shame which is experienced by both suicide victims, family of victims and further prevents the measurement of the problem by those in charge of treatment and prevention. This, in turn, is likely to reduce the effectiveness of policies and programmes on suicide.

5.4 Support offered by various stakeholders to both families and victims of suicide cases

The research revealed that there is low stakeholder involvement in offering support to both suicide victims and family members in Kabwe, apart from Zambia Police, MoH, the church, and

to a lesser extent the community. These institutions basically offer counselling and treatment MoH (2014), health centers and Zambia Police are the ones involved in handling suicide cases which is within their mandate. There are no NGOs on record who support/help suicide related issues in Zambia. The community and church offer counseling to victims and family members and to some extent financial and material help. The results are supported by Surgeon General of the National Action Alliance for Suicide Prevention, (2012) found out that by connectedness to individuals, family, community, and social institutions, suicide victims and family members have been aided. Butchart (2008) in his study of estimated cost of suicide behaviour, found that supportive church and community environments have helped suicide victims and families in coping and problem solving.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter presents an overview of some key issues discussed in the study as well as puts some recommendations with solutions suggested by the respondents. The conclusion gave a summarized overview of the entire research study, while the recommendations provided the suggestions and solutions to various stakeholders on what should be done to address the challenges of suicide prevalence cases in Kabwe urban.

6.2 Conclusion

The research revealed that mainly social and economic factors such as drug abuse especially excess drinking of alcohol among the most productive age groups, marital disputes and lack of financial support exacerbate suicide risks in Kabwe urban. Psychiatric disorders including a vicious cycle of depression, self-focus and self-blame, depressed mood, cognitive and behavioural consequences and negative experiences all contributed to suicidal behaviour.

On impacts of suicide, it was noted that following a suicide attempt, victims suffered from acute trauma and since their mental health impairment was further amplified, a relapse is possible. Evidently, the need for both emotional and psychological support is crucial after such an event. The aftermath of a suicide attempt or a completed one can be particularly devastating for relatives and friends left behind. The findings revealed that in cases of completed suicide, the main consequences on family members and friends include victimization by society and financial burden, which in some cases has led to shattered families. This can, in turn, give rise to serious psychological problems, including depression and post-traumatic stress disorder. It is, therefore, unequivocal that psychological help be provided as a natural recourse to close family/friends circle of suicide victims, especially parents and siblings, after such an event.

Institutions that offer support and services to suicide victims are the Zambia Police, MoH, churches, and community. There is no known NGO/s that are/is involved in helping out in suicide related.

6.3 Recommendations

This section provides some pointers towards areas of intervention in order to address the phenomenon of suicidal behaviour in Zambia. Suicide prevention can be understood in terms of the different types of risk factors which, when acting singularly and/or collectively, may lead an individual, on the pathway to suicide. Thus, it seeks to decrease these risk factors while increasing the protective factors that support and protect individuals from suicide.

1. Local prevention strategies which are people centered and may aim to increase access to healthcare, promote mental health, reduce harmful use of alcohol, limit access to the means for suicide and promote responsible media reporting.

2. Target vulnerable groups such as persons who have experienced a trauma or abuse, among other tragic incidents, by training personnel who assist the vulnerable and by offering services such as counseling and help lines. This is to ensure that the vulnerable individuals are supported and connected during those difficult times, through the promotion of strength and resilience. The result could be a decrease in the number of suicidal behaviours.

3. Adopting a multi-sectoral approach that allows stakeholders in the health, social welfare, education, youth and gender sectors, among others, to share best practices and collaborate.

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LIST OF APPENDICES

Appendix i Questionnaires Administered to Institutions

Introduction

This questionnaire is administered to solicit your views on the factors influencing the prevalence of suicide cases in Kabwe urban from the period 2013 to 2017.This is solely for academic purposes and all information obtained will remain confidential.

Township

Age

Sex

Occupation

IDENTIFICATION DATA

DEMOGRAPHIC DATA

SECTION A. DEMOGRAPHIC DATA. (TICK ONE CORRECT ANSWER ONLY IN THE BOX PROVIDED AND EXPLAIN WERE NECESSARY)

1. What is your gender?

   (A) Male (B) Female

2. How old are you?

   (A) Below 15 years (B) Between 15 – 30 years (C) Between 31 - 45 years

   (D) Between 46 – 60 years (E) Above 65 years

3. What is your marital status?

   (A) Married (B) Single

4. What level of education have you attained?

   (A) Primary (B) Secondary (C) Tertiary (D) Never attended any school

5. What is the total number of people in your household?

   (A) Below 5 (B) Between 5 and 10 (C) Between 10 -15

SECTION B: PRELIMINARY QUESTIONS

6. Have you ever heard of anyone committing suicide act in Kabwe urban?

(A) Yes (B) No

7. Do you know anyone who might have attempted or committed suicide in your area?

(A) Yes (B) No

8. How would you rate suicide cases in Kabwe urban between 2013 to 2017?

(A) Low (B) Medium (C) High (D) Very High

9. Do you have any member of your family, organization or community who might have committed an act of suicide?

(A) Yes (B) No

10. How many people committed suicides in your area from 2013 to 2017?

(A) 1 to 10 (B) 11 to 20 (C) 21 to 30 (D) 31 to 40

(E) Above 40

11. Which age group of people is commonly involved in suicide acts?

(A) 10 – 25 (B) 26 – 51 (C) Above 52

12. What was your relationship to the deceased?

(A) Relative (B) Client (C) No relation

13. How long did you know the deceased person?

(A) Less than six months (B) between six months and two years (C) More than two years

14. What was the behavior of the deceased person before committing suicide?

(A) Was sick (B) Talked about committing suicide (C) was Not Sick

15. What do you think are the causes of suicide cases in Kabwe Urban?

……
……
……

16. Can poverty be a cause for someone to commit suicide?

(A)Yes (B) No

17. Explain briefly:

……
……...……
……

18. Do you think depression is the cause of committing suicide?

(A)Yes (B) No

19. Explain according to your own views on the above question:

……
……..……

20. Can lack of counselling services to depressed persons lead to committing suicide?

(A)Yes (B) No

21. Does the increase in the number of suicide cases in Kabwe urban contribute to the raise in poverty levels?

(A) Yes (B) No

22. Can people who lack family support commit suicide?

(A)Yes (B) No

23. Explain your answer briefly:

……
……

24. Does abuse of drugs contribute to suicide acts in Kabwe urban?

(A)Yes (B) No

25. Explain your answer and state which type of drug(s) are commonly abused:

……

……

26. Are there any organizations in your area that deals in suicide cases?

(A)Yes (B) No

27. Name two or three of them:

……
……

28. Explain further your views:

……
……

29. Explain how suicide affect productivity in households?

.....
.....

30. Are there any awareness programmes on suicide in your area?

(A)Yes (B) No

31. In your own opinion, how do you describe the knowledge level of people on suicide cases?

(A)Low (B) Poor (C) High (D) Very high

32. Explain the intervention methods you think various stakeholders should put in place to carb suicide acts in Kabwe urban.

……
……
……

33. Suggest what you think should be done on people who attempt to commit suicide acts:

……
……

34. In your own opinion what implications do you think suicide cases have in Kabwe?

……
……

35. How is the impact on productivity on households affected by cases of suicide?

(A) Low (B) Medium (C) High (D) Very high

36. How do you rate the cost implications on persons who attempt suicide?

(A)Very expensive (B) Expensive (C) less expensive (D) No cost

37. What health implications are on persons who attempt suicide acts?

……
……

38. Does the raise in suicide cases contribute to moral decay in society?

(A)Yes (B) No

39. Explain according to your understanding on the above question:

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…….

Appendix ii Questionnaire for the Family Members of The Victims

This questionnaire is administered to solicit your views on the factors influencing the prevalence of suicide cases in Kabwe Urban from 2013 to2017. This is solely for academic purposes and all information obtained will remain confidential.

SECTION A. DEMOGRAPHIC DATA. (TICK ONE CORRECT ANSWER ONLY)

1. What is your gender? Put boxes for ticking

   (A) Male (B) Female

2. How old are you? Put boxes for ticking

   (A) Below 15 years (B) Between 15 – 30 years (C) Between 31 45 years

   (D) Between 46 – 60 years (E) Above 65 years

3. What is your marital status? Put boxes

   (A) Married (B) Single

4. What level of education have you attained?

   (A) Primary (B) Secondary (C) Tertiary (D) Never attended any school

5. What is the total number of people in your household?

   (A) Below 5 (B) Between 5 and 10 (C) Between 10 -15

SECTION B

1. Impact of suicide cases in Kabwe urban.

2. Factors leading to the commission of suicide cases in Kabwe Urban.

3. Support off victims of suicide in Kabwe Urban.

6. How long have you lived in this township / area?

(A) Less than 3 years (B) Between 4 – 7 years (C) Between 8 – 12 years

7. What is your occupation or what do you do for your living?

(A) Formal work (B) Informal work (C) Don't work

8. You need one question to establish relationship to deceased and another to establish number of years the respondent has known the deceased!!!

SECTION B. DETERMINIG SUICIDE PREVALENCE RATE

1. Have you ever heard of anyone committing suicide in Kabwe urban?

(A) Yes (B) No (C) None of the above

2. Do you know anyone who might have attempted or committed suicide?

(A) Yes (B) No (C) None of the above

3. How would you rate the suicide cases in Kabwe Urban between 2013 and 2017?

(A) Low (B) Fair (C) High (D) Very high

4. Do you have any member of your family, organization or community who might have committed suicide?

(A) Yes (B) No (C) None of the above

5. How many people committed suicide cases in your area each of the years from 2013 to 2017?

(A) Between 1 to 10 (B) 11 to 20 (C) 21 to 30 (D) 31 to 40 (E) Above 40 people

6. Which age group of people is commonly involved in suicide acts?

(A) 10 – 25 (B) 26 – 51 (C) 52 and above

SECTION C. FACTORS OF SUICIDE CASES

1. Do you think there are any reasons advanced for people to commit suicide acts?

(A) Yes (B) No (C) None

2. What are the common reasons advanced by people who commit or attempt to commit suicide?

(A) Illness (B) Drug abuse (C) Family neglect

3. What type of instruments or style do suicide takers use?

(A) Hanging by rope (B) Poisoning (C) Throwing themselves on dangerous points

4. In your own understanding and opinion, what factors do you think suicide takers advance before committing the actual act in Kabwe Urban?

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5. Briefly write or describe the people who commit suicide acts in your own opinion:

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6. Briefly write down two effects of suicide to affected families/community:

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SECTION D. (AWARENESS PROGRAMMES AND KNOWLEDGE GAP)

1. Is there any organization in your area that deals in suicide cases?

(A) Yes (B) No (C) None of the two

2. Name two or three of them:

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……
……
…….

3. Are there any awareness programs on suicide acts in your area?

(A) Yes (B) No (C) None of the two

4. Do you have any member of your family or community that might have committed suicide acts before?

(A) Yes (B) No (C) None of the two

5. In your own opinion, how would you describe knowledge level of people on suicide cases or acts in your area?

(A) Low (B) Poor (C) High (D) None of the mentioned

6. Suggest what you think should be done on people who attempt to commit suicide acts:

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Appendix iii Interview Guide

SECTION A: HOUSEHOLD INFORMATION (TICK ON ONE ANSWER PROVIDED).

I am Simutengu Davy a student with Mulungushi University based in Kabwe Town. This questionnaire is administered to solicit your views on the factors influencing the prevalence of suicide cases in Kabwe Urban from the period 2013 to 2017.This is solely for academic purposes and all information obtained will remain as such.

INSTRUCTIONS: Tick (✓) one possible answer and write short answers in the spaces provided.

SECTION A. HOUSEHOLD INFORMATION (TICK ON ONE ANSWER ONLY).

1. Gender

   (a) Male

   (B) Female.

2. Age

(A)Below 15 years (B) Between 15 to 30 years (C) Between 30 to 45 years (D) Between 45 to 60 (E) Above60 years.

3. Education standard/level

(A) Primary (B) Junior secondary (C) Senior secondary (D) Tertiary (E) Never attended school.

4. What is the total number of household members? (A)Below 3 (B) Between4-6 (C) Between7-9 (D) Above 10

5. How long have you lived in this township?((A)Below 3 years (B)4-5 years (C) 6-10 years (D)Above 11years.

6 .Have you ever heard of anyone committing suicide in your area? (A) Yes (B) No (C) None of the above.

SECTION B: TICK OR GIVE A BRIEF EXPLANATION ON THE QUESTIONS.

7. Would you be in a position to list the number of victims that committed suicide in your area per year? If yes or no, specify

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8. Are there any reason advanced why people commit suicide? (A)Yes (B) No (C) None of the above

9. Briefly indicate some reasons advanced by suicide takers you know.

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…….

10. How would you describe your rate of suicide cases in Kabwe urban between 2013 to 2017?

(A) Low (B) Fairly increasing (C) high (D) very high.

11. Explain briefly how you would describe suicide rate in Kabwe urban between 2013to2017?

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12. Do you think suicide cases have any adverse effects to the affected families, community and the entire town? (A) Yes (B) No (C) None of the above.

13. Briefly explain the effects of suicide to affected families?

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14. Is there any organization in your area that deals with suicide cases? (A)Yes (B) No (C) None of the above.

15. Write down some of the Organizations that deal with suicide cases you know in your area.

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16. Do you know anyone who might have committed suicide in your area? (A) Yes (b) No (C) none of the above

17. In your own opinion, how would you describe the people who commit suicide in your area?

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18. Are there any awareness programme on suicide acts in your area? (A) Yes (B) No (C) None of the above

19. What would you suggest should be done on suicide Acts?

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20. Do you think there are any reasons advanced by people who commit suicide act?

(A) Yes (B) No (None of the above

21. Write briefly the common reason you think are advanced by suicide takers before they die?……

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